

An exploration of the understanding of spirituality among patients and staff of the Chris Hani-Baragwanath Hospital

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Thesis submitted in fulfillment of the requirements for the degree *Philosophiae Doctor* in Social Work at the Potchefstroom Campus of the North-West University

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November 2013

Potchefstroom

We have always been involved in spiritual evolution.
We are spiritual beings,
we have always been spiritual beings
and we will always be spiritual beings.

~ Gary Zukav ~



The world is nothing but my perception of it.
I see only through myself.
I hear only through the filter of my story.

~ Byron Katie ~



Changing the world begins
with the very personal process of changing yourself,
the only place you can begin is where you are,
and the only time you can begin is always now.

~ Gary Zukav ~



ACKNOWLEDGEMENTS

The contributions of the following people herewith acknowledged with gratitude:

- Prof A Herbst for her guidance, patience and support.
- Dr E du Plessis for her additional guidance and support.
- The Department of Health: CHBAH for their permission to conduct this research and for all the logistical support needed in this study.
- The North-West University (Potchefstroom Campus) for financial assistance.
- The courageous employees and patients who selflessly participated in the study.
- My husband Daniel and our beautiful children, Sanelisiwe and Thandolwethu for their unconditional support.
- My friends who supported and encouraged me throughout the study.
- Gail Schmidt for all your support.
- Mrs Ina-Lize Venter for the language editing of the thesis.
- Mrs Marietjie du Toit for the final layout and technical editing of the thesis.
- Mrs Francina Smuts a dear friend for unfailing support and input
- Above all to God Almighty for good health, clarity of thought, means and the ability to complete the study.

DECLARATION BY THE STUDENT

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Degree/ Qualification: PhD (Social Work)

Title of the thesis/dissertation: *An exploration of the understanding of spirituality among patients and staff of CHBAH.*

I declare that this thesis is my own original work. Where secondary material was used, it was carefully acknowledged and referenced in accordance with University requirements.

I understand what plagiarism is and am aware of university policy in this regard.

SIGNATURE: TSNkomo

DATE: 26 Nov 2013

SUMMARY

An exploration of the understanding of spirituality among patients and staff of the Chris Hani Baragwanath Academic Hospital

Keywords: Medical social work, healthcare professionals, spirituality, religion, health, diversity, intervention, health care

Until recently, the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicine and surgery, and gives less importance to beliefs and to the faith in healing, in the physician, and in the doctor-patient relationship. This reductionist view of patients being only material body is no longer satisfactory. Patients and healthcare professionals have begun to value the role of elements such as faith, spirituality, hope and compassion in the healing process. The effect of such spiritual elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view, which included the non-material dimension.

The goal of this study was to explore the understanding of spirituality among healthcare professionals and patients at the CHBAH.

The primary research question, which this study attempted to answer, was:

What is the understanding of spirituality among the healthcare professionals and patients at CHBAH?

In view of this primary research question, the following secondary research questions were formulated:

- What does a literature review produce regarding spirituality in healthcare and what are the current practices related to spirituality in healthcare.
- What are the views of healthcare professionals and patients concerning the relevance of spirituality in their day-to-day lives and healthcare interventions?
- What are the spiritual needs of patients and to what extent does spirituality contribute towards their coping with health-related issues?
- Which practical and scientific recommendations can be offered to healthcare professionals regarding including/incorporating spirituality in healthcare services in CHBAH?

In view of the aim, the researcher identified the following specific objectives for this study:

- To explore spirituality in healthcare by means of a literature review;
- To explore and describe the views of medical social workers and other healthcare professionals about the relevance of spirituality in a healthcare setting;
- To explore and describe the understanding of spirituality among healthcare professionals and patients in CHBAH;
- To propose a protocol as an organizational framework on the incorporation of spirituality in healthcare at CHBAH.

This protocol should be implemented during social workers' and other healthcare professionals' interactions with patients.

Chapter 1 provides an introduction, problem formulation, goal, research question and the objectives of this study and a brief overview of the methodology.

Chapter 2 focuses on the description of research methodology that was utilised in this study.

Chapter 3 is composed of a literature study on spirituality and the religions identified and explored in CHBAH, as well as existing practices related to spirituality in health care.

In **Chapter 4**, the data generated through narratives from focus-group discussions and healthcare professionals' spiritual journey is processed and reported.

In **Chapter 5** a proposed protocol for inclusion of spirituality in healthcare services in CHBAH is presented and discussed in detail

Chapter 6 consists of the conclusions and summary of this study.

OPSOMMING

'n Verkenning van die begrip spiritualiteit onder pasiënte en personeel van die

Chris Hani Baragwanath Akademiese Hospitaal

Sleutelwoorde: Mediese maatskaplike werk, gesondheidsorg spesialiste, spiritualiteit, geloof, gesondheid, diversiteit, intervensie, gesondheidsorg

Tot onlangs toe nog het die gesondheidsberoep hoofsaaklik 'n mediese model nagevolg wat poog om pasiënte te behandel deur van medisyne en sjirurgie gebruik te maak, en minder aandag skenk aan oortuigings en aan geloof in genesing en in die geneesheer, en aan die dokter-pasiënt verhouding. Hierdie reduksionistiese beskouing van die pasiënt as slegs 'n materiële liggaam is nie meer bevredigend nie. Pasiënte en gesondheidsorgpraktisyns het begin waarde heg aan die rol wat sake soos geloof, spiritualiteit, hoop en medelye in die genesingsproses speel. Die effek van hierdie spirituele kwessies op gesondheid en lewenskwaliteit het gelei tot navorsing na 'n meer holistiese perspektief wat die nie-materiële dimensie insluit.

Die doel van die studie was om die begrip van spiritualiteit onder gesondheidsorgpraktisyns en pasiënte by die Chris Hani-Baragwanath Akademiese Hospitaal (CHBAH) te ondersoek.

Die primêre navorsingsvraag wat hierdie studie probeer beantwoord het, was:

Wat is die begrip van spiritualiteit onder gesondheidsorgpraktisyns en pasiënte by die CHBAH?

Met die oog op die primêre navorsingsvraag is die volgende, sekondêre navorsingsvrae geformuleer:

- Wat lewer 'n literatuuroorsig op oor spiritualiteit in gesondheidsorg, en wat is die mees onlangse praktyke betreffend spiritualiteit in gesondheidsorg?
- Wat is gesondheidsorgpraktisyns en pasiënte se opinies oor die toepaslikheid van spiritualiteit in hul daaglikse lewens en gesondheidsorg-intervensies?
- Wat is die spirituele behoeftes van pasiënte, en tot watter mate dra spiritualiteit by tot hulle hantering van gesondheidskwessies?
- Watter praktiese en wetenskaplike aanbevelings kan aan gesondheidsorgpraktisyns gemaak word rondom die insluiting van spiritualiteit in CHBAH se gesondheidsorgdienste?

In die lig van die doel het die navorser die volgende, spesifieke doelstellings vir die studie geïdentifiseer:

- Om spiritualiteit in gesondheidsorg te ondersoek deur middel van 'n literatuuroorsig;
- Om vas te stel wat die opinies van mediese maatskaplike werkers is rondom die toepaslikheid van spiritualiteit in die gesondheidsorg-omgewing;
- Om gesondheidsorgpraktisyns en pasiënte by CHBAH se begrip van spiritualiteit te ondersoek;
- Om 'n protokol as organisatoriese raamwerk voor te stel ter insluiting van spiritualiteit in CHBAH se gesondheidsorg. Hierdie protokol moet uitgevoer word tydens maatskaplike werkers en ander gesondheidsorgpraktisyns se wisselwerking met pasiënte.

Hoofstuk 1 verskaf 'n inleiding, probleemstelling, doel, navorsingsvraag en doelstellings van die studie, sowel as 'n kort opgawe van die metodologie.

Hoofstuk 2 fokus op 'n beskrywing van die navorsingsmetodologie waarvolgens die studie verloop het.

Hoofstuk 3 bestaan uit 'n literatuurstudie oor spiritualiteit en die gelowe wat by CHBAH geïdentifiseer en ondersoek is, sowel as bestaande praktyke betreffende spiritualiteit in gesondheidsorg.

In **Hoofstuk 4** word die data wat vanuit die fokusgroepvertellings en geestelike reise (*spiritual journeys*) van die gesondheidsorgpraktisyne voortgespruit het, verwerk en vermeld.

In **Hoofstuk 5** word 'n voorgenome protokol vir die insluiting van spiritualiteit by CHBAH-gesondheidsorgdienste voorgestel en in detail bespreek.

Hoofstuk 6 bestaan uit die gevolgtrekkings en opsomming van die studie.

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LIST OF RELIGIOUS SYMBOLS

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LIST OF ABBREVIATIONS

CHBAH	Chris Hani Baragwanath Academic Hospital
CEO	Chief executive officer
DEP CEO	Deputy Chief executive officer
HR	Human Resource
ADMIN	Administration
ITC	Information and technology communication
WHO	World Health Organization

CHAPTER 1

AN ORIENTATION TO THE STUDY

1.1 BACKGROUND TO THE STUDY

The researcher has more than ten years' experience of operational social work in different medical settings. In this capacity, the researcher has observed spirituality used as a coping mechanism for many patients who experienced both health and psychosocial challenges. Hence, her interest and endeavor to explore the understanding of spirituality among patients and health care professionals in CHBAH. Since holistic health care rated as priority in health related interventions, the issue of spirituality cannot be neglected as one of the basic levels of human functioning. Chris Hani Baragwanath Academic Hospital (CHBAH) was the health care facility where the researcher worked at the time of the study. Thus, the need for a deeper understanding of what spirituality means for patients and staff in such a large and diverse health care facility identified by the researcher and discussed with senior management and staff before the planning and the execution of this study was. With this background in mind, the actual problem that initiated this study described in the next paragraphs.

1.2 PROBLEM STATEMENT

A research problem is defined as a known difficulty, which ought to be dealt with through research (Grinnell, 2002:22; Grinnell & Williams, 1990:58). Fouché and Delport (2005:100) emphasise that the problem must be researchable and its meaning should have a clear significance and utility in practice. They add that there are various sources for the identification of research problems, such as observation

of reality, theory, previous research, curiosity and the interest of the supervisor. According to Collins (1999:42), “an area for investigation is defined in terms of the important questions which have not been answered and in terms of the additional information still needed”. From this theory the researcher concluded the unit of analysis for this study to be spirituality, and the question not yet answered (or still requiring additional information) to be an exploration of the understanding patients and healthcare professionals at CHBAH have of spirituality.

During her exploration of the topic, the researcher worked at CHBAH as medical social worker and she interacted with various spiritual belief systems among healthcare professionals and patients. She then concluded that a shared understanding of spirituality among healthcare professionals and patients could contribute to the clarification of circumstances or specific factors considered when dealing with a patient’s healing process. This new knowledge could enhance service delivery through relevant assessment and screening procedures, being more responsive to the patient’s needs, in order to expedite recovery. Research suggests that spiritual systems are so varied and personal, that the successful use of spirituality in counselling, therapy or caregiving often considered a farfetched ideal (Gerrie, 2008:6; Kasiram, 2006:16-18).

Similarly, South Africa is a country of spiritual diversity. However, due to the dispensation of socio-political segregation, there had been very little interaction among the variety of spiritual traditions prior to of residential areas, education and health services, more and more South Africans have come to encounter people of different spiritualities. This has led to a growing interest in the topic of spirituality among healthcare professionals and other disciplines (Gerrie, 2008:3). Despite this

growing recognition and the effect of so many spiritual values and beliefs, the topic is still in its infancy in the field of social work (D'Souza, 2007:S59). In addition, spiritual issues in the lives of clients or patients neglected because social workers and other healthcare professionals lack the knowledge and skills to address these issues in practice (Galanti, 2004:99). Patients at CHBAH represent a diverse variety of cultures and religions. This fact has brought medical social workers and other healthcare professionals to the realisation that they should be prepared to acknowledge the spirituality of these patients as well as incorporate it into their health interventions.

The validity of spirituality in social work practice is described by authors like Dudley and Helfgott (1990:56) in terms of its relevance in a variety of social work contexts. For example, understanding spirituality is essential to understanding the culture of numerous ethnic groups. Spirituality can become increasingly important during specific stages of a person's life: in times of birth, terminal illness, death, transition, loss, and celebration. Knowledge of spirituality is thus important for those working in a healthcare setting. Shermabeikian (1994:40) and Koenig (2000:54) contend that spirituality is an important feature of social work practice and ethics, considered a topic for education and clinical training. They believe that the relationship between the social worker and the patient or client does not only involve the traditional interventions, methods and skills, but also a two-way relationship that includes an exchange of beliefs, values and ideas that may or may not be directly addressed in clinical practice. According to Shermabeikian (1994:44), having a spiritual value or belief may be a powerful resource in the client's life that can be used in problem-solving, coping, processes of recovery or emotional healing.

Several articles that advocate for the inclusion of spirituality in both social work practice and education in social work literature contend that the topic is still a controversial one (Sarajjajool, 2006: 523). Most of this controversy is a result of the relationship of spirituality to religion (Cascio, 1998:16). According to Tyson and Pedersten (2001:6) spirituality is viewed as the spiritual belief to a Supreme Being who, in relation to health, is viewed as the spirit behind healing powers. To provide further background, a number of relevant concepts described in the contextualization of the problem.

1.3 MEDICAL SOCIAL WORK

According to Bender (2006:3), medical social work is defined as a specialisation field, which addresses health issues from a broad perspective. Healthcare incorporates all health-related areas, including mental healthcare, HIV (human immunodeficiency virus) and Aids (acquired immune deficiency syndrome), chronic care, women's and reproductive health, child and adolescent health, geriatric health, persons with disabilities, trauma and acute care, palliative and terminal care, rehabilitation, as well as primary healthcare to voluntary groups. In this study, the focus is on the understanding of spirituality among social workers, other healthcare professionals, and patients at CHBAH.

1.4 SPIRITUALITY

Sarajjajool (2006:6) defines spirituality as the coexistence of the inner realisation of something bigger than our life experiences and us. D'Souza (2007:S57) states that, although spirituality is a globally acknowledged concept, there is no consensus on how to define it. In *The turn to spirituality*, Korie (2006:104), however, manages to capture both the essence and diversity of the concept: "Spirituality refers to the

raison d'être of one's existence, the meaning and values to which one ascribes". Thus, everyone has spirituality, be it in a nihilist, materialistic, humanistic, or religious sense. There are diverse spiritualities of which each is culture-specific and expressive of its own historical, sociological, theological, linguistic, and philosophical orientation (D'Souza, 2007:S58). This study pays attention to the spirituality of a variety of religions, determined by the patients involved.

From these descriptions, it is clear that spirituality is a complex concept to define. It can be a coping mechanism of patients with health challenges, but ignorance and uncertainty about spirituality may hinder medical social workers and other healthcare professionals from including spirituality in intervention (Bay, 2006:343). These arguments lead to the research question described in paragraph 1.5.

1.5 RESEARCH QUESTION

The primary research question, which this study attempted to answer, was:

What is the understanding of spirituality among healthcare professionals and patients at CHBAH?

In view of this primary research question, the following secondary research questions formulated:

- What does a literature review produce regarding spirituality in healthcare?
- What are the views of healthcare professionals and patients concerning the relevance of spirituality in their day-to-day lives and intervention?
- What are the spiritual needs of patients and to what extent does spirituality contribute towards their coping with health-related issues?

-
- Which practical and scientific recommendations can be offered to healthcare professionals regarding spirituality in CHBAH?

1.6 AIM AND OBJECTIVES OF THE RESEARCH STUDY

According to Fouché and De Vos (2011:92), the terms ‘aim’ and ‘goal’ used interchangeably to refer to “the end towards which effort or ambition is directed”. Struwig and Stead (2001:135) indicate that the aim “delineates (describes) the scope of the research effort and specifies what information needs to be addressed by the research process”. The researcher concurs with the views of these authors. Thus, the general aim of this research study was:

- **To explore and describe the understanding of spirituality among patients and staff at CHBAH.**

In view of the general aim, the researcher identified the following specific objectives for this study, namely to:

- To explore spirituality in healthcare by means of a literature review;
- To explore and describe the views of medical social workers and other healthcare professionals about the relevance of spirituality in a healthcare setting;
- To explore and describe the understanding of spirituality among healthcare professionals and patients in CHBAH;
- To propose a protocol as an organizational framework on the incorporation of spirituality in healthcare at CHBAH. This protocol should be implemented during social workers’ and other healthcare professionals’ interactions with patients.

1.7 METHODOLOGY

At present, there are two well-known and recognized approaches to research, viz. the qualitative paradigm and the quantitative paradigm (Fouché & Delport, 2005:73-76). This study utilised a qualitative methodology (Fouche & Schurink, 2011:307-327). The methodology is briefly outlined, and described in more detail in chapter 2.

1.8 TYPE OF RESEARCH

The type of research applied in this study was applied research, as the aim was to improve service delivery. In the words of Rubin and Babbie (2001:79): “Applied research, however, is aimed at solving specific policy problems or at helping practitioners accomplish tasks. It is focused on solving problems in practice”; and Fouché & Delport (2011:108) “applied research is the scientific planning of induced change in a troublesome situation”.

1.9 RESEARCH DESIGN

Whereas a research design is a plan or a blueprint of how the research is to be conducted (Grinnell & Williams, 1990:45; Mouton, 2003:45), the research method refers to a systematic, methodological and accurate execution of the design (Fouché & Delport, 2005:75). Given the qualitative nature of this study, a descriptive, exploratory research design was considered the most applicable (Alston & Bowles, 2003: 32; De Vaus, 2001:1).

1.10 RESPONDENTS

The researcher used a non-probability sampling technique, called convenience sampling (Strydom & Delport, 2011:390), to enroll patients admitted to medical wards and specialised clinics of the Chris Hani Baragwanath Academic Hospital.

The motivation for the choice of this institution was the fact that patients admitted to these wards were most often diagnosed with conditions related to life phases in which a person might need a multi-disciplinary intervention that would necessitate an exploration of spirituality. The respondents participated in a spiritual journey and focus group to determine their understanding of spirituality whilst in the hospital environment. The point of data saturation determined the number of respondents. Healthcare professionals employed at Chris Hani Baragwanath Academic Hospital were also selected by means of purposive sampling and participated in focus groups to determine their understanding of spirituality in the healthcare setting.

1.11 METHODS OF DATA COLLECTION

The researcher collected data from respondents who were patients and healthcare professionals at the CHBAH in the Gauteng Province. The researcher utilised qualitative data-collection methods and techniques by including a plotting and analysis of spiritual journeys of healthcare professionals and focus groups (Greeff, 2005:287-309).

1.12 PROCEDURES

The researcher followed the following steps to structure the research process:

- Obtained consent to conduct the study from the Superintendent of the CHBAH and the Gauteng Provincial Department of Health (see addenda 2)
- conducted a relevant literature study (see chapter 3)
- Compiled and planned the applicable data-collection procedures (see addenda 6 and 7)
- Identified and recruited potential respondents.
- Obtained in writing the informed consent of respondents (see addendum 3)

-
- Began collecting data.
 - Analysed the collected data.
 - Compiled the research report and disseminated the data.

1.13 DATA ANALYSIS

Data analysis refers to the procedure(s) according to which the data is analysed (Weinbach, 2003:275). For the purpose of this study, the data was thematically analysed following Tesch's approach (Poggenpoel, 1998:334).

1.14 ETHICAL ISSUES

“Ethical guidelines serve as standards and the basis upon which each researcher ought to evaluate his own conduct” (Rubin & Babbie, 2001:470). The researcher is a registered social worker at the South African Council for Social Service Professions. She was able to conduct the research, as she was in daily contact with the target group in the course of her tasks as manager. For researchers in social sciences, the ethical issues are pervasive and complex, since data obtained at the expense of other human beings. The following ethical concerns, as stipulated by Mark (1996:40) and Strydom (2011:115), thus received attention in this study:

- Voluntary participation.
- Informed consent.
- Confidentiality.
- No violation of privacy.
- No harm to respondents.
- No deception of respondents.
- Ethical release of the findings.
- Ensuring action and competence of researchers.

-
- Cooperation with contributors.
 - Debriefing of respondents.

1.15 KEY CONCEPTS

Spirituality

Healthcare

Healthcare professionals

1.16 LIMITATION OF STUDY

The limitations of this research study are as follows:

- The research study was conducted with a sample of 48 respondents from healthcare professionals and patients from CHBAH, which may limit the generalization of the study.
- The study is qualitative in nature therefore no casual relationships between factors can be inferred.
- The study is exploratory, and data obtain are descriptive in nature.
- Some participants did not feel free to discuss their opinions, as they feared that their voices could be identified on tape. The motive for recording responses was explained to the participants, who were aware that CHBAH would not have access to the tapes.
- The smaller groups of allied professionals allowed for open discussion and the sharing of individual opinions. In larger groups, participation was more restricted.
- During the focus groups for healthcare professionals, the doctors were unable to participate due to their schedule on that day. Thus, the representation of healthcare professionals was limited.

1.17 STRUCTURE OF THE RESEARCH REPORT

This research report consists of six chapters:

Chapter 1: Orientation to the study, Introduction of the title, key concepts, problem formulation, research questions, aim, objectives, and brief outline of the research methodology

Chapter 2: Research methodology

Chapter 3: Literature review on the exploration of spirituality/religion in healthcare

Chapter 4: The exploration and description of the understanding of spirituality among healthcare professionals and patients at CHBAH.

Chapter 5: The protocol to incorporate spirituality in healthcare at CHBAH

Chapter 6: Summary, conclusions and recommendations.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

The purpose of this chapter is to describe the research methodology followed in this study. This study conducted from a qualitative perspective and was both explorative and descriptive in nature (Alston & Bowles, 2003:35; De Vaus, 2001:1). The aim of the study was to explore and describe the understanding of spirituality among healthcare professionals and patients at CHBAH.

The research process derived from the phases of the qualitative research framework outlined by De Vos (2002:84-85).

Phase one presents the research topic selection and research formulation, while phase two presents the research planning. Following is the description of what each phase entails;

2.2 PHASE 1

2.2.1 Selection of a researchable topic

The identified research problem formed the basis of this study. The researcher identified the research problem from literature, personal experience and an emphatic need for such research felt within the Department of Health and Social Services. The researcher judged the topic as researchable, based on her personal experience at CHBAH. Secondly, if implemented appropriately, it would contribute positively to addressing existing challenges at CHBAH.

Before a researcher can conduct research, there must be a research problem and a formulated answer to the research question (Fouché and Delport, 2011:70). In this instance, the question was, “What is the understanding of spirituality among healthcare professionals and patients at CHBAH?” Thus, the researcher was convinced that her research topic met the requirements as stated by (Fouché and Delport, 2002:70.)

2.2.2 The research approach

The qualitative research approach was chosen. Fouché and Delport (2011:65) note that the qualitative paradigm stems from a naturalistic interpretative approach, and aims to understand social life as well as the meaning people attach to everyday life. This approach attempts to elicit participant accounts of meaning, experience or perceptions, and the data produced is descriptive, thus allowing the researcher to be concerned with the meaning. Neuman (2006:144) states that, while qualitative research attempts to explain how people attach meaning to certain events and learn to see events from multiple perspectives, qualitative data involves the documentation of real events, recording what people say and observing specific behaviour. For the purpose of this research, the focus was on exploring the understanding of spirituality among healthcare professionals and patients at CHBAH. This approach was appropriate, as it enabled the researcher to collect data that could answer the research question. Secondly, a qualitative research method is appropriate to address issues of real life as respondents in the research experience them, as in this case.

2.3 PHASE 2: PLANNING

2.3.1 Research strategy

Selecting an appropriate research design is essential for any study, as it provides the map as well as different paths to follow during the research (Creswell, 2006:281). The researcher decided on the explorative and descriptive research design, as it was the most appropriate strategy for this particular research. Bless *et al.* (2006:47) are of the opinion that the purpose of exploratory and descriptive research is to gain a broad understanding of the situation, phenomenon, community, or person. In order to explore how healthcare professionals and patients at CHBAH understand spirituality, the researcher utilised these strategies. This proved to be appropriate, as the researcher gained a better understanding of the respondents.

2.3.2 Preparation for data collection and analysis

2.3.2.1 Population

Arkava and Lane define 'population' as referring to individuals in the universe who possess specific characteristics as cited in (Strydom & Venter, 2002:198). The researcher defined "population' as the total set of elements or entities the researcher is interested in (and focuses on), and to which the results obtained can be applied to. For this study, the population was healthcare professionals and patients at Chris Hani Baragwanath Academic Hospital. The researcher's decision to focus on this hospital in Gauteng proved suitable, as the area was most accessible to her, and it is characterised by diversity in spirituality amongst both healthcare professionals and patients.

2.3.2.2 Identification of respondents and sampling plan

Preparation

The preparation for data collection involved decisions about the sites of data collection, the population, as well as sampling procedures. The researcher chose the purposive non-probability sampling the sampling procedure. Strydom & Venter (2002:202) as "sampling done without randomisation" define the non-probability sampling. While Creswell (2006:334) defines purposive sampling as the purposeful selection of participants, chosen because they illustrate some feature or process that is of interest to the particular study, which was as follows:

- 12 nursing personnel
- 16 social workers
- 10 physiotherapists
- 10 occupational therapists
- 30 patients in three separate sessions.

The sampling criteria used were:

- The ability to understand English and/or any African language.
- Respondents to be patients and healthcare professionals at CHBAH.

-
- The willingness to participate.

The researcher found the criteria to be suitable, even though English proficiency was not a crucial factor due to the availability of a research assistant fluent in English and other African languages.

2.4 PHASE 3: DATA COLLECTION

2.4.1 Implementation

Empirical data gathered via the mapping of spiritual journeys and focus-group discussions from both health care professionals and patients (Creswell, 2006:20; Neuman, 2006:13). Focus-group interviews held with four groups of healthcare professionals (nurses, social workers, physiotherapists and occupational therapists) on different days (see Table 5 in chapter 4). In the total group of healthcare professionals, medical practitioners did not participate due to reasons that were beyond the researcher's control (for example their duty schedules). Another session held with patients (see Table 10 in chapter 4) and the findings presented separately under empirical findings in chapter four. Each respondent consented to sessions being voice-recorded and to his or her opinions reflected in reports on the focus group. The concept of a focus group explained: that participation was voluntary, that discussions were confidential, and that all respondents treated with respect.

The interviews conducted in English and various African languages. This was done to accommodate all respondents. The data transcribed into English. Bless and Higson-Smith (1995:110) describes focus groups as consisting of between four and eight respondents; interviewed together and selected according to explicitly stated criteria. Greeff (2005:305) defines focus groups as group interviews that focused, since they involve some kind of collective activity. However, in this study the researcher had more than eight respondents in her group. The fundamental reasons for the bigger numbers was the interest health professionals had in the topic, and the fact that the researcher was well known and had good relationships with managers and patients at the institution. Furthermore, some respondents opted to participate only in mapping their spiritual journeys; these spiritual journeys are included in chapter 4 on research findings. The researcher compiled open-ended questions and topics to elicit discussion amongst respondents. Having primarily

researched the topic in her pilot study, the researcher developed an interview schedule for the focus groups (see Addenda 4 and 5).

2.4.2 Pilot study

According to the Terminology Committee for Social Work (1995:45), a pilot study is the process whereby the research for a prospective survey is tested. The pilot study regarded as a small-scale trial run of the aspects planned for use in the main inquiry. The researcher believes a pilot study fine-tunes the research for further inquiry and helps to determine whether the methodology, sampling methods and analysis are adequate and appropriate. The researcher agrees with Babbie (2001:220) that a pilot study is a manipulated walk-through of the entire study design. Strydom and Delport (2011:384) states that the purpose of the pilot study is to improve the success and effectiveness of the investigation, therefore some explication must be given of the data-collection method used.

The researcher had executed a pilot study in the same manner as the planned main investigation. Prior to interviewing, the required information must be defined and an interview schedule drawn up. Because focus groups are designed to promote self-disclosure, the researcher conducted a pilot study and tested among CHBA Healthcare professionals and patients who were eventually not included in the sample, using the focus-group interview schedule. The pilot study assisted the researcher in determining the order and appropriateness of the questions asked, acting as a dress rehearsal for the focus group that ultimately formed part of the study. There were 10 patients and 12 healthcare professionals who participated in the pilot study.

Babbie (2001:216) states that if a measuring instrument thoroughly tested during the pilot study, certain modifications made before the main investigation, if necessary. This helps to improve the measuring instrument and ensures a more meaningful main investigation. The researcher believes that testing the measuring instruments help determine their applicability to the situation, as well as their validity, reliability, and sensitivity.

The interview schedule was tested, and the suitability of the data-collection procedures and sampling procedures (sampling frame) was tested. Strydom, (2005:216) recommends this to refine the questionnaire. The pilot study helped

determine the appropriateness of the predetermined questions. The order of the questions asked and the phrasing of some of the questions needed explanation to respondents.

The researcher is of the opinion that the data collection method was appropriate, as it provided responses to the research question; secondly, it depicted the real experiences of the respondents.

The researcher later found that she herself and the respondents had benefited from sharing their experiences in these focus-group interviews. Comparing different experiences seemed to empower the parties in terms of knowledge of various spiritual beliefs and the extent to which spirituality was underestimated. Greeff (2005:360) who states that focus groups fundamentally designed for listening to people and learning from them, thus exploring various views, supports this statement. The focus-group setting allowed interaction between the researcher and the respondents, and was conducted in a non-directive manner and facilitated as a free and open discussion by all respondents, as all were able to voice their opinion. Neuman (2006:296) compares the advantages and limitations of focus groups as summarised in Table1:

TABLE 1: ADVANTAGES AND LIMITATIONS OF FOCUS GROUPS

Advantages	Limitations
Respondents may query one another and explain their answers to each other.	Researchers cannot reconcile the differences that arise between individuals and the focus group regarding context responses.
People tend to feel empowered, especially in action-orientated research projects.	A moderator may unknowingly limit open, free expression of group members.
Open expression amongst members of marginalised social groups is encouraged.	Only a limited number of topics can be discussed in a focus-group session.
The interpretation of quality survey results is facilitated.	Focus-group studies rarely report all the details of a study design/procedure.

Natural setting allows people to express opinions/ideas freely.	A polarization effect exists (attitudes become extreme after group discussions).
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The above listed advantages and limitations provided an excellent guideline during the planning phase of the focus group; pitfalls avoided and the researcher could ensure that specific data collected during this exercise. The researcher agrees with Creswell (2006:215) focus groups are used to collect shared understandings from selected individuals. In this case, the aim was to collect opinions from specifically identified people: healthcare professionals and patients at CHBAH.

2.4.3 Focus-group procedure and practical arrangements

Arrangements made the researcher to travel to the hospital to conduct the focus-group discussions. Invitations sent out, dates agreed upon with all respondents, and attendance confirmed with the respondents. During the focus-group discussions, the practical arrangements made:

- English, Afrikaans and any other African language used during focus-group discussions.
- All respondents completed and signed a consent form (see Addendums 4 and 5), certifying that they participated voluntarily and that the data from the discussions could be used anonymously in the research report.
- Biographical information regarding respondents and their work experience completed as part of the attendance register (summarised in Table 5 and 10 in chapter 4).
- Ethical aspects such as confidentiality discussed with respondents and the research approval obtained from the Research proposal and Research Ethics Committee (see Addendum 1).
- Respondents were then invited to voluntary participate in focus-group discussions (see Addendum 3).
- The ground rules for discussions were agreed upon as set out in the focus-group guideline that was handed to each respondent (see Addendums 6 and 7)

-
- Permission to audio-record the focus-group discussions obtained and interviews structured according to a focus-group guideline.

The focus-group sessions facilitated at CHBAH in April 2012. Only 10 healthcare professionals participated in the plotting of a spiritual journey.

2.4.4 Process and procedure for plotting the journeys

The researcher gave the respondents a guide for plotting their spiritual journey, followed by the following request:

- Use the sheet of paper provided to draw the road of your life from birth until today. You may decide which information should be included on your road, but it should include information about your work.
- After you have made your life road, mark with an 'F' all incidents in your life that you associate with feelings of joy, sorrow, pain, coping, or hope.
- Then, look at your road of life and think about any spiritual or personal rituals you might have followed to help you deal with challenges or joys in your life. Mark these with the letter 'B'.
- On your map, indicate times when you experienced or needed religious (spiritual) support from your church, community, family, friends or anyone else and mark these with the letters 'RS'.
- Look at your map, indicate in which instances spirituality played a role in your life situation, and mark these with the letter 'C'.

It is important to note that themes deducted from the spiritual journeys only refer to healthcare professionals who participated in this study. The patients did not participate in spiritual journeys.

The processing, analysis and interpretation of data subsequently described.

2.5 PHASE 4: DATA PROCESSING, ANALYSIS AND INTERPRETATION OF RESULTS

Greeff (2005:318) notes that data analysis is systematic, sequential, verifiable, and continuous, and seeks to enlighten. Data analysis incorporates the complexities of the group interaction, and is undertaken after data collected. De Vos (2005:340)

views the process of data analysis as a spiral, with the researcher moving in analytic circles. The steps in this circle consist of collecting and recording, managing, reading, writing notes, describing, classifying, interpreting, representing, and visualising the data. Therefore, qualitative data analysis can be summarised as a process of bringing order, structure and meaning to the mass of collected data.

2.5.1 Data analysis

Feedback from the focus groups integrated and summarised using thematic analysis. Braun and Clarke (2006:79) state that thematic analysis are used for identifying, analysing and reporting patterns as they are found in the data. In this way, the meaning constructed by respondents regarding specific phenomena captured (Niewenhuis, 2007:102). According to Braun and Clarke (2006:83), it further aims to minimally organise and describe data, providing a rich and detailed, but also complex account of data.

Many researchers prefer qualitative thematic analysis, as it is easy to access and focuses on the level of meaning (Henning *et. al*, 2004:94). It involves a process of constantly moving back and forward in data sets (Braun & Clark, 2006:86). This forms part of data analysis, as it implies an intertwined process of data collection, process analysis and reporting instead of a mere succession of steps (Niewenhuis, 2007:105). Braun and Clarke (2006:87) identify six phases in the process of data analysis.

In this study, these steps combined with Tesch's analytic process (Creswell, 2006:238-39), to ensure data quality and trustworthiness remains intact as far as possible during this process. Threats to trustworthiness, such as respondent biases, taken into account in this process, as data from seven the focus groups constantly compared to identify differences and report as such. The phases of data analysis implemented in this study were:

- **Phase 1 – Becoming familiarised with the data:** All sessions with focus groups were voice recorded and typed afterwards. The researcher then read the data to become familiarised with the content of transcripts and to have a broad overview of all the information contained in the data.

-
- **Phase 2 – Generating initial codes:** The transcribed sets of data collected from both patients and health care professionals were analysed and every identified concept coded.
 - **Phase 3 – Searching for themes:** All four sets of data were reviewed for concepts pertaining to the understanding of spirituality.
 - **Phase 4 – Review and refinement of themes:** The data sets from all focus groups were combined into one set of data per refined code.
 - **Phase 5 – Defining and naming of themes:** The essence of each refined theme in the data set was identified and the theme was fit into the overall broad theory of spirituality.
 - **Phase 6 – Production of a report:** The data was organised into a logical structure to provide feedback of the information collected.

The analysis of interview transcripts and field notes based on an inductive approach, geared to identifying patterns in the data by means of thematic codes. “Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis” (De Vos 2011:306). Data was analysed using the constant comparative method (Glaser & Strauss, 2000:20) whereby line, sentence and paragraph segments of the transcribed interviews and field notes were reviewed to decide what codes fit with concepts suggested by the data (see Addendum 8 for a copy of the transcribed data of one focus group).

2.5.2 Data obtained from focus-group discussions

Seven focus groups (four for healthcare professionals and three for patients) with 78 respondents facilitated. To complement notes taken during these sessions, responses during focus-group discussions recorded via data voice recorder. Secondly, data gathered through the focus groups, transcribed verbatim and then analysed for themes and sub-themes (Braun & Clark, 2006:79). Verbatim quotes recorded according to themes and sub-themes, and substantiated with literature (see chapter 4 on research findings). Creswell (2006:237) describes the coding of data as a process of segmentation and labelling text according to descriptions and broad themes in the data. Although there are usually no set guidelines for coding,

Creswell (2006:238-239) refers to Tesch’s analytical process and describes a number of steps in the process for narrowing data into broad themes.

2.5.3 Data obtained from mapping of the spiritual journey and narratives

The details of how the process unfolded discussed in chapter 4. It should be noted that not all focus-group members participated in the mapping of the spiritual journey. However, the researcher was able to compile the report with the information of those who participated, as data saturation reached.

The phases of data coding, as described by Braun and Clarke (2006:87), applied in this study and, are summarised in table 2. Detailed feedback on the results discussed in chapter 4.

TABLE 2: PHASES FOLLOWED IN THE CODING OF DATA

Phases	Phase description
Becoming familiarised with the data	Get a sense of the whole, read everything, and analyse data as collected from the focus groups. Make notes as themes come to mind.
Getting initial codes	Choose one document (script/field note). Choose the most interesting, and the shortest, read through it to decide what it is all about. Make a note on the side with a box around it.
Searching for themes	Begin coding and identifying text segments and assigning a code word/phrase that best describes the content.
Review and refinement of themes	After coding the entire text, make a list of code words. Group similar codes together. Identify redundant codes and eliminate.

Define and name themes	Review data with the list and see if new codes emerge.
Production of the report	Reduce the list of codes that best describe the content of the data. This can be done by looking at themes most commonly discussed by respondents, most surprising themes, themes supported by most evidence, or themes that most correlate with literature.

The codes/data from this process enabled the writing of a qualitative report providing detailed information on specific themes rather than general information on many themes. Findings from the focus groups crosschecked with focus-group discussions and literature that was studied in the initial stage. The researcher is of the opinion that the findings of the study would be transferable to a similar setting with a similar population. The detailed feedback on the results of this study will be described in chapter 4.

2.6 ETHICAL ISSUES

Ethical guidelines “serve as the basis on which each researcher ought to evaluate her own conduct” (Strydom, 2011:114). Anyone involved in research needs to be aware of the general agreements about what is proper or improper in scientific research (Babbie, 2001:470). Having obtained ethical approval from the North-West Research Proposal and Ethics Committee (see addendum 1), the researcher took note of ethical guidelines, which were adhered to in the following manner:

The following ethical principles handled during the operation of the research study:

2.6.1 Informed consent and voluntary participation

The researcher ensured that respondents signed an informed consent form before they made the decision to participate. This was done in a written format and explained that no one would be coerced into participating; respondents were free to withdraw their participation at any given time (see addendum 4 and 5).

2.6.2 Violation of privacy/anonymity and confidentiality

Strydom (2011:119) views the right to privacy, self-determination and confidentiality as synonymous. Strydom (2011:119) states that privacy in its most basic meaning is to keep to oneself that which is normally not intended for others to observe or analyse. The researcher believes it is important to safeguard the privacy and identity of respondents. The privacy and confidentiality of the respondents was, therefore ensured through proper, scientific sampling. Access to collected data was also controlled, and will continue to be controlled, as the focus group tapes will be stored in a safe at the Department of Social Work, at the University of North-West, thereby restricting access to the data.

2.6.3 No deception of respondents

This principle refers to avoiding deliberately giving inaccurate information or withholding information from the respondents (Struwig & Stead, 2001:69). The researcher understands deception as deliberately withholding the truth for personal gain. The researcher withheld no truth for personal gain as this study is purely for academic purpose, deceived none of the respondents in this study, all respondents were fully informed about the study.

2.6.4 Actions and competency of the researcher

The researcher conducted the research under the direction of experienced supervisors at the North-West University. The researcher endeavoured to evaluate all possible risks and advantages of the investigation and assumed responsibility for honouring promises made to respondents (Strydom, 2011:123).

2.6.5 No Harm to the respondents

According to Strydom (2011:115), respondents could be harmed in a physical and/or emotional manner. Babbie, (2001:471) states that respondents may ask questions that elicit anxiety, embarrassment and loss of self-esteem, dredge up unpleasant memories or cause them to evaluate themselves critically.

For the purpose of this study, the researcher minimised the risk of harming respondents by restricting the obtaining of sensitive information only to what was relevant for the study. The researcher believes the potential for emotional distress

may be reduced by wording sensitive questions carefully, and offered respondents the opportunity to withdraw from the participation if they so wished.

2.6.6 Cooperation with contributors

The Medical advisory Committee of the CHBAH gave their permission for the study (see Addendum 2). The Research Proposal and Ethics Committee of the Faculty of Humanities, North-West University, Potchefstroom Campus (see Addendum 1), also granted approval for the research.

2.6.7 Ethical release or publication of the findings

The findings of the study to be introduced to the reading public in written form; otherwise, even highly scientific investigations would mean very little in terms of research (Strydom, 2011:126). The findings of this study recorded in this research report submitted to the North-West University in the form of a thesis. A copy handed to the authorities at CHBAH. The researcher will also submit two manuscripts to accredited social work in health journals for the review and possible publication.

2.7 IN CONCLUSION

The qualitative approach was classically applicable, as the information gathered was in the form of words and descriptions intended to give meaning to the social reality as experienced by the healthcare professionals and patients. The researcher was able to obtain first-hand information by means of the focus-group interview schedule (Addendums 6 and 7), as it allowed for further exploration of topics as they arose. Therefore, the data-collection methods – the focus-group interviews (with both healthcare professionals and patients) and the mapping of the spiritual journey narratives (by healthcare professionals – worked effectively in answering the research question.

The next chapter focuses on the exploration of literature on spirituality and health and the researcher's observation and experience regarding the database of patients in CHBAH.

CHAPTER 3

SPIRITUALITY IN HEALTH CARE: AN EXPLORATION OF THE LITERATURE

3.1 INTRODUCTION

This chapter provides a literature review on spirituality in health care, an overview of CHBAH as well as a short overview on the researcher's observation and experiences as a medical social worker at CHBAH. These experiences piqued the interest of the researcher, and led to the research. The following areas are covered:

- The researcher's personal experiences and a situational analysis conducted by the researcher at the CHBAH.
- Definitions of spirituality, various religions, and spirituality and healthcare.
- Some noted positive outcomes of spirituality/religions and conclusions.

For the purpose of this study, the terms 'spirituality' and 'religion' will be utilised interchangeably.

Because of the growing interest in the relevance of spirituality in health, the topic warrants continuous research. The researcher therefore conducted an extensive search into literature relating to the topic. An attempt was made to draw a comparison between the literary findings and the researcher's experiences during her social work practice at CHBAH. This exercise allowed the researcher to arrive at some conclusions and make valid recommendations.

During her social work practice at Potchefstroom Hospital and CHBAH, the researcher met patients of various spiritual beliefs. These encounters led to an interest in exploring different religions and the understanding social workers had of their patients' spirituality during interventions.

AN OVERVIEW OF THE CHBAH

The history of the Baragwanath hospital started soon after the discovery of gold on the Witwatersrand when a young Cornish lad, John Albert Baragwanath, arrived on the gold fields to make his fortune. The surname "Baragwanath" was derived from the Welsh word "Bara", which means bread, and "gwanath", which means wheat. He established a small trading post, the Wayside Inn, which became an informal hospital during World War II. In September 1940 the Secretary of State in London formally asked the South African Government if it would provide health care facilities for Imperial troops of Middle East Command. The British War Office suggested that two hospitals of 1 200 beds be built in South Africa and after due consideration one of these hospitals was designated for Johannesburg. In November 1941 construction started on the ground near the place where the old Wayside Inn had been situated. The British Government invested 328 000 pounds for a hospital with 1 544 beds. A number of names were considered for this hospital, but in the end it was named "The Imperial Military Hospital, Baragwanath". The first patients were admitted in May 1942 and Field Marshall Smuts officially opened the hospital on 23 September 1942 (Chris Hani Baragwanath Hospital, 2014).

Over the next 30 years, this hospital rapidly grew in size and status and today it not only provides for Soweto, but also serves as referral hospital for a large part of the country, including surrounding African States. It further contributes towards the training of health professionals and doctors graduating from the University of the Witwatersrand benefited significantly from the experience gained in this hospital. . After the tragic murder of the prominent activist, Chris Hani in 1997, his name was coupled to that of Baragwanath, to give the hospital the name "Chris Hani Baragwanath Hospital". This name was also further extended to include the academic nature of the hospital and today it is known as the Chris Hani Baragwanath Academic Hospital (CHBAH). Actually, the CHBAH can be seen as a microcosm of the economical and socio-political situation of South Africa.

Today, the CHBAH is the largest hospital in the world, occupying around 173 acres (0.70 km²), with approximately 3 200 beds and about 6 760 staff members. It is one of the 40 provincial hospitals in the Gauteng province and academic hospital for the University of the Witwatersrand Medical School, along with the Charlotte Maxeke

Johannesburg Academic Hospital, Helen Joseph Hospital and the Rahima Moosa Mother and Child Hospital. The mission of the CHBAH is to:

- Achieve the highest level of patient care based on sound scientific principles and administered with empathy and insight.
- Train healthcare professionals to be the best equipped and motivated to serve the sick and injured.
- Maintain and defend truth, integrity and justice for all, at all times, to the benefit of patients, staff and the community (Chris Hani Baragwanath Hospital, 2014).

The researcher had the privilege to be employed as medical social worker in the CHBAH and found the diversity and cosmopolitan nature of the patients and staff in this hospital to be an excellent population for this study.

3.2 A SUMMARY OF PATIENTS' RELIGIOUS AFFILIATIONS

The researcher obtained the database of patient admissions at Chris Hani Baragwanath Hospital ranging from January to June 2011, and took a sample of 40 patient admission files. The purpose of this was to explore the various religions to which patients belonged. The results are summarised in table 3.

TABLE 3: RELIGIOUS AFFILIATION OF PATIENTS ADMITTED TO CHBAH DURING JANUARY- JUNE 2011.

African religion	Baha'i	Buddhism	Christianity	Hinduism	Islam
8	2	3	14	3	10

3.3 CONTEXTUALIZING SPIRITUALITY

As mentioned, interest in the topic of spirituality has risen among social work educators and healthcare professionals. During the last decade, the social work profession has realised that spirituality, as a basic dimension of human development can't be excluded from social work (Dudley & Helfgott, 1990: 33). Shermabeikian (1994:44) states that having spiritual values or beliefs may be a powerful resource in a client's life. This resource applied in problem solving, coping, the process of recovery, or emotional healing. In addition, spiritual issues in the lives of patients

often neglected because healthcare professionals may lack the knowledge and skills to address these issues. Often the matter disregarded as being beyond their scope of expertise (Gerrie, 2008:16). According to Fouché & Delport (2011:107), three factors determine how research problems formulated: namely, the unit of analysis, the research goal, and the research approach. Bless and Higson-Smith (2000:64) further simplifies this by describing the unit of analysis as “the person or the object from whom the social researcher collects data”.

The overall aim of this study was to explore and describe the understanding of spirituality among healthcare professionals and patients at Chris Hani Baragwanath Academic Hospital. Therefore, this literature review explores the main religions encountered at the hospital together with the influence of spirituality on health. What follows, is the definition of spirituality as per the literature review.

3.3.1 A definition of spirituality

The researcher gave a definition of spirituality in chapter 1 (1.4), however, for the purpose of this chapter she felt further definitions adds value to the study. According to Carroll (2001:25-34), spirituality is not necessarily synonymous with religion, but it is based on the person’s own philosophical beliefs that may be related to different religions/beliefs such as Christianity, Buddhism, Hinduism, Islam and atheism. Spirituality is difficult to define. On the one hand, it may mean an inner quality that facilitates connectedness with the self, other people and nature – a relative quality that each person defines uniquely (Shermabeikain, 1994:12). On the other hand, the traditional definition involves one’s acknowledgement of and relationship with a supreme being (Gerrie, 2008:23). Traditionally, spirituality is often defined as a basic or inherent quality in humans that involves a belief in something greater than the self (Hudson, 2010:1); the spiritual believe in a supreme being who is viewed as the spirit behind healing powers (Tyson& Pederson, 2001:6).

‘Religiosity’, a related concept, refers to religious attendance, practice or activity. Many people profess spirituality without religious affiliation. Some even consider that religiosity influences the response to signs and symptoms of illness through rituals associated with disease prevention and health protection (Gerrie, 2008:56). Religious practices and activities drive the religious response to disease (Musgrave

& Sheridan, 2005:99-126). Although spirituality and religion are intertwined, there are clear, distinguishing characteristics in each of these concepts. The term, *religion*, often refers to:

- A supernatural power to which individuals are motivated or committed;
- a feeling present in the individual who conceives such power and,
- the ritual act carried out in a respect of that power (Wulff, 1997:88).

The word “spirituality” is taken from the Latin root, *spiritus*, meaning breath of life and is frequently used in the Hebraic Old Testament (*ruach*) and Greek New Testament (*pneuma*). It is often referenced in the context of religion and through conventional religious understanding, but Spilka’s (1993) review of the literature led to the most contemporary understanding of spirituality where it is categorized to be one of the following three categories:

- **A God-oriented spirituality**, where thought and practice are perused in theologies, either broadly or narrowly conceived,
- **a world –oriented Spirituality** stressing one’s relationship with ecology or nature,
- or **a humanistic (or people-oriented) spirituality** stressing human achievement or potential.

It can thus be concluded that spirituality should be viewed as a multi-dimensional construct. Deriving from various authors’ opinions, but primarily on the work of Hill et al. (2000), the researcher summarized the distinguishing characteristics of religion and spirituality in table 4.

TABLE 4: CHARACTERISTICS OF RELIGION AND SPIRITUALITY

CHARACTERISTICS OF RELIGION	CHARACTERISTICS OF SPIRITUALITY
• Deals with the ultimate concerns of people	• Results in a search for meaning in life
• Provides personal as well as social identity	• Offers an encounter with the transcendence
• Offers transformation limited within	• Offers a personal transformation

in-group borders	
<ul style="list-style-type: none"> • Stipulates behavioral patterns and encourages adherence to practice certain forms of religious expression 	<ul style="list-style-type: none"> • Creates respect and appreciation for the mystery of creation
<ul style="list-style-type: none"> • Offers a community in the religious system 	<ul style="list-style-type: none"> • Cultivates a sense of community
<ul style="list-style-type: none"> • Pro-social tendency, both in terms of personality and values 	<ul style="list-style-type: none"> • A search for ultimate truth
<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Includes a reference to transcendence or the sacred, but not necessarily God or gods as defined within religious traditions
<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Emphasizes an individual reality of connection with transcendence, others, and the world in general, without necessarily belonging or referring to a particular religious institution or group

According to Zinnbauer and Pargament (2005: 103) "...there is fewer consensuses, however, on other issues, for instance, whether spirituality is a concept broader than religiousness and whether it reflects a dynamic rather than static, and an emotion-based rather than beliefs-based reality". Although there are many common characteristics found between religion and spirituality, they remain two multidimensional constructs with potentially rich and dynamic interaction. For the purposes of this study, the researcher will use the concept spirituality.

Edwards (1980:234) defines 'spirituality' as "the underlying dimension of consciousness that openly waits and searches for a transcendent fulfillment of our human nature". Johnson (2009:194) describes the essence of spirituality as being "the urge toward that greater reality, experienced in the psyche as the feeling that there is something we ought to know but don't, a great secret that we are searching for". Similarly, Joseph (2009:15) perceives that "spirituality is at the ground of our

being and seeks to transcend the self and discover meaning, belonging and relatedness to the infinite". According to Henriot (1992:13), the role that spirituality plays in one's life is that of clarification, motivation and sustenance.

Williams (2005:22) defines Christian spirituality for example as the quest for a fulfilled and authentic life that involves taking the beliefs and values of Christianity and weaving them into the fabric of our lives so that they animate and provide the breath, spirit, and fire for our lives. Traditionally, spirituality is defined as the sum total of the knowledge, skills and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (World Health Organization, 2001:1). According to Eagger, (2001:89) spiritual skills and values can be taught directly in education, Not least they can be self- taught, both under supervision and from books. These skills include kindness, compassion, generosity, tolerance etc.

Based on the definitions from different authors and literature, the researcher concluded that spirituality involves believing in a supreme being that might mean different things to different people.

3.4 AN OVERVIEW OF AFRICAN SPIRITUALITY IN HEALTHCARE

The following paragraph focuses on the overview of African spirituality and healthcare. Although, this topic discussed under 3.8.1, the researcher is of the opinion that this discussion is important. It provides an opportunity to compare the African perspective with what the respondents to this research said and further look whether there are similarities or differences (see findings in chapter 4), as most of the respondents in this research are from an African culture (see table 3 in chapter 3).

Historically, within Africa "...there has been no distinction between the sacred and the secular, between the religious and non-religious, between the spiritual and the material areas of life" (Mbiti, 2000:2). When one speaks of spirituality in Africa, one talks about a way of life; one talks about life itself (Mbiti, 2000:24). From the African perspective, spirituality connected with all aspects of human experience (Kimaro, 1993:33). Divinity and humanity share life together (Parrinder, 2000:45). Setiloane

(1986:89) perceives African spirituality as the experience rather than the formulation and expression of religion in set terms. It is something lived and practised, but not discussed. In fact, African religion is so integrated as a way of life that African languages have no word for 'religion' as such (Mbiti, 2000:56; Setiloane, 1986:67). Given this integration, the terms 'spirituality', 'religion' and 'theology' refer to the same experience.

Inherent in African spirituality is a deep understanding that it consists of very practical actions within relationships in the community. It is precisely this African notion of community that needs exploration in order that its relevance to healthcare professionals even in their first year of study can begin to make sense. "The most cherished principle in life together is to include rather than separate" (Setiloane, 1986:10).

A number of social work authors (Canada, 1989; 66, Dudley & Helfgott, 1990: 44, Joseph, 2009:77; Loewenberg, 1988) maintain that the human experience of spirituality has been somewhat neglected in social work education and practice. However, social work and spirituality given greater attention in recent years, the rationale being that the profession is rooted in spiritual notions of human dignity and social justice and those social workers operate from an ecological perspective with the purpose of enhancing the interactions between people and their environments. People seen only as bio-psychosocial beings, but also as beings with an existential dimension (Setiloane, 1986:69).

Some of the literature reveals that this realm within social work has indeed been explored (Canada, 1988: 45). The researcher's opinion, which has been confirmed by literature, has been that physicians, however, are often uncomfortable about talking to patients about sexuality and spirituality (Boyle et al, 2004:66). They may need to overcome the feeling of being voyeurs through training and experience, and by realizing the importance of patients' spiritual histories in providing adequate medical care. Lack of information corrected by education and by taking inventories of patients' beliefs. Entering the personal and intimate portions of patients' lives physically or psychologically is an important privilege of being a physician and results in professional gratification from knowing the patient as a person (Carroll, 2001:33).

At this point, it would be of interest to discuss the historical background of spirituality in health care to have an understanding on how it was or is incorporated. In 1986, Hiatt proposed expanding the medical model to a biosocial-spiritual model; in 1990, whilst in the Templeton Foundation influenced curricular development of spirituality in medicine (Joseph, 2009:12).

3.5 CONCLUSIONS

Based on the overview, the researcher's opinion is that, in light of the existing information, health professionals in general should be aware of the patient's spirituality and should mobilise churches/faith from different religions as resources and partners in healthcare. In helping to meet this goal, the researcher endeavoured to complete this reach and present findings to CHBAH management. The findings presented in a form of a protocol, will serve a framework on how to include spirituality in healthcare at CHBAH.

3.6 HEALTHCARE WORKERS AND SPIRITUAL ISSUES

Differences in spiritual care offered by social workers influenced by their awareness of their own spiritual and cultural beliefs (Carroll, 2001:34). It is, therefore, imperative that medical social workers and other healthcare workers be aware of their own spirituality in order to render spiritual care to their patients. However, there are many reasons why healthcare workers do not regularly address spiritual issues. Many are unaware of the reasons why time and energy expended on addressing spiritual issues; others do not feel comfortable addressing such issues, or do not have the time and are concerned about overstepping boundaries.

At this point, it would be of interest to discuss one of the spiritual models in relation to healthcare.

3.7 THE BIOPSYCHOSOCIAL-SPIRITUAL MODEL

According to Fadiman (1999:60), "Medicine was religion. Religion was society. Society was medicine". The researcher agrees with Fadiman on the interrelationship between the biological, psychological, social and spiritual aspects of a human being, especially during the holistic treatment process. The following paragraphs cover the views that other authors have of the model.

Another strategy that put forth as a constructive way to understand the diverse variables that determine psychiatric illness is the bio psychosocial-spiritual model. This model includes inherited and pathological mechanisms; psychological-developmental and experimental factors; social-cultural and environmental influences and spiritual assessment of individuals' spiritual-religious resources (Smylie & Conyers 1991:16). The bio-psychosocial-spiritual model of medicine is a way of looking at the mind and body as two important systems that are interlinked. A psychiatrist, George Engel, in an article in *Science* in 1997, proposed this model (Sulmasy, 2002:29). Therefore, the addition of a spiritual dimension to the model is not in order to imply that religious/spiritual activities or religious/spiritual failings cause disease, but rather to consider that spiritual issues in a patient's life may serve to support or hinder a return to health (Parrinder, 2000:98). D'Souza (2007:S57-S59) feels strongly that the incorporation of spirituality and religion into clinical practice "will not only improve patient care, doctor-patient relationships and a patient's being, but may well come to be seen as the Salvation of biomedicine".

In conclusion, the researcher believes this topic researched is relevant to literature. The literature has clearly indicated the positive role played by the spiritual dimension in health. The following paragraph covers faith-based communities and faith-based organisations in healthcare, as resources that could play a significant role in including spirituality in healthcare

3.8 FAITH-BASED COMMUNITY ORGANISATIONS IN HEALTHCARE

The Department of Social Development's 2011 report on the *South African Non-Profit Sector* indicates the importance of faith-based communities (FBCs). Faith-based organisations (FBOs) are the third biggest sector (12%=8839 out of 76175), after social services (34%) and development and housing (21%). This is followed by the health sector (11%=8723). The South African Government's National Strategic Plan for 2012-2016 on HIV (human immunodeficiency virus), STIs (Sexually Transmitted Infections) and TB (tuberculosis) recognises the important role played by the faith-based sector and the network it provides.

A hallmark of South African society, apart from its diversity and inequalities, is the religious involvement of people and communities. In the 2011 Census, questions

about spirituality or religion were not included. The 2001 Census indicates that more than 80% of all South Africans had some religious affiliation (<http://www.statssa.gov.za>). The *2012 Gallup Poll*, however, indicated a 19% decline in religiosity from 83% (2005) to 64% (2012) Magezi, (2008:55). A very interesting trend is that levels of religiosity in South Africa are much higher in low-income groups (60%) than in high-income groups (49%).

Magezi (2008:255) is therefore correct in emphasizing the church's contribution to national health and well-being. The church is a subsystem of the community and, as such, can influence the community and society (Magezi, 2008:273). As much as the church, a clinic or a hospital considered part of the community, FBCs and FBOs can make an important contribution to the function and impact of these facilities. The church also has access to and can offer physical and human resources to the community, part of which could be health-related (Magezi 2008:274). The church provides social and community cohesion and its leaders can play an important role in societal and moral transformation (Magezi, 2008:274). Magezi (2012:305) pleads for the repositioning of churches from the periphery to the centre in order to make a meaningful contribution to public healthcare and indicates three areas of participation:

- Increasing access to primary and preventative care
- Improve delivery and quality of healthcare
- Improve patients' self-management of their disease.

FBOs and CBOs can also play an important role in community healthcare and primary healthcare. De Grunchy (2007:99) indicates the value that religion can add to health. Religion offers:

- presence;
- an integration of tangible and intangible health promoting factors;
- relationships and networks; and
- An interpretive framework.

FBOs also provide context for care, compassion and hope. According to DeLaune and Ladner (2006:66), people throughout history have dealt with illness, loss, suffering, trauma and pain in spiritual ways. According to Louw (2008:118-122), illness might be seen as an inner conflict and existential crisis. It causes conflict with

the body, the self (identity crisis), the environment, and a crisis of faith and ultimately an existential life crisis in which our sense of purposeful direction questioned. Illness further threatens our will to live, confronts us with our mortality as well as with our past actions, and its consequences for the future. Representatives of that community (whether professional or volunteer) build a bridge to the faith community to communicate that we are part of a bigger group who share in our humanity and vulnerability. The faith-based community is also an important resource to support healthcare workers in their commitment to provide compassionate care (DeLaune & Ladner, 2006:105).

It is clear that spirituality and FBCs/FBOs have an essential role to play in the provision of holistic, individualised healthcare. This is internationally recognised and there are already excellent best-practice models available. However, the nature and extent of this contribution in the South African context and how it enhanced it is not easy to define; this should be the subject of further practical theological and health research. For purposes of this study, the potential value of spirituality in health services will be briefly explored.

3.9 THE POTENTIAL VALUE OF SPIRITUALITY IN HEALTH SERVICES

According to Gunderson and Pray, (2006:99) faith groups often accompany a person in times of ill health, injury, dependency and death and that this presence contributes towards the psychosocial and spiritual health of individuals and families from the earliest of times. Gary and Pray (2006:105) further state that the history of health facilities often rely on Biblical stories like the injured Samaritan where even the hospitality extended to the injured Samaritan required an inn with a staff, payment and guarantee of future reimbursement.

In modern medicine, hospitals and health care continue to absorb a very great deal of their financial and personnel resources from religious systems. De Gruchy (2006:90) points out that health care professionals are all just humans, who also need spirituality to treat and care for those who are sick. Inside both patients and health care professionals there are personal fears and hopes and awareness that life for each and every one will end one day. Gunderson and Pray (2006:188) summarise this by referring to the critical role of spirituality in

the lives of both patients and health care providers: “Thus health seekers (and all their connected affinities) and health providers (in all their webbed complexity) can be seen as shaped, animated, moved to some degree by their religious character. The lives of all involved can be understood partly by looking at the causes of life as having a religious aspect: how it reflects qualities of connection, coherence, agency, blessing and hope.”

The work of Goleman (2006:90) also highlights the role of spirituality in resonance and emotional intelligence in organizational theories and performance. Much of the contents of these theories rely on explicitly Buddhist values such as mindfulness, compassion and hope. Spirituality can thus be seen as an organizational asset which contributes towards the “...capacity of the living web that is a hospital to find connection, coherence, agency, blessing and hope with the larger life of the systems” (Goleman, 2006:91).

It can be concluded that spirituality offers assets for both health service providers and patients. An example of how spiritual health services can contribute towards the well-being of communities in Africa is captured in the Masangane case study described by Schmid et al. (2006:56-58). This case study focused on the evaluation of the Moravian Masangane ARV programme in the Eastern Cape the specific objective to assess the ‘value added’ by religion (spirituality) for all stakeholders in the programme. The results of this study concluded that religion (spirituality) contributed to health care in the following ways:

- The churches contributed towards **access to communities**;
- Religions groups greatly helped in terms of **advocacy** in terms of HIV prevention and AIDS treatment;
- Local congregations offer a **reservoir of willing volunteers**;
- **Religious liturgy and rituals** can be combined with daily medicine schedules, compliance with treatment and asking the blessing on such treatment;
- **Spiritual support and counseling** can contribute towards general health counseling;
- Patients who are **marginalised** through poverty or their HIV states can be reached through spiritual and religious groups;

-
- Belonging to a congregation or faith group offers some kind of **inclusivity**, irrespective of people's backgrounds;
 - Church groups often have a **long-established credibility** among community members and
 - **Religious norms, values and rules** can be useful for patients having to adapt to a chronic or life threatening disease.

It is clear that religion and spirituality have potential to greatly contribute towards the care and treatment of patients and the support to families and health care providers. In the next section, the different religions encountered at the CHBAH will be briefly explored and discussed.

3.10 RELIGIONS ENCOUNTERED AT CHBAH

The researcher encountered at least six dominant religions in social work practice at the Chris Hani Baragwanath Academic Hospital. These religions are African religion; Baha'i, Buddhism, Christianity, Hinduism and Islam (see Table 3). The following discussion includes their emblems, a brief description and meaning as seen relevant to the understanding of spirituality.

3.9.1 African religion

FIGURE 1: AFRICAN RELIGION EMBLEM – A ROUND CLAY POT (GERRIE, 2008:10)



According to Mbiti (2000:3), African religion is characterised by a variety of concepts and practices but there is a sufficient number of common features shared in sub-Saharan Africa to distinguish this religious orientation from other world religions.

Throughout Africa, there is a belief in a Supreme Being. One or more names describe him in terms of either his activities or his place of abode. This Supreme Being created and set the world in motion and God is, above all else, the creator of all things and, as such, the basis of all that is (Arazu, 2000:115). According to Ejizu (2001:197-214), an intermediary is used when the Supreme Being needs to be addressed. These intermediaries are treated with respect, since respect for the intermediary is understood as respect for God. Intermediaries are the ancestral spirits; this religious arrangement mirrors general cultural patterns of interaction between living members of the community as well. The general view is that God is never far away from an African's thoughts or perceptions of the world. According to the Parliamentary Portfolio Committee of the Department of Arts and Culture (South Africa, 2001) African or traditional religion is described as unique and often misunderstood by Western religions. In the past African religion and traditional healers were referred to as barbaric and brought about a stigma towards traditional healers. According to the African traditional religion, a traditional healer must receive a calling from the ancestors or from God and need no formal education for this role.

Another aspect that is true for African people throughout sub-Saharan Africa is that good health means much more than just a healthy body. Besides a physically healthy body, good health also includes a harmonious, coordinated universe. 'Health', 'balance', 'harmony', 'order', and 'continuity' are keywords that describe good health. Not only does good health describe a desirable present condition for individuals and the community, but it also represents the goal towards which Africans strive.

3.9.2 BAHÁ'Í

FIGURE 2: THE BAHÁ'Í EMBLEM (GERRIE, 2008:22)



The Baha'i faith was founded more than one and a half centuries ago and is the youngest of the world's independent religions. Followers of this religion believe that Baha'u'llah was the messenger of God for this age, the age of humanity's maturity, a time anticipated by the traditions of humanity's past. The driving force behind the enlightenment of human nature according to Baha'u'llah, has been accomplished by the interventions of the Divine. It is believed that through the Divine's influence, the moral and spiritual faculties of humanity have been gradually developed and the advancement of civilization was made possible (Gerrie, 2008:25). Baha'i teachings regard humans as spiritual beings. They believe that we all possess an immortal soul and that this soul is a Divine Trust. The human body is referred to as the "Throne of the Inner Temple".

The essential message of Baha'u'llah is one of unity. The distinguishing feature of this social evolution is that humans recognize their own oneness and that the earth is their common homeland. A Spirituality Assembly is formed when there are nine or more adult Baha'i members present. These Assemblies are responsible for overseeing the affairs of the community under their jurisdiction and, in particular, serving Baha'i followers in the area.

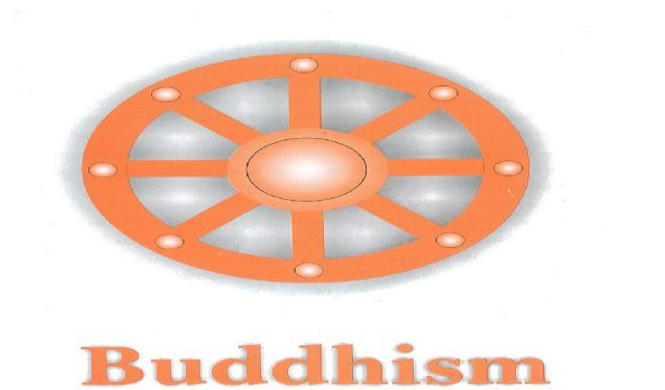
Baha'i followers believe that good health is the greatest of all gifts and that a healthy body will lead to greater spiritual and intellectual power; better memory and powerful reflections. Baha'u'llah taught that religion and science could be seen as the two wings of a bird, both of which are essential for flight. Therefore, healing consists of

material and spiritual processes, both being essential and complementary. Baha'is believes that spiritual healing on its own is not, and cannot be, a substitute for material healing, but is a valuable adjunct to it (Gerrie, 2008:6).

The Baha'i approach to spirituality and belief in God is, in essence, similar to African traditional beliefs. Both hold there is only one God, a supernatural force that created the whole world. That God is also not knowable. The understanding that knowledge of God is only possible through His manifestations also shared (Aikins, Smith & Richards, 2005:132-139).

3.9.3 Buddhism

FIGURE 3: THE BUDDHIST EMBLEM (GERRIE, 2008:29)



Buddhism is a considerably older religion. According to Williams (2005:38), Buddhism began in India about 2500 years ago, during the lifetime of an Indian prince called Siddhartha Gautama. Seeing the suffering in the world, he wanted to understand the reason for it and wanted to know how to end it. Through meditation, he found answers. The mentioned Siddhartha Gautama was later named, *Buddha*, which means 'enlightened one'. For the rest of his life he travelled through India and taught what he had learnt and how people could leave suffering behind.

In his first sermon after his enlightenment, the Buddha explained the human condition in terms of Four Noble Truths. The first Noble Truth characterises human existence as one of deep-seated unhappiness and endless suffering. The second Noble Truth is that human greed, selfishness and discontent causes suffering. The

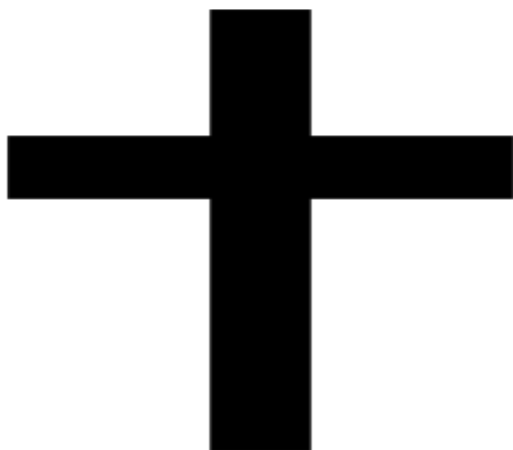
third Noble Truth establishes that stopping craving will stop suffering. The fourth Noble Truth prescribes that freedom from craving and greed attained by means of the Eightfold Path to Enlightenment (David, 1992:43).

In their daily lives, Buddhists try to keep five precepts: not to kill or harm living things; not to steal; not to use their sexuality in a harmful way; not to lie or say unkind things, and to refrain from intoxicants which lead to loss of mindfulness (specifically, drugs and alcohol) (Steward, 2001:187).

Buddhists believe that maintaining the body in good health will keep the mind clear and strong and that, by following Buddha's teachings, they will eventually leave all suffering behind and achieve a state of peace and happiness known as Nirvana. They also believe that enlightenment attained in this life and for this reason, life in all its forms must be treated with the utmost respect; this can be seen in the first of the Buddha's five precepts that forbids the taking of life in any form (Williams, 2005:34). Buddhists do not worship the Buddha as a god, but see him as a guide for their lives. Today, there are over 400 million Buddhists all over the world (Gerrie, 2008:31).

3.9.4 Christianity

FIGURE 4: THE CROSS: A CHRISTIAN EMBLEM (GERRIE, 2008:35)



The fourth major religion discussed is Christianity. *The Holy Bible* (Psalms 23:6-8) makes it clear that Jesus Christ is the founder of Christianity; therefore, Christians follow the teachings of Jesus Christ who lived approximately 2000 years ago in Palestine. Christians believe that Jesus is the son of God and that He came to earth

to save people from their sins (2 Corinthians 5:21). After Jesus' death, his disciples spread his teachings everywhere. Today there are approximately three thousand million Christians, following different Christian teachings. Christianity is the world's largest religion and its main message is salvation. In Christianity, religion regarded as codes about the meaning of life, and may be expressed through rituals and practices.

Christians believe in one God who created the world and watches over it; they also believe that God is kind and loving (John 3:16-17). He is always ready to forgive wrongdoing if one is truly sorry and promises to follow him (1 John 1:9). Christians believe God is everywhere and that He sees and knows everything. One becomes a Christian when one accepts Jesus Christ as Lord and Saviour, confesses one's sins, and repents. In this way, one inherits eternal life after death. Christians believe God acts in three distinct ways: as God the Father, who created and cares for the world; as God the Son, who came to earth as Jesus; and as God the Holy Spirit, who is at work in the world. These three beings are regarded as three beings in one God and constitute the Holy Trinity.

The Bible includes many examples of Christ healing the sick through the laying on of hands (Luke 8:40-50). This healing aspect of Jesus' ministry has drawn the Christian church into a ministry of caring for the sick. An essential response to sickness, pain and suffering is the life, death and resurrection of Jesus. Early Christians believed that disease and illness were the result of sin. Despite this emphasis on sin, the church did not totally disregard medical progress. Initially, the sick were encouraged to see physicians as servants of God. Through the centuries, medical and religious dimensions of healing separated and specialised. However, there are many parallels between the mainstream medical approach to physical health and the traditional Christian care of the spirit; for example, medicine will focus on diagnosis and prognosis, while traditional Christianity will include holistic, i.e. spiritual cleansing.

Owing to the existence of many denominations of Christianity, it is generally very difficult to present a single outlook on healthcare and, particularly, on controversial issues surrounding healthcare. Issues such as abortion, artificial insemination, blood

transfusion, euthanasia and organ donation are at times met with very different, and often directly opposite, responses (Tjale & De Villiers, 2004:43).

3.9.5 Hinduism

FIGURE 5: THE HINDU EMBLEM (GERRIE, 2008:43)



The fourth major religion discussed is Hinduism. Hinduism originated about 4000 years ago in India and about 80 per cent of India's population is Hindu (Louw, 2008:43). There are about 30 million Hindus elsewhere in the world. Hinduism is known for its tolerance. It has no fixed dogmas, no centralised life and no international council recommending any particular common conduct. Yet, the Hindu tradition is so strong and strangely timeless that homogeneity prevails.

According to Gerrie (2008:43), Hindus believe in a great soul or spirit, called Brahman. This great soul or spirit is omnipresent and omniscient. They also believe that every person has her or his own soul, called *atman*. Hinduism symbolically portrays the greatness and vastness of Brahman's power through thousands of Hindu gods and goddesses. Each one represents a different aspect of Brahman's power. According to Gerrie (2008:45), the three most important gods are Brahman the Creator, Vishnu the protector, and Shiva the destroyer.

Hindus believe in the law of opposites: good and evil; pain and pleasure; suffering and healing. Anyone who believes that one part of this duality is the whole truth is one-sided and unbalanced. Suffering and sickness become problems when they appear to be final and inescapable truths. When Hindus realize that one is not forever bound to the world of ill health and pain, then suffering no longer occurs (Gerrie, 2008:46). Becoming aware of Brahman isolates the individual from suffering because it involves detachment as opposed to attachment; suffering arises only

when individuals attach themselves to objects, which have passive value (Gerrie, 2008:52).

3.9.6 Islam

FIGURE 6: THE ISLAM EMBLEM (GERRIE, 2008:50)



Followers of Islam called Muslims. Islam means submission, which signifies that a Muslim is someone who submits to the will of Allah (God) (Gerrie, 2008:52). Muslims believe that success in this world and in the world to come achieved by obeying Allah's commands. When it comes to health and healthcare, oneness is a theme central to Islam. God is one and indivisible and of which He is the author, is indivisible as well. Since wholeness is the guiding principle of well-being and closely related to the concepts of health and illness, methods of caring and curing should follow this holistic perspective. Illness is not merely somatic (body) but seen as psychosomatic (mind & body) (Gerrie, 2008:55).

It is clear from the brief explanations above that suffering and healing feature in all the major religions of the world. Medicine and spirituality have worked in collaborative relationship to promote healing for thousands of years. The following discussion covers the historical background of spirituality in health, illness and the relationship between spirituality and medicine.

3.11 SPIRITUALITY IN HEALTH AND ILLNESS

Low (2008:9) says that coping with illness is an art when the patient sees illness as a very special opportunity for growth. Illness can also be a special vocation and responsibility in the context of our relationship with God and loving relationships with others. Coping with illness has to do with finding meaning in suffering, trusting when everything seem futile, transcending the anxiety of those around us, and living with

hope in the face of death. Louw (2008:10) emphasises that the task of pastoral care is not only to sustain the sick, but also to prepare the healthy for the crisis and opportunity of illness.

In Christian spirituality for example, *cure vitae* (the healing of life) is about:

“...theology of and from the viewpoint of Christian spirituality. It is about how new life is raised in Christ and the indwelling presence of the Spirit that can contribute to the empowerment of human being. It is about hope, care and endeavour to give meaning to life within the reality of suffering, our human vulnerability, and the ever-present predicament of trauma, illness and sickness” (Louw, 2008:11).

In *The Turn to Spirituality*, Koerie (2006:66) has managed to capture both the essence and the diversity of spirituality as a concept:

“Spirituality refers to the *raison d'être* of one's existence, the meaning and values to which one ascribes. Thus, everyone embodies spirituality, be it nihilistic, humanistic or religious. These are diverse spiritualities, each one culture-specific, expressing its own historical, sociological, theological, linguistic and philosophical orientation.”

In African spirituality on the other hand, God appears to be both distant (remote) and near, transcendent and immanent. In terms of spirituality, divinity is a force that moves and rules humanity and determines one's fate in the world. In African thought, inclusivity is important; therefore, African religion is both communal and anthropocentric. The role of ancestors and the veneration of ancestors in African spirituality emphasise the unity and continuity of life. African spirituality cannot be separated from the complexity of guilt and shame experiences (Louw, 2008:165; Masango 2006:88), concepts that are closely linked to health and illness.

The researcher is of the opinion that, when introducing a helping process into a healthcare setting or during the training of healthcare professionals, it should thus be inclusive or holistically covering all human diversity.

3.12 SPIRITUALITY/ RELIGION AND POSITIVE HEALTH OUTCOMES

Studies on various disorders in different populations at different times, pointed to the benefits of religion and positive health outcomes Folala and Heaton, (2008:96).

Most evidence comes from epidemiological studies; where findings are correlative, not causal (Chandler, 2002:244). There has been a growing interest in this issue and entire journals have been devoted to the topic. Between 2003 and 2005, 1 789 research-related articles were written on religion and spirituality with the following common themes: lower suicide rates; less anxiety; more purpose; lower mortality; less heart disease; lower blood pressure, and increased social support (Bussing *et al.*, 2005:322).

From the literature, it seems that religion influences coping (Gilligan & Furness, 2005:56) by giving people an optimistic view of the world. It helps by giving meaning and purpose to life. This then assists with better psychological integration. In crisis, religion gives hope and personal empowerment as well as some sense of control through prayer. It also helps provide answers to ultimate questions as well as social support through the religious community.

In research prior to 2000:

- 14 out of 23 studies suggest that religion lowers blood pressure;
- 23 out of 25 studies suggest that religion lowers smoking;
- seven out of 11 studies suggest that religious people suffer from less instances of heart disease;
- three out of five studies suggest that religious people are more likely to exercise; and
- 11 out of 14 suggest that religious involvement lowers mortality (Pearce, 2005:88).

Additional study results indicate the following:

- A 1995 study at the Dartmouth-Hitchcock Medical Centre found that one of the best predictors of survival among 232 heart surgery patients was the degree to which they drew comfort from religious faith (Chandler, 2002:250).
- A survey of 30 years of research on blood pressure showed that churchgoers have lower blood pressure than non-churchgoers do. Men and women who attend church have half the risk of dying from coronary heart disease as those who rarely attend.

-
- The discussion above thus confirms in crisis, religion gives hope and personal empowerment as well as some sense of control through. It also helps provide answers as well as social support in the religious community.

3.13 SUMMARY AND CONCLUSIONS

The researcher's opinion is that, in light of the existing information, health professionals in general should be aware of the patient's spirituality and should mobilise churches/faith from different religions as resources and partners in healthcare. In helping to meet the spiritual needs of patients, health professionals should relate to each patient as a unique individual. It is important to maintain hope and explore the patient's fears and doubts. A common preoccupation, especially in end-of-life situations, is the amount of suffering involved. Health care professionals can help by involving the patient's religious community for support to the community. Furthermore, it is the researcher's opinion that the inclusion of spiritual care in the social work curriculum could address the challenges experienced by social workers in the medical field.

South Africa is and always was a country of religious diversity. However, owing to the previous dispensation of socio-political segregation, people kept from experiencing the multiplicity of religious traditions in the country. Now, because of the integration of residential areas, education and health services, more and more South Africans encounter people of different religious and spiritual beliefs. Therefore, it is vital that healthcare professionals are well versed in this area.

Chapter 4 presents the research findings on the understanding of spirituality among healthcare professionals and patients at CHBAH.

CHAPTER 4

RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter reports the findings of the study in three sections. The first section focuses on the data collected from healthcare professionals (presented in a red colour). Section two presents the data gathered from the patient group (presented in green colour). Section three provides feedback from patients and healthcare professionals (presented in navy colour) on the suggested protocol for including spirituality in healthcare at CHBAH.

Since this study strives to explore the understanding of spirituality among patients and healthcare professionals at CHBAH, it is necessary to distinguish clearly between the two groups of respondents. Each section includes the biographic detail of respondents, the themes and subthemes that emerge from qualitative data collected, and the discussion of the findings. This chapter further compares the understanding of spirituality between healthcare professionals and patients. Lastly, there is feedback on questions asked to healthcare professionals and patients regarding what they would like included in the proposed protocol for CHBAH.

For ease of reading, the data-collection methodology is briefly summarised before the presentation of the findings. (The methodology discussed comprehensively in chapter 2.)

4.2 RESEARCH METHODOLOGY: A SUMMARY

This study followed a qualitative methodology within the exploratory and descriptive research designs. Two groups of respondents were included. The first group consisted of 48 healthcare professionals, including nursing staff, social workers, occupational therapists and physiotherapists. The second group consisted of 30 male and female patients treated in the hospital at the time of this study. Data collected by means of focus-group discussions with both staff and patients. Staff members also made drawings of their spiritual life journeys, from which additional

data collected. The focus-group schedule followed (for documentation, see addenda 1-3.) Data was analysed in terms of content and themes, following a combination of Tesch's approach to thematic analysis and the thematic analysis procedures of Braun and Clark (described in chapter 2).

4.3 RESEARCH FINDINGS

4.3.1 Section 1: Feedback from healthcare professionals

The results portrayed in this section identified from data collected during focus-group discussions with healthcare professionals at Chris Hani Baragwanath Hospital.

4.3.1.1 Profile of respondents

Respondents were invited to voluntarily participate in discussions held during four focus-group sessions at the hospital. Table 5 presents the biographical profile of respondents who signed consent forms participated in the focus groups and completed the spiritual journey exercise.

TABLE 5: PROFILE OF HEALTHCARE PROFESSIONALS WHO PARTICIPATED IN THE STUDY

The last two focus groups named 3A and 3B because they represent allied health professionals, namely physiotherapists (3A) and occupational therapists (3B).

Groups of respondents	Designation	Total number of respondents
Group 1 Nursing personnel (staff)	Nursing manager Professional nurses Nursing auxiliary Enrolled nurses Student nurses	12
Group 2 Social workers	Social work manager Grade 3 social workers Grade 2 social workers Grade 1 social workers	16
Group 3A - Allied	Physiotherapist intern	10

professionals:- Physiotherapists	Senior physiotherapist Chief physiotherapist Junior physiotherapists	
Group 3B – Allied professionals: occupational therapists	Chief occupational therapist Occupational therapist intern Senior occupational therapist Junior occupational therapists	10
TOTAL NUMBER OF RESPONDENTS		48

During the research process, 48 healthcare professionals participated in focus groups. Among the four groups, the allied professionals' groups 3A and 3B were smaller and more diverse in terms of race and religious beliefs when interviewed. This variety allowed for open discussion and individuals sharing their perceptions, thoughts and feelings. The social workers were more diverse in terms of their grading and areas of specialisation, allowing the respondents to elaborate on and provide more detail in their responses. The researcher was unable to secure an appointment with the doctors at the Hospital. Therefore, the biographic profile for the healthcare professionals does not include the entire medical team.

4.3.1.2 Themes identified from the focus-group interviews

Three main themes emerged from the focus group interviews with the healthcare professionals, namely:

- the understanding of spirituality;
- the impact of spirituality in healthcare; and
- Job satisfaction, commitment and personal fulfilment.

Themes and subthemes contain narrative accounts from the focus groups, using direct quotes. The discussion of these findings below, substantiated with literature.

4.3.1.2.1 Theme 1: Key Understanding of the concept ‘spirituality’

Table 6 reflects each group’s key understanding of the concept ‘spirituality’. These key phrases derived from the respondents’ direct quotes. It should be noted that certain professionals raised similar keywords, hence the repetition.

TABLE 6: HEALTHCARE PROFESSIONALS’ KEY UNDERSTANDING OF THE CONCEPT ‘SPIRITUALITY’

Group 1	Group 2	Group 3A	Group 3B
Nursing personnel	Social workers	Physiotherapists	Occupational therapists
Belief in God	Belief in God	Connecting with the higher being	Connecting with the higher being
Holiness	Connecting with Supreme		
Believing in something or someone	Believing in something or someone	Believing in something or someone	Believing in something or someone
Inner power	Relationship with self	Self-balancing	Inner consciousness
Having connections with the divine spirit	Holistic being, physical, emotional social and psychological	Connecting with ancestors	Connecting with ancestors
Meaningful relationships: church, family or friends	Meaningful relationships: church, family or friends	Believing in a symbol or an invisible spirit	A relationship with nature

The focus-group respondents have mostly similar understandings of what spirituality is, with minor differences. In short, this means that there seem to be multiple views of spirituality, but it comes down to more or less the same understanding: respondents have some kind of relationship with a greater power or being. For example, one view defines spirituality as something originating from the inside of the

individual. Another view is that spirituality tied to one's religious affiliation. Other respondents describe spirituality in relation to their workplace. Still another perspective argues that spirituality involves existentialist questions, e.g. what is the meaning of my work? Why am I doing this work?

It has argued that there are different definitions of the meaning of spirituality due to the strong personal nature of the word. Indeed, Freshman (1999:325) states that the emphasis on the uniquely personal aspect of spirituality contributes to the pluralistic aspect of the term in the workplace. Consequently, Freshman feels that these multiple views of spirituality are natural and logical; the search for a definite description of the term is therefore not the best. It would be better to understand the meaning of these multiple views of spirituality in the workplace, the benefits it holds, and the manner in which spirituality implemented or encouraged within organisations.

4.3.1.2.2 Theme 2: The impact of spirituality in respondents work environment

The key themes and their descriptions derived from discussions of the impact of spirituality on day-to-day life experiences, and it includes the following:

- **Service:** Healthcare professionals indicate that free expression of their spirituality enhances their services and daily activities.
- **Support:** Healthcare professionals describe spirituality as their source of support in their daily activities.
- **Fulfilling ones calling healthcare** professions mention that spirituality provides fulfilling experience in ones calling as healthcare professional.
- **Helping healthcare** professionals view spirituality as an effective tool in their endeavour to help themselves and their patients.
- **Gaining and imparting of knowledge:** Healthcare professionals indicate the more they understood their spirituality and their patients, the more knowledge they had, and the more able they were to impart this knowledge in their daily encounters.

-
- **Interaction:** Healthcare professionals have a feeling that understanding spirituality increases their interaction levels in terms of sharing spiritual ideas.
 - **Relationships:** Spirituality enhances positive relationships among staff, especially among those who share the same spiritual belief.
 - **Discrimination and rejection:** Free expression of spirituality sometimes leads to discrimination and rejection among staff members.
 - **Stereotypes:** Some spiritual beliefs viewed as better and others as secondary.

These are the themes derived from the focus-group discussions with healthcare professionals as they explained the impact of spirituality in their day-to-day life. The themes depict both positive and negative views. The groups seem to have slight differences in terms of the impact of spirituality in their day-to-day life. However, they mention its positive impact as the most dominating. Firstly, spirituality provides an opportunity to interact with others who have a different spiritual orientation or belief. Secondly, exposure to different spiritual beliefs broadens their frame of knowledge.

In terms of the negative response, some of the healthcare professionals indicate that sometimes discriminated against should their spiritual belief differ from the majority in their respective working areas. Secondly, their opinions tend rejected, especially if they were a minority group, or that there was a form of misbelief or mistrust when they expressed their views.

The existentialist views, where the search for meaning connected to what we are doing at the workplace, support the themes stated (Kahnweiler & Otte, 1997:176; McCormick, 1994:99; Naylor *et al.*, 1996:77; Neck & Milliman, 1994:8). The search for meaning has been one of the motivations most often quoted by people who quit their jobs to lead a more spiritually enriching life (Burack, 1999:280; Naylor *et al.*, 1996:56). The following quotes from respondents reflect the reasons why they have chosen to be healthcare professionals:

Respondents from group1: “I am doing nursing because it was a calling” and “To enable patients to help themselves”.

Respondents from group 2: “I am doing social work in the hospital to put food on the table” and “I did not have a choice”.

The third theme emerge from responses to the question, “What are the benefits of your spirituality in what you do on daily basis?” The following description depicts some benefits highlighted by healthcare professionals.

4.3.1.2.3 Theme 3: Job satisfaction, commitment and personal fulfillment

Work plays a central role in the lives of most people, as employees spend a large proportion of their lives at work. Therefore, it is important that work enhances their satisfaction and offers fulfilment. The work environment needs to promote positive emotions, engagement and motivation. As people express something of themselves through work, work should offer them an opportunity to display their skills and abilities. Job satisfaction therefore, is an integral ingredient of successful work engagement. Rothman (2005:10) states that in order to promote work-related health and wellness, it is essential to examine factors that combat burnout and exhaustion.

The following quotes from respondents reflect job satisfaction and a sense of fulfilment as they apply spirituality in their workplace:

“Spirituality grants me an opportunity to help.”

“Applying spirituality enables me to see envisaged positive results in my helping process.”

“Visibly you see immediate results in your intervention.”

“There is teamwork and a pooling of resources to an ultimate goal.”

These quotes reflect that nurses, social workers and allied professionals find their work to be meaningful when applying/using spirituality and they are doing what they have been called and trained to do. There is a sense of meaning and a feeling that they can make a difference.

The following quotes further indicate that optimal job satisfaction, commitment and personal fulfilment produce quality results for healthcare professionals. They feel that they are valued and their contributions considered meaningful:

“You can make a difference.”

“I can provide optimal patient care.”

The following quotes were additional to the responses mentioned above:

“My spirituality enables me to serve with commitment.”

“I am able to understand my limitation and be open to new ideas.”

“Less judgemental.”

These quotes appear to be a positive ground or foundation for freedom of expression of spirituality when doing so. Respondents portray an enhanced sense of acceptance; of individual contributions being valued and respected, thereby increasing organisational performance and cohesion.

Culliford (2002:244) supports these findings and identifies the following key elements of spirituality:

- An environment for purposeful activity, such as creative art, structured work, enjoying nature.
- Feeling safe and secure; being treated with respect and dignity and allowed to develop.
- A feeling of belonging, of being valued and trusted.
- Having time to express feelings to staff members with a sympathetic, listening ear.
- Opportunities and encouragement to make sense of and derive meaning from experiences, including illness.
- Receiving permission and encouragement to develop a relationship with God or the absolute (whatever the person conceives of what is sacred), therefore, a time, place and privacy in which to pray and worship, education in spiritual (and sometimes religious) matters, encouragement in deepening faith, feeling universally connected and perhaps also forgiven.

4.3.1.2.4 Honesty and trust

The following verbatim responses by healthcare respondents serve as examples of how spirituality can contribute towards honesty and trust in their work environment:

“I am entrusted with a responsibility to look and assist those who are unable to assist themselves.”

“I find that it is important to be honest at all times.”

“Sharing spirituality with patients develops a mutual trust.”

These verbatim quotes indicate that sharing of information about spirituality between healthcare professionals and patients can enhance positive relationships. Secondly, no one can feel judged, prejudiced or vulnerable.

4.3.1.2.5 Organisational loyalty

The following quotes indicate that organisational loyalty optimized and lead to quality results when healthcare professionals feel they are valued and their contributions are positively considered:

“You can make a difference.”

“I can provide optimal patient care.”

“Spirituality allows me to be myself.”

“My spirituality enables me to serve with commitment.”

“I am able to understand my limitation and be open to new ideas.”

The overall indication of these themes was a need to have some form of an official system in place for certification of spiritual care and spiritual needs recognition. However, In South Africa, there is no statutory requirement or official system in place for accreditation and certification of spiritual and pastoral care workers in healthcare. Neethling (2003) has done a study on the relevance of pastoral work in South Africa with specific reference to the Southern African Association for Pastoral Work. Neethling (2003:82) came to the conclusion that pastoral counselling is a possible national health resource for healthcare, spirituality, social change, reconciliation and multi-cultural application.

Ward (2002:155) has done an extensive review and evaluation of clinical pastoral education (CPE) in the South African context. She emphasises that CPE provides a valuable experiential training and personal growth opportunity for spiritual and pastoral counsellors in a clinical context. “The pressing problems facing ministry today demand that training for ministry must incorporate practical experience alongside theoretical knowledge” (Ward, 2002:227). The action/reflection model (with verbatim, personal and group supervision as its core) and exposure to a clinical setting provides a challenging learning environment (Ward, 2002:231-234). She warns, however, that CPE might not be the best fit for the culture and methods of ministry training in South Africa (Ward, 2002:242). For CPE to be valid it must

incorporate the cross-cultural customs and traditions in its context. Other challenges that need attention are language, gender issues, and questions of length and context.

It is clear that spiritual and pastoral work should be an essential (if not mandatory) part of holistic, patient-centred healthcare. It also provides a valuable opportunity for personal and ministerial training and practice.

South Africa, with its 342 public and 216 private hospitals, offers huge challenges and opportunities (National Department of Health; <http://www.doh.gov.za>; Hospital Association of South Africa; 2000). Generally, hospital managements are positive towards the provision of spiritual care and services. South Africa however, does not have systems such as European countries, where government or hospitals finance spiritual care services. Strategic planning should be integral to the functioning of spiritual departments and services and should include funding and infrastructure development. This will be crucial in the South African context and cannot be accomplished without the support and involvement of the faith-based community (FBC) and faith-based organisations (FBOs).

The following discussion focuses and elaborates on the respondents' plotting of their spiritual journeys.

4.3.1.3 The spiritual journeys

The following discussion emanates from the plotted spiritual journeys of the healthcare professionals. Figures 7 - 9 illustrate examples of the plotted spiritual journeys. The process and procedures briefly discussed to supply the necessary context, and Addendum 2 offers further detail.

Each respondent plotted such a spiritual journey. Data from the plots as well as the focus-group discussions thereof was analysed and categorised in themes. Examples of such journeys are included before presentation of the data.

4.3.1.3.1 Themes from the spiritual journeys of healthcare professionals

Figures 7 – 9 captures examples of the respondents' spiritual journeys. The respondents illustrated their spiritual journeys by linking it to their developmental life phases from childhood to adulthood.

FIGURE 7: SPIRITUAL JOURNEY 1

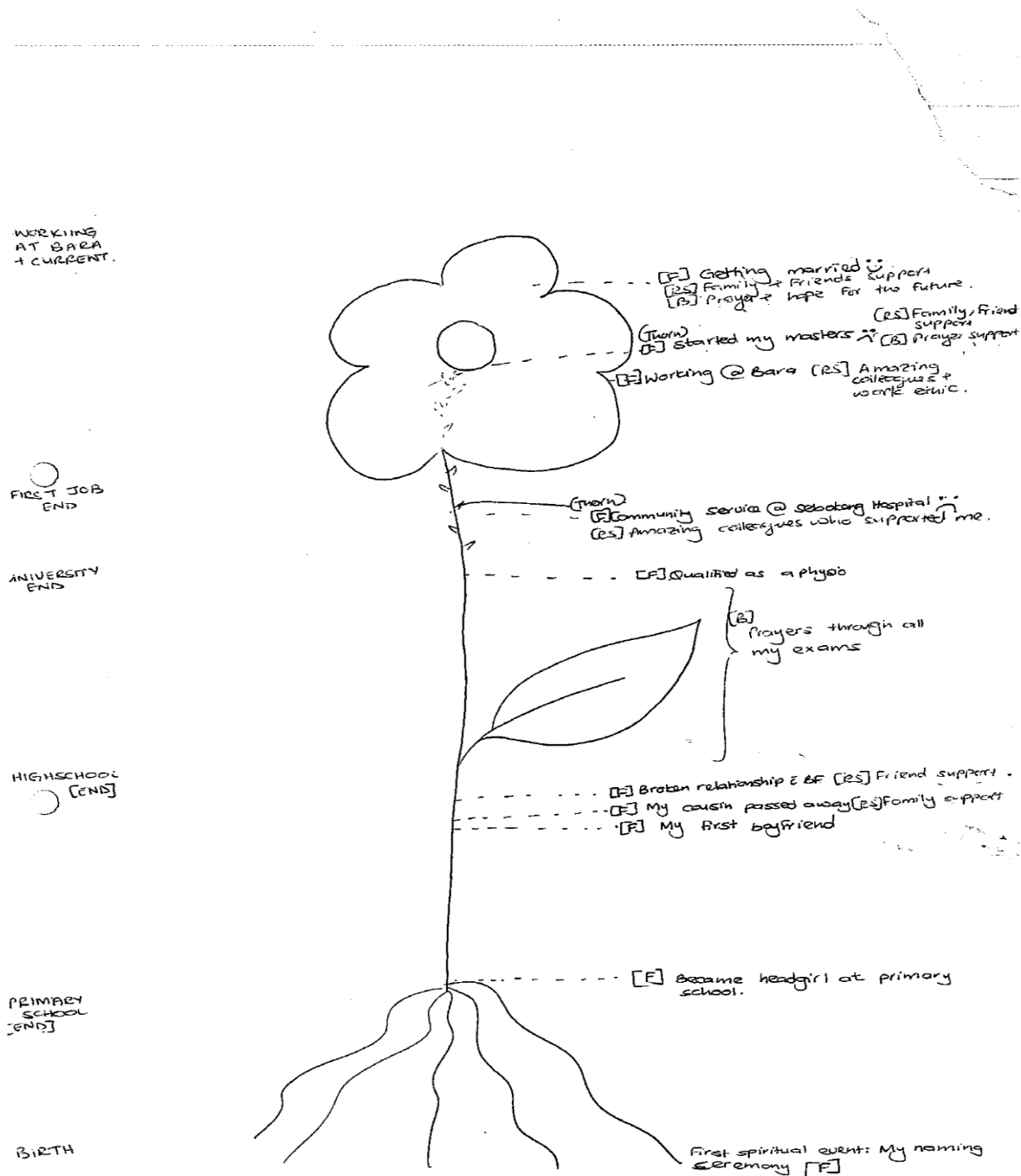
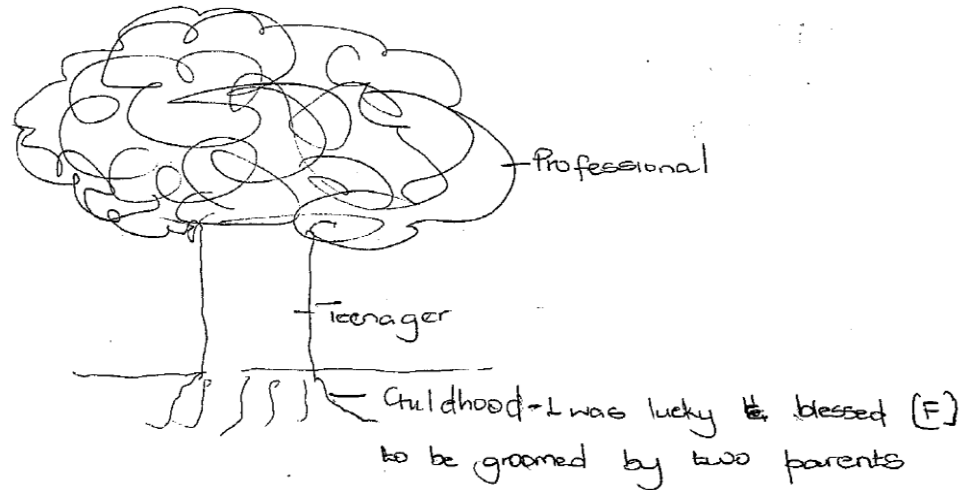


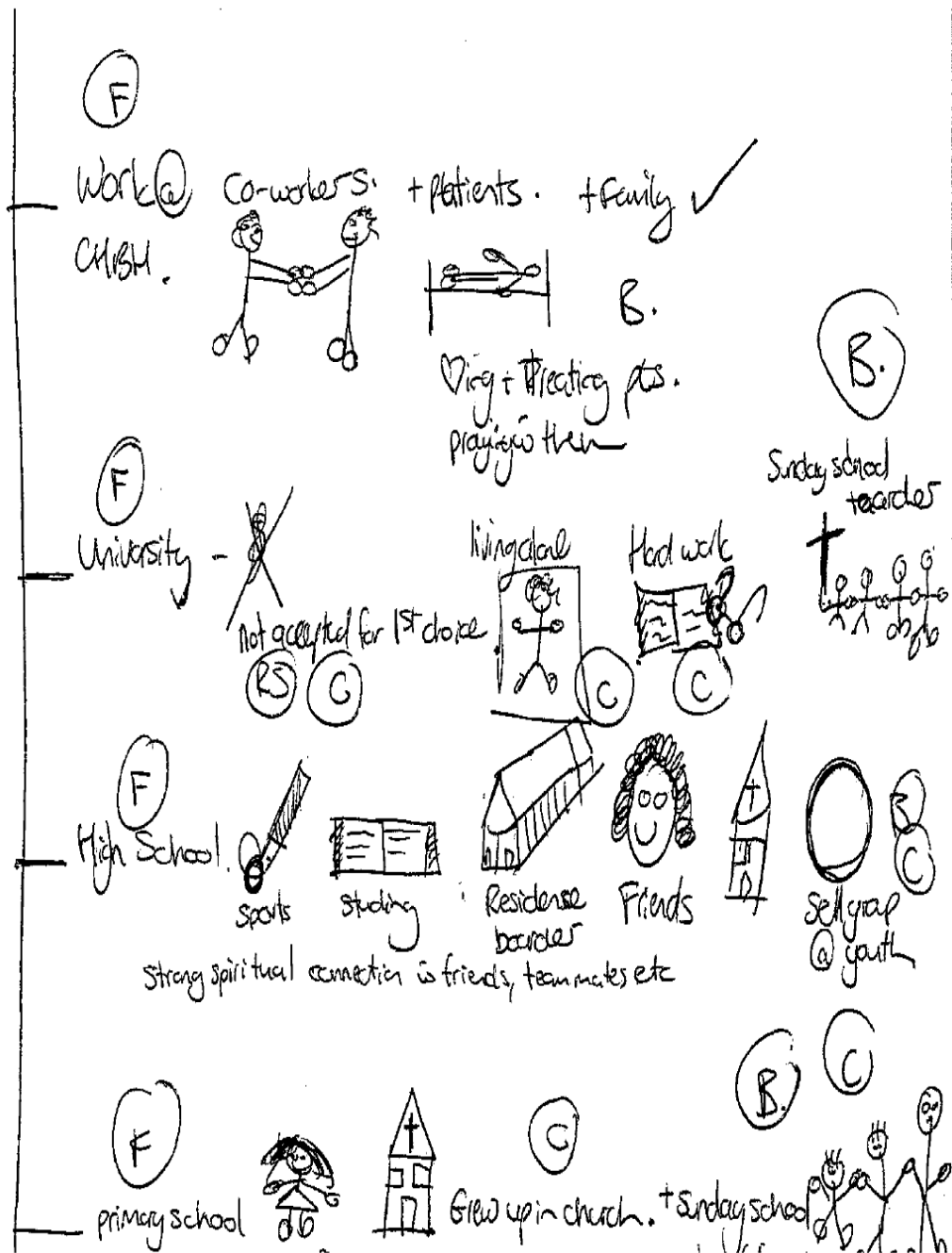
FIGURE 8: SPIRITUAL JOURNEY 2

IMAGINATION ROAD



Childhood	Teenager	Professional
<ul style="list-style-type: none"> ① lived with both parents ② Being taught the importance of going to church. 	<ul style="list-style-type: none"> ① Passing my matric which allowed me to do nursing. ② Prayer & family always helped when I'm in stressful situations. ③ When I lost my father whom was a cardiac patient my family & friends & church members were there to help me. ④ I prayed to God to keep my heart as good as it even after being professional 	<ul style="list-style-type: none"> ① My spirit being lifted up by patients acknowledging what I do. ② Being heart broken by losing a patient. ③ Giving God any problem that I come across at work helps. ④ Talking to a close friend about what's troubling me. ⑤ I needed friends & spiritual guidance when I had a fight with the colleague.

FIGURE 9: SPIRITUAL JOURNEY 3



From the analysis of all the spiritual journeys, the following themes identified:

- Spiritual beliefs
- Spiritual role models
- Spiritual rituals and activities
- Spiritual choices

These themes linked to the different developmental phases and summarised in Table 7.

TABLE 7: SPIRITUAL JOURNEY THEMES IN THE DEVELOPMENTAL PHASES

Childhood	Adolescence	Adulthood
<p>Spiritual belief</p> <ul style="list-style-type: none"> Mainly adopts that of the family in which a child is born 	<p>Spiritual belief</p> <ul style="list-style-type: none"> It is influenced by the family, friends and personal experiences 	<p>Spiritual belief</p> <ul style="list-style-type: none"> It is solely the individual's decision It is influenced by marital status
<p>Spiritual role models</p> <ul style="list-style-type: none"> Biological parents Grandparents Godparents Sunday school teachers 	<p>Spiritual role models</p> <ul style="list-style-type: none"> Biological / Godparents Friends Community Youth pastors or youth spiritual leader 	<p>Spiritual role models</p> <ul style="list-style-type: none"> Parents Pastors/church leaders/ministers of religion Friends
<p>Spiritual rituals and activities</p> <ul style="list-style-type: none"> Baptism Traditional ceremonies 	<p>Spiritual rituals and activities</p> <ul style="list-style-type: none"> <i>Ukuthomba</i> <i>Intonjane</i> Confirmation 	<p>Spiritual rituals and activities</p> <ul style="list-style-type: none"> Holy communion
<p>Spiritual choices</p> <ul style="list-style-type: none"> Spiritual decisions made by the parents 	<p>Spiritual choices</p> <ul style="list-style-type: none"> Limited spiritual choices Parental blessing on spiritual choices is required Limited spiritual independence 	<p>Spiritual choices</p> <ul style="list-style-type: none"> Wide range of spiritual choices Spiritual autonomy

The findings in Table 7 reflect that, as people grow tend to experience and express spirituality differently. Different things will be important to them at different developmental stages. In this study, it is clear that parents take charge in aspects of spirituality during childhood. Most respondents indicate that their parents had a key responsibility in their spiritual development and growth.

This study also explored the experiences of spirituality, in addition to the different developmental phases. Respondents indicate that their spiritual beliefs expressed in terms of their experiences. Westerhoff (1980:344) suggests that there are various styles of believing or experiencing spirituality into which people progress. He further states that we do not abandon earlier styles as we grow, but each development builds on the bases of an old one. Table 8 further illustrates the developmental experiences of spirituality.

TABLE 8: STYLES OF EXPERIENCING SPIRITUALITY

Experience of spirituality	Affirmative Faith/spirituality	Searching spirituality	Mature spirituality or Faith
Accepting spirituality of early childhood – responding to sights, sound, but unconcerned about the meaning.	The sense of belonging to a spiritual community, usually that of the parents, and uncritically assuming the beliefs and practices of that community. This is common in the primary years.	Questioning and critical style in which accepted norms are challenged. This is common among teenagers and young adults. It is not a sign that something has gone wrong, and is vital if adult spirituality is to develop.	Spirituality has been explored and questioned and is owned, consciously accepted and acknowledged with all the commitments to the life stage that spiritual faith demands.

Table 8 reflects that spirituality is not static; as individuals grow and mature, they question and have the ability to advance their spirituality as per their personal belief. The focus-group discussions with healthcare professionals confirm this, as they shared that during their childhood, parents took charge for their spirituality and they grow and mature they are at liberty to make decision regarding their spirituality.

4.3.1.3.3 Spirituality, life experiences and coping tendencies

Data from the journeys was analysed, linked to emotions, life experience and to determine the role of spirituality as a coping mechanism through the respondent's reference. These experiences emanate from both the focus-group discussions and the plotting of spiritual journeys.

TABLE 9: EMOTIONS AND LIFE EXPERIENCES FROM THE SPIRITUAL JOURNEYS

Emotions	Life experiences	Coping tendencies
Sadness	Loss of a loved one	Family, friends, church and community uplifted my spirit An opportunity to connect to my ancestors
Anxiety	Writing exams Dealing with a critically or chronically ill patient Difficult life situations	Keeping calm Acknowledging that there is One above me
Overwhelmed	Adulthood Professional pressures	Prayer Parental spiritual support keeps me grounded (firm foundation)
Depressed	Losing a patient Realising that I am HIV-positive	Reflection Rituals Sharing life stories/narratives revitalised my energy

Excitement	Achieving a professional goal	Understanding who I am; inner strength kept me determined
Happiness	Ability to contribute positively to other people's lives and be acknowledged	Ability to remain clear-headed
Stress	Professional and parental pressures	To be kept grounded (rooted in my culture and professional belief)
Frustration	Not getting along with relatives Financial constraints	Having hope for the future The courage to keep going

Traditionally, the concept of coping has been associated with focusing on strategies that has to do with emotions and problems. Thus, spirituality helps workers to cope as evident by healthcare worker's understanding of spirituality Williams *et al.* (1991) reviewed the literature on coping. These authors suggest that individuals, who believe that they can control their painful situation and that they are not severely disabled, appear to function better than individuals who do not have those beliefs. Louw (2008:9) says that coping with illness is an art when the patient sees his/her illness as a very special opportunity for growth. Louw (2008:10) emphasises that the task of pastoral care is not only to sustain the sick, but also to prepare the healthy for crisis and the possibility of illness. Feelings of emptiness and despair characterize spiritual distress (Ross, 2005:46). These feelings frequently encountered in situations involving physical or mental illness. However, through spirituality, people liberated from despair (Puchalski, 2001:289).

Although there were smaller differences between the experiences of the four groups, there were many similarities. Cultural differences existed but were overcome with understanding and respect from all focus-group respondents. The needs of patients and healthcare professionals are basic and the researcher felt that she could meaningfully contribute to this, hence the ultimate goal to propose a protocol to assist in including spirituality in the healthcare facility.

Linking spirituality to health is not a modern phenomenon. For several years, spiritual issues and medicine addressed in tandem; with the doctor, priest or shaman occupying the position of the healer of both spirit and body (Droege, 2002:16).

With the growing emphasis on holistic healthcare, spirituality is re-emerging as a relevant factor in treating the sick and disabled (Grobler, 2001:14). However, the concept of rationality in healthcare organisations makes members uncomfortable with discussing or expressing their faith or spirituality; it could even lead to a lack of vocabulary for such discussions (Baywood-Graber, & Johnson, 2001:38). Spirituality considered highly personal and private. If the patient and the healthcare professional lack a well-developed relationship, a dialog on spirituality deemed offensive (Cooper, 2001:38).

4.3.1.3.4 Spirituality and coping with the work environment

As work and family demands grow in our daily existence, our personal life needs more nourishment than ever to cope with the demand. In this regard, spirituality has appeared to be the best coping mechanism, as the decision to cope must come from deep inside a person's value system. Love, truth, patience and kindness are strong spiritual principles that could form strong pillars in one's daily struggles for balance. A respondent shared: "*When I lost my mom, the love, kindness and patience I received from my friends, colleagues and prayers sustained me*". The Joint Commission for Accreditation of Pastoral Services" assigned Van de Creeck and Burton (2001:83) to draw up a white paper on the role and importance of professional spiritual healthcare. They formulate the need for spiritual care in healthcare organisations as follows:

- Healthcare organisations are obliged to respond to the spiritual needs because patients and staff have a right to such services.
- Fear and loneliness experienced during serious illness generate spiritual crises that require spiritual care.
- Spiritual care plays a significant role when cure is not possible and persons question the meaning of life.
- Workplace cultures generate or reveal the spiritual needs of staff, making spiritual care vital to the organisations.

- Spiritual care is important in healthcare organisations when allocation of limited resources leads to moral, ethical, and spiritual concerns (A White Paper on Professional Chaplaincy).

4.3.2 Section 2: Feedback from patients

The results portrayed in this section identified from the data collected during the focus-group discussions with patients at CHBAH. The discussion focuses on the following aspects:

- The methodology: a summary
- Biographical detail of patient respondents
- Sub-themes: Patient’s understanding of spirituality and health
- Patient’s developmental process and life stages
- Sources of support and care

4.3.2.1 The methodology: a summary

Four focus groups with patients from specialised outpatient clinics for diabetes, breast health, urology, plastic surgery, internal medicine, and the step-down facility held over a period to accommodate the daily schedules and routine of the mentioned clinics. Purposive sampling was used. All discussions were audio recorded.

4.3.2.2 Biographical detail of patient respondents

Thirty patients participated in this part of the study. The biographical detail includes the patients, social support systems, and their gender and health challenges.

TABLE 10: PROFILES OF PATIENT RESPONDENTS

Number of Patients	Social support systems	Gender	Health challenges
3	Family and friends	3 males	Cardiac
7		7 females	Diabetes
12	Family/friend and	6 males,	Cancer

	community	6 females	
8	Family	2 females 6 males	Hypertension
Total =30			

The biographical profile for patients reflects both sexes who received treatment for health challenges in a number of clinics and the step-down facility. The patient focus group were representative of the patients at the Hospital. A number of themes and subthemes identified. The main themes included patients’ understanding of spirituality and illness, spirituality and life-developmental stages, and sources of support and care. The diverse group proved to be a rich source to explore and describe spirituality.

Following is a presentation of themes and subthemes that arose from the patient focus groups. Each theme and subtheme contains narrative accounts (direct quotes) from the respondents, and substantiated by literature.

4.3.2.3 Themes and subthemes: Patients at CHBAH and understanding of spirituality

4.3.2.3.1 Theme 1: Patients understanding of spirituality and health

The patients view health as the holistic well-being of an individual and describe spirituality as integral to the recovery or coping processes. The following are some verbatim responses related to this theme:

“I have observed that when I am ill and prayed about it, I feel better even before going to see the doctor.”

“In difficult times, I share with my special friends and after crying and sharing, I feel relieved.”

“My family perform some spiritual rituals or activities to resolve some life challenges.”

Research by the South African Medical Research Council (AIDS Bulletin, 2004, 219) suggests that the impact of illness may lead to sequential trauma associated with continuous traumatic stress. Many patients suffer multiple losses: a father, a mother,

siblings, grandparents, uncles, aunts and other relatives. In addition, they may lose friends, familiar surroundings, schooling, and their hope for the future. They are subject to surges of loneliness and sadness, triggered by particular memories (SA Medical Research Council, 2004:219). In their thoughts, they struggle or battle with many issues that could build them up or break them down. The success lies in the ability to control the thoughts and belief in their spirituality. Mathe (2006:17) agrees with this statement by saying: “Take control – you are what you think or believe in”.

When the researcher interviewed patients and requested to describe their spiritual journeys through their developmental life phases (not plotting), the following themes emerged:

4.3.2.3.2 Theme 2: Spirituality as integral to all developmental life stages

The focus here is on early childhood, middle childhood, adolescence, and adulthood.

4.3.2.3.2.1 Spirituality in early childhood

Table 11 presents the spiritual activities/rituals, what these rituals or activities symbolise, and the activities performed to actualise the practice or ritual in early childhood. All African spiritual activities/rituals and unfamiliar ones mentioned in the table, are described below.

TABLE 11: SPIRITUAL PRACTICES/RITUALS PERFORMED IN EARLY CHILDHOOD

Spiritual practices/ rituals	Culture	Symbolism	Activities
Honey tasting	Indian	Good life	Hair removal
<i>Imbeleko</i>	Xhosa	Welcome to life	Slaughtering of a goat or a sheep
Baptism	Christian	Faith	Church ceremonies
<i>Ukuthomba</i> (for girls)	Xhosa	Teenage years	Traditional ceremonies such as “umxhentso”
Circumcision(stage	Xhosa and Indian	Manhood	Determined by the

at which it is done varies)			particular faith such as “ukwaluka”
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In terms of experiences, most of the respondents mentioned that they had little or no memories of those childhood practices. This is mainly because most of their early childhood spiritual life activities decided on and performed by parents or relatives on their behalf.

The patients say, “Our parents told us that these activities were vital for our healthy upbringing, and that their commitment to these religious activities and beliefs made us who we are today”.

4.3.2.3.2.2 Spirituality in middle childhood and adolescence

Table 12 presents the spiritual practice/rituals in middle childhood and adolescence, what these rituals or activities symbolise and the activities performed to actualise the practice or ritual.

TABLE 12: SPIRITUAL PRACTICES/RITUALS PERFORMED IN MIDDLE CHILDHOOD AND ADOLESCENCE

Spiritual practice/rituals	Culture	Symbolism	Activities
Baptismal	Christian	Faith	Church ceremony
<i>Ukuthomba</i> (for girls)	Xhosa	Teenage-hood	Traditional ceremony “ukombelela”
Circumcision(stage at which this is done may vary)	Xhosa and Indian	Manhood	Various per belief such “ukwalusa”

Table 12 indicates the responses on different symbols and activities that are honoured and performed to affirm the individual’s spirituality. The responses also reflect that different cultures perform spiritual rituals as determined by their cultural orientation.

4.3.2.3.2.3 Spirituality in adulthood

TABLE 13: SPIRITUAL PRACTICES/RITUALS PERFORMED IN ADULTHOOD




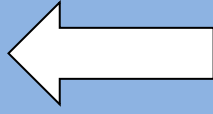






Spiritual practice/rituals	Culture	Symbolism	Activities
Intentional baptism	Christian	Christian conviction	Immense in water
Anointment	Christian	Servitude	Church ceremony or slaughtering depending on the culture
Holy communion	Christian	Active member of the church	Church ceremony, dedicated Sunday sermon
Group cells	Christian	Commitment to Christian belief	Partnership in prayer Traditional ceremony

Table 13 reflects that at this stage of development, spirituality is a matter of choice based on experiences and conviction, and affirmed by performing spiritual activities.

The developmental stages, as described in the previous tables, indicate that a number of activities or approaches are being applied in the lives of the patients to honour one's spirituality. This indicates that an integrated approach to deal with spirituality recommended as part of the protocol to include spirituality in healthcare at CHBAH. What follows, is a diagram depicting the implementation of the integrated approach, an example of such drawn from a Christian viewpoint.

Low (2008:65) has developed the following framework, which integrates the existential, psychological and spiritual issues over the developmental stages of patients' lives.

DIAGRAM 1: AN EXAMPLE OF AN INTEGRATED APPROACH SPIRITUALITY OF PATIENTS

Existential issues experienced during various developmental stages	Life needs (Being basic needs)	Christian spiritual healing/therapy
Anxiety: experience of loss/rejection 	Intimacy: Affirmation and self-actualisation	Grace:  Unconditional love Role of God-images
Guilt/shame 	Freedom/deliverance	 Forgiveness/reconciliation
Despair/doubt 	Anticipation: meaning	 Eschatological realm of hope
Helplessness/ Vulnerability 	Support system	 Fellowship/ koinonial/diakonia
Frustration/anger  (disappointment and frustration; structural issues: poverty/unemployment/violence/ crime)	Life fulfilment/direction/ transformation	 Gratitude and joy/ethics

Source: Louw (2008:65)

The opinions of the patient respondents about the relationship between spirituality and religion are diverse. “Generally speaking, one can be spiritual without being religious”. Being religious is however, not always equated to being spiritual.

Being able to describe the relationship between spirituality and religion does not mean consensus and clarity about the definition of each. Koenig (2000:54) emphasises that this is problematic for research.

Koerie (2006:104) describes the consensus as follows:

“By way of summary, therefore, spirituality in general refers to the values to which we subscribe which give meaning and orientation to our lives. Spirituality entails the on-going harmonious integration of the human person.

Religion, on the other hand, has connotations of institutional and ritual origin. Spirituality refers to something that is deeply personal, inward, and experiential in the lives of its practitioners. Spirituality is linked to art and music, to the aesthetic sense and thus offers access for those who locate themselves in the secular or find themselves resistant to religious discourse.

The following themes emanate from the discussions held with the patient focus groups.

4.3.2.3.3 Theme 3: Sources of support and care

This theme deals with the patients’ expressions of their understanding of spirituality. The central developmental task of the individual is emancipation from parents, as well as the development of identity (Canada, 1989:69). It appeared as if being dependant on other people (e.g. family members), whilst they actually need to move towards guided independence, is a source of frustration and pain for the respondents. ‘Instant independence’ in the case of illness appears to have left the respondents with worry, fear and anger, as they feel deprived of their independence responsibilities in some instances.

The respondents mention four key sources of support and care; Following are these key sources and a brief description.

4.3.2.3.3.1 Relatives and families

The verbatim quotes below confirm the role played by family support during illness:

“In the beginning, I could do it (eating) but later my grandmother on my father’s side came to fetch him when it became really worse. My father and my granny looked after me”.

“Granny looked after my mother, later she was moved to hospitals she was very sick.”

“My sister and the nursing people looked after her. When they saw my sister could not, they took my mother to the hospital.”

“My aunt nursed my mother at the end.”

“I was so scared. I did not know what to do anymore until my mother came.”

“In the midst of my illness, my grandmother came and informed my family of rituals that had to be performed. My parents listened and my situation changed.”

Older siblings and even a helper at home appeared perceived as the trustworthiness source of emotional, spiritual support and advice.

Literature confirms that strong families have a sense of spirituality defined in different ways (Barnett & Blakie, 2003:118). A strong spiritual base identified as an important strength for families that helps them celebrate and value the gift of life. Barnett & Blakie (2003:119) confirm that relatives mostly care for those family members in need of support. Research also points to the power and value in a strong spiritual base for building strong families. Spirituality therefore, demonstrated in the family’s ability to overcome life’s most challenging events. From this study, it also became clear that relatives often take on more responsibility for the care of their sick ones. Respondents experience relatives as supportive, especially in terms of nursing of the ill, and funerals.

4.3.2.3.3.2 Friends

The verbatim quotes below are explicit examples of friends considered as source of spiritual or even general support during illness:

“I talk to my friends.”

“I have many friends, but I only talk to one. Some of the others gossip about me, because I go to hospital often. They want to know why.”

“I have a special friend from next-door neighbour. We sit around and talk, and sometimes if I have to do too much at home, I call him to help.”

“I have three friends. We do hair and talk, maybe walk around a bit, because we have the same illness, we encourage each other.”

“I have one friend, she always visit me when I am sick, for encouragement and support.”

The role played by friends in spiritual support is very critical, especially in helping to define identity in the case of adolescents (Castrogiovanni, 2004:1). However; this is not always the case. Maputo (2004:58) quote Kendrick (1998:99) about the difficulties patients may experience: “Their anger at the unfairness of the world often contaminates their peer group relationships as they are likely to feel bitter that their friends have not had to cope with what they have had to deal with”. In addition, the bible provides good examples of how friends can be supportive. This might be helpful from a Christian perspective.

Most of respondents in the study identify friends as sometimes the most important source of support to them. This is congruent with the views expressed in the literature. In summary, having friends and supportive relationships increases a patient’s spiritual health.

These biblical passages support this belief. The passages are from the New King James Version:

Proverbs 17:17 – “A friend loves at all times.”

Proverbs 27:9 – “Ointment and perfume delight the heart, and the sweetness of man’s friend gives delight by hearty counsel.”

Ecclesiastes 4:9, 10 – “Two are better than one, because they have a good reward for their labour. For, if they fall, one will lift up his companion. But ,woe to him who is alone when he falls, for he has no one to help him up.”

The researcher is of the opinion that the passage in Ecclesiastes does not have to be interpreted literally as in ‘physically falling and possibly injuring yourself’. Interpreted as, for example, ‘falling by experiences, unpleasant events, sickness and the death of a loved one’. A true friend will be available to help one journey through these unpleasant events.

4.3.2.3.3.3 The community

Respondents viewed the community as a source of support and care. However, a perception of 'being different' can clearly be seen in this subtheme. Young patients participating in the study appears to be suspicious of community members, except for persons associated with home-based care groups, or belonging to a church or a support group who serve as a regular source of support to some. Following are some of the verbatim quotes indicating the community as source of support:

"... you get people who feel sympathy for me ...I really want their support and appreciate it when they lend a hand in my time of need."

"While others said ...God punished you for being like this...for what you are."

"A home-based care group came to give us food, support and prayers and I felt less pain."

"Why did it happen to me? Sometimes I do not believe in God and then I talk to the helper and my prayer group. Then they say, 'No, if God does something, He wants you to learn about life'. ... I think I have learnt enough now."

"They came to pray at my home. I am happy with God."

"Initially I was angry at God, but not anymore."

"They care about me, because they advise me on what to do if I have problems".

"I love God – I am very happy with God. He is very important in my life. There is no single night in my life that I don't pray before I go to sleep".

(Chile and Simpson, 2004:44) reveals that there is a strong link between an individual and the collective. In some cases, the community isolates the sick and they respond by isolating themselves further from the community.

According to the literature, the quotes above are real: spiritual communities provide benefits not to found in other social cultures. Throughout history, people have sought out such communities. In these communities they reveal the most important and personal developments in their lives. Joys and sorrows, vows and confessions, hope for better life beyond life on earth and fears shared in spiritual communities (Alexander,2010:56) .Yet, spiritual communities have also been the causes of much deep-set heartbreak and disappointment. Corruption and disparity have destroyed churches, synagogues and mosques as well as numerous alternative spiritual

communities. Then the faithful scatter, and some decide to never trust or be part of a spiritual community again (Alexander, 2010:106).

4.3.2.3.3.4 God and the church

The respondents have ambivalent reactions towards God and the church. It appears that the support of the church often stops at a certain point, leaving the patients to deal with their pain alone. They link this lack of support with their view of God, namely that He let the patients down.

Some respondents indicate despair in their time of need by asking “Why? Why does it happen to me?” and by saying: “...sometimes I don’t believe in God, because I feel He let me down”.

Other respondents voice a clear conviction in the church’s support:

“The church helped, they also conduct frequent visits to our home”.

Some respondents believe that religious support, be it from the church, family members or others, does provide some relief:

“The helper, she is very religious and she understands. She always gives the right advice according to the Bible. She is a Christian and she raised us up according to the church values. She taught us that if things go wrong or we are in pain, just go to God and pray and He would help you.”

Kasiram (2006:16) highlights the effectiveness of the relationship between social work and theology. D’Souza (2007: S58) believes that spirituality and its application in clinical practice plays an important role in patients’ recovery.

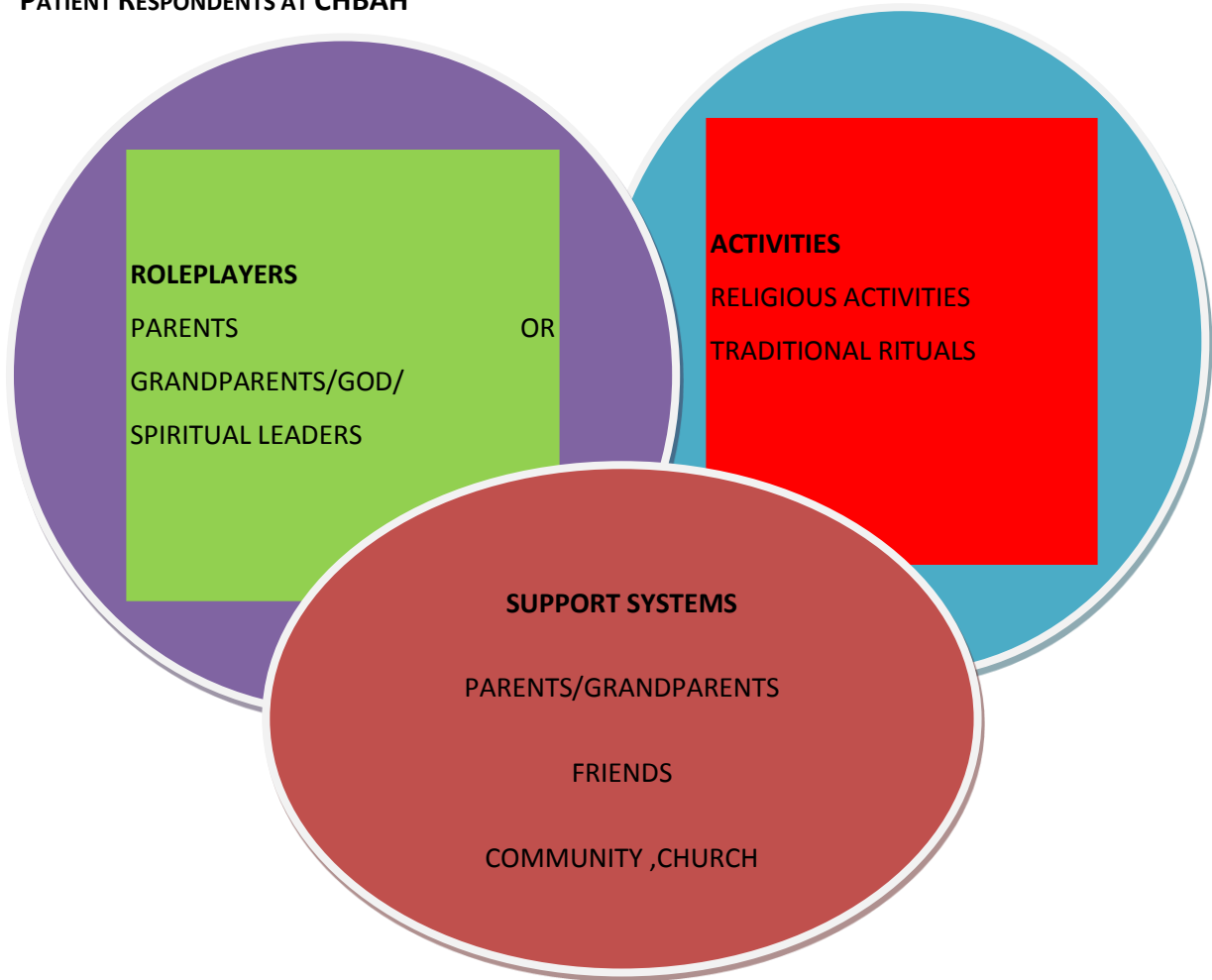
According Zambrani, (2010:55) Spiritual support is perhaps the best support one can attain. Other types of support tend to address a specific need, but spiritual support goes to the core of the issue, to we gain greater perspective of the situation that helps us to see solutions, remedy the problem and transcend the up and downs associated with life

4.3.2.4 The understanding of spirituality: a comparison of the views held by healthcare professional and patient respondents

In their understanding of spirituality, respondents share common understanding concerning spiritual activities, role players and support systems. These comparisons

drawn from the respondents' various cultural backgrounds and experiences. Their ideas grouped and discussed here, by using colours. The purple circle presents key role players identified by both groups; the blue circle presents activities performed, and the pink circle presents support systems. The description per circle follows below the diagram.

DIAGRAM 2: SPIRITUALITY: A COMPARISON OF THE UNDERSTANDING OF HEALTHCARE PROFESSIONAL AND PATIENT RESPONDENTS AT CHBAH



4.3.2.4.1 Role players

The focus-group discussions concerning spirituality in the respondents' developmental stages indicate that different individuals have played or are playing a role in their lives. Both groups view parents and spiritual leaders as key role players. Respondents see parents, grand/godparents as providing the foundation in terms of spiritual teachings and spiritual leaders who either nurtures or bring new understanding or dynamic on spiritual matters.

4.3.2.4.2 Support systems

In terms of support systems, respondents view friends, parents and the community as sources of support to affirm or build spiritual identity.

4.3.2.4.3 Activities

Spiritual activities vary from culture to culture. The following activities highlighted **honey tasting** which is an Indian spiritual practice. The child made to taste honey after birth as a sign that life will be good and sweet only if the child is respectful. **Imbeleko** is a Xhosa spiritual activity to welcome a new-born baby into the family. **Ukuthomba/umemulo** done in a Xhosa or Zulu culture as an indication that the girl child has reached maturity. **Circumcision (ulwaluko/ukusoka in IsiXhosa)** seen as one of the spiritual activities. However, the time at which performed in one's life, depends on the cultural background; some do it at birth while others do it when the boy child has reached the age of 18 years. Christians view **baptism** as a spiritual activity of welcome, while cell groups viewed as fellowship, which enhances the sense of belonging in a Christian family.

The respondents consider the spiritual/religious activities mentioned above as very important and necessary for a complete nurturing of one's developmental process. Some activities considered as a form of protection against evil.

4.3.2.4.4 An understanding of spirituality: a conclusion

The researcher's observation is firstly, that there are similarities in the spirituality of respondents over the lifespan, i.e. parents took lead in the spiritual activities and beliefs of their children. Secondly, children make their own confession of their spirituality under minimal supervision or guidance. Lastly, in adulthood, all have independent decision as they are then considered matured enough to do so.

Traditionally, the healthcare professionals did not want to engage with spirituality. Since the respondents more or less equate it to religion, seen as outside the scope of healthcare. As indicated in this report, this has changed. The healthcare benefits of religion and spirituality acknowledged and became part of the discussion about health and illness. Religion and spirituality can also play a very important role in the life of healthcare professionals. In many cases, tied to a sense of calling or personal

philosophy about care. It also plays a role in resilience, coping with a stressful environment and in preventing burnout.

The following section presents the feedback regarding a suggested protocol for CHBAH.

4.3.3 Section 3: Feedback on a suggested protocol for including spirituality in healthcare in CHBAH

These responses emanate from the focus-group discussions with both healthcare professionals and patients and may be useful in the development of a protocol for including spirituality in health care. The responses are therefore, presented collaboratively and in no order of priority:

- **In-service training:** Both groups view in-service training for healthcare professionals and ward talks for patients as vital tools to inform and address spirituality. For sustainability, this process should be on-going, e.g. bedside training or morning staff talks.
- **Orientation (e.g. to the different spiritual viewpoints/religions):** Both groups mention that orientation of staff in spirituality is important, however, it should be holistic and inclusive in covering all relevant forms of spiritual beliefs.
- **Training:** Healthcare professionals feel a need for formal training of spiritual matters. For this training to succeed however, management has to buy-in, e.g. by ensuring that workshops or short courses on spirituality conducted regularly within the organisation to accommodate new appointees. Patients feel that non-formal training accommodated; well-experienced and knowledgeable community leaders given an opportunity to do presentations in allocated slots. This means training offered to healthcare professionals and patients should be of high quality. It was also clear that the combination of formal and experienced peer-group training providers seen as important by respondents.
- **Facilitation of the implementation of a protocol to include spirituality in healthcare:** Healthcare and patients respondents feel that the hospital management should facilitate the implementation of the protocol implementation process and ensure that all stakeholders informed, including the community in their catchment area. In addition, patient respondents mention that it would be of

benefit if the spirituality admission expectations of the institution were e.g. completion of relevant forms on spirituality communicated to the community in advance and on a continuous basis to familiarise the community and reduce unnecessary conflict on the patient admission process and the healthcare professionals.

- **Advocacy:** The process to advocate for acknowledging the inclusion of spirituality and its role in the healthcare setting recommended. Orientation as a form of training in spirituality aspects will facilitate healthcare professionals to develop a wider range of coping and treatment references for a holistic healthcare approach. The orientation programme should be planned over time and include multi-professionals. Facilitate the balance between healthcare ethics and patients. The continued support through informal processes such as peer group support, supervision, fellowship and mentoring, identified as the key to influence the sustainability of the process.

Based on the results, the researcher is of the opinion that spirituality is a source of comfort for many patients. Although not expecting healthcare professionals to discuss and focus on their spirituality, as they understand the nature of their work, patients did mention that they expect healthcare professionals to ask about coping and support mechanisms. Some observational studies suggest that people who have regular spiritual practices tend to live longer. Patients, who are spiritual, may utilise their beliefs in coping with illness, pain and life stresses (Koenig *et al.*, 2001:54). Others on the other hand, view spiritual wellbeing as related to the ability to enjoy life, even in the midst of symptoms including pain. A proposed protocol for CHBAH to include spirituality in healthcare intends to address most of these aspects.

4.3.4 Consolidation of discussions

The respondents (i.e. healthcare professionals and patients) experienced the following:

- Currently, respondents do not perceive the hospital as supportive when it comes to spiritual needs.
- **Sadness, fear and anxiety** are the three most frequently experienced emotions related to spirituality experienced by the patient respondents.

-
- Religious groups seen as the most constant source of assistance, however, considered less visible.
 - Respondents have insufficient opportunity to express their spirituality because of the nature of hospital or healthcare norms.
 - Spirituality and spiritual needs suppressed.
 - Respondents felt inadequate in dealing with diverse spiritual beliefs.
 - Training and prevention campaigns do not take spiritual beliefs and practices into consideration.

These aspects will form part of compiling guidelines for the hospital management, namely a protocol to include spirituality in healthcare

The focus groups were the main source for the data gathered in this study. Information from the literature study integrated with the results from the focus-group discussions. The focus groups facilitated according to focus-group guidelines, attached as one of the addendums. These guidelines provided an opportunity for respondents, who were both professionals and non-professionals, to reflect on their experiences or understanding of spirituality. Data was analysed and reported on and checked against the literature.

The main themes summarised as:

- Understanding of spirituality – The insight of respondents regarding their understanding of spirituality in their day-to-day life shared and considered valuable and important.
- Spirituality as a source of support – Experiences and insight shared by all respondents, clarified the importance of spirituality as a source of support in one's overall lifespan.

The above research findings thus provided the answer to the research question, namely: "What is the understanding of spirituality among patients and healthcare professionals at CHBAH?"

In support of these findings, literature supports the encouragement of spirituality in the workplace can lead to benefits in areas as creativity, honesty and trust, which may ultimately lead to increased organisational loyalty. Spirituality can further assist the healthcare professionals and patients to expand the frontiers of his

consciousness beyond the normal boundaries, leading to increased intuition and creativity (Cash & Gray, 2000:130, Guillory, 2000:56 Harman & Horman, 1990). Spirituality thus has the potential to link the creative power of the human mind with that of God's (Gunther, 2001:59). Spirituality has indeed been associated with Maslow's higher needs, such as "belonging and also some sense of achievement" (Burack, 1999:284). The economic-technological perspective theory suggested includes this sense of personal achievement as a reason for movement towards spirituality (Tischer, 1999:274). Spirituality increases commitment by establishing a trustful climate in the workplace (Burack, 1999:285). Organisational commitment is a concept that seeks to capture the nature of attachments formed by individuals, to their employing organisations (Ketchand & Strauser, 2001:1). Though the quotes suggest that spirituality produces good results, some experiences mentioned by healthcare professionals and patients reflect some limitations at Chris Hani Baragwanath Hospital.

Based on these findings, themes and conclusions, the researcher would propose a protocol for CHBAH management on how best to consider and accommodate the spirituality of both healthcare professionals and patients (see Chapter 5).

Addressing spirituality in healthcare offers a unique opportunity for healthcare professionals and patients. Firstly, it is immediately relevant to individuals and communities and to the South African society and addresses core issues that also relate to other problems. In addition, everybody involved will be engaged in some way on a personal level, because spirituality touches the core of humanity.

The following chapter focuses on the proposed protocol presentation to the CHBAH management.

CHAPTER 5

PROPOSED PROTOCOL FOR INCLUDING SPIRITUALITY IN HEALTHCARE AT CHBAH (CHBAH)

5.1 GENERAL INTRODUCTION

This study strived to explore the understanding of spirituality among healthcare professionals and patients at CHBAH. The specific objective was to develop guidelines in the form of a protocol to include spirituality in healthcare service delivery at the hospital. The implementation of the protocol should ideally have top management's buy-in, as this is believed to influence the active involvement of other stakeholders (Ketchand & Strauser 2001:11). In this case, the researcher expects to present the protocol to the top management meeting at the CHBAH to obtain their involvement in the implementation of the protocol.

5.2 INTRODUCTION TO THE PLANNED PROTOCOL

The Medical Dictionary (2006:876) defines a protocol as a written plan specifying the procedures followed in giving a particular examination, conducting research, or providing care for a particular condition. A protocol is further defined as the rules for any procedure or process in a specific institution (World Book Dictionary, 2003).

For the purpose of this research, 'protocol' defined as the procedures followed to include spirituality in healthcare service delivery at CHBAH. This protocol designed from literature, focus-group discussions and a mapping of healthcare professionals' spiritual journeys. The empirical results of this study based on the understanding that spirituality can influence a person's well-being and general health and professional experiences.

According to Sikhwomen (2001), the protocol development process entails a number of steps. These steps were the basic points of reference in developing this protocol and applied as follows:

5.2.1 Steps followed in the development process

1. Identify the healthcare issue that requires a protocol, namely the need to include spirituality in healthcare services (see chapter 1).
2. Use the findings and conclusions of this research as well as relevant literature, as a foundation to develop the protocol (see chapters 2 to 4).
3. Ensure that the following questions are answered in the proposed protocol:
 - a. What should the protocol to include spirituality in healthcare at CHBAH entail?
 - b. Why is the protocol needed?
 - c. How can the protocol be developed?
 - d. Who should develop and implement the protocol?
 - e. What is the significance of including spirituality at CBAH?

With this background in mind, this protocol designed and structured according to the following aspects:

- Purpose and service principles
- Definition of key terms
- Role-players
- Roles and responsibilities
- Implementation
- Protocol monitoring and evaluation

The proposed protocol processes discussed in more detail in the following paragraphs.

5.2.2 Purpose and service principles

The purpose of this protocol is to provide an organisational framework for including spirituality in healthcare services at CHBAH. The Health Comprehensive Guide (2000) emphasizes that healthcare professionals need to have an understanding of and appreciation for the beliefs and religious preferences of their patients in order to

provide optimal care for them. The researcher agrees with this statement, and emphasises that this principle should be applicable to patients as well as to enhance respect amongst patients themselves and between healthcare professionals and patients.

Spirituality is recognised as a factor that contributes to the health of many lives (Bhagwan, 2002:17). The concept of spirituality is found in all cultures and societies, expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All these factors can influence how patients and healthcare professionals perceive health and illness and how they interact with each other.

The following paragraph highlights principles that contribute to a person's general health and should be considered as service principles in this protocol. The *Batho Pele* principles and the principles associated with the social work profession are specifically emphasised. These principles should be kept in mind throughout the implementation of this protocol.

The *Batho Pele* principles include aspects such as consultation, openness and transparency (Department of Public Services). The social work principles on the other hand, focus on respect for the inherent worth of all individuals; the promotion of autonomy and self-determination; and respect for human dignity (Deci & Ryan, 2002:88). From this background as well as from the results, the researcher compiled the following principles to be emphasised in this protocol:

- Respect and recognition for the codes of conduct of various disciplines represented in the healthcare team
- The protocol should enable the inclusion of spirituality in healthcare service delivery at a minimal standard level and is subject to continuous review in view of spirituality diversity
- The autonomy of patients should be taken into consideration and their definite involvement in their healthcare and spirituality should be encouraged
- Entry into the communities in the catchment area of CHBAH should be carefully negotiated and communities should be consulted in mechanisms and processes to include spirituality in the broader healthcare context in an open and transparent manner

5.2.3 Definition of key terms

Healthcare, spirituality, role-players and protocol are the key terms applicable to the protocol.

5.2.3.1 'Healthcare'

'Health' defined as a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO, 2005). 'Healthcare' defined as the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions (Medical Dictionary, 2006:288). A general medical definition for 'healthcare' is "efforts made to maintain or restore health especially by a trained or licensed professional" (D'Souza, 2007:54). For the purpose of this study, 'healthcare' is considered as care to maintain or restore the holistic well-being of a patient, which include the mental, physical, emotional, spiritual and psychological dimensions of the patient.

5.2.3.2 'Spirituality'

Due to a variety of viewpoints on 'spirituality', this concept is difficult to define. When one speaks of spirituality in Africa, one talks about a way of life; one talks about life itself (Mbiti, 2000:24). According to Carroll (2001:34), 'spirituality' is not necessarily synonymous with religion, but it is based on the person's own philosophical beliefs that may be related to different religions/beliefs such as Christianity, Buddhism, Hinduism, Islam and atheism. In the context of this study, 'spirituality' is a way of life, and a belief in: someone or something – God or a symbol, visible or invisible, divine or ancestors.

From the definitions of 'spirituality' as well as from the results, it is clear that spirituality may involve religion and religious activities, but in the end, spirituality involves a number of personal choices and beliefs that will affect every individual's way of life and health, and which may serve as a coping mechanism and provide support and care.

5.2.3.3 Role-players

For the purpose of this study, role-players identified as CHBAH management, healthcare managers and professionals, patients, religious leaders and the community.

5.2.3.4 Protocol

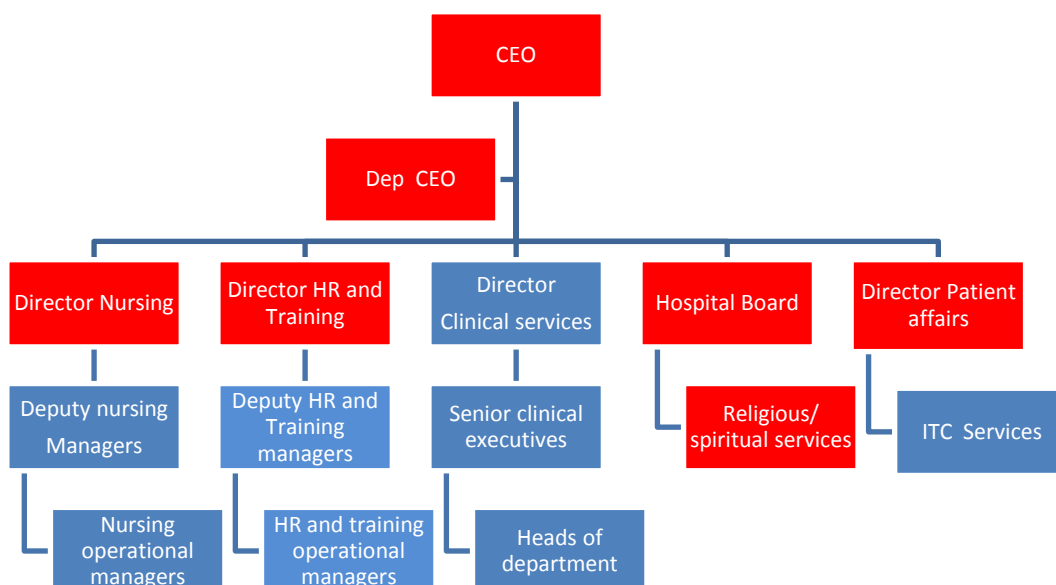
According to the Medical Dictionary (2006:991), a protocol is a written plan specifying the procedures followed in giving a particular examination conducting research, or providing care for a particular condition or situation. For the purpose of this research, the protocol is a written plan specifying the activities and procedures to include spirituality in healthcare at CHBAH.

5.3 ROLE-PLAYERS IN THE PROTOCOL

5.3.1 Organogram and lines of communication in CHBAH

Diagram 3 presents the organogram with role-players in the protocol and the associated lines of communication in CHBAH. The role-players are fundamental to the endorsement and implementation of the proposed protocol, their roles and responsibilities are described.

DIAGRAM 3: CHBAH MANAGEMENT ORGANOGAM AND LINES OF COMMUNICATION



The respondents indicate that the management should take lead in ensuring that all in CHBAH understand and respect spirituality. The following role-players should be directly involved in the protocol by virtue of their role and commitment to healthcare service delivery:

5.3.2 CEO, Deputy CEO and the Hospital board

The CEO is the entry point for presentation of the protocol, as he/she will be in a position to facilitate the meeting with various directors, heads of departments and managers (presented in red in Diagram 3). The heads of departments and managers are the supportive key in cascading the protocol to their respective departments through their unit or operational managers (presented in blue in the organogram). CHABH hospital management, in this case including these stakeholders will be responsible to:

- prepare an implementation plan for the roll-out of the protocol;
- ensure that the protocol is communicated to all staff;
- continuously monitor and evaluate the protocol; and
- Revise the protocol when needed.

5.3.3 Human resource section

From this study, it is apparent that the human resource section not only plays a role in the rollout of the protocol, but also in the appointment of spiritual caregivers at CHBAH. In the next paragraphs, the appointment and employment of spiritual caregivers at CHBAH discussed.

5.3.3.1 Appointment and employment of spiritual caregivers

The results of this research indicate that patients and healthcare professionals are from different religious affiliations and denominations. Therefore, a diverse group of spiritual caregivers should render spiritual services at CHBAH. The hospital board might decide to employ such spiritual caregivers in part time or full time positions.

5.3.3.2 Qualities and qualifications of spiritual caregivers

Spiritual caregivers must be of good standing in the community and be acceptable to their own faith community. They should also have the right personal qualities as stated the National Hospice and Palliative Care Organization.

Spiritual caregivers must:

- have undergone or be willing to undergo essential training;
- have proven ability to get on with people from diverse backgrounds;
- have knowledge and understanding of spirituality;
- be able to work on the basis of mutual respect for patients, caregivers and healthcare professionals; and
- Be able to listen empathetically to the personal beliefs based on the context of the orthodox teachings of their spiritual community.

5.3.3.3 Responsibilities of the employed spiritual caregivers

The spiritual caregiver will be responsible for the following activities:

- Plan, develop and deliver a spiritual care service to meet the assessed need, for example in acute units, a 24-hour and 7-day service.
- Visiting and supporting patients through spiritual care, pastoral conversation and religious ministry as appropriate.
- Conduct services of worship in a quiet room, chapel, sanctuary or other suitable venue.
- Support staff through pastoral care, the ministry of presence and where appropriate, counselling.
- Establish and maintain contact with local faith, religious and spiritual communities.

A spiritual caregiver does not always have to be an ordained minister or clergy. The hospital board and hospital management can arrange with spiritual communities to recruit and train a layperson for this work.

The afore-mentioned activities of spiritual caregivers originate from the guidelines of Scotland's National Health System, which also applies this procedure.

-
- Choosing spiritual caregivers is therefore a hospital board and management decision, but there should be allowance for diversity according to patient and staff needs.

5.4 TRAINING SECTION

The training section is well vested in different spiritual beliefs and religions and will be able to facilitate or cultivate a productive environment for training regarding diversity and the role of spirituality in healthcare. The training section must ensure continuous professional development, in-service training and orientation for new staff members. A number of development and training recommendations will be discussed in the following sub-paragraphs.

5.4.1 Healthcare professionals orientation on spirituality

After appointment, it is important that there should be some kind of orientation and/or training regarding the contents of this protocol and the fundamental aspects associated with spirituality in healthcare. An orientation plan developed for the process of strengthening the integration of spirituality in healthcare. This plan based on the unique needs and expectations of healthcare professionals, the healthcare management team and the patients of CHBAH. The following steps should guide the orientation plan or programme:

- Develop a standardised training programme to create an awareness of spirituality in healthcare and to develop spiritual sensitivity among staff
- Continuous orientation programmes
- A proper in-service training programme
- Clarification of the expectations of patients and staff
- Develop and support processes for the management and other healthcare professionals (e.g. peer support)
- Patient education and community awareness and empowerment
- Clarify the expectations of the programme to patients and healthcare professionals.

The detail of the suggested steps discussed as follows:

5.4.2 Development of a standardised training plan/programme on spirituality in healthcare

The CHBAH training department in liaison with the management should develop the plan. This plan will determine whom to nominate for training on spiritual awareness and sensitivity. The availability of the plan will ensure continuity and sustainability in the appointment of new members of the healthcare and management teams, e.g. training manager, human resources manager and the spiritual caregiver.

5.4.3 Continuous orientation for healthcare professionals

Newly appointed staff at CHBAH must undergo a basic orientation programme. Orientation in a new work environment is a common labour practice and a process of introducing new staff or people to the organisation or a new environment (Lussier, 2003:246). The importance of a continuous orientation programme is also emphasised by Swanepoel *et al.* (2008:298-299), who refer to orientation as a structured process which will allow new staff to feel at ease in a new environment. The results obtained during focus-group discussions, suggest communicating the plan to neighbouring healthcare providers and catchment areas to ensure a smooth referral or admission process. The researcher is of the opinion that good communication about the programme should lead to increased cooperation among all involved. Furthermore, competent management of the programme should allow stakeholders to experience a sense of belonging within the organisation.

5.4.4 In-service training

While the importance of the academic capacity of a healthcare professional cannot be overlooked, these skills should also be acclimatised to reality. During the focus-group discussions, respondents were asked to comment on different ways to facilitate personal and professional growth. The respondents confirm that activities such as teaching, coaching, counselling and mentoring can contribute towards growth, and highlight the importance to address judgement and attitudes when it comes to diverse spiritual exposure. Furthermore, training should offer opportunities for growth in personal and professional development in terms of spirituality. Dilt (2003:37) provides a comprehensive differentiation of opportunities for facilitating

growth among individuals, including healthcare professionals. These opportunities are highlighted and applied according to the purposes of this protocol.

- ✓ **Teaching:** Helping an individual or a group develop cognitive skills and capabilities associated with spirituality in health care.
- ✓ **Coaching:** Helping another person to improve awareness and to set and achieve goals in order to improve particular behavioural performance. In this protocol, it will involve increasing sensitivity towards the diverse aspects of spirituality.
- ✓ **Counselling:** Helping an individual or a group to improve performance by resolving situations from the past. In the context of this protocol, staff/healthcare professionals should be assisted in working through spiritual issues within themselves.
- ✓ **Mentoring:** Helping to shape an individual's belief and values in a positive way while, in this context, not allowing one's beliefs to interfere with expected work outcomes.

These development issues should be included in the suggested formal training of staff members. The learning-associated process and activities could be intentional and planned, focusing on a specific learning outcome; or unintentional and unplanned, where an opportunity for growth presents itself to be utilised by a healthcare professional or any other person.

The next section places more emphasis on the development and support processes for the management and other healthcare professionals to increase awareness on spirituality in healthcare and to promote the implementation of this protocol.

5.5 DEVELOPMENT AND SUPPORT PROCESSES FOR THE MANAGEMENT AND OTHER HEALTHCARE PROFESSIONALS

Respondents from the focus groups state that they had chosen to become healthcare professionals and that most of them perceive it as a calling. The demands and stressors associated with healthcare are widely described and experienced. Therefore, it is important to acknowledge the vulnerability of healthcare professionals towards stress-related illness and professional burnout. The work environment can affect healthcare staff's own spirituality – positively and

negatively. In this respect, social support among healthcare professionals are vital and measures should be in place to give them the necessary psychosocial and spiritual support. This process depends on interrelationships between healthcare professionals, management and their respective training departments. Based on an assessment of the discussed themes, an orientation process can be developed to introduce healthcare professionals to methods of effective integration of spirituality into healthcare.

5.6 PATIENTS, COMMUNITY AND RELIGIOUS LEADRES

With regard to the patients, community and religious leaders roles and training activities, the best way would be informing the patients and the community about the protocol through the following:

- Allow patients to share their spiritual needs
- To reflect on spirituality as a source of support and care
- Conduct awareness activities on spirituality
- Allow religious leaders to actively participate (give input or co-facilitate the activities) as spiritual caregivers at CHBAH. The following discussion presents how patients and the community will be informed about the protocol.

5.6.1 Patient education and community awareness and empowerment

The training committee will compile pamphlets on spirituality. Nursing personnel will then distribute it to wards and the community during awareness campaigns. This will yield positive results in terms of community participation and ownership in the endeavor to increase spiritual sensitivity. In addition, healthcare professionals will offer continuous and consistent educational talks to patients while waiting for doctors' consultation. Religious leaders could further get involved through spreading the message to their families, friends, churches, faith groups and community leaders.

5.7 HEALTHCARE MANAGERS AND HEALTHCARE PROFESSIONALS

5.7.1 Assessment of patients' spiritual needs

One of the final aspects of this protocol involves the assessment of patients' spiritual needs. Since this will not be the sole responsibility of a single discipline or staff member in CHBAH, it is important that all healthcare professionals should be empowered with knowledge on how to assess the spiritual needs of a patient.

According to Bardes (2004:44), assessment is a systematic collection, review and use of information about a specific situation in order to find solutions to challenges or to instigate development. Palomba (2005:16) defines assessment as a process of gathering and discussing information from multiple and diverse sources. This is to develop a deep understanding of what people know, understand, and can do with their knowledge. When assessing spirituality, the focus will be on gathering and discussing information on a spiritual level with the purpose of assisting patients in to use their spirituality as strength in their healing, compliance to treatment or adaptation to long-term health challenges.

The question may arise: What should be considered in a spiritual assessment? Puchalski (2001:355) considers the following aspects as vital in the spiritual-care assessment:

- **Compassionate –presence** – described as being present and attentive to the patients and being supportive to them in their suffering – physical, emotional or spiritual
- **Listening** – to patients' fears, hopes, pain and dreams
- **Spiritual history** – being attentive to all dimensions of patients and their families in terms of body, mind and spirit

In order to facilitate a spiritual assessment, Puchalski (2001:355) developed the acronym FICA as a method of taking a spiritual history. The method covers the following:

F: Faith and belief

Ask: Are there spiritual beliefs that help you cope with stress or difficult times?

I: Importance and influence

Ask: Is spirituality important in your life?

Are there any particular decisions regarding your health that might be affected by these beliefs?

C: Community

Ask: Are you part of a spiritual or religious community?

A: Address and action

Think and ask: *What should I, as healthcare professional, do with information the patient shared?*

- Refer to the spiritual coordinator who will then refer the patient to the chaplain, meditation or another spiritual resource. But from the results it is evident that the patients themselves also play a role.

Throughout these aspects, it is important to understand professional boundaries. Only well-trained spiritual caregivers should facilitate in-depth or advanced spiritual counselling. Spiritual assessment should not impose a view, but should seek to elicit the thoughts, memories and experiences that give coherence to a personal life. Therefore, healthcare professionals have an important task of screening patients' spiritual needs through the FICA method. The aim of such screening assessment should be to determine:

- ✓ what spiritual need the patient might experience;
- ✓ whether the patient's family is being cared for and whether services are required at home. If necessary, a referral should be made to relevant stakeholders; and
- ✓ whether there are problems in the family that might have a negative effect on the coping or recovery of the patient.

The screening function of the healthcare professionals should be communicated to patients and other referring stakeholders in the catchment area/community surrounding CHBAH. During the screening process, the healthcare professional

must always explain to the patient what the role of the healthcare professional is and what type of assistance is available.

During the initial assessment phase, the healthcare professional should adopt a non-judgmental and non-condemnatory attitude towards the patient and vice versa; they should accept one another and respect each other as unique individuals entitled to self-determination, as someone with intrinsic value and a specific orientation towards spirituality (Anandrarajah & Hight. E, 2001:88). The healthcare professional must empower the patient to make decisions about his/her personal affairs as well as those of the family.

Assessment should be seen as a continuous process aimed at providing information on the situation of the patient that could serve as a guide for holistic healthcare intervention. Therefore, assessment should take place in a relationship where an effort is being made to establish trust.

Diagram six presents the channels for the distribution and management of the protocol. In this diagram the processes in terms of roles are illustrated.

DIAGRAM 4: CHANNEL FOR THE PROTOCOL DISTRIBUTION AND MANAGEMENT FRAMEWORK



The description of roles and responsibilities in terms of managing the distribution and acquisition of the protocol were modified from the standard operating policy of the New South Wales ambulance service (Fischer, J.M. 2000:113). The senior patient affairs officer and senior information technology and communication (ITC) officer should be responsible for the protocol distribution and management of the protocol. This includes:

- Overseeing the management of protocols and distribution processes
- Ensuring that notification advice reaches all staff including: clinical training officers and operational managers
- Ensuring healthcare professionals' compliance with new and/or amendments, acknowledgement of receipt, implementation and audit procedures
- Reconciling acknowledgement and audit documentation and maintaining a central database register.

Operational managers are responsible and accountable for junior healthcare professionals within their departmental controls. Operational managers should:

- comply with procedures as outlined for managers and
- ensure that supervisors and station managers comply with this protocol.

Nursing station managers are responsible to ensure that newly appointed healthcare professionals are provided with, and maintain, current protocols. Nursing station managers should:

- procure protocols for all healthcare professionals within their area of responsibility;
- ensure that healthcare professionals remove out-dated protocols and insert the latest version;
- ensure that healthcare professionals sign for the receipt of protocols and provide verification of individual version control audit; and
- liaise with the training department or training educators for training issues that arise from new or amended protocols.

Healthcare professionals are responsible and accountable for ensuring that personnel protocols comply with this protocol and that current protocols are maintained. To ensure compliance, healthcare professionals should comply with healthcare service directives and version control and audit procedures. Healthcare

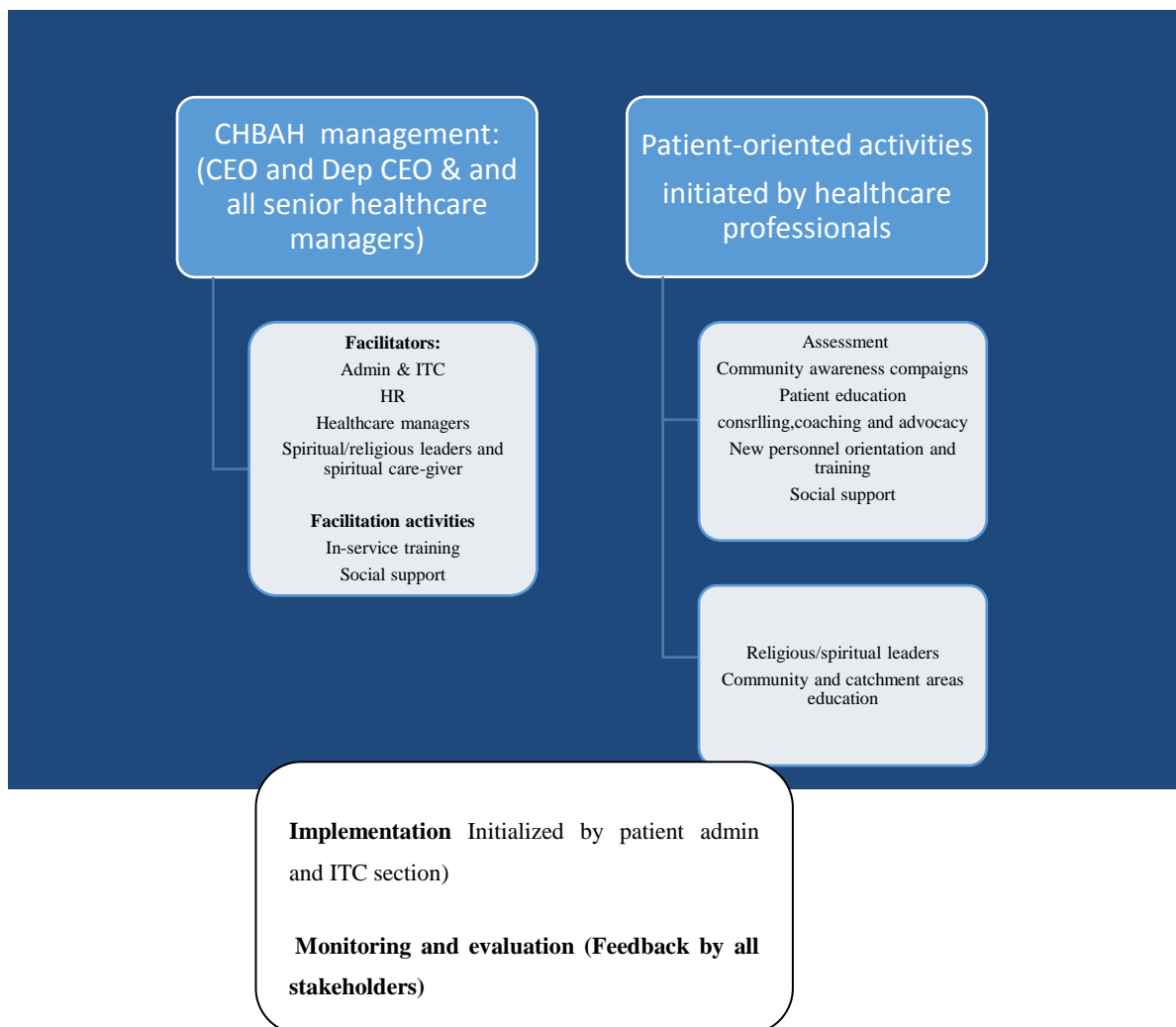
professionals should further take reasonable action to notify the senior administration officer and ITC senior officer of errors or inconsistency in the spirituality in the protocol. They should also seek assistance, if required, for clarification and /or training issues.

5.8 PROTOCOL IMPLEMENTATION AND MANAGEMENT FRAMEWORK

The following discussion covers the *HOW* of the protocol implementation management by focusing on staff appointment, facilitation of training, qualities and responsibilities of staff and creating awareness for the protocol among patients and within communities.

The protocol a process is illustrated in Diagram 5 (see overleaf) followed by a description of the suggested protocol activities.

DIAGRAM 5: IMPLEMENTATION PROTOCOL PROCESSES AND ACTIVITIES



5.8.1 Facilitation as key component in the protocol implementation and management process

Based on the results, the protocol should be initially facilitated and implemented by hospital management. This mean that they should master "... the art of leading people through a process towards agreed upon objectives in a manner that encourages participation, ownership and creativity from all involved" (Schrest, 2003:1). In the context of this study, facilitation is thus the act of leading role-players (healthcare professionals, patients, communities and management at CHBAH):

- ✓ towards an agreed objective on including spirituality in healthcare
- ✓ through processes focused on the inclusion of spirituality in healthcare (orientation, training, coaching, supervision and support);
- ✓ in such a way that all role-players take ownership and provide input into the process of integrating spirituality into healthcare.

The result of using facilitation as a process in the implementation of the protocol would therefore be to achieve exploration of the understanding of spirituality between the healthcare professionals and the patients. Only specific facilitators can facilitate the processes.

The following paragraph discusses the concept 'facilitator' and the role of facilitators in the implementation of the protocol.

5.8.2 Facilitator

According to American Society for Training and Development (ASTD, 2007:1), a facilitator is described as "one who guides the learning destination of adults and equips the learners for self"- development and continuous learning. Therefore for the purpose of this study, facilitators clearly identified followed by role clarification. From the findings of this study, the researcher identified a number of potential facilitators for strengthening the integration of spirituality in healthcare.

Table 14 lists the potential facilitators and summarises their associated roles.

TABLE 14: LIST OF FACILITATORS AND THEIR ROLES IN THE IMPLEMENTATION OF THIS PROTOCOL

Facilitator	Roles associated with each facilitator
CHBAH management	<ul style="list-style-type: none">✓ Participate in selecting training service-providers✓ Facilitate implementation of the training programme
Healthcare professionals	<ul style="list-style-type: none">✓ Contribute to the identification of spiritual needs✓ Participate in selecting training service-providers
Hospital board	<ul style="list-style-type: none">✓ Participate in selecting training service-providers✓ Assist in fundraising should there be a need for training
Community representation	<ul style="list-style-type: none">✓ Contribute by identifying spiritual needs (patients' perspective)✓ Participate in creating awareness on the Hospital's approach to include spirituality in healthcare
Internal training department	<ul style="list-style-type: none">✓ Facilitate training✓ Monitor progress✓ Evaluate results

Following the purpose and service principles at tis protocol, hospital management should involve the various role players, and negotiate/consult with them with regard to specific activities and the open and transparent implementation of the protocol. Table 14 outlines examples of actions the hospital management need to negotiate with the role-player for the successful implementation of the protocol. Hospital management might consider the following facilitation process during the implementation of the diagram (see diagram 5).

5.8.3 The facilitation process and role clarification

Diagram 6 describes the facilitation process as it pertains to the different roles.

DIAGRAM 6: THE FACILITATION PROCESS AND ROLE CLARIFICATION



5.8.4 Protocol document management framework

Following the identification of the facilitators and the clarification of their roles, the process to manage the distribution of the protocol document has to be set.

This process is summarised in Diagram 6, where the channel for the protocol management framework is illustrated.

Once the management of the protocol document ensured, the following step is to appoint staff and facilitate training towards the inclusion of spirituality in the general healthcare services at CHBAH.

5.9 PROCEDURES FOR INCLUDING SPIRITUALITY IN HEALTHCARE PROTOCOL

This protocol issued annually, except where patient safety or clinical risk considerations require urgent dissemination.

5.9.1 Notification and distribution

Notification will be by means of standard operating procedure (SOP) (for the protocols) and administration memoranda (for amendments). The notification will provide the following information:

- The general nature of amendments
- The requisition procedure
- Audit requirements and documentation to facilitate the audit

5.9.2 Electronic version

The administration and ITC senior officers will update new and/or amended protocols and version control indexes in CHBAH intranet. They will also ensure that electronic security measures are in place to protect electronic protocols from unauthorised changes.

The final aspect associated with this protocol relates to quality assurance and sustainability discussed under monitoring and evaluation part of the protocol.

5.10 PROTOCOL MONITORING AND EVALUATION

Structure the evaluation process to include specific measuring criteria and a set period. The internal training department along with management can develop such criteria. Healthcare professionals should also do a formal evaluation on those who attend the training. The researcher suggests that the evaluation process be simple but focused, and that be based on Kirkpatrick's four-level evaluation process as described by Clark (2011:1). These levels are:

- Level 1: Reaction (of the healthcare professional and patients). At this level, the healthcare professionals and patients could benefit in terms of providing the

management with continuous feedback on the efficiency or lack of as the protocol is implemented. This feedback could serve as tool to modify the protocol.

- Level 2: Learning (the capacity to perform acquired knowledge or skills while in the work environment). Level 2 could work well and yield positive results, when healthcare professionals are given opportunity to apply the skills and knowledge they acquired on spirituality with constant supervision and peer review. On the other hand patients may serve as a source to spread the message in their community leading to ownership.
- Level 3: Behavioural/performance (the extent to which the healthcare professional gained knowledge and skill) as healthcare professionals and patient would have contributed to the implementation of the protocol, the behavioural or performance in the healthcare setting might bring about positive results e.g. spiritual belief tolerance.
- Level 4: Result or impact (efficiency/morale of the healthcare professionals and extent to which patients benefit). The ultimate goal for all role-players is the implementation of the protocol that will address health professionals and patients spiritual needs. Therefore, active participation by all role-players will result in improved morale and efficiency, and that the spiritual needs of the patients are met.

This process of evaluation will provide feedback on the progress of healthcare professionals and stakeholders, as well as assist in identifying areas of needed additional support and training.

5.11 SUMMARY OF THE PROPOSED PROTOCOL

The main goal of this study was to explore the understanding of spirituality among healthcare professionals and patients at CHBAH, with the aim of developing guidelines in a form of a protocol to include spirituality in the healthcare at CBAH. Diagram 3 combines the information gathered throughout this study to form a schematic structure defining the aspects and processes involved in reaching the goal of the study.

Diagram 4 presents the process in terms of who is responsible, what needs to be done, how it has to be done and why it has to be done. In this instance the focus is particularly on the roles and responsibilities of stakeholders in the protocol.

The protocol designed to include spirituality in healthcare at CHBAH and developed by using the information collected through various methods of data collection during this study. Implement the protocol according to the needs of the healthcare professionals and patients. Moreover, be informed by feedback and evaluation processes and be adjusted where necessary, this protocol should be flexible. This protocol holds the potential to improve holistic healthcare in CHBAH.

5.12 CONCLUSION

Management forms an integral part of human service-delivery. When the management team is not equipped to fulfill the responsibilities in the healthcare setting, many stakeholders suffer, and the credibility of the institution is impaired.

The researcher recommends the following:

- The understanding of spirituality among healthcare professionals and patients to be supported.
- All role-players should be actively involved
- Community forms part of the team, therefore, inputs from the community should be considered
- Management teams should take the lead during this process.
- Not overlook a careful balance between the spiritual needs of healthcare professionals and their patients.
- A standard orientation programme should be developed, implemented and evaluated.

This chapter provided a detailed discussion on the protocol to include spirituality in healthcare. A number of conclusions and recommendations will follow in chapter 6.

CHAPTER 6

SUMMARY, EVALUATION, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The purpose of this chapter is to summarise the content of this research study on the understanding of spirituality among healthcare professionals and patients at CHBAH. The researcher will also make recommendations to CHBAH management and healthcare professionals regarding the implementation of the protocol for the inclusion of spirituality in the delivery of healthcare. To recapture the content of the study, a brief description of each chapter follows.

6.2 SUMMARY OF THE STUDY

- In **Chapter 1**, the researcher explained the relevance of the topic, formulated the problem, and set the objectives of this study.
- **Chapter 2** focused on the research methodology: a structure presented to ensure that the study complies with the expected social research standards and practices.
- **Chapter 3** dealt with the literature review on the topic of spirituality. The literature review provided an overview of the current situation regarding spirituality in healthcare. The comprehensive literature review served as background to the contextualisation of spirituality and healthcare in CHBAH.
- In **Chapter 4**, the results obtained from healthcare professionals as well as patients discussed, forming the foundation for a protocol to include spirituality in healthcare.
- In **Chapter 5**, the researcher proposed a protocol to include spirituality the healthcare at CHBAH.
- **Chapter 6**: The purpose of this chapter is to provide a brief summary of the preceding chapters, including conclusions arrived at and recommendations

derived from these chapters. The chapter also evaluates each objective and the overall goal of the study.

6.3 EVALUATION OF THE GOAL AND OBJECTIVES OF THE RESEARCH

6.3.1 Evaluation of the goal of the study

The goal of this study was to explore the understanding of spirituality among healthcare professionals and patients at CHBAH. This would improve the knowledge base and insight of healthcare professionals that would further enable them to render holistic healthcare services.

The goal was achieved, as the study provided information on the understanding of spirituality.

6.3.2 Conclusions regarding the objectives of the study

This study had three objectives, namely:

6.3.2.1 Objective 1

- To explore spirituality in healthcare by means of a literature review.

An intensive literature study was taken as reflected in Chapter 3, which serves as evidence of the researcher having achieved the objective.

6.3.2.2 Objective 2

- To explore and describe the views of healthcare professionals and patients on the understanding of spirituality in a healthcare setting.

The empirical study was undertaken by means of focus-group discussions and spiritual journeys with healthcare professionals, as well as focus-group discussions with patients at CHBAH. The results of the seven focus groups conducted (48 respondents took part) are reflected in Chapter 4. This objective was also achieved.

6.3.2.3 Objective 3

- To explore and describe the understanding of spirituality among healthcare professionals and patients in CHBAH. Focus groups were conducted with patients from various medical units at CHBAH. The results presented in Chapter 4 testify to the achievement of this objective.

6.3.2.4 Objective 4

- To propose a protocol on the incorporation of spirituality in healthcare at CHBAH.

A protocol was developed and proposed to serve the purpose of including spirituality in healthcare at CHBAH. The impact and importance of the evaluation and feedback was added to the structure of the protocol (see Chapter 5).

This objective was achieved with the compilation of this research report.

6.4 EVALUATION OF THE RESEARCH QUESTION

The formulation of a research question was relevant, as the study was qualitative and exploratory. The following question summarised the overall aim of the study:

What is the understanding of spirituality among healthcare professionals and patients at CHBAH?

The study has been able to answer this question, as in the discussion of the following main themes that were identified in this study:

- Understanding spirituality
- Spirituality as a source of support
- The respondents' expectations of CHBAH regarding spirituality

It can be concluded that spirituality has a positive impact on the emotional, social and physical status of the healthcare professionals and patients at CHBAH.

6.5 RECOMMENDATIONS

Based on these conclusions, the following recommendations are to be proposed to CHBAH management and healthcare professionals:

6.5.1 Recommendations for the improvement of services on a micro-level

6.5.1.1 Resources needed to include spirituality in healthcare

CHBAH management should facilitate the provision of professional spiritual care of the highest quality to patients and healthcare professionals in a way that is consistent with their individual faiths/spiritual traditions. Thus, the inclusion of spirituality in healthcare at CHBAH can be achieved by providing an accessible counselling and administrative centre for patients and healthcare professionals in need of spiritual counselling. This centre must provide a caring and supportive environment for patients and healthcare professionals. CHBAH should support patients who are being discharged by tasking departments like medical social work, with the responsibility to link them with community resources offering spiritual care.

6.5.1.2 Relationship management to improve an awareness of the spiritual needs of healthcare professionals and patients in the healthcare setting:

CHBAH management, in consultation with the religious ministers, have to facilitate the spiritual care of patients by the representatives of their faith communities outside the hospital. The facilitation process must include organising and overseeing spiritual/religious meetings (e.g. church services and memorial services) and providing a place of worship where people could also go for meditation and/or prayer. In addition, there should be open dialogue about how the process of including spirituality in healthcare at CHBAH should unfold. All role-players need to clarify ethical issues, especially with regard to the spiritual beliefs of a patient or healthcare professional (e.g. the beliefs of Jehovah's Witnesses and Hindus).

6.5.1.3 Training

Human resource and training divisions, along with healthcare managers should consult with management to recruit, train and supervise newly appointed healthcare professionals. The training section should introduce programmes that foster work engagement by redesigning the existing in-service training manual in order to cater

for the inclusion of spirituality. Spiritual self-awareness programmes designed to help healthcare professionals understand their own spirituality and further respect diverse spiritual beliefs. On a more formal training basis, it could be beneficial to include spirituality as one of the modules for healthcare professionals (including social workers), so the topic does not shock when it arises in the real work environment.

The other recommendation on training is to source volunteers, who will comply with the selection criteria of spiritual care and counselling of the spiritual care-giver (see Criteria, Roles and Responsibilities in Chapter 5). The volunteers should attend relevant accredited training as organised by the training section of CHBAH. Once they are accredited, they could visit wards, receive supervision and literature, and refer relevant issues to healthcare professionals when the scope is beyond their capabilities.

6.5.1.4 Establish support groups

Healthcare professionals should provide spiritual and emotional support among themselves by mentoring one another in dealing with diverse spiritualities. The hospital training department should ensure that healthcare professionals have access to literature on spirituality. Further, support provided in the form of various media, for example the use of videos or cassettes in meditation or prayer rooms.

6.5.2 Recommendations for improvement of services on a macro-level

Strengthening the integration of spirituality into a healthcare environment

6.5.2.1 Implementation of a protocol to include spirituality in healthcare services

Healthcare professionals are to be encouraged to assess the spiritual needs of patients and provide spiritual care as well as emotional and developmental support to patients in need. A course on spirituality as part of a comprehensive healthcare is recommended as part of their undergraduate studies.

6.5.2.2 Spiritual care and bereavement counselling

Provision for 24-hour spiritual care and counselling to accommodate patients admitted after normal working hours as well as accommodating the spiritual needs of those healthcare professionals on duty at the time.

Healthcare professionals are the most important asset in healthcare. If healthcare professionals are misinformed about matters of spirituality, it could be detrimental to their patients and their own well-being. Preventing the detrimental effects and enhancing sound relationships among healthcare professionals, CHBAH, patients and communities is vital. Interdependence is a process; therefore, all stakeholders need to take an active role in the process of including spirituality in healthcare at CHBAH to ensure sustainability.

Future research

The following are suggestions for future research:

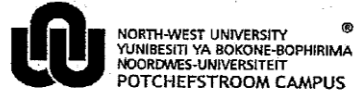
- ✓ The evaluation of the protocol to include spirituality in healthcare services.
- ✓ How can spirituality as coping mechanism benefit patients?
- ✓ What spiritual support programmes or activities could be developed to address spiritual needs in a healthcare setting?
- ✓ It is recommended that the inclusion of diverse spiritual beliefs in healthcare training institutions be explored.

6.6 SUMMARY

This chapter provided an overview of the research study and the resulting report. A summary was provided of the research methodology and its effectiveness. The qualitative process was successfully employed to answer the research question and to achieve the objectives. Recommendations to CHBAH management were made on both micro and macro levels. Finally, the researcher identified and recommended possible future research topics.

ADDENDA

ADDENDUM 1: LETTER OF APPROVAL: RESEARCH PROPOSAL AND ETHICS COMMITTEE



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
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Tel: 018 299-1111/2222
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To whom it may concern

School of Nursing Science
Tel: 018 2991884
Fax: 018 2991827
Email: emmerentia.duplessis@nwu.ac.za

21 June 2011

Dear Sir/Madam

Confirmation of ethical clearance

Regarding the research: *The role of spirituality in medical social work (PhD Candidate: Mrs TS Nkomo, Promotor: Dr A Herbst, Co-promotor: Dr E du Plessis)*

This research will focus on exploring and describing the role of spirituality in medical social work. In view of this general aim, the following are specific objectives for this study:

- To explore the role of spirituality in medical social work by means of a literature review.
- To ascertain medical social workers' views concerning the relevance of spirituality in social work intervention.
- To investigate the needs of patients concerning spirituality as a coping mechanism.
- To provide guidelines for medical social workers concerning the role of spirituality in medical social work for implementation during social work interaction with patients.

This research is a sub-study in an overarching research project, entitled: *Strengthening the resilience of health caregivers and risk group*, with ethical clearance from the Ethics Committee of the North-West University (Ref no NWU-00036-11-S1). The co-investigators are Prof MP Koen and Dr E du Plessis.

Background information and link with sub-study:

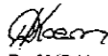
The co-investigators identified the problem that the resilience of health caregivers as well as risk groups should be strengthened by means of a comprehensive, multi-faceted approach and that research should be conducted on how resilience of health caregivers and risk groups can be strengthened by means of such an approach. The purpose of the overarching research is thus to develop a comprehensive, multi-faceted approach to strengthen the resilience of health caregivers as well as risk groups. We intend to reach this purpose through the following objectives:


- To explore and describe the resilience of health caregivers and risk groups

-
- To implement and validate strategies developed by Koen, Van Eeden and Wissing (2010c) to strengthen resilience of professional nurses and other health caregivers and risk groups
 - To explore and describe faith community nursing as intervention to strengthen the resilience of health caregivers and risk groups
 - To explore and describe sensory stimulation as intervention to strengthen the resilience of health caregivers and risk groups

To achieve these objectives, it is necessary to explore and describe various health caregivers and risk groups. Within this overarching research project, Mrs TS Nkomo (Student number: 22263489) intends to focus on spirituality of health caregivers and risk groups, as mentioned above. The results of this sub-study will contribute to reaching the objectives of the overarching project, because an exploration and description of spirituality – which is a fundamental aspect of resilience (Koen, 2010) – will inform the development of a multi-faceted approach to strengthen resilience. The methodology and ethical aspects of Mrs Nkomo's study is congruent with the methodology and ethical aspects of the approved overall study on resilience. We therefore confirm that the sub-study of Mrs TS Nkomo is covered by the above-mentioned ethical clearance.

Yours sincerely


Prof MP Koen
Co-investigator


Dr E du Plessis
Co-investigator

ADDENDUM 2: LETTER OF PERMISSION TO CONDUCT RESEARCH: GAUTENG HEALTH CHBAH

MEDICAL ADVISORY COMMITTEE
CHRIS HANI BARAGWANATH HOSPITAL
PERMISSION TO CONDUCT RESEARCH

Date: 15 April 2011

TITLE OF PROJECT:

An exploration of the understanding of spirituality among patients and staff of the Chris Hani Baragwanath Hospital

UNIVERSITY: North-West University, Potchefstroom

Principal Investigator Ms TS Nkomo

Department: Social Work

Supervisor (if relevant): Dr AG Herbst

Permission Head Department (where research conducted)

Date of start of proposed study: May 2011

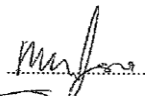
Date of completion of data collection Dec 2011

The Medical Advisory Committee recommends that the said research be conducted at Chris Hani Baragwanath Hospital. The CEO /management of Chris Hani Baragwanath Hospital is accordingly informed and the study is subject to:-

- Written consent be obtained from all participants in the study
- Permission having been granted by the Committee for Research on Human Subjects of the University of the Witwatersrand.
- the Hospital will not incur extra costs as a result of the research being conducted on its patients within the hospital
- the MAC will be informed of any serious adverse events as soon as they occur
- permission is granted for the duration of the Ethics Committee approval.

PROF JOHN PETIFOR
~~M.B.Ch.B. (S.A.)~~
~~CHIEF MEDICAL OFFICER~~

Recommended
(On behalf of the MAC)
Date: 15 April 2011


Approved/Not Approved
Hospital Management
Date: 19/04/2011

ADDENDUM 3: INVITATION TO PARTICIPATE IN FOCUS- GROUP DISCUSSIONS

Addendum 3: Invitation to Focus Group discussions



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School for Psychosocial Behavioural Sciences

Enquiries: Alida.Herbst@nwu.ac.za

To whom it may concern

POST GRADUATE STUDIES: MS T.S NKOMO

Ms Nkomo is a registered PhD student at this University. She intends to do a research project in the field of medical social work with specific interest in the role of spirituality in the bio-psychosocial well-being of patients.

The following title for her thesis was suggested by the research committee of the Faculty of Health Sciences at this University:

An exploration of the understanding of spirituality among patients and staff of the Chris Hani Baragwanath Hospital

She already submitted a proposal in this regard and is in the process of obtaining ethical permission from the Ethics Committee. As part of the ethical approval, it is expected that Ms Nkomo first obtain the permission of the institution in which she works, as well as from the Gauteng Department of Health.

Your consideration of her planned research is appreciated.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Ag Herbst'.

DR AG HERBST

SENIOR LECTURER: SUBJECT GROUP SOCIAL WORK

ADDENDUM 4: LETTER OF INFORMED CONSENT FOR HEALTHCARE PROFESSIONALS

LETTER OF INFORMED CONSENT FOR HEALTH PROFESSIONALS

Title of the study: The exploration of the understanding of spirituality among healthcare professionals and patients at the Chris Hani Baragwanath Academic Hospital.

Principal Researcher: Thobeka S Nkomo, PhD. (Social Work) student, University of North-West: Potchefstroom Campus, Potchefstroom.

TARGET GROUP: Health professionals and patients at Chris Hani Baragwanath Academic Hospital.

Participant's Name: ----- **Date:** -----

Purpose of the Study: To explore the understanding of spirituality among healthcare professional and patients at the Chris Hani Baragwanath Academic Hospital.

Procedure: As a participant in this focus group, you will participate and be asked questions about your understanding of spirituality. The focus group proceedings will be tape recorded for the purpose of collecting the data and the duration will be approximately forty five minutes. The data will be stored according to the prescribed standards of the Universty of North-West.

Risks and Discomforts: No known medical risks or discomforts are associated with the participation in this study. Should you experience any emotional harm as a result of the focus group; debriefing will be provided by the researcher at the end of the focus group session.

Benefits: The results this study will assist the hospital to understand your views of spirituality and assist in developing and implementing guidelines that will enhance your services regarding spirituality.

Participants Rights: You may withdraw from participating in this study at any time and withdrawal from the will not have any negative implications for the participant.

Confidentiality and anonymity: The data collected during the focus groups using a tape recorder and field notes will remain confidential. This data will be transcribed after the group and your name will not be used instead a number. The data will not be linked to your name or identity, maintaining anonymity. The results may be published in a professional journal or presented at professional conferences, but will never linked to your identity.

I----- understand my rights as a research participant, and I voluntary consent to participate in this study. I understand what the study is about and the procedures in this study. I will receive a copy of this consent form.

Participant's signature

Date

Signature of the researcher.

ADDENDUM 5: LETTER OF INFORMED CONSENT FOR PATIENTS

Title of the study: The exploration of the understanding of spirituality among healthcare professionals and patients at CHBAH.

Principal Researcher: Thobeka S Nkomo, PhD. (Social Work) student, University of North-West: Potchefstroom Campus, Potchefstroom.

Target group: Patients at Chris Hani Baragwanath Academic Hospital.

Participant's Name: -----**Date:** -----

Purpose of the Study: To explore the understanding of spirituality among healthcare professional and patients at CHBAH.

Procedure: As a participant in this focus group, you will participate and be asked questions about your understanding of spirituality. The focus group proceedings will be tape recorded for the purpose of collecting the data ant the duration will be approximately forty five minutes. The data will be stored according to the prescribed standards of the University of North-West.

Risks and Discomforts: No known medical risks or discomforts are associated with the participation in this study. Should you experience any emotional harm as a result of the focus group; debriefing will be provided by the researcher at the end of the focus group session.

Benefits: The results this study will assist the hospital to understand your views of spirituality and assist in developing and implementing guidelines that will enhance your services regarding spirituality.

Participants Rights: You may withdraw from participating in this study at any time and withdrawal from the will not have any negative implications for the participant.

Confidentiality and anonymity: The data collected during the focus groups using a tape recorder and field notes will remain confidential. This data will be transcribed after the group and your name will not be used instead a number. The data will not be linked to your name or identity, maintaining anonymity. The results may be published in a professional journal or presented at professional conferences, but will never linked to your identity.

Understand my rights as a research participant, and voluntary consent to participate in this study.

I----- understand what the study is about and the procedures in this study. I will receive a copy of this consent form.

Participant's signature _____

Date _____

Signature of the researcher

ADDENDUM 6: GUIDELINES AND INTERVIEW SCHEDULE FOR HEALTHCARE PROFESSIONS FOCUS-GROUP ACTIVITY

PhD (SOCIAL WORK)

School of Psychosocial Behavioural Sciences: Social Work Division,
Faculty of Health Sciences, North-West University: Potchefstroom Campus

THOBEKA SWEETNESS NKOMO

STUDENT NUMBER : 22263489

PROMOTER : Prof A. G. Herbst (School for Psychosocial
Behavioural Sciences: Social Work Division)

CO-PROMOTER : Dr E Du Plessis (School for Medical Science: School
of Nursing Science Department)

Discussion guidelines and interview schedule for healthcare professionals' focus groups

(a) Welcome and Introduction

- Introduce group facilitator
- Welcome participants and thank them for participation

Icebreaker

Introduction of participants to each other:

- Issuing of name tags
- Brief background on spirituality
- Reasons for being in the meeting and importance of participation

(b) Aim of the study

- To explore the understanding of spirituality among patients and healthcare professionals at CHBAH. The purpose of this focus group is to explore your understanding of spirituality in your place of work, and to explore how you can implement it in your day-to-day activities.

(c) Guidelines for participation

- Cell phones should be turned off or placed in silent mode. If, due to the nature of your work, you should need to respond, do it quietly and respectfully and then re-join the group.
- Freedom of expression
- No right or wrong answers
- As the focus group is recorded, only one person is allowed to speak at any time
- Members do not need to agree with other. However, please listen carefully and respectfully as others share their views
- Group interaction and participation is encouraged

(d) Completion of the informed consent form

- Handing out of forms and pens
- Read through the form, highlight and explain aspects of importance
- Collect signed forms

(e) Description of how the discussion will proceed

Participants are briefed on what to expect and given the opportunity to ask questions, comment on the format, or help to structure the process.

The facilitator then introduces each topic and asks questions to get the discussion off the ground. She makes some observation and takes notes as this process unfolds. Further questions may be asked or participants may be requested to share their personal experiences.

(f) Questions for discussion

- What is your primary duty/job in this ward?
- Why are you doing this job?

-
- What is your understanding of spirituality?
 - Plot your spiritual journey by following the instructions described in (g).
 - I would like you to plot your spiritual journey as an imaginary road. You may decide which of your spiritual life from birth until today you would like to include on this journey map. Please try to answer the following questions
 - What impact does spirituality have on your day-to-day work situation in this hospital?

(g) Activity: Mapping my road of life

- Hand out paper and pencils
- Plot your spiritual journey as per instruction
- I would like you to use this sheet of paper to draw the road of your life from birth until today. You may decide which information should be included on your road, but it should include information about your work.
- After you have made your drawing, I would like you to mark with an **F** all incidents in your life that you associate with joy, sorrow, pain, coping, hope or any other feelings
- Then, take a look at your road of life and think about any spiritual or personal rituals you might have followed to help you deal with challenges in your life. Mark these incidents with the letter **B**.
- On your map, indicate times when you experienced or needed religious (spiritual) support from your church community, family, friends or anyone else and mark it with the letters **RS**
- Take another look at your map and indicate in which instances spirituality played a role in your dealing with life situations. Mark these with a **C**.

ADDENDUM 7: GUIDELINES AND INTERVIEW SCHEDULE FOR PATIENTS FOCUS-GROUP ACTIVITY

PhD (SOCIAL WORK)

School for Psychosocial Behavioural Sciences: Social Work Division,
Faculty of Health Sciences, North-West University: Potchefstroom
Campus

THOBEKA SWEETNESS NKOMO

STUDENT NUMBER : 22263489

PROMOTER : Prof A .G Herbst (School for Psychosocial
Behavioural Sciences: Social Work Division)

CO-PROMOTER : Dr E Du Plessis (School for Medical Science: Nursing
Department)

Discussion guidelines and interview schedule for patients' focus groups

(a) Welcome and Introduction

- Introduce group facilitator
- Welcome participants and thank them for participation

Icebreaker

Introduction of participants to each other:

-
- Issuing of name tags
 - Brief background on spirituality
 - Reasons for being in the meeting and importance of participation

(b) Aim of the study

- To explore the understanding of spirituality among patients and healthcare professionals at CHBAH. The purpose of this focus group is to explore your understanding of spirituality in your workplace, and to determine how you can implement it in your day-to-day activities.

(c) Guidelines for participation

- Cell phones should be turned off or placed in silent mode. If, due to the nature of your work, you should need to respond, please do it quietly and respectfully and then re-join the group.
- Freedom of expression
- No right or wrong answers
- As the focus group is recorded, only one person is to speak at a time
- Members do not need to agree with others. However, please listen carefully and respectfully as others share their views.
- Group interaction and participation is encouraged

(d) Completion of the informed consent forms

- Hand out forms and pens
- Read through the form, highlight and explain aspects of importance
- Collect signed forms

(e) Description of how the discussion will proceed

Participants are briefed on what to expect and given the opportunity to ask questions, comment on the format, or help to structure the process.

The facilitator will then introduce each topic and ask questions to get the discussion off the ground. She will make some observations and take notes as this process unfolds. Further questions may be asked or participants may be requested to share their personal experiences.

(f) Questions for discussion

- What is your understanding of spirituality?
- I would like you to describe your spiritual journey as a developmental process. You may start your spiritual life from birth until today
- What would you like to see in this hospital regarding spirituality?

Feelings	What role does your spirituality play in handling life, sorrows, enhancing life's joys or coping in your work environment?
Behaviour	Are there particular spiritual rituals that help you deal with life's challenges?

(h) Discussion

(i) Closing comments

(j) Summary and Conclusion

Thank you for your participation

ADDENDUM 8: AN EXAMPLE OF A TRANSCRIBED INTERVIEW

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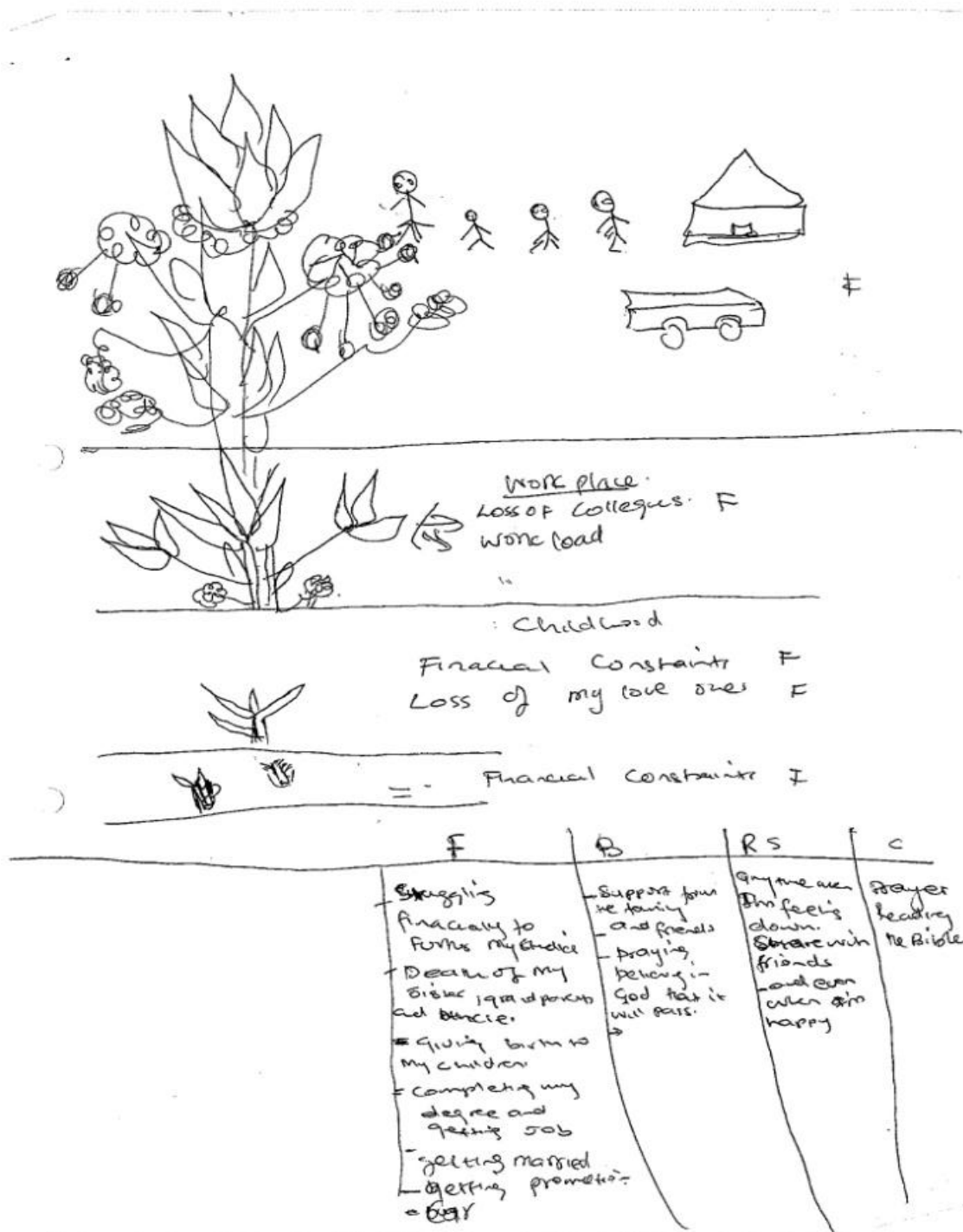
I've made an example of this talking stick, when I talk it means everybody else keeps quiet and listen to my opinion when I'm done, another person will get an opportunity to express his or her _____. And then you can _____ expression is highly encouraged. Okay that was the introduction and also mention that at the end of the study I will make time or give myself time to come and give the report what were the outcome of the, the study that I have conducted. Eh in the recordings or in the, as the, the informed consent has indicated you will not be your name will not be mentioned in any way in the report, the overall report. It will remain an anonymous. As the consent form has indicated form has indicated feel free to participate. When you feel you're no longer comfortable with participating you withdraw. So what we did before you participated we completed the _____ the informed consent, then we signed and then we agree to participate, so you take one copy of the informed consent, read it through and then sign it if you feel you would like to participate. And then I've also mentioned eh we will be using the charts for notes in case I've missed something or I can't hear something clearly on the tape-recorder, I'll be able to capture the notes or get the information from the charts to avoid thumb sucking on the results. So that's why I use both charts and the tape-recorder. So in the first type which was this one, we were explaining what is your role or duty in the hospital. So from the four of you I'll ask, if there's an extra page of the A4, if you can just respond for me I'll add the information to, to this one. What is the role, in this question when you respond you'll say social worker grade three, you're doing oh surgical kids, what is it exactly that you're doing at surgical kids. If you're social worker grade two you do the same. Social worker grade three, you don't have to mention your name, you just indicate you're a social worker in grade three or a social worker in grade two in which unit, what are you doing. You're responding for this question one. Question two we _____ why are you doing the job that you are doing. So you will explain, you just add there, was it for money, was it for, it's a calling or was it passion, was it is there other reasons you just add it and then I will add also them there. Or if you feel free you may at the end of the activity just come and add what you want to add. If you feel you think it's better to come and write here another one writing on a separate A4 I will also accept that. We did, eh what is your role, why you're doing what you're doing, the job that you're doing and then we came to the core business, what is your understanding of spirituality. So the team members or the group members have given their understanding of spirituality so you can give your indication or your understanding what do you understand the quality to be, so that you give those different opinions, you can also give your opinion. And then, okay these were the responses on that, it's confident. We're now doing the activity from where we draw our spiritual journey. Yes ma

R: _____

I: Can I get these, thank you.

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ADDENDUM 9: AN EXAMPLE OF A PLOTTED SPIRITUAL JOURNEY



ADDENDUM 10: CONFIRMATION OF EDITING

2013-11-01

Potchefstroom

Hiermee gee ek, Ina-Lize Venter, kennis dat ek die volgende verhandeling op versoek van die student, me. Thobeka Nkomo, en met die goedkeuring van haar promotor, dr Alida Herbst, taalkundig versorg het. Die verhandeling is met korreksies en voorstelle vir verbeteringe in die sorg van die student oorhandig, waarna dit haar vry gestaan het om enige voorstel/korreksie te aanvaar of te verwerp.

Die taalversorger is 'n lid van SAVI (die Suid-Afrikaanse Vertalersinstituut) (lidmaatskapnommer 1001925).

I, Ina-Lize Venter, hereby declare that I proofread and edited the following dissertation upon the request of the student, ms Thobeka Nkomo, and with the approval of her promoter, Prof Alida Herbst. The edited text was returned to the student, still containing corrections and suggestions for improvements, which she was at liberty to accept or reject at her discretion.

The language editor is a member of SATI (the South African Translators' Institute) (membership number 1001925).

**AN EXPLORATION OF THE UNDERSTANDING OF SPIRITUALITY AMONG
HEALTHCARE PROFESSIONALS AND PATIENTS AT CHRIS HANI
BARAGWANATH ACADEMIC HOSPITAL**

Yours respectfully

Ina-Lize Venter

(0825273021)

Ina.hulk.venter@gmail.com

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