Themes and Narratives Relating to Faith and Healing in the Area of Durban, South Africa.

Natalie Strohmyer
SIT Study Abroad

Follow this and additional works at: https://digitalcollections.sit.edu/isp_collection
Part of the Medicine and Health Sciences Commons, and the Religion Commons

Recommended Citation
https://digitalcollections.sit.edu/isp_collection/1502

This Unpublished Paper is brought to you for free and open access by the SIT Study Abroad at SIT Digital Collections. It has been accepted for inclusion in Independent Study Project (ISP) Collection by an authorized administrator of SIT Digital Collections. For more information, please contact digitalcollections@sit.edu.
Themes and Narratives Relating to Faith and Healing in the area of Durban, South Africa.
Abstract

This project will examine the integration of faith in the healing process through interviews to discover emerging themes. These themes will use narratives, secondary sources, and analysis to delve into some of the questions. Caring for the entirety of a patient is an important role of healthcare and examining the role of faith in healing can illuminate another aspect of the doctor-patient relationship.

Faith is very personal and I am interested in looking at the different effects that this has on a person in regards to their outlook on healthcare and the role of the healthcare professional. I would like to explore how the Ukukhanya Life Care Centre is integrating faith in the healing process, and the results it has. I will take multiple perspectives into account including the perspectives of those working at Ukukhanya, those attending the Life Care Centre, and medical professionals to obtain a blend of opinions. However, given the time and content I will be speaking with those coming from a Christian perspective and this needs to be noted. I will be using interviews, guided discussions, focus groups, natural conversation, and possibly surveys to collect data. The time constraints and abstract topic will not yield generalizable data, but can be used to further the discussion on spirituality in healing and stimulate discussion of a holistic approach from a primarily Christian perspective.
# Table of Contents

Abstract 2

Table of Contents 3

Acknowledgments 4

Introduction 4

Methodologies 6

Literature Review 10

Findings and Analysis 12

  Faith and Healing 12
  Ways Faith is Integrated into Healing Facilities 18
  Faith Healing 24
  What Happens if Someone is Not Healed? 33
  Concerns with Faith and Healing 40
  Faith and Healing from the Perspective of Medical Professionals 46

Personal Thoughts and Lessons Learned 52

Final Thoughts 53

Bibliography 55

Appendix 1: Interview Questions 58

Appendix 2: Consent Form 59

Appendix 3: Statement on Ethics 60

Appendix 4: Human Rights Research 62
Acknowledgments:
Above all I would like to thank my family and close friends for all of the support and love that I have received throughout this process. I have been so blessed and really couldn't feel more blessed. I would also like to thank Penny Dugan for all of the time and effort she put in with me inside and outside the Ukukhanya Life Care Centre. Her compassion and care really changed the way that I look at this topic. I would also like to thank those who I interviewed. I was welcomed by all those I spoke with, and genuinely loved hearing all of their stories and opinions. I would like to thank the School for International Training, my advisor Dr. Charles Chouler, and my professors Clive Bruzas and Zed McGladdery. Lastly, I would like to thank Katie Cicollelo, Allison Kroll, Jessie Friedmann, Megan Odenthal, and Mia Tabberson. I could not have done this semester without you all and I truly believe that my real learning occurred through my relationships with you. I will take pieces of you with me beyond this trip and hope that I have left pieces of myself with you.

Introduction:
This project will focus on the integration of faith and healing, the benefits and the concerns from a Christian perspective. A lot of these questions are not going to come to any traditional form of conclusion. But they are all important components of what my independent study will consist of. I was able to see where my learning and conversations took me in discovering not only what those I came in contact with think about the importance of this integration, but what I think about it. How I can take what I am learning and implement it in my own life. The
information that I received will not be able to be used to draw generalization. It will be specific to those that I spoke with, the township, and organization that I am worked with. I do not think that since generalizations cannot be drawn, the information, opinions, and personal stories are any less important. In a world of science, research, and answers the integration of something so abstract as religion and medicine struggles to find solid conclusions, but stimulates debate. Even if I cannot change the world of medicine, I hope to add to the commentary of what caring for the entirety of a patient means, and if including faith can help to provide the best possible care. I hope to provide a foundation for more questions to be asked and explored, both for others and myself. As said by Leonard Cohen in his song Anthem, “there is a crack in everything, that’s how the light gets in.” (Cohen 1992)

The integration of faith and healing is not a new concept and was around long before the miracles of modern medicine. In order to really understand where faith and healing stand now, its important to understand the historical and biblical context on faith and healing. After all, modern medicine is just that, modern, what was done before its origin? Many faiths and cultures can draw elements of faith and healing from its history, but I will focus specifically on Christianity as it pertains to this paper. Healings are first spoken of in the Bible, specifically miracles, in the New Testament with Jesus. There are countless examples of miracles throughout the Gospels, in her book Healing in the History of Christianity by Amanda Porterfield, “Almost a third of Mark is devoted to accounts of miracles, including half of all verses in the opening ten chapters.” (Porterfield, 2005, 32) These miracles are primarily healings and Jesus dealt largely with exorcisms and healing the sick. Later
on in the New Testament, after Jesus’ death, there is the story of the Pentecost. In the book of Acts the Holy Spirit comes upon the disciples and they are given the power to also perform various healings and miracles. This story is found in Acts Chapter 2. It is this anointing and belief in the power of healing through faith that stood as part of the foundation of Christian missionaries. Porterfield says, “Early Christians nursed the sick to emulate the ministry of Jesus, and to express their faith in the ongoing healing power of Christ.” (Porterfield, 2005, 47) This thought process was still seen as the root of many of the motivations from those who are Christian and in medicine. In his paper, Epidemics, Networks, and the rise of Christianity, Rodney Stark says, “Christian values of love and charity were translated into practices of social service in the times of crisis, thereby creating a network of medical care.” (Stark, 1992, 2) Christianity has long had a history of using faith and healing in combination, and this thought still exists for some despite the medical advances that have been made. It seems as though the separation of faith and healing has created a rupture where some still strive to reach beyond what medicine is capable of.

Methodologies:

In going about trying to understand the discussion of the integration of faith in healing it was first important to understand where I stood on the topic. I am a strong Christian and perceive the world through this paradigm. I am also a Religious Studies student while pursuing a future as a physician. All these components make the topic of faith in healing one that is close to my heart and that I wanted to learn more about through this project. I did not begin this project with the aim to prove or
disprove any of the topics that will be discussed, but to document particular opinions and dimensions on this topic from a Christian faith standpoint. Those who I spoke with and whose words helped to form my project all come from a Christian background and it is important to note that this project is not coming from an neutral viewpoint, nonetheless, these stories contain opinions and beliefs that are held and add to the ongoing discussion of the integration of faith in healing, its importance, its concerns, and its methods.

My starting point for getting into contact with people who would be open to this topic of discussion was by working at the Ukukhayna Life Care Center from April 8-April 19, 2013. The mission statement of this organization is, “showing the love of Jesus to those affected by HIV/AIDS.” (Missions 2009-2011) The organization serves the township of Ntuzuma in Durban, South Africa. The Ukukhanya Life Care Centre is directed by Penny Dugan and I primarily worked with her over the three week span. The mission of this organization is to extend the love of Christ to those in the community and provide an element of healing through the incorporation of faith. Spirituality and its role in healthcare is a growing field of research, and due to the abstract nature is difficult to generalize. However, it is the goal of this project to help stimulate further research and debate over a more holistic approach to healthcare. By volunteering with them I was able to meet people within and associated with the organization and form trusting relationships that led to the asking of my questions for this project.

These interviews form the basis of my data and were then used to discover certain themes that arose from the discussion of integrating faith in the healing
process. I performed a series of interviews that resulted in the 11 total, ranging from medical professionals, to members of the Ukukhanya staff, to members of the Ntuzuma community. Of these interviews, six produced solid usable data and I would like to give further background into these six interviews. It is important to note that the other interviews still provided intriguing information and opinions that are used, but for reasons such as language barriers do not make up the bulk of the data. The first interview took place on April 12, 2013 with Tyler Williamson. Tyler Williamson is a member of the Bethel School of Ministry and visited the Ukukhanya Life Care Centre to perform faith healings and offer prayer. The second interview took place on April 14, 2013 with Dr. Mitchell and his wife Marianne. He was a missions doctor and she was a nurse. They worked at Shongwe Mission Hospital for many years, as well as New Zealand, and the Department of Health. They come from strong missionary families and had a lot to share. Another interview took place that evening with Dr. Nishlan and Meryl Govender. They are both doctors currently working rurally, and are both Christians who worked closely with the Ukukhanya Life Care Centre. I was put into contact with them through the director Penny Dugan. On April 15, 2013 I was able to speak with Thembi Mkhize, one of the caregivers at the Ukukhanya Life Care Centre. She provided a unique perspective as both someone working in medicine, as well as being a community member. On April 16, 2013 I spoke with Anny Moys who worked previously with the HIV/AIDS program at McCord Hospital and has had experiences where she believes faith directly impacted her healing. On April 17, 2013 I spoke with Dr. Mannie, a physician at McCord hospital who is also a church elder and is involved in
a band that works with a group that holds services for prayer and healing. On April 18, 2013 I spoke with Penny Dugan, the director of the Ukukhanya Life Care Centre and heard how she began the organization, where the motives were, and her perspectives on faith and healing. Lastly, I spoke with Dr. Ter Haar on April 22, 2013. He came to South Africa with his wife from Holland and worked as a mission’s doctor in Transkei for 38 years. He is now retired and had some interesting perspectives and life experience in the integration of faith and healing.

The interviews that were conducted were set up in much the same way. After casual conversation and allowing for questions both directed at them and me, I asked for a personal background on who they were and what was important to them. This provided a foundation of trust to help make the conversation more comfortable. I then had a list of questions that I had already written and that followed along the same lines for everyone, except medical professionals who I also asked questions of regarding how having a faith impacted physician-patient interactions, and how having a faith helped them through daily struggles. From these questions and their answers I was able to probe into themes that emerged. These themes were based off of common answers, contradicting answers, and points of conversation that stimulated the most debate. These themes provide the headings for the various sections and are broken down to help make the information easier to understand and access. Included in each section is the primary interview data that was obtained, secondary data, and personal analysis on the topics. The secondary data was found using keywords such as faith and healing, the effects of prayer, and spirituality and health. Other various sources were found
throughout lectures this semester and upon referral from those that I spoke with. For example, Dr. Ter Haar recommended that I look into the work of Paul Tounier.

There is also a final section at the end to include personal thoughts and lessons learned. This project encompassed a lot of personal issues and questions that I have been interested in and I wanted to make this section distinctly separate from the opinions and thoughts of those that I met throughout this project. My personal thoughts are just that, they are personal, and should not be regarded as providing any sound conclusions or trying to persuade in any regard. This project has an overarching theme of faith and this should not be mistaken for saying that faith, or any particular faith is the right answer to tough issues such as healing and medicine. However, medicine doesn’t have all the answers and faith is one way that people do try to come to terms with their disease. This project will explore how some Christians view their faith and the benefits and concerns of integrating faith with the healing process in Durban, South Africa.

**Literature Review:**


This article is a great introduction to what religion and spirituality are and why they are important in a medical setting. It integrates all of the major religions and shows how they have made an impact on the healthcare field. The article breaks down the integration of faith in the healing process starting with the historical contexts and moving up through modern medicine. It includes various studies that give statistical data and
gives actual numbers that can be worked with. Perhaps most important in this article, is the admittance that there are limits on what can be methodologically studied when it comes to something so vast and abstract as religion and spirituality in a healthcare setting. The article also delves into how bringing up spirituality may affect the physician-patient relationship and the positive impacts this may have on the health treatment plan and outcome. I think that it is an important article to be contained in my study because it presents a concise overview of what incorporating faith in healing means from various angles and with the use of studies and data.

Puchalski, Christina M. "The role of spirituality in healthcare." Baylor University Medical Center 14, no. 4 (October 2001).

This article may be the most important to my project as in engages many of the topics that I would like to incorporate in my exploration of faith in the healing process. By focusing on multiple components of spirituality in a healthcare setting it presents a multi-faceted view of both the positives and negatives this may provide. The primary focus on this article is the need for compassionate care to be employed by medical professionals. In order to provide this compassionate care the physician needs to engage more fully with the patient as a person, including taking a spiritual history to better serve the patient in a holistic manner. Especially in the cases of chronic or terminal illness existential questions arise and this article presents the importance of dealing with these questions from the perspective of the patient and medical professional. An aspect that is of particular value is the inclusion of how religion at times can be detrimental and cause guilt, shame, and anger associated with the illness. There is an element of discussion about how healing is not just physical, but that sometimes the most important forms of
healing come in acceptance and hope. Issues of social support, optimism, and positive mental outlook are also brought up in this article and its association with spirituality in the healing space. The article includes various points of data resulting from studies, surveys, and case studies. It presents the data in the form of stories correlated with factual numbers, similar to the way that I hope to bring together all the aspects of my independent study project.

Findings and Analysis:

Faith and Healing

When trying to understand the integration of faith and healing it is important to start with the basics and understand what the two words separately mean first. What does faith and healing mean? What is it important to have faith in? How much faith is needed? Is physical healing the only way that could be considered healing? Or is the deeper healing within the soul; is the real healing a form of acceptance, of coming to terms with the limits of our physical bodies? As T.S. Elliot once said,” Learn to wait without hope, do we have the wisdom to know what to hope for? (Elliot 1943)

There was an interesting quote that kept coming up throughout my asking for a definition of faith, “Everyone believes in something.” Whether believing in a God, a medicine, a treatment, a physician, or even a meditation technique or a sports team, everyone puts their faith in something. Coming from a Christian background and speaking with those who share the same paradigm, the differences in definitions that arose were quite interesting. One of the perspectives on faith in the
healing process spoke to the broader view of what it meant to have a basic faith without the need for any religious affiliation. Faith can simply be the belief in something that we cannot know or see. This faith is what forms the basis for medical treatment. There is an underlying faith and belief that the doctor will be able to provide the best treatment, and a faith in the process itself. While speaking with Dr. Ter Haar on April 22, 2013, he brought up this point along with the placebo effect. He gave the example that if someone goes to the doctor, that there is a belief that whatever pill the doctor gives for the pain will work. Even if the pill does absolutely nothing, there is that element of faith that it will work, and often that belief alone will cause the headache to go away. (Ter Haar 2013) This faith is had by any patient who goes to the doctor with the intent of being healed, because the healing is underscored by faith in the process. The second type of faith that I encountered is faith in God or in the Christian sense, a belief in Jesus Christ. This was the more popular type of faith that was discussed with the integration in the healing process among those that I spoke with. There was an underlying theme in discussing faith in God as being the main foundation for healing and the core element in “faith healings.” In speaking with a group from Bethel College in Redding, California on April 12, 2013 one of the men, Tyler Williamson, said that “if you are Christian that just means that you have a faith in Christ and the words and promises of God.” (Williamson 2013) He worded it in a way of having to choose between having a faith in what the doctor and medicine says is your health outlook, or in the promises that the Bible states. This contradiction was echoed throughout many of the conversations I had and will be discussed later on in this paper. Meanwhile Dr.
Nishlan Govender and Dr. Meryl Govender, a couple who are both physicians and whom I met with on April 14, 2013, simply stated that there doesn’t have to be a choice between which to have faith in, but that faith is a hope and sense that God will do whatever is needed in the health situation, including working through medicine. (D. M. Govender 2013) This viewpoint included having a belief in God as well as a belief in the treatment and that whatever happened would be God’s will.

Perhaps the most important point to keep in mind when discussing elements of faith is that it is a belief in something that we do not know or understand, whatever that may be, and trusting that whatever is supposed to happen will happen. Faith and religious elements are often used to describe or make sense of situations that we cannot know or understand. Medicine has made profound progress in diagnosing disease, providing treatment, and enhancing quality of life. Modern medicine can now help the blind to see, the lame to walk, and even impregnate women. These feats are commendable, yet for anyone who has been in a serious medical situation the areas where medicine fall short are acute. There are gaps that medicine and research cannot fill, pain that cannot be cured with a pill, and wounds that will not heal. For those who believe in more, these gaps can be filled, pain can be eased, and wounds can be healed. Faith reaches past the capacity of medicine and can offer the comfort and peace that a sterile room and surgical equipment cannot. Faith has played a role in medicine up until the modern day and a call for the return of integration is being heard. There is a new field of practitioners and patients who realize this need and employ the use of both to provide the best possible quality of care. As someone who wants to become a part of
the medical field I want to learn from South Africa and the spirit of those I have met. I want to see the importance of faith in healing so that I can someday provide my patients with the best possible care, reaching beyond medicine alone. A friend of mine once told me that science does a great job of explaining the mechanisms of how something happens, but when it comes to the whys of this world it can fall short. Another friend asked me once, why just because science didn’t have an answer to something why it needed to be filled with a God or a higher power? This question is perfectly valid, and I do not have the explanation, neither this study nor I will be able to provide an answer, but will give examples of how some people are filling this uncertainty with something that gives them hope, having a faith.

Healing can be defined in various ways. Using the bio-psycho-social approach, there can be the healing of the physical body, of the mental capacity, and of the social or relational aspect of a person. According to the World Health Organization used by Dr. Ter Haar, “Health is the state of complete well-being, physically, socially, and mentally and not just the absence of disease.” (Ter Haar, 2013) As Dr. Ter Haar kindly put it, “Nobody has yet seen such a specimen here on earth.” In his book In the Shadow of Tradition, he broke down health as a condition whereby, “1. The individual is making optimal use of his/her physical and psychological potential in spite of inherent limitations; 2. The individual is adapting in an appropriate manner to a changing environment; 3. The individual has reached a spiritual maturity corresponding to his/her biological age.” (Ter Haar, 2013, 238) Of course there are certain questions that arise with this definition, such as what does it mean to have spiritual maturity correlated with age, how can that be
evaluated? But it does present health as containing a spiritual component. This is seen in many arenas outside the Christian context as well, for example in Zulu culture with sangomas, “healing therefore aims at the restoration of broken relationships and may involve confession, forgiveness and restitution, elements which cannot be mediated through standard medical methods.” (Ter Haar 2013)

Dr. Mannie at McCords hospital broke down healing into three facets on April 17, 2013. First, that there is the physical aspect, for example being treated for the flu or an abscess. Second, that there is an emotional healing, for example suffering from depression. Lastly, that there is an aspect concerning spirituality and being lost spiritually. (Mannie 2013) Dr. Nishlan Govender spoke of healing as having both a physical component and another that went hand in hand with belief. Healing could take place on a deeper level of acceptance; especially with those that have a terminal disease often didn’t involve much of the physical. (D. N. Govender 2013) His wife brought up the thought that the disease and physical lack of healing can often lead to an opportunity to come to a point of brokenness where some patients accept a faith. She explained that the burden of the disease allows people to become seekers of options outside the medical realm and discover a desire for some external motivation, such as a God. (D. M. Govender 2013) Penny Dugan is a woman who has worked in AIDS hospice care for a considerable amount of time and has seen many hopeless situations. I worked with her throughout the project and interviewed her on April 18, 2013. Penny explained that healing often comes in many ways. She mentioned that she has seen miracles, but not necessarily defined in the standard fashion. She defined her miracles as not having seen people who were HIV positive...
suddenly testing negative, but seeing those who were once on their deathbed recover. She spoke of death sometimes being the ultimate form of healing. She said that she has seen many patients who are just done fighting and that death is a final release. Lastly, Penny explained what she termed “healing of heart issues.” This included stories of people who were angry and bitter with what had happened in their lives and that when patients finally came to a point of reconciliation with others, with God, and with themselves they were able to die peacefully. (Dugan 2013)

Marianne Mitchell, wife of Dr. Mitchell and long time missions nurse, echoed this story of acceptance as healing when she spoke about a past patient she had treated when I spoke with her on April 14, 2013. In her nurses training she faced helping with a patient who was terrified of death. Not wanting to push her religion on other people Marianne just spoke with some people from her church to see if they could offer her any comfort. When she eventually died, this woman died with her hands in the air calling Jesus’ name. (M. M. Mitchell 2013) This was one story where faith helped to ease the fear of death and bring about a spiritual healing that didn’t lead to physical healing, but allowed the woman to die at peace. These stories of healing tend to fall in line with what Dr. Christina Puchalski mentioned in her study,

“Cure is not possible for many illnesses, but I firmly believe that there is always room for healing. Healing can be experienced as acceptance of illness and peace with one’s life. This healing, I believe, is at its core spiritual.” (Puchalski 2001)
Healing is not something that can be easily defined, given the many aspects of humanity. Although the physical is the most closely linked with healing in a medical sense it can take many different forms and being aware that not all diseases are going to be cured, and that not all pain is going to leave is important to acknowledge. Death is a natural process of life and it comes down to accepting what healing can take place, instead of what healing we may want to take place. There are growing bodies of thought that look into what not being physically healed can mean for a person and this will be discussed more in depth later in the paper.

**Ways Faith is Integrated into Healing Facilities**

Through personal observation and speaking with members of specific facilities that claimed to integrate faith into their healing I was able to see a number of ways that faith was manifested. The first and perhaps most obvious way that I saw faith being used in these facilities was physically. I was able to volunteer at the Ukukhanya Life Care Centre in the township of Ntuzuma for two weeks and observe how they worked as an AIDS hospice proclaiming a Christian message. Outside of their establishment is a sign with their name and the mission statement, “showing the love of Jesus to those affected by HIV/AIDS.” (Missions 2009-2011) I observed that there was a verse painted on the wall of each of the rooms with the hopes of giving off a message of hope. One such verse appeared twice and read, “For I know the plans I have for you,” declares the Lord, “plans to prosper you and not to harm you, plans to give you a hope and a future.” This verse can be found in Jeremiah 29:11. At one point throughout the project I had the privilege of helping to bring someone in the community to McCord’s hospital for treatment. I was able to watch
slides speaking of McCord’s Christian values and their mission statement, intermixed with clips of the cartoon show, *Supa Strikas*. Their mission statement says, “To share the love of Jesus Christ in providing a comprehensive and holistic health service appropriate to prevailing needs of the surrounding communities, in partnership with relevant stakeholders. To bring care, hope and excellent medical care to our patients.” (Hospital 2011) This is displayed throughout various parts of the hospital. A hospital chaplain is also available for prayer upon request.

Less obvious than the physical elements of faith in the facility is how it is integrated into the patient treatment. Coming from a country with such strict separation of Church and State, I was unsure of how this actually worked or in what ways it could be implemented while respecting patient rights and still providing proper treatment. I feel like this is a very tricky line to walk in knowing when to bring up elements of faith, how to respect the wishes of the patient even if it goes against your belief system, and maintaining professionalism.

In speaking with several missionaries who lived through the transitions I was able to learn about the historical and cultural context that many of the hospitals and clinics, although now public, stem from religiously. The first couple that I spoke with was Dr. and Mrs. Allan and Marianne Mitchell. They described themselves as coming from “missionary stock” and had a wealth of knowledge and experience. He practiced as a generalist at Shongwe Mission Hospital and there met his wife Marianne who was working as a nurse. At Shongwe Mission Hospital, Dr. Mitchell spoke of various Gospel messages and worship songs playing throughout the day via
the PA system. When I asked specifically how Shongwe integrated faith into their practices he said that,

“Although not directly to the patients, there were always morning prayers with the sisters that was within earshot of the patients and hymns were often sung throughout their work. There were also evangelists and missionaries that were employed by the hospital and used often when patients were close to death. I personally often prayed over patients in the operating theatre. These were common practices not only at Shongwe, but also at King Edward and McCord.” (D. A. Mitchell 2013)

In my conversation with Dr. Mitchell, many of the hospitals and healthcare facilities in South Africa trace their lineage to missionaries and various mission facilities. Most of these are now being taken over by the government and are losing that religious aspect. When the government began to take over many of these facilities he mentioned a separation of church and state and the need to respect the beliefs of patients as well as non-religious employees and not force religion. However, Dr. Mitchell spoke of a “missionary ethos” that still lasts even in many of the public facilities with nurses praying and the use of worship songs. He speaks of these methods that were originally strictly missionary as infiltrating the culture, and almost becoming a cultural, rather than spiritual practice. As he got older and took on more senior positions he was still often asked to lead the meetings in prayer. (D. A. Mitchell 2013)

Dr. Ter Haar came from a similar standpoint, his family also lived on the hospital grounds and he became an example of the Christian faith not only in his profession, but in his personal life where he mentioned that if he and his wife got into an argument, that the whole hospital knew about it. He spoke of how every
morning began with prayers and a bible study with all of the staff to be able to come together and “start the day off right.” He told of having the government takeover and put an end to the morning meetings because they were no longer “under the mission.” Once they ended having these morning meetings staff still got together to discuss various problems going on in their home lives and in the community where they tried a number of secular methods and books to find solutions, only to end up back doing a bible study, but this time by choice. (Ter Haar 2013)

The Ukukhanya Life Care Centre is founded on Christian values, even if the people that come there are not religious. Being unaffiliated with the government and being fully funded without being subsidized by the government allows the freedom to embody their beliefs. They offer morning prayer and devotions for people who wish to attend. In speaking with one of the caregivers, Thembi Mkhize, she described various ways that she integrates her faith into how she cares for the people at Ukukhayna. Most often, she conducts the morning prayer and explained, “If I think of various things to bring up during the devotion that morning at home, I’ll bring it to work and share it with those who attend the devotion.” (Mkhize 2013)

She mentioned praying with patients who requested it and speaking about her faith with those who were open to it. According to Thembi, there was a change in patients attitudes after prayer and that they looked to be happier and often smiled. She said that even among those who cannot speak that she can see their desire. (Mkhize 2013)

At McCord hospital, I was able to witness some of the ways that they integrate faith in healing when I went with Allison Kroll on March 26, 2013 for a
clinic visit. In the antenatal clinic in the morning they hold a small church service complete with a message, prayer, and singing for those who want to take part. Dr. Mannie spoke of this practice, as well as his praying with patients who request it. For example, he mentioned praying with scared mothers before cesarean sections. He also brought up integrating faith not only with patients, but its importance among staff and tying faith into their seminars. He brought up, Batho Pele which means People First, and how even though it is a saying from the government he can tie in spiritual undertones when speaking with his staff. Putting the patient first brings up questions such as what type of person am I and how can I choose to be happy? In his presentations he brings up happiness as a choice to love God and to love yourself, to learn to forgive. (Mannie 2013) As a physician and a musician he composed such songs as this set to the tune of “All My Loving” by the Beatles,

“Close your eyes and imagine,
You’re God’s own creation,
Don’t let, anyone, put you down,
And when, you feeling low,
I just want you to know,
That God makes no mistakes, and you no fake.
I am special, I will not go down,
I am special, Lord help me not to frown.” (Mannie 2013)

The most widely brought up method of how faith is integrated is through the use of prayer. However, there were many differing opinions on how this looked and how it should be implemented while maintaining a professional relationship with all of the patients. For the most part, it seemed as though prayer was kept out of
patient treatment unless personally requested or heard from the medical staff via morning prayers. (D. A. Mitchell 2013) This helps to maintain the professional relationship and keep doctors from getting involved with patients on this level if it would not be beneficial to the patient. In her article, Christina Puchalski brings up this issue of doctors and prayer with their patients, especially those who are of a differing spiritual viewpoint. Even as a Christian doctor it is imperative to remember that the patient came for medical needs, not spiritual, and that those needs should not blur the line between doctor and patient. It is important to have an understanding of the spiritual needs of the patient, but given that a patient is already in a vulnerable or compromised state, to lead in spiritual issues would be unprofessional and the prayer needs to be from an outside source. (Puchalski 2001) Where this line becomes sticky is in the topic of praying for a patient, but not with a patient. Several people that I spoke with brought up praying for guidance and wisdom in surgery or diagnosis and praying for patients that were really struggling. Where is the line drawn between praying with patients, even those who request it, praying for patients who otherwise would refuse prayer, and praying for personal guidance as a believer and someone who wants to perform their job to the best of their abilities? Is there a clear line between praying for someone and disrespecting their religious views?

**Faith Healings**

I went into this project with the rather naïve thought that I would be able to avoid the topic of faith healings and miracles. Integrating faith and spirituality is a way that I thought may be able to treat a patient in a more holistic manner and I was
looking to get opinions on this, in addition to this however were stories of healings through faith. The first major issue that needs to be discussed before sharing these stories is skepticism. As should be the case for any new drug, treatment, and even a new hair product there needs to be a certain element of proof that it succeeds. In going along with the spirit of science and medicine is experimentation. Throughout my chemistry courses I have learned that for an experiment to gain credibility one of the key points that it needs to contain is the ability for it to be replicated. Various medical procedures and treatments were tried and replicated over and over again to prove that they could work. Proof comes with the standard that it can be repeated and shown on command. Miracles and faith healings cannot do this, almost inherently. These matters need to be handled with a healthy amount of questioning, on a personal level. These are stories that carry weight for the individual person and no large sweeping claims can be made, because ultimately it comes down to individual interpretation, a faith not a knowing. For some, a medical miracle may have taken place, while for others it may have its roots traced back to some scientific theory or biological mechanism.

Historically, faith healing has been around since before the Bible. The Bible focuses largely on the concept of healing as well as an emphasis on hope. The concept of prayer and belief with being healed is seen through many of Jesus’ miracles in the New Testament, but what does it mean in today’s world to integrate faith and healing, and more importantly what does it mean to be healed through faith? In a Christian context, faith healing can be traced specifically to scripture in the New Testament. In these words, Jesus healed the sick, caused the blind to see,
the lame to walk, and the deaf to hear. Anyone who came to Jesus and believed was healed. This contains some important elements that will be further discussed. First, it says that all who came to Jesus were healed, it doesn’t say that some weren’t and some were. So what does that mean for those who aren't healed through faith healing? Second, there is an element of belief that needs to happen before healing takes place. In another piece of scripture Mark 1:1-6, Jesus is in his hometown of Nazareth, where he faces people who don’t believe in him and therefore leaves without healing many. This brings up the question of how much faith is enough faith to be healed? Is the result of not having enough faith remaining with the disease? Lastly, it says that those who came to Jesus were healed. Jesus has not been around physically walking the Earth for some 2000 years, so where does this healing power come from? The Holy Spirit is attributed to being an extension of God and the healing mechanism, but what does it look like and how can it be accessed? If it could be so readily used like it is in scripture then why isn’t it used more often in the world? As put by Dr. Mannie, “there is a fine line between believing in God and praying for healing and not going to the doctor. If prayer worked every time, we would have prayer buildings instead of hospitals.” (Mannie 2013) (Man 2013)What does faith healing actually look like and how can one know that actual healing was accomplished? Is it physical healing as was earlier discussed, or something else? These stories are not meant to convince or make claims, but rather to promote discussion and bring up different dimensions of thought when it comes to being literally healed through faith.
On April 12, 2013 there was a faith healing group that came to the Ukukhanya Life Care Centre. It was a group of about 15 people ranging in age from early 20s to 50s from the Bethel School of Ministry in Redding, California. They were in South Africa as a part of their outreach and had been praying with various people ranging from the Workshop to McCords hospital and everywhere in between. As they began the service one of the men approached me to help explain the mechanisms of what was going on. This was very helpful, as I have never been to a faith healing and have always been quite skeptical myself. In observing what was occurring throughout this service the man explained that one of the first steps that occurs in a faith healing is what is termed “laying hands.” Laying hands is what happens when they are putting their hands on various parts of the person that they are praying with. (Man 2013) I thought that it was focused on the point of pain or perhaps as a source of comfort to put the person at ease, but he explained to me that they believe that where the hands are making contact with the person is actually the impact point. The impact point is where they believe that the Holy Spirit leaves their hands and enters the body of the sick person. There was a large emphasis on the power not being from the person, but the imagery of a person being a vessel and that Holy Spirit moving through them. The next step is more difficult to describe and to understand, granted the point is that it is not really about the knowing or the understanding. There is some manifestation of the Holy Spirit in the form of sounds. It was not a specific language or any certain song or pattern of words that were used. When I asked the man to explain what was happening he phrased it that, “the Spirit was communicating directly to the spirit of the person in a prayer language.”
Third, there was another person involved that was speaking to the person directly, not using a prayer language. The role of that person was to communicate messages of encouragement and hope. (Man 2013) This prayer continued for quite some time and I observed what I could only interpret as change in demeanor in those that were prayed over that I am not going to pretend I can explain or understand.

Tyler Williamson was one of the young men in this group that I spoke with at the end of the prayer session to get his opinion on how he felt about faith healing. He is currently in his first year at the Bethel School of Ministry and spoke of what he physically felt while faith healing. He told me that he felt an overwhelming compassion and love. This he explained as physical warmth that he believed to be the presence of God in his hands, along with sometimes the feeling of weight and electricity. He described the healing rooms that they have at Bethel. He works in them every Saturday and says that he has seen hundreds of people healed from various cancers, terminal illnesses, and pain. He told me that, "seeing people healed is like seeing God's finger." (Williamson 2013) Obviously these are very sweeping claims and when I asked him if there is ever any physical or medical proof to support these healings he said that they always encourage people who have come to go back to their doctor for testing or x rays, etc. and to submit these to the weekly newsletter. He also mentioned the research of a man by the name of Randy Clark who is currently working on his dissertation to prove the validity of faith healing. In his research he prays with people who have various pieces of metal, i.e. rods or screws, in their bodies and shows x-rays afterwards that do not contain any metal. (Williamson 2013) None of this work is published or complete, but it would be a
very interesting study to look into if completed. This just raises the question that if hundreds of people were being healed miraculously and it were medically proven, is there a reason why we have not heard about it or had research published? As a skeptic, should something inherently rooted in faith need to be scientifically proven? I am neither medically or ministry trained and do not have the ability to make a sound decision either way.

Anne Moys was another woman that I met who had personal experience with what was for her, a miracle. I asked her to describe if she had any opinions on incorporating faith in the healing process and she proceeded to tell me about some of the health issues that she has recently had. She held the strong belief that prayer had made a difference in her treatment.

I began with a badly fractured lower humerus which was subsequently badly repaired. I lost most of my range of motion and was unable to bend my elbow to either flex or extend. After fifteen months of being unable to perform daily tasks I found a surgeon who was willing to repair the damage that had been done. The surgery was successful and I was doing well until an abscess formed. An abscess is a bad infection that in my case had adhered to the metal of my right arm. I had to return to the hospital for another operation and go on antibiotics. Despite this treatment, I developed a second abscess. After a CT scan, the doctors determined that the course of treatment should be to take out the plates in my arm where the infection had adhered, go on a course of antibiotics, and perform another surgery to replace the plates. I agreed to go through with the treatment plan on the condition that my doctor would allow me some time to rely on my faith and believe that prayers for healing would
heal, instead of undergoing the surgery. The doctor allowed this for a trial period with the restriction that I would continue to take my CRP tests to monitor if the infection got out of hand and I would need to resume my antibiotic treatment and undergo the surgeries. A normal CRP (C-reactive protein) test has a result <5. At the height of my infection I had a level of 64. On Monday at 6 in the morning, I took my last antibiotic and the test result was 2. This made sense because I had just taken my pill. On Thursday, the test result was again 2. Two weeks later, I retook the test and my result was 1. One month later I was still good and six and a half months later I’m still good and has now almost my complete range of motion back. (Moys 2013)

Her goal was to pass the “peanut test” of putting a peanut in her mouth and she proudly showed that she could in fact pass. There could be a possible number of explanations medically to make sense of her recovery or it simply may have occurred by chance, considering all is still unknown about the human body and how we heal, but for her she gives the credit to her healing because of her faith.

Lastly, there was a story from Dr. Ter Haar about a case that he could not understand or explain medically. His story began in the surgical theatre.

I was operating on a young boy who had a condition where one bowel had gone into the other. This is a particularly difficult procedure because the more that you try to get one out the tighter the muscle contracts. I had finally done all that I could when I stopped operating and put down my surgical equipment. I asked my nurses to pray with me and I prayed that he had reached his limit and that God needed to intercede in the surgery. After the prayer I looked and the bowel had entirely loosed of its own accord. I was not able to explain this medically. (Ter Haar 2013)
This is just one example of where there is a gap in what we know about medicine and the workings of the human body and what unexplainable things sometimes happen.

Again, I do not present these stories as proof or to back up any claims, but to give various stories and opinions of those that I was able to speak with. It is important to think logically about such things, but to also realize that often logic comes up short and it is up to the individual to make the final say. If any of these situations had happened to others of a different faith or no faith at all the interpretations could be very different, but as it stands these people chose to attribute it to their faith and as examples of what faith healing means on a very personal level. These situations are not replicable and very individual, largely the people that I spoke to and the stories that they felt to be faith healings were kept fairly quiet. On one occasion Dr. Mitchell was praying in church for a man who was supposed to go in for cervical neck surgery the next day and was in a great deal of pain. This same man approached Dr. Mitchell the next year and explained who he was saying that he had been healed and hadn’t needed the surgery. When encouraged to tell the church and have his story told as an example he said that he preferred that no one know and that it be kept quiet. (D. A. Mitchell 2013) Perhaps this is another explanation for why faith healings are not as common, because it is a matter of personal faith and as long as it is real for that person, is proof and affirmation really needed?

Another dynamic that could be brought up with the idea of faith healings is the effect of hope and how this correlates with positive thought and healing. Hope
and a positive outlook often extend beyond what modern medicine is capable of.
Several studies that I have come across point to a correlation between a strong faith
and a positive attitude. For example an article I read called the “Role of spirituality
in healthcare” from the University of Baylor Medical Center says,

“Some studies indicate that those who are spiritual tend to have a more positive
outlook and a better quality of life. For example, patients with advanced cancer who found
comfort from their religious and spiritual beliefs were more satisfied with their lives, were
happier, and had less pain” (Puchalski 2001)

From this same study came the results of a survey done to look into the impact that
prayer had on pain levels,

“Results of a pain questionnaire distributed by the American Pain Society to
hospitalized patients showed that personal prayer was the most commonly used non-drug
method of controlling pain: 76% of the patients made use of it (14). In this study, prayer as
a method of pain management was used more frequently than intravenous pain medication
(66%), pain injections (62%), relaxation (33%), touch (19%), and massage (9%). Pain
medication is very important and should be used, but it is worthwhile to consider other
ways to deal with pain as well.” (Puchalski 2001)

Although this does nothing to prove the existence of miracles or that using
prayer alone is the answer to all medical scenarios or pain, it does present
spirituality as another device may provide comfort to those who believe in its
healing capacity. In another study looking at end of life care for those with
gynecological cancer,

“Spiritual beliefs can help patients cope with disease and face death. When asked
what helped them cope with their gynecologic cancer, 93% of 108 women cited spiritual
beliefs. In addition, 75% of these patients stated that religion had a significant place in their lives, and 49% said they had become more spiritual after their diagnosis” (Roberts JA 1997)

I wanted to look at whether this is true, how having a faith changes the perspective of someone diagnosed with HIV/AIDS. If having this faith helps to provide any sort of comfort or make sense of the situation, as said by Victor Frankl, a concentration camp survivor, ““Man is not destroyed by suffering; he is destroyed by suffering without meaning” (VE 1984) When discussing with Penny Dugan how faith is integrated with healing she described to me the breakdown of what she has encountered in working with those with AIDS. She said that especially towards the end of the disease that people get very hopeless when medicine says that there is nothing more that can be done. This hopelessness can stem from any number of the issues that they face, particularly fear and shame. There is fear of death and the pain associated with it and a fear of the progression of the disease and rejection from society. The shame stems from the social stigma associated with AIDS in both South Africa and the United States. In addition to the shame from the stigma is shame in how they got the disease in the first place, and if they were responsible for transmitting it to others. (Dugan 2013) For Penny, she feels that having a faith helps patients to cope with these issues. She explained that for her, “the perfect love of God will cast out fear and give hope that they sill have a future and a chance to live. That God loves them just as they are and that they are not judged, just loved.” (Dugan 2013)This hope she described as being everything. That having hope is having a confidence in healing, not that I’m going to get better, but that I have a purpose. (Dugan 2013)
What Happens if Someone is Not Healed?

On the other side of faith healing unexplainable reasons for why someone is not healed. If someone doesn’t miraculously heal, did prayers fail? What if someone dies? Is it because they did not have enough faith, is it because they doubted God’s ability to heal in a moment of weakness? It is this issue that I have a hard time rationalizing, how and why some are healed, yet others experience the pain and death of disease with no response to prayer. Death is a natural process, part of the cycle of life, and wanting to go into a field as complex as medicine I am trying to accept the questions of why some are healed and others are not. And that is often extends beyond what modern medicine is capable of. There were various explanations for why some people are not healed while others are ranging from the belief that illness is from the devil, to not believing hard enough, to God’s will. The most prevalent two options that I received as explanation were that someone didn’t believe hard enough that they could be healed, therefore weren’t healed, and that not being healed was part of God’s will, that there was some reason for their disease. I found it interesting that everyone came from the same faith background, yet had come to radically different conclusions.

In speaking about people not being healed there were a few conversations in particular that I engaged with. The first person being Tyler Williamson from the faith healing, when I asked him how successful the faith healing usually was, he said that the majority were healed. (Williamson 2013) This prompted me to asking about the minority, why had they not been healed? His explanation for this was that in his experience some were not healed because they harbored some form of resentment
or inner turmoil that ultimately led to not being able to experience the healing power because of bitterness. He said that there can be some things preventing the healing, that the healing is part us and part God, citing the biblical story of Jesus in Nazareth and the unbelief of the people. There was an aspect of their ministry known as SOZO that comes from the Greek word for body, soul, and spirit healing that he mentioned as a possible way to be free from the bitterness and be physically healed. (Williamson 2013) Another person that I spoke with that brought up the belief of not being healed because of not believing enough was Dr. Mannie. He mentioned that he had been suffering from tendonitis in his Achilles and that no amount of prayer and faith in the healing was curing the pain. When I asked him why he thought that was he simply stated that he did not know, that maybe he didn’t have enough faith or that maybe it was God’s will. (Mannie 2013)

Along with not believing enough, is the idea that the disease is a result of doing something wrong in the past; that the disease serves as a sort of atonement for past wrongs. There is a belief that they deserve the illness that they got. This can be true in some sense, for example an alcoholic or a smoker may be forgiven, but they still live with the lasting effects of a bad liver and lungs. (Ter Haar 2013) However, the belief that because you were sinful in some moral way and that that led to having cancer or AIDS can be devastating when it comes to accepting and possessing peace before you die. In the article, The Role of Spirituality in Healthcare, there is a story about a woman who had an abortion when she was a young woman and sees her diagnosis with AIDS as her punishment. Riddled with guilt she claims, “I have been waiting for the punishment, and this is it.” (Puchalski 2001) In this
case, the disease is a form of retribution and there is no hope of hiding from God’s punishment. From a medical standpoint recognizing this as a spiritual issue and being able to refer her to someone to help her work through her guilt could not cure her of AIDS, but it could help her work through her anger and ultimately get the medical care that was needed. (Puchalski 2001) This thought of disease as a form of retribution extends beyond Christianity and the idea of karma comes to mind. The idea that if you are a good person, good things will happen, and if you are a bad person, bad things will happen. What happens though when bad things happen to good people? In the idea of Reincarnation, perhaps it is punishment for something that happened in a past life.

God’s will. What does this mean? According to various people that I spoke with God’s will can be summed up as believing that whatever happens is what is best for their lives, that they may not understand it but that it serves some purpose. That God does not always work in the way that we think or want, but that ultimately everything that happens is in his control and it is what he wants that matters, not what we want. (Ter Haar 2013) As Dr. Ter Haar put it, “every prayer must end with Thy will and not my will be done.” (Ter Haar 2013) There is no magic formula for how to word a prayer so that it might happen and so that God can bypass the medical process and instantly heal. It doesn’t matter if you pray for so many hours for so many days with so much intensity, because ultimately no one really knows why some people are healed and others are not, and that’s a hard reality to swallow. The situation of people believing and having a faith but not being healed was one of the biggest concerns that those I spoke with had about integrating faith and healing,
because the truth is that not all who believe are healed. In her book Healing in the History of Christianity, Amanda Porterfield says,

“Part of Christianity’s appeal as a means of coping with suffering is the idea that suffering is not meaningless but part of a cosmic vision of redemption...while the effectiveness of Christian practices as a means of to relief from suffering has contributed enormously to their popularity, the real genius of Christianity has been to embrace pain and disability and death and to not limit the meaning of health and healing to their expulsion.” (Porterfield 2005)

This is one explanation for why some are not healed, that suffering and how you face suffering is a major point in Christian teachings. In the Bible, Jesus is never quoted with having said that life would be painless and all would be happy. Having a faith does not equate with having an easy life.

There are countless heartbreaking stories about people who have tried to be healed but who have still gotten sick or passed away. Dr. Mannie knew of patients who died as a result of not taking their diabetes medication because they went to prayer circles, and countless other stories are similar to this. (Mannie 2013) Dr. Ter Haar now works with Lifeline and encounters patients who test HIV/AIDS positive, yet refuse ARV treatment because they believe that with enough prayer they will be able to test negative, he has yet to see such a case. One of the hardest stories that I heard also came from Dr. Ter Haar about a woman who had been paralyzed when a tree fell on her and was unable to bear children. Upon her friend’s advice, she fasted and prayed and went to see a faith healer. When he told her to stand that she had been healed, she crumpled to the floor, he hope and resulting faith completely
crushed. (Ter Haar 2013) Stories of faith not healing a person can be damaging on a physical, emotional, mental, and spiritual level for the individual. This pain can also extend to family members and close friends. Dr. Meryl Govender saw the results of this with one of her friends. Her friends father was dying of cancer and the family prayed long and hard that he would be healed. The father still ended up dying and Dr. Govender watched her friends backslide in their faith as a result. The children could no longer see God as something sovereign because of the pain they experienced in the disappointment of his death. (D. M. Govender 2013) I have personally heard this story echoed many times as the reason for no longer having a faith, how can a good and loving God allow something like this to happen? Perhaps the most realistic and applicable answer that I received to this question was from Penny Dugan, when she simply stated, “I don’t know.” (Dugan 2013) She proceeded to tell me a story about the first time that she prayed for someone who was dying, and the man died. She told me that she felt as though she had done something wrong. She believed that God could heal so she didn’t know why the man wasn’t. The only conclusion that she could come to is that she believed it when God says that all you have to do is pray and ask, “your job is to pray, and it’s God’s job to heal.” (Dugan 2013) She brought up that it is really easy to question this working with those who are infected with HIV/AIDS, but that even though they aren’t cured, many go on to lead long fulfilled lives. In response to the thought that not being healed could be rooted in the person’s not believing enough she said that, “God asks you to believe, but that healing is not contingent on our own faith.” (Dugan 2013) Penny
believed that prayer and faith healing is not something that is a cause and effect relationship, that really, we simply don’t know. (Dugan 2013)

There is a body of thought surrounding the idea of not being healed, and using that as a learning opportunity and of expanding consciousness. Even in medicine, not just with faith healing, not everyone is going to be healed. So what can one do with a terminal illness? In a quote I heard echoed by Dr. Mitchell, “do not let this illness leave me until it has taught me what I needed to learn.” (D. A. Mitchell 2013) Behind the theory of health as expanding consciousness is the belief that having a disease or serious illness can, “evolve into a search for meaning and relatedness.” (Newman, n.d., 24) Using the uncertainty or having a terminal illness lends itself to much questioning and reflection. In speaking with Dr Govender, at the end of the conversation he mentioned that he wished that there were some way that medical schools could integrate spirituality into its teachings. Not a particular belief system or way of thinking about religion even necessarily, but how to approach the big life questions that many patients ask. When dying many are forced to face such questions as; Who am I? Why am I here? Did my life hold purpose? What will happen when I die? These are all questions that we will all someday have to try to come to terms with, or choose to ignore. I am not sure that there is anyway that dealing with these issues from patients can be addressed, but there is beginning to be a shift towards more holistic patient care to be able to better address these questions. (D. N. Govender 2013) According to Margaret Newman, “Amidst the uncertainty of disease, there is a rhythmical coming together and moving apart until the clients see clearly—a moment of insight regarding the meaning and action
potential in their live.” (Newman, n.d. 24) The results of this article show various elements of change in those with severe illness, for example women diagnosed with breast cancer, “in comparison to their described interactions prior to diagnosis, the women were more sensitive to their own needs, were more receptive of caring gestures from others, and generally felt a greater appreciation and connectedness to life.” (Newman, n.d. 24) This was similar to those who were diagnosed with HIV stating that, “participants found new meaning in their lives and their relationships.” (Newman, n.d. 24) There seems to be a marked growth in how one deals with having such an illness and coming to terms with the uncertainty presented by the disease. In a much smaller and insignificant scale, it reminds me of how this experience of being abroad and apart from all that I consider normal has forced me to strip away things that don’t matter and get to the core of who I am and what my values are despite the change of environment. There is a quote that was brought to mind when I realized that I would be working with those dying of HIV/AIDS from the book *Tuesdays with Morrie,* “learn how to live and you learn how to die, learn how to die and you learn how to live.” (Albom 1997) This theory of health as expanding consciousness was told by Marianne Mitchell about her mother. Her mother did not pass away until she was 103, and Marianne spoke fondly of her mother in her final days. She told me about how her mother spent her final days reconciling and working on relationships, even writing countless apology letters for inconsequential things because she wanted to make sure that everything she could do and everything she could say was done and said before she passed. (M. M. Mitchell 2013) Granted, not all of us get 103 years to come to terms with our life and
what it meant, but it is still a testament to taking the time to reflect on our lives and be at peace with the thought of death.

**Concerns with Faith and Healing**

Looking at the spirituality of a person and treating someone in a more holistic manner can be beneficial to both the well being of the patient, as well as the health practitioner. However, it is also important to address issues of concern with integrating faith and healing. The most prevalent concern was that of not being healed and trying to understand. Another concern was when is it appropriate to use prayer. Dr. Ter Haar mentioned that other facilities often use prayer when they are going into a complex surgery or with an especially bad case. He spoke of the importance of not using prayer as a magic formula that would always result in a quick fix. Using prayer specifically in these cases can often be seen by the patient as having some sort of magical element, or on the other side just be seen as an empty ritual. He spoke of the importance of treating all medical procedures, from surgery to medication, on the same “danger level” and not allotting prayer or faith in only seemingly difficult circumstances. (Ter Haar 2013)

Ultimately, the reason that a patient is in a medical facility is because they need medical treatment or are suffering from a health issue. Patients do not come to the doctor for issues of faith and even if they have a strong faith, most importantly they need to be properly treated medically. By integrating or relying too strongly on faith this could make a bad impression on the patient. There is a fine line between using prayer for wisdom and guidance and appearing incompetent as a physician. (D. M. Govender 2013) First and foremost, in a medical facility is medical ability. Dr.
Mitchell warned of, “being so heavenly minded that you become of no earthly use.”

(D. A. Mitchell 2013) He described the importance of having good skills and remarked that if he ever needed surgery he would choose someone who was good, someone who was the best. He, like I would assume most people, would choose someone who was well-skilled over someone who shared his faith, that just because you possess a faith as a medical professional does not mean that you should not still strive to be top quality. (D. A. Mitchell 2013)

Dr. Meryl Govender also described her concern with integrating faith in healing and how that would effect the interaction between people of different religions. She remarked that there was a difference in practicing your own faith and offending people of other faiths. (D. M. Govender 2013) This is definitely a concern that needs to be addressed in keeping faith as something that is a personal choice. Respecting the religious beliefs of those who do not possess the same as you is of utmost importance and all should be afforded the same quality of healthcare regardless of religious affiliation. In thinking about differing faiths in a religious healing facility, I had to wonder how hospitals such as McCord can integrate a Christian faith with care of patients who are not of the same affiliation or may not even be religious at all. Dr. Mannie made the point that oftentimes when someone is really sick it doesn’t matter who or what is offering the prayer, that any prayer is comforting. (Mannie 2013)

This concern about faith and healing possibly marginalizing groups is an important thing to consider. It is important to understand what the motives behind integrating the faith might be and how it is coming across to those who think
differently. The Church has done a lot of good work in its history, yet its message of “Good News” is often tainted with judgment. Despite Christ being friends, not judgmental, but friends with many of the marginalized groups of society, the Church has often been the cause of the stigma in society. There is a battle in the Church over societal issues such as homosexuality, pre-marital sex, and consequently HIV/AIDS. Many churches have realized the need to provide aid and safety to those who have fallen under the burden of HIV/AIDS. But is it a safe space or is it a space marred by judgment? How are those with HIV/AIDS approached, with love or as “fallen” people? I am under no illusions that the church, for all the good that comes from it, is filled with flawed people.

In working at the Ukukhayna Life Care Centre I observed a different mentality from the director, Penny Dugan, than I have among some of my experiences in religious settings at home. She emphasized the power of love that resulted from her faith and that although it had originally been difficult getting connected with members of the community that she was a firm believer in showing, not just speaking your love. She remarked that she would, “lay down her life to show compassion.” (Dugan 2013) Despite heartbreak within the organization, being the victim of several acts of crime, and even being car-jacked at gunpoint she continued to work in the community. She took countless people to the hospital to get ARVs, got many of the townships babies on ARVs, and I accompanied her on a visit to McCord to admit one of the men. I finally asked her where her motivation for working with those who had AIDS came from and she told me her story. Penny described her story starting with getting married in college to a man she loved and having three
children by the time she was 25. It was around this time that she began noticing that her husband was having more and more trouble in handling his alcohol and became concerned. Suspecting an affair, she confronted her husband about the possibility of another woman and found that instead of another woman her husband had been with other men. Following this explanation of homosexuality they decided to be separated until he decided how he would like the relationship to proceed. In this time the news of a new disease, HIV/AIDS was becoming more well-known. As a result of his infidelity, her husband warned Penny that he was being tested, and that she should be as well. The results returned and they found out that he was HIV/AIDS positive and that she was negative. Penny chose to react out of love to her husband and ended up caring for him until his death. This led to her passion for caring for those who were infected with AIDS and crossing societal lines of stigma.

She described to me a few key points in her life where she became more affirmed in her approach of love instead of judgment. One occasion was when she was approached by a man who charged her with forcing people in her Christian AIDS hospice to stop being homosexual, to which she responded, “how to you do that?” She invited the man to come and see the facility and speak with those who were there and come to his own conclusions, to which he wrote a nice article called, “Something Positive”, after realizing that she did not have an agenda. She told me, “when people genuinely know that you care nothing about them matters, and shame on us if we make them feel bad.” (Dugan 2013) Another key story that she told me also directly addresses the topic of HIV/AIDS, homosexuality, and the Church. She
explained that she had once been on a board for AIDS that included herself, nuns, and a homosexual male prostitute. Her story was,

_A key point to my thinking on this topic came when I was on a board with a male homosexual prostitute and some nuns. We were all riding back from the meeting and the nuns asked me if I agreed with homosexuality. I told them that I didn’t and they proceeded to ask me how I could care for those with AIDS if I did not agree with them. I told them that it was like having teenage kids in a sense, that I could love people but that didn’t mean that I had to agree with them. Throughout this conversation the male prostitute kept quiet, but later when he was in the hospital requested that I come pray with him. I told my husband about him and came to find out that he was one of the men that my husband had been with while we were married. This thought made me sick to my stomach on so many levels, but God asked me if I will love this man in my Name? So I went to the hospital and I prayed with him. He told me that he just wanted to tell me that, “you’re right and the nuns were wrong.” You can not accept my lifestyle and my choices, but I can tell that you accept me as a person. The genuine love of Jesus comes through and people want to receive it. I don’t have to change who I am or what I believe because who I am and what I believe allows me to love people in this way._ (Dugan 2013)

I do not know what the right answer is when it come to integrating faith in healing and how this could keep groups from being marginalized. But Penny Dugan provided one way of looking at these topics and emphasizing the importance of love that she draws from her faith as being more effective then judgment of those who go against what she believes. The golden rule of, “love your neighbor as yourself” came to mind when listening to Penny speak and throughout story I was reminded of a particular song that captures how this might look, “Learn to Love” by
Needtobreathe. This song, much like Penny’s story, emphasizes the need of love to be the message to those who are struggling, not one of judgment.

“Till we know the pain of a broken heart

We can’t walk through the fires we didn’t start

Just hold on to the way it is tonight

And learn to love through the darkness and the light

I’m on your side” (Needtobreathe 2011)

This song also echoes elements of what Penny wanted the Ukukhanya Life Care Centre to stand for. In trying to assess her motives for working in a township in South Africa with a 47% prevalence rate of 500,000 (Missions 2009-2011) I asked her why she had decided to begin this organization. She responded that, “Our goal was showing the love of Jesus to those affected by AIDS. This meant showing care and compassion to those who usually faced such a terrible stigma by accepting them, loving them, and helping out with practical things. I wanted it to be a place of refuge where people could recover, alleviate burdens, minister to spiritual and emotional needs, and just give a reason to live. I want to call it a life care centre instead of a hospice because even though the have a life defining illness it doesn’t mean that they cant still have a fulfilling life and hope for a future.” (Dugan 2013)

There are many important things to consider when approaching the integration of faith and healing, but perhaps more important than any of these concerns is the how. Not what in is being said or done necessarily, so much as how are people being approached. Are they being respected and loved in the name of faith or are they being judged and stigmatized? There needs to be a professional line
between having a faith and forcing a faith, between prayer and taking advantage of a
vulnerable power imbalance, between respect and manipulation, and most
importantly there needs to be an element of understanding and love. This reaches
beyond religious affiliations, societal beliefs, and preconceived ideas into caring for
people as people instead of a label.

**Faith and Healing from the Perspective of Medical Professionals**

I was able to speak with a number of well-qualified Christian medical
professionals throughout this project and found it interesting that many of them felt
that the concept of faith and healing fell close to their hearts as well. Those that I
spoke with felt that having a faith directly impacted much of their interaction with
patients and how they viewed their profession. They brought up key issues that
having a faith plays in the life of a medical professional including providing a more
holistic view of the patient, aspects of patient interaction, and personal daily
struggles. In a field as complex as medicine, it is important to remember that first
and foremost you are working with people. Patients are not just what results from
an illness or a diagnosis, but patients have families, jobs, and hobbies. There is so
much more to a person than their physical body. Realizing the people are spiritual
beings can change treatment dramatically and present a more holistic option. This
concept of holistic healing has been around long before modern medicine and past
fathers of medicine even encouraged a whole person view. I was directed to the
work of Paul Tournier by Dr. Ter Haar and became interested in his concept of “la
medicine de la personne.” In this method of medicine the patient was treated on a
more equal level than traditional Western medicine and was involved in deciding patient treatment.

I was interested in exploring how having a faith impacted the doctor patient relationship of those that I interviewed. A critique of the modern medical system is the sterility of the environment being echoed in the treatment of the patient. How does including discussion and support in the doctor patient relationship affect the relationship? As a health professional how does having a faith impact patient treatment? How does it help or take away from the profession? In the article by Dr. Christina Puchaski,

“Compassionate care calls physicians to walk with people in the midst of their pain, to be partners with patients rather than experts dictating information to them... The physician will do better to be close by to tune in carefully on what may be transpiring spiritually, both in order to comfort the dying and to broaden his or her own understanding of life at its ending” (Puchalski 2001)

I think including the patient in the discussion of treatments and working in a partnership is vital to a successful treatment. We have been learning the importance of building and maintaining relationships with the emphasis on empowerment and participation in developmental strategies, so why not in the health care field as well? By entering into a deeper understanding of each other, and taking the time for patients to actively participate in the treatment, it provides a way to take ownership and an element of control over an issue that largely leaves people feeling helpless in the wake of disease. The issue of professionalism comes up when discussing how much or how intensely spirituality should be brought up in the medical setting. Is
there even a desire among patients to have this addressed? In an article by D.E. King, “"Many patients expressed positive attitudes toward physician involvement in spiritual issues. Seventy-seven percent said physicians should consider patients’ spiritual needs, 37% wanted their physicians to discuss religious beliefs with them more frequently, and 48% wanted their physicians to pray with them. However, 68% said their physician had never discussed religious beliefs with them." (King DE 1994) This could work to the benefit of patient health outcomes as well as sustaining doctor-patient relationships. These relations are at the core of promoting the trust and understanding imperative to a successful medical treatment. These findings for a desire of physicians being aware of spirituality were also reflected in another study by Dr. Chattopadhyay,

"It is noteworthy that patients' interest in physicians' spirituality and their agreement with physician prayer increased with seriousness of ailments- 19% during an office-visit, 29% in hospitalization and 50% in near-death scenario. The most acceptable situations for spiritual discussion were life-threatening illnesses (77%), serious medical conditions (74%) and loss of loved ones (70%). Among those who wanted discussion of spirituality, desire for physician-patient understanding (87%) was the most important reason for discussion. Many patients believed that information concerning their spiritual beliefs would influence physicians' ability to encourage realistic hope, give medical advice and also change medical treatment." (Chattopadhyay, 2007, 263)

There seems to be a differing of awareness of spirituality correlating with the severity of each case, but there is no harm in simply asking. Bringing up spirituality may not help everyone, but it may help some and should be at least considered. Interestingly, the article by Dr. Chattopadhyay also brought up the results of
physicians addressing spiritual needs to contrast with the desires of patients. The article says that,

“In a study of physician preferences regarding spiritual behavior, about 85% of physicians believe they should be aware of the patients’ spirituality. However, most would not ask about spiritual issues unless a patient was about to die... Another study found that less than 10% of physicians routinely initiated spiritual history. There are a number of reasons for this apparent discrepancy between what physicians think they should do and they really do. These include lack of training for taking spiritual history, constraint of time, personal reservations and apprehension that addressing religious issues while practicing medicine runs the risk of taking over the role of the priest and clergy in the society.” (Chattopadhyay, 2007, 262)

In speaking with some of the physicians I asked how they felt that having a faith impacted their relationship with patients. Dr. Mannie told me that by having a faith and bringing up faith with his patients that it helped to build a strong rapport and help base the relationship in trust by bringing up a personal matter. (Mannie 2013) Both of the Dr. Govenders only saw benefits. Dr. Nishlan Govender brought up that there are many daily struggles that are faced in working with patients. He mentioned the concept of transference and how it is important to remain professional and not take personal burdens into the workplace, and likewise not to take the burdens of one patient into another. On particularly frustrating days he said that he often had to take some time alone and pray to cool off before interacting with more patients that, “That faith is having the strength to know the Helper will help deal with problems.” (D. N. Govender 2013) The job of anyone in medicine is dealing with people and being aware and careful of how you interact. His wife, Dr.
Meryl Govender said that in working with patients and her own burdens that, “God gives me the strength to face challenges with patients without bringing baggage. He gives me the grace and strength that I need and am able to draw from God Himself.” (D. M. Govender 2013)

On a more personal note, those in medicine that I spoke to brought up various ways having a faith helped them personally in dealing with struggles of the job. Nursing and medicine have been called, “the caring professions,” (D. A. Mitchell 2013) and it takes a special person to work with patients on such an intimate, personal, and sometimes heartbreaking level. In the article, “Managing Emotions in Medical School: Students’ Contacts with the Living and Dead” by Sherryl Kleinman, “Students draw on aspects of their training to manage their emotions. Their emotion management strategies include transforming the patient of procedure into an analytic object or event...by relying upon these strategies, students reproduce the perspective of Western medicine and the kind of doctor-patient relationship it implies.” (Kleinman, 1989, 56)

How can one maintain the humanity of a person while performing medical procedures, or being in close contact with disease and death? Can having a faith help to maintain a more holistic view of a person? In what ways can having a faith keep a medical student and physician from losing hope and become disheartened?

Having a faith prompted Dr. Meryl Govender to go above her job description with a particularly violent male patient who accused her of telling everyone that he had HIV/AIDS. She explained that everyone had fled but that she asked God for the courage to calm the man through the Spirit. She attributed her boldness to faith and
she managed to calm the man. She said that, “God enables and strengthens, that he gave me the words and wisdom to approach.” (D. M. Govender 2013) She also mentioned her use of faith when working in the emergency room. In especially stressful situations skills are not as good as they would be in a calm situation and that she prays, “God, work through my hands,” (D. M. Govender 2013) as a way to calm down. Speaking with Dr. and Mrs. Mitchell about how they feel having a faith has impacted their work Marianne spoke of the importance of, “having a calling.” (M. M. Mitchell 2013) That she went into nursing with the belief that it was her purpose in life, and that she would do it to the best of her abilities, “as if working for the Lord himself.” (M. M. Mitchell 2013) For her, working for the Lord through nursing, “meant dealing with patients in His name, with His love flowing through you.” (M. M. Mitchell 2013) This helped her in dealing with difficult situations with the thought that, “nothing comes from you because you are doing it all for God, and you do it with Joy.” (M. M. Mitchell 2013) Her husband, Dr. Mitchell, brought up the quote that, “medicine is the handmaiden of the Gospel.” (D. A. Mitchell 2013) To Dr. Mitchell, “The most important and critical interaction is between the patient and physician, there is a bonding and sharing in the sacred moment of pain that is very intimate, lovely.” (D. A. Mitchell 2013) He mentioned that throughout his practice, that faith helped him tremendously. Dr. Mitchell told me, “In medicine, particularly surgery, you become very conscious of how little you know, and I often prayed for wisdom.” (D. A. Mitchell 2013) He also mentioned that as a doctor death is inevitable, “to become a surgeon you need to be tough emotionally because many die and some don’t get better and it is not easy to come to terms with.” (D. A.
Mitchell 2013) There is a quote by the founder of TB sanatorium, Dr. Edward Trudeau used in an article by Dr. William E. Cayley Jr, “The role of a physician is to cure occasionally, to relieve often, and to comfort always.” (William E. Cayley Jr. 2006, 42) Dr. Mitchell mentioned that death is always a struggle, especially when you think that someone will live, and that he turned to his faith, family, and colleagues for support. He spoke of needing to admit limits and that sometimes nothing more could be done. These are hard, difficult matters where there are no easy answers. (D. A. Mitchell 2013) There is no quick fix to the pain of disease or death, but for the physicians that I spoke with faith helped them find solace and peace amidst the chaos. For them, faith helped to offer the encouragement, joy, and comfort that they needed to handle the issues of life and death, health and sickness.

**Personal Thoughts and Lessons Learned**

This project was interesting and promoted much growth academically, but even more so personally. As someone with a strong faith and desire to go into the medical field, the people that I spoke with and the issues that were brought up will stay with me throughout the rest of my learning and life. More so than the topics discussed in this paper, I learned so much about the power of generosity and taking the time to realize the importance of the little things. I was welcomed into the homes of those that I spoke with, given vast amounts of food, and entrusted with their stories and thoughts, of which I could not feel more blessed. I went into this program with expectations of wanting to see surgeries and get in on the action, but I learned the importance of taking the time to do the little things and see the impact that they have. It is the nail painting, it is the listening, and it is the
hand holding that makes a good doctor a great one. In my life I have seen those who begin the most enthusiastic and optimistic become bogged down in the negative aspects of modern medicine, and I hope that the lessons that I have learned from those I encountered on this trip will help me to maintain these characteristics. I learned that it is ok to become disheartened by death, I have seen with my eyes the dying and learned from them how to live. Most importantly, throughout this project I have learned even more about where I stand in my faith. It is something that is deeply personal and not something that I say as a way to convince or persuade, but I have seen the importance of interpretation and that there are some things that cannot and perhaps should not be proven. Through this project I have seen the importance of caring for the entirety of a person and I hope to never lose my regard for humanity, to take the time to learn favorite colors, hobbies, and names of parents and siblings. These are quite possibly the real keys to trust, love, and ultimately healing. My independent project is a reflection of who I am and what I hope to become.

**Final Thoughts**

There will never be a clear answer on where the healing ends and the faith begins. What may be truth and life for one person may not be for the next. This project did not have the aim of coming to any conclusions, which makes this section rather ironic, but rather this project was a time to consider other perspectives and continue the dialogue on the integration of faith and healing. The project was meant to compile varying thoughts and opinions from a Christian perspective and see some of the benefits and concerns involved. As the world becomes more focused on
industry and looks to science for answers, it is important to remember that not all questions will have answers. I had the chance to read the book, The Invisible Man by H.G. Wells over my project and found his questioning of the negative impacts of technology strangely similar to my own. Modern medicine and the profession of physicians is a fairly recent development. The separation of faith and healing is new and with that rupture comes a yearning for something more. For some that more may take the form of a new study or treatment, for some the more might be rooted in intellect, but for some the more is found through faith. I hope that this project can help others begin to think about these difficult questions and discover answers for themselves, after all, “Everyone believes in something.”
Bibliography


Dugan, Penny, interview by Natalie Strohmyer. Faith and Healing (April 18, 2013).


Govender, Dr. Meryl, interview by Natalie Strohmyer. Faith and Healing (April 14, 2013).


Haar, Dr. Ter, interview by Natalie Strohmyer. Faith and Healing (April 22, 2013).


Mannie, Dr., interview by Natalie Strohmyer. Faith and Healing (April 17, 2013).


Puchalski, Christina M. "The role of spirituality in healthcare." *Baylor University Medical Center* 14, no. 4 (October 2001).


William E. Cayley Jr., MD. "HE LAST WORD Comfort Always Our most important role as a physician is being a comforter to the sick." *MDiv Fam Pract Manag* 13, no. 9 (October 2006): 74.


Appendix 1: Interview Questions

1. In what ways faith can influences outlooks on health issues?
2. How can healing and faith be defined?
3. What are some concerns with integrating faith and healing?
4. How does including discussion and support in the doctor patient relationship affect the relationship?
5. As a health professional how does having a faith impact patient treatment? How does it help or take away from the profession?
6. Do health professionals feel that spirituality aids in patient health and if so why?
7. Does religion helps medical professionals in dealing with daily struggles?
8. What does it mean to have faith included in the healing process?
9. Is physical healing the only way that could be considered healing? Or is the deeper healing within the soul; is the real healing a form of acceptance, of coming to terms with the limits of our physical bodies?
10. What is the role of prayer in faith and healing? Prayer and hope for what?
11. If someone doesn’t miraculously heal, did prayers fail? What if someone dies? Is it because they did not have enough faith, is it because they doubted God’s ability to heal in a moment of weakness?
12. How much of the role of faith in healing is not so much about the faith, but about the community support, acceptance, and hope that it often provides?
13. Do any specific religious components provide evidence of patient improvement?
14. What prayers and passages of scripture are used specifically?
15. How often do people request prayer?
Appendix 2: Written Consent Forms

Consent Form For Adult Respondents in English

I can read English. (If not, but can read Zulu or Afrikaans, please supply). If participant cannot read, the onus is on the researcher to ensure that the quality of consent is nonetheless without reproach.

I have read the information about this study project and had it explained to me, and I fully understand what it says. I understand that this study is trying to find out (*Learner to state objectives*):

- The integration of faith in healing
- How faith impacts the outlook on healthcare
- How a more holistic approach to medicine affects overall treatment

I understand that my participation is voluntary and that I have a right to withdraw my consent to participate at any time without penalty.

I understand and am willing for you to observe and take notes …. And ask me questions …. (*Learner to indicate what questions will be asked*)

In what ways faith can influence outlooks on health issues?

How can healing and faith be defined?

What are some concerns with integrating faith and healing?

I do/ do not require that my identity (and name) be kept secret (*delete inapplicable*). I understand that, if requested, my name will not be written on any questionnaire and that no one will be able to link my name to the answers I give. If requested, my individual privacy will be maintained in all published and written data resulting from this study project.

I do/ do not (*delete inapplicable*), give permission for a photograph of me to be used in the writeup of this study or for future publication. I understand that the learner will not use or provide any photographs for commercial purposes or publication without my permission.

I understand that I will receive (*learner to indicate what will be given*)… or no gift or direct benefit for participating in the study.

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (18 Alton Road, Glenmore, Durban).

I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982).

I agree to participate in this study project.

Signature (participant)_____________ Date:_____________

Signature (learner)___________________________ Date: _______________
Appendix 3: Ethics Statement

SIT Study Abroad Statement on Ethics
(Adapted from the American Anthropological Association)
This document must be read, signed, and submitted to the AD prior to ethics review meeting.

In the course of field study, complex relationships, misunderstandings, conflicts, and the need to make choices among apparently incompatible values are constantly generated. The fundamental responsibility of students is to anticipate such difficulties to the best of their ability and to resolve them in ways that are compatible with the principles stated here. If a student feels such resolution is impossible, or is unsure how to proceed, s/he should consult as immediately as possible with the Project Advisor and/or AD and discontinue the field study until some resolution has been achieved. Failure to consult in cases which, in the opinion of the AD and Project Advisor, could clearly have been anticipated, can result in disciplinary action as delineated in the “failure to comply” section of this document. Students must respect, protect, and promote the rights and the welfare of all those affected by their work. The following general principles and guidelines are fundamental to ethical field study:

I. Responsibility to people whose lives and cultures are studied
Students' first responsibility is to those whose lives and cultures they study. Should conflicts of interest arise, the interests of these people take precedence over other considerations, including the success of the Independent Study Project (ISP) itself, for if the ISP has negative repercussions for any members of the target culture, the project can hardly be called a success. Students must do everything in their power to protect the dignity and privacy of the people with whom they conduct field study. The rights, interests, safety, and sensitivities of those who entrust information to students must be safeguarded. The right of those providing information to students either to remain anonymous or to receive recognition is to be respected and defended. It is the responsibility of students to make every effort to determine the preferences of those providing information and to comply with their wishes. It should be made clear to anyone providing information that despite the students' best intentions and efforts anonymity may be compromised or recognition fail to materialize.
Students should not reveal the identity of groups or persons whose anonymity is protected through the use of pseudonyms.
Students must be candid from the outset in the communities where they work that they are students. The aims of their Independent Study Projects should be clearly communicated to those among whom they work. Students must acknowledge the help and services they receive. They must recognize their obligation to reciprocate in appropriate ways.
To the best of their ability, students have an obligation to assess both the positive and negative consequences of their field study. They should inform individuals and groups likely to be affected of any possible consequences relevant to them that they anticipate.
Students must take into account and, where relevant and to the best of their ability, make explicit the extent to which their own personal and cultural values affect their field study.
Students must not represent as their own work, either in speaking or writing, materials or ideas directly taken from other sources. They must give full credit in speaking or writing to all those who have contributed to their work.

II. Responsibilities to Hosts
Students should be honest and candid in all dealings with their own institutions and with host institutions. They should ascertain that they will not be required to compromise either their responsibilities or ethics as a condition of permission to engage in field study. They will return a copy of their study to the institution sponsoring them and to the community that hosted them at the discretion of the institution(s) and/or community involved.

III. Failure to comply
When the AD(s) feel that the student has violated this statement of ethics, the student will be placed on probation.
In the case of egregious violations, students can be subject to immediate dismissal under the conditions of the SIT STUDY ABROAD dismissal guidelines.
I, ______Natalie Strohmyer______________, have read the above Statement of Ethics and agree to make every effort to comply with its provisions.

Date: _1 April 2013___________
Application for Review of Research with Human Subjects

Complete all questions (complete on separate pages where applicable, and staple to this cover sheet). Submit this document with your ISP proposal and related document to your Academic Directors.

1. Name: Natalie Strohmyer
2. Program: SFH Durban Social Policy and Community Health
3. Student Phone: 0837001217
4. Title of ISP: The Integration of Faith in Healing through the Ukukhanya Life Care Centre Serving the Ntuzuma Township of Durban, South Africa.

5. Site of ISP: Ukukhanya Life Care Centre
6. Funding Source, if any: SIT
7. ISP Advisor Name, Title, and Contact Telephone: Dr. Chouler, MD, chouler@crus.co.za

8. Brief description of the purpose of the study.
   The focus of this project will be to examine the integration of faith in the healing process. Caring for the entirety of a patient is an important role of healthcare. I would like to explore how the Ukukhanya Life Care Centre is integrating faith in the healing process. I will take multiple perspectives into account including those working at Ukukhanya, those attending the Life Care Centre, Religious Studies professors, religious leaders, and medical professionals to obtain a multi-faceted, realistic view. Time constraints will not yield generalizable data, but can be used to further the discussion on spirituality in healing.

9. Brief description of procedures relating to human subjects’ participation:
   a. How are participants recruited? And Is an inducement offered?
      I will be interacting with and interviewing those that I come into contact with working in the Ukukhanya Life Care Centre. I will meet them through the assistance of the director, Penny Dugan. I will also be interviewing religious leaders in the community. Religious Studies staff through the University of KwaZulu-Natal, and various medical professionals. Those included in the project will not be given any inducement aside from the occasional snack or drink.

   b. What is the age range of the participants?
      The age range of the participants will be adults over the age of 18, this will include those who are experts in the field, religious leaders in the community, medical professionals, and those working and attending the Ukukhanya Life Care Centre. Minors will only be involved following permission and informed consent from the legal guardian.
c. What is the gender breakdown of the participants?
Participants will be male and female. Some participants may be members of the LGBTQ and everyone will be protected ethically with informed consent, anonymity, and the choice to refuse publication.

d. What are other relevant characteristics of subjects, including (but not limited to) institutional affiliation if any?
The subjects will range from black Zulu speakers in the township of Ntuzuma in Durban, South Africa to Religious Studies faculty members at the University of KwaZulu-Natal. Other subjects will be religious leaders and medical professionals in the Durban area. Some of the subjects may be HIV/AIDS positive and they will be only be included in the study if they are able to give informed consent. If they are on intense medication and/or are otherwise compromised they will be protected and not included in the project.

e. What is the number of participants?
The number of participants is subject to vary, but due to limited time will probably be under 10.

f. If there is a cooperative institution, how was their permission obtained?
I will be volunteering in the Ukukhanya Life Care Centre in the Ntuzuma township and was granted permission from the director Penny Dugan, who I will be working with.

g. What will subjects be asked to do, and/or what information will be gathered? (Append copies of interview guides, instructions, survey instruments, etc.)
The subjects will be interviewed with casual conversation and in-depth interviews to gather a range of opinions on the integration of faith in the healing process. By interviewing members of Durban with differing backgrounds and areas of expertise I hope to gain a well-rounded view. Depending on how receptive those who come to the Ukukhanya Life Care Centre are, I may conduct a focus group to understand opinions on how faith has played a role in health with members of the staff and/or members of the community. None of these methods have explicit guides or surveys involved.

h. If subjects are interviewed, who are the interviewers?
I will be the primary interviewer of subjects and plan on conducting all of them myself. If there is a language barrier I will hire an interpreter and pay them R60.

i. In what language(s) will you interview participants? How will interpreters be paid?
I will be interviewing primarily English speakers and conducting the interviews personally. If an interpreter is needed for validity I will pay them R60.

j. How will the interviewers be trained and paid?
I will be the interviewer and no training or payment will be required. R60 will be paid to a trusted interpreter if needed.

10. Protection of human subjects. Before completing this section, you must read and agree to comply with both the SIT Study Abroad Statement of Ethics, SIT Human Subjects Policy, and the program’s additional Human Subject Research Guidelines.
   a. **Have you read and do you agree to comply with the SIT Study Abroad Statement of Ethics, SIT Human Subjects Policy, and the Human Subject Research Guidelines in the SCRHM course and handbook?**
      I agree to comply with the above guidelines.
   
   b. Do subjects risk any stress or harm by participating in this research? If so, why is this necessary? How will these issues be addressed? What safeguards will minimize the risks?
      For the most part subjects do not risk any harm by participating in this project. By working with those who may be HIV/AIDS positive it will be important to keep them protected, as their participation may result in stress or emotional harm due to the stigma and vulnerability associated with this disease. I will respect those who may suffer stigmatization safe by using informed consent, anonymity, and be sure that the right to refuse or take back statements will be honored. Furthermore, those who may be comprised due to treatment or medication associated with HIV/AIDS will not be included in the study, and only those who are able to give informed consent will be.
   
   c. How will you explain the research to subjects and obtain their informed consent to participate? Append your Informed Consent Form.
      I will explain the research to the subjects in English and use an interpreter if the subject is Zulu speaking. I will have the subjects sign an informed consent form (attached) if they would like to proceed with the project. They will be able to be protected and anonymity will be honored. They will be aware that they can take back their statements at any point and that the subjects words will be removed. If minors are involved, informed consent will be obtained through their legal guardian and they will be protected.
   
   d. If subjects are minors or not competent to provide consent, how will it be obtained?
      If minors are included in the project, informed consent will be given through their legal guardians. Protection will include anonymity, the right to refuse or take back their statements, and respect. Those who are undergoing HIV/AIDS treatments and are thus compromised will not be included in the project.
   
   e. How will subjects be informed that they can refuse to participate in aspects of the study or may terminate participation whenever they please?
In my explanation of the project and explaining the informed consent form I will include the ability to end the interview at any point. The subject will be aware that they reserve the right to take back their statements at any time and will be left with my contact information so that I can honor their request if needed.

f. If subjects are students or clients or program partners, how will you protect them from feeling coerced due to the (if only perceived) power differential? I will protect subjects from feeling coerced by assuring them of their right to refuse any statements and the right to anonymity. To eliminate any power differential I will conduct my interviews in a conversational manner and allow space for the person being interviewed the opportunity to ask me any questions they may have as well.

g. How might participation in this study benefit subjects? Participation in this study will not result in monetary benefits, but this study will help stimulate debate on including spirituality in the healing process and hopefully lend itself to creating a more holistic approach and improved patient care.

h. Will participants receive a summary of results or other educational material? Specify who will receive what. Penny Dugan will receive a summary of the results to aid in the integration of faith in healing at the Ukukhanya Life Care Centre.

11. How will the following be protected?

a. Privacy (protecting information about participants): Refers to an individual and their investment in controlling access to information about themselves.) 50 – 100 words
Privacy of the subjects involved in the study will be protected. They will be given informed consent before proceeding with any part of the study and will be aware of their right to privacy. This will be protected through the use of anonymity and the limiting of any identifying facts of the subject. Some of the subjects may be HIV/AIDS positive and to avoid stigmatization any information that is given will be placed under a different name and the subject will be protected. To ensure privacy they will reserve the right to ask me to remove any statements at any time.

b. Anonymity (protecting names and other unique identifiers of participants): Names should not be attached to the data, unless subject chooses to be identified. 50 words
If a subject wishes to remain anonymous I will honor that right and not include any names or other identifying information in my project. They will be given a different name and the information will not be traced back to the individual. If they feel uncomfortable or wish to take back any statements, I will honor this.

c. Confidentiality (protecting data about participants): How is access to data limited? Consider how coding will kept separate from information obtained; how data will
be stored and when will it be destroyed; whether data will be used in the future and, if so, how permission for further use will be obtained? 50-100 words

The confidentiality of subjects will be protected through informed consent. Interviewees will have the right to remain anonymous and will be given different names or labels, such as Subject 1. Data will be stored on notebook paper and converted to files on my computer that are password protected. Subjects will be aware that their statements may be published and that if they choose to remove their statements at any point, they will be left with my contact information so that I can honor their request. Permission will be requested and signed informed consent will be received from the subject if the project will proceed any further.

12. Are there any other details or procedures of the study that should be known by the ISP Ethics Review Committee, and if so, discuss. 1-1000 words

The Ethics Review Committee should be aware of the sensitive nature of working with those who may be HIV/AIDS positive. Being HIV/AIDS positive lends itself to stigmatization and vulnerability. The Ukukhanya Life Care Centre does not perform any medical procedures, and I will not include those who may be on intense medication or are other compromised because they are unable to give valid informed consent. I will not take advantage of those who are suffering. I come from a strong religious affiliation and I am aware of my biases as a white Christian American. I will not give my religious views throughout my interviews, but will keep an open mind and respect the differing viewpoints that I may come into contact with. These are important components of my project, but with care and respect will be conducted in an ethical manner.

By signing below I certify that all of the above information (and that attached) is true and correct to the best of my knowledge, and that I agree to fully comply with all of the program’s ethical guidelines as noted above and as presented in the program and/or discussed elsewhere in program materials. I further acknowledge that I will not engage in ISP activities until such a time that both my ISP proposal as well as my Human Subjects Research application are successful and I have been notified by my Academic Directors to this effect.

Student’s name (printed)

__Natalie Strohmyer__________

__Natalie Strohmyer__________
Student’s name (signature)