

The Clergy's Call in Palliative Care: Competencies, Challenges, and Opportunities Within the BPSS Model

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ABSTRACT

Background: Palliative care requires holistic support that addresses biological, psychological, social, and spiritual needs, with clergy playing a central role in delivering the spiritual and relational dimensions of care. The biopsychosociospiritual (BPSS) framework offers a comprehensive lens for evaluating the contribution of clergy within palliative settings. **Aim:** This study aimed to identify the biopsychosociospiritual competencies most crucial for Catholic clergy in improving palliative care and to examine the challenges and barriers they face in delivering care guided by these competencies. **Methods:** A mixed-methods design was employed, combining survey questionnaires with qualitative insights from clergy participants (n 197), and data were analysed using descriptive statistics, one-way ANOVA, and thematic interpretation. **Results:** Clergy demonstrated strong competencies in the spiritual and psychosocial domains, particularly in fostering trust, providing emotional support, and guiding meaning-making at the end of life. In contrast, notable weaknesses were evident in the biological dimension, with most groups scoring below the 75% consensus threshold. Across the board, systemic barriers such as inadequate clinical training, limited collaboration with medical personnel, and resource constraints were consistently reported, underscoring the structural challenges that hinder clergy effectiveness in palliative care. **Conclusion:** These challenges restrict the clergy's ability to fully align with interdisciplinary models of palliative care. The study concludes that targeted training, institutional collaboration, and policy support are essential to empower clergy as integral partners in delivering holistic, BPSS-guided palliative care.

Keywords: Palliative care, Biopsychosociospiritual framework, Clergy competencies, Catholic clergy, Nairobi, Interdisciplinary care, Barriers to care

INTRODUCTION

Palliative care (PC) represents a transition in healthcare, moving beyond the traditional biomedical model that prioritises disease eradication toward a holistic, person-centred approach that addresses physical, psychological, social, and spiritual suffering (Epstein & Street, 2011; Eliasson, & Steen Carlsson, 2022; Fitchett et al 2020). Globally, the demand for palliative services is increasing sharply, particularly in low- and middle-income countries (LMICs), where health systems often lack the capacity, trained workforce, and sustainable funding to meet rising needs (WHO, 2023; Sleeth et al., 2025; Baruch & Holtom, 2008). Africa alone faces a projected 126% increase in palliative care needs by 2060, with disparities in access creating an urgent public-health and ethical imperative to strengthen systems (Sleeth et al., 2025). In Kenya, although the National Cancer Control Strategy and the Essential Package for Universal Health Coverage integrate palliative care, service gaps remain stark: while approximately 850,000 Kenyans require palliative care annually, only about 15,000 actually receive it (Harding et al., 2013). This inequity is compounded by the increasing burden of non-communicable diseases and cancer, with projections indicating over 42,000 new cancer cases and 28,000 deaths annually by 2035, alongside a 30% rise in the NCD burden (Sung et al., 2021; Ali et al., 2020). Addressing these challenges demands not only multidisciplinary teams capable of delivering continuous, biopsychosocial care, but also sustainable public financing, opioid availability, workforce training, and community mobilisation (Knaul et al., 2018).

Within this context, clergy play a critical role as spiritual carers, uniquely positioned to support patients' emotional and existential needs. Palliative care is inherently holistic and patient-centred, encompassing the physical, psychological, social, and spiritual dimensions of suffering, and clergy contribute to all of these domains (World Health Organization, 2024). The integration of biopsychosociospiritual (BPSS) competencies, skills that enable practitioners to address the complex interplay of bodily, psychological, social, and spiritual needs, is essential for effective PC delivery. These competencies allow clergy to facilitate meaning-making, dignity, and relational well-being, thereby enhancing quality of life for patients and their families (Temel et al., 2010; Haun et al., 2017; Puchalski et al., 2009). The Catholic tradition, in particular, reinforces this holistic ethos, viewing the human person as an integrated unity of body, mind, and spirit (St. John Paul II, 2005; Pope Benedict XVI, 2007; Pope Francis, 2015). Palliative care, therefore, is not merely symptom management but a moral and spiritual obligation that honours human dignity and supports patients' existential and relational needs (Makunda et al., 2024; Carifio & Perla, 2019).

Evidence suggests that BPSS competencies materially impact patient outcomes. Chaplaincy-led interventions, including prayer, empathetic listening, life review, and culturally sensitive spiritual guidance, have been associated with improvements in spiritual well-being, coping strategies, emotional resilience, and overall quality of life in both home-based and institutional palliative settings (Labuschagne et al., 2020; Ooms et al., 2023; Mahilall & Swartz, 2021; Liefbroer, 2021; Clyne et al., 2022; Gayatri et al., 2021; Mah et al., 2024). Chaplains serve as communication bridges between patients, families, and healthcare teams, enhancing understanding of patient values and promoting shared decision-making (Klitzman et al., 2022; Marin et al., 2015). Quantitative studies demonstrate that chaplain visits increase patient satisfaction and fulfilment of spiritual and emotional needs, while qualitative research highlights the crucial role of clergy in addressing existential concerns and facilitating end-of-life discussions (Handzo et al., 2014; Selman et al., 2018). Despite these promising findings, the research base remains heterogeneous, often limited by small sample sizes, lack of standardised interventions, cultural specificity, and inconsistent longitudinal follow-up (Balboni et al., 2017a, 2017b; Candy et al., 2012; Xing et al., 2018; Jaman-Mewes et al., 2024).

Implementation of BPSS-aligned palliative care, particularly in LMIC contexts, faces considerable barriers. Training gaps, absence of standardised protocols, and insufficient integration within healthcare systems constrain the effectiveness of clergy in PC (Mahilall & Swartz, 2021; Doobay-Persaud et al., 2023). Cultural and religious diversity further complicates spiritual care delivery, with clergy needing to navigate varying beliefs and practices while maintaining person-centred approaches (Cheboi et al., 2023; Poncin et al., 2020). Additionally, resource limitations, inequitable access to care, and systemic weaknesses in healthcare infrastructure impede comprehensive implementation, particularly in rural or underserved regions (Grant et al., 2011). The intersection of these challenges underscores the necessity for evidence-informed frameworks that assess clergy BPSS competencies and identify training and support needs.

Given this background, there is a pressing need to systematically evaluate the BPSS competencies of Catholic clergy engaged in palliative care within the Archdiocese of Nairobi. Doing so will illuminate both strengths and gaps in clergy preparedness, inform targeted educational initiatives, and support the integration of spiritual care into interdisciplinary palliative teams. Understanding these competencies, alongside the barriers clergy face in implementing holistic care, is essential for designing contextually appropriate interventions that enhance the quality of palliative care and uphold the dignity, meaning, and well-being of patients facing life-limiting illnesses. This study therefore seeks to provide a data-driven framework for improving clergy effectiveness, thereby contributing to the broader goal of comprehensive, culturally sensitive, and ethically grounded palliative care in Kenya.

METHODOLOGY

Design

This study employed a convergent mixed-methods research design, which deliberately integrates quantitative and qualitative approaches to provide a comprehensive understanding of the biopsychosociospiritual (BPSS) competencies of Catholic clergy and the challenges they encounter in palliative care delivery. The design facilitates the simultaneous collection of numerical data on competencies and barriers, alongside rich,

contextual qualitative insights into clergy experiences, perceptions, and practices. By enabling triangulation of findings, the approach strengthens the validity of conclusions, allowing for the corroboration of quantitative trends with qualitative narratives. Moreover, this design captures the multifaceted nature of palliative care ministry, accommodating both measurable skills and the nuanced interpersonal, cultural, and spiritual factors that influence clergy performance and decision-making in real-world settings.

Participants

The target population comprised all Catholic clergy (N = 275) in the Archdiocese of Nairobi, spanning 16 deaneries, 128 parishes, and 12 hospital chaplaincies. A census design was employed to capture the full spectrum of clergy experiences and competencies, avoiding sampling bias and ensuring representation of both hospital and parish-based ministry contexts. Quantitative data were obtained from 197 respondents (87.6% response rate), while qualitative data were collected via interviews from 10 hospital chaplains (83.3% response rate).

Instruments

Competencies were measured using the BPSS Competence Inventory for Clergy (BPSS-CIC), a 23-item questionnaire assessing biological, psychological, social, and spiritual competencies. The BPSS-CIC was developed by adapting items from established international frameworks and scales (e.g., WHO, 2018; Van Leeuwen & Cusveller, 2004), along with additional validated guidelines to ensure comprehensive coverage of the biopsychosocial-spiritual domains. Items were contextualized for clergy roles and scored on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). Domain scores were computed as averages. Pre-testing with 30 clergy confirmed clarity and contextual relevance, and Cronbach's alpha values ranged from 0.82 to 0.91, indicating high reliability suitable for parametric analysis (Tavakol & Dennick, 2011).

The Chaplaincy Barriers Scale (CBS), consisting of 8 Likert-type items, was included to assess perceived challenges in providing BPSS care, adapted from Jackson-Jordan et al. (2018) and Doobay-Persaud et al. (2023). Pre-testing was conducted with 30 clergy from the Catholic Diocese of Nakuru to ensure clarity, relevance, and appropriateness. Items were refined based on feedback, improving face validity and internal consistency. Cronbach's alpha coefficients for the four BPSS domains ranged from 0.82 to 0.91, demonstrating high reliability suitable for parametric analysis (Tavakol & Dennick, 2011).

Data Analysis

Data analysis employed a mixed-methods approach that integrated quantitative and qualitative procedures to examine the contributions of biopsychosociospiritual (BPSS) competencies to palliative care effectiveness and to identify barriers faced by Catholic clergy. Quantitative data were processed in R (version 4.3) and summarised using descriptive statistics to characterise competencies across biological, psychological, social, and spiritual domains, as well as to map patterns across demographics such as age, education, priestly status, and years of service. Hierarchical regression analyses were then conducted to determine the relative influence of each BPSS domain, with assumptions of normality, linearity, homoscedasticity, and multicollinearity satisfied. Likert-scale responses were treated as near-interval data, composite scores were normalised for comparability, and missing values (<5%) were handled through listwise deletion. Findings from this phase showed that spiritual care was the strongest predictor of holistic palliative care, followed by psychological, social, and biological competencies.

Qualitative data from semi-structured interviews with hospital chaplains underwent thematic analysis with inductive coding to identify patterns in competency application and barriers to care. These narratives provided rich insights into the lived realities of clergy, emphasising the centrality of spiritual and psychological support, culturally sensitive social interventions, and persistent gaps in biological competencies. When triangulated with quantitative findings, the qualitative evidence reinforced the value of Clinical Pastoral Education (CPE) and other structured training initiatives in addressing skill deficits and enhancing interdisciplinary collaboration. Together, the two strands of analysis provided a comprehensive picture of clergy contributions

and challenges within the BPSS framework, underscoring both the strengths and systemic limitations shaping palliative care delivery.

Ethical Considerations

Ethical approval was obtained from the Archbishop of Nairobi and adhered to National Commission for Science, Technology & Innovation (NACOSTI) regulations. Participation was voluntary, with written informed consent obtained from all participants. Confidentiality was ensured through anonymisation, secure digital storage, and password-protected files. The researcher's dual role as clergy and investigator was explicitly acknowledged, with measures to minimise bias including transparency in reporting, clear boundaries between pastoral and research activities, and systematic documentation of methodological decisions (Francis, 2015). All procedures adhered to respect, beneficence, and justice, and no monetary incentives were offered to preserve participant autonomy. The study also passed plagiarism checks, ensuring academic integrity (APA, 2020).

Crucial Competencies

To determine which BPSS competencies most strongly influenced the perceived efficiency of palliative care, the study ranked the four domains using two approaches: correlation analysis and coefficient estimates. These rankings provide a clear hierarchy of importance, showing both the strength of association and the unique contribution of each competency. Table 1 shows the ranking of competencies based on their individual correlations with palliative care efficiency. All four domains exhibited strong positive correlations, with values ranging from 0.71 to 0.84. Spiritual competency ranked highest ($r = 0.842$), followed closely by psychological competency ($r = 0.830$). Social competency followed in third place ($r = 0.791$), while biological competency, though lowest, still demonstrated a strong positive correlation ($r = 0.713$).

Table 1 Ranking of BPSS Competencies by Influence on Palliative Care Efficiency

Competency	Rank	Correlation (r)	Coefficient Estimate (β)	Interpretation
Spiritual	1	0.842	0.60	<i>Strong +ve influence & correlation</i>
Psychological	2	0.830	0.30	<i>Positive influence and correlation</i>
Social	3	0.791	0.25	<i>Positive influence and correlation</i>
Biological	4	0.713	0.20	<i>Positive influence and correlation</i>

In addition, the ranking was refined by examining coefficient estimates to determine the unique influence of each competency when considered together. As shown in Table 1 above, spiritual competency remained the strongest contributor ($\beta = 0.60$), followed by psychological competency ($\beta = 0.30$). Social competency ($\beta = 0.25$) and biological competency ($\beta = 0.20$) also contributed positively, though to a lesser extent. Taken together, these rankings confirm a consistent hierarchy: spiritual skills are the most critical for effective palliative care, followed by psychological, social, and finally biological competencies. Further analysis by demographic categories provided deeper insights into the consensus levels across the biological and psychological domains.

For the biological dimension (Table 2), results indicated notable variations across age, training, education, priestly status, and years in service. Younger priests (25–34 years) scored moderately (72.2%), reflecting competencies that still require improvement, while the oldest group (75+) demonstrated full consensus (100%), suggesting well-applied competencies. Continuous Professional Education (CPE) training emerged as a critical differentiator, with trained clergy attaining much higher consensus (86.2%) compared to their untrained counterparts (52.1%). Education levels showed consistently moderate outcomes (56.9–58.9%), implying that higher academic attainment did not necessarily translate to improved biological competencies. Similarly, missionary priests (63.2%) outperformed diocesan priests (56.1%). Years of service revealed fluctuating consensus, with a peak at 63% among those with 21–30 years, but lower outcomes for both very new (59.3%) and very long-serving clergy (35.7–61.1%).

Table 2 Consensus on Biological Dimension Competencies by Demographic Category

Demographic	Category	Mean	Competent Responses	Total Responses	Consensus (%)	Interpretation
Age	25–34	2.94	39	54	72.2	Competencies need improvement
	35–44	2.66	253	450	56.2	Competencies need improvement
	45–54	2.71	291	492	59.1	Competencies need improvement
	55–64	2.65	91	162	56.2	Competencies need improvement
	65–74	2.11	7	18	38.9	Competencies need improvement
	75+	3.33	6	6	100.0	Competencies well applied
CPE Training	Trained	3.30	181	210	86.2	Competencies well applied
	Not Trained	2.56	506	972	52.1	Competencies need improvement
Education	Baccalaureate	2.67	354	612	57.8	Competencies need improvement
	Masters	2.72	251	426	58.9	Competencies need improvement
	Doctorate	2.69	82	144	56.9	Competencies need improvement
Priestly Status	Diocesan	2.65	471	840	56.1	Competencies need improvement
	Missionary	2.78	216	342	63.2	Competencies need improvement
Years in Service	0–10	2.71	235	396	59.3	Competencies need improvement
	11–20	2.67	237	426	55.6	Competencies need improvement
	21–30	2.76	189	300	63.0	Competencies need improvement
	31–40	2.36	15	42	35.7	Competencies need improvement
	41–60	2.44	11	18	61.1	Competencies need improvement

Turning to the psychological dimension (Table 3), similar demographic patterns were observed, though with slightly higher overall consensus scores. Younger and older extremes again showed the strongest outcomes, with priests aged 25–34 (75.6%) and those above 75 (100%) performing best, compared to mid-range age categories where competencies still needed improvement (68.1–74.4%). CPE training proved even more impactful here, with trained clergy reaching a very high consensus of 91.4%, in contrast to only 69.1% among the untrained. Across education levels, slight variations were observed but none crossed the threshold into “well applied” competencies, with scores clustering between 71.5% and 77.5%. Service years also showed consistent challenges, with all categories scoring in the “needs improvement” range (60–74.8%).

Table 3 Consensus on Psychological Dimension Competencies by Demographic Category

Demographic	Category	Mean	Competent Responses	Total Responses	Consensus (%)	Interpretation
Age	25-34	3.09	34	45	75.6	Competencies well applied
	35-44	2.98	279	375	74.4	Competencies need improvement.
	45-54	2.97	302	410	73.7	Competencies need improvement.
	55-64	2.82	92	135	68.1	Competencies need improvement.
	65-74	2.6	8	15	53.3	Competencies need improvement.
	75+	3.4	5	5	100	Competencies well applied
CPE Training	Trained	3.43	160	175	91.4	Competencies well applied
	Not Trained	2.85	560	810	69.1	Competencies need improvement.
Education	Baccalaureate	2.96	373	510	73.1	Competencies need improvement.
	Masters	2.95	254	355	71.5	Competencies need improvement.
	Doctorate	2.98	93	120	77.5	Competencies need improvement.
Years in Service	0-10	2.98	241	330	73	Competencies need improvement.
	20-Nov	3.01	262	355	73.8	Competencies need improvement.
	21-30	2.91	187	250	74.8	Competencies need improvement.
	31-40	2.69	21	35	60	Competencies need improvement.
	41-60	2.8	9	15	60	Competencies need improvement.

Extending the analysis to the social dimension (Table 4), demographic variations again revealed important patterns. Younger priests aged 25–34 demonstrated strong outcomes (80%), while those in the 35–44 (75.5%) and 45–54 (75.9%) brackets also showed competencies that were well applied. However, consensus declined in the older categories, with 55–64 years (65.2%) and 65–74 years (46.7%) falling into the “needs improvement” range, and those above 75 recording only 60%. CPE training remained a decisive factor, with trained clergy (88.6%) outperforming the untrained (70.7%) by a wide margin. Education reflected mixed outcomes: baccalaureate holders performed better (75.7%, well applied), while those with master’s (71.8%) and doctoral degrees (72.5%) still required improvement. Years of service also showed variation, newer clergy (0–10 years, 76.4%) and those with 21–30 years (75.6%) exhibited well-applied competencies, while both the mid-career (74.1%) and long-serving categories (51.4–40%) fell below the threshold, signaling areas needing reinforcement.

Table 9 Consensus on Social Dimension Competencies by Demographic Category

Demographic	Category	Mean	Competent Responses	Total Responses	Consensus (%)	Interpretation
Age	25–34	3.09	36	45	80.0	Competencies well applied
	35–44	2.97	283	375	75.5	Competencies well applied
	45–54	3.02	311	410	75.9	Competencies well applied
	55–64	2.79	88	135	65.2	Competencies need improvement
	65–74	2.53	7	15	46.7	Competencies need improvement
	75+	2.60	3	5	60.0	Competencies need improvement
CPE	Trained	3.33	155	175	88.6	Competencies well applied
Training	Not Trained	2.89	573	810	70.7	Competencies need improvement
Education	Baccalaureate	2.97	386	510	75.7	Competencies well applied
	Masters	2.97	255	355	71.8	Competencies need improvement
	Doctorate	2.94	87	120	72.5	Competencies need improvement
Years in Service	0–10	3.02	252	330	76.4	Competencies well applied
	11–20	3.01	263	355	74.1	Competencies need improvement
	21–30	2.91	189	250	75.6	Competencies well applied
	31–40	2.63	18	35	51.4	Competencies need improvement
	41–60	2.47	6	15	40.0	Competencies need improvement

For the spiritual dimension (Table 5), the highest consensus levels across all domains were observed. Here, nearly all demographic groups achieved the “well applied” threshold. Younger clergy (25–34) scored an impressive 92.6%, while the oldest groups (65–74 at 88.9% and 75+ at 100%) demonstrated especially strong consensus. Those in the middle age brackets consistently ranged between 77.2% and 83.1%, reflecting stable application of competencies. CPE training again played a pivotal role, with trained clergy achieving very high consensus (93.3%), though even the untrained maintained well-applied competencies (79.9%). Education levels showed uniformly strong outcomes, with doctorate holders achieving 87.5%. Years of service presented a largely positive picture, as all groups except those in the 31–40-year bracket (71.4%) reached or exceeded the “well applied” threshold, and the longest-serving priests (41–60 years) demonstrated full consensus (100%).

Table 10 Consensus on Spiritual Dimension Competencies by Demographic Category

Demographic	Category	Mean	Competent Responses	Total Responses	Consensus (%)	Interpretation
Age	25-34	3.39	50	54	92.6	Competencies well applied
	35-44	3.1	367	450	81.6	Competencies well applied.
	45-54	3.18	409	492	83.1	Competencies well applied.
	55-64	3.15	125	162	77.2	Competencies well applied.
	65-74	3.11	16	18	88.9	Competencies well applied.
	75+	4	6	6	100	Competencies well applied

CPE Training	Trained	3.48	196	210	93.3	Competencies well applied
	Not Trained	3.09	777	972	79.9	Competencies well applied.
Education	Baccalaureate	3.14	505	612	82.5	Competencies well applied.
	Masters	3.13	342	426	80.3	Competencies well applied.
	Doctorate	3.33	126	144	87.5	Competencies well applied.
Years in Service	0-10	3.15	329	396	83.1	Competencies well applied.
	20-Nov	3.17	348	426	81.7	Competencies well applied.
	21-30	3.13	248	300	82.7	Competencies well applied.
	31-40	3.07	30	42	71.4	Competencies need improvement.
	41-60	3.56	18	18	100	Competencies well applied

Qualitative interviews further illuminated how these competencies were practiced in the field. The findings revealed that spiritual and psychological competencies were most strongly expressed, while social and biological dimensions showed more variability. Spiritual care emerged as the chaplains' central role, with practices such as administering sacraments and leading prayer viewed as top-priority. Beyond rituals, their presence itself carried profound meaning: "Presence over answers" (Chaplain 002) and "They thanked me for listening" (Chaplain 004) highlighted how spirituality and psychological support often intertwined in moments of vulnerability. Similarly, empathy and attentive listening were repeatedly emphasized as crucial skills, reinforcing the quantitative evidence that psychological competencies were highly influential in patient care.

By contrast, social and biological competencies were more uneven. In the social domain, chaplains often acted as mediators, helping families navigate conflicting treatment preferences through culturally sensitive interventions. One chaplain noted, "Balancing aggressive treatment wishes" (Chaplain 007), while another shared, "An elder's reassurance resolved refusal of surgery" (Chaplain 010). The biological domain was the least prioritized, with many chaplains acknowledging limited training and clinical space: "Doctors asked me to leave" (Chaplain 003). Even so, they still contributed by advocating for pain management, facilitating medical access, and suggesting home-care solutions. These accounts underscore that while competencies varied in strength, chaplains consistently leveraged their presence to bridge gaps in holistic palliative care.

Challenges and Barriers

Building on the competencies explored above, the study also examined the constraints clergy face in delivering palliative care. Several barriers emerged across cultural, institutional, and personal domains, reflecting both systemic limitations and the clergy's own preparedness. The survey revealed that lack of formal training for clinical requests was a prominent barrier, with nearly half of respondents agreeing or strongly agreeing that this limited their effectiveness. Similarly, limited collaboration with non-medical personnel and difficulties in using standard clinical assessment tools were widely acknowledged, underscoring the structural gaps in integrating clergy with medical teams. Emotional exhaustion from repeated exposure to death also surfaced as a significant personal challenge, highlighting the psychological toll of their pastoral role.

Table 11 Perceived Challenges and Barriers in Delivering Palliative Care

Challenge/Barrier	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Non-intentional difficulties after initial visits	2 (1.0 %)	37 (18.8 %)	124 (62.9 %)	34(17.3 %)	0(0.0 %)
Emotional exhaustion from repeated exposure to death	2 (1.0 %)	48 (24.4 %)	110 (55.8 %)	31(15.7 %)	7(3.6 %)
Uncomfortable to assist in rituals affecting peace	3 (1.5 %)	56 (28.4 %)	99 (50.3 %)	30 (15.2 %)	0 (0.0 %)
Difficult ignoring standard clinical assessment tools	3 (1.5 %)	28 (14.2 %)	137 (69.5 %)	28 (14.2 %)	1 (0.5 %)
Culturally inappropriate to disagree with patients	3 (1.5 %)	59 (29.9 %)	100 (50.8 %)	28 (14.2 %)	4 (2.0 %)
Skilled at recommending palliative care	4 (2.0 %)	27 (13.7 %)	134 (68.0 %)	28 (14.2 %)	4 (2.0 %)

Limited collaboration with non-medical personnel	1 (0.5 %)	22 (11.2 %)	138 (70.0 %)	32 (16.2 %)	4 (2.0 %)
Lack of formal training for clinical requests	0 (0.0 %)	38 (19.3 %)	71 (36.0 %)	76 (38.6 %)	12 (6.1 %)

Other challenges were more context-specific, such as discomfort in assisting with rituals that could affect peace, or navigating cultural expectations where disagreeing with patients is considered inappropriate. These findings illustrate the tension between the clergy's pastoral mission and the practical realities of delivering holistic palliative care in a medicalised environment. Qualitative insights offered depth to the numeric findings on challenges faced by clergy in delivering palliative care. Limited collaboration with medical professionals stood out, with Chaplain 003 recalling, "Doctors asked me to leave," a remark that echoed the sense of exclusion clergy often feel within hospital systems. The struggle to work with standardised clinical tools also surfaced, as many clergy described a mismatch between rigid assessment instruments and the more pastoral, relational methods they are accustomed to. Several suggested the development of user-friendly spiritual, psychological, and social assessment tools to bridge this gap. Clergy further highlighted the lack of structured follow-up, noting that after an initial visit, patients and families were often left unsupported.

Emotional fatigue and resource insufficiency also emerged as significant barriers. Chaplain 001 admitted, "I'm struggling after my own family loss," pointing to how personal grief can magnify professional strain. Similarly, Chaplain 008 recounted the harrowing situation of parents being forced to choose which child would receive treatment, underscoring the stark realities clergy encounter in public hospitals. While some clergy felt skilled and adequately prepared to respond to clinical requests, others expressed a lack of formal training, reflecting a diversity of perceptions regarding readiness. Taken together, these narratives bring to life the statistical patterns, revealing how systemic gaps, training inconsistencies, and emotional demands converge to hinder clergy effectiveness in palliative care.

These challenges, while widely shared across clergy, were not always perceived in the same way. The qualitative narratives and quantitative trends point to systemic and emotional strains, but the extent to which these barriers were felt appeared to vary depending on personal and professional characteristics. To explore these patterns further, one-way ANOVA tests were conducted to assess whether perceptions of barriers differed significantly across age, education level, priestly status, years in service, and completion of Clinical Pastoral Education (CPE) training Table 6.

Table 6 One – way - ANOVA Testing to compare the Challenges

Grouping factor	Barrier / Challenge (DV)	p-value	Significance
Age (six bands)	Lack of formal clinical training	0.843	n.s.
	Limited collaboration with medical staff	0.839	n.s.
	Sufficient resources	0.786	n.s.
	Cultural / religious divergence	0.838	n.s.
	Difficulty with assessment tools	0.857	n.s.
	Urban challenges (Nairobi)	0.681	n.s.
	Emotional drain	0.75	n.s.
	Lack of structured follow-up	0.795	n.s.
Education level	Lack of formal clinical training	0.742	n.s.
	Limited collaboration	0.683	n.s.
	Sufficient resources	0.907	n.s.
	Cultural / religious divergence	0.725	n.s.
	Difficulty with assessment tools	0.933	n.s.
	Urban challenges	0.721	n.s.
	Emotional drain	0.821	n.s.
	Lack of structured follow-up	0.579	n.s.
Priestly status	Lack of formal clinical training	0.027	sig.
	Limited collaboration	0.002	sig.
	Sufficient resources	0.065	n.s.

	Cultural / religious divergence	0.03	sig.
	Difficulty with assessment tools	0.011	sig.
	Urban challenges	0.001	sig.
	Emotional drain	0.013	sig.
	Lack of structured follow-up	0.004	sig.
Years in service	Lack of formal clinical training	0.38	n.s.
	Limited collaboration	0.379	n.s.
	Sufficient resources	0.771	n.s.
	Cultural / religious divergence	0.492	n.s.
	Difficulty with assessment tools	0.24	n.s.
	Urban challenges	0.376	n.s.
	Emotional drain	0.33	n.s.
	Lack of structured follow-up	0.316	n.s.
CPE training	Lack of formal clinical training	1.17×10^{-4}	sig.
	Limited collaboration	4.42×10^{-4}	sig.
	Sufficient resources	3.06×10^{-4}	sig.
	Cultural / religious divergence	7.68×10^{-4}	sig.
	Difficulty with assessment tools	4.68×10^{-4}	sig.
	Urban challenges	8.70×10^{-5}	sig.
	Emotional drain	5.93×10^{-4}	sig.
	Lack of structured follow-up	5.52×10^{-4}	sig.

The analysis showed that age, education, and years in service did not significantly shape clergy perceptions of barriers. Regardless of these demographic factors, most participants reported similar struggles with limited collaboration, resource insufficiency, emotional fatigue, and difficulties using standardized assessment tools. This suggests that such challenges are broadly shared across the clergy population, cutting across generational and experiential divides. By contrast, priestly status and CPE training emerged as significant determinants. Those with different priestly roles (e.g., parish priests vs. chaplains) reported varying degrees of strain, particularly regarding clinical collaboration, cultural/religious divergence, and emotional drain. Even more striking, clergy who had undergone CPE training consistently reported significant differences in how they perceived barriers across all domains, especially in relation to clinical preparedness, structured follow-up, and urban healthcare challenges. These findings highlight the importance of professional role and formal pastoral training in shaping how clergy engage with and navigate the complexities of palliative care.

DISCUSSION

This study set out to examine the competencies and barriers Catholic clergy in the Archdiocese of Nairobi encounter in delivering palliative care, guided by the biopsychosocial–spiritual (BPSS) model. The findings reveal a complex picture: while clergy demonstrate strong grounding in the spiritual dimension of care, their competencies in the biological, psychological, and social domains are uneven and frequently fall short of the consensus threshold. These limitations are compounded by systemic barriers, most notably the lack of formal training in clinical aspects of care and limited collaboration with healthcare professionals. Taken together, the results underscore both the unique contributions clergy make to holistic care and the pressing need for structured training to address gaps in biological and psychosocial literacy.

The most striking finding is the widespread deficiency in biological competency, which emerged as the weakest domain across nearly all demographic groups. This is consistent with international research demonstrating that clergy, while highly valued for their spiritual and emotional presence, often feel underprepared to engage with the biomedical aspects of palliative care (Miller et al., 2023; Balboni et al., 2014). In Nairobi, this gap was evident irrespective of age, years of service, or academic qualifications, confirming that routine pastoral practice and theological education do little to equip clergy with the skills needed to assess physical symptoms or interpret clinical data. Prior work highlights how seminary curricula are deeply rooted in theology and pastoral care but lack formal biomedical training, leaving clergy unable to meet the clinical demands of interdisciplinary palliative care teams (Puchalski et al., 2009). The finding that only

clergy with Clinical Pastoral Education (CPE) training surpassed the competence threshold supports the growing consensus that specialised, practice-based training is essential for clergy to contribute meaningfully to the biological dimension of care (Saad et al., 2017).

Psychological and social competencies were somewhat stronger but still inconsistent across demographic subgroups. Clergy were frequently recognised for their empathetic presence and their ability to listen to patients' fears and anxieties, echoing research that highlights clergy's natural strengths in psychosocial support (Fitchett et al., 2020). However, without training in structured assessment tools, these skills remain informal and uneven, which aligns with studies showing that clergy often rely on intuition rather than evidence-based practices when addressing mental health concerns (Best et al., 2020). Similarly, the social domain revealed gaps in navigating family dynamics and interprofessional collaboration. Missionary clergy, who are more exposed to diverse healthcare contexts, appeared somewhat better prepared, but diocesan clergy, whose pastoral duties are largely parish-based, struggled more. This echoes findings by Saad et al. (2017), who note that clergy embedded in parish life often have fewer opportunities to develop the collaborative skills required in hospital or hospice settings.

By contrast, the spiritual dimension was the area of greatest strength, with clergy achieving near-universal consensus on competence. This is unsurprising, as spirituality is central to pastoral identity and formation. Studies consistently highlight the unique and indispensable role clergy play in addressing existential distress, meaning-making, and end-of-life spiritual needs (Szilagyi et al., 2024; Puchalski et al., 2009). However, while this strength is valuable, an overreliance on spiritual interventions risks narrowing clergy contributions to a single dimension of holistic care. In contexts where physical symptom management or psychological support are urgently required, spiritual care alone cannot suffice. As Wade and Halligan (2023) argue, holistic care demands integration of all BPSS dimensions, and the clergy's imbalance across these domains highlights an urgent training and systems-level challenge.

The analysis of barriers helps explain these competency patterns. One-way ANOVA tests showed that age, education, and years of service had no significant effect on clergy perceptions of barriers, suggesting that deficits are not the product of individual variation but of structural and systemic factors. By contrast, priestly status and training were decisive. Diocesan clergy reported greater difficulty collaborating with medical professionals and navigating urban challenges, likely reflecting the competing demands of parish administration and limited institutional support for healthcare involvement. Missionary clergy, with their broader exposure, faced somewhat fewer constraints, though they too fell below the competence threshold. This resonates with Jackson-Jordan et al. (2018), who highlight that ministerial context shapes the extent to which clergy can participate effectively in healthcare delivery.

Most notably, training status was the single most powerful determinant of both perceived barriers and competencies. Clergy with CPE training consistently reported fewer challenges, less emotional exhaustion, and greater confidence in clinical collaboration. This finding is strongly supported by prior research showing that structured, supervised training enhances clergy resilience, equips them with transferable clinical skills, and fosters interprofessional competence (McCann, 2023; Puchalski et al., 2009). The effect sizes observed here were unusually large for psychosocial research, underscoring the transformative impact of training. By contrast, untrained clergy not only struggled with biological literacy but also reported higher levels of emotional drain and systemic obstacles. This reflects global findings that untrained clergy often feel overwhelmed in the face of repeated exposure to death and dying, in part because they lack structured coping frameworks and institutional support (Best et al., 2020).

Taken together, these results highlight the centrality of training in shaping clergy contributions to palliative care. While spirituality remains the clergy's strongest asset, their limited competencies in other domains pose a barrier to fully realising the BPSS model of care. Without structured training and institutional reforms, clergy risk being sidelined in interprofessional teams, confined to spiritual care while unable to engage meaningfully in biological, psychological, or social discussions. This is particularly problematic in Nairobi's rapidly urbanising healthcare environment, where interprofessional collaboration is essential to meet the needs of patients facing complex, multidimensional suffering. In conclusion, this study reinforces that while Catholic clergy in Nairobi possess deep strengths in spiritual care, their contributions to the broader BPSS model

remain limited by systemic gaps in training, collaboration, and clinical literacy. Training, especially through CPE, emerges as the single most powerful lever for change, capable of reducing barriers, strengthening competencies, and enabling clergy to deliver care that is truly holistic. Addressing these gaps is not merely a matter of professional development but a moral imperative to ensure that patients and families facing serious illness receive comprehensive, compassionate, and integrated support.

Theoretical Implications

This study reinforces the biopsychosociospiritual (BPSS) framework as a robust model for palliative care by showing how competencies cluster differently across its four dimensions, confirming both its conceptual soundness and its diagnostic value in identifying areas needing intervention. While clergy demonstrate strong capacity in spiritual care, their weaker biological and psychosocial competencies highlight the need for integrated approaches that value all dimensions equally, supporting Szilagyi et al., (2024) view that suffering cannot be alleviated through spiritual interventions alone. Accordingly, the findings point to three priorities: incorporating CPE or equivalent training into seminary and ongoing formation to strengthen biological and psychosocial skills; creating institutional pathways that enable clergy to serve effectively in interdisciplinary teams; and ensuring ongoing support, such as supervision and interprofessional dialogue, to sustain engagement and prevent burnout. Overall, the BPSS model proves particularly relevant in fragmented healthcare contexts, offering a holistic structure that bridges biomedical and pastoral traditions while echoing international calls for clergy training and integration as essential to advancing comprehensive care (Balboni et al., 2013; Szilagyi et al., 2024).

Practical Implications

The study also carries significant practical implications. First, training emerges as the most decisive lever for change. Tailored clergy programs in palliative care, especially those grounded in Clinical Pastoral Education (CPE), are essential to build biological, psychological, and social competencies while sustaining spiritual strengths. Such training would enhance confidence, reduce emotional fatigue, and enable clergy to operate as credible partners in interdisciplinary teams. Second, at the policy level, greater collaboration between the Church and healthcare institutions is required. Formal partnerships, role definitions, and shared protocols would institutionalise clergy contributions beyond ad hoc pastoral visits, ensuring consistent integration into palliative care delivery. Third, systemic and cultural barriers must be addressed. These include resource constraints, limited follow-up structures, and persistent perceptions that clergy should confine themselves to spiritual matters. By fostering dialogue, providing adequate resourcing, and recognising the multidimensional nature of suffering, both Church and healthcare systems can enhance the quality and inclusivity of palliative care.

Limitations and Suggestions for Future Research

This study has several limitations that should be acknowledged. The sample size was relatively small and limited to clergy within the Archdiocese of Nairobi, which may restrict the generalisability of findings to other dioceses in Kenya or different cultural settings. Reliance on self-report measures also introduces the possibility of social desirability bias, where clergy may overstate competencies or underreport challenges. Furthermore, the cross-sectional design limits causal inferences about the relationship between training and perceived barriers.

Future research should consider expanding the scope to include non-Catholic and interfaith clergy, thereby reflecting Kenya's broader religious diversity and enhancing generalisability. Adopting longitudinal designs would also be valuable for capturing changes in competencies over time, particularly following targeted training programs such as Clinical Pastoral Education. In addition, more robust statistical analyses examining predictive factors—such as clergy demographics or prior training—could provide deeper insights into what shapes competency development. Mixed-methods approaches, incorporating patient and healthcare professional perspectives, would further enrich understanding by triangulating clergy self-assessments with external evaluations. Finally, developing and validating clergy-specific assessment tools that align with the BPSS model would advance both research and practice, enabling more precise identification of training needs and competency development.

CONCLUSION

This study set out to examine the biopsychosociospiritual (BPSS) competencies of Catholic clergy in the Archdiocese of Nairobi and the barriers they face in providing palliative care. The findings affirm that clergy are well equipped with essential spiritual and relational skills, positioning them as vital contributors to holistic palliative care. However, their effectiveness is constrained by notable barriers, particularly the lack of formal clinical training, limited structured collaboration with medical personnel, and systemic challenges such as resource insufficiency and inconsistent follow-up. These gaps highlight a misalignment between the clergy's pastoral strengths and the broader interdisciplinary demands of evidence-based palliative care.

Addressing these barriers requires intentional investment in clergy training, stronger collaboration between the Church and healthcare institutions, and supportive systems that recognise the full scope of BPSS care. Expanding Clinical Pastoral Education, embedding clergy roles in policy frameworks, and fostering sustainable resource-sharing models would enhance their capacity to contribute meaningfully. By empowering clergy with the necessary competencies and support, the Church and healthcare systems can together ensure that patients and families facing life-limiting illness receive comprehensive, compassionate, and truly holistic care.

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