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PALLIATIVE CARE
Re-discovering the ethical value of "Tuo-yo kod Rito Jatuo" in Luo culture of Kenya

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Benedict Odhiambo

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Chapter I. Introduction

1.1. General Introduction

Palliative care appeals to modern man as a recent social construct of past decades, although, it has historically existed and been practiced by all cultures through its many different forms as way of "being concretely human"[1]. The terminally ill, whose fates existed between life and death had a special care within traditional medicine termed as traditional care as an equivalence to current end-of-life care and palliative care in reference to the conventional medicine.[2]

Traditional care existed as a system and form within the traditional medicine described as the holistic generation to generation approach given to the extensive body of knowledge and therapeutic practices extracted from modelled theories, beliefs and experiences expressed through skills and practices of indigenous to cultures which incorporates the use of plant, animal and mineral based medical concoctions in treatment, diagnosis, prevention and maintenance of the total well-being of a person.[3] Traditional care and medicine has been used "for centuries […] in the management of diseases by man"[4] offering "palliative approach to illness"[5] and "best hope for relief of suffering in dying patients"[6] prior to conventional medicine.

Stolberg, in his book, *A History of Palliative Care, 1500–1970*, affirms that "palliative care is definitely not an invention of the nineteenth or twentieth century. Its history goes back much further. The physician's obligation to continue to assist the

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[1] *"Konkrete Mitmenschlichkeit"* Walter JENS – Hans KÜNG, Menschenwürdig sterben. Ein Plädoyer für Selbstverantwortung, München 1995, 39 [Own Translation].

[2] Cf. Alan B. ASTRAW, Thoughts on Euthanasia and physician-Assisted Suicide, in: Howard M. SPIRO, et.al., (eds.), Facing Death. where Culture, Religion, and Medicine meet, New Haven–London 1996, 44.

[3] Cf. A. A. ELUJOBA, et al., Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa, African Journal of Traditional, Complementary and Alternative Medicine 2/1 (2005) 46–61, here: 47–48. URL: https://journals.athmsi.org/index.php/ajtcam/article/view/57 [accessed: 10 January 2026]. See Also: Daniel Waweru GAKUYA, et.al., Traditional medicine in Kenya. Past and current status, challenges, and the way forward, Scientific African 8/1 (2020) 1–7, here: 2. [doi.org/10.1016/j.sciaf. 2020.e00360].

[4] Grace Njeri NJOROGE – Joan Wanjiku KIBUNGA, Herbal medicine acceptance, sources and utilization for diarrhoea management in a cosmopolitan urban area (Thika, Kenya), African Journal of Ecology 45 (2007) 65–70, here: 65. URL [accessible from University of Vienna]: https//doi-org.uaccess.univie.ac.at/ 10.1111/j.1365-2028.2007. 00740.x [accessed: 21 March 2025].

[5] Michael STOLBERG, A History of Palliative Care, 1500–1970. Concepts, Practices and Ethical Challenges, (P&M 123), [trans.by Logan KENNEDY and Leonhard UNGLAUB], ed. by Stuart F. SPICKER et.al., Würzburg 2017, 7. URL: https://content.e-bookshelf.de/media/reading/L-9843048-444b7f33e8.pdf [accessed: 04 March 2025].

[6] ASTRAW, Thoughts on Euthanasia and physician-Assisted Suicide, 46.

severely ill and dying when all hope for cure was lost"[7], was limited to the precise alleviation of suffering through the "deliberate shortening of life of the terminally ill"[8] as *euthanasia medicinalis,* which also entailed death through suffocation considered as medicinal instead of needless suffering and inappropriate prolongation of life when death was inevitable. But, in the recent decades, palliative care has increasingly established a clear distinct path of operation following the human dominance in skills, knowledge and technological knowhow prompting the need of humanity to be more concretely humane in the handling the terminally sick, their relatives and ethical issues surrounding dying and death, thereby reducing dying to a process and phase of life.[9]

The positive appraisal in palliative care has been necessitated by the increased growth in medicine through "pro-longation of the living-dying interval […].Where medical advances allow people to live for long periods with chronic debilitating illnesses"[10] due to "an expanded evidence base, new care-delivery models, […] increasing public and professional awareness"[11], and the growing number of "non-communicable diseases (NCD) including cancer and stroke"[12]. Moreover, there is an increase in the number of the aging community requiring different kinds of social supports globally.[13] This contributively raises the need of ensuring that the 'affected are protected against emergencies and are leading a healthy, dignified, comfortable and active life'[14].

Although palliative care began and developed with hospice as a unit and remains connected with it. Palliative care transcends hospice care which is limited to advanced cancer cases as that "care leading to what can be termed as a dignified death"[15]. Palliative care goes further to embrace all terminal situations of life e.g. "kidney failure, chronic liver disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological disease,

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[7] STOLBERG, A History of Palliative Care, 2.
[8] Ibid., 6.
[9] Cf. ibid., 2–3.
[10] ASTRAW, Thought on Euthanasia and Physician-Assisted Suicide, 47.
[11] Amy S. KELLY– R. Sean MORRISON, Palliative Care for the Seriously Ill, in: NEJM 373/8 (2015) 747–755, here: 747. URL: https://www.nejm.org/doi/full/10.1056/NEJMra1404684#body-ref-r001 [accessed: 08 April 2025].
[12] WORLD HEALTH ORGANIZATION- SOUTH EAST ASIA REGIONAL OFFICE (WHO-SEARO), (ed.), Report of the WHO South-East Asia Regional workshop on expanding availability and access to Palliative Care, Colombo/Sri Lanka 2023, art.1, 5. URL: http: www.who.int/ [accessed: 04 May 2025].
[13] Cf. WORLD HEALTH ORGANIZATION (WHO), Better Palliative Care for Older People, ed. by Elizabeth DAVIES – Irene J. HIGGINSON, WHO-Europe, Copenhagen 2004, art. 1, 10. URL: https: www.who.int/iris/handle/10665/107563 [accessed: 02 May 2025].
[14] Cf. WORLD HEALTH ORGANIZATION (WHO), Palliative Care. Key Facts, (05 August 2020). URL: https://www.who.int/news-room/fact-sheets/detail/palliative-care [accessed: 31 March 2025].
[15] *"ein menschenwürdiges Sterben in einer Sterbeklinik"* JENS – KÜNG, Menschenwürdig sterben, 41 [Own Translation].

dementia, congenital anomalies […] drug-resistant tuberculosis"[16] as well as NCDs, HIV/AIDS, spinal injury, aging and any condition confining one to situation of support. Palliative care is embraced and administered outside the confines of the hospice and diseases, in attending to the aging, although aging is not a disease, but a life process.[17] Palliative care offers an opportunity where the "team members can work closely with the patient and the family to forestall conflicts, avoid moral crises, and share the emotional burden that these inherently troubling situations carry."[18] Thus, it is a necessary and crucial component of the universal health coverage and support for all.[19]

Unfortunately, the access to palliative care remains limited. According to the global facts; "Each year, an estimated 56.8 million people, including 25.7million in the last year of life, are in need of palliative care […] worldwide, only about 14% of the people who need palliative care currently receive it"[20]. Of this number presented globally, "78% of them live in low-and middle -income country[ies]"[21]. Whereas, "For children, 98% of those needing palliative care live in low-and middle-income countries with half of them living in Africa."[22]

World Population Review (WPR) 2025, has classified Kenya as a lower-middle income country.[23] This ranking locates Kenya amongst those countries experiencing the delivery insufficiency in palliative care. According to the *Kenya Palliative Care Policy 2021–2030*, "about 800,000 Kenyans are in need of palliative care every year. Unfortunately, [only] 14,552 Kenyans are accessing these services. Access […] is even more limited among children with less than 5% of pediatric patients".[24] In my view, this report may presents the real deficit gap ration between the number requiring support and the number receiving the care but the factuality concerning the recorded figure as to those who are in need of the service, those who are accessing the service and those who can't access the service in relation to the figures presented remains debatable.

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[16] WORLD HEALTH ORGANIZATION (WHO), Palliative Care. Key Facts.
[17] Cf. WORLD HEALTH ORGANIZATION (WHO), Better Palliative Care for Older People, art 3, 20.
[18] ASTRAW, Thoughts on Euthanasia and physician-Assisted Suicide, 46.
[19] Cf. WORLD HEALTH ORGANIZATION (WHO), Why Palliative Care is an Essential Function of Primary Health Care, WHO 2018, 4. URL: http: www.who.int/ [accessed: 04 May 2025].
[20] WORLD HEALTH ORGANIZATION (WHO), Palliative care. Key Facts.
[21] MINISTRY OF HEALTH, Kenya Palliative Care Policy 2021–2030, Nairobi 2021, 17. URL: https://kehpca.org/wp-content/uploads/2020/05/KENYAS-PALLIATIVE-CARE-POLICY.pdf [accessed: 24 March 2025].
[22] WORLD HEALTH ORGANIZATION (WHO), Palliative care. Key Facts.
[23] Cf. WORLD POPULATION REVIEW (WPR), Middle-Income Countries 2025. URL: https://worldpopulationreview.com/country-rankings/middle-income-countries [accessed 21 July 2025].
[24] MINISTRY OF HEALTH, Kenya Palliative Care Policy 2021–2030, 4.

According to 2019 census, the entire population of Kenya is approximated at 47.5 million.[25] Hence, the recorded 800,000 accounts only for around 1.7% which is quite low, considering that there exists not only service inaccessibility within the health system based on the settlement pattern, where majority of the Kenyan population reside in the rural areas characterized with a diverse "geographical, cultural and the economical variations"[26]. But also, attributive inaccessibility in the flow of funds around the public healthcare system between the National and County governments. Since, healthcare is a devolved unit, as well as the existence of alternative care options in traditional medicine.[27]

Concern is raised, whether the tally of the presented figures considered also those under the home-based alternative care. It is worth noting that, within Kenya, the "access to health facilities is estimated to be good in urban areas but inadequate in rural areas"[28]. Hence, those receiving the alternative care under "home-based care"[29] is proportionately considered to be higher as compared to those within the conventional care attributed to also by the "high poverty levels and increased disease burden"[30]. Within the conventional medicine, it "is estimated […] [that] overall[y] in Kenya, the doctor: patient ratio is 1:7142. However complementary practitioner: Patient ration is much better e.g. 1:987 *Mathare* [urban areas] and 1:378 *Kilungu* [rural area]."[31] *Mathare* a sub-urban area within Nairobi accounts for more under traditional alternative home care due to the scarcity of traditional caregivers as compared to *Kilungu* a rural area where their ratio is low due to the presence of many traditional caregivers.

Traditional medicine is prevalent within Kenya.[32] Kenya is composed of a diverse cultural mix of many ethnic groups endowed with unique cultural knowledge and skills about variety of traditional medicinal plants bearing particular cultural ethnic identity.[33] As

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[25] Cf. KENYA NATIONAL BUREAU OF STATISTICS (KNBS), 2019 Kenya Population and Housing Census, Vol. I (Population by County and Sub-County), Nairobi 2019, 1–49, here: 5; 10. URL: https://www.knbs.or.ke/reports/kenya-census-2019/ [accessed: 30 April 2025].
[26] Mark W. MOSES, et.al., Performance assessment of the country heath systems in Kenya: a mixed methods analysis, in: BMJ Global Health 6/6 (2021) 1–13, here: 2. URL: https://gh.bmj.com/content/6/6/e004707 [accessed: 02 April 2025].
[27] Cf. ibid.
[28] Julian GÖTSCH, et.al., The Health Care System in Kenya, in: Global dynamics of Social Policy CRC 1342/40 (2024) 1–16, here: 10. [doi.org/10.26092/elib/3011].
[29] "Home-Based Care"- an initiative which involves supporting people living with [terminal illness such as HIV/AIDS]and caregivers at home." Hannah BROWN, Living with HIV/AIDS. Ethnography of care in Western Kenya, [unpublished diss. University of Manchester] 2010, 17. URL: https://www.proquest.com/docview/1314564901? [accessed: 31 March 2025].
[30] NJOROGE – KIBUNGA, Herbal medicine acceptance, 65.
[31] J.W. MWANGI, Integration of Herbal Medicine in Health Care of Developing Countries, in: EAMJ 81/10 (2004) 497–498, here: 497. [DOI: 10.4314/eamj. v81i10.9230].
[32] Cf. GÖTSCH, et.al., The Health Care System in Kenya, 11.
[33] Cf. NJOROGE –KIBUNGA, Herbal medicine acceptance, 65.

a result, it is assumed that, "many people in Kenya are already taking herbal medicines, which are usually prepared at home, obtained from herbalists, pharmacies or supermarkets".[34] This affirms the reality, that the 70–90% of the population in the global south, especially within the Sub-Saharan Africa continue to use the traditional medicine as the first-line choice of care.[35] Hence, forming the essential coverage of primary health care delivery to common ailments[36] due to its availability and affordability.[37]

Most of African populations, continue to prefer home-based care and dying at home instead of hospital because of their "way of looking at the world and experiencing life"[38] as a life lived within a community religiously, where the extended family still has a role to play as opposed to life within the urban spaces and as well as life in the global north, where "the dissolution of the extended family and single life has changed many things"[39]. A real African in the traditional setting is generally religious and communal,[40] thus, emotionally close.[41] This influences the practicability and receptibility of *Tuo-yo kod Rito Jatuo* at home (*Dala* – rural home) as compared to the hospital set-up or in *Kapango* – Urban rental spaces.

Another contributing factor for traditional medical preference is the trust developed on the traditional medicine and "the concern about the adverse effects of conventional drugs […] while herbal medicine appears to offer more gentle means of managing chronic, debilitating diseases […] than conventional medicine"[42]. There also exists a great concern drawn from the causes of some of the African diseases such as: sorcery, witchcraft, evil magic or spirits, curse, broken taboos or oaths, of mystical causes,[43] which do not respond to the conventional medicine and are better managed at home where medication "is also a religious matter […] to prescribe the right cure"[44].

In Luo traditional medicine, "disease etiology and therapies are embedded in indigenous religious beliefs […] drawing of elements from both the physical and spiritual

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[34] MWANGI, Integration of Herbal Medicine in Health Care of Developing Countries, 498.
[35] Cf. Jason M. NAGATA, et.al., Medical Pluralism on Mfangano Island. Use of medicinal plants among persons living with HIV/AIDS in Suba District, Kenya, in: Journal of Ethnopharmacology 135/2 (2011) 501–509, here: 501. URL: https://doi.org/10.1016/j.jep.2011.03.051 [accessed: 31 March 2025].
[36] Cf. MWANGI, Integration of Herbal Medicine in Health Care of Developing Countries, 497. See Also: ELUJOBA, et al., Traditional Medicine Development for Medical, 47.
[37] Cf. GÖTSCH, et.al., The Health Care System in Kenya, 11.
[38] Cf. John S. MBITI, Introduction to African Religion, London et al. 1975, 12.
[39] *"die Auflösung der Großfamilie und das Single-Dasein hat vieles verändert"* JENS – KÜNG, Menschenwürdig sterben, 41 [Own Translation].
[40] Cf. MBITI, Introduction to African Religion, 27.
[41] Cf. BROWN, Living with HIV/AIDS, 20.
[42] MWANGI, Integration of Herbal Medicine in Health Care of Developing Countries, 497.
[43] Cf. MBITI, Introduction to African Religion, 111–112.
[44] Ibid., 134.

worlds in the disease management"[45] based on their anthropocentric religious ontology[46] involved in promotion of vitality in both quantitative and qualitative manner.[47] The "spiritual aspect is basis of the supernatural dimension […] of consulting ancestral spirits for diagnosis and treatment".[48]

Luo community cared for their sick, even in hopeless cases, waiting for mysteries and extraordinary interventions from the invisible world that they believe would may alter the course of illness for betterment. Like other Africans, they share in the argument of *Mbiti* that the "universe is both visible and invisible unending and without limits"[49] sustained by the "impulse of life"[50] referred to as *Ngima* (life). *Ngima* is understood analogically as the engine, making visible and invisible within the spatial duration of time. *Ngima* unravels itself in all entities and in all cosmological levels naturally, through encouraging, defending, and own re-invention within their own essence in time,[51] realized and interpreted through the moral rational action of the human life.[52] *Ngima* bridges the close relationship between the transcendence and immanence aspects of existence in continuum, where the concept of death, as death *per se* or the total *annihilation* of life does not actually exist.[53] Life/*Ngima* is sacred and is to be protected at all costs by everyone till natural death. Life processes are in a push and pull in an integral cyclic motion[54] within an established community present through birth, life, death and re-birth.

According to Mbiti, death is a gateway process progressively removing a person from the *Sasa* phase to the *Zamani* phase. Physical death does not annihilate a person,

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[45] Bethwell O. OWUOR et.al. Indigenous Snake Bite Remedies of the Luo of Western Kenya, in: Journal of Ethnobiology 25/1 (2005) 129–141, here: 130–131. [Doi: http://dx.doi.org/10.2993/0278-0771(2005)25 [129: ISBROT] 2.0.CO;2].

[46] "Anthropocentric ontology in the sense that everything is seen in terms of its relation to man. These categories are: 1. *God* as the ultimate explanation of the genesis and sustenance of both man and things 2. *Spirits* beings made up of superhuman beings and the spirits of men who died long time ago 3. *Man* including human beings who live and those about to be born 4. *Animals* and plants, or the reminder of biological life 5. *Phenomena* and objects without biological life" Cf. John S. MBITI, African Religions and Philosophy, New York 1969, 20.

[47] Cf. Jude Thaddeus BUYONDO, The Critique of Bioethical Principlism in Contrast to a Black African Approach to Bioethics, Oregon 2024, 122–123.

[48] Aceme NYIKA, Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/AIDS, in: Developing World Bioethics 7/1 (2007) 25–34, here: 26, [doi:10.1111/j.1471-8847. 2006.00157.x].

[49] MBITI, Introduction to African Religion, 35.

[50] MERRIAM-WEBSTER, *"élan vital."* Merriam-Webster.com Dictionary. URL: https://www.merriam-webster.com/dictionary/%C3%A9lan%20vital. [accessed: 12 September 2025].

[51] Cf. Jude Thaddaeus BUYONDO, Holistic Bioethics, Oregon, 2024, 76.

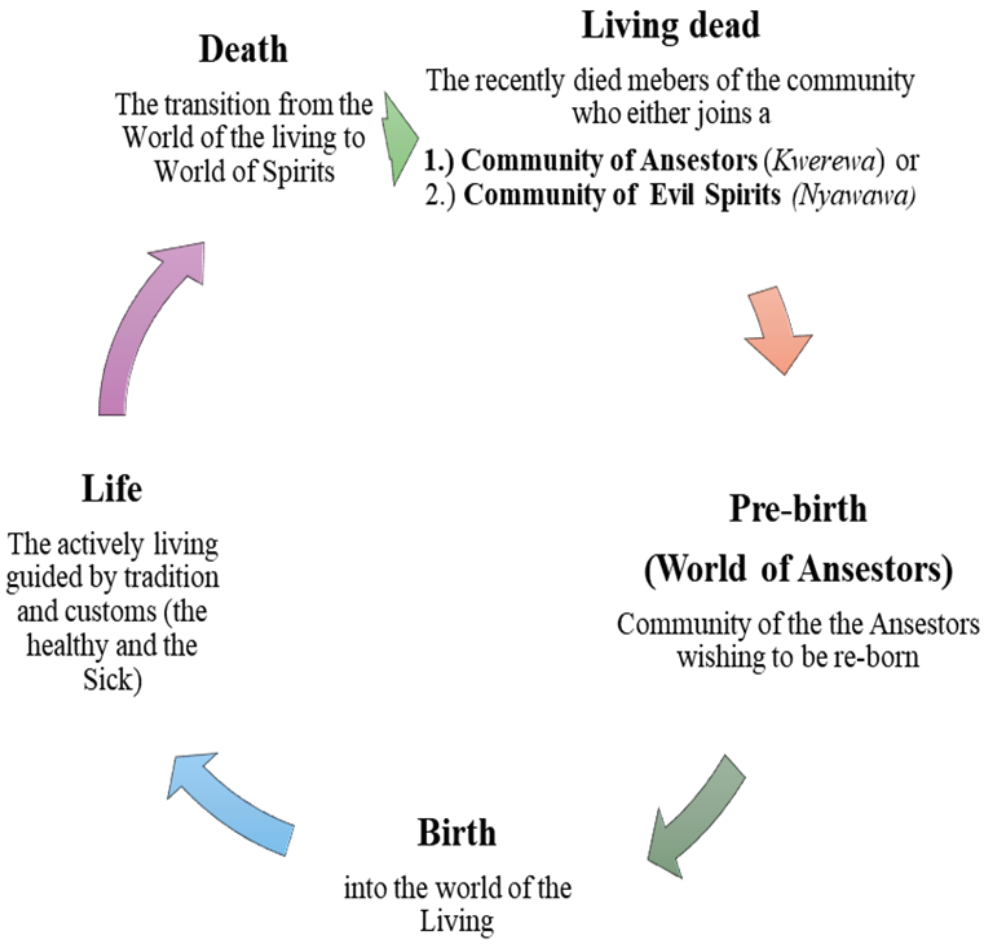
[52] Cf. Eberhard SCHOCKENHOFF, Ethik des Lebens. Grundlagen und neue Herausforderungen, Freiburg i. B. et.al. 2009, 153.

[53] Cf. Michael CHEPKWONY, Understanding death among the Kalenjin, The Standard (9 November 2012). URL: https://www.standardmedia.co.ke/article/2000070299/understanding-death-among-the-kalenjin [accessed: 10 January 2026].

[54] Cf. BUYONDO, Holistic Bioethics, 63.

because the individual continues to live within *Sasa* phase, as one becomes a memory to the relatives, friends and those who knew him in life and have survived him. Since, the individual is dead, but a live in the memories, he becomes a living-dead within the Sasa. However, when the last person who knew the departed individual dies, then living-dead becomes completely *dead* as he is forgotten, he enters into the *Zamani* phase.[55] where, it is believed, the individual is amongst the community of good spirits/Ancestors/ called *Kwere* or bad/Evil spirits referred to as *Nyawawa.*[56]

Figure 1: Life is *in Continuum*



[55] Cf. MBITI, African Religions and Philosophy, 32.

[56] *Nyawawa, a* Luo word for bad spirits – spirits of the dead, they are all the same and can never be distinguished whether it is a spirit of a grandfather or of a child. it's a state of dammed spirits who do not have rest and so occasionally come back to haunt and cause harm/misfortunes and sickness to living community members. (NB: When the spirit identifies with a particular deceased and has come back to a particular individual for sake of vengeance on their participation in the death of the deceased, then it is referred to as *Chien*, that is a spirit demanding justice or seeks to lay bare the hidden truth.

For Luos, "the divine and the human do not stand in competition with each other, but rather in an intimate partnership."[57] Therefore, *ngima iloko aloka ok gole oko* – life's form is always changed and cannot be completely extinguished/ removed, because*, ngima emaduong' kinde duto* – life is of the greatest value in all aspects at all times. They abhorred any contrary acts contributing to discontinuation or immature loss of life, e.g. *euthanasia medicinalis* as it brought about the dreaded *Chien*[58] – the vengeance of the spirit of dead and rather appealed more to a kind of *theological euthanasia* (type of *euthanasia* committed by God/gods as result of petitions) only in in extreme cases of suffering. Luo community revered the dead, as affirmed by E.E Pritchard that:

> any old person who was neglected may cause a relative to be more attentive by the threat You will see me, 'meaning that when the person is dead, he will haunt those who neglected him unless they make amends. People who are happy and contented in life do not cause trouble when they are dead. it is the disgruntled and resentful who cause trouble.[59]

As a result, they avoided anything that would aggrieve the spirit (ghost) of the dying. For, "when a ghost is aggrieved it is unhappy among the dead and may cause injury to those who wronged it in life".[60] This prompted the kinsmen to take good care of their sick hoping for *nindo*[61] *maber – 'good death'* considered from the "experience of death from the point of view of the sick and their relatives and for the perception and evaluation of ethical dilemmas in dealing with the dying"[62] as a blessing to the community.

1.2. Research Problem

In the 21st Century, the traditional practice of *Tuo-yo kod Rito Jatuo* still complements the conventional medicine within the *Luo* community. What are the postulated reasons

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[57] *"Göttliches and menschliches stehen zueinander nicht in einem Konkurrenzverhaltnis, sondern in einer intimen Partnerbeziehung."* Karl-Wilhelm MERKS, Göttliches Recht, Menschliches Recht, Menschenrechte. Die Menschlichkeit des *ius divinum*, in: Stephan GOERTZ and Magnus STRIET (eds.), Nach dem Gesetz Gottes. Autonomie als Christliches Prinzip, Freiburg. i. B et.al. 2014, 9–46, here:11 [Own Translation].

[58] *Chien – "cien"* [Chien], and in some degree of the notion of ghostly vengeance […] tell us that sickness may be due a ghost […] these troublesome ghost[s] are usually those of grandparents who afflict their grandchildren because their children have been neglectful of filial duties." E.E. EVANS-PRITCHARD, Ghostly Vengeance Among the Luo of Kenya, in: Man 50 (1950) 86–87, here: 86, No 133. URL [accessible from University of Vienna]: https://www-jstor-org.uaccess.univie.ac.at/stable/2794672? [accessed: 30 April 2025].

[59] E.E. EVANS-PRITCHARD, Ghostly Vengeance Among the Luo of Kenya, 86.

[60] Ibid.

[61] *Nindo* – meaning Sleeping, this word may signify normal sleep as well as may refer to death, it is used depending on the context. When used in the context of death it refers to the duration of the sleep, as such everlasting sleep, based on their concept of Life, that is *in continuum*. Cf. Eunice APIYO, *Tuo-yo kod Rito Jatuo,* Telephone Conversation with the Author from 29 March 2025, Kisumu – Vienna.

[62] STOLBERG, A History of Palliative Care, 9.

accounting for its consistency and relevancy, especially its close association with quality and concrete humanness within the deplorable parameters of health.[63]

1.3. Research Purpose

This study seeks to establish the exact nature of palliative care within the Luo Culture of Kenya, in relation to extension of life and the quality of remaining life.

1.4. Research Objectives

This study aims to re-discover the value of *Tuo-yo kod Rito Jatuo* in underscoring the role of incorporating a socio-religious and cultural approach in terminal illness situations and its possible contribution within medical ethics and medicine as a field. Since, accessing basic health care needs in rural Africa is still a challenge.

1.5. Significance and Scope of the Study

This study seeks to capture the "spatial practices of care in circulation around home and hospital"[64] from diagnosis in the case of terminal illness, while incorporating and integrating the socio-religious effects of culture founded on the kin-support spatialized within homestead. There are expected challenges emanating around this study on a basis of coalescing of responsibilities and obligations of "a home-based kin-care"[65], in respect to *Tuo-yo kod Rito Jatuo as* an amorphous traditional practice juggling between medicine, religion and culture.

Moreover, this study may not appease or be applicable to everyone, because the experience of sickness is personal and individual. It remains varied between individuals as well communities, in the way different people accept, cope and deal with their sickness and sick members.[66] Therefore, the choice of Luo Culture is to delimit the scope of the study within the Luo material culture and tradition to which I am conversant with as *a Jaluo*[67].

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[63] Cf. GBW. LEE, et al., Complementary and alternative medicine use in patients with chronic diseases in primary care is associated with perceived quality of care and cultural beliefs, Family Practice 21/6 (2004) 654–660, here: 654. [Doi:10.1093/fampra/cmh613.Epub2004 nov5.].

[64] BROWN, Living with HIV/AIDS, 17.

[65] "Home-based kin-care" is a Concept of care which excludes non-kin forms of home-based care. According to Carol Thomas, but within the context of this study it includes everyone with priority to kinsmen and women. Cf. Carol THOMAS, De-Constructing Concepts of Care, Sociology 27/4 (1993) 649–669, here: 650. URL: https://www.jstor.org/stable/42855270 [accessed: 25 April 2025].

[66] Cf. Hans-Christoph PIPER, Kranksein-Erleben und lernen, München 1974, 10.

[67] *Jaluo,* a term used to refer to a Male member of Luo Community meaning (son of Luo), just as *Nyar-Luo,* refers to a female member meaning (Daughter of Luo), but by extension the word *Jaluo* when ungendered

Since, culture is progressive and not static, this study may be applicable amongst the closely related Nilotic cultures of the major Luo groups such as the: *Dinka's, Nuers, Anuak's, Acholi's, Padhola's* as well as the neighboring *Bantu* communities, who have assimilated some of Luo practices as a "result of Luo-Bantu interactions"[68].

1.6. Methodology

The information contained in this study has not been generated through quantitative field research work, but is restricted to the theoretical analysis of the historical data and re-study of other various available literature resources and empirical data collection available in the various libraries, online books and publications, and internet sources which are of help. In Luo Culture, there still exists inadequate material of documentary facts, prompting reliance on the western available sources. As a result, topical telephone-correspondence with some traditional medicine practitioners (Community Health workers (CHWs) have been incorporated, as well as my pastoral work as a counsellor amongst the Stepping Stone HIV-Positive Women Group. But of most significance to this study, is my experience, during the treatment and end-of-life care from the bedside of my late sister Irene, whose one-month care brought to my attention the sharp difference and the expectation deficit that exist between the traditional care and hospital care within the Kenyan hospital setting.

1.7. Overview of the Study

This study is divided into four chapters. The first chapter, outlines the general introduction, key concepts and definitions. It extends to introduce the whole work through the study problem, purpose, objective, significance and scope, methodology employed in the research, contents and structure, the population and the location under the study. It further opens the study to other chapters by introducing palliative care and its practice within the Kenyan health care system where the traditional care of *Tuo-yo Jatuo* as an alternative care is practiced. The Second chapter handles the necessity of palliative care, through the crisis of terminal illness, the preliminary stages of diagnosis and acceptance and concludes with

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can also be collectively be used to refer to any community member in singular irrespective of the sex-gender, just as collectively *Jo-Luo* meaning Luo community. The Term *Jaluo* as an equivalence of the word *Person* in English. Etymologically the word *"Luo"* comes from […] the word *'luwo', 'lupo'*, or *'luw'*, means to speak, to follow or to come after. […] the term *Lupo*, means fishing, *'luwo rech'*, to follow fish '*Joluo'* comes from the word *'Jolupo',' Jalowo','Janewo'* which means fishermen […] the word *Luo* should generally be the term referring to people who previously lived along the Nile valley. Cf. A.B.C. OCHOLA-AYAYO, Traditional Ideology and Ethics among the Southern Luo, Uppsala 1976, 14.

[68] ibid., 12.

a case study situation of the legendary Job (terminally ill patient) and his wife (support/Care giver) to remotely highlight the need of palliative care. This is due to striking similarity with special focus on religious causes and others factors which can as well be analogically applied to the study population.

Third chapter presents the patients care under *Tuo-yo kod Rito Jatuo*. This chapter focuses, examines, postulates and compares this type of care *a vis a vis* the conventional-hospital care, thus seeking an *exposé* on the alternative complementary care. In addition, it concludes with the traditional spiritual care yielding into good death preparations and transition of life through death. In this chapter focus is given to the social, ethical, cultural and spiritual implications of care on the life around the severely sick and their family and the community at large. Lastly, the fourth chapter gives an overview glimpse of a general conclusion on possible contribution of traditional medicine and care and the existing possible tensions between alternative complementary care and the conventional hospital care. Further, giving a possible future recommendation.

1.8. The Study Population and Setting

The population under the study is the Luo community. The term *'Luo'* has been primarily used to designate '*Lwo'*, the language spoken by different related Nilotic groups comprising of the *'Acholi', 'Alur', 'Shilluk'* and others living within the Nile-Valley. Luo is a national name designating a tribe, specifically referring to the southern Luo living around Lake Victoria in the Nyanza region of Kenya and in northern Tanzania and speaking *'Dho-luo'* as a language. This name *Luo* was employed when "the southern Luo found themselves among the groups that they greatly differed from linguistically; they stressed that they were Luo People *(Joluo)* and not 'Nilotic' people."[69] Thus, clearly identifying themselves as *Joluo* –a people of Luo origin

The study setting refers to these Southern Luos, but limited to those who "inhabit the Central and South Nyanza districts [Sub-Counties] of the Nyanza Province [region] of Kenya",[70] within the following four Counties: Kisumu, Homabay, Siaya and Migori.[71] "The province lies astride the equator, lat. 0°35'S long. 34°45'E bound to the west by Lake

[69] Cf. ibid., 14.
[70] Bethwell A. OGOT, A History of Southern Luo. Vol.1 Migration and Settlement 1500–1900, Nairobi 1967, 127.
[71] Cf. Pamela ABUYA, Women's Voices on the Practice of *Ter* among the Luo of Kenya. A Philosophical Perspective, in: Fabula 43 1/2 (2002) 94–101, here: 94. URL: https://www.degruyterbrill.com/document/doi/10.1515/fabl.2002.028/html [accessed: 02 February 2025].

Victoria and to the south by the republic of Tanzania."[72] Luos have an approximate population of 4.1million people according to the Kenya National Census of 2019.[73] They are primarily fishermen, hence defining their settlement around the lake. They also practice mixed subsistence farming and keeping of cattle, with other sources of income from small scale gold mining. They are patriarchal and patrilocal who live in homesteads known as *Dala.*

Within *Dala* (homestead), a man lives with his wife or wives as in monogamy or polygamy sets of marriage together with his children and married sons' and their families. "Home is a plot of land, usually rural or semi-rural, generally consisting of number of houses (house: Ot - singular, *Udi*-plural) within a marked boundary"[74]. For a Luo, "a house (*Ot*) can be anywhere, perhaps a rental space within town Kisumu or Nairobi, but home (*Dala*) refers only to one place, the 'ancestral home' and place where one will be buried."[75] It is within the *Dala* (homestead), where this care in the strict sense took place. This study does not seek to be strictly limited to the geographical location of the population or the setting of *Dala* but rather, to encompass the broader cultural location and setting extending from ancestral locality and subsequently to this population in diaspora locality, in the *Ute-Kapango* –urban rental spaces.

1.9. The Notion of Palliative Care

Care is a wide concept encompassing both the emotive and practical aspects. It carries the idea of consciousness about dealings with the self or another as the 'other'. It entails stepping-in to assist the 'other' in covering or coping-up in moments of vulnerability caused by "the disvalue of disease or illness"[76]. According to Mary Daly, care is "an encompassing concept […] imbued with moral purpose, […] away of being in the world"[77], implying both the "dual meaning of care in terms of 'caring *for* someone' (carrying out a caring work) and 'caring *about* someone' (having caring feelings)".[78]

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[72] OWUOR et.al. Indigenous Snake Bite Remedies of the Luo of Western Kenya, 130.
[73] Cf. KENYA NATIONAL BUREAU OF STATISTICS (KNBS), 2019 Kenya Population, 37–38.
[74] BROWN, Living with HIV/AIDS, 65.
[75] Ibid.
[76] James A. MARCUM, An Introductory Philosophy of Medicine. Humanizing Modern Medicine, (P&M 99), Texas 2008, 259.
[77] Mary DALY, The Concept of Care. Insights, Challenges and research avenues in COVID-19 times, in: Journal of European Social Policy 31/1 (2021) 108–118, here: 108–111. URL [accessible from University of Vienna]: https://uk.sagepub.com/en-gb/journals-permissions [accessed: 15 May 2025].
[78] THOMAS, De-Constructing Concepts of Care, 649.

Care is hermeneutically context based applied to refer to labour, resource and relational orientation involved in provision of required assistance.[79] This notion, exposes the social constructs of care as transcending the concept of its nature within set of social relations. That is, care as "a vital sphere of human engagement and welfare-related activity focused on practices oriented to meeting the perceived need."[80] Among the traditional cultures, care can be conceptualized and localized within the "cluster of values and practices"[81] based on kinship. Drawing from Hannah Browns implication of care as social practice.[82] In the context of this work care is "an ethical orientation and practice, requiring attentiveness to the need and willingness to respond to it in direct action (care-giving) and reaction to the care process"[83], spatially practiced in the spaces of home and hospital for anthropological engagement[84] arising out of obligations of relatedness[85] through "emotions and practices".[86]

Warren Reich argues that caring is directed to medicine and general well-being of a person, since, it entails both bodily element of worry or concern and the spiritual element, which connects with the divine for the well-being of another.[87] Thus, "to be human is to care and be cared for",[88] in relation to "the essence of human personality […] capable of vast experience and susceptible to disorder and anguish"[89]. Caring is the central aim and goal of medicine, it comprises of a conglomeration of responses to human vulnerability and suffering, frailty and pain but it is also packaged in compassion, comfort, empathy, sympathy kindness, support, listening and being-there in bearing the weight of the disease together.[90]

In the Luo traditional medicine, understanding of caring and curing is one and the same in practice and aspect, and was perceived to be associated with the women, since they are traditionally the key in carrying out most of the household chores and

[79] Cf. DALY, The Concept of Care, 109.
[80] DALY, The Concept of Care, 113.
[81] Ibid.
[82] Cf. BROWN, Living with HIV/AIDS, 18.
[83] DALY, The Concept of Care, 110.
[84] Cf. BROWN, Living with HIV/AIDS, 21.
[85] Cf. ibid., 16–17.
[86] Ibid., 60.
[87] Cf. MARCUM, An Introductory Philosophy of Medicine, 270–271.
[88] Ibid., 271.
[89] Ibid.
[90] Cf. ibid., 273.

management including caregiving and home-nursing of the sick.[91] Therefore, care is considered to be associated with the emotive aspect of love and is gendered. Hence, is "positively associated with the nutritional status among women".[92] They administered food as part of medicine and medicine as part of food and there lies a very thin difference in between, that is observable only when one is sick.[93] Since, they "have always been charged with caring for those to whom they minister."[94] Luo women provided healthcare and related activities in the back yards of their kitchens and farms,[95] where they prepared *Yath Nyaluo* (Luo traditional medicine), as infusions to be drunk or washed in, as anointing or with the food to be eaten.[96]

Therefore, in *Dho-luo* – Luo language, care is the repeated integral ethical orientation within social human engagement based on mitigating a required support, accounted for by several words: *"hero* (v) love, like, favour, admire; *rito* (vt.), wait, watch, take care of, guard; *rango*, (vt.) look for, search force, wait for, care for. await; *pidho* (vt.), rear, bring up, nurse [a child], nurture, breed cattle, plant seeds; *konyo (*vt.) help, assist, aid, support".[97] These words connote both "the emotional feeling and the emotional action"[98] of care.

1.9.1. Notion of Palliative Care

The concept of palliative care developed as a response from humane physicians like Laurent Joubert, who in 1580 argued that it was out of medical obligation for physician to express medical concern for the terminally ill patients who had no prospect of healing, despite being under historical prohibitive and inhumane directives from Hippocrates not to treat patients suffering from incurable illnesses but to show concern only in treating curable and easy- to- treat illnesses.[99]

Palliative care is a coined composite word consisting of *Palliative* and *Care*. The term '*palliative'* is from the Latin word "*pallium"* meaning a cloak, a covering or a

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[91] Cf. Gillian H. ICE, et.al., Care Giving, Gender and Nutritional Status in Nyanza Province, Kenya. Grandmothers Gain, Grandfathers Lose, in: American Journal of Human Biology 23/4 (2011) 498–508, here: 500. [DOI: https://doi.org/10.1002/ajhb.21172].
[92] Ibid., 498.
[93] Cf. MARCUM, An Introductory Philosophy of Medicine, 271.
[94] Ibid., 271.
[95] Cf. Agnes A. ODINGA, Women's Medicine and fertility. A social history of reproduction in South Nyanza Kenya, 1920–1980, [unpublished diss. University of Minnesota, Minnesota] 2001, 15. URL: https://openlibrary.org/books/OL19802035M/Women's_medicine_and_fertility, [accessed: 19 March 2025].
[96] Cf. BROWN, Living with HIV/AIDS, 76.
[97] Ibid., 60.
[98] Ibid., 61.
[99] Cf. STOLBERG, A History of Palliative Care, 15-16.

wrapping. The word *'Palliare'* connoting 'the action of covering with a cloak.[100] In other words, it is understood as the 'covering with a cloak or wrapping' of patients as "a special form of care".[101] And the term "*Care"*, implies the realization of the comprehensive support applicable in a terminal illness situation.[102]

According to World Health Organization (WHO 2002), palliative care is defined as:

> an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual.[103]

Palliative Care is an "interdisciplinary specialty […] provide[ing] an added layer of support to patients, their loved ones and the treating clinician's",[104] in a multi-interdisciplinary approach to bring holistic relief at all times and the improvement of the quality of life and the needs of a patient and those affected through: focusing on symptoms, on the social environment, on the psychological resilience, and on the spiritual orientation and sense of purpose.[105] Because, sickness is spiritual and has spiritual demands.[106]

Palliative care begins from early diagnosis of a patient with a life limiting illness that involves the perfect assessment of best methods and practices applicable at home or in the hospital. It is geared towards giving the optimal care to patients with incurable advanced illness, providing a patient-oriented humane care, to assist in dealing with the alleviation of pain and other related problems[107]. And to positively influence the patient through good handling, communication and counselling to be a *"geduldigen patienten",*[108] (a patient patient) in that, the patient is led to express own willingness in the acceptance of suffering unconditionally, and with the courage in affirming life and upholding its dignity in entirety as required, while adapting to new situations and conditions as they present

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[100] Cf. Gerhard MARSCHÜTZ, Theologisch ethisch nachdenken, Vol. 2, Würzburg ²2016, 301.

[101] DEUTSCHE GESELLSCHAFT FÜR PALLIATIVMEDIZIN (DGP), Einsatz Sedierender Medikamente. Was kommt auf Sie zu und was ist zu beachten? ed. by Forschungsverbund SedPall und iSedPall (2025/07) 1–42, here: 6. URL: https://www.dgpalliativmedizin.de/dgp-veroeffentlichungen/broschueren [accessed: 21 July 2025].

[102] Cf. MARSCHÜTZ, Theologisch ethisch nachdenken, 301.

[103] WORLD HEALTH ORGANIZATION (WHO), Palliative Care for Older People. Better practices, ed. by Sue HALL, et.al., 2011, 6. URL: http: www.who.int/ [accessed: 04 May 2025]. See Also: WHO, Why Palliative Care is an Essential Function of Primary Health Care, 3.

[104] KELLY – MORISSON, Palliative Care for the Seriously Ill, 747.

[105] Cf. DEUTSCHE GESELLSCHAFT FÜR PALLIATIVMEDIZIN (DGP), Einsatz Sedierender Medikamente. Was kommt auf Sie zu und was ist zu beachten? 10–12.

[106] Cf. Walter SCHAUPP, Spiritual Dimension des Krankseins-der christliche Patient, in: Ulrich H.J: KÖRTNER, et.al., (eds.), Spiritualität, Religion und Kultur am Krankenbett (IERM) Vol.3, Vienna 2009, 165–175, here: 165.

[107] Cf. Sigrid MÜLLER– Karl HUNSTORFER, Einführung in die Medizinethik. Palliativmedizin (Lecture), University of Vienna, 27 October 2024, Vienna.

[108] "*Geduldigen Patienten"* -a term which *Piper* uses to refer to patients who have developed the virtue of patience, not out of their Christianity but through learning and counselling in accepting their condition and situation without complaining. PIPER, Kranksein-Erleben und lernen, 26.

themselves within the course of illness.[109] While, also following the life sustaining treatment till the end of life without disregarding dying as a natural and a normal human process.[110] It is the "only way through which dying can be a more easy process instead of being difficult."[111]

With a basis on the patient-oriented care, palliative care is also an reaches out to the relatives and friends of the ill patient, who take care of the severely sick with love and counselling, especially, in cases of home-based care, while offering the necessary support required for their understanding of the illness or dying phases, and dealing with shocks, depressions as a help in aiding and lightening their acceptance of death.[112] Thus, palliative care is as an interactive, empathic solidarity and care geared towards a subjective and relative well-being of the terminally ill and their social relations.[113]

1.9.2. Palliative Care and Palliative Medicine

Palliative care and medicine accompany and support each other in achieving one goal.[114] Palliative medicine is an aspect and part of palliative care with a particular focus on the humane dying process, while palliative care is the whole care in all its aspects.[115] These terms are often used interchangeably to mean one and the same care and actions by the support team.[116] In the Luo traditional medicine, the distinction between palliative care and medicine equally do not exist and is comprehensively as single unit referred to as *Tuo-yo Jatuo*. As comprehensive service, medication and care combine all acts that are religiously and therapeutically performed with the aim of relieving pain and extending life of the patient.[117]

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[109] Cf. DEUTSCHE GESELLSCHAFT FÜR PALLIATIVMEDIZIN (DGP), Einsatz Sedierender Medikamente, 10.
[110] Cf. WORLD HEALTH ORGANIZATION (WHO), Palliative care for older people, 6.
[111] *"Nur so kann ihm das Sterbens statt erschwert erleichtert werden."* JENS – KÜNG, Menschenwürdig sterben, 40 [Own Translation].
[112] Cf. ibid.
[113] "Kant concludes this list of familiar components of well-being with a nonspecific inclination: 'entire well-being and contentment with one's condition'." Cf. Logan GINTHER, Kantian Objectivism and Subject-Relative Well-Being, in: Dialogue 61 (2022) 407–419, here: 409. URL: https://doi.org/10.1017/S0012217322000269 [accessed: 10 February 2025].
[114] Cf. MÜLLER–HUNSTORFER, Einführung in die Medizinethik. Palliativmedizin.
[115] Cf. MARSCHÜTZ, Theologisch ethisch nachdenken, 301–302.
[116] Cf. DEUTSCHE GESELLSCHAFT FÜR PALLIATIVMEDIZIN (DGP), Definitionen zur Hospiz und Palliativversorgung (2016), 1–17, here: 2–3. URL: https://www.dgpalliativmedizin.de/images/DGP_GLOSSAR.pdf [accessed: 10 May 2025].
[117] Cf. NAGATA, et.al., Medical Pluralism on Mfangano Island, 502.

1.9.3. Palliative Care within the Health Care System

The World Health Organization (WHO) in its approach, proposes a health system that works in upgrading the well-being of the population and provides equitable financing and sensitivity to non-medical expectations of the population. This proposal regards to be of priority the person's dignity, confidentiality, autonomy and communication. The health systems ought then to function in: financing, creating resources, delivery of health services within their contexts and fostering stewardship in respect to the challenges and needs of those involved making the required services available.[118] Since, palliative care is basically concerned with the psychosocial care, dignity and quality of life of those involved. The universal access to palliative care has been affirmed by the World Health Assembly (WHA) Resolution 67.19 as an ethical imperative that should be integrated within the public healthcare systems at the primary health care level as crucial for the attainment of UHC.[119] This study locates the traditional *Tuo-yo kod Rito Jatuo* as foundational pillar through which the proposed health system can thrive.

1.9.4. Organization of the Health Care System in Kenya

The history of conventional medicine and practice in Kenya is conjoined with colonization and white settlers, which from the onset set out to suppress the practice of pre-existing traditional medicine. The main focus of conventional medicine was to provide health care services to settlers, the African and Asian labour force and curb the spread of tropical diseases.[120] This established healthcare system was three tier and racially organized, with the European, Asian and African in such a manner that they also received healthcare in separate facilities and by different staffs and different services hierarchically. The central colonial government became responsible for policy development and provision of special care within those hospitals in urban centers while allocating some responsibilities to the local Native councils such as prevention and sanitations under the provincial authorities, but with minimal supervision, since it wasn't their priority.[121] The pre-existing traditional medicine remained with the bulk of the population, since the white settlers offered the African population the least to sustain their life while keeping them usable.[122]

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[118] Cf. WORLD HEALTH ORGANIZATION (WHO), Palliative care for older people: better practices, 6–7.
[119] Cf. WORLD HEALTH ORGANIZATION (WHO), Why Palliative Care is an Essential Function, 1.
[120] Cf. GÖTSCH, et.al., The Health Care System in Kenya, 4.
[121] Cf. ibid., 4–5.
[122] Cf. ibid., 4.

At independence, the Kenya government centralized the inherited a three-tier health system.[123] On the contrary while respecting the complexity of the Kenyan health care system and with aim of leveraging the healthcare within the entire country. Each particular region across the divide, maintained its unique challenges which played important role in determining the patterns of some diseases e.g. malaria and water-borne diseases, yellow-fever, HIV/AIDS and those associated with malnutrition, later contributing to devolution[124] of health system from 2013 onwards. The national government transferred some of the management of healthcare system from the national to county level government.

Devolution was done according to 2010 Constitution, to handle and address the elaborate health care needs in country, as stipulated in Article 6 as follows: "(1) The territory of Kenya is divided into counties",[125] with separation of powers and functionality between "(2) The governments at the national and county levels [as] are distinct and inter-dependent and shall conduct their mutual relations on the basis of consultations and cooperation."[126] The constitution moreover, elucidates that, "(3) A national State organ shall ensure reasonable access to its services in all parts of the republic, so far as it is appropriate to do so having regard to the nature of the service."[127] This constitution guarantees all the Kenyan citizens on economic and social rights that, "Every person has a right to the highest attainable standard of health, which include the right to healthcare services"[128] as well as medical emergency without considering their background.[129]

1.9.4.1. The Kenyan Health Care System and its delivery on Palliative Care

A functional and a well performing healthcare system, working as a single functional unit, is the primary foundational base for a healthy nation with low morbidity, low mortality and the necessary survival of a patient.[130] In Kenya, health system is robust incorporating both conventional /bio-medicine and complementary/alternative options. Although lot of factors

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[123] Cf. GÖTSCH, et.al., The Health Care System in Kenya, 6.
[124] "Devolution: a transfer of jurisdiction and authorities to territorial and indigenous and self-governments, from the federal government ranging from authority over such areas of health, to the regulation of lands and resources (Stephanie Irlbacher-Fox and Stephen J. Mills) […] Kenya chose a cooperative system of devolved government." Onesimus Kipchumba MURKOMEN, Devolution and Health System in Kenya (24 October 2012). URL: https://www.healthpolicyproject.com/ns/docs/Kenya_Kipchumba_Presentation.pdf [accessed: 9 April 2025].
[125] CONSTITUTION OF KENYA,2010, art.6§1, in: Kenya Gazette Vol.CXII-No.88 (03 September 2010) 15. URL: https://new.kenyalaw.org/akn/ke/act/2010/constitution/eng@2010-09-03 [accessed: 06 April 2025].
[126] Ibid., art. 6§2.
[127] Ibid., art. 6§3.
[128] Ibid., art. 43§1(a).
[129] Cf. ibid., 43§2.
[130] Cf. Kurt, WEISS, Das Gesundheitswessen auf dem Krankenbett, in: Wirtschaftsinformatik &Management 14/2 (2022) 82–90. URL: https://doi.org/10.1365/s35764-022-00390-x [accessed: 7 April 2025].

influence the delivery of both. Poverty of stands out, as it directly affects the delivery of conventional care, affecting a number of the citizens leaving them only the traditional care.[131] Again, the growing increase in the use of "complementary and alternative medicine use in patients with chronic diseases in primary care".[132]

Additional contribution is ignorance, lack of knowledge and traditional beliefs on the causes of diseases e.g. limiting the causes to mystical origin, or breaking of taboos (*kweche)* and lack of clear-cut symptoms of illnesses, as in the case of "*Chira"*[133] within Luo traditional medicine.[134] The Conventional medicine equally continues to reel from "the 'brain drain', migration, poor working conditions, poor human resources for health management, low salary and delayed payment […] leads to recurrent health worker strikes […] contributed[ing] to low health worker retention"[135] positively impacting in the increased use of herbal medicines prepared at home or obtained from herbalist.

1.9.4.2. Palliative care in the Kenyan National Policy

In following the World Health Assembly (WHA) Resolution 67.19 about a decade ago, many countries incorporated palliative care services within their national healthcare policies through passing of favorable legislation processes aimed at enhancing and implementing palliative care services, not only through the primary health care, but, also through community settings.[136] So*, the 2010 Constitution of Kenya*, guarantees its citizens the "right to the highest attainable standard of health, which include the right to healthcare services"[137], which extends to the palliative care. The Kenyan health care developed palliative care policy meant to strengthen and provide guidance in implementation of its

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[131] Cf. Alexandar CHAGEMA, Why St. Mary's Hospital Mumias has closed after 117 years of service, in: Radio Maisha (29 August 2025). URL: https://www.standardmedia.co.ke/radiomaisha/western/article/2001528054/why-st-marys-hospital-mumias-has-closed-after-117-years-of-service#. [accessed: 2 September 2025].

[132] LEE, et al., Complementary and alternative medicine use in patients with chronic diseases, 654.

[133]"*Chira (Luo) or enkiera (Suba)* is a distinct illness concept with a long history in East Africa, yet it shares many similarities with HIV/AIDS regarding sexual transmission and wasting symptoms. *Chira* is an illness recognized and documented long before the emergence of pandemic HIV/AIDS in Africa, is characterized by extreme thinness, wasting, weakness, and diarrhea, particularly with blood (Parkin,1978; Whyte and Kariuki,1991). *Chira* and AIDS have become inextricably linked in conversations regarding unexplained illness […] The causes of *Chira* are all related to the transgression of principles governing sexuality or seniority*[kweche]*. For instance, adultery committed during a wife's pregnancy, contact with uninherited widow, disregard of seniority rules, or failure to observe the proper separation of sexuality between generations" NAGATA, et.al., Medical Pluralism on Mfangano Island, 502.

[134] Cf. BROWN, Living with HIV/AIDS, 69–71.

[135] Rose Nabi Deborah Karimi MUTHURI et.al., Predictors of Health-Related Quality of Life among Healthcare Workers in the Context of Health Systems Strengthening in Kenya, Healthcare 9/1 (2021) 1–16, here: 2. [https://doi.org/10.3390/healthcare9010018].

[136] Cf. WORLD HEALTH ORGANIZATION (WHO), Why Palliative Care is an Essential Function, 1.

[137] CONSTITUTION OF KENYA, 2010, art.43 (1).

services within its devolved system entailing the "integration of multi-disciplinary, multi-sectoral and inter-governmental approach to its implementation framework."[138]

1.9.5. Situating *Tuo-yo kod Rito Jatuo* as Palliative Care

Tuo-yo kod Rito Jatuo, is directly synonymous to *'home-based kin-care'*, a concept developed by Hillary Graham as a concept of care, "that refers simultaneously to the place in which it is carried out ('his home') and within the interactive social relations through which it is carried out ('family, friends') […] it is also care by one's family, governed by the normative obligations of kinship, is typically provided without pay".[139] This implies, a type of concern, in which a physician's support is endowed with both "sympathy as, 'an affinity, association, or relationship so that whatever affects one, similarly affects the other'"[140] and that of empathy in the appreciation of a patients state in reaching out naturally out of the closely-knit family relationships of kinship depending on the intimate connections.[141] Where the care-giver or "the physician remains detached yet interested."[142]

In distinguishing "between Empathy and sympathy, Wispe argues that, 'In Empathy, the empathizer reaches out for the other person. In sympathy, the sympathizer is moved by the other person's well-being […] empathy is a way of knowing. Sympathy is a way of relating' […]".[143] From this clarification, *Tuo-yo Jatuo* entails both empathy and sympathy. *Tuo-yo Jatuo* is a compound word stemming from *Tuo-yo* transliterated as *'to make sick'* and *Jatuo-* patient/ *'the Sick'*. Basically, transliterating as '*making the sick-sick*, meaning being sick with a patient, to imply the deeper meaning of understanding the patient in situation and condition, (Empathy) to the extent, one is not a bother, but reaches out and seeking the well-being of the other.

Tuo-yo Jatuo is understood within the general care of the patient known as *Rito Jatuo* in this cultural community. The existing difference between *Tuo-yo kod Rito Jatuo* lies in the independence of the patient and the advancement of illness. When the patient is partially independent and carry's on with primary self-care with additional support, then, it is referred to as '*Rito Jatuo'* but when the patient losses complete independence and must

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[138] MINISTRY OF HEALTH, Kenya Palliative Care Policy 2021–2030, 4.
[139] Hillary GRAHAM, The Concepts of Caring in Feminist Research. The case of Domestic Service, Sociology 25/1 (1991) 61–78, here: 65. URL: https://www.jstor.org/stable/42854787 [accessed: 19 May 2025].
[140] MARCUM, An Introductory Philosophy of Medicine, 262.
[141] Cf. ibid., 262–264.
[142] Ibid., 262
[143] Ibid.

fully depend on other, then it is '*Tuo-yo Jatuo'*. The term *Tuo-yo Jatuo*[144] was employed to signify the severity of the situation.

Tuo-yo kod Rito Jatuo is "often understood to be tightly bound up with the emotional closeness and love associated with the familial realm",[145] exemplified by the collective support for the other as the 'other' needy.[146] It strives to realize the subjective and relative well-being of the patient wherever it is attainable, although, mostly applicable within the traditional set-up of home (*Dala*). *Tuo-yo Jatuo* at home included other traditional religious activities and rituals of healing and health considered as part of the illness support in the strict sense.[147] For, it takes both emotional love and care from someone in the family to willingly and dutifully attend to another family member in such manner of a severe situation without coercion, pay and without complain. *Tuo-yo Jatuo* is organized through an obligated informal care-givers, who are closely related in coping up with inevitable stress experienced by the ill person.[148]

1.9.6. *Tuo-yo kod Rito Jatuo*, a Model for the Kenyan Health Care System

Historical developmental effects on the conventional medicine in Kenya has affected the humanistic or humane qualitative delivery of healthcare services to patients.[149] As argued by Githui Donatus, the basis of the problem underlying the Kenyan public healthcare system "was found to be the weakening influence of the healthcare institution to instill ethical concerns on the physicians, nurses and other members of society on healthcare management"[150] directly affecting the human touch, unlike, the traditional *Tuo-yo kod Rito Jatuo*. The impact of emotional detachment within the conventional care is worrying, and greatly affecting the sympathetic care delivery,[151] by creating "a critical distancing reaction which prevents the practitioner from entering sympathetically into patient's situation"[152].

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[144] *Tuo-yo Ja-tuo*-transliterated as: making the sick-sick; or 'being sick with the sick or suffering with the Sick' in the light of an Empathic solidarity, all the above are the close equivalents in meaning and understanding of the tongue. This term played a very important role, in courtship and marriage too. As it was a value considered in referring to kin care in extreme cases of terminal illness

[145] BROWN, Living with HIV/AIDS, 19.

[146] Cf. UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO), Bioethics Core Curriculum. Section 1, UNESCO 2008, 54. URL: https://www.npojip.org/contents/book/unesco-e.pdf [accessed 20 July 2025].

[147] Cf. MBITI, Introduction to African Religion, 134.

[148] Cf. GRAHAM, The Concepts of Caring in Feminist Research, 64.

[149] Cf. MARCUM, An Introductory Philosophy of Medicine, 259.

[150] Donatus GITHUI, Ethical Issues in Healthcare in Kenya. Acritical analysis of healthcare stakeholders, in: Research Journal of Finance and Accounting 2/3 (2011) 121–140, here: 121. URL: https://core.ac.uk/download/pdf/234629194.pdf [accessed:10 February 2025].

[151] Cf. MARCUM, An Introductory Philosophy of Medicine, 260.

[152] Ibid., 261.

There exist negative acculturation offshoots of colonization in patient handling within the Kenyan public healthcare sector, where "the quality and availability of services reflected the racialized hierarchies of the colonial society with the European settlers at the top and services provided to the African population ranked lowest"[153]. This segregation continues to be at play several years after the independence. The practice of segregation is now acculturated and exists between the *'the wananchi'* or *'have nots'* (the poor majority in the public) and 'the *Sonkos'* or *'haves'* (the rich who can afford or the people of class in the private) they provide "a higher quality of care than the others but cannot be afforded by the majority of the population"[154]. Although, this existing disparity of inhumane handling of patients between both the public and the private sectors has failed to spill over into the alternative traditional medicine care and practice, that has historically preserved its traditional humane and empathic purity within its unique cultural flora.

According to Githui, the illness affecting the Kenyan public healthcare sector lies in the lack in foundational ethics as basis for their considerations, not only within the health sector but human handling in general.[155] Thus, "within the Kenyan systems, ethics and moral issue, especially within the healthcare field are of major concern."[156] Since they are regulated and accessed legally based on laws.[157] On the contrary, the "ethical behaviour calls healthcare providers to conduct themselves in a manner that is beyond the demands of what is legal; it also asks them to behave in manner that is ethical according to guidelines of their profession"[158]. In order to avert the arising quality-of-care crisis within the public healthcare sector,[159] which can only be attested to by "those who have visited the public hospitals, either at in-patient or out-patient".[160] "In Kenya, there is a wide popular discourse that nurses are often harsh and frequently treat patients cruelly"[161]. Therefore, the need for integrating the empathic approach, which the traditional care of *Tuo-yo kod Rito Jatuo* which is imbued with the deep sense of humanly compassionate assistance as its foundation ought to teach the public conventional medicine in Kenya.

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[153] Cf. GÖTSCH, et.al., The Healthcare System in Kenya, 4.
[154] Ibid., 9.
[155] Cf. GITHUI, Ethical Issues in Healthcare in Kenya, 124.
[156] Ibid.
[157] Cf. ibid.
[158] Ibid.
[159] Cf. MARCUM, An Introductory Philosophy of Medicine, 260.
[160] Brenda GAMONDE, 5 Annoying Things About Kenyan Nurses, in: Business Today (18 February 2019). URL: https://businesstoday.co.ke/5-things-know-kenyan-nurses/ [accessed: 16 July 2025].
[161] BROWN, Living with HIV/AIDS, 170–171.

Chapter II. Necessity of Palliative Care

Palliative care focusses on the remote health and wellbeing in the presence of terminal illness, diagnosis and multiple crises arising along the course of handling of such a disease situation, which a sick person left alone cannot manage alone. Palliative care is consequently concerned with the required *impromptu* response from our humanity, where everyone responsibly shares their thoughts and care in offering assistance to the affected.[162] The following chapter purposes to provide the preliminary stages necessitating comprehensive assistance from its initial beginnings and also seeks to expound and clarify further on how each step plays a forerunner role into the required care within an emerging situation. An additional case study into the legendary Job's sickness has been used to elucidate and expound analogically the study population.

2.1. The Crisis of Illness/Sickness

Sickness attack is a sudden occurrence like lightening, within a short time, a person becomes subdued.[163] and experiences a breaking of "*das seiende"*[164] – the being in personhood into "I am my body and I have my body"[165], a personal experience and physicality known as *"selbsterfahrung und leiblichkeit"*[166] – the conscious experience of the bodily reality, differentiated as *'Körper und Leib'* or *'Ich' und 'selbsts'*[167] (Body and flesh, or 'I' and 'self'). Where the body (subject) is experienced as being external and the other 'other'(object), a feeling of parts in relation to whole. e.g. I feel pain in my stomach and head, as to 'I have headache and stomachache'.[168] Sickness distances and socially alienates one from everyday normalcy,[169] making one to give-up own status, lose self-independence, well-being, freedom and take up a new role of being a patient – *Jatuo.*[170]

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[162] Cf. PIPER, Kranksein-Erleben und lernen, 15–17.
[163] Cf. Anton GOTS, Wenn einer Krank ist unter euch. The Christian in service to his sick fellow Men, Linz 1979, 15.
[164] Günther PÖLTNER, Grundkurs Medizin-Ethik, Wien ²2006, 51.
[165] "*ich bin mein Leib und ich habe meinen Leib"* ibid., 70.
[166] SCHOCKENHOFF, Ethik des Lebens, 141.
[167] Cf. ibid.
[168] Cf. PÖLTNER, Grundkurs Medizin-Ethik,70. See Also: MARCUM, An Introductory Philosophy of Medicine, 49.
[169] Cf. PIPER, Kranksein-Erleben und lernen, 15.
[170] Cf. Reinhold GESTRICH, Gespräche mit Schwerkranken. Krisenbewältigung durch das Pflegepersonal, Stuttgart ³2006, 23.

2.1.1. Crisis

Crisis is considered as sudden happening dangerously threatening the bodily-life existence requiring a radical solution.[171] It can gradually alter a situation from normalcy, to acute, or chronic within a very short span of time. It is traditionally understood as a transitional stage of an event towards something altogether different, in which the more powerful subdues the weak giving rise to unaccounted uncertainty.[172] This term 'Crisis' has Greek roots from the word *'Κρίσις'* introduced by the verb '*κρίνω'* to mean: to separate, judge, reason, decide, quarrel, fight or to divorce.[173] According to *Oertel*, Crisis can be understood to imply that decisive point in an illness situation, or a decision signal – *Entscheidungszeichen* or a state or condition requiring making of decision in the case of an alarming circumstance.[174] Crisis is a process concept,[175] "a transitional or temporal concept *(Verlaufsbegriff*) […] towards a decision"[176]. It has a varying understanding prompted by circumstances of human life.

In the health sector, Crisis "refers to both the observable condition and the judgement *(judicium)* about the course of illness. At such a time, it will determine whether the patient will live or die."[177] Thus, refers to;

> the worsening of a disease [...], that patients are in a critical condition. This means that they may or may not make it, but in any case, the current situation is only a painful and, in the long term, unbearable transitional phase, the phase of decision, so to speak.[178]

A decisive point in time or alarming state of events in which the health parameters changes,[179] casting uncertainty and insecurity and demanding an acute agency and a necessary decision as process.[180]

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[171] *"Im allgemein erwartet man im Fall existentieller Bedrohungen auch große, radikale Lösungen."* Cf. ÖSTERREICHISCHE AKADEMIE DER WISSENSCHAFTEN (ÖAW), Epistemische Sicherheit. Zur Rolle Wissenschaftlicher Expertise in Chronischen Krisen (Projektbericht) March 2024, Vienna, 14. URL: https://epub.oeaw.ac.at/ita/ita-projektberichte/ITA-2024-01.pdf [accessed: 26 July 2025] [Own Translation].
[172] Cf. ibid.
[173] Cf. Reinhart KOSELLECK–Michaela W. RICHTER, Crisis, in: Journal of the History of Ideas 67/2 (2006) 357–400. here, 358.
[174] Cf. Eucharius Ferdinand Christian OERTEL, Gemeinnütziges Wörterbuch zur Erklärung und Verdeutschung der im gemeinen Leben vorkommenden fremden Ausdrücke. Vol. 2. Ansbach ²1806, quoted in: Reinhart KOSELLECK–Michaela W. RICHTER, Crisis, in: Journal of the History of Ideas 67/2 (2006) 357–400, here: 366.
[175] Cf. ÖSTERREICHISCHE AKADEMIE DER WISSENSCHAFTEN (ÖAW), Epistemische Sicherheit, 14.
[176] KOSELLECK–RICHTER, Crisis, 361.
[177] Ibid., 360.
[178] *"die Zuspitzung eines Krankheitsverlaufs […], dass sich Patient: innen in einem kritischen Zustand befinden. Das heißt, sie werden es schaffen oder auch nicht, aber die aktuelle Situation ist in jedem Fall nur eine- leidvolle und auf Dauer unerträgliche – Übergangsphase, sozusagen die Phasen der Entscheidung"* ÖAW, Epistemische Sicherheit, 14.
[179] Cf. KOSELLECK–RICHTER, Crisis, 364.
[180] Cf. Uriel ROSENTHAL, September 11: Public Administration and the Study of Crises and Crisis Management, in: Administration and Society 35/2 (2003) 129–143, here: 132. URL [accessible from

2.1.2. Sickness Crisis

Sickness seeks breaking and erasing of the individual's vitality. It causes the rise of essential issues which changes a person life's rhythm leading to confusion and anomalies in health parameters, where the body can no longer holds in place. It creates what Piper refers to as the *"die entleere Zeit"*[181] or an empty time and hours replacing it with the daily normal activities of life. For the healthy, time is planned, programmed and activities flow, everything within its time, "a time for every purpose" (Ecclesiasticus 3:1f) to wake up and to sleep. The ill on the contrary, especially the severely ill spend the whole duration of a day confined to bed in an isolated room, busy with their own thoughts, sometimes without simple bouts of sleep.[182] Sickness presents apart from dealing with physical suffering and spiritual suffering, it presents the problem of the empty time – '*die entleere Zeit'.* A time in which "people suddenly confront long evaded questions of meaning and purpose. What does it mean to be alive? Why go on in face of incurable illness?"[183].

2.1.3. Sickness, Illness and Health

The notion sickness or illness are similar in describing the state of wellbeing of a person. Illness is a term which refers to the subjective experience of symptoms and signs of a disease in an undiagnosed state, while the idea of sickness is the objective experience of the medical condition or disease outlining the diagnosis from the external outlook in relation and comparison to other experiences.[184] Just as illness/sickness cannot be defined, so neither can health be, because both illness, sickness and health are abstract concepts descriptive of a state or condition of person or are dependent on constructed personal or social worth relating to what is considered be constituting the well-being of an individual person. Where illness /sickness exists in terms of values,[185] and cannot be clearly grasped without the personal lifestyle and social setting of its occurrence, since they occur within their range of setting, according to Cassell.[186]

University of Vienna]: https://journals-sagepub-com.uaccess.univie.ac.at/doi/epdf/10.1177/0095399703035002001 [accessed: 16 August 2025].

[181] PIPER, Kranksein-Erleben und lernen, 12.

[182] Cf. ibid., 13.

[183] ASTRAW, Thoughts on Euthanasia and Physician-Assisted Suicide, 49.

[184] Cf. This vs. That, Illness vs. Sickness. URL: https://thisvsthat.io/illness-vs-sickness [accessed: 12 December 2025].

[185] Cf. MARCUM, An Introductory Philosophy of Medicine, 63.

[186] Cf. ibid., 70.

To understand illness or sickness, the definition of health is necessary. According to WHO, health is the "state of complete physical, mental and social well-being and not merely absence of disease or infirmity."[187] Health should then be understood as the general well-being of a person. Therefore, in relation to this definition of health, illness and sickness can be analogically understood as the malfunctioning of a system or an organ within a person that has consequently tampered with the normal chemical and biological exchange leading to an interruption or some alteration within the functioning order, affecting the general well-being of a person.[188] Although, "what makes something a disease is not only biology but also our social values: 'Disease is the aggregate of those conditions which, judged by the prevailing culture, are deemed painful, or disabling, and which at the same time, deviate from either the statistical norm or from idealized status'(King, 1954, p.197)."[189]

In an African moral thought, "disease is not just physical condition […]. It is a religious matter".[190] So, in determining the causes of illness, socially the religion is employed to gauge the cause and if possibly health it and restore normalcy, although biological observations of symptoms are also employed to determine whether the cause of illness equally is mystical, or sent by someone, as in the case of sorcery. Hence, some rituals are often performed on the sick and in the family when a person was sick to know the cause and uproot the impurity brought about by illness.[191]

2.1.4. Sickness within the Current Traditional Culture

Currently, due to acculturation of the traditional cultures,[192] Luo culture, consider both the spiritual-religious basis and bio-medicine investigations to be at par, in determining the causes of illnesses and healing them, since sickness is both physical and spiritual. There are many avenues of these investigations for possible solutions that are often burdensome and weary to the patient due to the mixed practice, further worsening the patient's situation, which may lead also into psychic sickness. In severe illness or sickness, dialogue

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[187] WORLD HEALTH ORGANIZATION (WHO), Constitution of the World Health Organization, basic principles, 7 April 1948, 1–18, here: 1. URL: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1 [accessed 30 July 2025].
[188] Cf. PÖLTNER, Grundkurs Medizin-Ethik 76–79. See Also: MARCUM, An Introductory Philosophy of Medicine, 64.
[189] MARCUM, An Introductory Philosophy of Medicine, 71.
[190] MBITI, Introduction to African Religion, 134.
[191] Cf. ibid.,134.
[192] Cf. Brandon D. LUNDY, Acculturation, in: F. Abiola IRELE -Biodun JEYIFO (eds.), The Oxford Encyclopedia of African Thought, Vol. I, New York et.al. 2010, 9-11, here: 9.

plays a significant role. Dialogue opens the world of the patient into an interpersonal relationship with the world around them.[193] Dialogue seeks to resolve the possible dissolution of the unity of body-soul and the essence of our identity as persons which sickness casts into crisis.[194] Because, sickness isolates and tampers with the familial relationships, wider friends and relatives' network, and extends to the social, religious, cultural, political and professional environment circles, within a one's engagements.[195] Sickness commands the community through the constructed network of relationships to respond in all forms of support and care.[196]

2.2. A Case Study of Job's Sickness and the Communal Dimension of Sickness

Job is "a historical figure"[197] whose story is having an exceptional reverence amongst the three major monotheistic religions: Christianity, Islam and Judaism.[198] The story of Job's misfortunes and eventual loss of his health is weaved in resounding theological message, on whether "it does not pay to be religious"[199]. This story is about "a prince brought low and preserves his serenity."[200] It is a parable that has been used for teaching.[201] Legendary Job was not only a *wealthy*[202] (Cf. Job 1:2–3), and a *"righteous man"*[203] (Cf. Job 1:1, 4,

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[193] Cf. GESTRICH, Gespräche mit Schwerkranken, 24.
[194] Cf. Andreas HELLER, Kranke, in: LThK³,6, Sp. 410–417, 410.
[195] Cf. GOTS, Wenn einer Krank ist unter euch, 7–10.
[196] Cf. ibid., 8.
[197] Samuel TERRIEN, Job. Poet of Existence, New-York 1957, 28.
[198] Cf. ibid., 23.
[199] Ibid., 20.
[200] Ibid., 24.
[201] Cf. ibid., 30.
[202] *Wealth* in the biblical context refers to the abundance of material possessions, resources and riches. It encompasses not only money but also land, livestock and other forms of property. […] In O.T, it is a sign of God's blessing and favor. Cf. Roger SCHOLTZ, I heard of You…But Now My Eye Sees You. Re-Visioning Job's Wife, OTE 26/3 (2013) 819–839, here: 825. See Also: Cf. BIBLE HUB, "Wealth". URL: https://biblehub.com/topical/w/wealth.htm [accessed: 15 July 2025].
[203] *Righteous man,* In the biblical context, […]is one who lives in accordance with God's laws and commands, embodying moral integrity and uprightness.… [it refers to] a life that is pleasing to God and aligned with his will. O.T understanding is often associated with adherence to the law given by God. The Hebrew word for righteousness, "*tsedeq,*" conveys the idea of justice, rightness and ethical conduct. A righteous man is one who lives in harmony with God's covenant, as exemplified by figures such as Noah [Gen. 6:9], Abraham [Gen.15:6], and Job. [In the N.T] Greek word *"dikaios*" is used to describe righteousness, emphasizing a state of being right with God [Matt.5:6, Rom. 3:22] …a righteous man…is characterized by a life of faith, obedience and moral integrity, he seeks to align his actions and thoughts with God's will, demonstrating love, justice and mercy in his interactions with others. The righteous man is also marked by a deep trust in God's promises and commitment to living out the principles of the Kingdom of God. Throughout the scripture, the righteous man is assured of God's favor, protection and ultimate vindication. His life serves as a testimony to the transformative power of God's grace and the hope of eternal life through Jesus Christ. BIBLE HUB, "Righteous Man". URL: https://biblehub.com/topical/r/righteous_man.htm [accessed: 15 July 2025].

22; 2:10) but also was "the greatest of all the people of the east" (Job 1:3d) in the "*land of Uz"*[204] (Job 1:1).

Job unexpectedly became poor and severely ill, due to successive in unexplainable events unknown to him (Cf. Job 1:6–12; Job 2:1–7). He lost his wealth – to Sabaeans, Chaldeans and to natural catastrophe (Cf. Job 1:14–17), this events was immediately followed by the demise of all his ten children: seven sons and three daughters (v.18)] making them (him and his wife) childless and lastly his health became broken and frail as Jobs entire body came to a state of turmoil, when he was afflicted "with loathsome [painful] sores from the sole of his feet to the crown of his head" (2:7), ushering him to unbearable pain comparable to the agonies of cancer patients, "whose screams of pain echoed through […] day and night and whose ulcerous, decomposing tumors let off an unbearable stench."[205]

These successive instances are believed to have pushed Job into a mental turmoil, due to the consequential loss of his possessions, death of his children, excruciating pain all over his body and perhaps an aching heart – having been righteous with a deep trust in God promises, favour and protection, leading him into hopelessness. The sores covering his whole body "were incurable and painful"[206]. He never attempted cure, but instead worsening of the situation. "Job scrapped the bloody matter with a shard"[207]. This situation of Job, characterizes depressed persons who also worsen their situations without knowing it. Often, following sudden in unexplainable dangerous events, threatening to life and existence, some depressed persons have entered into psychological crisis, where suicide becomes the available option. On the contrary, Job remained steadfast in faith. Despite the psychological push by own wife, to "curse God and die" (Job 2:9).

Following the argument of William Blake, Job's wife was always with him and was directly and emotionally involved in everything as a faithful wife.[208] While, in situations of acute and catastrophic crisis, it is typical of wives to be generally very supportive, wives soothe and confront the existing situation with encouraging and comforting words to their husbands. Unfortunately, Job's wife having reached unbearable point became impatient

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[204] "The land of Uz", remains unknown whether its falls within Edom or Aram and only remains symbolical. Marcus WITTE, Der Leidende Mensch im Spiegel des Buches Hiob, in: Markus WITTE, Hiobs viele Gesichter. Studien zur Komposition. Tradition und frühen Rezeption des Hiobbuches, Göttingen 2018, 65–80, here: 67.
[205] STOLBERG, A History of Palliative Care, 2–3.
[206] Thomas AQUINAS, The Commentary on the book of Job [trans. by Brian MULLADY], ed. by Joseph KENNY, 2002. URL: https://isidore.co/aquinas/english/SSJob.htm [accessed 18 March 2024].
[207] Ibid.
[208] Cf. SCHOLTZ, I heard of You…But Now My Eye Sees You, 823–824.

and rebelled when he was ill and incapacitated by the disease[209] and became distant in thoughts, thus making him refer to her as a "Fool"[210]. Generally, it is considered normal, that a person may lose his possession in seeking to save his life, but when he loses all possession, family and health, a possible confusion and depression become inevitable.[211]

2.2.1. Job's Wife

The Septuagint account deeply presents a vivid description of the precarious situation of Job's wife (Job 2:9 LXX) in the context that is lacking in the Masoretic Text "Then his wife said to him, "Are you still holding your innocence? Curse God and Die!" (Job 2:9 MT). In that, apart from caring for the unbothered Job, she confronted the situation as a concerned wife, who is seeking the acknowledgment of the reality at hand, although in a manner likewise understood by many to be very irritating.

> 9 Then after a long time had passed, his wife said to him, "How long will you persist and say, [9a]'Look, I will hang on a little longer, while I wait for the hope of my deliverance?' [9b]For look, your legacy has vanished from the earth–sons and daughters, my womb's birth pangs and labors, for whom I wearied myself with hardships in vain. [9c]And you? sit in the refuse of worms as you spend the night in the open air. [9d]As for me, Iam one that wonders about and a hired servant–from place to place and house to house, waiting for when the sun will set, so I can rest from the distresses and griefs that now beset me. [9e]Now say some word to the lord and die!" Job 2:9 [LXX].[212]

It is worth noting that, "every form of care has its limits: whether it's doctors or nurses, they have other duties to attend to. Relatives and friends usually cannot simply take time off work to care for seriously ill patients."[213] So, Jobs wife's concern was also consumed with other personal loads of care apart from being Job's wife. These loads were central and very unique to her as a mother especially in the case of her ten dead and unburied children that extinguished her future as a woman without a future yet still expected by the society to start again and rebuild (cf. Job 2:9b). In addition, it was about her new social status, from a queen is reduced to a day-to-day laborer and beggar, moving from house to house to fend

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[209]Cf. F. Rachel MAGDALINE, Job's Wife as Hero. A feminist -Forensic Reading of the Book of Job, in: Bible interpretation 14/3 (2006) 209–258, here: 123. DOI: https://doi.org/10.1163/156851506776722985.

[210] Katherine LOW, Job's Wife, in: Encyclopedia of the Bible and its Reception, Vol.14, Berlin–Boston 2017, 393–397, here: 394.

[211] Cf. Thomas AQUINAS, The Commentary on the book of Job.

[212] Albert PIETERSMA – Benjamin G. WRIGHT (eds.), A New English Translation of the Septuagint. And the other Greek Translations traditionally included under that title, New York –Oxford 2007, 667–696, here: 671. URL [accessible from University of Vienna]: https://research-ebsco-com.uaccess.univie.ac.at/c/tvp6zc/ebook-viewer/pdf/4zae763xlz/section/lp_667 [accessed: 14 January 2026].

[213] *"Jede Pflege hat ihre Grenzen: Ob der Arzt oder Schwestern, sie haben noch andere pflichten. Die Angehörigen oder Freunden, sie können sich zu meist beruflich nicht einfach für die Pflege von Schwerekranken freistellen lassen."* JENS–KÜNG, Menschenwürdig sterben, 41 [Own Translation].

for herself and her the ailing husband (Cf. Job 2:9d). A woman who was living in surplus now reduced to a woman in want and lack.

Job sickness and the condition of Job's wife carry with it the communal dimension of sickness. When one is severely sick, the surrounding community is sick too, and everyone is called on board to empathically support. Jobs wife should be understood as chronically and psychologically overburdened and broken. A woman who is calling for help and support, for her cry, is a cry of despair of woman who has tried her best,[214] to a point that she is only remaining with death as the only solution to her problems, and so she encourages and challenges Job too, to undertake it and end it all, through "any word to the Lord and die" (Job 2:9e). This situation of Jobs wife presents a deep sited crisis, resounding in many quotas of the terminal illness situations. A situation advocating for an added support, which only Palliative Care can offer.[215]

2.2.2. Job's Wife and Euthanasia

The short message of Jobs wife "Curse God and Die!" (Job 2:9MT) can be used in an argument for an assisted euthanasia (*Euthanasia medicinalis*) from chronic illness perspective, where death is seen as blessing and alleviation of pain and not really a curse.[216] Although it can be considered as an impious suggestion not arising from the possibility of impiety but a heavy suggestion that takes into an account the situation of Job and is geared towards Job's own benefit of relieving him from his suffering and pain.[217] Job's wife is interested in the fate of her husband out of mercy as a wife, that instead of Job's endless suffering, it is better that his suffering and pain finally comes to halting end.[218]

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[214] "The cry of despair of a woman who has toiled to provide food and home for her family and who has seen these destroyed[…] to articulate the cry of an agony of a woman who has labored to give birth to ten children and who has seen them murdered […]the cry of pain of a woman who has been a faithful companion to her husband but who is debased by him[…cry of frustration of a woman who fully understands the intellectual issues involved but who is not taken seriously […]the cry of the rejection of a woman who is made in the image of God but who remains unanswered by God[…]the cry of confusion of a woman who is expected to build her home and produce more children with no hope of future for them[…]the cry of outrage of a woman who sees her daughters treated in different way as sons." Cf. Gerald WEST, Hearing Job's Wife. Towards a feminist Reading of Job, in: OTE, 4, (1991), 107–131, here: 119. See Also: Benedict ODHIAMBO, Ijobs/ Hiobs Frau in 2:9–10 und Ihr Rabbinischer und Patristischer Rezeption, (Seminar Paper), University of Vienna: Frauen Am Rande-Biblische Frauenfiguren in rabbinischer und patristischer Rezeption, July 2024, Vienna.

[215] Cf. ibid.

[216] Cf. ASTRAW, Thoughts on Euthanasia and physician-Assisted Suicide, 45.

[217] Cf. TERRIEN, Job. Poet of Existence, 42.

[218] Cf. Arianna ROTONDO, Interpretationsschicksale von Frauengestalten aus der biblischen Weisheitsliteratur, in: Agnethe SIQUANS – Markus VINCENT (eds.) Biblische Frauenfiguren in der Spätantike (Die Bibel und Die Frauen, Vol. 5.2) Stuttgart 2022, 94–114, 95.

According to Hans Küng's argues that, "active euthanasia, which directly aims to shorten life constitutes 'mercy killing'"[219]. Job's wife suggestion constitutes *passive euthanasia* from a theological point of view.[220] So, "the best argument that one could make regarding whether this is euthanasia is that she is encouraging him to end his own life through a type of God-assisted suicide."[221] She believed that by cursing God, Job would be punished with death. "God is not an agent of mercy in the minds of these people; rather, he is an abuse perpetrator"[222] so, Job ought "to provoke his abuser to the point of death"[223].

Jobs wife "in the light of her own suffering and pain"[224] found herself in a double situation that propelled her death wishes casted on a hope of an altered ending of their situation through death. There lies the good intention of relieving her husband from his sickness and suffering out of her pity. Again, she also seeks reprieve from her daily cares filled with "cries of despair, pain, frustration, rejection, confusion and outrage and all that part of this woman's untold story"[225].

In Luo traditional medicine, such kind of merciful considerations involving indirect passive theological euthanasia demanding spiritual interventions on the severely ill situations just as in the case of job and his wife,[226] are often coined in a very sweet saying, '*Waweye ne dwach Nyasaye*'[227] – abandoning one to the will God. Or *Nyasaye onego o-ome odhi oyue* – God ought to call him unto rest. Are generally ambivalent, implying either merciful good death or miraculous healing unto the patient.

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[219] *"Aktive sterbehilfe, die active Euthanasie, welche direkt auf Lebensverkurzüng abzielt: der 'Gnadentod'"* JENS – KÜNG, Menschenwürdig sterben, 46 [Own Translation].
[220] TERRIEN, Job. Poet of Existence, 42.
[221] MAGDALINE, Job's Wife as Hero, 212.
[222] Ibid., 213.
[223] Ibid.
[224] SCHOLTZ, I heard of You…But Now My Eye Sees You, 821.
[225] Ibid.
[226] In order to theologically review her case, Job's wife is a victor through her unpleasant words, which wards of the threat of danger caused by unjustified assault on Job through the option of cursing God so that Job will not only abandon his faith but to question the action of God, making her precursor to job's. questioning Voice. Thus she draws from her husband a verbal response that protects him from the deemed collapse of his faith on God(Cf. SCHOLTZ, I heard of You…But Now My Eye Sees You, 835.) such that when Job eventually cursed nature, it clear that she pushed Job from passivity to assertiveness without being impious but into a deeper relationship with God, resulting into restoration as recorded in Job 42:10–17(Cf. MAGDALINE, Job's Wife as Hero, 214)
[227] *Waweye ne dwach Nyasaye* – is a Luo word transliterated as; "We have abandoned him to will of God." this statement has the same connotation of Job's wife "Curse God and Die!" (Job 2:9), it carries with it the connotation of tiredness and the resignation of their will from the caregiving team. Especially, when they empathize with the sick on their groaning from their unending pain, and would wish for the agony to end. But since, they have no power over the situation, they accept the situation and call on God to make his will clear, by taking the sick to rest.

2.2.3. Necessity of Palliative Care for Job's Case

In examining both the situation of Job as a patient and Job's wife as a caregiver in the light of Job's sickness as claiming the finiteness and frailty of life.[228] Job's sickness offers Job, the opportunity to experience life totally in new way of being, as a different unique individual with different strength of the will. It also presents another situation of the Job's wife, as the 'other person' although supportive but is individuated with other loads of care. It is within this reality of life, of balancing between obligated support and taking care of 'other loads of care, that palliative care offers comprehensive solidarity which is very necessary, as it steps-up its support with a helping touch encompassing the entirety of a patient together with relations making the situation bearable through holistic alleviation of pain.[229]

2.3. Palliative Care and Diagnosis

Diagnosis with a terminal illness evokes an immediate and a life-threatening feeling characterized with both physical and spiritual crisis.[230] It is life altering, where one becomes a perpetual-patient *(Jatuo*) in life. The patient must patiently, re-learn about: living with a perpetual-suffering, how best to take care of their own health and their limited future, the importance of their personal space and place in life, and how to go about experiencing all that is left in life qualitatively.[231] The severe patient's perspective of life, is often a very different one, depending on how the breaking of the bad news is done. When it is not properly done, it can sound like *hukumu ya kifo* (death sentence) which shifting the whole focus towards sickness. Thus, robbing the patient, the normal experience of life due to overconcentration on the illness, its effects, weight and gravity on dependence and demise. Therefore, a well relayed message during diagnosis works miracles. Since, every individual person is uniquely individualized in temperament which can guide the recommendations of the appropriate therapy.[232]

It belongs to the physicians to influence the fear of diagnosis into giving a sense of security and the expectations through own competence. This has a long-lasting influence

[228] Cf. GOTS, Wenn einer Krank ist unter euch, 9.
[229] Cf. ibid.,14.
[230] Cf. ASTRAW, Thoughts on Euthanasia and Physician-Assisted Suicide, 49.
[231] Cf. GESTRICH, Gespräche mit Schwerkranken, 22–23.
[232] Cf. MARCUM, An Introductory Philosophy of Medicine, 271.

on every decision a patient makes.[233] Encouraging statements changes and strengthens the spirited fights mobilizing for healing and the required endurance in influencing the will to live.[234] Moreover, application of the principles of *Nonmaleficence* in relation to *beneficence*, in which due care is taken in imparting the knowledge and associated skills in considering the required truth and the needed support for the survival and remote revival back to their pre-terminal diagnosis well-being.[235] It portrays the moral duty for the benefit of another [236] by arousing a possible conformity with their new situation of perpetual-sickness[237]through expression of words and sentiments in treatment and avoiding hurting feelings.[238]

2.3.1. Communication and Conversation

Communication plays a vital role in the well-being of any individual's life, and no-one can live without it. A good communication assists before, during and after the diagnosis and in the necessary accompanying in the fight for life where truth supports hope,[239] since it is a gateway to recovery. It is the conversations that initiates the contact between humanity and the support team connecting the needy with the required need.[240] Once an initial contact has been created, accessing assistance becomes easier: when, how and where it is required. It therefore, belongs to the support team, to understand and acknowledge their role within this area, their availability and readiness to help and serve those in need should be unmatched. That is "being there and being ready for others when someone needs help."[241] Their availability necessitates nearness and openness through good conversation, which makes *Jotuo* -patients, to feel good, safe and welcomed, allowing them to open-up, be accompanied and guided in the sickness journey.

Foundation of a good communication must be laid on the grounds that the addressed (the patient) has the capacity to understand and take responsibility in

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[233] Cf. Eggert BELEITES, Wahrheit am Krankenbett. Zum Spannungsfeld zwischen Therapie, Fürsorge und Medizinrecht, in: Josef RÖMELT, (ed.) Wahrheit am Krankenbett. Ärztliche, juristische und theologische Reflexion zu Kommunikation zwischen Arzt und Patient, (Erfurter Theologische Schriften, Vol. 31), Leipzig 2002, 9–20, here: 17–18.
[234] Cf. ibid., 16.
[235] Cf. MARCUM, An Introductory Philosophy of Medicine, 236– 237.
[236]Cf. ibid., 237.
[237] Cf. GESTRICH, Gespräche mit Schwerkranken, 23.
[238] Cf. MARCUM, An Introductory Philosophy of Medicine, 261.
[239] Cf. BELEITES, Wahrheit am Krankenbett, 16.
[240] Cf. GESTRICH, Gespräche mit Schwerkranken, 9.
[241] *"dazusein und bereit zu sein für den anderen, wenn jemand hilfe braucht."* ibid., 12 [Own Translation].

determining the mode of communication and how it is to be relayed.[242] Of importance is the initial rapport between patient and support team, so the communication is tailored and truthful in accordance with the level of education and physicians' involvement, role and trust is already established,[243] that, the coming near of the support team is not interpreted as dictating a personal position concerning the sickness, but rather attentive listening to the patient, to guide, observe and create the feeling of having the space and a room within the patient, to feel secure, to trust the process, to recognize, to accept the truth of condition, to think-over, make decisions, to honestly ask questions on areas of doubts and to speak about the way forward.[244]

These conversations flow from the basis of both the sick and the healthy being *"leiblich-personales wesen"*[245] and *gleichberechtigt* or physical-personal beings and are in equal terms in communication.[246] That is, they are persons with bodily, individual existence and experience, conscious of themselves and the world around them, are capable of personal human relationships within a given time and environment, are endowed with same human dignity and should be communicated to as persons with free-will capable of self-determination.[247] Healthy conversations are designed to occur through the support team, who strive to be open and sensitive at the same time, showing readiness for an engagement in an open and honest exchange of thoughts and feelings as well as being ready to offer support on areas of need. They are achieved through friendliness and happiness, and physically and emotional alertness to sickness and to the patient in the conversation.[248] Such conversations follows a mother-child relationship model irrespective of the age, are full of mercy to the helpless, curved from humanness and truthfulness, and are served in the spirit of honesty to assist and to guide.[249] They are deemed to be felt through the atmosphere, facial expressions and body language, and the choice of voice and words.[250] And aim to help the support team handle the arising medical, human, familial and social problems with understanding.

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[242] Cf. Georg HORNTRICH, Kommunikation und Wahrhaftigkeit Angesichts von Zeitdruck und Machtstrukturen, in: Josef RÖMELT, (ed.) Wahrheit am Krankenbett. Ärztliche, juristische und theologische Reflexion zu Kommunikation zwischen Arzt und Patient, (Erfurter Theologische Schriften, Vol. 31), Leipzig 2002, 49–70, here: 51–52.
[243] Cf. BELEITES, Wahrheit am Krankenbett, 15.
[244] Cf. GESTRICH, Gespräche mit Schwerkranken, 11.
[245] PÖLTNER, Grundkurs Medizin-Ethik, 63.
[246] Cf. HORNTRICH, Kommunikation und Wahrhaftigkeit, 59–61.
[247] Cf. PÖLTNER, Grundkurs Medizin-Ethik, 49–51.
[248] Cf. GESTRICH, Gespräche mit Schwerkranken, 11.
[249] Cf. ibid., 51.
[250] Cf. ibid., 54.

2.3.2. Doctor and Patient Relationship

Of all the communications of the support team, the conversation between doctor and the patient takes the precedence, even within the shortest time available. Because this conversation and relationship is not only supportive but curative based. In a special way, a doctor belongs to the world of the sick and sickness.[251] He is the helper to the needy who are sick.[252] And the sick without fear, responds to their professional questioning, confides in them and openly tell them everything concerning the functioning and misfunctioning of their bodies.[253]

In Luo traditional medicine, *Ajuoga*[254] (doctor) is often referred to as second to God – *"Daktari en Nyasaye mar ariyo"* because, they are the only ones who can save and heal just as God does. Founded on this confidence, the patients *Jotuo* (plural, singular *Jatuo*.), trust doctors (*Ajuoke*) and often describe their situations in depth and in a manner and with utmost truth, to which they can never share with anyone else without being shy. This relationship is based on the communication and trust developed between both of them as result of good listening from each other.[255]

2.3.2.1 When to say the Truth/Lie in Medicine

In medicine telling the truth is both a virtue and a tool for diagnosis for doctors. For doctors, "they ask and the patient answers as desired"[256]. In Luo traditional medicine, truth not only plies the role as a tool for diagnosis but it is also as symbol of purity and responsibility. It is used in appeasing the spirits of the 'Ancestors for healing' or in finding the right diagnosis for an illness. Therefore, conveying the truth is necessary as long as it promotes and prolongs the life of the patient. Although, "the telling of the truth itself, too,

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[251] Cf. PIPER, Kranksein-Erleben und lernen, 37.
[252] Cf. PÖLTNER, Grundkurs Medizin-Ethik, 89.
[253]Cf. WEISS, Gesundheitswessen auf dem Krankenbett, 83.
[254] "*Ajuoga mikori gin ngero achiel, to tichgi ema opogore. Achiel tiyo gi gagi, to machielo tiyo gi mbofwa githietho joma odhi irgi. Ka ngato kare chandore, kata otuo gi midekre, kata chiege nyodo otamo, kata dobedo chandruok manade, odhi ir ajuaga mondo onyise gino makelo chandruok eka onyalo nyise ndake bende. Ajoga mikori nyalo koro ni ng'ato gimoro mabiro timore, kendo kaka onyalo pusore e korno kobedo kor marach. Kamoro onyalo koro ning'ato kor mar hawi […] nitie bende ajuoge miluongo ni nyamrerwa. Gin ajuoge mabeyo mobedo jakony mier gi mon gi jo machandore […] ok ginyal nego ng'ato."* (The word Doctor has two meanings one uses castings of stones in treatment of those who come to them for help as others prophesy on good and bad and how to go about the prophesy as well there are others known as midwife (*Nyamrerwa)*. All of them are of great help to the community and do not harm or kill people). Paul Mboya AKOKO, *Luo Kitgi gi Timbegi,* Kendu-bay [6]1997, 199.
[255] Cf. PÖLTNER, Grundkurs Medizin-Ethik, 105–106.
[256] *"Sie fragen und der Patient antwortet – wie gewünscht"* HORNTRICH, Kommunikation und Wahrhaftigkeit, 49 [Own Translation].

can be very difficult, particularly when one is literary standing beside a bed with a patient facing an unfavorable or uncertain prognosis. In such a situation, one may not know what one ought to communicate as to how much one should say or even how to say it, and the exact people, who ought to be kept in mind."[257]

Disclosure and silence are practiced by the physicians based on their experience and competence in handling the expectations of the patients.[258] Therefore, truthfulness and empathy are pre-requisite to both healing and non-healing illnesses.[259] But, the practice empathy may necessitate lying as due prudence is observed when the situation seems to be severe and when relaying such truth can be catastrophic i.e. leading to immediate death.

In Luo traditional medicine, lying is often employed when the illness is also psychologically based.[260] Or when the disease is so advance and can lead to sudden death. For example, in a particular case, a dialysis patient further complained of severe pain in the chest and fever during a dialysis appointment, several medical tests were conducted, after which the physicians wished to inform the patient about his new diagnosis with a lung cancer. But his son who was attending him prohibited them from doing so, since it might be too stressing to his father considering their situation at home. They had their mother (patient's wife) who had an advanced case of Parkinson's disease, and the patient in question had also a sick toddler. All that in total would be very weary and worrying to the patient and ought not to be added to, by the new cancer diagnosis when equally dealing with kidney failure and poor health. In this scenario, the son is empathically shielding the patient from truth. But medicinally, it is necessary to take into account and speak the truth when required, especially when a patient no longer wants to be lied to and truth can no longer be held on too. It is important to bring in the required care and prudence within the proportionate balance.[261]

Truth plays important role in Doctor-Patient relationship, "because the value of truth itself aims at reliability in human relationships"[262]. In truth, trustworthy relationships are built, where acceptance of truth eases the difficulty of facing finitude openly and in

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[257] *"Wahrheiten zu übermitteln, kann ausgesprochen schwierig sein, besonders wenn man am Bett eines Kranken mit ungünstiger oder unsicherer prognose steht. Was und wie viel soll oder darf man sagen? Wie soll man es sagen? Wer soll in die Information einbezogen werden."* BELEITES, Wahrheit am Krankenbett, 9 [Own Translation].
[258] Cf. ibid., 16-17.
[259] Cf. ibid., 13.
[260] Cf. HORNTRICH, Kommunikation und Wahrhaftigkeit, 49.
[261] Cf. ibid., 50.
[262] *"denn der Wert der Wahrheit zielt selbst auf die Verlässlichkeit zwischen menschlicher Beziehungen"* ibid., 49.

acknowledging the limits of curative medical interventions and accepting the reality of life as is that suffering and death are part of life.[263]

2.3.2.2. Paternalistic and Interactive relationship

Doctors' ought to be close and at the same time, observe reasonable distance in handling their sick. The doctor should speak with the sick about that which is anomaly, and the grounds for medications with clarity. It demands trust, because, when the expected change and aversion of the crisis do not materialize then mistrust between them develops.[264] Such a relationship demands that the expected ethos is to be analogically of paternalistic (*father-child*) relation, developed through contact over time. It should also be more interactive in nature, involving both the patient and the doctor, to understand each other and fight the disease together.[265] It ought to be from a communication relationship, that is open , productive and *gleichberechtigt*[266] and informed by the Hippocratic model, which is built on trust and humaneness and informed by the first principles of *benefacere* – that is doing any good possible to heal and that of *nihil nocere* – involving doing everything possible not to hurt anyone.[267]

2.3.2.3. Confidentiality

Confidentiality is pivotal in the management of an illness, since it concerns an individual person: "It's about flesh and blood, it's about sick people, it's about individuals with names, addresses, personal identification numbers, personal characteristics, and it's about their own personal health impairments."[268] Therefore, the created space between the doctor and the patient is a helping room protecting the patient against danger of self-revelation in seeking help. The doctor ought to communicate with the patient in a dignified manner. As a person capable of clearly understanding and determining own future, without prejudice, explain and inform the *Jatuo*-patient on the underlying medical-truths, beginning with the diagnosis, the therapies, preventions, risks, procedures, rehabilitations, medications and expectations. While taking into consideration the condition of the patient and the

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[263] Cf. ASTRAW, Thoughts on Euthanasia and physician-Assisted Suicide, 45.
[264] Cf. PIPER, Kranksein-Erleben und lernen, 39–41.
[265] Cf. ibid., 42.
[266] Cf. HORNTRICH, Kommunikation und Wahrhaftigkeit, 61.
[267] Cf. PÖLTNER, Grundkurs Medizin-Ethik, 89–92.
[268] *"in Fleisch und Blut, es geht um kranken Menschen, es geht um ein Individuum mit Namen, Adresse, personal Nummer, persönlichen Eigenschaften und es geht um seine eigene, persönliche, gesundheitliche Beeinträchtigung."* WEISS, Gesundheitswessen auf dem Krankenbett, 86 [Own Translation].

understanding of the disease.[269] Thus, assist the patient to understand both the nature of the disease, symptoms and the required management of the aligned condition, and the available management options, which should materialize in the making of relevant decisions pertaining, to economic status and fitting to self-life situation and condition, requiring their cooperation.[270] This ought to help the patient in managing own fears, hopelessness, false pride, mistrust, and falling into crises.[271]

In Luo traditional medicine, understanding of the medical information and confidentiality is quite different from the western medical understanding. While in the western medicine, the medical confidentiality, demands and ethically stresses on the limitation of the medical sensitive information between the medical practitioner and the patient,[272] except in moments of danger and the spread of an infection or in circumstances when dying has already began.[273] The flow of medical information and confidentiality in Luo traditional medicine, concerns the Guardian (*Jarit Jatuo)* as is the patient. It follows the following order; the doctor informs the Guardian depending on the severity of the condition and the ripple effect of the information, the guardian either informs the head of the family or the patient. While following the advice on dissemination of information in the cultural manner, the guardian may further inform other relatives selectively, to control the confidential information as regarding: who, what, when and how to inform the rest based on the kin-ship ties. This is done in order not to prevent the vulnerability due to information leakage as well as balancing the information to mitigate the negative influence of too little information which may affect the required social insurance and support from the remaining majority. This assists them in managing the sick traditionally, since, when the family understands the situation, everyone is called on to be in solidarity.

2.3.2.4. Autonomy and Decision Making

One is autonomous, when one is capable of acting on the basis of chosen deliberations, respected as deliberations of a person.[274] The question pertaining to Autonomy is considered in relation to illness, especially on "the extent to which a person's illness limits

[269]Cf. PÖLTNER, Grundkurs Medizin-Ethik, 106.
[270] Cf. ibid.
[271] Cf. PIPER, Kranksein-Erleben und lernen, 42.
[272] Cf. PÖLTNER, Grundkurs Medizin-Ethik, 110.
[273] *"bei der Pflicht zu präventiver Aufklärung Dritter über die Erkrankung eines Patienten z.B: bei bestehender Ansteckungs gefahr"* Cf. ibid., 102; 112.
[274] Cf. MARCUM, An Introductory Philosophy of Medicine, 234.

their autonomy and what impact this has on their self-determination"[275]. Since, it is determined by what a person consciously controls in own thought. Autonomy, plays a significant role in diagnosis, and the reception of required assistance.[276] It gives liberty to actions.[277]A patient's autonomy *(voluntas aegroti suprema lex)* is primarily directed in protecting the doctor in case of mishandling of the patient as stipulated in work ethics. Autonomy ascertains that a patient has willingly and knowingly agreed for the actions pertaining to the good his/her heath is to be undertaken as wished and only the wished.[278] It also protects the professional relation between the doctor and the patient and the support team.[279] In Luo traditional medicine, Autonomy lies in fluidity in the sense that no one is considered autonomous in his own perspective, since the individual thought and decisions must always echo the collective thought of the community and where any doubt exists then a consultation of the communal thought is sought.

2.4. Palliative Care, Acceptance and Coping

Palliative care conversation should have a positive influence by making a break through into the soul through friendliness and patience. It should aim to stir within the patient, the urge to re-identify, re-establish and put-up the best self forward, being physically and socially present, recognizing and showing interest in life and being able to stand on own feet.[280] It should encourage them to recognize that they are not alone on their own but are having an understanding supportive team, a feeling of love and genuine support like that of a mother to child. In the Luo traditional medicine, Agnes Odinga argues that; "issues of trust and continuity"[281] on matters of preference and benefit favoured the traditional *Nyamrerwas* (CHWs), since it was fostered by the kin-ship and neighbourliness, that created openness to assistance and availability in times of need.[282]

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[275] *"inwieweit mit der krankheit der selbstmächtigkeit eines menschen eingeschränkt ist und welche Auswirkungen dies auf seine Selbstbestimmung hat"* HORNTRICH, Kommunikation und Wahrhaftigkeit, 58 [Own Translation].
[276] *"Selber denken lernen' heißt in Wirklichkeit zu lernen, wie man über das Wie und Was des eigenen Denkens eine gewisse Kontrolle ausübt. Es heißt, selbstbewusst und aufmerksam genug zu sein, um sich zu entscheiden, worauf man achtet, und sich zu entscheiden, wie man aus Erfahrungen sinn Konstruiert".* Cf. David Foster WALLACE, Das hier ist Wasser/This is Water, Köln 2012, 18, quoted in: Stephan GOERTZ–Magnus STRIET, (eds.) Nach dem Gesetz Gottes. Autonomie als Christliches Prinzip, Vol. 2 Freiburg i. B et. al. 2014, 152.
[277] Cf. MARCUM, An Introductory Philosophy of Medicine, 235.
[278] Cf. PÖLTNER, Grundkurs Medizin-Ethik, 93–95.
[279] Cf. BELEITES, Wahrheit am Krankenbett, 11.
[280] Cf. GESTRICH, Gespräche mit Schwerkranken, 47–48.
[281] ODINGA, Women's Medicine and fertility, 101.
[282] Cf. ibid.

Chapter III. *Tuo-yo kod Rito Jatuo* – Traditional Palliative Care

Promotion of life is "the supreme moral ideal and the highest interest"[283] to an African thought as noted by Buyondo. In their actions they either relationally increase or decrease life.[284] In Luo traditional medicine and care of *Tuo-yo kod Rito Jatuo,* promotion of life is very central, seeking to salvage life from the attempted assault, breakage and dissolution of personhood, through employing concrete humane compassion in the process of defending the dignity of the human person.[285] Their "outlook encompasses not only the ill body but the whole person."[286] And by extension "the relational healing of the community […] involves[ing] the whole creation and the three-dimensional community"[287] bound vertically and horizontally through kinship.[288]

The concept *Tuo-yo kod Rito Jatuo* is guided by code of ethics,[289] entailing the promotion of the holistic care of a person and the entire surrounding environment imbued with *Ngima* – the life-giving force.[290] Generally, the whole community is considered to be sick, when a member is sick. This is reverse expression of the famous words of Malcom X, "When 'I' is replaced by 'We', even illness becomes wellness"[291], collectively expressed in the African understanding as 'I am, because we are; and since we are, therefore, I am.'[292] Paraphrased in Luo as *wa-tuo-yo Jatuo* –we are sick with the sick or we are taking care of the sick. Health is considered as a value of values *–Ngima e maduong*.[293] This chapter focuses on the physical, psychological, emotional, spiritual care of the ill-body and possible end of life care within a triad unity involving the spiritual world, the living world and the non-living sharing with each other.[294]

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[283] BUYONDO, The critique of Bioethical Principlism, 107.
[284] Cf. ibid., 107–110.
[285] Cf. NYIKA, Ethical and regulatory Issues surrounding African Medicine, 26.
[286] BUYONDO, Holistic Bioethics, 98.
[287] ibid.
[288] Cf. MBITI, African Religions and Philosophy, 136.
[289] Cf. ABUYA, Women's Voices on the Practice of *Ter* among the Luo of Kenya.
[290] Cf. BUYONDO, Holistic Bioethics, 102–105.
[291] MALCOM X, "when 'I' is replaced by 'We', even illness becomes wellness", in: Rise &inspire, how can replacing "I" with "We" Turn illness into Wellness? blog, 21 February 2025. URL: https:// riseandinspire.co.in/2025/02/21/how-can-replacing-i-with-we-turn-illness-into-wellness/ [accessed: 30 august 2025].
[292] Cf. MBITI, African Religions and Philosophy, 142.
[293] Cf. BUYONDO, Holistic Bioethics, 102.
[294] Cf. ibid., 63.

3.1. Morality in Luo Culture

In his book, *Luo Kitgi gi Timbegi*, Paul Mboya grounds the Luo moral thought envisioning morality, as a shield for a person's individual action within the community of persons leading to harmony. *"Chik kod timbe mabeyo mondo obedi ka kuot ma ng'ato sirorego, korito piny gweng', kata dala. Piny maonge chik, kata piny maji ok dewie chik en piny mokethore maonge huma maber e nyim pinje."*[295] Morality characterizes human beings, in the way a person behaves and acts, is principally grounded on some codes bearing moral values and principles,[296] inculcated from culture, tradition, religion, historical education as well as the situational experience scrutinized by the ethics.[297] Ethics is understood as a theory of the moral where the moral underscores the rightness or wrongness of an action as per the duty, virtue, rules/laws on which judgement is determined.[298]

Every group of people hold a unique code of theory composed of moral values and principles guiding their moral value system and which influences and justifies moral actions of their members.[299] The moral insights and understanding are locally determinable but the moral experience remain universal.[300]Moral concepts are those dominant reflections of actions that have socially been integrated as morally binding and passed from generation to generation, orientating and regulating the individual actions of their members as a community.[301] They expressively reveal the moral cognitive power of reasoning, intuitions and emotions, objectiveness and truthfulness of moral judgements and the reality of moral facts forming background of any action and practice.[302] Ethical theories express the unique way of life of a people, attempt to formulate ways in which foundational principles of morality and virtues are protected. It can either be deontological – from rationality and religion and concentrated in consciousness, aiming at doing the right thing and avoiding the wrong one as a duty for well-being of others,[303]or virtues based or even consequential based.

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[295] AKOKO, *Luo Kitgi gi Timbegi*, i.
[296] Cf. MARCUM, An Introductory Philosophy of Medicine, 207.
[297] Cf. UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO), Bioethics Core Curriculum. Section 1, 9.
[298] Cf. Bettina SCHÖNE-SEIFERT, Grundlagen der Medizinethik, Stuttgart 2007, 9.
[299] Cf. MARCUM, An Introductory Philosophy of Medicine, 207.
[300] Cf. UNESCO, Bioethics Core Curriculum. Section 1, 9.
[301] Cf. PÖLTNER, Grundkurs Medizin-Ethik, 17.
[302] Cf. SCHÖNE-SEIFERT, Grundlagen der Medizinethik, 24.
[303] Cf. MARCUM, An Introductory Philosophy of Medicine, 211–212.

3.2. Sources of Luo Moral Codes

The Luo traditional moral concepts not only exhibit the absolute ethical theories which are divinely determined and deontological in nature, to which one is providentially called to participate in perceiving the unchanging truth. But they also exhibit the relative ethical theories that are experientially human, culturally and socially tested.[304]

Luo moral reasoning follow a consequential theory of ethics.[305] Consequentialism holds that "certain normative properties depend only on the consequence"[306] and only the results of ones actions are *per se* intrinsically important in the justification of the moral worth aiming for maximum benefit of many people.[307] As a result, "whether an act is morally right depends only on the consequences of that act itself as opposed to the consequences of the agent's motive of rule or practice that covers other acts of the same kind."[308] Moral actions of Luos exhibit the application of the principle of utility. In determination of foundation of moral decision, the overall utility apply to "the (1) human nature [...], (2) social ethos, and (3) personal ethos of individual lifestyle choices"[309] as a criterion for qualifying an act to be morally right to be done.[310]

3.3. Luo Traditional Moral Principles and Ethical Theories

The Luo traditional moral principles are both absolute and relative ethical theories. The following are the over-all moral principles /theories: 1.) *Itimo Maber Itimo ne In, Itimo Marach Itimo ne In.* It transliterates that, 'Every good Act done, is done unto-Self and Every bad Act done, is done unto-Self.' This principle has its basis in the conscience of the acting subject, through own judgement to voluntarily act, such that if an act is good for the subject, then is equally good to the object. It centralizes on the Self-measure for all actions. 2.) *Piny*[311] *Luorore*- (Earth rotates), It implies world affairs are in turns; It is based on the African concept of time and space, in which the matters concerning actions and affairs are in turns just as the Earth rotates, today is your turn, tomorrow it will be my turn. 3.) *Nyasaye Neni*- (God sees you), the omnipresent God sees all acts and judges them

[304] Cf. ibid., 219–220.
[305] Cf. SCHÖNE-SEIFERT, Grundlagen der Medizinethik, 30.
[306] Walter SINNOT-ARMSTRONG, Consequentialism, in: Edward N. ZALTA & Uri NODELMAN (eds.), The Stanford Encyclopedia of Philosophy, Winter 2023. URL: https://plato.stanford.edu/archives/win2023/ entries/ consequentialism/ [accessed: 16 September 2025].
[307] Cf. MARCUM, An Introductory Philosophy of Medicine, 220.
[308] SINNOT-ARMSTRONG, Consequentialism.
[309] *" (1) die menschliche Natur […], (2) das gesellschaftliche ethos und (3) das personliche Ethos der individualen Lebensgestaltung"* PÖLTNER, Grundkurs Medizin-Ethik, 57.
[310] Cf. ibid.
[311] *"Piny"* to mean the Earth /World.

accordingly, and renderers justice accordingly, he rewards good acts, punishes the evil acts and also avenges.

3.3.1. *Itimo Maber Itimo ne-In, Itimo Marach Itimo ne-In* – the 'Good' is Done Unto-Self, the 'Bad' is Done Unto- Self

This is a rationally based principle in the Luo traditional ethics. It centralizes the moral decisions on the acting subject. It is principally grounded on the dignity of the human person lying in the performance of the duty of obligation binding us to act for the good of others. [312] That is, when the supposed action is morally right to be done to acting subject, then it is equally morally right and applicable to be done to anyone else and so when it is morally wrong and can't be applied on the acting person, then it should not be applied to the rest. When this principle is oppositely formulated, it states that; *kik itim ne wadu gima ka otimni to rach ni.* (Do not do unto another, that which when done to you as the acting subject is accounted as morally wrong. Thus, it fits within the universal principle, *"das als gut erkannte is zu tun, und das als böse erkannte ist zu meiden*"[313] or do what is recognized as good, and avoid what is recognized as evil. This principle that is based in the human conscience helps in protecting the subject from using a person as an instrument (an object) and postulates the self as the basis for any practical action as a duty towards another.[314]

3.3.2. *Piny Luorore* – (Earth Rotates) World Affairs Goes in Turns

This principle originates from the cosmological perception of the cultural and the religious in relation to the before and after in which everything exists to achieve an end purpose.[315] The term *Piny luorore* is an attestation to the cosmological observations based on the notion of time in space as experienced individually and collectively within in an indefinite rhythm and pattern of nature (in terms of day and night) and not within the linear conception of time within the western thought as to be within past, present and future.[316] So, the chances of an activity repeating itself within the timeline of life of an individual is highly probable, as events goes in turns. This principle regulates human actions through defining the morally right according to the modes of responsibility.[317]

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[312] Cf. MARCUM, An Introductory Philosophy of Medicine, 212.
[313] PÖLTNER, Grundkurs Medizin-Ethik, 54.
[314] Cf. Ibid.
[315] Cf. MBITI, African Religious and Philosophy, 19–21.
[316] Cf. ibid., 22–23.
[317] Cf. MARCUM, An Introductory Philosophy of Medicine, 214–215.

Within this structure, the obligation to support the vulnerable is indispensable, since, vulnerability such as illness is a reminder of the common need of each other's support. Underneath it, lies the implication of the social need of support, that can overcome the precarious situations of life that eventually falls back to support the actors in-turn, and if the needy cannot support, then the same shall be done by others members of the community, since good act done does not go unrewarded.[318]

3.3.3. *Nyasaye Neni* – God Sees

This principle is religiously based on the eternal and intrinsic attributes of God. Most people and communities consider God to be omniscient, that he knows all things, omnipresent that is he is everywhere, and omnipotent that is almighty. Therefore, basing on all these attributes, Luos believed that dignity of the human person flows from grasping this reality about God.[319] This principle of *Nyasaye Neni*, flows from the inalienable dignity of man from God. Man ought to offer response other than any creature through recognizing in everyone the essence and existence of God.[320] This "relationship with God can be ignored or even forgotten or dismissed, but it can never be eliminated"[321], since, it claims for the justice of God. God as the creator of the universe and life, is the one capable of ordering all forces of *Ngima* (life) to their good. Just like *Nuers,* Luos also believed that "'God evens things out' rewarding good to those who follow good conduct, and evil to those who follow evil conduct, and overlooking breaches done accidentally or in error."[322] Thus, a moral subject ought to ethically judge the acts and their consequential results, whether it is morally right to be undertaken before God, who sees every action and judges, and be ready to bear the underlying consequences of their actions on the basis of reward or punishment.[323]Since, everyone has been entrusted with the life of the other, all people ought to consciously act in a manner that promotes life in its entirety because everything was created good.[324]

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[318] Cf. ASTRAW, Thought on Euthanasia and Physician-Assisted Suicide, 47.
[319] Cf. MBITI, African Religious and Philosophy, 39.
[320] Cf. PONTIFICAL COUNCIL FOR JUSTICE AND PEACE, (PCJP) Compendium of the Social Doctrine of the Church, Vatican 2004 [Reprint Nairobi 2007–2008], no.105–109.
[321] Ibid., no. 109.
[322] MBITI, African Religious and Philosophy, 48.
[323] Cf. SINNOT-ARMSTRONG, Consequentialism.
[324] Cf. PONTIFICAL COUNCIL FOR JUSTICE AND PEACE (PCJP), Compendium of the Social Doctrine of the Church, no. 112–114.

3.4 Other Principles

Other principles which are not clearly expressed in Luo ethical understanding are those of solidarity, subsidiarity, responsibility and participation but they are expressed in a mixed manner without clearcut boundaries within the following theories/concepts of: *Nyuol Ber, Achiel e teko* and *Nyodo nokonyo Omboga.*

3.4.1. *Nyuol Ber* – (Pro-creation is Good) and the Concept of Participation

Human procreation is a good. it ensures continuity of lineages and the community. The promotion of life culturally centered on it. Human procreation was termed the gate of life through which God brought more members into the community. And anyone who could not pro-create was considered cursed by the Ancestors and gods, and was still assisted to have a generation. The concept of *Nyuol-Ber* brings the idea of participation into practice. Through pro-creation the family, clans and entire community is ordered into age-set groups according to order of seniority, 'on the first to be born basis'. Thus setting the stage for the age-set (*Mbas/Rika*) morality, which outlined the structure of socialization within the kinship ties, especially on levels of participation, solidarity and subsidiarity and responsibility as a group which defined brotherhood beyond that limitation defined by blood, "a cooperation deviating from normal division of labour"[325] as witnessed in the agricultural production limited by blood *as Jokamiyo* (belonging/begotten by to same woman)*, Jokawuoro* (belonging / begotten by the same man)*, keyo* (cousins) *and limbamba* (neighbours belonging to different clan).[326]

3.4.2. *Achiel e Teko* (Streng lies in Unity) the Luo Solidarity Concept

It is within *Nyuol-ber* Principle, that solidarity was understood in a strict sense as a commonly shared value in all round spheres of life and not limited to the vulnerability, but was a way of living the social and communal life and its activities. After the concept of *Nyuol-Ber,* the idea of unity was stressed- *Achiel e teko*. It brought all age-sets together in matters of life, of vulnerability and socializations, and celebrations. It is the soul of life of the community. This concept identified and brought together the members of the family (*dhoot*) as well as the entire clan (*anyuola*), and the community stipulating the order participation and subsidiarity as units within a single collective unit. "*Koro gi chano ji e*

[325] OCHOLA-AYAYO, Traditional Ideology and Ethics among the Southern Luo, 18.
[326] Cf. ibid.

anyuola ka anyuola; dhoot ka dhoot wuotho mana kachiel; jo ka wuoro[327] *wuotho mana kokiewo, mondo kawasigu dwaro nego ng'ato to owadgi, kata osiepne, nyalo wirone.*[328] (The community was organized into clans, as per family and as unity from same paternity in unity side by side so as to protect and defend each other).

Solidarity has been defined "as a moral value oriented towards a collective care of the vulnerable members of the community to allow them experience a mutual sense of belonging."[329] It is a way of cooperation in an obligated accountability enshrined in our nature as human beings individually or socially and to which we are encouraged to respect and promote in special regard to the vulnerable.[330] and in doing so in unified cooperation in fulfilment of duties, the principle of subsidiarity guards against possible exploitation from the any other level.[331] "Solidarity in general is the realization and constant awareness that we are one human family."[332]

African basic solidarity is such that the society is pieced together in the sense that individuals welfare of his family, that of the extended family, the sub-clan and clan and the whole ethnic community are knitted together that peace in a part is only possible when the whole is peaceful, and so is the thinking pattern of an individual member, such that he first thinks of the collective society before thought of an individual responsibility.[333] Buyondo proposes that interactive solidarity is a fitting African approach, because humanitarian solidarity is inadequate in defining solidarity. Since solidarity within an African context is integrally incorporating all life within the whole tripartite community living, living dead and the unborn as well as the non-living as localized within shared values.[334] This approach underscores unity in certain circumstances, share needs and problems of others and tends to identify and defend the human dignity of each individual within the community.[335]

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[327] *Joka Wuoro,* – Same Paternity due to common practice of polygyny within the community, where a man was in *Doho*- had many wives, sometimes three wives namely; *Mikayi* – 1st wife, *Nyachira* – 2nd wife and *Reru* – 3rd wife and other after third wife. Cf. *Akoko,* Luo Kitgi gi Timbegi, 70–71

[328] Ibid., 21–22.

[329] BUYONDO, Holistic Bioethics, 8. See Also: UNESCO, Bioethics core curriculum Section 1, 45.

[330] Cf. UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO), declarations on bioethics 2005, art 24§ 3 UDBHR.

[331] Cf. PONTIFICAL COUNCIL FOR JUSTICE AND PEACE (PCJP), Compendium of the Social Doctrine of the Church, no. 187.

[332] Tarcisio AGOSTONI, Every Citizen's Handbook. Building a peaceful society, Nairobi [3] 2005, 63.

[333] Cf. ibid., 63.

[334] Cf. BUYONDO, Holistic Bioethics, 8; 63.

[335] Cf. AGOSTONI, Every Citizen's Handbook, 237.

3.4.3. *Nyodo nokonyo Omboga*- Principle of Responsibility

The concept of *Nyuol-Ber* and the idea of *Achiel e Teko* is closely connected to the principle theory of responsibility of *'Nyodo nokonyo Omboga' –the offspring has the responsibility towards the parents)*. According to this theory, each community member, clan member and family member is called upon to participate in accordance to the kinship ties and capability to vulnerable individual member. And whomever does not partake of the said responsibility is liable for the curses and Chien from the said relation within the lineage when the person passes on. Therefore, it is common that every individual member of the community has an alienable responsibility towards the promotion of the common good of the family relations in the name of the forefathers and of all in the honour of our Ancestors.[336].

3.5. Organization of *Tuo-yo kod Rito Jatuo*

In the African understanding, the "elaborate kinship system acts like an insurance policy covering both the physical and metaphysical dimensions of human life."[337] The organization of kinship;

> is reckoned through blood and betrothal (engagement and marriage). It is Kinship which controls social relationships between people in a given community: …, it determines the behaviour of one individual towards another. Indeed, this sense of kinship binds together the entire life of the "tribe" … Almost all concepts connected with human relationships can be understood and interpreted through the kinship system. This it is which largely governs the behaviour, thinking and the whole life of the individual in the society of which he is a member…The kinship system is like a vast network stretching laterally(horizontally)in every direction, to embrace everybody in any given local group. This means that each individual is a brother or a sister, father or mother, grandmother or grandfather, or cousin, or brother-in -law, uncle or aunt, or something else, to everybody else. That means that everybody is related to everybody else, and there are many kinships terms to express the precise kind of relationship pertaining between two individuals.[338]

The organization of *Tuo-yo kod Rito Jatuo* takes place under kinship within the family set-up, which is often a wider circle of members than the western understanding of a family, and within a "household"[339] (*dhoot)* in the *Dala* (homestead), where people live together both as nuclear as well as extended family.[340] This is what in the western thought of Michael Brown as refers to as 'home based care', a philosophy of care spatialized at home

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[336] Cf. PONTIFICAL COUNCIL FOR JUSTICE AND PEACE (PCJP), Compendium of the Social Doctrine of the Church, no. 166–167.
[337] MBITI, African Religions and Philosophy, 189.
[338] Ibid., 135–136.
[339] "The household is the smallest unit of the family, consisting of the children, parents and sometimes the grandparents." ibid., 140.
[340] Cf. ibid., 139.

applied within the structural organization of the Luo traditions and culture guided by the underlying understanding of kinship, that stipulates how life is lived together under the concepts of *Dak and Luor.*[341]

In the concept of *Dak, (*the family group) implies that the members of a family – *dhoot* assist each other through all life processes and where they cannot, the required support is received from the extended family and then the clan (*Anyuola*). This concept of *Dak* stipulates apart from Age-set group, that solidarity exists hierarchically from the clan level, under the family tree and relations following kinship ties. The concept of *Luor* (honour or respect), is meant to bring order, it sees to it that everyone is given honour and respect worthy of status, so is to roles, duties and obligations.[342] These two Concepts of *Dak* and *Luor* outlines the *Chike* (moral codes) and *Timbe* (actions) as *Kweche* (taboos) in line with the *Tije* (roles and duties or obligations) and *Dwaro* (demands or responsibilities) within the hierarchy of positions and families. They define the boundaries of actions and care. They are put in place to keep, protect and defend the *kanyakla mar Jo-modak* (the family bond as group and team) in all circumstances of life and also aid in the alleviation of the isolation and weakness that sickness of a member sets in motion.[343] when a particular duty cannot be performed by the immediate obligated family member within the nuclear family, then said responsibility can be performed by a member within the same status of *Luor* in the extended family (within *Dala* or outside *Dala)* and a long to *Anyuola* (clan) and *gweng'* (village).

Concepts of *Dak and Luor,* stipulate the patterns of avoidance and distance to be observed.[344] For instance, as a boy or a man, it is a taboo to see your mother's nakedness, it implies that, a man or boy cannot wash/ nurse his own mother. *Odinga Agnes* affirms this through what she refers as "medicalization of sexuality and reproduction"[345] which was resisted and brought about, the ridicule of the men involved.

3.5.1. Supportive Care

In Luo traditional medicine, accompanying the *Jatuo*-the sick, lies at the core of the family life. It defines the *achiel mar jo-dhoot* (Unity of the family as people). Depending on the level of *Luor* (respect), from within the household of the sick, there is always the presence

[341] Cf. BROWN, Living with HIV/AIDS, 142.
[342] Cf. ibid., 172.
[343] Cf. PIPER, Kranken sein-Erleben und lernen, 11.
[344] Cf. BROWN, Living with HIV/AIDS, 174.
[345] It implied the "male examination of female sexual organs at the local dispensaries" something that was a taboo. ODINGA, Women's Medicine and fertility, 72.

of someone (*Jarit Jatuo*) who is ever present and available to nurse the sick. Always present by the bedside of the sick: to protect, to feed, wash them/ clean and change soiled clothes and beddings, assist with timely medications and to accompany them to further medical care. When one was sick "a trip to hospital was almost never an activity undertaken by a[sick] person alone because it necessitated family members to assist with transport to and from hospital and also raise money to pay for the medicine and treatment".[346]

This *Jarit Jatuo* (guardian) was a trusted confidant to whom the patients were open and free and could confide in-case of dying wishes. *Jarit Jatuo* in the stature of a nurse is assigned based on the concept of *Luor*. And was the patient's most preferred to assist him or her (male or female) at home as well in the hospital alongside the nurses. The presence of *Jarit Jatuo,* reminded the patient that they were not alone so to assist them psychologically that they continue to fight for their life.[347] Because, "the severely ill needed this purely human support for their healing process"[348]. *Dak*-household concept plays a very important role in handling of sickness in an organized and structured manner. The family ensures that the *Jatuo* is assisted in dealing with *die entleere Zeit* (the empty hours) defined by sickness. *Dak* concept is designed to handle the possibility of regress and disappointments from friends and other non-cooperating family members through comforting and encouraging the sick. Through it, the family cushions their sick and their suffering. In making sickness memorable through distracting the mind of the sick to qualitatively focus on the best of the available time, through the participation of each family member, who represents a unique and different storyline and memory to share. It is a way of supporting the sick in lightening the weight of sickness borne out of love to bring a healing effect, where sickness no longer becomes a burden but a way of being and accompanying each other.[349]

> Accompanying does not mean identifying oneself, becoming one with someone else's suffering, but walking alongside the sick person and never giving up at a certain distance...'This concept has [...] some advantages [...]: It leaves room for movement and change; it expresses reciprocity; it does demand devotion, but that within defined limits [...] It is about being there, accompanying another for a while and for a distance. When you think of companionship, the image of traveling comes to mind. Companionship often comes about through a chance meeting, and companionship ends when the common goal that created the connection is no longer relevant. A good companion is someone who participates of their

[346] BROWN, Living with HIV/AIDS, 76.
[347] Cf. PIPER, Kranken sein-Erleben und lernen, 42–43.
[348] *"Wer Schwerer erkrankt, braucht auch diese rein mitmenschliche Begleitung für den Heilungsprozess"* GESTRICH, Gespräche mit Schwerkranken, 31.
[349] Cf. ibid., 30–31.

> own free will, who does not impose themselves and can allow the other person to make their own journey [...] Companions are together for a while, but they also have their own lives to lead. Separation is an essential part of companionship. So, in the professional care that the nurse offers, you can see a realization of love, if the professional distance is missing or is there to an excessive degree, then this love can be lost. But in the carefully balanced relationship, as I have described it as companionship, lies a gift to the other.[350]

3.5.2. Emotional Care

Severe illness is not a complete narrative in itself from the external perception of the situation but also an incomplete narrative centrally involving and revolving around life in its deep connection with both the finitude and infinite dimensions, characteristically expressed in multiplicity of styles and forms. This narrative of severe illness delves not only within the medical facts and illness details but also remains entrenched into the larger life narratives with others entrenched in: the rituals performed, the crisis experienced, the feelings and emotions exchanged within the sickness period. These narratives are often crafted into appropriate mediums of communications, i.e. poetry, and stories that are never burdensome but spirit elevating, through which eliciting expression of feelings and emotions such as love, pain, loneliness, fear, anger etc. Severe illness narratives are often treated as an alternative medium of treatment, for they aim at healing the broken spirit.[351] Professor Johanna Shapiro underscores the centrality of illness narratives, since they take into account "the value of the Patient's voice in the practice of medicine."[352]

In the Luo traditional medicine, the severely ill were accompanied and keep in-touch with the *laufenden* (on-goings) through coined stories as a way of monitoring them and keeping them engaged. They were encouraged to re-tell their life stories not excluding

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[350] *"Begleiten heißt ja nicht sich identifizieren, eins werden mit fremden Leiden, sondern neben dem Kranken hergehen und dabei einen gewissen Abstand nie aufgeben…'Diese Konzeption hat […] einige Vorzüge aufzuweisen […]: Sie lässt der Bewegung und Veränderung Raum; sie drückt Wechselseitigkeit aus; sie fordert zwar Hingabe, das aber in definierten Grenzen […] Es geht um ein Dabeisein, das einen anderen für eine Weile und Wegstrecke begleitet. Wenn man an Begleitung denkt, kommt einem ja das Bild vom Reisen vor Augen. Zur Begleitung kommt es oft durch ein Zufallstreffen, und Begleitung endet, wenn das gemeinsame Ziel, das die Verbindung schuf, nicht mehr aktuell ist. Ein guter Begleiter ist, wer aus freien Stücken teilnimmt, wer sich nicht aufdrängt und dem anderen zugestehen kann, seine eigene Reise zu machen […] Begleitende sind für eine Weile zusammen, aber sie haben auch ihr je eigenes Leben zu führen. Trennung gehört wesentlich zur Begleitung hinzu. So kann man also in der fachkundigen Pflege, die die Krankenschwester anbietet, eine Verwirklichung von liebe ausmachen, fehlt der professionelle Abstand oder ist er in übergroßem Maße da, dann kann diese Liebe verloren gehen. Aber in der sorgsam ausgewogenen Beziehung, wie ich sie als Begleitung darstellt habe, liegt ein Geschenk an den anderen."* J. MAYER-SCHEU, Vom Behandeln zum Heilen, Göttingen 1982, 82f, quoted in: Reinhold GESTRICH, Gespräche mit Schwerkranken. Krisenbewältigung durch das Pflegepersonal, Stuttgart ³2006, 31 [Own Translation].

[351] Cf. Stella, BOLAKI, Illness Many Narratives. Arts Medicine and Culture, Edinburg 2016, 2f. URL [accessible from University of Vienna]: https://www.cambridgeorg.uaccess.univie.ac.at//core/services/aopcambridgecore/content/view/D76273763CE93781E2E67C5077C3211E/9781474402439int_p125_CBO.pdf/introduction_illness_as_many_narratives.pdf [accessed: 10 February 2025].

[352] Johanna SHAPIRO, Illness Narratives. reliability, authenticity and the empathic witness, in: Medical Humanities 37/2 (2011) 68–72, here: 68. [DOI: 10.1136/jmh.2011.007328].

the illness story as a therapeutic means of making their sickness lighter and in acceptance of their situational predicament. The stories of the severely ill are not just stories but are both a conscious and unconscious representation of their world as patients making sense of their encounter with life in illness. Through re-telling of past events with their embedded participation, especially those jovial moments in which the patient happily participated, to re-enact the event. To enable the patient re-think about events and people and re-experience the mood and emotions at these events that the person, recognizes and appreciates the life lived as well as enable the person re-connect and ask about people to whom long have lost contact, apart from the everyday assumptions and perceptions of everyone about them and their sickness.[353] These narratives create avenues for instructions on matters: medication, culture, religion and social and offered opportunities for strengthening of patient's spirit to persevere through the illness leading them into conversion forgiveness.

Amongst the emotional care are the healing songs and dances, especially, the *Miend Juogi* (dance of the spirits) – through which the dancers dramatized the healing processes in a provoking and an involving manner to assist them get rid of the spirits, particularly, if it was believed that the disease was caused by the anger of the ancestral spirits or curses.[354] The traditional healers used these songs and dances in the diagnosis and prescription of medication and to promote healing through the elevations of the emotional and spiritual wellbeing of the patient and the family.[355] This has presently been taken by the indigenous Luo traditional religious sects and groups where *Roho*[356] sect presents a good example.[357]

3.5.3 Spiritual Care

Spiritual Care is very central[358] and integral to palliative care. It provides it with the holistic medical orientated action (physical, spiritual and social well-being) in caring for

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[353] Cf. ibid.
[354] Cf. Charles Nyakiti ORAWO, Healing dances. A case Study of the Luo *Juogi* and the *Dawida Mwazindika* Dances, International Journal of Business of Social Science 3/2 (2012) 143–162, here: 143. URL: https://ir-library.ku.ac.ke/server/api/core/bitstreams/31251595-0792-4eab-b4e4-e08574b43c65/content [accessed:30 July 2025].
[355] Cf. ibid., 144.
[356] *Roho* means Ghost/Spirit.
[357] Cf. Donwilson ODHIAMBO, Church Members in Nairobi Hold Traditional 'Bringing Out' Ceremony for New Baby, in: Getty Images, (16 February 2025). URL: https://www.gettyimages.at/detail/nachrichtenfoto/members-of-roho-fweny-are-dancing-to-spiritual-songs-nachrichtenfoto/2199380620 [accessed: 22 August 2025].
[358] Ulrich H. KÖRTNER, et.al., (eds.), Spiritualität, Religion und Kultur am Krankenbett, Vienna, 2009, V.

the terminally ill in a whole manner.[359] It advocates for the openness in the essence of personhood fostering hope, love and the mystery of faith,[360] because the human person occupies the very center of existence and everything else lies in that relation.[361] In Luo traditional medicine, spiritual aspect forms its foundation, due to the unity of the "body, soul and spirit"[362] that brings the totality of human person in connection with the supernatural dimension.

Spiritual care connects Luo traditional medicine with the ancestral spirits, who through consultations assist in revealing the diagnosis and the required treatment method aiding in healing. A person being a spiritual medium, is believed to be susceptible to both the visible and the invisible forces like witchcraft, curse or former existence or to an aggrieved ancestral spirit.[363] It is fundamental, to therapeutically incorporate the faith effects of prayer and healing processes in addressing the arising doubts, spiritual questions and concerns.[364] For example, "the first question a patient asked the pastor who visited him right after greeting him was: 'What did I do to deserve this?! I've worked my whole life and tried to help other people (he was a doctor) – and now this!'"[365] Severe illness does not recognize our former profession or status, but the fact of being seriously sick tags along psychic loads, pains and human existential questions, life wishes, life decisions even if the question of God is not directly at the center of discussion.[366]

Health and spirituality are part of human life. They both cause and function to account for the totality of human life's quality and well-being, whether in health or in sickness (physical and spiritual).[367] The need for spiritual care is necessary to assist the physicians in addressing such matters surrounding the spiritual domain of philosophical and theological matters.[368] Spiritual care generally depends on the religions freedom and the up-bringing of each individual in beliefs and spiritual system and on how one integrally

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[359] Cf. Traugott ROSER, Spiritual Care: Ethische, organisationale und spirituelle Aspekte der Krankenhausseelsorge. Ein praktisch -theologischer Zugang, (Münchner Reihe Palliative Care, Vol. 3) Stuttgart 2007, 244.
[360] Cf. Sigrid MÜLLER, Spiritualität am Krankenbett – Motivation, Grundlage, Kriterien und Ziel aus einer christlichen Perspektive, in: Ulrich H.J: KÖRTNER, et.al., (eds.), Spiritualität, Religion und Kultur am Krankenbett (IERM) Vol.3, Vienna 2009, 200– 209, here: 202.
[361] Cf. MBITI, African Religions and Philosophy, 119.
[362] MÜLLER, Spiritualität am Krankenbett, 206.
[363] Cf. NYIKA, Ethical and regulatory Issues surrounding African Medicine, 27.
[364] Cf. ROSER, Spiritual Care, 245.
[365] *"die erste Frage, die ein Patient dem ihn besuchenden Pfarrer gleich nach der Begrüßung stellte, lautete: 'Womit habe ich dies nun verdient?! Mein Lebtag hab' ich gearbeitet und versucht, anderen Menschen zu helfen (er war Arzt) – und nun dies!'"* PIPER, Kranksein-Erleben und lernen, 24 [Own Translation].
[366] Cf. SCHAUPP, Spiritual Dimensionen des Krankseins-der christliche Patient, 165.
[367] Cf. ROSER, Spiritual Care, 245; 276.
[368] Cf. KELLY–MORRISON, Palliative Care for the Seriously Ill.

responds phenomenologically to religious matters. Therefore, spiritual care differs totally from an individual to an individual,[369] since, the patients have the option to either choose and request for it or as well, completely reject it.

The Luo traditional spiritual care is part and parcel of the community life in which the whole communal traditional medical care adheres, unlike conventional medical care, where, there exists some aspects, to which patient can also decide for the self,[370] as most decisions are spiritually determined. It is also through spiritual conversations, that the terminally ill patients are assisted to a better psychological quality of life through: "consultation, collaboration und referral"[371]. Helping them to instill courage and trust step-by-step- to accept the reality of the situation and condition as well as submission to natural death without involving the family in the burdensome non beneficial interventions near the end of life. Spiritual care aims at setting the focus on the accompanying and letting-go and transcending earthly things, as a way of preparation for good-death and the next stage of the life cycle. Thus, assisting in higher life quality scores, as the dying-itself is zero rated as a mere transition of life and not loss of life, hence, death is understood as celebration of life lived and a farewell party to the next stage of existence.[372]

3.6. End of Life Care

Preparations for death is a part of the preparation for the severely ill members, since death stands as the gate between the world of the living and of the world of the spirit as well as the visible and the invisible. Preparation for death comes in the forms of rituals and of ceremonies.[373] Therefore, visits and mending of the relations with the severely sick creates a moment of dialogue and revision and mending of the lost social bonds, as each one takes a moment to re-connect and exit the bond in good terms and with caution each one says their last words.[374] Preparations for death is not only a traditional practices within other cultures, but is also a shift taking shape as majority of the global populations continue to yearn for the home-based care and dying at home instead of hospital or hospice, as "they want neither sedation nor to be rendered unconscious with the help of psychotropic drugs or morphine, which deprives them conscious engagements with relatives and friends. And

[369] Cf. SCHAUPP, Spiritual Dimensionen des Krankseins-der christliche Patient, 168.
[370] Cf. ROSER, Spiritual Care, 246.
[371] Ibid., 253.
[372] Cf. KELLY– MORRISON, Palliative Care for the Seriously Ill.
[373] Cf. MBITI, African Religions and Philosophy, 195.
[374] Cf. ibid.,196.

all want to say goodbye and die with clear conscience"[375]. Clearing of any obstacle in the relationship is based on a "'precautionary principle' […] better safe than sorry"[376]. In the Luo traditional medical care, the importance of mending relationships ensured that the living remained safe from repercussions of the dead in the case of bitter death and in averting the event of possibility of any ghost haunting (*chien)*. It expressed the depth of an African religiosity through "integral hospitable life"[377] making the visit to the dying very important and the last words of the dying a Testament/ will.

3.6.1 Advanced Care '*Oweye gi Nyasache'* – Abandoned to God's Will

Ywa-ruok gi Tuo (Prolonged illness) makes illness appear as normal –a part and parcel of daily life and not as an emergency, which is contemptuous to deep care as letting-it -be begins to creep into the support team, because, there is nothing new that may improve the condition of the patient except the magnanimous intervention of God. it's a sign of resignation as well as a symbol of deep trust and faith in God showing that dying process has already begun, so, they are letting God, to either to heal the patient or take him away from all the toils and sufferings. It is within these circumstances, that a patient is referred to as, *Oweye gi Nyasache* (left for God's will). In the context of union, transition and transcendence, it focuses mostly on the earthly life areas which are especially important to the dying process till culmination in death. It involves the spiritual care and guidance through grief, the rituals and rite surrounding the dying process and death through prayers, blessings and ointments for both the dying and the relatives according to the tradition.[378]

3.6.2. Truth at the Side of a Deathbed

Disclosure and sensitive conversation at the death bed is considered very important especially within the last face of life during *oweye gi Nyasache* stage (abandoned to Gods will stage) within the Luo tradition. It carries with it, the obligation to speak the truth in honesty. Bedside truth is a very comprehensive communication done in steps and in stages within a network to achieve goals and purposes dealing with the illness experience, forgiveness as well as the future prospects and the shaping of interpersonal relationship

[375] „die das bereits zerstörte Leben nicht mehr ertragen, deren unbeschreibliche Schmerzen auch durch die am stärksten sedierenden Mittel der Palliativtherapie nicht verschwinden. Sie möchten nicht mit Hilfe von Psychopharmaka oder Morphium ruhiggestellt oder bewusstlos gemacht und so des Dialogs mit Angehörigen und Freunden beraubt werden. sie möchten bei klarem Bewusstsein Abschied nehmen und sterben." JENS – KÜNG, Menschenwürdig sterben, 42 [Own Translation].
[376] BUYONDO, Holistic Bioethics, 99.
[377] Ibid., 161–162.
[378] Cf. ROSER, Spiritual Care, 147–148.

within the family before one cross-over to the next life.[379] The time of sickness comes accompanied with deep thoughts and reflection. The declaration of all hidden and sensitive and factual information which a person has ever had in life is made e.g. the undeclared properties wealth and unknown debts, secret wives/concubines or children born our wedlock in case of a man and the unfinished wishes are declared. But those, that are considered hurting, maybe reserved with a secret oath to the trusted only to be revealed after death, when judged as further sources of conflict. During this face of truth, only the concerned people are involved in brokering solutions, confessions, reconciliations or testament. The duty of saying truth before transitioning to the next life is very essential and an important step in the life of the severely ill, as they are encouraged to let-go and focus on the journey ahead, in union with those fore-gone members of the family. At this point conflicting information's are avoided as a lot of listening is done and clarity is sort.

3.7. Dignified Death

In sickness changes life rhythms and the person of the sick depending on how best the empty time has been utilized. For, example, a hardened and unforgiving person changes the heart for the better, when the reality of death hits.[380] Also, there exists notable changes from the support team and from all-around. According to Ecclesiastes 3:1–2, the writer underscores the reality of time that, there exists an appointed time for everything and every affair under the Sun. A time to be born and a time to die, but Küng strengthens this biblical grounding of finitude, by noting that, death is definitely not the end of everything.[381] When the reality of death knocks on a person, being busy with the self –care re-aligning one's life to achieve calmness is indispensable.[382] "Death, according to many African societies is the last phase of an elaborate celebration of the life cycle. Death is widely regarded as a rite of passage that prepares the spirit of the deceases to journey on to the next realm."[383]

Amongst the Luos, death is conceived as a departure for a journey without return to far distant home or as sleep without ever waking up and not as a complete annihilation since, the person continues to live hereafter.[384] Therefore, the onset of dying quashes and makes easy the existential questions of life to be less stressing. Dying marks the shift in

[379] Cf. BELEITES, Wahrheit am Krankenbett, 12–13.
[380] PIPER, Kranksein-Erleben und lernen, 13.
[381] Cf. JENS – KÜNG, Menschenwürdig sterben, 73.
[382] PIPER, Krankensein und lernen, 11.
[383] CHEPKWONY, Understanding death among the Kalenjin.
[384] Cf. MBITI, African Religions and Philosophy, 206.

care models, since *Thoo ok thiedhi* – death is incurable and inevitable, "it is an individual affair in which nobody else can interfere or intervene […] for which there is neither cure nor escape".[385] Thus, the mood and the atmosphere become moderately jovial, as most time is dedicated to storytelling to engage the patient's memory to gauge when dying has actually began. Applicable at this prime point too are any pending requests which are allegorically introduced to the patient (in cases of family head), that have been held secretive or some un deliberated issues requiring decisions.

The focus shifts to preparations for the dying with dignity, that is dying with a hope of joining the community of the ancestors as all is converted to a celebration of life lived with its major feast culminating on burial day.[386] These assists the them in composure and submission, thus making saying farewell and letting go easy. It remotely signifies that everything is again normal and okay, that even the sick may get fooled by death that they are at last getting healed or that they are not badly off and are on the right track of recovery while the reality of death of the sick member remains real,[387] hitting the relatives so hard that their acceptance of the situation and courageous submission through words are only those: of encouragement, of trust, of hope and of comfort to the dying focusing on the meaning of transcendence and new life in community of ancestors.

The dying is courageously reminded to watch over and help alleviate the suffering by pouring the blessings upon them. They are reminded *kik inindi* not to sleep but to stay awake; meaning: to avenge their death, if their death was unnatural –as a result of sorcery, witchcraft or violence. The dying is taught about the uniqueness and transformation of *bedo Tipo* –becoming a Ghost, amongst the *living- dead,* and never to be afraid but join in the journey and submit without bitterness and lamentations, since, others shall also join later. They are assisted with cleansing rituals, prayers and mantras e.g. calling of the names of the *living–dead.* to prepare and assist. All these are done with expectations and confidence in hope, such that, when the dying begins to communicate with both the long–dead relatives and can as well communicate with living, she or he is considered to have begun transitioning to the next world and when it culminates in quiet and peaceful death without panic or screams, it is considered a good death.[388]

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[385] MBITI, African Religions and Philosophy, 207.
[386] Cf. JENS – KÜNG, Menschenwürdig sterben, 74.
[387] Cf. ibid., 75.
[388] Cf. ibid.

Chapter IV. General Conclusion

The use of collective and traditional care has long been associated with the rural areas of Kenya where its practice is wide spread and is further necessitated by the availability of herbal medicinal plants unlike in urban areas where the access is limited. Although it has greatly impacted in the management of HIV/AIDS and other disease such as malaria, tuberculosis, and others in reducing the excessive mortality, morbidity and disability, while leveraging on the inadequacy of the provision conventional medical care in the rural set-ups of global south.[389] There are major issues associated with its rise and use especially, when a rural based patient is transferred for further treatments in higher facilities of care located within the urban areas. In such moments of encounter, the disparity of knowledge due to literacy level often leads to obstinacy on the side of the patients against the available conventional methods giving rise to tensions.[390]

4.1 Tensions between Hospital Care and Traditional Care

In most cases tensions between the traditional care and conventional care occur from the technicality experienced within integration process of the traditional methods into the healthcare system bringing with it: policy problems, regulation, safety, quality, efficacy and the rational use traditional methods due to its accessibility and affordability against the presumed adverse effects of the conventional drugs.[391] The collective traditional care is also perceived as an alternative "gently means of managing chronic"[392] diseases without "the failure to acknowledge that the patient is dying and that comfort is the most appropriate goal, and […] the misuse of high technology in a manner that prolongs the dying process […] requires[ing] families consent when the technology serves no human purpose"[393] remains unnecessary and is avoided while also accompanying everyone involved adequately within the same process of treatment. It primarily discourages the approaches to incurable illness which tend to focus unnecessarily on the extremes of treatment without a recourse to the limits and costs.[394]

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[389] Cf. ELUJOBA, et al., Traditional Medicine Development for Medical, 53.
[390] Cf. NJOROGE – KIBUNGA, Herbal medicine acceptance, 65.
[391] Cf. MWANGI, Integration of herbal Medicine in national healthcare of developing Countries, 498.
[392] Ibid., 497.
[393] ASTRAW, Thoughts on Euthanasia and physician-Assisted Suicide, 44.
[394] Ibid., 45.

4.1.1. Emotional Detachment

Within bio-medicine emotional detachment is regarded as a chief value as it enables the physician to handle many patients without emotionally feeling drained, for the care is about the society and the patients' diseased state. On the contrary humane care demands a little bit of empathy and concern from both the physician and the patient to which traditional medicine and care values as the core of the treatment.[395] In conventional/bio-medicine, to have emotions is detrimental to the social structures of medicine in the area of patient-physician relationship. It is thus, ethically demanded that doctor "should endeavour to act upon the patient's sentiments according to a well-considered plan"[396]. In which, they are "aware of their feelings and emotions […] which are likely to be 'harmful' and 'irrelevant' to patient's care […] and so 'try to do as little harm as possible, not only in treatment with drugs, or with the knife, but also in treatment with words, with the expressions of own sentiments and emotions."[397] Emotion is considered to be under proportionate guard, what traditional medicine hails as a chastened emotional care, which is fully human but regulated within its confines of role, duties and relations. In Luo traditional medicine, healing is considered as an act of God and respect to human dignity and dignity of the patient is protected within these codes punishable by the mystical forces. This traditional understanding is close to the argument of Halpern that, "a chastened empathy provides 'an interactive but fundamentally detached relationship"[398] which is broadening the concept of emotional detachment as compared to the traditional care, which is emotionally based, since its care within a kin-ship model.

4.1.2. Diagnosis

In diagnosis giving false hope or harsh prognosis should be altogether discouraged.[399] The fundamental point of departure should be based on the uncertainty of the situation of the patient, when life is hanging on the balance between living and dying. This is the critical face of care which often perplexes physicians as concerning 'how far' the medical decision should go and to what extent is within their power to do.[400] Sometimes they "are ill equipped to decide whether a person's life is worth living"[401].

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[395] Cf. MARCUM, An Introductory Philosophy of Medicine, 259.
[396] Ibid., 260.
[397] Ibid., 261.
[398] Ibid., 265.
[399] Cf. ASTRAW, Thought on Euthanasia and Physician-Assisted Suicide, 48–49.
[400] Cf. ibid., 46.
[401] Ibid., 49.

The discloser of the entire diagnosis to a patient, according to the western model, or to disclose it partly in terminal cases in traditional care remains debatable. In the area of the traditional medical is determined by the social solidarity effects of togetherness, and lies within the responsibility of the *Jarit Jatuo* to discloses it to the patient step by step and the rest of the concerned family members following the principle, that too little is avoided, and not too much is equally said. Although the acculturation has put a lot of traditional processes in question, where some people agree that it is okay to follow the western model, while for others continue to consider it as catastrophic and traditionally not allowed. Dr John Weru observes that, currently the conventional bioethics as is constituted, is found to be leaning towards the western ideology and in its practice.[402]

4.1.3. Issue of Autonomy

Autonomy of the patient casts a lot more a challenge between the alternative traditional practice which follows a structured or communal way of decision-making, and demands all disclosure and participation of the community organs in all decision-making while the conventional medical practice guarantees this right to patient and only delegated where the patient is incapacitated. In such instance, one can argue that the medical education is western in its principles, where the Autonomy of the patient is prioritized but the communal basis and concern for each other is lost in the process, as individualistic approach is applauded, while within the traditional care, the social and communal well-being is importantly shared and the kin-ship concern is prioritized too in matters concerning the medical decisions, that they feel as part of the process and not visitors.

Again, spiritual care as the foundation of Luo traditional care is religiously oriented and bound to the triad community involving the ancestral spirits, the decisions of the traditional healer are often of precedence. And in its ritualistic nature, it often transcends into magical realm of treatment, thus, over-looking and limiting the informed consent and often breach privacy and confidentiality, which further affect the potential risks and benefits of the treatment as they are never seriously taken into consideration.[403] While, the hospital care relies on the scientific evidence as foundation for all of its processes, where, spirituality forms part of care and ethics.[404]

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[402] Cf. John K, WERU, Ethical issues Faced by Health Care Professionals in the provision of Palliative Care in Kenya, in: Journal of Pain and Symptom Management 67/5 (2024) 590–591, here: 590. URL: https://doi.org/10.1016/ j. jpainsymman.2024.02.402 [accessed: 23 April 2025].
[403] Cf. NYIKA, Ethical and regulatory Issues surrounding African Medicine, 27–28.
[404] Cf. HORNTRICH, Kommunikation und Wahrhaftigkeit, 57.

Consequently, both conventional and complementary medicine agree on "Disclosure and family roles in decision making, advanced care planning, and discussions around advanced directives and approaches"[405]. But due to the paternalistic nature and power-play some doctors have seen it as unnecessary to share the information with the *Jarit Jatuo* (Guardian), something which hurts the family/relatives, more so, when the intended procedure fails and the patient is incapacitated. Although, most "issues occur […] due to concerns about how much and what kind of care should be provided to patients with limited life expectancy and who should be involved in the decision making"[406] The support team ought to take into consideration, the desires of the patient as well as those of the family even when it involves the choice of life over death.[407] Since, the question surrounding the responsibility of the decision in case of a mishaps can result in pain and sometimes a lifelong psychological torture.[408]

4.1.4. Cultural Norms

Ethical issues ought to be contextualized within the cultural norms of the people and the consideration of the familial interrelations as well as in the view of available resources. So that western model of bioethics can be able to fit well within the different African systems and help in providing solutions to the arising dilemmas and possible integration.[409] Severe sickness and emergence of new contagious disease such as Covid-19, presents new challenges, new orientations and dimensions for patients and their families and altering their perspectives of life and ways of care, consciously calling for dire diligence in care and management. This is because, severe sickness takes the affected through life changing processes and at times the result may also lead to loss of faith in God and a shift on people's perspective on life affecting their life choices. Such an experience, demands constantly learning a new on how best to go about with the new situations and constant new beginnings to which communal solidarity offered in traditional care can either help solve[410] or may as well not be able to solve leading to experimentation of what works and applicable with individual situations.

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[405] WERU, Ethical issues Faced by Health Care Professionals, 590.
[406] Ibid.
[407] Cf. ASTRAW, Thought on Euthanasia and Physician-Assisted Suicide, 46.
[408] Cf. HORNTRICH, Kommunikation und Wahrhaftigkeit, 57.
[409] Cf. WERU, Ethical issues Faced by Health Care Professionals, 591.
[410] Cf. PIPER, Kranksein-Erleben und lernen, 67–69.

4.2 Future Recommendations

As the existing loopholes within the alternative medicine and care continually expose the patients to harm, the notable special attribute of *Tuo-yo Jatuo kod Rito Jatuo* lies in the undervalued emotive sphere. The extreme lack of empathy in conventional care in Kenyan public hospitals ought to be faulted as unwarranted as it makes the medical care more mechanical and detached from their humane perspective of medicine.[411] Physicians are superb and efficient in their knowledge and skills, unfortunately their cold approach to patients due to effects of the colonization archetypes, professional mask, and overbearing paternalistic approach causes detachment leading to distressing scenarios. The errors caused by this emotional detachment has pushed quite a number of physicians to experience burn-out and depression, that has again reverberated within the system. We all agree that knowledge and skill are important, because, they save life. Nevertheless, to be human and equally empathic is free and it does a lot more and is equally important in medicine too.

Humans are not machines, but persons with hearts capable of emotions, although medicine is profession in need of knowledge, skill and human heart. There is need for reconnecting the emotional sphere through development of proper empathy within the Kenyan conventional medicine with more focus on the person-oriented care which tend to fail at times.[412] As further reiterated by Francis Peabody, that, the fundamental moral precept for the physicians, lie in the secret of care of the patient, a sort of caring, entailing attentiveness and alertness to the person of the patient and sympathy to the whole situation with friendliness that leads to trust and confidence.[413] The traditional medicine while remaining as the alternative to the primary healthcare in the public health for the majority of the population around the globe especially in global south,[414] and the preferred within the traditional rural Luo set-ups, is negatively affected with symptomatic self -prescription and medication leading to drug-abuse and treatment of non-existent diseases or overdosage where both systems are concurrently used. Again, most conventional drugs are developed from the plants as primary extracts, therefore, strict adherence to one mode or seeking the physician's advice before using both forms is of importance.

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411 Cf. MARCUM, An Introductory Philosophy of Medicine, 265.
412 Cf. ibid., 266.
413 Cf. ibid., 273.
414 Cf. R.R. ALVES – I.M. ROSA, Biodiversity, traditional medicine and public health: where do they meet? in: Journal of Ethnobiology and Ethnomedicine 3/14 (2007) 1–9, here: 4. URL [accessible from University of Vienna]: https//doi-org.uaccess.univie.ac.at/10.1186/1746-4269-3-14 [accessed: 10 February 2025].

List of Abbreviations

AJHB	American Journal of Human Biology
ARGE	Anderssprachige Gemeinden in Erzdiözese Wien
CHWs	Community Health Workers
DGP	Deutsche Gesellschaft für Palliativmedizin
EAMJ	East African Medical Journal
HBC	Home based Care
HIV/AIDs	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
IKAP	Inkulturation Academie für Priests
KNBS	Kenya National Bureau of Statistics
CHWs	Community Health Workers
ICUs	Intensive Care Units
MTRH	Moi Teaching and Referral Hospital
NCD	Non-Communicable Diseases
NEJM	The New England Journal of Medicine
ÖAW	Österreichische Akademie der Wissenschaften
P&M	Philosophy and Medicine
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UDBHR	Universal Declaration on Bioethics and Human Rights
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHA	World Health Assembly
WHO	World Health Organization
WHO SEARO	World Health Organization- South East Asia Regional Office
WPR	World Population Review
OTE	Old Testament Essays
LThK	Lexikon für Theologie und Kirche

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Abstract I.

This study explores the Luo traditional medicine practice of *Tuo-yo kod Rito Jatuo* (empathic solidarity and care of the sick) as a cultural form of palliative care in the Luo community of Kenya. The post-colonial healthcare has seen the acculturation seeking a balance between the conventional care offered within the hospital and the complementary traditional care offered within the traditional setting, which has forced a lot deliberations with regard to issues concerning patient care, especially around those terminally diseased patients and families residing within the rural and semi-urban settings. Traditionally, within these settings, the traditional medicine has historically supported patients within their deep-rooted social, communal and spiritual practices till now. Therefore, discounting the idea that palliative care is a recent phenomenon. *Tuo-yo kod Rito Jatuo* is founded and grounded within the principle of *Ngima* or the vital force of life. It envisions life as something that is sacred, continuous, as well as inextricably bound within both the visible as well as invisible worlds, in which life, death, as well as ailments, are actually transition points within the wider spiritual continuum in the cosmological cycle. In reality, care therefore, becomes something specifically human, not only in the medical environment, but also in the social, ethical, and religious context, founded on human dignity and solidarity as guiding principles, until the natural end of life.

This study highlights the tension that exists between conventional hospital care and the traditional home-based-kin-care provided by the relatives, especially in rural areas of the Global South, where alternative, complementary care provided within the traditional medicine is practiced and remains the first-choice in any medical decision, due to its accessibility, availability, and affordability. The study highlights how the cultural beliefs, community obligations and responsibilities, and religious ideals, continue to shape and influence the preference for home-based care, which is still considered more gentle, humane and religiously appropriate than conventional hospital care which is quite emotionally detached, by situating the Luo practices of *Tuo-yo kod Rito Jatuo* within the broader discourse on medical ethics and universal healthcare. it advocates for the integration and concrete inculturation of the humane care of *Tuo-yo kod Rito Jatuo* and its socio-religious and cultural dimensions into palliative care models in helping to

compensate for the necessary deficit in palliative care services experienced in the Global South in comparison to the Global North.

Methodologically, the study relies on the historical analysis, literary reviews and personal experiences in pastoral and community health engagements within the community. The findings indicate that, with acknowledgements and support of the traditional care structures, which has already begun through the involvement of CHWs could complement conventional methods in a holistic manner for patients and their families. The study confirms that, whether conventional or traditional, palliative care remains a moral expression of our human solidarity, its ethics being founded upon vulnerability, suffering and the inevitability of death.
Keywords: *Tuo-yo kod Rito Jatuo,* Palliative Care, Luo Traditional Medicine, Conventional Medicine, Care and Home-Based Care; Culture and Spirituality.

Abstrakt II.

Diese Studie untersucht die traditionelle Luo-Medizinpraxis „*Tuo-yo kod Rito Jatuo“* (empathische Solidarität und Pflege von Kranken) als kulturelle Form der Palliativpflege in der Luo-Gemeinschaft in Kenia. Im postkolonialen Gesundheitswesen wurde eine Akkulturation angestrebt, die ein Gleichgewicht zwischen der konventionellen Versorgung im Krankenhaus und der ergänzenden traditionellen Versorgung im traditionellen Umfeld herstellt. Dies hat zu zahlreichen Überlegungen hinsichtlich der Patientenversorgung geführt, insbesondere in Bezug auf unheilbar kranke Patienten und deren Familien, die in ländlichen und halburbanen Gebieten leben. Traditionell hat die traditionelle Medizin in diesen Gebieten die Patienten bis heute im Rahmen ihrer tief verwurzelten sozialen, gemeinschaftlichen und spirituellen Praktiken unterstützt. Daher ist die Vorstellung, dass Palliativmedizin ein neues Phänomen ist, nicht zutreffend. *Tuo-yo kod Rito Jatuo* basiert auf dem Prinzip von *Ngima,* der Lebenskraft. Es betrachtet das Leben als etwas Heiliges, Kontinuierliches und untrennbar mit der sichtbaren und unsichtbaren Welt Verbundenes, in dem Leben, Tod und Krankheit tatsächlich Übergangspunkte innerhalb des größeren spirituellen Kontinuums im kosmologischen Kreislauf sind. In der Realität wird Pflege daher zu etwas spezifisch Menschlichem, nicht nur im medizinischen Umfeld, sondern auch im sozialen, ethischen und religiösen Kontext, gegründet auf Menschenwürde und Solidarität als Leitprinzipien, bis zum natürlichen Ende des Lebens.

Diese Studie beleuchtet die Spannungen, die zwischen der konventionellen Krankenhausversorgung und der traditionellen häuslichen Pflege durch Angehörige bestehen, insbesondere in ländlichen Gebieten des Globalen Südens, wo alternative, komplementäre Pflege im Rahmen der traditionellen Medizin praktiziert wird und aufgrund ihrer Zugänglichkeit, Verfügbarkeit und Erschwinglichkeit nach wie vor die erste Wahl bei allen medizinischen Entscheidungen ist. Die Studie zeigt auf, wie kulturelle Überzeugungen, gemeinschaftliche Verpflichtungen und Verantwortlichkeiten sowie religiöse Ideale weiterhin die Präferenz für die häusliche Pflege prägen und beeinflussen, die nach wie vor als sanfter, humaner und religiös angemessener angesehen wird als die konventionelle Krankenhausversorgung, die emotional eher distanziert ist, indem sie die Luo-Praktiken von *Tuo-yo kod Rito Jatuo* in den breiteren Diskurs über medizinische Ethik und universelle Gesundheitsversorgung einordnet. Sie plädiert für die Integration und konkrete Inkulturation der humanen Pflege von *Tuo-yo kod Rito Jatuo* und ihrer sozio-religiösen und kulturellen Dimensionen in Palliativmodelle, um das notwendige Defizit an Palliativleistungen im globalen Süden im Vergleich zum globalen Norden auszugleichen.

Methodisch stützt sich die Studie auf historische Analysen, Literaturrecherchen und persönliche Erfahrungen in der Seelsorge und im Bereich der Gemeindegesundheit innerhalb der Gemeinschaft. Die Ergebnisse zeigen, dass die Anerkennung und Unterstützung traditioneller Pflegestrukturen, die bereits durch die Einbeziehung von CHWs begonnen hat, konventionelle Methoden auf ganzheitliche Weise für Patienten und ihre Familien ergänzen könnte. Die Studie bestätigt, dass die Palliativversorgung, ob konventionell oder traditionell, ein moralischer Ausdruck unserer menschlichen Solidarität bleibt, deren Ethik auf Verletzlichkeit, Leiden und der Unausweichlichkeit des Todes basiert.

Schlüsselwörter: *Tuo-yo kod Rito Jatuo*, Palliativversorgung, traditionelle Luo-Medizin, konventionelle Medizin, Pflege und häusliche Pflege; Kultur und Spiritualität.