Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

June 2025. Volume 12. Number 2

Research Paper

Transforming Unani Tibb: Integrating Spiritual Care Into Clinical Practice Through Consensus

Mujeeb Hoosen[1*], Nicolette Vanessa Roman[2], Thuli Godfrey Mthembu[3], Mursaleen Naseer[4]

1. School of Natural Medicine, Faculty of Community and Health Sciences, University of the Western Cape, Bellville, South Africa.
2. Centre for Interdisciplinary Studies of Children, Family and Society, Faculty of Community and Health Sciences, The University of the Western Cape, Bellville, South Africa.
3. Department of Occupational Therapy, Faculty of Community and Health Sciences, University of the Western Cape, Bellville, South Africa.
4. Department of Moalejat, Ajmal Khan Tibbiya College, Faculty of Unani Medicine, Aligarh Muslim University, Aligarh, India.

Use your device to scan and read the article online

Please cite this article as Hoosen M, Roman NV, Mthembu TG, Naseer M. Transforming Unani Tibb: Integrating Spiritual Care Into Clinical Practice Through Consensus. Health Spiritual Med Ethics. 2025; 12(2):117-130. http://dx.doi.org/10.32598/hsmej.12.2.664.1

http://dx.doi.org/10.32598/hsmej.12.2.664.1

Article info:
Received: 09 Dec 2024
Accepted: 05 Apr 2025
Publish: 01 Jun 2025

Keywords:
Consensus workshop, Clinical guidelines, Spirituality, Spiritual care, Unani Tibb

ABSTRACT

Background and Objectives: Unani Tibb is a holistic medical system incorporating traditional healing practices from Africa, Europe, the Middle East, and Asia. It emphasizes healing the mind, body, and soul; however, spirituality and spiritual care often remain underexplored in practice. There is a recognized need for guidelines on spiritual care within Unani Tibb clinical practice as a vital component for transformation.

Methods: A two-phased sequential exploratory research design was used to create guidelines for integrating spirituality and spiritual care into clinical practice. Phase two involved a consensus workshop with Unani Tibb stakeholders from South Africa, informed by the findings of phase one, which included various quantitative, qualitative, and mixed-methods studies. Qualitative data from phase two underwent thematic analysis to extract key insights.

Results: A diverse panel of 14 registered educators, practitioners, researchers, and experts in Unani Tibb was successfully formed from three provinces in South Africa. This collaborative effort led to the development of 40 comprehensive guidelines to enhance spiritual care within Unani Tibb clinical practice.

Conclusion: The consensus workshop recommends that Unani Tibb spiritual care guidelines reflect its foundational philosophy. This includes establishing competencies in spiritual care, facilitating the process of spiritual history-taking, conducting temperament analyses, outlining treatment protocols, implementing a referral system, and promoting ongoing personal and professional development by integrating aspects of spirituality and spiritual care.

*** Corresponding Author:**
Mujeeb Hoosen
Address: *School of Natural Medicine, Faculty of Community and Health Sciences, University of the Western Cape, Bellville, South Africa.*
Phone: *+27 (21) 9592615*
E-mail: *mahoosen@uwc.ac.za*

Copyright © 2025 The Author(s);
This is an open access article distributed under the terms of the Creative Commons Attribution License (CC-By-NC: https://creativecommons.org/licenses/by-nc/4.0/legalcode.en), which permits use, distribution, and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.

Introduction

Spirituality and traditional medicine are intrinsically linked and vital to communities worldwide [1-4]. Traditional practices incorporating spirituality and religion play a crucial role in most communities' health, well-being, and healing [4-6]. Unani Tibb represents the culmination of over 10,000 years of traditional healing practices derived from Africa, Europe, Asia, and the Middle East [7, 8]. Known as Greek medicine, Unani Tibb is a traditional medicinal system founded on the healing principles of Hippocrates, Galen, and Ibn Sina [4, 8]. The West recognizes Ibn Sina as Avicenna, the "Prince of Physicians", a title he earned through his mastery of various fields, including medicine and philosophy [4, 8].

Ibn Sina expanded upon the humoral and temperamental theories established by Hippocrates and Galen, creating a comprehensive medical practice that encompassed philosophy, ethics, etiology, pathology, psychology, spirituality, spiritual care, religion, metaphysics, diagnosis, and treatment [8, 9]. He authored over 220 notable works, with the "Canon of Medicine" becoming the foremost medical textbook in both the East and the West for several centuries [8, 9]. In his renowned "Book of Healing", Ibn Sina delves into the concepts of the soul, spirituality, spiritual care, and their connections to intellect, mental faculties, and emotions. He emphasized the importance of person-centered care within a biopsychosocial-spiritual model [8, 9]. However, studies indicate a lack of integration of spirituality and spiritual care concepts in the Unani Tibb profession, highlighting a significant theory-practice gap both nationally and internationally [10-12].

Spirituality is a fundamental aspect of humanity that influences individuals' quest for meaning and purpose, encompassing various beliefs and practices, while religion provides a structured framework for expression [13, 14]. Research shows that higher levels of spirituality and religiosity are linked to better health outcomes, highlighting the need for healthcare professionals to address patients' spiritual needs as part of ethical care [5, 13-20]. Spiritual care is crucial for holistic patient care and has demonstrated benefits for mental and physical health, quality of life, hopefulness, and resilience [5, 13-20]. However, spiritual care is often overlooked in healthcare settings, particularly within traditional medicine systems, like Unani Tibb [10-12, 18].

Unani Tibb represents one of the most ancient forms of traditional medicine, practiced in more than 82 World Health Organization (WHO) member countries, including South Africa [10-12]. The practice of Unani Tibb has undergone significant transformations over time and across different regions, influenced by many factors, including politics, religion, economics, and colonialism [10-12, 21]. The Western medical paradigm, particularly in colonized areas, has adversely affected the preservation and implementation of holistic principles of traditional medicine. To achieve broader acceptance, Unani Tibb was compelled to conform and adapt within a reductionist biomedical framework that prioritized mechanistic practice over holistic approaches [10-12]. In South Africa, traditional healing systems faced criminalization and were regarded as uncivilized, unscientific, and superstitious under the apartheid regime [22-24]. A substantial portion of the South African population currently engages with traditional medicine intricately linked with religion and spirituality. Given South Africans' rich linguistic, cultural, and spiritual diversity [22-25], healthcare professionals are encouraged to address the cultural needs of the population by integrating spiritual care into clinical practices [4, 11, 12, 18, 25].

In 2019, the need for spiritual care guidelines in Unani Tibb was acknowledged during the South African Tibb Association's National Annual General Meeting and further discussed at an International Conference hosted by Muslim Aligarh University in partnership with the Ministry of AYUSH. The research highlighted a strong demand for these guidelines from various Unani Tibb stakeholders [4, 11, 12]. Clinical practice guidelines are essential tools to enhance decision-making processes and ensure the delivery of high-quality, patient-centered care [26]. This study is dedicated to developing comprehensive and consensus-driven spiritual care guidelines specifically tailored for Unani Tibb clinical practice, in response to the current absence of such guidelines [4, 11, 12]. Addressing this significant gap aims to foster an integrated approach that recognizes and incorporates spiritual care into patient treatment, promoting holistic well-being and improved health outcomes.

Methods

Guideline development process

The research team agreed on a two-phased sequential explanatory research design to develop guidelines for integrating spirituality and spiritual care into Unani Tibb clinical practice [4]. In phase one, a scoping review on the role of spirituality and spiritual care in complemen-

tary and alternative medicine [10] was conducted, followed by a series of quantitative [11], qualitative, and mixed-methods studies [12]. These studies identified and explored the role of spirituality and spiritual care in Unani Tibb education and practice. In stage one, 44 registered Unani Tibb practitioners participated in a quantitative study [11], followed by 28 registered Unani Tibb students and educators in a mixed-methods study in stage two [12]. In stage three, five registered Unani Tibb practitioners and five patients participated in the qualitative study. The combined study findings and recommendations informed the proposed spiritual care guidelines for the consensus workshop of phase two. A summary of the findings from the quantitative, qualitative, and mixed-methods studies of phase one is presented in Table 1.

Study design

Workshops are a significant research methodology contributing to learning, teaching designs, and clinical practices. They are particularly effective in participatory research, promoting meaningful negotiation and authentic participation between researchers and participants [27]. The primary objective of the consensus workshop is to co-generate ideas through structured feedback and to synthesize individual responses until a consensus is achieved. This group technique fosters productive small-group discussions and enables rapid feedback [28]. For the purposes of this study, the consensus workshop was deemed suitable for developing spiritual care guidelines pertinent to Unani Tibb clinical practice. The research was guided by the question: "How can spiritual care guidelines be developed for Unani Tibb clinical practice utilizing a consensus workshop?"

This investigation employed a qualitative research design, which is recognized as a valuable method for data collection [29]. The consensus workshop approach has been acknowledged as a reliable mechanism for generating valid data [30]. Critical components for the success of a consensus workshop include the involvement of participants with shared interests, completion within a defined timeframe, ensuring that attendees possess experience and familiarity with the research topic, facilitating active participation from all individuals, and achieving a formulated outcome upon completion. The consensus method has garnered recommendations in areas, such as spiritual care, palliative care, nursing, and social work [13, 14, 30].

Before the consensus workshop, the proposed spiritual care guidelines were disseminated via email to eight certified experts in spiritual care, specializing in education, research, and clinical practice within an international spiritual care association. All feedback and recommendations provided by these experts were duly integrated into the finalized guidelines. Then, a pilot study was conducted involving university faculty researchers across various interdisciplinary fields, including interdisciplinary studies of children, families, and society, occupational therapy, spiritual care education and practice, social work; complementary and alternative medicine, interprofessional education and practice, industrial psychology, and nursing education. The pilot study was executed in a manner consistent with the intended approach for the main study. All participants provided critical insights regarding the methodology and feasibility of the research. Their feedback significantly enhanced the reliability and validity of the final study, and all recommendations were incorporated into the final version of the study.

Sampling strategy

A pragmatic approach informed the sampling method for the consensus workshop. A purposive sampling technique was employed to identify Unani Tibb experts and stakeholders from the national regulatory body, an institution of higher education, a professional association, and a non-profit organization dedicated to the research, practice, and education of Unani Tibb in South Africa. This group also included study participants from previous quantitative, qualitative, and mixed-methods studies conducted in phase one.

Participants and inclusion criteria

The researcher sent email invitations for a consensus workshop to 55 potential panelists in the field of Unani Tibb. The invited experts and stakeholders were drawn from the University of the Western Cape, the Ibn Sina Institute of Tibb, and the South African Tibb Association (SATA). The inclusion criteria were as follows:

1. Academics with experience in teaching, research, and publishing on Unani Tibb and/or spirituality/spiritual care.

2. Registered Unani Tibb practitioners qualified in multiple health professions (such as allopathic medicine, nursing, psychology, social work, nutrition, and African traditional medicine).

3. Registered Unani Tibb practitioners who have been actively practicing in community clinical settings for five years or more.

Table 1. A Summary of the findings from the quantitative, qualitative, and mixed-methods studies of phase one

Phase 1	Findings and Recommendations That Informed the Proposed Spiritual Care Guidelines of the Consensus Workshop
Stage 1: Quantitative study Sample group: Registered Unani Tibb practitioners, regulators, and association members	Spirituality and spiritual care were regarded as fundamental to Unani Tibb philosophy and medical ethics. Positive perceptions and attitudes regarding spirituality and spiritual care were recorded for Unani Tibb practitioners. The spiritual needs of patients were considered vital to Unani Tibb treatment. Unani Tibb practitioners reported a lack of training and knowledge in spirituality, spiritual care, and spiritual assessment tools. Unani Tibb practitioners expressed a high level of discomfort and a low level of confidence when addressing matters of spirituality in practice. The role of spiritual care in the scope of practice is unclear. Barriers to spiritual care included insufficient knowledge and training, insufficient. time, general discomfort, and concern about offending the patients. There is a need for spiritual care educational initiatives using a multidisciplinary approach by experts.
Stage 2: Mixed-methods study Sample group: Registered Unani Tibb students and educators (lecturers, clinical supervisors, external moderators and external examiners)	A heightened level of spiritual awareness was recorded for Unani Tibb students and educators. Participants viewed spiritual care as integral to Unani Tibb philosophy, education, and practice. The lack of spirituality and spiritual care content in the curriculum was confirmed. Spiritual care is beneficial to all (students, educators, practitioners, and patients). Uncertainties regarding the role of spirituality and spiritual care in Unani Tibb practice. Barriers to spiritual care included insufficient knowledge and training, general discomfort, cultural diversity, a concern of offending the patients, and institutional barriers. Formal integration of spirituality and spiritual care concepts in Unani Tibb education was identified as a necessity to ensure the integrity of the holistic approach required by the profession.
Stage 3: Qualitative study Sample group: Registered Unani Tibb practitioners and their patients	A high level of spiritual care competence was recorded for Unani Tibb practitioners. Participants viewed spirituality and spiritual care as part of Unani Tibb philosophy and clinical practice. Traditional healing practices based on religion and spirituality are interwoven into Unani Tibb therapies. Barriers to spiritual care included insufficient knowledge and training, general discomfort, cultural diversity, and concern about offending patients. Spiritual care is essential for both practitioner and patient. Spiritual care guidelines are urgently needed for Unani Tibb clinical practice.

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

4. Registered Unani Tibb practitioners trained and/or qualified in spiritual care, religion, counseling, traditional healing, metaphysics, spiritual therapies, emotional healing, psychotherapy, or related fields.

5. Registered Unani Tibb practitioners who have participated in previous studies on spirituality and spiritual care in South Africa.

6. Registered Unani Tibb practitioners who are current or former professional national regulatory body board members.

7. Registered Unani Tibb practitioners who are current or former executive board members of the SATA.

8. Registered Unani Tibb practitioners who are currently practicing, teaching, researching, or publishing on Unani Tibb from the Ibn Sina Institute of Tibb.

All participants were registered Unani Tibb practitioners actively involved in various areas of the profession (n=14). Some were also registered and practicing in other health professions, including nursing (n=2), psychology (n=1), medicine (n=1), counseling (n=1), and nutrition (n=1). A few participants held master's degrees in medical bioscience (n=1), child and family studies (n=1), and anthropology (n=1). Most participants held Unani Tibb degrees (n=11), while a few had postgraduate diplomas in Unani Tibb (n=3).

Most participants were female (n=12), with a small number being male (n=2). Most participants (n=12) received training in traditional healing methods, including reflexology, African traditional medicine, reiki, energy healing, divination, spiritual healing, traditional healing methods, prayer medicine, and hijama (religious cupping therapy). A few participants (n=2) reported training in religious studies, with one specializing in Islamic sciences (including Quran memorization, explanation, and translation, as well as Prophetic narrations) and another in counseling and mental health (n=1).

Most participants were involved in multiple areas of the profession, including education (n=11), clinical research (n=11), representation on the national regulatory body (n=4), and service on the professional association executive committee (n=7). Some Unani Tibb experts (n=3) had more than 20 years of clinical experience,

Table 2. Unani Tibb experts and stakeholders' information

Variables	Category	Number
Age (y)	26-35	3
	36-45	7
	46-55	2
	56-65	1
	66-70	1
Gender	Female	12
	Male	2
Location in South Africa	Northwest Province	1
	Gauteng Province	4
	Western Cape Province	9
Qualifications in healthcare	Master of science (medical bioscience)	1
	Master of arts (child and family studies)	1
	Master of arts (anthropology)	1
	Bachelor of science in complementary health sciences	11
	Bachelor of science in complementary medicine in Unani Tibb	11
	Postgraduate diploma in Unani Tibb	3
	Postgraduate diploma in health professions education	1
	Bachelor of science in medicine and surgery	1
	Bachelor of arts (psychology and media)	1
	Bachelor of arts honours (psychology)	1
	Diploma in nursing	2
	Higher diploma in health sciences	1
	Counsellor	1
	Reflexology	1
	Nutritionist	1
	African traditional healer	1
	Reiki master	1

Variables	Category	Number
Courses/workshops completed	Hijaama (religious cupping therapy)	1
	Spirituality	1
	Islamic studies	4
	Prayer medicine	1
	Spiritual healing/reformation	1
	Bible studies	2
	Islamic psychology and counselling	1
	Islamic marriage counselling	1
	Islam and mental health	1
	Traditional health	1
Unani Tibb clinical experience (years)	5-10	6
	11-15	4
	16-20	1
	21-25	3
Unani Tibb education	Former/current educator (coordinator, lecturer, clinical	3
	supervisor external moderator/examiner)	11
Unani Tibb clinical research	Former/current researcher	11
Unani Tibb Professional Association	Former/current executive board member	7
National regulatory board	Professional board member/Unani Tibb council representative	10
	Education Committee/Finance Committee	4
Are you spiritual/religious/both?	Both	14
Religion	Islam	11
	Christianity	3

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

while others (n=4) had over 14 years of experience. The stakeholders varied in their clinical experience, with some having five years or more (n=3) and others having 10 years of experience (n=3).

In this study, most participants were identified as Muslim (n=11), while some were identified as Christian (n=3). All participants (n=14) considered themselves both religious and spiritual. A total of eight Unani Tibb experts and six Unani Tibb stakeholders participated in this study (Table 2).

Data collection

This study aimed to gain participation from multiple experts and stakeholders across all provinces in South Africa. An online platform for the consensus workshop was adopted to mitigate financial, time, and geographical constraints. Data were collected from registered Unani Tibb experts and stakeholders in regulation, education, clinical practice, and research.

Consensus workshop protocol

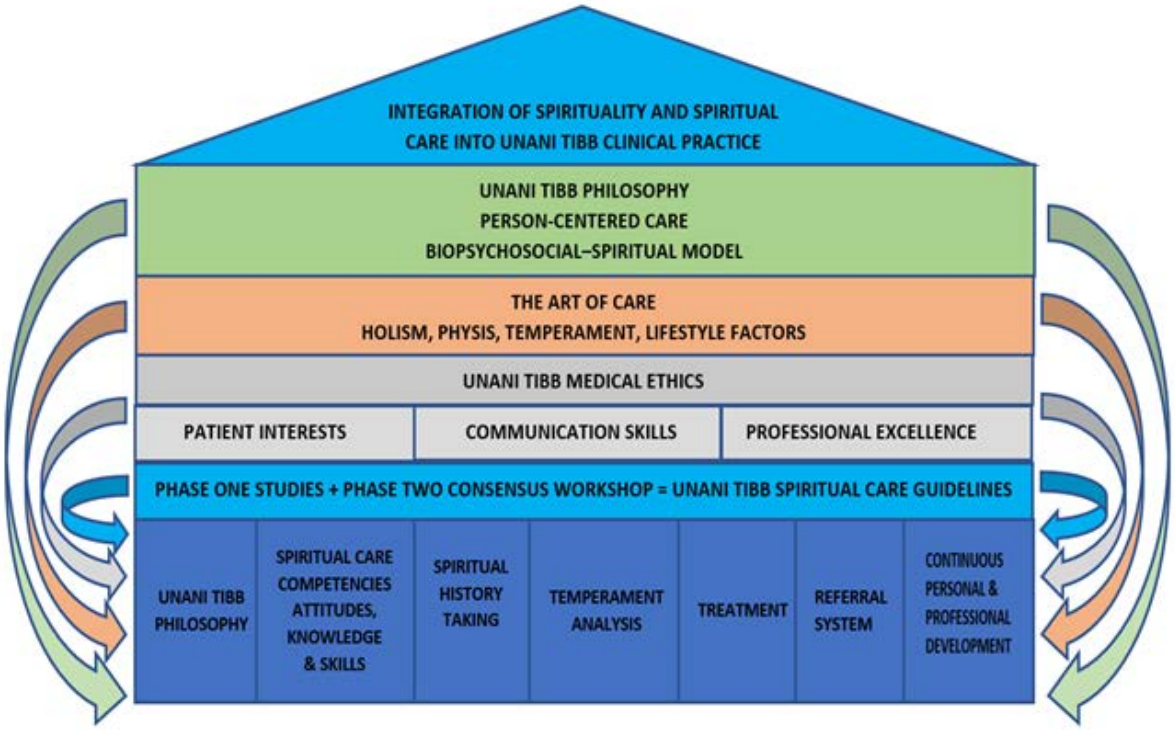

Figure 1. Integration model of spirituality and spiritual care into Unani Tibb clinical practice

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

The study researcher acted as the facilitator for the consensus workshop. The facilitator outlined the workshop's aim, objectives, and procedures for reaching a consensus, followed by facilitating group discussions and encouraging individual opinions, expressions, and suggestions. All participants had an equal opportunity to share their ideas, engage in discussions, critique, and vote on the proposed guidelines.

The workshop was conducted online via the Google Meets platform and lasted for 2 hours and 30 minutes. It was scheduled at a date and time suitable for all participants. The entire session was video recorded, and the audio was transcribed using Google Meets' automated built-in functions. This ensured that all information was accurately captured and readily available for retrieval, analysis, and verification. Transcribed data could be cross-checked with the video recordings to ensure accuracy. Video conferencing has become a popular and effective platform for teaching, learning, and reaching consensus in various academic, research, and clinical settings. It provides a shared space fostering community and practice across vast geographical locations [27]. Participants were located in three provinces in South Africa, making this online platform the most suitable option for this cohort.

The first part of the workshop introduced the background of the study and lasted for 50 minutes. It summarized the findings of quantitative, qualitative, and mixed-methods studies on spirituality and spiritual care in the Unani Tibb profession. Participants were encouraged to ask questions at any point during the presentation. The second part focused on presenting the proposed guidelines, which lasted for 1 hour and 30 minutes. The facilitator connected the findings of each published study to each item of the proposed guidelines. Participants were emailed the published studies before the workshop to familiarize themselves with the origins of the proposed guidelines.

The panel of experts and stakeholders was requested to provide verbal and written feedback regarding: 1) The value, usefulness, and feasibility of each guideline; 2) The language used and its suitability for the Unani Tibb clinical setting; and 3) Any recommended deletions or additions to the spiritual care guidelines.

During the workshop, participants were consistently encouraged to voice their opinions at any point and at the end of each presented guideline. They were reminded to click the 'raised hand' icon to indicate their readiness to comment. The facilitator promoted participant engagement by periodically encouraging questions, comments,

impressions, and opinions. The dialogue remained unobstructed, free from interruptions by the facilitator or other participants, allowing each participant to speak for as long as needed without restrictions. This approach fostered dynamic discussions and gave participants adequate time to ponder and respond. Further discussions occurred only after it was clear that participants had finished their initial responses, leading to in-depth, descriptive information and vibrant interaction among all participants (Table 3).

Participants were also encouraged to use the chat box to express their views and ideas, allowing for follow-up questions or comments related to feedback from others. This contributed to the integrity of the iterative process necessary for reaching a consensus. During the workshop, an online Word document containing the proposed guidelines was shared with all participants. The document included columns for 'Agree', 'Yes', or 'No' for each item, along with an adjacent column for comments. This document remained online for three weeks, and all participants had commentator rights. All suggestions and recommendations from participants were considered and integrated into the finalized guidelines. The online document facilitated transparency during the member-checking period, allowing for verification by all participants and achieving a final group consensus on the spiritual care guidelines.

Qualitative data were analyzed through thematic analysis, starting with familiarization to gain insights. Next, the data were coded by identifying relevant segments, organized into categories, and refined into main themes and sub-themes. Each theme was reviewed against the coded data and the full dataset. Finally, the essence of each theme was defined and compiled into a comprehensive report of the findings [29].

Results

Unani Tibb experts and stakeholders reached the following consensus:

1) All participants agreed on 40 guidelines pertinent to clinical practice. They provided feedback on each guideline's value, usefulness, and feasibility for Unani Tibb clinical practice (Table 3).

2) It was recommended and agreed upon to add one word to two guidelines (guidelines 2.2 and 4.1) and to amend a term within one guideline (guideline 2.9). These changes have been incorporated into the finalized guidelines (Table 4).

3) The iterative process leading to the finalized guidelines received unanimous approval. Table 3 presents the finalized guidelines and participants' comments, overall impressions, and closing remarks for each guideline.

Discussion

To our knowledge, there are no established spiritual care guidelines within Unani Tibb clinical practice. Practitioners urgently require these guidelines to address their patients' spiritual needs. A significant portion of the South African population relies on traditional healing practices for their health and well-being, many of which are closely intertwined with religious and spiritual beliefs. Research indicates that South Africans expect spiritual care from Unani Tibb practitioners; however, the profession lacks comprehensive spiritual care guidelines [4, 11, 12].

The objective of the consensus workshop was to develop spiritual care guidelines to assist Unani Tibb practitioners in their clinical work. Experts and stakeholders in Unani Tibb reached a consensus on the following key guidelines: 1) Philosophy of Unani Tibb, 2) Spiritual care competencies, 3) Spiritual history-taking, 4) Temperament analysis, 5) Treatment, 6) Referral system, and 7) Continuous personal and professional development. Integrating spirituality and spiritual care into Unani Tibb clinical practice draws from prior studies, Unani Tibb philosophy, and medical ethics (Figure 1). The finalized guidelines are based on an international consensus report to enhance the spiritual dimension of whole-person care [13, 14]. The report provides a framework for incorporating spiritual care across various healthcare facilities and applies to all clinical environments [13, 14]. A workshop on spiritual care in Unani Tibb emphasized establishing a foundational level of care consistent with expected standards across health professions [13, 14]. These recommendations align with Unani Tibb medical ethics, prioritizing patient interests, effective communication, and professional excellence [31].

The philosophy of Unani Tibb serves as a foundational guideline, emphasizing a holistic, person-centered approach in healthcare that incorporates biopsychosocial and spiritual components [8, 32]. Panelists agreed that spiritual care should be standard practice within Unani Tibb due to the holistic foundations of the profession. There is a pressing need for guidelines to bridge the

Table 3. Finalized guidelines and comments by experts and stakeholders

Spiritual Care Guidelines for Unani Tibb Copyright © 2025, M Hoosen. All Rights Reserved.	Comments by Experts and Stakeholders
1.Philosophy of Unani Tibb 1.1 Unani Tibb recognizes the integration of the physical, psychological, social, and spiritual aspects of healthcare.	"Our main focus is holistic treatment." "I agree however I do feel the spiritual aspects still need attention as it's not addressed as it should and that could be due to insufficient knowledge from the practitioner." "I appreciate that 'psychological'(broader) is used here, instead of 'mental'." "A person has to believe in spirituality in order to give the care aligned to this philosophy."
2. Spiritual care competencies: Attitudes, knowledge and skills 2.1 Spiritual care attitudes 2.2 To be aware that spirituality, religion, culture, historical and social background, and ethnicity are important aspects of human diversity 2.3 To demonstrate respect and appreciation for patients from diverse spiritual, religious, or secular backgrounds. 2.4 To be aware of one's spiritual and religious background, beliefs, and biases which may influence clinical practice. 2.5 To cultivate an empathetic, non-judgmental, and spiritually nourishing clinical environment.	"Patients choose any of us in the Unani Tibb field for the spiritual aspect, therefore, I fully agree with this." "The person needs to have spiritual knowledge and the correct attitude to treat a patient." "Every practitioner needs to respect the patient's spiritual belief." "The awareness about spirituality in comparison to religion and culture and historical background and ethnicity is so important." "Yes, and being aware of your biases and insecurities." "Having done this in both nursing and metaphysical workshops that I have attended, there is a step-by-step, as much as it is personal and intimate there is a necessary factor as practitioners that we provoke, like mentioned earlier, to ignite the aspect of spirituality in that person." "Essential, as the opposite can turn patients away and distance them from the healthcare provider, this is a constant work in process and requires a great deal of self-awareness."
2.6 Spiritual care knowledge 2.7 To understand the concepts of spirituality, spiritual care, and religion. 2.8 To understand the difference between religion and spirituality. 2.9 To understand how religion and spirituality are interconnected. 2.10 To be aware of diverse religions, spiritual beliefs, and traditional healing systems common in the community. 2.11 To be aware of diverse religious and spiritual beliefs and practices that may support healing and health promotion 2.12 To be aware of experts in mental health, spirituality, spiritual care, religion, and traditional healing. 2.13 To understand that the delivery of spiritual care depends on spiritual care knowledge and competencies. 2.14 To know one's limitations in delivering spiritual care and to refer to the appropriate spiritual caregiver.	"The practitioner has to have the knowledge in order to deal with spiritual issues." "I believe we should have a certain amount of knowledge on each religion out there, very briefly not too in-depth." "As Unani Tibb physicians we should differentiate between religion and spirituality as sometimes, we overlap the two." "Strongly agree, also I feel these things are constantly evolving." "When you know where people are coming from and what their foundation is, it is just so much easier to bring in the aspect of spirituality." "Yes, networking and a strong referral system are important." "I absolutely agree with all of them, and the reason for that is because we need to know if I am going to send my patient to someone in Cape Town or Durban that there is a standardized competency and knowledge so that everyone is on the same page." "An appropriate spiritual caregiver can be life-changing for the patient and have a positive ripple effect."
2.15 Spiritual care skills 2.16 To inquire about the spiritual and/or religious background and practices of the patient as part of the routine medical history-taking 2.17 To conduct formal spiritual history-taking based on standardized tools such as FICA (Faith, Beliefs, Importance, Community, Address in care or action), SPIRIT (Spiritual belief system, Personal Spirituality, Integration, Rituals, Implications, and Terminal events) or HOPE (Hope, Organized religion, Personal spirituality, Effects of care and decisions) amongst others. 2.18 To identify the spiritual and/or religious concerns of patients and make appropriate referrals when necessary. 2.19 To deliver spiritual care according to one's level of knowledge, competency, and qualification. 2.20 To actively engage with research and professional developments regarding spirituality, spiritual care, and religion and to establish an evidence-based practice. 2.21 To collaborate with a network of experts in mental health, spirituality, spiritual care, religion, and traditional healing.	"Patients may have suffered trauma that they associate with religion, spirituality or 'God' and this can need time and a careful approach. We need to develop the competency to be aware of the sensitivity here." "Competency definitely required here." "If we all have the same qualification and there is consistency, I can send my patient to a doctor and I will know she will carry on where I started because we following a step-by-step aspect of learning on how to bring about spirituality in someone's life." "I feel this would depend on the presenting complaint and/or reason the patient seeks treatment. An acute illness like a 'cold' may not necessarily need the religious background to be questioned about in the history taking as it is likely to be a quick consult." "Yes, to constantly strive to improve to give the patient the best." "Spirituality is such a focal area in research, globally there are those that are trying to re-ignite spirituality and bring it back into the medical model. I think that is really big." "The fact that the community has opened the door to identify and acknowledge spirituality as a major component in healing is a step in the right direction."

Spiritual Care Guidelines for Unani Tibb Copyright © 2025, M Hoosen. All Rights Reserved.	Comments by Experts and Stakeholders
3. Spiritual history-taking 3.1 Invite the patient to share their worldview (secular, religious, or spiritual) and related practices. 3.2 To invite the patient to define spirituality and describe spiritual goals in their context. 3.3 To gather information about the patient's views and values (traditional, religious, and spiritual). 3.4 To identify concerns, needs, and resources relating to spirituality. 3.5 To identify spiritual/religious/secular community support structures (may include people and places). 3.6 To identify patients who need a referral to a traditional healer, spiritual healer, religious leader, spiritual care practitioner, spiritual therapist, or mental health professional.	"Yes when indicated and/or relevant." "I feel this should be in relation to their health/ main complaints." "Yes, that is if the patient is willing." "Healing comes in so many different ways but more so in what people believe in." "It does play an important role to do a background check on different religions, on different social backgrounds and ethnicities." "That surgery of mine is a healing place, we even have prayers there." "A handout with this information should be available for each patient to take home so the patient has the information on hand for when it is needed." "Yes, I am concerned about not knowing when a referral is needed/ necessary." "Yes, because the patient will be healed by what they are spiritually aligned to."
4. Temperament analysis 4.1 To consider and include the spiritual characteristics of the patient's temperament (Mizaj).	"This could be helpful." "Very interested in the link between temperament and spiritual characteristics (strengths, weaknesses, etc.)."
5. Treatment 5.1 To consider and include the spiritual or religious aspects of the patient in the treatment plan (lifestyle/governing factors, prescribed medication, and therapies)	"Spirituality comes into play during treatment and management and it becomes infused into the governing factors." "Yes, strongly agree." "Consider the issue of Hijaama (a traditional form of cupping) also known as spiritual treatment via cupping therapy."
6. Referral system 6.1 Should be professionally and culturally diverse and include registered healthcare professionals, religious leaders, certified spiritual care practitioners, spiritual therapists, and traditional healers.	"One must know their limitations and refer." "To refer to people that have the know-how."
7. Continuous personal and professional development 7.1 Continuous personal development 7.2 To increase knowledge of one's worldview and spiritual/ religious/traditional background. 7.3 To increase knowledge and awareness of one's biases and barriers that may inhibit spiritual care in practice 7.4 To increase knowledge and application of spirituality and spiritual care concepts in one's life 7.5 Continuous professional development 7.6 To develop spiritual care competence through interprofessional education and practice (to engage with experts in spirituality, spiritual care, mental health, traditional healing, and religious studies) 7.7 To increase knowledge of belief systems (secular, religious, spiritual, and traditional) and varying views and approaches to healing.	"Spirituality is not only personal to the patient but it is also personal to the practitioner as well because it requires a lot of introspection and reflection and you have to face your own 'demons'." "Yes, so that we can change our worldview, if necessary." "To be constantly accountable and present to do this work, but also the art of knowing when to take a break (self-care) as it can be exhausting." "Just as the patient is vulnerable coming to me with these spiritual concerns I noticed my vulnerability in that and my own incompetency in that." "Yes, so that we are aware of the developments in our environment." "We need to be knowledgeable so that we have a diverse view of the world."
Closing remarks and overall impressions of the guidelines	"Overall, I am happy with all of these guidelines, because honestly I just needed some form of reference where this is concerned. I feel that this is an excellent initiative." "When you dealing with human emotions and human spirituality, it is a lot of scaffolding, a lot of layering that needs to take place, but the fact that you have laid this foundation now and you opening up the realm of continuous professional development focusing on spirituality, I think that is the step in the right direction and it can only get better from here on." "This definitely gives me more confidence and contentment." "I think these guidelines are extremely useful." "The evidence was not just from an academic realm but it was also participatory, from a community basis which I think was a very good aspect, there is a lot more detail that needs to be happening but this is a good start." "I'm just happy for some sort of reference point which this is a good example of and in the future we can just refine it some more." "This is a good guideline as a starting base for us." "As we went through it you answered my questions, particularly the 'situatedness' which is more expansive, it is not just the religious but also the traditional backgrounds, particularly because we are on the African continent and we are working from sub-Saharan Africa. For me, that was very well put." "I want to wrap up and say thank you for the experience and for involving us and for the knowledge you have shared and all the best with the completion of this."

Table 4. Amended guidelines

Spiritual Care Guideline	Expert/Stakeholder Recommendations	Amended Guideline
2.2 To be aware that spirituality, religion, culture, social background, and ethnicity are important aspects of human diversity.	"One's historical background significantly shapes one's mindset by influencing not only values but spirituality and belief systems as well."	2.2 To be aware that spirituality, religion, culture, historical and social background, and ethnicity are important aspects of human diversity.
2.9 To understand how religion and spirituality are connected.	"Connected (single thread) or interconnected (web of connections)"	2.9 To understand how religion and spirituality are interconnected.
4.1 To consider and include the spiritual characteristics of the patient's temperament	"The term 'temperament' has taken on different meanings, particularly in the behavioral sciences, not accurate with regard to temperament as understood in Unani Tibb - 'Mizaj' may be a more accurate term to use, with broader meaning."	4.1 To consider and include the spiritual characteristics of the patient's temperament (Mizaj)

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

theory-practice gap, as supported by previous studies on Unani Tibb education and clinical practices [4, 11, 12]. The guidelines highlight spiritual care competencies, which encompass attitudes (guidelines 2.1 to 2.5), knowledge (guidelines 2.6 to 2.14), and skills (guidelines 2.15 to 2.21). Research indicates that spiritual care competence is essential for holistic patient care [4, 11-14, 18, 19]. While practitioners in South Africa demonstrate positive attitudes toward spiritual care, they encounter challenges regarding knowledge and skills [4, 11, 12]. Experts emphasize the significance of cultural awareness and the historical impact of apartheid on traditional healing practices [22-24], advocating for multicultural sensitivity in healthcare. Similar concerns regarding cultural competence in spiritual care are also present in fields, such as psychology [20], nursing [17], and occupational therapy [18].

A consensus was reached on enhancing spiritual care in South Africa, highlighting the need to understand and differentiate spirituality, spiritual care, and religion. Panelists stressed the importance of recognizing the connections between religion and spirituality in traditional healing and called for practitioners to be aware of diverse religions for appropriate referrals [22-25]. Engagement with local faith groups, spiritual leaders, and traditional healers is recommended for managing spiritual care [25]. Concerns were raised about the potential overreach into the domains of other professions, including psychology, palliative care, and theology. These views support earlier studies that found Unani Tibb practitioners were unclear about their role in spiritual care due to ambiguities in their scope of practice [4, 11, 12].

Concerning guidelines 2.15 to 2.21, which address spiritual care skills, all panelists concurred on the significance of incorporating spiritual history-taking as a fundamental skill for providing spiritual care [13, 14, 18-20]. However, some panelists observed that not all patients may need spiritual history-taking, especially in cases of acute conditions, like the common cold. One panelist also proposed that spiritual history-taking could be more suitable during follow-up consultations, considering the level of trust required to begin spiritual care (guidelines 3.1 to 3.6). These insights further emphasize the necessity for spiritual care tools to classify patients according to their specific spiritual care needs.

Research shows that Unani Tibb practitioners are largely unaware of spiritual assessment tools [4, 11, 12]. Panelists recommend using standardized instruments, like FICA, SPIRIT, or HOPE during routine medical histories (guideline 2.17). They stress the need for training in spiritual care to address potential trauma related to spirituality (guideline 2.20) and underscore the importance of spiritual care competencies for holistic practice [4, 11, 12]. Essential skills for Unani Tibb include making appropriate referrals (guidelines 3.6, 6, and 6.1), providing competent spiritual care (guideline 2.19), and collaborating with experts (guideline 2.21). The panelists advocate for incorporating spiritual aspects into temperament analysis (guidelines 4 and 4.1) and integrating spiritual dimensions into treatment plans (guidelines 5 and 5.1), in alignment with traditional healing practices in Unani Tibb across various regions [4, 8, 11, 12, 32, 33].

The panelists recommended dividing guideline 7 into two subtopics: Continuous personal development (guideline 7.1) and professional development (guideline 7.5). They highlighted that personal development in spiritual care is essential for professional growth [13, 14, 19] and recognized the importance of spiritual care for patients and practitioners. They proposed adding self-awareness and self-care to guideline 7.4, underlining that

understanding personal beliefs and biases is vital for effective spiritual care (guideline 7.3). Personal well-being in spiritual care was also emphasized. Additionally, the panelists pointed out that ongoing professional development is crucial for improving spiritual care competence in Unani Tibb clinical practice (guideline 7.5) and recommended an interprofessional approach that includes community stakeholders, like religious leaders and healthcare professionals (Guideline 7.6). These suggestions align with findings from various studies in Unani Tibb [11, 12, 25].

After a consensus workshop, panelists reviewed and approved the guidelines for Unani Tibb clinical practice, deeming them valuable, feasible, and transformative. This study is the first to establish spiritual care guidelines for Unani Tibb through a consensus workshop. It aimed to assist and guide Unani Tibb practitioners in integrating spirituality into their practice, potentially benefiting other traditional medicine systems as well. The findings could influence a position statement by the South African Tibb Association and should be disseminated and evaluated nationally and internationally for efficacy.

Conclusion

This study presents an essential framework for integrating spiritual care into Unani Tibb clinical practice, ultimately enhancing holistic patient care. The consensus workshop provided invaluable, multifaceted insights, which were instrumental in shaping the spiritual care guidelines tailored for Unani Tibb. The implications of this research extend beyond theoretical discussions, offering practical benefits for community-based studies focused on healthcare interventions within similar demographics in South Africa and internationally. This pioneering work in the Unani Tibb field lays a solid groundwork for future research into the intersections of Unani Tibb, spiritual care, and traditional medicine. Furthermore, this paper is crucial in advancing our understanding of the rich tapestry of religious, spiritual, and traditional healing beliefs and practices in South African communities. To maximize the impact of these spiritual care guidelines, continued research is vital to assess their effectiveness within the unique South African context.

Ethical Considerations

Compliance with ethical guidelines

This study was performed in accordance with the principles of the Declaration of Helsinki. Ethics clearance for this study was obtained from the Biomedical Research Ethics Committee at the University of the Western Cape, South Africa (BM20/2/7). The Ibn Sina Institute of Tibb and SATA granted permission to access the contact lists of Unani Tibb experts and stakeholders. All participants received an information sheet, consent form, confidentiality agreement for the focus group, and a participant information sheet via email. Every participant provided informed consent and approved the online video recording and automated transcription. Participation was entirely voluntary, and participants were assured of confidentiality and the right to withdraw from the study at any time without any repercussions.

Funding

This work is based on research partially supported by the National Research Foundation of South Africa (NRF) for the grant, Unique Grant No. NFSG23033088314. Any opinions, findings, conclusions, or recommendations expressed in this material are those of the authors, and the NRF does not accept any liability in this regard.

Authors' contributions

Conceptualization: Nicolette Vannesa Roman and Mujeeb Hoosen; Methodology: Nicolette Vannesa Roman and Mujeeb Hoosen; Software: Mujeeb Hoosen; Validation: Nicolette Vannesa Roman, Thuli Godfrey Mthembu, and Mursaleen Naseer; Formal analysis: Mujeeb Hoosen; Investigation: Mujeeb Hoosen; Resources: Mujeeb Hoosen; Data curation: Mujeeb Hoosen; Writing of the original draft: Mujeeb Hoosen; Writing, review and editing: Nicolette Vannesa Roman, Mujeeb Hoosen, Thuli Godfrey Mthembu, and Mursaleen Naseer; Visualization: Mujeeb Hoosen; Supervision: Nicolette Vannesa Roman, Thuli Godfrey Mthembu, and Mursaleen Naseer; Project administration: Nicolette Vannesa Roman and Mujeeb Hoosen; Funding acquisition: Nicolette Vannesa Roman and Mujeeb Hoosen.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgments

The authors thank the University of the Western Cape, SATA, and the Ibn Sina Institute of Tibb for their support throughout this study. They are also grateful to the Unani Tibb experts and stakeholders in South Africa for participating in this study. We thank Lucinda Landau (certified spiritual care practitioner, registered psychotherapist, and chaplain at St. Joseph's Healthcare Hamilton) for

reviewing the draft guidelines for this study. We also thank Simon Lasair (certified spiritual care practitioner and director of educational development at the Canadian Association of Spiritual Care) for providing valuable insights, recommendations, and consultations during this study. The authors are grateful to Maryam Mohseni Seifabad, in the Department of History of Medicine, School of Persian Medicine, Tehran University of Medical Sciences for providing the Persian translation of the abstract of this paper.

References

[1] World Health Organization (WHO). WHO traditional medicine strategy: 2014-2023. Geneva: World Health Organization; 2013. [Link]

[2] World Health Organization (WHO). WHO global report on traditional and complementary medicine. Geneva: World Health Organization; 2019. [Link]

[3] WHO Team. WHO Traditional medicine global summit 2023 meeting report: Gujarat declaration. J Ayurveda Integr Med. 2023; 14(5):100821. [DOI:10.1016/j.jaim.2023.100821] [PMID]

[4] Hoosen M, Roman NV, Mthembu TG. The development of guidelines for the inclusion of spirituality and spiritual care in unani tibb practice in South Africa: A study protocol. J Relig Health. 2022; 61(2):1261-81. [DOI:10.1007/s10943-020-01105-5] [PMID]

[5] Koenig HG. Religion, spirituality, and health: the research and clinical implications. ISRN Psychiatry. 2012; 2012:278730. [DOI:10.5402/2012/278730] [PMID]

[6] Qureshi NA, Khalil AA, Alsanad SM. Spiritual and religious healing practices: Some reflections from saudi national center for complementary and alternative medicine, riyadh. J Relig Health. 2020; 59(2):845-69. [DOI:10.1007/s10943-018-0677-0] [PMID]

[7] World Health Organization (WHO). WHO benchmarks for the practice of unani medicine. Geneva: World Health Organization; 2022. [Link]

[8] Bhikha R. Why Tibb is: A science of medicine, the art of care. Hist Philos Med 2022; 4(2):11. [DOI:10.53388/HPM20220401011]

[9] Pajević A, Pajević I, Hasanović M, & Jakovljevic M. Medicine and psychology of Ibn Sina (Avicenna)-A unique scientific and religious approach. Psychiatr Danub. 2021; 33(3):64-73. [DOI:10.5005/sar-1-1-2-64]

[10] Hoosen M, Roman NV, Mthembu TG. The role of spirituality and spiritual care in complementary and alternative medicine: A scoping review. Bangladesh J Med Sci. 2020; 20(4):714-24. [DOI:10.3329/bjms.v20i4.54125]

[11] Hoosen M, Roman NV, Mthembu TG, Naseer M. Unani Tibb practitioners' perceptions and attitudes towards spirituality and spiritual care in Unani Tibb practice in South Africa. BMC Complement Med Ther. 2023; 23(1):189. [DOI:10.1186/s12906-023-04002-y] [PMID]

[12] Hoosen M, Roman NV, Mthembu TG, & Naseer M. Unani tibb students' and educators' perceptions of spirituality and spiritual care in education in South Africa: A mixed methods study. Afr J Health Prof Educ. 2024; 16(3):e1625. [DOI:10.7196/AJHPE.2024.v16i3.1625]

[13] Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, et al. Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. J Palliat Med. 2009; 12(10):885-904. [DOI:10.1089/jpm.2009.0142] [PMID]

[14] Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: Reaching national and international consensus. J Palliat Med. 2014; 17(6):642-56. [DOI:10.1089/jpm.2014.9427] [PMID]

[15] Lasair S. A narrative approach to spirituality and spiritual care in health care. J Relig Health. 2020; 59(3):1524-40. [DOI:10.1007/s10943-019-00912-9] [PMID]

[16] Lasair S. What's the point of spiritual care? A narrative response. J Pastoral Care Counsel. 2019; 73(2):115-23. [DOI:10.1177/1542305019846846] [PMID]

[17] Melhem GA, Zeilani RS, Zaqqout OA, Aljwad AI, Shawagfeh MQ, Al-Rahim MA. Nurses' perceptions of spirituality and spiritual care giving: A comparison study among all health care sectors in Jordan. Indian J Palliat Care. 2016; 22(1):42-9. [DOI:10.4103/0973-1075.173949] [PMID]

[18] Mthembu TG, Wegner L, & Roman, NV. Guidelines to integrate spirituality and spiritual care in occupational therapy education: A modified Delphi study. Occup Ther Ment Health 2017; 34(2):181-201. [DOI:10.1080/0164212X.2017.1362367]

[19] Costeira C, Querido A, Ventura F, Loureiro H, Coelho J, Benito E, et al. Spiritual care[givers] competence in palliative care: A scoping review. Healthcare. 2024; 12(11):1059. [DOI:10.3390/healthcare12111059] [PMID]

[20] Vieten C, Lukoff D. Spiritual and religious competencies in psychology. Am Psychol. 2022; 77(1):26-38. [DOI:10.1037/amp0000821] [PMID]

[21] Alavi S. Unani medicine: health, religion, and politics in colonial India: New York: Routledge; 2021. [Link]

[22] Galvin M, Chiwaye L, Moolla A. Religious and medical pluralism among traditional healers in Johannesburg, South Africa. J Relig Health. 2024; 63(2):907-23. [DOI:10.1007/s10943-023-01795-7] [PMID]

[23] Mahilall R, Swartz L. Spiritual care practices in hospices in the Western cape, South Africa: The challenge of diversity. BMC Palliat Care. 2021; 20(1):9. [DOI:10.1186/s12904-020-00704-z] [PMID]

[24] Mothibe ME, Sibanda M. African traditional medicine: South African perspective. London: IntechOpen; 2019. [DOI:10.5772/intechopen.83790]

[25] Selman LE, Harding R, Agupio G, Fox PT, Galimaka D, Mmolend, K, et al. Spiritual care recommendations for people receiving palliative care in sub-Saharan Africa: With special reference to South Africa and Uganda. London: Cicely Saunders International; 2010. [Link]

[26] De Leo A, Bloxsome D, Bayes S. Approaches to clinical guideline development in healthcare: A scoping review and document analysis. BMC Health Serv Res. 2023; 23(1):37. [DOI:10.1186/s12913-022-08975-3] [PMID]

[27] Ørngreen R, Levinsen KT. Workshops as a research methodology. Electron J E Learn. 2017; 15(1):70-81. [Link]

[28] Cantrill JA, Sibbald B, Buetow S. The Delphi and nominal group techniques in health services research. Int J Pharm Pract. 1996;4(2):67-74. [DOI:10.1111/j.2042-7174.1996.tb00844.x]

[29] Creswell JW. Research design: Qualitative, quantitative, and mixed methods approaches. Thousand Oaks: Sage Publications; 2017. [Link]

[30] Davids R, Roman N, & Schenck C. The co-development of a framework to support parents of children with a hearing loss: Using a consensus workshop. Soc Work. 2023; 59(1):24-41. [DOI:10.15270/59-1-1091]

[31] Azmand S, Heydari M. Medical ethics according to Avicenna's stance: A synopsis. Galen Med J. 2017; 6(4):e768. [DOI:10.31661/gmj.v6i4.768]

[32] Bhikha R, Glynn J. Review article: The role of Tibb in integrative medicine for diseases of lifestyle. Bangladesh J Med Sci. 2017; 16(1):13-20. [DOI:10.3329/bjms.v16i1.31126]

[33] Hoosen M. Temperament an important principle for health preservation in Tibb an-Nabawi and Unani-Tibb. Bangladesh J Med Sci. 2017; 16(4):487-95. [DOI:10.3329/bjms.v16i4.33600]