The right of individuals to look for a better quality of life within their own life-spans—and to build toward a better life for their children—these are personal aspirations which must become public values. But a healthy sense of public integrity, in my view, will be difficult to nurture over time without a strong religious underpinning. In the Islamic tradition, the conduct of one's worldly life is inseparably intertwined with the concerns of one's spiritual life—and one cannot talk about integrity without also talking about faith. For Islam, the importance of this intersection is an item of faith, such a profound melding of worldly concerns and spiritual ideals that one cannot imagine one without the other. The two belong together. They constitute "a way of life."

Address by His Highness the Aga Khan to the School of International and Public Affairs, Columbia University (Columbia, USA), 15 May 2006

University of Alberta

Tanzanian Nurses' Understanding of Spirituality and Practice of Spiritual Care

by

Khairunnisa Aziz Dhamani

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfilment of the requirements for the degree of

Doctor of Philosophy

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DEDICATION

This thesis is dedicated to my parents and my family, who have offered me unconditional love, support, and encouragement throughout the course of this study. Although my father is no longer with us physically, he shares our joys and happiness in heaven.

ABSTRACT

Spirituality is an integral part of a person's wholeness and therefore has an effect on and plays an important role in health and illness (Burkhardt & Nagai-Jacobson, 2002; Hill & Pargament, 2003; Macrae, 2001; Reed, 1998). Nurses are required by national and international nursing bodies as well as hospital accreditation agencies, to identify patients' spiritual needs and intervene by integrating spiritual care into their nursing care. However, to date, no nursing studies have described Tanzanian nurses' experiences of spirituality and spiritual care. The qualitative method of interpretive description was used. A purposive sample of fifteen registered nurses who were engaged in direct clinical practice at one of the private not-for-profit hospitals in Dar es Salaam, Tanzania was drawn (Thorne, 2008; Thorne, Con, McGuinness, McPherson, & Harris, 2004). In-depth interviews using open-ended questions were carried out, tape-recorded, and transcribed verbatim. The data collection and analysis occurred concurrently. The transcripts were coded using inductive analysis. Themes related to spirituality and spiritual care that emerged from data were: meaning of spirituality, meaning of spiritual care, recognition of spiritual needs, interventions to respond to spiritual needs, challenges addressing spiritual care, and factors positively influencing the provision of spiritual care. Several recommendations for enhancing spiritual caregiving practices were given by participants. The findings from this study offer a basis for assessment, planning, and intervention strategies that nurses can apply in integrating spiritual care in clinical practice (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004).

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LIST OF ACRONYMS

AKH	Aga Khan Hospital
AKH-TZ	Aga Khan Hospital, Tanzania
AKU-ANS, EA	Aga Khan University-Advanced Nursing Studies Program, East Africa
ATR	African Traditional Religion
BSc	Bachelor of Science
CIA	Central Intelligence Agency
CNA	Canadian Nurses Association
EN	Enrolled Nurse
HIV	Human Immunodeficiency Virus
HREB U of A	Health Research Ethics Board, University of Alberta
ID	Interpretive Description
IDRC	International Development Research Centre
LPN	Licensed Practical Nurse
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NANDA	North American Nursing Diagnosis Association
NIMR	National Institute of Medical Research
Post- RN BScN	Post Registered Nurse Bachelor's of Science in Nursing
RN	Registered Nurse
TNMC	Tanzania Nurses and Midwives Council
TSh	Tanzanian Shilling
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

Spirituality and religion are central to many people, including Africans, during times of crisis and critical illness. As Homsy et al., (2004) mentioned, African traditional medicine's holistic approach to healing integrates the "spirit-mind-body" (p. 905). There is growing evidence in the literature to suggest that spirituality positively influences the ability to cope with illness, the prevention of illness (Molzahn, 2007), the ability to find meaning and purpose in life, and overall well-being (Cotton et al., 2006; Litwinczuk & Groh, 2007; Olive, 2004; Yi et al., 2006). Life-threatening situations sometimes give rise to some of the most complex spiritual questions related to illness, death, and dying (Cotton et al., 2006; Ellis, Campbell, Detwiler-Breidenback, & Hubbard, 2002; Molzahn, 2007), and clients may wish to address these questions with nurses. Nurses are therefore required to be knowledgeable about and prepared to deal with the spiritual component of care and to support their clients in these times of need. Knowledge related to spirituality can be acquired through various means but fundamental to understanding spirituality generally is a nurse awareness of her/his own spirituality. In her study exploring the process that nurses use to learn to care for spiritual needs, Hood (2004) mentioned that "nurses draw on their own spirituality, or faith traditions, for knowledge to guide the practice of spiritual care" (p. 4).

This interpretive descriptive study was undertaken to explore Tanzanian nurses' understanding of spirituality and their practice of spiritual care. The dissertation is comprised of seven chapters. In chapter One I: (a) briefly discuss

the concept of spirituality and its relationship to health and healing, (b) provide a brief historical description to illustrate how nurses integrate spirituality in their practice, (c) describe the purpose of the study, (d) state the research questions for the study, and (e) describe the significance of the study. Chapter Two contains the literature review, which examines the current understanding of the concept of spirituality in nursing and it's integration into nursing care. A detailed description of the study method is presented in Chapter Three. The study findings are presented in Chapters Four, Five, and Six. Chapter Four covers findings related to spirituality and spiritual care, Chapter Five is about findings related to identifying and responding to spiritual needs, and Chapter Six presents findings related to challenges in addressing spiritual care. Discussion, implications of the study, strengths and limitations of the study, and recommendations are presented in Chapter Seven.

The Concept of Spirituality and Its Relationship to Health and Healing

Spirituality is an integral part of a person's wholeness and therefore has an effect on and plays an important role in health and well-being (Macrae, 2001; Molzahn & Sheilds, 2008; Taylor, 2002). According to the holistic paradigm, body, mind, and spirit are considered "intertwined" and "interpenetrating unity" (Burkhardt & Nagai-Jacobson, 2002, p. 5) of a being rather than three separate parts. Therefore, as a whole person, every experience, including health and illness, is considered a spiritual experience. Also, Wane (2005) elaborated on indigenous knowledge about spirituality and health practices in Africa and considered spirituality an integral part of people. Moreover, for indigenous

Africans, healing is a sacred act, and they see "sick bodies, sick minds and spiritual depletion" as a whole rather than fragmenting the healing interventions (p. 35). These healers also believe that when one dimension of being suffers, the other dimensions are impacted as well (Wane, 2005). Hence, spirituality cannot be separated from the physical, psychological, and social aspects of human life (Burkhardt & Nagai-Jacobson, 2002; Wane, 2005). In fact, Burkhardt and Nagai-Jacobson stated that "spirituality infuses all of who we are, and we come to know our spiritual selves as we embrace all the spheres of our being" (p. 5). This may mean that our choices about how we live in any sphere of our lives, how we relate to others or nature, and how we care for ourselves physically, mentally, or spiritually all influence our being. This assumption has a great impact on health care in general and on nursing care in particular. It is important that nurses recognize that people under their care are more than just health problems; they are holistic beings who require support to meet their needs which includes spiritual needs (Burkhardt & Nagai-Jacobson, 2002).

The concept of spirituality is very abstract, highly subjective, and not a visible or perceptible entity to which nurses can provide direct care. But nurses can remain vigilant to the ways in which patients express spirituality in physical, psychosocial, and spiritual forms. For example, Anandarajah and Hight (2001) stated that spirituality is expressed in cognitive (search for purpose and meaning in life, beliefs, and values), experiential (feelings of love, hope, comfort, inner peace), and behavioral (external manifestation of spiritual beliefs and inner state) forms. These forms of expression help us to appreciate that it is not human beings

who have spiritual experiences, but rather spiritual beings who have human experiences (Burkhardt & Nagai-Jacobson, 2002).

To understand the concept of spirituality for this research study, it is essential to define the terms *spirituality* and *spiritual care*. Because of the subjective nature of spirituality, it has been challenging for scholars, including nursing scholars, to agree on a specific or all inclusive definition. However, the definitions of spirituality all share some common elements, which is described in Chapter Two. For this research study, I use Tanyi's definition of *spirituality* as it supports the worldviews of people regardless of their religious orientation. I have added *social well-being* in her definition because spirituality is also related to connecting with others, a Higher Being, and the self in developing meaningful relationships (Burkhardt, 1989; Mahlungulu & Uys, 2004; Reed, 1992). Her proposed definition for spirituality is:

> a personal search for meaning and purpose in life, which may or may not be related to religion. It entails connection to self-chosen and or religious beliefs, values, and practices that give meaning to life, thereby inspiriting and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace, and empowerment. The results are joy, forgiveness of oneself and others, awareness and acceptance of hardship and mortality, a heightened sense of physical and emotional well-being [as well as social well-being], and the ability to transcend beyond the infirmities of existence (Tanyi, 2002, p. 506).

Definitions of spiritual care, like the concept of spirituality, differ based on individuals' understanding of spirituality. For this study, I define spiritual care as an approach that nurses use to integrate all aspects of patient care (Taylor, 2002). Many nurse scholars have considered a person as an embodied soul rather than body as separate from spirit (Anandarajah & Hight, 2001; Burkhardt &

Nagai-Jacobson, 2002; Macrae, 2001; McSherry, 2007; Newman, 1995; Reed, 1992; Walton, 1996). Therefore, it is recommended to integrate spiritual care into physical and psycho-social care, because it is impossible to divide care into individual dimensions. Nasir Khusraw, who was an 11th-century Iranian and one of the most important theologians of the Ismaili faith community, also eloquently described the connection of spirit and body: "In [the] human body there is no place devoid of the soul; if a place were to be devoid of it, that place would not be alive and moveable" (Hunzai, 1998, p. 52). According to Khusraw's philosophy, it can be assumed that mind, body, and spirit are intimately intertwined and act in unison. It is not surprising to note that nurses have recognized this interconnectivity and interdependency link between these dimensions and have usually strived to provide holistic care since the inception of nursing care practice.

McSherry (2007), when describing the term holism and holistic practice in nursing, discussed that the physical, psychological, social and spiritual dimensions of an individual share equal importance and deserve equal care. She clarified that these dimensions are not meant to fragment and reduce individuals into "manageable units" (p. 59), but to appreciate the manner in which these dimensions are interrelated and interconnected. She discouraged the health care professionals from addressing people as *units* to avoid the care becoming reductionist (McSherry). On the one hand, in this phenomenon of spirituality it may seem appropriate to consider physical and psychological care as spiritual as it is all encompassing; but, on the other hand, there is a another worldview that considers physical and psycho-social dimensions separate from spirituality and

therefore, denies the influence of spirituality on health and illness (Paley, 2008). Nurses who hold this view may not consider providing spiritual care as part of their role. However, in general, integrating spiritual care is seen as a required nursing role since most jurisdictions consider the inclusion of spiritual care as a professional requirement.

Paley (2008) has argued that the concept of spirituality is a *shallow, artificial* and *unnecessary concept* (p. 8) in health care because it is beyond the bounds of scientific enquiry. In addition, he contended that human experiences such as finding meaning in suffering, spiritual need, depression or end of life experience are better understood in psychological or neuropsychosocial terms rather than as a spirituality concept. In fact, he suggested incorporating spirituality literature into social psychology, neuro and pharmacopsychology (Paley, 2008). It is possible that the human experiences may be explained in physiological and psychosocial aspects but what is important to realize is that, "man is unique and his nature is a unity; not a dualistic composition of physical body and spiritual soul, but an entity in which both find expression in the whole" (Bradshaw, 1994 as cited in Baldacchino & Draper, 2001, p. 835).

It is evident that Paley, coming from a naturalistic perspective, has difficulty comprehending the conceptual definitions of spirituality. The naturalistic perspective is only one of the many worldviews and not acknowledging the other perspectives may lead to limited ways of understanding a phenomenon. Nonetheless, putting forward various perspectives and subjecting those perspectives to a full range of critique in the understanding of spirituality is

vital for a discipline (Pesut, 2008). With the postmodern worldview, the boundaries of science are expanding and it is hoped that the knowledge generated of the unseen and unobservable phenomena will be considered legitimate and valued.

Historical Description

Spirituality and spiritual care have long been a part of nursing care, and a brief historical description of nursing and spiritual care is essential to understand the spiritual aspect of the nursing discipline. Historically, the term spirituality has not been used directly in nursing care because people often spoke of spirituality in terms of religious beliefs and practices (Burkhardt & Nagai-Jacobson, 2002). However, we now know that spirituality is considered broader and more universal than religiosity.

According to Paul (2000), Nutting and Dock were among the first nurse historians to document ancient nursing history systematically. They described how religious beliefs influence practices of healthy living and healing. It can be assumed that women in most ancient cultures carried out activities similar to modern nursing (Paul, 2000). From primordial times, nurses and spiritual healers in all societies worked as partners (Clark & Olson, 2000).

Narayanasamy's (1999) and Taylor's (2002) reviews of historical trends offered a further perspective. According to these authors, the discipline of nursing emerged from religious perspectives, and women mostly provided nursing care and assisted priest-physicians in early Palestinian, Chinese, Indian, and Egyptian civilizations. Early Christians organized themselves to serve the poor and nurse

the sick and disabled, and they equated this act of service with service to God (Burkhardt & Nagai-Jacobson, 2002; Macrae, 2001). For centuries, nursing was viewed as a noble vocation in countries where Christian beliefs prevailed. In fact, well into the 1900s a large proportion of nurses were members of religious orders (Paul, 2000). Florence Nightingale, the founder of modern nursing, also advocated for holistic nursing care and emphasized that integrating spiritual care into nursing practice is essential to healing (Macrae, 2001; Taylor, 2002).

Nurses continued to provide spiritual care until the mid 20th century, when tensions in many Western countries began to rise between those who saw nursing as a spiritual call to service and those who saw nursing as a profession that affords personal reward. "By the mid-twentieth century, religion became less visible as a component of nursing" (Taylor, 2002, p. 36), and spiritual care was viewed as having little or no value in the modern scientific and technological health care system. However, the last three decades have seen a renewed interest in spirituality and spiritual care in the nursing discipline.

Purpose of the Study

Spirituality, as a basic characteristic of humans and a contributor to human health, is regarded as part of nursing practice (Reed, 1992). The purpose of this study was to understand and explain the concepts of spirituality and spiritual care as Tanzanian nurses comprehend them.

Research Questions

How do Tanzanian nurses describe/understand the concepts of spirituality and spiritual care? How do Tanzanian nurses practice spiritual care?

Significance

Recently, the professional practice standards of the Tanzania Nurses and Midwives Council [TNMC], the American Association of Colleges of Nursing, the Canadian Nurses Association (CNA), the North American Nursing Diagnosis Association, and the Joint Commission on Accreditation of Healthcare Organizations in the USA have made it mandatory to integrate spiritual care into nursing practice (Beckman, Boxley-Harges, Bruick-Sorge, & Salmon, 2007; Burkhardt & Nagai-Jacobson 2002; CNA, 2005; Carson & Koenig, 2008; TNMC, 2007). The results of this study shed light on how Tanzanian nurses understand spirituality and practice spiritual care. The study findings have the potential to influence the development of interventions that could assist Tanzanian nursing students and nurses to routinely offer patients spiritual care as part of holistic nursing care, thus increasing the possibility of positive health outcomes. This research study also serves as a continued investigation of the spiritual dimension of human health and has contributed to nursing knowledge from the perspective of Tanzanian nurses.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this literature review is to examine the current understanding of the concept of spirituality in nursing and its integration into nursing care. In this chapter I present the following topics: (a) conceptualization of spirituality in the nursing discipline; (b) relationship between spirituality and religion; (c) African perspectives on spirituality, religion, and health; (d) spiritual nursing care; and (e) the gaps identified in the current knowledge related to spirituality, and spiritual care in the African context. This literature review is followed by an overview of the context of the country in which this study took place.

Conceptualization of Spirituality in the Nursing Discipline

Why Integrate Spirituality Into Nursing Practice?

Nursing as a practice-based discipline is interested in human concerns and experiences, including spirituality and spiritual care. Yuen (2007) stressed that spiritual care is an integral part of the science and art of healing and thus an important aspect quality care. Spirituality as a human phenomenon is therefore relevant to the nursing discipline. Life transitions, such as birth, illness, suffering, recovery from illness, or dying, often deepen the meaning and purpose of life (Carson & Koenig, 2008; Molzahn, 2007; Reed, 1991a). On the other hand, in a time of crisis people may react by experiencing disharmony of mind, body, and spirit. Because nurses are present with patients most of the time in inpatient settings and accessible as well in out-patient settings, they are in a unique position not only to provide care, but to also safeguard their patients' wholeness, integrity,

and harmony. Callister et al., (2004) concurred with this view and referred to nursing as a soul-nourishing career rather than just one of caregiving. Also, a holistic nursing perspective supports the interconnectedness of mind, body, and soul and therefore incorporates the physical, social, emotional, and spiritual dimensions of care (Baldacchino & Draper, 2001).

The nursing discipline, in a conscious or unconscious way, has continued to integrate spiritual care (Goldberg, 1998; Hood, Olson, & Allen, 2007). Also, because a function of nursing is to promote health, spiritual care becomes a nursing responsibility (Burkhardt & Nagai-Jacobson, 2002; Carson & Koenig, 2008), and helping clients with the new demands of illness becomes a mandatory role (Baldacchino & Draper, 2001). Although it may seem challenging to integrate spirituality into nursing care, nurses can foster peaceful resolutions to patients' health concerns by assisting them in meeting their spiritual needs pertaining to health care (Tanyi, 2002). Some authors such as Taylor (2003), by interviewing cancer patients and family caregivers, Emblen and Halstead (1993) by comparing narrative responses from patients, nurses, and chaplains, and Galek, Flannelly, Vane and Galek (2005) through literature analysis pertaining to patient spiritual needs, have identified various spiritual needs of patients. Emblen and Halstead (1993) urge nurses to provide relevant spiritual care based on spiritual needs "in order to create an optimal potential for healing in biological, psychological, and social dimensions" (p. 182). When patients' spiritual needs are met, spiritual health can be achieved. According to Mira (2004), the outcomes of spiritual health are physical, psychological, and social well-being. Recognizing

the spiritual outcomes enables nurses to provide more effective spiritual care (Mira, 2004).

Connection of Body, Mind, and Spirit

Many scholars have acknowledged that human beings are comprised of a spiritual as well as a physical and a psychosocial dimension (Baldacchino & Draper, 2001; Beckman et al., 2007; Hill & Pargament, 2003; Reed, 1992; Taylor, 2002). Human experiences, including spiritual experiences, can be explained in physiological and psychosocial terms. It can be said that "we are essentially spirit beings who have entered physical form, rather than physical beings that have a soul or spirit" (Burkhardt & Nagai-Jacobson, 2002, p. 117), which means that we are embodied spirits (Burkhardt & Nagai-Jacobson, 2002; Carson & Koenig, 2008). This perspective views the body as a vehicle through which to know the world, experience our existence, and express ourselves in this physical form (Burkhardt & Nagai-Jacobson, 2002). Furthermore, paying attention to the body will enable us to touch base with our rich inner resources and make us realize that the body rests on the spirit (Burkhardt & Nagai-Jacobson, 2002). Because of the body, mind, and spirit interconnectedness, when one dimension is affected, all other dimensions are affected as well (Anandarajah & Hight, 2001; Carson & Koenig, 2008; McSherry, 2007; Wane, 2005). Hence, in providing nursing care, and for optimal health, we need to consider and nurture all human dimensions (Olson et al., 2003).

Conceptual and Operational Definitions of Spirituality in the Literature

Etymologically, spirituality is related to breathing, a fundamental essence that "energizes and guides action and thoughts" (Taylor, 2002, p. 4). Baldacchino and Draper (2001) stated that the concept of spirituality is derived from the Latin word *spiritus* or spirit, which is the vital force that not only motivates people, but also influences their lives, health, behaviours, and relationships. Many Africans also associate spirit with breathing, but when they see that a person has stopped breathing, they recognize only the termination of physical life, believing that the spiritual life continues beyond death (Mbiti, 1991). Nurses and non-nurse scholars have offered various definitions of spirituality (Hill & Pargament, 2003; Koenig, 2004; Mira, 2004; Reed, 1992; Taylor, 2002), but it is difficult to agree upon a single definition because of their inadequacy in addressing various perspectives, religious affiliations, and cultural embeddedness (Chiu, Emblen, Hofwegen, Sawatzky, & Meyerhoff, 2004; Molzahn & Sheilds, 2008).

The conceptualization of spirituality is further complicated because of an implied understanding of spirituality as an intangible force or a supernatural or ineffable phenomenon. Mira (2004) also contended that defining spirituality as a concept is not easy regardless of whether we know what it means. Despite this challenge, conceptualizing and recognizing the attributes of spirituality are important to enable nurses to provide more effective spiritual care. According to Fawcett (1997), operational definitions define concepts in terms of empirical utility by connecting them with the real world. Andrews (2008) suggested the use of metaphor to enhance our understanding of spirituality because it helps to

connect one aspect of life to another by using a shared symbol to explain life's events. Moreover, analogies and metaphoric explanations offer solutions to life's mysteries that can be viewed as a group worldview or as a major paradigm. Mira used the analogy of clouds to explain human spirituality: The clouds appear real from the ground, but upon climbing, people see them as only dense fog and cannot grasp them with their hands. Similarly, "understanding human spirituality often feels like capturing the clouds" (p. 29). In addition, Mira contended that defining spirituality as a concept is not easy despite our assumption that we know what spirituality means. According to Hood (2004), such conceptual confusion has made it difficult for nurses to recognize, acknowledge, and document spiritual needs and other aspects of spiritual care.

Some scholars do not view spirituality as connected to a personal God and do not acknowledge a relationship of body and mind to spirituality (Paley, 2008). The reason for denying the existence and influence of spirituality may be due to a positivistic perspective, because spirituality pertains to metaphysics and cannot be measured objectively through human observation. But this challenge may be minimized by embracing a post-positivistic perspective. According to this perspective, nonobservable phenomena [for example, spirituality] have existence but these phenomena serve to explain the functioning of observable phenomena (Crossan, 2003; Schumacher & Gortner, 1992). In relation to the concept of spirituality, one can extrapolate that, although spirituality is not seen or evident, its influence on physical, emotional, or psychosocial phenomena, which are observable, helps to explain health/illness or the healing or curing aspects. Reed

(1998) acknowledged the complex nature of spirituality and mentioned that spirituality loses its meaning when we use words to describe the concept; however, she argued that the conceptualization of spirituality requires conceptual clarity, empirical grounding, and operationalization by translating various definitions from various studies.

To determine the current understanding of spirituality, Chiu et al., (2004) conducted an integrative review and cross-cultural examination of spirituality. They identified 9 articles out of 73 in which researchers conceptualized spirituality, and they suggested common themes from their findings: "Spirituality is a life-giving force; meaning making; making most of life now; a sense of connectedness with Self, Others, Nature, and Higher Being; transcendence/transacting self-preservation; and religious practice" (p. 409). Through a thematic analysis of the definitions from the above articles, Chiu et al., acknowledged multiple conceptual definitions of spirituality, such as existential reality, transcendence, connectedness/relationship, and power/force/energy. In addition, Chiu et al., reviewed 46 quantitative research articles that utilized various research instruments to measure the degree of one or more attributes of spirituality and described overarching operational definition categories: existential, relational, transcendental, subjective, and expressive.

According to Reed, the human developmental process continues throughout one's life-span despite the obvious physical changes and deterioration that commonly occur with the aging and dying processes (Reed, 1983; 1995; 1998). Within this developmental-contextual paradigm, a key element of the

process of human developmental change is the capacity for self-transcendence (Reed, 1992). Self-transcendence broadly refers to developmental maturity whereby there is extension of conceptual boundaries along with broadened life perspectives and purposes (Reed, 1991b). Critical life events, transitions or illness may lead to expansion of self- boundaries in multiple ways (inwardly, outwardly and temporally, transpersonally) through introspective activities, concerns for others' welfare, and by integrating perceptions of the past and the future to enhance well-being (Reed, 1991b; Runquist & Reed, 2007). Reed indicated that self-transcendence and a spiritual perspective contributed significantly towards well-being of vulnerable individuals. She defined spiritual perspective as "a perceived connectedness to a purpose or process greater than the self" and that it empowers the self (1991c, p. 74). Newman (1995) also indicated that varying degrees of spiritual development empower clients toward well-being by positively directing their spiritual energy. Valuing self and finding meaning in life events are acts that involve and reflect spirituality (Taylor, 2002). Nurses' understanding of this phenomenon will certainly enhance their interactions with patients and may have a positive influence on their recovery.

According to Clark (2000), spirituality is the experience of "being in relationship with" (p. 21), and religion is a "community within which to share reflection and celebration around experiences of being in relationship with" (p. 25). The literature review related to conceptual and operational definitions and descriptions of spirituality includes religious practices and behaviours as

important entities in spirituality. What is religion, and how is it related to spirituality?

Relationship between Spirituality and Religion

The term *religion* is derived from the Latin *re-ligare*, which means to "re-tie" or "reconnect" (Burkhardt & Nagai-Jacobson, 2002, p. 13). A religious structure or framework binds people together at an additional level through shared values and belief systems (Burkhardt & Nagai-Jacobson, 2002). Yuen (2007) defined religion as a social institution with a specific belief system and rituals and spirituality as including reverent respect for God or a supreme power and connectedness with nature. Other definitions of religion from the literature include an institution with certain values, rituals, and beliefs about God; a definable boundary that provides guidelines to which individuals adhere; a worldview to answer questions related to ultimate meaning; guidance on how to live harmoniously with self, others, nature, and God; and a framework for moral codes and conduct that guides people to relate to self and others (Burkhardt & Nagai-Jacobson, 2002; Dyson, Cobb, & Forman, 1997; Hill & Pargament, 2003; Mira, 2004; Tanyi, 2002; Taylor, 2002). Religion may provide a bridge to spirituality and enhance spiritual experience. For Nightingale, spirituality served as the goal and religion as a means, and she believed that the boundaries between these two concepts were less clear because religious beliefs and practices shaped and interpreted the spiritual experience, which is not controlled, bounded, or possessed (Macrae, 2001). For Khusraw (as cited in Morewedge, 1950/1998),

spirituality and religion both offered a sense of ultimate destinations in living and a viable path for reaching these destinations.

More recently, the meaning of religion has been perceived more negatively as a fixed system of ideological commitments that prevent the expression of dynamic personal elements of spirituality (Hill & Pargament, 2003; Hollins, 2005; Pesut, 2008). This view separates and polarizes religion from spirituality. While this distinction between religion and spirituality allows the inclusion of people who are not religious, it "ignores the fact that all forms of spiritual expression unfold in a social context and that virtually all organized faith traditions are interested in the ordering of personal affairs" (Wuthnow, 1998; as cited in Hill & Pargament, 2003, p. 64). Moreover, we may not realize that this polarized view of religion and spirituality may lead to unnecessary duplication of concepts and measures. Chiu et al.'s (2004) integrative review process clearly pointed out the overlap and connection between spirituality and religion. However such view may be of limited use if one considers that patients and nurses may not have a religious affiliation and conceptualize spirituality outside of a religious framework.

Yuen (2007) also compared spirituality and religion and described spirituality as more of a personal search for a "transcendent understanding" (p. 78), whereas religion includes activities within organized groups. Although these terms have different definitions, they share common ground, which is "a search for the sacred through the experience of subjective feelings, thoughts, and behaviors" (p. 78). According to Clark (2000), religion acts as a tool to enhance

spiritual experience and provides an environment for sharing. As well, it connects people and sustains networks of relationships. Although religion provides a particular worldview for understanding spirituality, we need to acknowledge that many ways of accessing spirituality transcend religion (Burkhardt & Nagai-Jacobson, 2002). This understanding is particularly important for nurses who provide person-centred care that goes beyond satisfying particular religious needs.

Religion also influences factors that directly affect the delivery of health care; for example, medical decision making, beliefs that conflict with medical care, spiritual struggles that create stress and impair health outcomes, exposure to and detection of diseases, and treatment compliance (Koenig, 2004). These factors play a role in successful coping and recovery and the health outcomes of patients for whom nurses and other health professionals care (Carson & Koenig, 2008; Koenig, 2004). According to the varied descriptions of spirituality and religion, religion appears to be a narrower concept than spirituality, but some authors viewed spirituality and religion as tightly connected concepts. Having described the current literature on spirituality and religion mostly from Western authors' perspectives, it is important that I also address African people's general perspectives on spirituality and religion in the context of health.

African Perspectives on Spirituality, Religion, and Health

For most African persons, spirituality and religion are not separated but, rather, intertwined (Tangwa, 2000). Therefore, when I discuss African religion, I am discussing the African concept of spirituality too. Wane (2005) eloquently asserted that, the indigenous way of knowing sees "no separation between

science, art, religion, philosophy, aesthetics or spirituality" (p. 31). Also, to understand African spirituality, it is imperative to understand the traditional African perception of a person (Tangwa, 2000). For Africans, the human person is loose and flexible like plastic, and this plasticity allows "transmigration, reincarnation, transformation, and transmutation, within and across species (animals, plants, inanimate objects and forces including superhuman spirits)" (Tangwa, 2000, p. 42). Africans' worldview of a person permits them to consider anything in existence "brother/sister" (p. 42) and to reverentially respect nature and all living (visible or non-visible) things because indigenous Africans consider the universe or universes as one large system in which everything is connected to every other thing (Tangwa, 2000; Wane, 2005). Can Tangwa's and Wane's discussion about indigenous ways of perceiving the world and people be generalized across all African people? In Africa in general and in Tanzania in particular, the majority of Africans are Christians and Muslims, so other questions raised here are, "Who follows African Traditional Religion (ATR)? Has it been replaced by other religions?" To answer these questions, it is necessary to know the history of ATR. In the following account I briefly describe how ATR evolved in Africa.

Magesa (1997) and Mbiti (1991), referring to archaeological evidence on the origin and development of man, stated that Africa is the original home of all the peoples of the world and *the cradle of civilization*. Moreover, Mbiti (1991) mentioned that the early forms of man's life is suggested to be found in Ethiopia, Kenya and Tanzania, which existed about two million year ago. Magesa (1997)

asserts that, “if human culture and civilization have Africa as their “mother,” the religions of humanity cannot but have an African element in them” (p. 28). Their religion has originated on African soil, and therefore, it belongs to its indigenous people. Their religion is also termed as African Traditional Religion (ATR) (Magesa, 1997; Mbiti, 1991). Religion in Africa gradually evolved over many centuries as people lived through different life situations and experiences (Magesa, 1997; Mbiti, 1991). Since there is no founder of African religion, people are not bound by any single authority and therefore, are free to hold different views and beliefs. These views differ on a number of factors including people’s geographic locations, language, and tribes (Mbiti, 1991). But within this diversity lies a fundamental unity in belief and outlook of the world (Magesa, 1997). Magesa elaborated his argument about Africans’ religious unity in diversity by stating that “the difference is one of emphasis and development, not of essence” (p. 16). Therefore, African religion is seen as one in its essence by Magesa (1997), Mbiti (1991) and many other African scholars.

Religion is assumed to be one of the African heritages and it is expressed in all forms of life. Through the course of man’s history in Africa, a number of changes have occurred in ways of life and they have shaped religion; religion, in turn, has affected the ways of living in Africa. Thus, ATR is pragmatic and realistic (Mbiti, 1991). In Africa, religion is part of every aspect of human life. It has influenced not only Africans’ social and cultural lives, but also their political and economic activities (Magesa, 1997; Mbiti, 1991). Safeguarding and upholding the life of people close to them and the world around them is part of

African values and moral systems, along with other universal morals such as, love, truth, justice, respect, fidelity, and so on (Mbiti, 1991). Thus, "African Religion affects the African way of life" (p. 11). The nature of African religion consists of beliefs, practices, ceremonies and festivals, religious objects and places, values and morals, and religious officials or leaders (Mbiti, 1991).

African religious beliefs include people's worldview about the universe, God, spirits, human life, life after death and magic. These beliefs are expressed in the form of practices, ceremonies and rituals. Festivals are occasions celebrated to rejoice an event or occasion such as harvest time, rainy season, or the birth of a child. Religious places and objects include such things as shrines, sacred hills, amulets, charms, and masks. Values and morals are another important part of African religion. They help people to live in community, and to maintain peace and harmony with each other, and nature. Religious leaders such as diviners, medicine men, priests, rain-makers, kings, and rulers are considered human keepers of religious heritage and therefore, are a vital part of African Religion. These essential parts work together to provide the full meaning of African religion (Mbiti, 1991).

Over some centuries, Christianity and Islam have influenced Africans. Most have converted to either Christianity or Islam but Magesa (1997) and Mbiti (1991) assert that at the core level, these African converts remain aligned with ATR. As ATR provides answers to many of the problems of people's lives, many Africans are unwilling to give up their ATR even after adopting other religions like Christianity and Islam (Magesa, 1997; Mbiti, 1991). Mbiti asserts that the

African preserves much of his/her indigenous religious background and cultural values even after converting to a different religion. Magesa (1997), in the preface of his book "African religion: The moral traditions of abundant life," writes that even if it appears publicly that these African converts are performing rituals, rites, and laws according to their changed religion, their inner motivation ascribes to African religion. Moreover, Magesa stated that world statistics regarding Africans converting to Christianity [Islam] maybe misleading. According to Mbiti as cited by Magesa, when African people convert to other religions, they do not leave behind their traditional religiosity or their worldview which is shaped by African religion. The changes seen

> are generally on the surface, affecting the material side of life, and only beginning to reach the deeper levels of thinking pattern, language context, mental images, emotions, beliefs and response in situations of need. Traditional concepts still form the essential background of many African peoples (Mbiti, 1969 as cited in Magesa, 1997, p. 6).

As in every society in the world, Africans also consider health and healing important concerns. Their interpretation is that disease is not only a physical state, but also a religious matter. Therefore, religious practices and rites are used to diagnose and cure people of a disease. Also, communal health rituals are carried out to deal with the outburst of epidemics in the village (Mbiti, 1991). These rituals include witch hunts and cleansings and local diviners or medicine men drive away the spirits. Mbiti contends that despite modern education and people following religions like Christianity and Islam, it is difficult to eliminate this belief from their life. Wane (2005) reported that "rituals provide not only healing

for participants but facilitate access to transformation, the recovery of memory, and the reaffirmation of each individual's life purpose" (p. 35).

Illnesses and spirit possessions are also based on African's religious beliefs. In some parts of Africa, it is customary to call the name(s) of departed relative(s) to relay their prayers to God because it is considered rude to approach God directly (Mbiti, 1991). This practice and many other African rituals and ceremonies signify that, for Africans, the death of a person is not the end of life, but the continuation of life hereafter. Many African people believe in the existence of invisible beings, including spirits, in an invisible part of the universe. They also believe that spirits may attack people by taking away their possessions or causing epidemics and that some witches or other individuals who use unknown spirits harm people, including their relatives and neighbours. Therefore, it is often considered necessary to seek the assistance of a diviner or a medicine man, who then performs religious rituals and ceremonies (Mbiti, 1991). Through rituals, subtle invisible energies that are present in the natural environment are harnessed by performing rituals for healing purposes (Wane, 2005). Indigenous Africans seem to embrace Reed's (1992, 1998) concept of transcendence. For them, spirituality provides a space that allows people to go beyond their "social locations and limitations" (Wane, 2005, p. 35) and offers the possibility of interconnecting at a different and higher level (p. 35).

The current literature, as I have mentioned, signifies that the indigenous ways of thinking still prevail in Africans even in the 21st century. Approximately 85% of the sub-Saharan population, including South Africans, use the services of

traditional healers, although the practice differs according to the culture, the location, and the type of healer (traditional doctor, diviner, faith healer) (International Development Research Centre [IDRC], 2004; Peltzer & Mngqundaniso, 2008). According to Peltzer and Mngqundaniso, people approach traditional healers first to treat sexually transmitted diseases, including the human immunodeficiency virus (HIV). The IDRC reported that the southern Africa region has one traditional healer for every 200 people. This ratio is considerably higher than the patient-modern doctor ratio in a number of countries in Africa, which is one of the reasons that departments of health in African countries are partnering with traditional healers to continue to provide safe, effective, and quality services to African people (Mngqundaniso & Peltzer, 2008). The reasons that patients seek the assistance of traditional healers are that healers meet their needs and pay special respect to their culture and spiritual matters. In addition, patients feel that traditional healers take a more holistic approach to health promotion and management (Mngqundaniso & Peltzer, 2008; Peltzer & Mngqundaniso, 2008). In summary, according to various authors the philosophy and the worldview of traditional healers and Africans differ from Western views.

Spiritual Nursing Care

Spiritual nursing care is defined as the way in which nurses integrate all aspects of patient care (Taylor, 2002). Many nurses equate spiritual care with overall effective holistic nursing care (Harrington, 1995). The holistic paradigm acknowledges that “humans are whole, integral, body-mind-spirit beings in continual interaction within an environment” (Burkhardt & Nagai-Jacobson,

2002, p. 5). Understanding this wholeness is basic to providing nursing care that includes attention to each of these dimensions. In addition, clinicians who personally understand and are aware of their own spirituality are in a better position to interact with and support patients (Burkhardt & Nagai-Jacobson, 2002; Yuen, 2007). Although we may not realize it, nurses as healers engage in a deeper state of consciousness and evolve and transform during the process of healing therapy, just as patients do (Hemsley & Glass, 2006). Spirituality and religion both offer a sense of an ultimate destination in life and a viable path to reach this destination. Individuals may have religious and spiritual struggles that affect their health and well-being because they elicit ultimate questions and concerns about various issues such as self-worth, self-control, doubts, trustworthiness, and the faithfulness of others (Hill & Pargament, 2003). The processes of doubting, searching, and questioning in the religious and spiritual realms lead to the growth and development (Hill & Pargament, 2003) of a holistic being.

Nurses often provide service to patients, families, and communities in times of physical suffering and spiritual distress. According to the North American Nursing Diagnosis Association (NANDA) International (2007), spiritual distress is the "impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature and/or a power greater than oneself" (p. 208). During a period of physical or psychological illness, patients and families also focus their attention on the spiritual dimension to gather strength to cope with the situation (Blanch, 2007; Carson & Koenig, 2008; Mahlungulu & Uys, 2004). The spiritual dimension of

care is complex and therefore requires that nurses collaborate with a multidisciplinary team, including a hospital chaplain or a similar figure, to promote holistic care by focusing on the body, mind, and spirit dimensions (Carson & Koenig, 2008).

Because the physical, psychological, and spiritual dimensions of the whole person are integrated and influence one another, it may be difficult to differentiate the care provided for each dimension. Hood (2004) stated that spiritual care or spiritual need is usually regarded as and intertwined with biopsychosocial needs and care rather than a distinct entity. But according to some nurse scholars, there are distinctions between each of these dimensions. For instance, the physical dimension relates to world consciousness (e.g., seeing, hearing, tasting); the psychological dimension involves issues of human relationships on an immediate level—that is, remaining aware of self (e.g., loss, grief); and the spiritual dimension remains conscious of God or a deity and connects to supreme values or the Ultimate (Spilka et al., 1983 & Stoll, 1989 as cited in Taylor, 2002). Taylor suggested that these distinctions help nurses to avoid misinterpreting spiritual needs as other needs.

Research undertaken to assess terminally and non–terminally ill (chronic) patients' perspectives of spirituality has also shown differences between spiritual care and care of the body and mind (Mahlungulu & Uys, 2004; Reed, 1991a). For example, Mahlungulu and Uys explained that spirituality for the patients in their study meant having more of a relationship with God, others, and self; being human; and respecting others; whereas the patient participants in Reed's study

reported that receiving spiritual interventions from nurses meant being allowed time for personal prayers and asking others or family to pray for them, nurses' inquiring about their beliefs or concerns, organizing a visit with clergy or hospital chaplains, and being allowed time for family to talk and read religious materials. These interventions indicate that for patients too, spiritual care is distinct from physical and psychological care. But it is also possible that these patients' specific responses resulted from the way that the questionnaire was structured (Reed, 1991a) to determine the participants' preferences for spirituality-related nursing interventions.

A number of tools have been designed to assess patients' spiritual needs and care, and they are mainly structured in a manner to distinguish spiritual needs and other aspects of spiritual care from physical and psychosocial needs and care. For example, Burkhardt and Nagai-Jacobson (2002) gave examples of six spiritual-assessment instruments; the main focus of the items in these instruments is on measuring interconnectedness/relationships with self, others, nature, and the Divine; the purpose or meaning in life/illness; inner resources; transcendence; and beliefs and religious affiliations; but they failed to incorporate an integrated view of bio-psycho-socio-spiritual being. Assessment tools limit the capture of patients' holistic views of spirituality and the demonstration of how nurses perceive spirituality as separate from body and mind. But Burkhardt and Nagai-Jacobson argued that spirituality is related to all health concerns and, therefore, as nurses carry out the nursing process, they must address spirituality in the midst of identifying concerns and needs by "determining appropriate outcomes,

developing plans, and organizing overall care to ensure incorporation of each person's selfhood, values, and worldviews" (p. 340). Because of the above-mentioned different perspectives of spirituality and spiritual care, which Hood (2004) termed *conceptual confusion*, it is possible that practicing nurses have difficulty integrating and documenting spiritual care in their health care practices.

Harrington (1995) examined perceptions regarding the nature of spiritual nursing and the status of spiritual care in relation to normal nursing care of two groups of nurses, from acute (n=10) and hospice care settings (n=10). Some participants in her study were fearful to handle spiritual issues and strongly believed that spirituality was a private matter and that they should not interfere regarding this topic. But hospice nurses felt more comfortable discussing spiritual issues as the underlying philosophy of their practice was care and not cure. Although it was not made clear in the study which group of nurses referred their patients to chaplains, it was mentioned that less than half of Harrington's study participants referred their patients for spiritual care.

According to Reed (1991a), some aspects of spiritual care include demonstrating a nonjudgmental attitude, maintaining a person's dignity, supporting patients in their decisions, and facilitating the search for the meaning of illness. Nurses can also show spiritual care in other ways, such as communicating effectively, listening, demonstrating true concern and empathy to establish a trusting relationship, and responding sensitively to the patients' spiritual and cultural belief systems (Callister et al., 2004). Our presence, or soul-to-soul encounter is fundamental to integrating spirituality into nursing and

health, although nurses may not recognize or acknowledge it (Burkhardt & Nagai-Jacobson, 2002).

Gaps in Current Knowledge of Spirituality

Whether nurses are aware that they are intervening in spiritual needs or not, they generally perform spiritual nursing care during routine care (Burkhardt & Nagai-Jacobson, 2002; Hood et al., 2007). A few studies have explored nurses' perceptions of spirituality and spiritual care but most of them have been conducted in Western countries (Harrington, 1995; McSherry, 1998, 2007; Ross, 1997; Stranahan, 2001). So far, I have found only one study relevant to the African context on spirituality in nursing (Mahlungulu & Uys, 2004). Their sample included nurses (71.4%), patients (25%), and relatives (3.6%). When reporting the findings, the authors did not mention separately the perspectives of nurses regarding the concepts of spirituality. Therefore, it is difficult to know the views of nurses. But overall, the findings from the South African context suggest that spirituality is a quest for a transcendent relationship with God/Supernatural power, and others; is not within the person but "it is the person in totality" (p. 23) and influences the way in which it pervades all spheres of reality (Mahlungulu & Uys, 2004). The following questions remain unanswered following this literature review. What are Tanzanian nurses' perspectives on spirituality and spiritual care? Do they differ in their views from Western nurses? To date, no research studies have been reported in Tanzania on Tanzanian nurses' experience of integrating spiritual care into their nursing practice. It was therefore worth

considering a study such as this one to explore the perspectives of Tanzanian nurses.

Country Context

Tanzania is an Eastern African country with a population of about 39.5 million (World Health Statistics, 2008). It is bordered by the Indian Ocean on the east; Burundi, Rwanda, and the Democratic Republic of the Congo on the west; Kenya and Uganda on the north; and Malawi, Mozambique, and Zambia on the south. Tanzania is spread over an area of 945,087 sq km, almost double the size of California (Central Intelligence Agency [CIA], 2008). Although Tanzanian is one of the poorest countries in the world (Shiner, 2003; World Health Statistics, 2008), it is a model country in Africa because of the very few serious conflicts over national integration and its success in integrating its 123 tribes into a new nation state after its independence (Hood, 1988). Tanzania has a number of powerful tribal groups, each with its own developing economies, people of diverse cultures, and markedly different religions. The number of Muslims and Christians in Tanzania is approximately equal, and it has a small but important nonindigenous minority (Asians and Europeans). These factions could have caused serious conflicts soon after independence but Julius Nyerere's concept of egalitarianism created and preserved the new nation by promoting social unity and offering the people of Tanzania a chance for a better life (Arnold, 2005; Hatch, 1972; Hood, 1988).

In addition, Julius Nyerere, the first president of Tanzania brought about the union of the two states of Tanganyika and Zanzibar through a federal structure

(Arnold, 2005; Hatch, 1972; Hood, 1988). On April 26, 1964, Tanganyika and Zanzibar were amalgamated to form the nation of the United Republic of Tanganyika and Zanzibar, which was later renamed the United Republic of Tanzania (Arnold, 2005; Hatch, 1972; Hood, 1988). Under this union, Zanzibar retained significant autonomy over all areas except for union matters such as foreign affairs (Arnold, 2005; Tanzania National Website, n.d.c). The first president of Zanzibar was Abeid Karume.

Tanganyika and Zanzibar received their independence from Britain separately: Tanganyika on December 9, 1961, and Zanzibar on December 10, 1963, as a constitutional monarchy under the Sultan. On January 12, 1964, the Africans revolted against the Sultan in Zanzibar, and a new government was formed (Arnold, 2005; Davidson, 1992; Hatch, 1972; Tanzania National Website, n.d.c; Hood, 1988). Therefore, Zanzibar celebrates its independence on January 12 each year rather than on December 10.

For administrative purposes, Tanzania is divided into 26 regions (21 on the mainland and 5 in Zanzibar island) and 130 districts (120 on the mainland and 10 in Zanzibar island). Currently, Tanzania's political capital is Dodoma, whereas, Dar es Salaam remains the main commercial capital (Tanzania National Website, n.d.a). The official languages are English and Swahili. Soon after its independence, Julius Nyerere became the prime minister, but a few weeks later he resigned from that post and became the president of Tanzania (Arnold, 2005; Hatch, 1972). Nyerere's one-party rule maintained the unity of the state, but its rule came to an end in 1995 when Tanzania had its first multiparty democratic

elections (Arnold, 2005; Davidson, 1992; Hatch, 1972; Juntunen & Nikkonen, 1996).

Gender Issues

Like many other African countries, Tanzania has a patriarchal society, and thus women and female children face more disadvantages than men do. The gender imbalance is seen across all spheres of life; for example, in political activities, access to education, employment and health care, property rights, the discriminatory judicial laws, and so on (Bond, 2005). The harms inflicted on women through violation of their human rights include the customary inheritance laws[1] that lead to "poverty, harassment, ostracism, ill-heath, and psychological damage" (Magoke-Mhoja, 2005). According to Magigita (2005), women's participation in political life has been very low despite the fact that they form the majority of the voters in Tanzania. Regarding the right to education, the Constitution of Tanzania embraces gender balance; however, in reality, women are underrepresented in terms of enrolment at the university level.

Tanzania has taken some action to correct the gender imbalance, and one of the strategies that it adopted is affirmative action (Limbu, 2005, p. 30). This strategy signifies the positive action to overcome the systemic organizational forms of discrimination against and exclusion of women (Limbu, 2005). This affirmative action has influenced women's access to educational opportunities and political life to some extent. For example, women's participation in political affairs has increased from 7.5% in 1961 to 22% in the 2000 general elections, and

[1] A customary practice in which one of the male relatives or the brother of the deceased husband inherits the widow.

the establishment of a quota system in universities has increased women's higher education enrolment (Limbu, 2005; Magigita, 2005). According to the Thirteenth Amendment of the Constitution in 2000, the number of constituency seats reserved for women legislators has also increased to 20% and is expected to rise again in the future (Magigita, 2005). One of the objectives of the Ministry of Community Development, Women and Children is to create an enabling environment for women (as well as for men) to participate effectively and equally in socioeconomic and political reform (Tanzania National Website, n.d.d), but this is possible only if society considers women creditworthy; if they are empowered economically, intellectually, and politically; and if the legal system and customs are fair and gender neutral (Tungaraza, 2005).

Health Care System

Julius Nyerere was a socialist, and under his leadership during the postindependence period he ensured that primary health care, health services, and education were free for everyone, and the health of the population improved significantly (IDRC, n.d.; Shiner, 2003). But by the mid 1980s Nyerere's policies failed as a result of inadequate financing and implementation. In addition, the economic crisis in the late 1970s caused by the increased oil prices, decreased value of exports, and devaluation of the local currency decreased health expenditures. This crisis had direct consequences for the health of the population and resulted in a rise in morbidity and mortality rates and the inability to maintain health facilities and educated staff (IDRC, n.d.; Shiner, 2003).

Health Sector Reforms

In response to the crisis, the Ministry of Health ([MoH] currently known as the Ministry of Health and Social Welfare [MoHSW]) embarked on major health-sector reforms in 1993 to improve the quality of health services and increase equity in health services accessibility and utilization (Shiner, 2003). The reforms were directed towards managerial changes or the decentralization of health services; financial changes, such as the introduction of user fees for services, health insurance services, and community health funds; and organizational changes that encouraged the private sector to complement the public health services (Tanzania National Website, n.d.b). After independence, the state provided the most health services, and only a limited number of private-for-profit health services were available in major towns. In fact, post-independence, the government discouraged private practice; and in 1977 the Private Hospitals (Regulation) Act banned private-for-profit health services (Tanzania National Website, n.d.b). The prohibition of private health services had a further negative impact on the population's health, but under the 1993 health-sector reforms, the government allowed private health care providers to have a role and encouraged them to collaborate with the government to improve the quality of health services in the country (Tanzania National Website, n.d.b).

The introduction of user fees and other strategies to recover costs and revive the system under the health-sector reforms further deteriorated poor Tanzanians' access to health services. Masaiganah (2004) and McIntyre et al., (2008) charged that the health-sector reforms caused the low-income

socioeconomic groups to suffer the most inequities in access to affordable health care. Furthermore, the Tanzanian government is not autonomous in developing health policy; it depends on donor agencies (mainly WHO, the International Monetary Fund, UNICEF, and the World Bank) for the funding required for health care spending (Shiner, 2003). McIntyre et al., reported that nearly 23% of the total health care resources come from donors and 5% from nongovernmental organizations. Masaiganah (2004) and Shiner (2003) raised the concern that, rather than complementing the efforts of government agendas or addressing the welfare of the people of Tanzania, donor agencies have a negative influence on health care policy in the country.

Human Resources for Health

In Tanzania the government remains the main provider of health services and owns nearly 64% of all health care facilities. Of all of these facilities, about 87% are dispensaries, 9% are health centres, and 4% are hospitals. Approximately 17% of health care facilities are owned by nongovernmental organizations and 15% by private organizations (McIntyre et al., 2008; MoHSW, 2006). Furthermore, the MoHSW reported that the government employs nearly 74% of all health care workers in the country, and the rest work for private-for-profit and private-nonprofit organizations.

Table 1 shows the estimated health care professional workforce in Tanzania, according to the MoHSW (2006) and World Health Statistics (2008). Estimates are not available for the number of traditional healers in Tanzania, but they are assumed to outnumber modern health care professionals because the

Table 1

Comparison of Health Workforce per 10,000 Population (year 2000-2006)

Personnel	Density per 10,000 population			
	Tanzania	Kenya	Uganda	Canada
Nurses and midwives	4	12	7	101
Physicians	<1	1	<1	19
Dentistry personnel	<1	<1	<1	12

majority of the population believe in and turn to them for the treatment of various illnesses, including HIV/AIDS (MoH, 1990). Table 1 compares and reveals that Tanzania is experiencing a human resource crisis in the health sector (World Health Statistics, 2008). The MoHSW, with the support of WHO and other international organizations, is focusing on expanding the number and quality of health care professionals in the country (Tanzania National Website, n.d.e).

Nurses and other health care professionals are working in a very challenging environment where the burden of disease remains high compared to the available human resources in health care. In Tanzania, poverty underlies a number of health problems. Approximately 50% of the population live below the poverty line (Tanzania National Website, n.d.a). In addition to the deficiency in critical human resources, financial resources are also very limited. For example, in 2005, the total expenditure on health per capita was 40 (international dollar), and the total expenditure on health as a percentage of the gross domestic product was 5.1% (World Health Statistics, 2008), which is far below the global figures. According to World Health Statistics, basic amenities such as clean water (55%)

and sanitation (33%) are available only to a limited population. Moreover, negative health indicators (Table 2) are considerably higher than the global figures (World Health Statistics, 2008). Table 2 compares the Tanzanian health indicators with those of Kenya and Uganda, its neighbouring countries, and Canada as one of the developed countries in the world.

Table 2

Comparison of Selected Health Indicators

Health indicator	Tanzania	Kenya	Uganda	Canada
Life expectancy at birth (in years; male/female; 2006)	50/51	52/55	49/51	78/83
Maternal mortality ratio per 100,000 live births (2005)	950	560	550	7
Neonate mortality rate per 1000 live births (2004)	35	34	30	3
Infant mortality rate per 1000 live births (2006)	74	79	78	5
Child mortality rate under five year per 1000 live births (2006)	118	121	134	6

(Adapted from World Health Statistics, 2008)

The major preventable deaths for children under five are caused by malaria, anemia, diarrheal diseases, malnutrition, pneumonia, HIV/AIDS, and injuries. For the adult population, HIV/AIDS and tuberculosis are the major causes of morbidity and mortality, along with noncommunicable diseases such as hypertension, diabetes, and cancer (MoHSW, 2006; World Health Statistics, 2008). Post independence, numerous efforts have been made to improve the quality of and accessibility to health services, but the situation of health remains bleak (Masaiganah, 2004). Having policy statements but no ability to implement

them because of problems with the health care delivery system requires that the situation be rectified.

To improve on these indicators, Tanzania is now struggling to meet the Millennium Development Goals ([MDGs] Ministry of Planning, Economy, and Empowerment, 2006). In 2000, at the United Nations Millennium Summit, representatives from 189 countries and 149 heads of state from developed and developing countries pledged to meet the eight stated MDGs[2] by 2015 (WHO Regional Office for Africa, 2005). It has been a very difficult target to meet, and Tanzania has so far shown mixed progress towards achieving the MDGs (Ministry of Planning, Economy, and Empowerment, 2006). Nurses need to play a major role in achieving the MDGs.

Nursing Education

Nurses are frontline workers and the backbone of a health care delivery system. According to Moyo (2007), the Registrar of TNMC, in 2007, 18,500 nurses were registered in the country. After independence the MoH created education programs for nurses, but for many years before that, young boys with a primary education or illiterate elderly women who were called *dressers* provided nursing care in Tanzania (Juntunen & Nikkonen, 1996, p. 538). Currently, the types of education programs offered to nurses are a Grade A diploma in nursing

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[2] Goal 1: Eradicate extreme poverty and hunger;
Goal 2: Achieve universal primary education;
Goal 3: Promote gender equality and empower women;
Goal 4: Reduce child mortality;
Goal 5: Improve maternal health;
Goal 6: Combat HIV/AIDS, malaria, and other diseases;
Goal 7: Ensure environmental sustainability;
Goal 8: Develop a global partnership for development. (WHO Regional Office for Africa, 2005, p. 1)

(RN) and a Bachelor of Science (BSc) degree in nursing. Two-year advanced diplomas are offered in mental health, paediatrics, theatre management, anaesthesia, public health, midwifery, nursing education, and ophthalmology (TNMC, 2007). Since 2007, the TNMC no longer approves programs for entry to the Grade B–enrolled nurses (ENs) (similar to LPNs in Canada). But bridging programs are available for ENs who wishes to get a diploma in nursing. For the past few years government and private institutions have also begun to offer bridging programs for diploma nurses to upgrade their qualifications to the BSc level. The TNMC provides licensing and registration, which is mandatory, to these nurses (United Republic of Tanzania, 1997).

Conclusion

The literature review in this chapter highlights diverse definitions and understandings of the concepts of spirituality and spiritual care in nursing. Despite the differing worldviews, nursing has strived to embrace spiritual care in clinical practice for centuries. The literature reveals that spirituality is discussed in the context of the holistic nature of human persons and from religious perspectives. Various authors' discussions of Africans' perspectives on spirituality also shows that spirituality and religion are inextricably connected and that culture shapes African people's understanding of religion and spirituality. The literature also highlighted that African people greatly value traditional healers.

The literature on spiritual care revealed that for some nurses, spiritual care meant encompassing religious practices, while for others it meant assisting patients identify the meaning and purpose in life. Various authors, in the

literature, have recommended viewing spirituality from a broader perspective rather than only from a religious framework. This chapter also provided information about Tanzania where the study took place. The TNMC also requires that Tanzanian nurses integrate spiritual care into their clinical practice. The overview of the literature has provided me with background from which to ask the nurse participants in this study for their views on spirituality and spiritual care and context into which their responses can be considered.

CHAPTER THREE: METHOD

Scientific work is born out of a quest for the nature of phenomena and the relationships among these phenomena and investigators have used every possible method to describe, understand, and explain phenomena (Gustafsson, 2002). As a nurse researcher, I was eager to understand and explain the concepts of spirituality and spiritual care as Tanzanian nurses comprehend them. For my research study, I have used the interpretive description method to provide direction for qualitative description and an extension into the realm of interpretation and explanation (Thorne, Con, McGuinness, McPherson, & Harris, 2004) to describe how Tanzanian nurses view spirituality and integrate spiritual care into clinical practice. The purposes of this chapter are to present an overview of the interpretive description method and to describe the setting, sample, process of recruiting participants, data-collection procedure, and data analysis. Last, I will describe the strategies I used to establish rigor and the ethical considerations to reduce or prevent harm to the study participants.

The purpose of this study was to understand and explain the concepts of spirituality and spiritual care as Tanzanian nurses comprehend them. When I began to develop my study, I had originally planned to use grounded theory. But as I started having discussions with my supervisors, I realized that my research questions did not align with grounded theory method as I did not intend to develop a theory of spirituality or of spiritual nursing care in Tanzania. As a result, I started exploring phenomenology. As my research questions did not intend to answer human subjective experiences of spirituality and spiritual care, I

considered interpretive description. I was introduced to this method in a qualitative methods course. Interpretive descriptive method fits well with the focus and scope of my study.

Overview of the Interpretive Description Method

Thorne, Reimer Kirkham, and MacDonald-Emes (1997) developed the interpretive description method in response to an expressed need to generate knowledge through alternative research methods (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). This method reflects the evolution of qualitative methodology within the domain of the nursing discipline. The interpretive description method also answers many complex, experiential, and contextually embedded questions relevant to nursing science that traditional qualitative methods cannot answer fittingly (Thorne, Con, et al., 2004; Thorne, Reimer Kirkham, et al., 2004).

The three traditional qualitative methods that are still predominantly used in nursing are phenomenology, grounded theory, and ethnography. According to Thorne (2008), these traditional methods have evolved from the social sciences: psychology/philosophy, sociology, and anthropology. Although subspecialists within each of these disciplines work in a practical context, the origin of the discipline follows the philosophical underpinnings of the social sciences, which are firmly anchored in theoretical and empirical problems rather than the practical problems that nurses address in their day-to-day work (Thorne, 2008). Therefore, Thorne asserted, the knowledge generated from these traditional research methods addresses problems of a more basic nature—of social group behaviours—and the

core nature of human experience instead of the practical problems of nursing (Thorne, 2008). In addition, researchers who follow these traditional methods are expected to adhere to the methodological roots to ensure the quality of their studies.

Interpretive description appreciates and uses a wide variety of data-collection and analysis strategies from the traditional methods, but strictly adhering to a traditional methodological position is considered a limitation in the researcher's ability to answer clinical questions in a meaningful manner (Thorne, 2008). Thus the interpretive description method emerged as a distinct qualitative approach to offer "a clinical description with an interpretive or explanatory flavor" (Thorne, Reimer Kirkham, et al., 2004, p. 3) to answer complex experiential questions that nurses and other applied health researchers ask (Thorne et al., 1997). According to Thorne, Con, et al., (2004), nurses and other applied health researchers have found that interpretive description as a research design provides a logical structure and a philosophical rationale to answer qualitative inquiries.

The interpretive description is an approach to knowledge generation in alignment with nursing's and other health professions' applied disciplinary domain (Thorne, 2008; Thorne et al., 1997; Thorne, Reimer Kirkham, et al., 2004). Thorne and her colleagues called this method *atheoretical* because the intention is not to construct a theory or to theorize, but to generate inquiries related to the clinical problems of health and illness that researchers can describe and interpret in terms of patterns of "experience, action, or expression" (Thorne,

2008, p. 68). For example, Ravenscroft (2005) used the interpretive description method to study the experience of kidney failure in seven research participants with diabetes and identified six themes which had direct implications in clinical practice. The findings from this study suggested that nephrology nurses need to develop communication tools to enable continuity of care and enhance patient-health care provider relationships, to create opportunities for hemodialysis (HD) treatment time to be more productive, stimulating and interactive, and "to make HD treatments less intrusive on client time offering opportunities at normalizing life" (Ravenscroft, 2005, p. 508).

Byrd and Garwick (2006), Elmberger, Bolund, Magnusson, Lützén, and Andershed (2008), Payne and Goedeke (2007), Predeger and Mumma (2004), Thorne, Hislop, Armstrong, and Oglov (2008), and many others have also used this method to identify issues for clinical inquiry and have applied the knowledge generated from these inquiries into practice context.

With regard to philosophical alignment, interpretive description orients itself with an interpretive naturalistic perspective. The descriptor *interpretive* itself denotes its positioning within nondualistic philosophical traditions, and the term *description* denotes the detailing of findings built on inductive reasoning and not just the reporting of what the researcher observed through human subjectivity (Thorne, 2008, p. 48). This anthropomorphism sees reality as multiple, constructed, and contextual (Evans, 2002; Thorne, 2008; Thorne, Reimer Kirkham, et al., 2004). In regard to methodological congruence, interpretive description shares ideas that are informed by key axioms within Lincoln and

Guba's naturalistic inquiry tradition (Lincoln & Guba, 1985; Thorne, 2008; Thorne, Reimer Kirkham, et al., 2004). Thorne considered sharing ideas with naturalistic inquiry because inquiry into a disciplinary problem has several common sets of assumptions about human experience. Thus, Lincoln and Guba's naturalistic-inquiry axioms represent the epistemological and methodological foundations for interpretive description (Thorne, 2008; Thorne, Reimer Kirkham, et al., 2004).

The key axioms are as follows: (a) multiple realities are constructed in the context of complex human experience and may well be contradictory; thus, reality is subjective; (b) because the researcher (inquirer) and the participant (object of inquiry) interact and influence one another, they are inseparable; (c) theory must emerge from the data rather than using an a priori theory; (d) the focus is on human commonalities and individual variance within the area of inquiry; and (e) inquiries are conducted in as naturalistic a context as possible to maintain the respect, comfort, and ethical rights of all participants (Lincoln & Guba, 1985; Thorne, 2008; Thorne, Reimer Kirkham, et al., 2004). In addition, interpretive description, by virtue of its reliance on interpretation, yields constructed truths (Thorne, Reimer Kirkham, et al., 2004) rather than facts. Clearly eliciting these philosophical underpinnings, interpretive description ensures that the knowledge that is developed is legitimate and therefore applicable to the discipline. Thus interpretive description addresses very well epistemological and methodological positions and disciplinary affiliation.

The goal of interpretive description is to answer specific questions related to practical aspects of the nursing discipline. The method presumes the availability of theoretical knowledge, a clinical pattern, and scientific reasons for conducting the study. Therefore, in the interpretive description method, the critical review of literature/knowledge forms the basis for the preliminary analytic or guiding framework (Woodgate, 2008), which in turn assists in the sampling, design, and early analytic decisions. However, the researcher is required to remain vigilant in the analytic process because the original analytic structure may represent the collection and analysis process and thus produce merely a "glorified content analysis" (Thorne, Reimer Kirkham, et al., 2004, p. 10) or the premature closure of emerging conceptualizations (Predeger & Mumma, 2004). The early analytic stage guides researchers in identifying the nature and shape of the preliminary theoretical framework, and they are expected to gradually distance from it because alternative conceptual meanings arise during further data analysis (Thorne, Con, et al., 2004; Thorne, Reimer Kirkham, et al., 2004).

According to Thorne, Con, et al., (2004); Thorne, Reimer Kirkham, et al., (2004); and Thorne (2008), the product of an interpretive description approach is a coherent conceptual description of common themes and patterns related to the topic of interest, in this case spirituality, that also account for individual variation. Thorne, Reimer Kirkham, et al., argued that the descriptions created are tentative truth rather than the original and coherent new truth of the descriptions in a traditional qualitative study. Furthermore, they clarified that the interpretive aspect of this method is a critical examination within the methodological

guidelines that is consistent with the nursing discipline's practical-application endeavour rather than free-floating theorizing (Thorne, Reimer Kirkham, et al., 2004). Therefore, the findings from such a study have the potential to offer a basis for assessment, planning, and interventional strategies that nurses can apply in solving clinical problems in a logical and ethical manner (Thorne, Reimer Kirkham, et al., 2004).

Setting

I recruited nurses who were currently working in Aga Khan Hospital in Dar es Salaam, Tanzania. The hospital is an 80 bed multispecialty facility and is part of Aga Khan Health Services, which are private, not-for-profit health care systems that exist in developing countries (Aga Khan Hospital, Dar es Salaam, 2003). I recruited nurses from different wards of the hospital (medical, surgical, paediatrics, maternal, operation room, and intensive care) to capture meaningful and varying descriptions of the concepts of spirituality and spiritual care.

Population and Sample Size

At the time of data collection, 110 nurses were working at the Aga Khan Hospital. Of these 110 nurses, 13 had a post registered nursing bachelor's degree in Nursing (Post- RN BScN), 70 had a diploma in nursing (RN), and 27 were enrolled nurses (similar to LPNs in Canada). Ninety two nurses were females and 18 were male. Ninety nurses identified themselves as Christians and 20 as Muslim. Except for three nurses, all of them were of African origin. Similar to other qualitative studies, interpretive description requires smaller samples because it is based on a smaller-scale qualitative investigation (Thorne, Reimer Kirkham,

et al., 2004). The sample size in interpretive descriptive method can be of any size but generally it varies from five to thirty (Thorne, 2008). In relation to data saturation as a justification for concluding data collection, Thorne (2008) argues that, in the disciplinary context of health research, there is infinite variation in relation to participants' experiences (2008) and therefore, saturation is not a valid goal of the interpretive description method. However, data that offer sufficient depth to report meaningful description of the phenomenon under study are considered.

Having said this, it was not an easy decision to settle on a number of interviews as I did not know how soon I would get adequately significant information. While I was performing concurrent preliminary analysis during data collection and reporting this analysis to my supervisors, I carried on with further interviews. After conducting 13 interviews, I observed that further gathering of data was not significantly yielding a deepening of understanding of the phenomena under study (Hunt, 2009). Therefore, my supervisors and I reached a decision that two more interviews would suffice as I seemed to have sufficient depth of description to report. Strauss and Corbin (1998) also assert that the goal in a qualitative study is not the representativeness of the sample but "the concern is with representativeness of concepts and how concepts vary dimensionally" (p. 214). Therefore, 15 study participants were recruited to provide me with meaningful descriptions of the concepts *spirituality* and *spiritual care* and to elicit important questions and concerns related to the phenomena for further research consideration (Thorne, 2008).

I purposively drew the samples for this study to capture expected and emerging variations (Ravenscroft, 2005; Thorne et al., 1997; Thorne, Reimer Kirkham, et al., 2004) within the concepts of spirituality and spiritual care. Purposive sampling involved selecting nurses who were directly engaged in clinical practice and were able to articulate their thoughts related to spirituality and spiritual care (Guba & Lincoln, 1989; Thorne, 2008). To achieve the maximum variation in sampling, I ensured that participants varied in gender, religious background, years of clinical experience, professional qualifications, and area of work. During the data collection, it was observed that the first six participants were Christian nurses and there were no Muslim nurses participating. To have variation in terms of religious background, snowball sampling technique (Polit, Beck, & Hungler, 2001) was introduced. The first Muslim participant and the subsequent participants were requested to refer other Muslim nurses who met the study's eligibility criteria.

Gaining Access to the Field Site

I negotiated entry to the field site and access to the study participants at different levels. First, I submitted the study proposal to the Health Research Ethics Board at the University of Alberta (HREB- U of A). After receiving approval from HREB- U of A, I contacted the director of Nursing Services at the Aga Khan Hospital, Tanzania (AKH-TZ) to inform her of the intent and design of my study and to gain her support. She forwarded my study proposal to the Ethics Committee of AKH-TZ. After receiving approval from the Ethics Committee of AKH-TZ, I forwarded my proposal to the National Institute of Medical Research

(NIMR), Tanzania for their approval. Along with the study proposal, I submitted approval letters received from HREB-U of A and AKH-TZ to NIMR (See Appendix A).

After receiving approval from NIMR, I again contacted the Director of Nursing Services at the AKH-TZ to seek her approval and facilitation in the process of recruiting study participants. She and, in her absence, the Acting Director of Nursing Services were my resource people whenever I needed information pertinent to my study such as total number of registered nurses and the religious background of nurses in the hospital, or for giving reminders to nurses about the study. The Director invited me to attend their combined quarterly staff and nursing management meeting to present information about the proposed study. Unfortunately the meeting was postponed and I was not able to present the information on the said date. Later, when I was not in Dar es Salaam, the Director had a meeting and she presented the study information (Appendix B) to registered nurses, head nurses and nursing managers. Had I been informed of this meeting before hand, I would have attended it. The head nurse of each unit was given recruitment advertisement flyer (Appendix C) by the director to put up on the notice board. Later, I made sure that the flyers were posted prominently on notice boards of each unit.

I am an employee of Aga Khan University and although I did not require ethical approval from this institution, I had to brief the Dean of Aga Khan University-Advanced Nursing Studies Program, East Africa (AKU-ANS, EA) and the Academic Head of AKU-ANS, Tanzania campus, on my study proposal and

my plans for the data collection. I had separate meetings with them. Upon my request, they offered me a vacant office in the ANS premises. I used this office for the duration of my data collection for conducting interviews. I was also permitted to use filing cabinet and photocopying resources at the campus.

Inclusion Criteria

The participants in this study were recruited based on the following inclusion criteria: nurses (a) working in Aga Khan Hospital, (b) engaged in direct clinical practice, (c) have more than one year of clinical experience in patient care, (d) have the ability to articulate their thoughts (in English) on spirituality and spiritual care, and (f) be willing to talk about and reflect on their experiences with the phenomena under study.

Recruitment of Participants

The advertisement flyers (Appendix C) on the notice boards of different wards of the hospital clearly offered information on the purpose of the study, including my contact details. Interested participants contacted me by telephone. During the initial telephone conversation with potential participants, I ensured that the individual met the inclusion criteria, and then I arranged a time for the interviews at the convenience of participants in my office at AKU-ANS. During the data collection period, there was no situation where I had to refuse participants in enrolling in the study. There was one time when I took the contact details of one potential Christian participant and asked her to wait until I call her. Later on she was contacted and she agreed to be part of the study. This was the time when I was waiting for Muslim participants to approach to me.

Data Collection

The primary data-collection strategy was in-depth face-to-face interviews with the research participants. An interview guide consisting of semi-structured and open-ended questions (Appendix D) was developed to elicit a description of spirituality, spiritual care, and spiritual caregiving practices. In addition, the questions also addressed the hindering and enabling factors for the integration of spirituality into nursing practice and traditional healing practices. The purposes of the semi-structured interviews were to explore, in detail, participants' views, beliefs, and experiences on spirituality and spiritual care (Gill, Stewart, Treasure, & Chadwick, 2008; Ravenscroft, 2005). Moreover, the semi-structured interviews allowed elaborating on the information that was important to the participants which may have not been previously thought as pertinent to a research study (Gill et al., 2008). I conducted all the interviews in my office at AKU-ANS, TZ premises. The office was convenient to me and I assumed it was convenient to the participants as it was close to the hospital, would provide privacy, and would maintain anonymity of research participants. I did not check with participants regarding their convenience for a place to conduct interviews but none of them raised any concerns about interview location. Except for one participant, all the participants came for interviews after completing their shift duties. Each participant was reimbursed for transportation costs.

Prior to the interview, I gave participants a letter of information on the study (Appendix E) and obtained their informed consent to participate (Appendix F). I requested that each participant complete a demographic

information sheet (Appendix G), which consisted of the participant's gender, age range, highest professional qualification, years of clinical experience, and area of work. An identification number was assigned to each consent form and demographic information sheet. These documents were kept in locked filing cabinets. I reassured my participants that I would handle all of the information in a confidential manner and that the final report will not identify them.

The interviews lasted from 47 to 85 minutes. To strengthen the credibility of the findings, participants' answers were regularly checked by paraphrasing, clarifying, and summarizing. As data collection and analysis occurred concurrently, the emerging categories and themes were tested during succeeding interviews. All the interviews were audio-taped on a digital ICD recorder with the participants' permission. I maintained field notes immediately after each interview. The field notes consisted of my reflection on what was happening in the interview, nonverbal behaviour of the participants, and the themes emerging from interviews (Payne & Goedeke, 2007; Woodgate, 2008). Also, at the end of each interview and sometimes after two interviews, I reflected on the interview process, the depth of the responses, my biases, the areas to be explored in detail with prospective participants or/and need for further follow-up. I noted my reflections in my reflective journal. A reflective journal was also maintained to record "reflections regarding decision-making throughout the data gathering research process" (Payne & Goedeke, 2007, p. 647).

After each interview, the data from the ICD recorder was transferred to my computer and saved as a voice file with a participant number. Later,

pseudonyms were assigned to each participant. I transcribed each interview verbatim as soon after the interview as possible and after each interview I coded the transcript. The transcripts were saved in my computer as Micro soft Word documents. I also gave each participant a notebook to take notes on their reflection and experience of providing spiritual care or to write any additional information related to the phenomenon of spirituality. The participants were given three months, starting from early September to November 2009, the date of first interview, to share their notes with me. Only two participants provided me with their reflective notes.

A pilot interview was carried out before proceeding with actual interviews to assess the clarity and relevance of the interview guide (Lundberg & Kerdonfag, 2010) and to get the feedback from my supervisors on my interview skills. I e-mailed the transcript of the pilot interview to my supervisors. I received feedback on it and then I again e-mailed my initial first two interview transcripts to them for further feedback. The feedback from my supervisors helped me improve my interviewing skills and in turn it assisted me to gather rich data from study participants. Later, I continued e-mailing my transcripts to my supervisors as soon as I completed transcribing. I continued with the rest of the interviews until sufficient depth of meaningful description of the phenomenon under study was collected. Throughout the data collection period, I communicated regularly with my supervisors.

Data Analysis

According to interpretive description, the collection of data and the analysis occurred concurrently. This method is the same as that which was proposed by Lincoln and Guba (1985). The critical review of the literature/knowledge related to nurses' spirituality and spiritual care in chapter two formed the basis for the preliminary analytic framework. As mentioned before, the reflective journal was also referred to when making decisions about data analysis. Interpretive description gives the researcher the freedom to utilize coding approaches from other forms of qualitative research methods. In consultation with my co-supervisors, I decided to utilize Creswell's (2003, p. 191-195) six suggested generic steps of data analysis which included coding approaches as well. As recommended by Thorne (2008) and Creswell (2003), initial analysis took place by reading and re-reading the transcripts and I attempted to gain an understanding of the overall picture of the phenomena under study. The description of the overall picture of the study was noted in my reflective journal and was shared with my supervisors.

Detailed analysis began with a coding process. The coding process involved organizing participants' sentences and paragraphs with similar properties into categories (Creswell, 2003; Thorne, 2008). I developed a table in a Word document to copy and paste sentences and paragraphs from the transcripts with common properties into categories. Several categories evolved from the analysis of data. Broad-based in vivo codes were assigned to each of the categories generated. The opinion and expertise of my supervisors was sought to confirm the

coding process and the use of codes. Recoding of two categories was done with the consultation of my supervisors as existing codes did not represent categories well. Later, data content belonging to each category was grouped in one place before performing preliminary analysis (Creswell, 2003).

Categories that characterized spirituality, spiritual care, and other related phenomena were grouped together into themes. These themes represented the major findings of this qualitative study and are described in the following three chapters (Creswell, 2003). The initial themes were tested and refined in subsequent interviews with research participants throughout the study (Payne & Goedeke, 2007). I examined and re-examined similar characteristics of the groups of data to arrive at a range of alternatives and thus convey the essence of the phenomena under study in the final analysis (Thorne et al., 1997; Thorne, Reimer Kirkham, et al., 2004). A similar process was utilized for analyzing reflective notes that had been submitted by two participants. Two participants were contacted for clarifications of information and follow-up on evolving themes. These follow-up meetings lasted from 12 to 30 minutes.

During initial analysis I asked myself questions such as “What is happening here?” “What am I learning about this?” (Thorne et al., 1997, p. 174), “Why is this here?” and “What does it mean?” (Thorne, Reimer Kirkham, et al., 2004, p. 13) to search for alternative linkages, exceptional instances, and contrary cases to broaden the conceptual linkages (Thorne et al., 1997; Thorne, Con, et al., 2004; Thorne, Reimer Kirkham, et al., 2004). Thorne and her colleagues stressed that the breadth is more important than precision in the early phase of coding and

organizing processes. Thus, the early analytic stage guided me in identifying the nature and shape of the preliminary analytical framework, and gradually I distanced myself from it as alternative conceptual emphases arose during further data analysis (Thorne, Con, et al., 2004). For example, the literature review done for this study guided me to develop a preliminary analytical framework such as: conceptualization of spirituality and spiritual care, relationship between spirituality and religion, and the holistic nature of nursing care. As I progressed with data analysis, I made a conscious effort to move away from the preliminary analytical framework to "capture the essence of the idea presented in the data" (Creswell, 2003, p. 195).

Referring to the questions "What am I learning about this?" (Thorne et al., 1997, p. 174), "Why is this here?" and "What does it mean?" (Thorne, Reimer Kirkham, et al., 2004, p. 13) periodically also helped me ensuring inductive analysis and also prevented me from premature coding and interpretation of the data (Predeger & Mumma, 2004). In the final stage of the data analysis, with the assistance of my supervisors, who have knowledge and expertise in spirituality and spiritual care, we agreed on final categories and themes derived from the data to ensure that they make sense and can be useful to health care professionals (Thorne, Con, et al., 2004; Thorne, Reimer Kirkham, et al., 2004). Hence, in the interpretive description method, validating the findings with expert/experts, in this case, my supervisors, was more appropriate than asking the research participants to do so (Thorne, Reimer Kirkham, et al., 2004). The review process with experts, journal writing, reviewing field notes with transcribed interviews, and prolonged

immersion with the data enhanced rigor of the study (Mayan, 2008; Payne & Goedeke, 2007; Woodgate, 2008).

Rigor

As with any qualitative research study, interpretive description needs to be rigorous, and the debate on establishing common criteria for rigor or the quality of a qualitative study in general continues (Caelli, Ray, & Mill, 2003). Qualitative researchers have proposed a number of criteria that are in use, but they have argued that finding common criteria is not only difficult, but also impossible because different qualitative approaches are grounded in specific philosophy, and therefore the criteria for one approach may fail to match those for the other approach (Caelli et al., 2003). Therefore, Caelli et al., have suggested that researchers must be able to "articulate a knowledgeable, theoretically informed choice regarding their approach to rigor" and "select an approach that is philosophically and methodologically congruent with their inquiry" (p. 15) to produce quality studies.

Thorne (2008) and Thorne, Reimer Kirkham, et al., (2004) suggested general principles to ensure the rigor, which they termed credibility of research conducted with the interpretive description method. Lincoln and Guba (1985) have used the term trustworthiness to evaluate the study. Thorne (2008) suggested the following evaluation and critique criteria: epistemological integrity, representative credibility, analytic logic, interpretive authority, moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth. Lincoln and Guba's (1985) trustworthiness criteria, for

example, credibility, transferability, dependability, and confirmability are partly integrated into Thorne's (2008) credibility criteria. It is unnecessary to compare and contrast different criteria of credibility used by various qualitative researchers but one can see the overlaps in the criteria mentioned by Thorne (2008).

Epistemological Integrity

The research questions in this study on Tanzanian nurses' understanding of spirituality and spiritual care were consistent with the stated epistemological foundation and have disciplinary relevance. Tanzanian nurses are required to integrate spiritual care into their practice. But the knowledge gap in nursing literature related to Tanzanian nurses perceptions of spirituality and practice of spiritual care was identified. Hence a clinical inquiry was undertaken to generate knowledge from these inquiries so that it can be applied into practice context. In addition, the study has contributed to the advancement of knowledge in spirituality domain. The research questions guided me in selecting my data sources and interpretive strategies. This resulted in epistemological integrity, which is considered as the first criteria for qualitative research study's credibility (Thorne, 2008).

Representative Credibility

Representative credibility was achieved through in-depth interviews with participants and prolonged immersion with the data. Also, the in-depth description of the phenomena of spirituality and spiritual care, description of the participants' recruitment process, and highlighting commonalities and variations within findings represent credibility of the study. Nurses in this study represented

different units of the hospital and had varied clinical experiences and education preparation. Also, before joining AKH, the majority of the participants had worked across different hospitals in Tanzania.

The involvement of my co-supervisors throughout data analysis process added to the overall credibility of the study but representative credibility in particular. The in-depth interviews as a primary data source, input from my co-supervisors in data analysis, and reflective notes from participants provided triangulation of the phenomena under study and contributed towards trustworthiness of the findings (Hunt, 2009).

Analytic Logic

As an investigator I was deeply involved with data, for example, transcribing interviews, reading and re-reading transcripts, and generating summary of the overall picture of the phenomena under study. The inductive analysis that occurred concurrently with the data-collection and the analytic steps (described in data analysis section) show that a inductive reasoning process occurred in this study. As mentioned by Thorne (2008), an audit trail was generated for this study. For instance, I have clearly described the decision I took in consultation with my co-supervisors in relation to choosing the study participants, ending the data collection process after interviewing 15 participants, using Creswell's data analysis steps, and formulating and agreeing on categories and themes that emerged from data. The decision making process used to analyze data reflect analytic logic, which is another principle of the credibility procedure.

Interpretive Authority

Thorne (2008) defines interpretive authority as: the transparent presentation in the research report of the power relation, the subjective construction of knowledge, and the researcher's position in the study. The voluntary participation in the study, the ethical standards used in recruiting and interviewing participants, and participants allowing to choose the date and time for being interviewed suggest balancing of power relations in the study. Because the philosophical underpinning of interpretive description is associated with the interpretive paradigm, the findings of this study are constructed realities. Thorne, Reimer Kirkham, et al., (2004) contended that, in generating the findings, the researcher as interpreter influences the credibility of the study. To account for my interpretation of the data, I have described participants' narratives in detail before labelling categories and themes. Also, extensive discussion of findings and analysis of data with my co-supervisors gives me confidence to state that I have strived to remain true to participants' views.

Ayres (2007) and Mayan (2008) explained that the influence of the researcher on a study is considered in an audit trail because it documents the researcher's choices and decisions, including subjective interpretations, which leads to theoretical rigor. As a researcher, I maintained a reflective journal to guide me as well as to document the reactive process of interpretation and counter bias within the research process (Thorne, 2008; Thorne et al., 1997). In addition, I kept field notes to record the context of the data-gathering episodes after each interview and linked them to the phenomena under study.

Moral Defensibility

Another principle of rigor suggested by Thorne (2008) is moral defensibility. This criterion requires that researchers justify the need for the study and rationalize the need to select specific study participants and protect them from harm. The purpose of this study and the ethical considerations taken into account in this study and described in the last section of this chapter, reflect my need to meet the moral defensibility criterion. Moreover, to meet this criterion, I have rationalized the need for and use of the knowledge that was shared by Tanzanian registered nurses (Thorne, 2008).

Disciplinary Relevance

Disciplinary relevance was another essential criterion of credibility. It relates to the knowledge generated from the research and the extent to which it is "appropriate to the development of disciplinary science" (Thorne, 2008, p. 227). The discipline of nursing is committed to assessing and evaluating spirituality. Also, nurses are required to be involved in spiritual care (Canadian Nursing Association, 2005; Cavendish et al., 2007; Hodge, 2006; TNMC, 2007) hence providing spiritual care falls under the realm of nursing. Therefore, this research study will add to the nursing knowledge about the spiritual dimension of human health and will especially contribute to the development of nursing knowledge from a Tanzanian nurses' perspective.

Pragmatic Obligation

Pragmatic obligation reflects the recognition of a researcher about the usability of the knowledge generated from the research. Thorne (2008) and

Thorne, Reimer Kirkham, et al., (2004) contend that conducting a research without knowing its usability in practice is against the social mandate of a health science discipline. Because of the social mandate of nursing there is an expectation that the knowledge evolved from the research will be useful. I believe that the result of this study will contribute to the development of content on spirituality and spiritual care in nursing curriculum in Tanzania. In addition, the ways of identifying spiritual needs and the interventions suggested by participants will assist Tanzanian nursing students and nurses to offer patients and their families' spiritual care as part of holistic care and assist them in achieving positive health outcomes.

Contextual Awareness

An interpretive description produced constructed truths related to spirituality and spiritual care rather than facts because of the reliance on interpretation. The context in which the knowledge related to spirituality and spiritual care was generated in this study was Tanzanian nurses' perspectives. The constructed truth regarding the same phenomena may differ if context is changed, for example, a different group of nurses or different types of hospitals. In my study, although spirituality and spiritual care are indeed universal, they are modulated by context. The findings of this study are directly relevant for Africa, but they are also relevant for the purpose of comparing with other countries and for considering the beliefs of Africans who immigrate to the Western world.

Probable Truth

Interpretive description falls within the qualitative paradigm, therefore, the truths constructed in this study are probable truths rather than absolute truths as conceived in a positivistic paradigm. However, there is a considerable value in the knowledge developed based on probable truths. The aim of interpretive description is not to generalize the findings but to develop a deeper level of understanding of the phenomena of interest.

As an investigator, I remained conscious that, based on my choice, I have constructed the probable truths, findings, or stories; therefore, honesty and prudence are critical because erroneous findings may have serious consequences (Thorne, Reimer Kirkham, et al., 2004). To avoid some of the common pitfalls in qualitative data analysis, I remained vigilant in the analytic process to avoid "overdetermination of pattern" (p. 16) and overreliance on *in vivo* statements.

Ethical Issues

I submitted the research proposal for ethical review. The following were the main ethical considerations that I paid attention to in order to preserve the dignity, safety, autonomy, and privacy of my study participants. As stated earlier, once I obtained ethical and administrative approval for this study, information related to the study was shared with staff nurses in their meeting and later invitation flyers were posted on hospital units. Nurses who were interested in participating contacted me directly, thus reducing risks of coercion. I did not recruit participants through my pre-existing relationships but I knew some who had been students when I was a faculty member at Aga Khan University. I had no

concurrent association with them or with nurses of Aga Khan Hospital. Therefore, they were not under any undue pressure to agree to participate in the study.

Once I had established that they understood the purpose and methods of study and read the information letter, consent was obtained. I stored the signed consent forms and information that I gathered for the study separately in locked cabinets. My supervisors were given an electronic copy of all data for safe keeping. I preserved the anonymity of the research participants by eliminating their names and identifiers from the transcripts and records; only I as the researcher have had access to the names of the participants. Also, I used pseudonyms to maintain anonymity of participants. The pseudonyms selected in this study are names commonly seen in the Tanzanian population. When a statement made by participants was likely to reveal their identity, I made sure that, it was used in a way that concealed their identity.

I have preserved the research study material appropriately to maintain confidentiality. I have reimbursed the research participants transportation costs of Tanzanian shillings (TSh) 20,000 per visit and TSh 5,000 for telephone calls. To assist me in my research, only my co-supervisors had access to the data during the study and participants were informed about this. I will keep the information that I gather for at least five years after I have completed the study. The information collected for this study might be looked at again in the future to answer other questions. If this happens, the ethics board will first review the new study proposal to make sure that the information is used ethically.

There were no known discomforts or risks associated with this study. The participants were informed that they could refuse to answer any question they wished to. They had the freedom to withdraw from the research study at any time they wished to, without giving me a reason. I also informed them that their participation in or withdrawal from this study would not affect the conditions of their employment. However, none of the participants felt uncomfortable or withdrew during the interviews.

Conclusion

To understand the spiritual care practices of Tanzanian nurses, I have chosen to use interpretive description as the method. As in any qualitative study, interpretive description establishes rigor such as representative credibility, analytic logic, interpretive authority, and moral defensibility to evaluate the quality of the method. Having described the sampling, data collection, and data analysis for this study, I hope that it will foster an understanding of spirituality and spiritual care practices from the perspective of Tanzanian nurses and become the basis for assessment, planning, and interventional strategies for nurses and other health care professionals.

CHAPTER FOUR: FINDINGS RELATED TO SPIRITUALITY AND SPIRITUAL CARE

In this chapter I present the analysis of the data that was collected from 15 nurse participants from Tanzania including their demographic information. The two main research questions posed in the study were: How do Tanzanian nurses describe/understand the concepts of spirituality and spiritual care? How do Tanzanian nurses practice spiritual care? To answer these research questions, eleven guiding questions were used during each interview (Appendix D). The themes that emerged from the analysis of data form three different chapters. In this chapter I focus on: the meaning of spirituality and the meaning of spiritual care. The next two chapters include: recognition of spiritual needs, interventions to respond to spiritual needs, challenges addressing spiritual care, factors positively influencing the provision of spiritual care, spiritual care versus nursing care, impact of receiving spiritual care, and the traditional healing practices to deal with spiritual matters.

To protect the confidentiality of the participants, I have used pseudonyms to identify their quotes. I assigned Christian male and female names to represent Christian nurse participants and Muslim male and female names for Muslim nurse participants. For example, Ghanima, Jumma, and Ombeni were Muslim nurse participants while the rest of the participants in the study were Christians. Also, I used alphabetical order to assign pseudonyms.

Demographic Information of the Participants

As mentioned in previous chapter, I collected the demographic information from all 15 nurse participants before initiating the actual interviews. Seventy three percent (n = 11) of participants were female while 27% (n = 4) were male. Thirty four percent (n = 5) of participants were between 26 and 40 years of age, while 66% (n = 10) were older than 41 years of age. Figure 1 illustrates the age range of the participants:

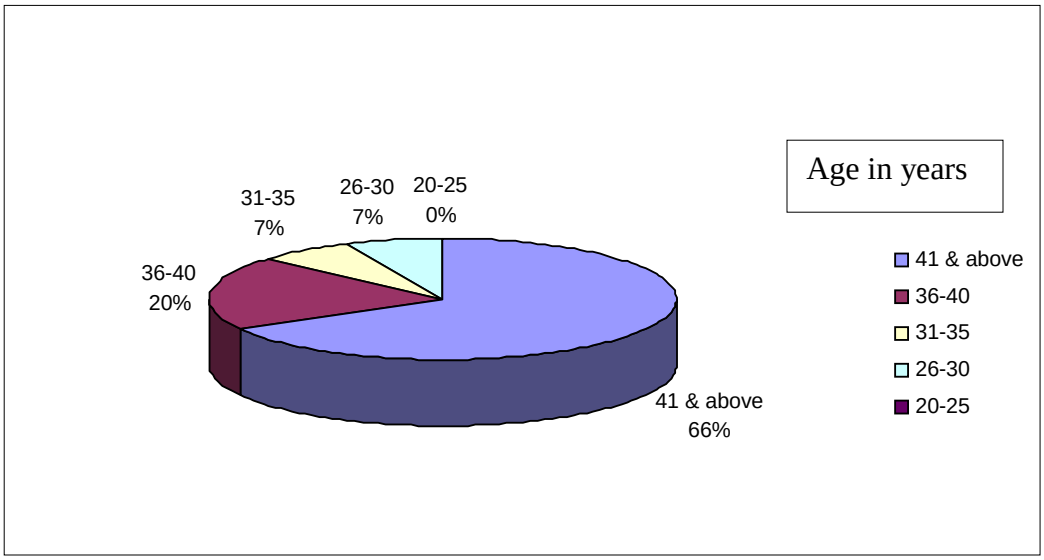

Figure 1. Age distribution of the participants.

The nursing qualifications varied amongst study participants. Fifty three percent (n = 8) of them had post registered nursing bachelor's degree (Post RN BScN). Of these 53%, one participant had an advanced diploma in education before acquiring Post RN BScN degree. Forty seven percent (n = 7) of the participants were diploma prepared registered nurses. Of these 47%, there were two participants who had been enrolled nurses (similar to LPNs) before obtaining diploma nursing. These two participants had 34 and 16 years of clinical

experience as enrolled nurses before obtaining their diploma. They had obtained their diplomas four years before the time of data collection. The number of years of clinical experience for all the participants ranged from 1 year to 38 years, the average years of experience was 20.8 years. Eighty percent (n = 12) of the study participants had worked outside Aga Khan Hospital (AKH) whereas 20% (n = 3) of the participants had never worked outside the AKH. The type of clinical facility varied for the 80% of participants who had worked elsewhere before joining AKH. They had worked in faith-based, public, private for profit, and private for non-profit hospitals. Figure 2 illustrates the types of hospitals in which these 80% participants had worked before joining AKH:

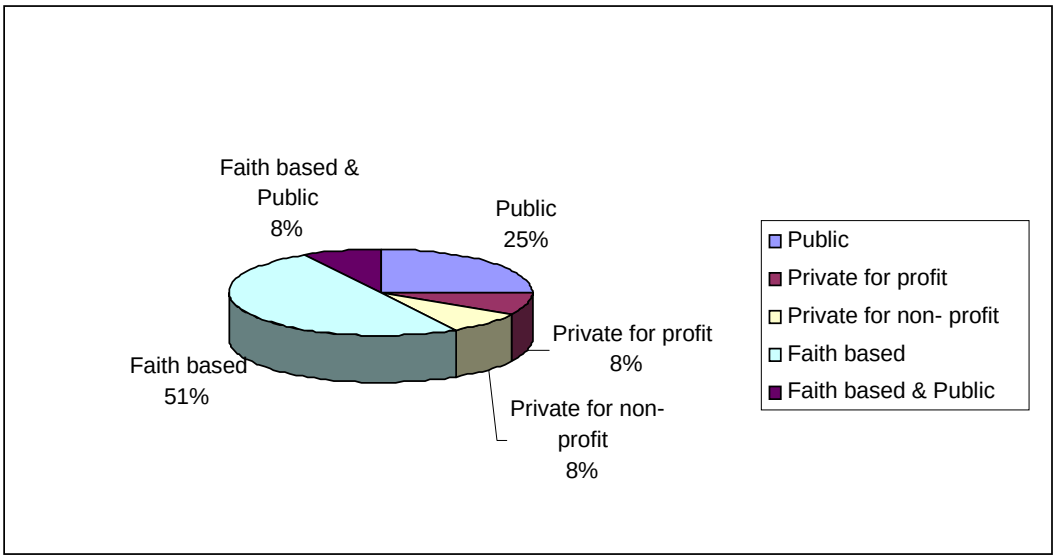

Figure 2. Types of hospital worked in before joining AKH

The participants in this study were recruited from different units of the hospital. Figure 3 shows the units of the hospital from which they were recruited.

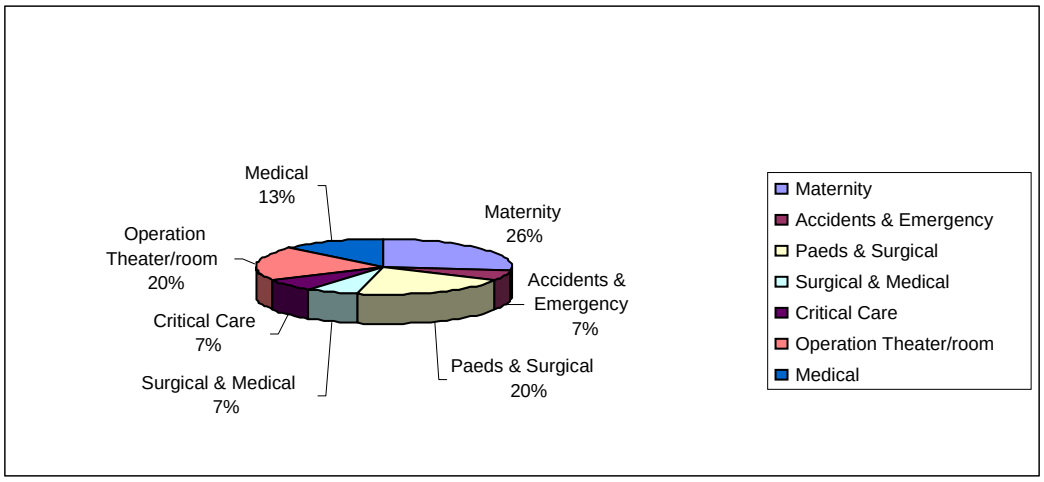

Figure 3. Current units of clinical practice.

Of the 15 participants, four (27%) were float nurses and rotated between two different units of the hospital at the time of the study. The participants were not asked about their religion or the denomination of a religion but they self identified their religious affiliation. Eighty percent (n = 12) of participants said they were Christians while 20% (n = 3) mentioned they were Muslims. The participants did not mention their belonging to any particular Christian or Muslim denominations. Having illustrated the demographic information of the participants, the following section presents the first theme of the study. In describing study findings, a few or several participants represent three to four participants, some participants represents more than four but less than 7 participants, and 10 or more participants signifies a majority or many participants.

Meaning of Spirituality

Spirituality has been part of the nursing discipline from its inception. Due to the multi-dimensional nature of spirituality, it is expressed in a variety of forms. These forms of expression differ for individuals, communities, tribes,

nations, religious groups and non-religious groups, and further vary due to cultural and ethnic background of people. Spirituality in all its forms is to be assessed, understood, respected, and valued within nursing practice. Currently, there is some literature available to help nurses understand the Western perspective of spirituality but there is dearth of information available from Eastern or African perspectives of spirituality in nursing. This study was conducted to fulfill the need to explore and describe the meaning of spirituality from the worldview of nurses practicing in Africa, specifically Tanzanian nurses.

All the participants, when describing their understanding of spirituality, stated that spirituality was a belief in God, a Creator, a Super Power, an Unseen Person, or a Supreme Being. Also, they expressed spirituality as synonymous with religion, and spirituality as an inner self guiding moral for a person's ethical conduct. The sub-themes that evolved from their expression of spirituality were: spirituality in reference to God, spirituality in reference to religion, and spirituality in reference to moral and ethical conduct. The description below includes the findings of these sub-themes.

Spirituality in Reference to God

Analysis of interview transcripts revealed that all participants' viewed spirituality as belief in God and acknowledging the qualities of a God. They used the other names of God such as a Creator, Super Power, Unseen Person, and Supreme Being. Some of them elaborated on their understanding of God based on the teachings of their religious and stated that having complete faith in God was

an important aspect of their lives. Esther's (EN, RN, 38 years of clinical experience) view about spirituality was as follows:

> [Person] has a belief, there is an unseen Person, there is [pause] a Creator, who is giving us this, . . . should I say life? So there is a life, and this life is something that nobody knows from where it is coming. There is someone or something in this world who gives life and who takes away life. Once death comes to people, the spirit part is out, the heart is out and nobody can put it back except God.

For Ghanima (BScN, 29 years of clinical experience) spirituality meant, "for someone to have a faith in God." Karen's (BScN, 7 years of clinical experience) understanding of spirituality was:

> Have faith maybe in a Creator depending on different faiths [pause], one has a belief that [the] Creator gives power to people to work and [the Creator] is also involved in our day to day being. Look at my own faith, Christians believe in God, the Holy Spirit, heaven and hell. He [God] is the one who gives the ability to people to do everything and allows us to breathe the air that keeps us alive. He is the one who gives life and all the life on this earth and all that we are able to do is through Him.

For Celeste (BScN, 26 years of clinical experience), spirituality meant, "someone believing in something, that there is the Super Power somewhere, regardless of any religion. I believe that there is a Super Being somewhere." Many participants described spirituality in relation to the presence of a soul in the body and a belief that the soul returns to God when the body disintegrates. For example:

> God gave us this structure, whereby this body contains that soul, that internal thing and when we die of course, this body will disappear but the soul will remain. . . . That's how we learn from the Bible and that's why I am saying that I consider spirituality as something preparing the soul. (Laurencia, BScN, 25 years of clinical experience)

Isaac (RN, 23 years of clinical experience) also supported the above view and stated:

> A soul cannot be seen physically but is within the body. What we usually think is, if the soul is clean, then you go to the heaven, if you do not have a clean soul then you go to hell, it is a belief in many religions.

To have a clean soul one needs to perform good deeds in the world as highlighted by the same participant:

> Spirituality is the inner most feeling that I am doing good things in this world so I think I am a clean person. I am a clean slate in the world. Certainly if I die, God will welcome me [laughs], God will welcome me to heaven.

As seen above, many participants have described spirituality in relation to God and one would note that each of them has given some description of qualities of God as per their religious understanding. Fiona (RN, 34 years of clinical experience) stated that:

> According to my religion, we believe that we are going to meet with God and I can be saved for the eternal life. Other people also have a belief in meeting with God but their ways are different [based on religion].

Ghanima said, “God is someone who accepts prayers which in turn provides spiritual satisfaction to people.” Laurencia thought, “God is the one who cures the diseases of people.” Ombeni (RN, 15 years of clinical experience) also said, “People believe that God is the one who gets us sick or gets us better.” In addition, God was believed to be a listener of people’s prayers and a healer and He was also believed to be the creator of this earth. Natalia (EN, RN, 20 years of clinical experience) said, “When I am talking about God, I know that all human

beings, not only human beings, even the plants and insects and everything, living and nonliving materials, has been created by God."

It is important to note that, all the participants, regardless of their religion, described spirituality as a belief in God. They acknowledged the power of God, they appeared to be strong in their belief about the existence of God, and expressed the nature of God being unseen. "Actually viewing God, this is too deep in my soul. To believe, to support the belief in God, the presence of God is just the belief, I can't just see the image of God but believe that there is God" (Michael, RN, 17 years of clinical experience). When participants have related spirituality with God and God as an Unseen Being, they have also described spirituality as being an intangible and eternal entity.

Further to our discussion above, analysis revealed that the majority of the participants viewed spirituality as synonymous with religion. The following illustrations highlight the intricate link between spirituality and religion.

Spirituality as Synonymous with Religion and the Role of Culture

As described in chapter two, for most Africans, spirituality is intertwined with religion or faith. It is therefore, not surprising to find nurse participants in this study to have equated spirituality with religion, although in their responses I could hear subtle differences. If one compares the understanding expressed by these nurse participants about spirituality and religion, it is difficult to differentiate the two because both the explanations portrayed a belief in God and a code of moral and ethical principles. The subtle differences between the two arose when the participants were asked to compare spirituality with religion. In

this section, religion and faith will be used interchangeably. Before describing the relationship between the two I will illustrate the participants' views about the term religion. Angelina (BScN, 32 years of clinical experience) said, "religion is part of... can I say is a section of what helps us to nurture our spirituality? It is a way or the part that people use to nurture their spirituality." Karen also believed that religion makes a person spiritual:

> I can say that depending on whatever religion one comes from, each religion has its own way of spirituality. As we can find that maybe a person of a certain faith is quite spiritual in that he ensures that he has time to perform his prayers and he maintains the religious festive periods, for example, Muslims fasting during the month of Ramadan and Christians during Easter time.

Bora (BScN, 19 years of clinical experience) believed that

> Religion is a part which helps him or her to believe in God. Religion is a belief of somebody, that you are a Lutheran, or you are a Catholic, or Roman Catholic. When one goes to church and hears the words of God from the Father it helps you spiritually.

For Esther, religion was an outward entity and it would have meaning only if one has faith in a religion. She expressed:

> Religion is something that is, I will say that I am a Christian or I am a Muslim but it does not necessarily mean that I have faith in it; it is just an outward entity. I maybe am known as a Muslim by name or I am known as a Christian by name but that doesn't matter, it doesn't have any impact in my heart or my spirit.

Karen mentioned that religion defines or demarcates a group of followers based on similar understanding and beliefs about God. For example, she said:

> What I understand on the term religion is, I could say a certain kind of group maybe believing in a certain kind of God or Power and believing that it is the source of life and everything. So for example, Christians are called Christians because they are the followers of Christ and Muslims

> because they are the followers of Prophet Mohammad, Buddhist the same, followers of Buddha.

Natalia mentioned, "If we talk about religion, it means that all matters, all issues are related to God who created everything including living things and non living things." In addition, like spirituality, religion was also expressed as a framework for moral and ethical conduct. Laurencia was explicit in stating that religion teaches moral values such as not abusing or killing people but implementing those values in day to day activity is spirituality. Having learned the moral values through religion but not demonstrating those values in action was considered being worthless. Therefore, for her, religion and spirituality were interlinked but she felt that spirituality was more powerful than religion and she felt that religion was on the outside while spirituality is when one makes their religion internal. Laurencia stated:

> Religion I can say is something which guides people to do things right because in religion, you are being told not to do this, for example, not to kill and not to abuse. This is being taught by our religion so it is a guide. When I follow my religion internally it is spirituality. Spirituality is more powerful than religion because we are being taught not to kill ok, that is religion but spiritually, I have to understand why I should not kill and if I kill, well, . . . my soul will be sinned [pause], these things [spirituality and religion] are going together. Be it a Christian or a Muslim, one has to implement the teachings in day to day actions. Islam is a religion? . . . Yes, but spiritually what does that Muslim do? How does he behave? How does he present himself to people? That's why I said spirituality is more powerful than religion.

Angelina's views were similar to those of Laurencia. She said, "According to my understanding it is almost like one thing, because when we talk about God and faith, it goes together. Believing in God and faith I take it as one thing, they relate." But on the other hand, like Laurencia, she also pointed out that spirituality

was a broader concept as it allows a person to understand and follow the religion. Angelina expressed:

> I see religion as a small thing, because it means I can have a religion, it is easy to be baptized and become a Christian, already I am a Christian because I am baptized, but for the spiritual part, you have to work, you have to understand it. . . . It tells me or directs me to act spiritually. It will guide your life, your activities, your thinking, talking, the way you do things, it takes time. You are used to doing things against God's wishes, so you have to learn to go in the line of God's wishes, but having religion so what. It doesn't matter, I am a Christian, whether baptized or not. So I see that spirituality as a bigger thing.

According to many participants, a religion gives identity to a person as a Christian or a Muslim but to act as a Muslim or a Christian is based on a person's spiritual understanding. The following descriptions further elaborate on the link between religion and spirituality. Isaac stated:

> Religion and spirituality [pause] they are like similar things, they are actually one thing. The person who is religious usually wants to have a very clean soul all the time. He wants to respect his or her faith accordingly. There is some relationship [pause], religion is the faith one has, spirituality is that belief, that I am doing good things in life. Sometimes you don't necessarily have a religion but you are spiritual.

Fiona too compared spirituality with religion and said, "Spirituality and religion are connected because spirituality deals with souls and religion helps to deal with souls, to believe in good things. It is interchangeable; there is no difference between spirituality and religion." When participants associated spirituality with religion and could not identify a major difference, a question was asked about how they viewed the spirituality of the people who had no religion. The majority of the participants assumed pagans as non-religious people but

acknowledged that these people have spirituality. The following description will highlight the participants' views about non-religious people and their spirituality.

All the nurse participants in this study thought that every human being regardless of religion has spirituality based on beliefs in some principles of life, beliefs in traditional practices, or being good human beings. There was only one participant who thought that people without a religion have negative spirituality whereas those who have a religion possess a positive spirituality. She elaborated on these two dimensions of spirituality by using an example from her clinical experience. She illustrated:

> So I saw these two people dying and I compared between this death and the other one. The other was peaceful [positive spirit] and this one was painful [negative spirit]. This person [with negative spirituality] was saying, "I am now seeing the fire, the fire is coming to me" and he was abusive, he was shouting but I couldn't help him. That's why I was saying a positive and a negative spirit. Someone like a nurse can talk to the person who has a negative spirituality to gain hope. But it was so unfortunate that it was too late for this person, he died in that spirit, in that state [and] it was so so painful. (Esther)

Furthermore, she said:

> In positive spirituality, people feel hopeful, believe that the one who has created will give hope, assistance, help to people. It is the positive part. We all have the spirit, but it is the positive and the negative.

Whereas Celeste thought that whether people have religion or no religion, they both possess healthy and unhealthy spirituality. Celeste elaborated on healthy versus unhealthy spirituality as follows:

> Healthy spirituality is a state of humility in which one is at peace with [the] self and others. Hence, it is reflected in ones actions such as kindness, caring, forgiving, sharing, helping others, [being] sympathetic, and [being] empathetic. Unhealthy spirituality is a state of emptiness with no values. As a result, one will not live to his words, may use spirituality

> for manipulating others for his/her own good, arrogance, uncaring and most of the time is disconcerted. They have difficulties in self control and relating with others.

The rest of the participants did not talk about dimensions of spirituality but indicated what makes them spiritual when discussing people they described as pagans. Bora stated that:

> Actually for those who do not believe in religion they have something to believe in, like pagans, they do not believe in religion and even God, but they have something they believe in and it can help them in other ways because it is their belief.

Ghanima understood that pagans believe in mountains rather than God and said, "Maybe they believe in rituals [pause], even if they don't have religion they must have something that they believe in, mountains or whatever, but they have beliefs." Natalia said people in general believe in rituals and these rituals evolve from their specific culture. Hence she felt that culture plays a role in understanding and following a religion. She said that, "cultures are related with religious matters and also God. Culture is taboos, beliefs, and customs. When I am talking about culture, we get our beliefs from culture so according to [cultural] beliefs you find that people believe in [or do not believe in] God."

Dorothea (BScN, 15 years of clinical experience) had a similar view. She said, "I think, according to his or her culture one believes in God [or does not believe in God], so provides care to the patient accordingly." Celeste believed that culture influences in shaping a person's religion and spirituality. She stated, "Culture is the way one lives, it has great impact on one's faith which in turn shapes and influence a person's spirituality." These quotes on culture suggest that

interpretation and practice of faith and spirituality are subject to one's cultural background. According to Isaac:

> These pagans depending upon the type of tribes, have their own beliefs. During the harvesting time of a year or during the rainy season, they usually collect together as a community and they slaughter a goat and then burn it and pray to God through their ancestors, "Please God, help us," so that they ask God to help the tribe and the community.

Angelina said, "I know even if they don't believe in anything, at least they have something, some principles they live on." She also added:

> When somebody has no religion or belief or any spiritual belief of some kind, they have the traditional beliefs, or taboos, which they live with, they believe in. They don't have any God or relationship, but believe in taboos or traditional things. Because they believe in traditional practices and taboos, they are spiritual. Although these people don't believe in anything [religion or God], their actions, their thinking, their way of talking, their way of doing things are marvellous [moral behaviour]. They demonstrate love, compassion, and are supportive.

Celeste expressed a similar view:

> They have their beliefs, and [pause] they have a way to connect with their spirituality. They do not belong to any of these religious groups but still they have a belief in something, they have their own beliefs. In their life they have their inner side, that is what will show what is right and wrong, these are the things that will automatically impose on you from deep inside and that is spirituality.

Natalia stated:

> I know that there are people who are pagans who don't believe in God but have native beliefs. Every human being, every creature has been created by God [pause], maybe they are spiritual. Although they don't believe in any religion and don't believe in God but generally we can consider them spiritual beings.

The aforementioned discussion on the meaning of spirituality revealed that spirituality was a belief in God and it was synonymous with religion. In addition,

the majority of the participants described pagans as non-religious people but who have spirituality based on their own belief system. In the following discussion, I will continue presenting the last sub-theme of the meaning of spirituality. The analysis of the data from the participants revealed that spirituality was a guide to moral and ethical personal conduct.

Spirituality as an Inner Self Guiding Moral for Ethical Conduct

More than half of the participants described spirituality as being part of their inner self or something that is "in their heart". They believed that spirituality guided their lives and allowed them to remain moral and ethical in their day to day activities and conduct including nursing care activities. In addition, participants were explicit in mentioning that spirituality is an inner aspect of the human being. It was described as unseen and intangible, unlike physical matter. Natalia expressed:

> Spirituality is intangible, you can't touch it, it is not seen physically [pause] but it is a kind of [a] feeling, you can't touch [it] like physical things. . . . Also when we talk about spirituality, it is a kind of belief, you can't hold but it touches the inner part of human beings. It is related to the inside of human beings; . . . that is how I am saying inner, from the heart.

Angelina said:

> Spirituality will guide your life, your activities, your thinking, talking, the way you do things. . . . Spirituality is the faith or belief the person has in God. . . . Faith will allow me to handle another person in a human way, [knowing] that I am dealing with a human being, I will take this person as an individual, unique person. This is an individual and I have to respond to their needs in a "humanity" manner.

Similarly Bora stated that, "Spirituality is that thing which comes from the internal . . . of the human being, it is coming from the heart. I think spirituality is

something [that makes] somebody polite, [and allows them to] give something which is recommended and good in the society." Celeste's statement supports the above two views when she expressed that, "Spirituality is not only the part of the human being, who we are [and their] belief in super power, but also being good; these values are what spirituality [is about]." In addition, she mentioned that:

> Defining spirituality is complex, it is complex because it is something that [pause] it is not a kind of thing, that you can tell someone is black and white. It is [the] inner-self, it is in you, you can feel it but you can't see it, it is not easy to explain it to someone, it is not measureable, it is not tangible, you can't see it, nor quantify it. It's not easy to define it, explain it, although you know it.

Spirituality for some participants, was associated with having faith in God and the inner-self, while some participants thought that spirituality gives them not only courage to tolerate sufferings in life but also to accept death with much joy. Karen illustrated that:

> If you have faith in God it will bring peace and joy even though a person may be suffering from illness. This person is taking it as a joy because she or he has a faith that there is a certain Being somewhere caring for him and he is not going through this alone but somebody is dealing with it.

Similarly, Laurencia not only related spirituality with spirit and inner feelings but also believed that spirituality helps someone accept death with confidence and without fear. She said:

> Spirituality deals with, . . . it is something internal, which makes somebody to be ready [for] and to accept death. It is something which guides me to do something good, not to do sins to others, not to do bad things to others, yes, to live happily with community because it gives me the direction of what to do in my life.

It appeared that the participants, when relating spirituality with moral and ethical conduct, feared God or wished God to be happy with their deeds. The participants in this study were Christians and Muslims and when describing their understanding of spirituality both groups talked about being influenced by the moral teachings of their respective religion. Some of them expressed the way they have to behave in this world and with fellow human beings. Besides their religion providing moral teachings, they also described their religion as being related to how they would be rewarded or punished based on their deeds. Isaac stated:

> If you have a clean soul you go to the heaven, if not a clean soul then you go to hell, it is belief in most religions. Spirituality is actually the inner most feelings of spiritual satisfaction. You feel that, "I am good and following God's rules properly and praying accordingly and I am showing good manners to my fellow human beings, I don't sin, yeah, . . . I am not a sinner, I am a clean slate in the world." Certainly if I die, God will welcome me [laughs], God will welcome me to heaven.

Likewise, Laurencia said:

> Look at my own faith, Christians believe in God, [the] Holy Spirit, heaven and hell. Many people have [a] fear of God so when you talk about spirituality, they come to think if I do this it will be wrong before my God, wrong according to my religion or faith.

Therefore conforming to religious teachings was considered being spiritual. For example, Bora mentioned, "Christians can believe that if I do this or maybe follow [the] Ten Commandments which we are given by God, it will help me to reach heaven." Michael said:

> Spirituality means I have to follow good deeds. If I told you God is with me, I have to do nice things in order for God to be happy. In so doing I am a better person. I may have to show myself as an example, [so] when somebody sees me, [they] can say actually, "he is a good man."

For Humphrey (BScN, 11 years of clinical experience), spirituality encompassed the various characteristics of God such as love, compassion, and forgiveness. He and other participants believed that demonstrating these characteristics to fellow humans was their moral responsibility. Love, compassion, and forgiveness were explained by Humphrey as follows:

> There are nurses who are working hard, following instructions, following doctor's orders, staying with patients and spending time, helping patients and supporting patients according to patient's problems. Responding to patient's call bell immediately, helping patients with a discharge plan is another sign of love. If you have love, you can love me, if you have love, you can be ready to give forgiveness, maybe if you love your patient and if your patient is abusing you, you can forgive him. Yeah, I saw the relation between love, forgiveness, and spirituality.

According to Angelina, "All faith people believe in love, compassion, assistance, and helping others" and therefore, she insisted on demonstrating such love to her fellow human beings. Natalia reiterated this view:

> If God loves people, so we also have to love people, patients have to be loved as human beings, they are human beings, and they have a right to be loved. You respect, you value them [patients], and you give them dignity.

It was interesting to note that when describing spirituality, the participants mentioned the above characteristics and the same characteristics were used to demonstrate spiritual care interventions. A detailed analysis of love, compassion, and forgiveness as part of the interventions will be discussed in the spiritual care interventions section of the findings.

From the above descriptions on the meaning of spirituality, all the participants believed that spirituality was belief in God. Also, it emerged from the analysis that spirituality was equated with religion although in some aspects

spirituality was considered beyond religion. People may belong to a specific religion but on its own it was considered meaningless unless they followed the guidance provided by their faith or religion. The participants thought that spirituality was implementing religious moral values into daily practice. However, the participants also mentioned that it is religion that nurtures spirituality or makes a person spiritual. Thus the above descriptions suggest that spirituality and religion are not only interrelated and may be similar but also are interdependent entities.

Having described the participants' understanding of the meaning of spirituality, the next questions of the interviews related to their understanding about spiritual care. The following section focuses on their understandings of spiritual care.

Meaning of Spiritual Care

One of the roles of nurses is to provide spiritual care to their patients and families. But how is spiritual care defined and understood by nurses? Therefore, participants in this study were asked to describe their understanding of spiritual care. Analysis of interview transcripts revealed that for a majority of the participants, spiritual care encompassed religious practices, holistic nursing care, and healing practices. In addition, similarly to spirituality, spiritual care was described in a variety of ways. Some of the participants alluded to the holistic nature of nursing when expressing the meaning of spiritual care. They thought that once nurses include spiritual care in their practice, it promotes healing rather than only curing of human beings.

The sub-themes of the meaning of spiritual care include: spiritual care encompasses religious practices and spiritual care encompasses holistic care. Some of the participants have included spiritual care interventions when describing the meaning of spiritual care, however there is a separate section on spiritual care interventions which will be presented later.

Spiritual Care Encompasses Religious Practices

Many participants in this study equated spirituality with religion. They also indicated that religion and spirituality cannot be separated as they are linked inextricably. Perhaps this was one of the reasons why their spiritual care descriptions included religious care or religious practices. For the majority of the participants in this study, spiritual care meant incorporating religious practices or beliefs into the provision of nursing care. Their responses also included rationales for providing spiritual care to their patients.

As stated by Angelina, "spiritual care, it means that somebody is incorporating the belief of spirituality into their care. Spiritual care is adhering to your client's beliefs about God." Similarly, Karen mentioned that, "Spiritual care is how you use some kind of faith or religious beliefs in giving care to certain people, respecting their beliefs, and serving them well." Likewise, Natalia expressed spiritual care as, "incorporating religious beliefs when reassuring and counseling the patient."

For Bora, "Spiritual care is the care which you can give to relieve tension or psychological problems without using medication or any kind of treatment, for example, by using the words from the Bible. For Karen, "assisting the priest with

Holy Communion with patients in the ward is also a way of providing spiritual care." For Dorothea, spiritual care was to reinstate hope in her patients by involving priests and encouraging prayers. She stated that:

> Some patients lose hope so you try to counsel them, to make them understand what you are doing at your work, [in] your nursing care. When they understand what you are doing, then you can help them by calling, maybe a pastor, to make them [remember to] believe in God, . . . so you can call a pastor or a Father to come and pray for them, if they wish only, but not forcing them.

Esther described spiritual care:

> I will say that spiritual care is that part of the care, which touches the inner part of the person, the unseen area of this person and the faith of the person [pause], which touches that area which will give worth to people, give this person a positive outlook on life even if this person failed to be cured but there is always hope and positive expectations.

Furthermore, the same participant said that spiritual care is care given to enhance hope in people:

> This person feels now at least I have someone else, "[I am] not alone because we know that there is God," even if it is not God, there is someone who is keeping them. So with that belief, regardless of what religion, this person is at least hopeful, you have touched the spirit. This person feels, "at least now I am comfortable as I have someone who is giving me another hope, which I didn't have before." When someone has this will-power and spirit, it will assist a lot in the curing part of the body. This is the area which I think is very important in nursing, where spirit is concerned. (Esther)

Fiona considered spiritual care as an activity to respond to the concerns that may be raised by some patients. She said, "Once the patient gets sick, he will think about his soul. First thing he will say is, "Oh! if I die at this time, where I am going?" So you converse with the patient" based on his/her religious beliefs. Fiona thought that reassuring patients was a spiritual caregiving act. She said:

> Most of the patients who are coming to the hospital, they come with distress, distress that they are going to die, death is going to come, so they just despair everything of their lives. You talk to them about their beliefs in God, that God is there who will do everything for them, although we are doing the nursing things, but God will help them. So to remove the stress which they are having, we talk to the patient. If you belong to the same religion, [you] start talking about those beliefs if comfortable. If you do not belong to the same religion as [the] patient, you can ask somebody who resembles his beliefs, so he talks to the patient. Some of them, they get cured immediately without any medication.

Laurencia also had a similar view about spiritual care:

> When we talk about spiritual care, we are talking about the soul, preparing somebody or helping somebody to heal the soul, I mean [pause] yeah, to heal the inside part of somebody, to be ready to accept whatever. So a patient may say that, "I am suffering from this but God is with me, I believe I will be cured, even if I am not cured at least, I will die peacefully." It means [pause] it is something that keeps somebody ready for something, it will make him or her feel better, and prepared for anything.

Ghanima described spiritual care as

> to give support to a person on accessing, on attending to his needs, his spiritual needs. As I said before, someone might ask, "I need to pray or at 7 AM I always need to pray." If you allow that you are attending [to] the spiritual needs and that is spiritual care.

Humphrey stated, "My understanding of spiritual care is the care mostly involved [with] praying with the patients and talking about God's news [reading Holy Scripture] so that they get relieved of psychological distress." From the above descriptions, one can deduce that the term spiritual care meant incorporating religious beliefs. Celeste's excerpt allows us to understand the basis of such perception. She said:

> Spirituality is based on religion, a certain religion, and then you can go through that religion. Actually that will make it even easy for a nurse

> when caring for such a patient. If [the] patient has a connection with a certain religion then you can easily link.

There were some nurses who believed that spiritual care encompassed physical and psychological care in addition to integrating religious practices. "Spiritual care is body care and psychological care" including encouraging clients to trust God (Michael). Likewise, Bora considered supporting patients with physical care as spiritual care. She said, "Providing some of the things that they [patients] may not have like soap, so that they can take a bath." As mentioned by Ombeni, "Our day to day activities are spiritual care in addition to providing religious care." In the nursing discipline, when nurses provide care for the physical, psychological, social, and spiritual needs of their patients, it is termed "holistic nursing care." Some of the participants alluded to the holistic nature of nursing when expressing the meaning of spiritual care. Therefore, participants were asked to share their views about holistic care and spiritual care. The following discussion highlights the connection between holistic care and spiritual care.

Spiritual Care Encompasses Holistic Nursing Care

As discussed above, some of the nurse participants viewed spiritual care as holistic nursing care. There were mixed views about the holistic nature of care provided by nurses. Some of the participants viewed holistic care as recognition of all dimension of an individual—physical, psychological, and social, and spiritual as separate entities whereas others viewed holistic care in an integrated manner. They appreciated the relationship between each dimension and the

impact that it may have on the person if there was disruption in any one of the dimensions.

Isaac believed that spiritual care is part of nursing care. He said:

> There is a connection between physical, psychological, and spiritual aspects. There is a deep connection. Though spiritual care and the rest of the care are a bit apart in understanding, they need to be understood to be one thing, they should come close, [they] need to be one thing.

He further stated that, "Holistic care, . . . we take the person as a whole with all his needs as a whole. It means the body, the mind, and the soul." Celeste, by using an example of a patient with a fracture, raised a concern about nurses fragmenting their care and suggested to see all the aspects of humans as intertwined. She said:

> Most of the time when we encounter a patient you just focus on the problem like if it is a fracture, we focus on the fracture, we forget the other parts of the patient, that he is an individual, he has his spiritual needs, he has his social needs, he is someone more than a patient in a bed with a fractured leg. So that's why I was saying, that is the whole being, that is why you are talking to a person as a whole, because these aspects overlap, or they are like interlinked, you can't totally separate [them]. If psychologically [I'm] not fit, even spiritually I won't be able to concentrate, reflect, and pray or recite, I won't be able to do that.

Similarly, Esther stated that

> a whole is total care. In our medical terms or nursing terms, we say, you regard a person mentally, physically, spiritually, so this is a whole person. The person has a spirit, the person has a mental aspect, and there are social things, and physical things. That's why I said that you consider all aspects when providing care.

Esther raised a concern about nurses paying little attention to the holistic nature of human beings. She said, "Although this is part and parcel of the training and it is to be incorporated when you are caring for someone as a whole person,

this spiritual part [pause] the most of this part is left unattended." Jumma (RN, one year of clinical experience) stated, "Health includes these aspects, spiritual, physical, so if one aspect among them maybe a problem can affect the whole system as the body is one." Karen stated:

> Spiritual, physical, psychological they all can be brought in together or merged into one basket when caring for a client in need and to be used right; . . . I mean, in day-to-day working. You really need to involve spiritual care so that the whole basket can be full.

Likewise, Natalia said:

> If we remind ourselves of the World Health Organization's (WHO) definition, what is health? Health is a state of well being, spiritually, socially, mentally and physically and not merely an absence of disease. If any human being is to be helped, he needs all those things, has to be physically fit, has to be mentally fit, and has to be spiritually fit, and he has to be socially fit.

Natalia further stated that, "I want to insist that when caring for any human being we need to provide physical, spiritual, social and psychological care, it is an important aspect." Ombeni also believed that there was no fragmentation between physical, psychological, social, and spiritual aspects. She said, "There is no difference between physical, psychological, and spiritual care, they go together. For example, somebody is sick, [so that person] needs psychological support, close observation, [and] spiritual care." The participants in this study did not talk much about social needs when describing the holistic nature of nursing. But they realized that attending to social issues was an important aspect of holistic care and also in resolving social problems, spiritual support was necessary. For example, Bora said:

> Sometimes we get a patient with a social problem, so I stay there, talk with her and listen to the problem. If she doesn't remember God, if she doesn't know the words from the Bible and I know that there is a verse that will help her psychologically, I ask her to read those lines from the verses and sometimes she feels better. To help with social problems or psychological problems we need the spiritual support.

Esther also mentioned that spiritual interventions helped when addressing social problems. She said as follows:

> Social and spiritual aspects are two different things. Socially someone might have a problem, which will be tackled socially, but also in that area if this reassurance or the spiritual part is not touched then the social problem can still remain as a social problem. So social problems impact spiritually and need to be tackled at a spiritual level as well.

Within the holistic nature of nursing care, the participants alluded to the connection between healing and spirituality. They believed that healing was a spiritual process because it involved integrating religious practices and seeking the grace of God. They considered the healing process beyond the curing process and believed that the focus of nursing is healing. It was interesting to note that despite recognizing the healing aspects of nursing care, they acknowledged focusing more on the physical aspects of care. The descriptions below illustrate their views about healing versus curing within a holistic model of nursing care.

When participants were expressing their understanding related to spirituality and spiritual care, many of them brought up the terms healing and curing. The medical treatment and the nursing care, without integrating religious practices, were equated to curing people. When medical treatment and nursing care incorporated spiritual or religious care, it was associated with healing the person. Also, they all believed that God has the healing power and as nurses one

can contribute towards healing by incorporating some of the spiritual care. Esther said:

> Nursing is more about healing rather than curing. I am saying healing rather than curing because you might have an illness and while you have an illness, you go to a doctor, you are expected to be cured, but the healing part is more inside, something which is within someone, so something which you can't get to through medicines only, or through what nurses are doing. It is something inward. The healing part is more inward. So if someone is healing it is the spiritual area that is touched. Sometimes people lose hope. When you touch the spirit part of this person, this person feels, "now at least I have someone else, [I'm] not alone." When someone has this will-power and the spirit, it assists a lot in the curing the body. This is the area which I think is very important in nursing, where spirit is concerned.

Ghanima elaborated on the terms "curing" and "healing" by stating:

> Curing is eradicating, maybe to remove the suffering. For example, I have diarrhea, if I get antibiotics I can be cured. On the other hand, if I have something like a mental problem or a psychiatric problem, by having those psychiatric medications it may not cure but if I get the spiritual support, it can help in healing. Because of my faith it will make my mind stable, that's where someone thinks that I have been healed, though the disease is still there. A person has satisfaction of some sort and believes that I will be healed and psychologically it makes him stable.

Humphrey believed that nurses usually attend to the curing of the body while healing is performed by clergy. He said:

> A patient is admitted to the hospital, he or she is sick and when you give the treatment it means that we want to cure, it is like curing. Healing is related to spirituality, I mean it occurs through these church people [pause]; we say that God heals people. Mostly we nurses focus on the curing part.

Jumma expressed:

> Healing occurs when the religious leaders ask God to help people in their illness and to return them to their normal condition. Healing is the solution of the problem, maybe physical illness. In fact, healing is the resolution of the illness. People may be helped through spiritual beliefs, through

> spiritual care. You give him maybe spiritual words or you have performed prayers.

Karen believed that the clinical procedures such as medication administration and wound dressing were meant to cure the person but the actual healing is done by God. She gave the following example to explain her understanding about curing versus healing:

> If a person is ill and comes to a hospital, the doctor sees the patient and prescribes the medication, so the nurse is giving the medication. So the medication is meant to cure the problem. But now for healing to occur, for example, let's say there is a wound on a body, the body is created by God. [pause] . . . Who controls the formation of the new skin? It is God. According to science we learn that this is a tissue repair process, the nurse will do the dressing, maybe apply some honey for the dressing or whatever medication. But it is the power of God which allows this person to continue breathing and having these nutrients absorbed through the food and all the antibiotics to get into the skin to prevent infection. So really this part of spirituality is very important in the day to day life of our profession.

Laurencia believed that a nurse focuses on both aspects of care, healing and curing. She explained:

> I can't heal without cure. If somebody is in pain, or somebody has a wound, you won't stitch the wound? You won't dress the wound? You won't give painkiller and just give the word of God? No, he or she won't listen to you (laughs) so you have to deal with both, so as a nurse I cure and I heal.

Furthermore, she said:

> Somebody is sick or I am sick, give me the treatment and I will be cured because this is a body. But soul, we don't cure the soul but we heal the soul because there is something inside, so that is healing and not curing. Curing is, for example, somebody has malaria or somebody is in pain and you give them painkillers, give them treatment and the antibiotic. But there is something within him or her so that is what is needed to be tackled and that is healing; . . . that is the soul.

The above illustrations indicate that nurses may contribute to the healing process. They stated that the healing of a patient occurred when a nurse incorporated religious practices when performing the routine work. Having faith in God was an important component of the healing process.

Conclusion

All the participants in this study described spirituality in reference to God. They primarily used the term God when describing spirituality but they also referred to other terms such as a Creator, Supreme Being, Super Power, and Unseen Person. Based on participants' religious affiliation, certain characteristics were attributed to God. For example, God was considered Omnipresent, Omniscient, Omnipotent, compassionate, loving, and judging. Some participants connected soul to spirituality and believed that the soul was an eternal part of a human being. The participants also expressed spirituality in terms of religious beliefs and practices. They believed that religion strengthened their belief in God and that it helped nurture their spirituality. However, participants acknowledged spirituality is a broader concept than religion and that spirituality motivates people to incorporate religious teachings into daily practice to become a better human being. The participants described pagans as people not having a religion or not believing in God but as possessing a spirituality. They were portrayed to believe in taboos and rituals which they thought made them spiritual.

Spirituality was also described as an inner-self guiding people's moral and ethical conduct. The participants mentioned that the inner-self was an intangible and unseen entity unlike physical things but it guided people's actions, motives,

and attitudes. They mentioned God as a judge and believed that people are rewarded for good deeds or punished for not demonstrating good actions. Characteristics like love, compassion, and forgiveness were said to be demonstrated to people in general and patients in particular as part of an expression of spirituality. They suggested that spirituality helped people to accept illnesses and sufferings with joy. They believed that illness and healing were brought about by God and that God would ultimately rescue them from difficult times.

For the participants in this study, spiritual care meant adhering to the patients' beliefs about God, incorporating religious practices, and respecting patients' religious beliefs. Also, for them, spiritual care meant touching the inner part or "the heart" of a person, enhancing hope and reducing tension and stress, and assisting people in accepting the condition or illness or even the impending death without fear. The participants also recognized the holistic nature of nursing care and alluded to the importance of healing in nursing. Having discussed the general understanding of spiritual care, the next chapter describes the ways spiritual needs of patients are identified by study participants and how they intervene to address spiritual care in their nursing practice.

CHAPTER FIVE: FINDINGS RELATED TO RECOGNITION AND RESPONSE TO SPIRITUAL NEEDS

Recognition of Spiritual Needs

Participants considered that identifying spiritual needs of patients needed to occur before providing spiritual care. However, participants, sometimes included spiritual interventions when describing spiritual needs. Throughout the data gathering process, it appeared that the participants experienced difficulty separating spiritual needs and spiritual interventions. The reason for this difficulty may be due the nature of the topic of spirituality and spiritual care. For example, talking and listening were used for the purpose of identifying spiritual needs as well as spiritual interventions. Later in the chapter, a detailed account of spiritual interventions will be discussed.

Communication, the health status of patients, beliefs in witchcraft and devils, and close observation of the environment and expressions of feelings were identified as a means of recognizing spiritual needs of patients. The following discussion will highlight each of the methods used by participants for recognizing the spiritual needs of their patients.

Communication

Analysis of the interview transcripts revealed that the majority of the study participants used communication as a means of identifying spiritual needs of their patients. Everyone in this study stated that communication was a central means to identifying spiritual needs of their patients. The participants believed that communication with their patients allowed them to assess patients' religious

or/and spiritual needs so as to provide spiritual care appropriately. Bora said, "It is good to know patient's religion and patient's views about religion. It is important to know how frequently patients attend church, so it is good to know that background before you [nurse] can use spiritual care interventions." Similarly, Angelina mentioned that, "maybe through [the health] history you know if he believes in any God, or what."

Celeste stressed the importance of interaction that is necessary between a nurse and a patient if spiritual needs are to be identified. She believed that patients will open up once the rapport is built and the nurse will get clues related to spiritual needs. She mentioned:

> Once the rapport is established between you and the patient, then the patient will open up and in the dialogue, when you are caring for the patient, you have to pick up the cues that show that there is a spiritual need here. . . . Someone is trying to express a spiritual need, and this is expressed in different ways. Someone can just say like, "what did I do wrong to God, or why me of all the people?" Or some other people will say that, "but I always prayed." This will give you a clue that there is a need to address his or her spiritual needs.

On the other hand, Celeste also thought it was possible that some patients will not talk directly about their spiritual needs but will use certain terms which will indicate to a nurse that it is timely to inquire about spiritual needs. She expressed:

> When they talk to you they give you some terms that guide you and again it depends on the interaction and how it goes. If a patient gives you an indication, then you can inquire from the patient where the patient will express more openly and will indicate. Sometimes I just sit and listen yeah, listen to them, talk, talk, and talk and if someone will come up with mentioning, "I wish I can do something," then you offer like what is your religion, your belief before you start the interventions. (Celeste)

Similar to Celeste, Dorothea expressed the way her patients would give her clues and how she would plan to provide spiritual care. For example, her patients who used to pray regularly, now refused to pray while sick or when a patient states, "this can't help me anymore, so I don't believe in anything." So through talking you understand, you get to know this person's needs for spiritual care" (Dorothea). For Karen, patients may not talk about God or religious beliefs but may indicate the need through the signs and symptoms that he or she may be suffering. She said, "At times you are with a client and he or she says, "Do you think I will get back to normal health, or will I get better, or will I be healed from this kind of pain?"

Ghanima also believed that through communication one can identify the spiritual needs of patients. She said:

> By communicating with patients, if you are talking to your clients, you can ask, "do you like to be attended? Would you like to see your priest? Would you like to see your Imam? Sometimes they say, "Yes we do." It depends from patient to patient.

She further stated:

> You can start by talking, maybe a patient's relatives can say, "our patient is in a very bad shape [terminally ill]." You say, "Oh, together with medicine, God will [pause] sometimes God can do wonders through prayers." Sometimes if you say that and if someone is agreeing to that, then you know that this person is in need of such support. Sometimes it should come from them.

Also, Jumma acknowledged that communication and observation will help to identify the patient's spiritual needs. He said:

> I think you can identify it through conversation, through observation of the patient. When you are talking to a patient, the patient may believe that "my problem has become worse since I have come here," so I can ask her,

> "what is your belief and your problem?" and she will be free to tell you each and everything, "I believe that my problem can't be solved in the hospital. I should go to somebody, maybe an imam or priest or a traditional healer; . . . I should go. But here in the hospital I can't be cured." So here is the way to identifying the need through conversation with patients.

In addition, Jumma mentioned that, "Yeah, maybe you can go and ask a patient about his religious beliefs and once you identify the patient's religious beliefs you can ask him or try to request him to ask the imam to pray for him." There was one participant who brought forward a point which none of the other study participants mentioned. She said that through health history taking if she comes to realize that her Christian patient was married to four wives, she would initiate spiritual care. She said:

> Sometimes we identify the spiritual need because we see sometimes a patient who is severely sick, and maybe has four wives and is a Christian and you know, it is not allowed for Christians to have four wives. Sometimes you intervene, I do sometimes, I go and talk to this man, "yes, you are sick but how do you see your life? Are you preparing your life spiritually? How do you see it? Have you discussed with your family? Have you discussed with your pastor or priest? We have the telephone number of the pastor in the ward and sometimes you call them." She further stated that, "being a Christian they know that to have four wives in this church is not right. When you die in that state you won't be buried in a Christian procedure. (Laurencia)

It appears from the interview with Laurencia that it was appropriate for a nurse to inquire about such personal matters as they were directly related to spirituality. To know the views of a patient when such communication occurs, I asked, "When you were talking to, for example, this man who had four wives, how did he take your advice? Do you think as nurses you are forcing things on them about these religious matters or spirituality?" Laurencia said she was not

imposing her value systems on her patients but she initiated such kind of communication with patients only after receiving their verbal consent. In fact, she said that patients and their families appreciate such counseling and guidance. She further said, “No, we are not forcing, if somebody doesn’t see value or doesn’t agree you can’t force. You advice and then the patient decides. . . . They like it, at least those whom I have taken care of, they like it.”

Many participants in this study mentioned that it was not always that the nurses were identifying the spiritual needs but patients themselves requested spiritual care services based on their needs. Therefore, the other ways through which nurse participants recognized patient’s spiritual needs were patients’ or patient’s relatives requests for a pastor or imam to carry out certain religious services in the ward, asking for Holy Books, and requesting nurses to pray for them. The following excerpts from the participants illustrate the ways through which their patients would indicate their spiritual needs. Natalia stated, “You do a needs assessment, talking, and making observations. The patient will tell you that I have this problem, or that problem. The patient herself initiates it.” Jumma said:

> You know, sometimes the patient himself or herself may say that, “this problem needs spiritual care, so I should go to the Imam or maybe go to a traditional healer” because sometimes they believe that this problem is traditional, so they should ask a traditional healer or should go to the imam or if they are Christians then they go to a pastor or a priest.

Karen said her clients would point out spiritual needs by requesting, “Can I have my religious leader come over as I need to share something? I need to pray, I need a certain kind of service from a specific religious leader, a kind of service which is given to the sick.” Michael shared that the requests from his patients

about performance of some religious practices suggested spiritual needs. For example, his patients would request for prayers before retiring to bed:

> Sometimes when a patient comes to you, [they] tell you, "I will not be able to sleep without having my prayers. I need someone to pray for me." A patient can tell you, "this time I am not ready to be cared for because I am praying." I am supporting his needs for privacy and also I am respecting the patient's religious beliefs.

For Karen, her patients would request her to pray before performing any procedure. For instance, she said, "Sometimes patients might ask a nurse to pray. For example, "Before you administer that medicine to me can you pray for me?" Sometimes her patient's relatives in the Intensive Care Unit (ICU) will request her, "this is the holy water and please give it to the patient whenever he needs water" and that suggested Karen the need for spiritual care.

Also, Laurencia expressed that, "some patients demand it themselves and they ask, "Do you have any service here? Can I get these things? Can I get a pastor?" And we allow them [pastor] to come even if it is not visiting hours." She further stated, "Patients' request nurses to pray for them, "Sister can you pray for me?" and she would pray for them. Celeste's patient also asked for religious services in the ward. She said:

> If you are taking care of your patients you reach a point through dialogue and that trust where they would ask you to call [pause], they tell a nurse, "is there any service?" Sometimes, relatives come to nurses asking them, "do you have such a service, or if we bring our spiritual leader is it ok?" we just say it is ok.

Bora stated:

> Patients themselves can communicate to nurses their spiritual needs. They can communicate. . . . They normally walk with a Bible, and when they, maybe they left their Bible at home, they would just ask the nurse, "Do

> you have a Bible? I want to read the Bible but I do not have a Bible, I want to read something." That will indicate the spiritual need that she wants to read Bible so let me find it and give it. Also, the communication of social problem or psychological problem will indicate the need for spiritual support.

At times Laurencia would assess the needs by asking patients directly if they were interested in praying. She stated:

> I have the names, I know if this is a Christian or a Muslim and the way I start is to greet them, I introduce myself and ask, "How do you feel?" "Ok, you will be cured or you will be relieved of this and this if you pray together with taking a medication. Have you heard about this [referring to verses from Bible]? Where do you worship? I mean which church do you go to? Who is your pastor?" I tell them this one is from so and so congregation, "Are you ready to be attended?" Because I don't do anything without patient's consent, if he accepts I do organize it otherwise I don't do anything without a patient's consent.

Humphrey said, "Maybe a patient says, "We need Father to pray so patients call the pastor from St. Peter's Church." For Fiona, when her patient would request a pastor, to do confession, it indicated a spiritual need of the patient. She expressed that, "sometimes patients want to confess and ask nurses to call the priest." The other religious practice which provided clues to Isaac about spiritual needs was a request for religious books:

> There are those who sometimes seek religious books, "do you know where to get religious books?" Ok, there are also some who can actually say, "As per my faith these are the timings of my prayers and I would like to pray at this time."

Dorothea thought that patients indicating a wish to read the Bible or asking for Holy Communion were expressing spiritual needs. She stated that when her patients asked for such services, she would arrange it with a priest. Also, Esther stated that, "Sometimes the relative might say, "Ok, I need spiritual

counseling." As seen from the above excerpts it was noted that nurse participants felt the importance of assessing their patients spiritual needs. These needs were identified by nurses, patients, and their relatives through communication. Besides communication, the health status of a patient also indicated to nurses the presence of spiritual needs. The following description elaborates on nurses' ability to diagnose patients' spiritual needs based on their health conditions.

Health Status of Patients

Participants stated that when their patients were found terminally ill or hospitalized for a long period of time it often indicated a spiritual need. Ghanima stated, "And sometimes you may find a patient very sick, and relatives may come and say that we want to bring an imam to come and pray for our patient, maybe our patient is in his last minutes." She further expressed that:

> There is a terminally ill patient, the relatives most of the times were around, you see them fumbling here and there, others do ask, but others they never ask. But being a human being sometimes you think that they need something. You pose, I mean suggest to them about spiritual care. It is not necessary that you call a priest when this person is dying or almost dying but at least they can attend to them so that they can remember that you did something. You can also pray for the patient.

Esther also thought that people who are terminally ill have spiritual needs. She said:

> It is like a dying patient because we are nurses we know that, of course, we are not God, but there are some illnesses where you find that nothing can be done [pause], this person's end is coming. You find that this patient is struggling for life, this patient is screaming from pain so I need to sit and talk to this patient. So you find that need.

For Dorothea, patients who were hospitalized for a longer period of time required spiritual care. She said, "Patients ask me, if they are admitted in the

hospital for a longer time, to make arrangement with a priest or a father to visit them." Few participants considered patients newly diagnosed with HIV/AIDS and patients undergoing surgeries such as amputation of limbs or removal of some other body parts as in need of the spiritual care. Natalia said:

> She was tested for HIV and she was positive and she was very sad because she didn't think that she would have it. The husband asked the wife to forgive him but that mom was very depressed (sigh). What we did was to call the pastor after talking with the mom.

Regarding surgical patients, Michael stated:

> Maybe you see him depressed, for example, these surgeries, you know, this patient is going to loose part of his body or the one whose part of the body will be removed, he needs spiritual care. Therefore, I can say there is service as usual but this one needs real care, high care, together with spiritual care.

Having worked in a labour and delivery unit for few years, Laurencia indicated that most of the women in labour would request nurses to pray for easy delivery and normal birth of a child. Also, women heading to the operating room for emergency cesarean sections would also plead to nurses to pray for them. Thus Laurencia thought that women in labour were in high needs of spiritual care.

When participants said that the spiritual needs were high in patients as described above, a question such as, "who do you think requires spiritual care?" was asked. Most of the participants agreed that every patient required spiritual care but due to lack of time and nurses, it was difficult to reach out to everyone. Therefore, they had to prioritize their spiritual care based on the above situations. Isaac said, "Most of the patients require spiritual care, if we could incorporate spiritual care, it would be [like providing] complete care to the patient."

Jumma, Natalia, and Bora all believed that every patient requires spiritual care. Bora's words can be used to express this view, "every patient requires spiritual care because I think that it is the part which normally makes patients more happy. . . . If I can introduce those words to my patients, it can make him or her more happy, and [he or she will] listen to me." Ghanima said, "On my side, it is not only for specific groups or specific characters of patients, it is for everybody, whoever is in need." But she was careful to not impose her values on patients who did not want it. She said, "You know, you won't go into the room and tell someone, "would you like to pray?" (smiles) but do it whenever they want."

But there were many participants who clearly indicated that despite their understanding of each patient requiring spiritual care, they identified spiritual needs and provided care only to a specific category of patients. As Humphrey expressed, "If we can manage, then we can give it to all patients because all patients need spiritual care, but with the shortage of nurses, one nurse may be caring for 10 patients and it is not easy for her to provide to all patients the spiritual care." Dorothea said, "I don't provide to every patient I meet, not to all patients, some of them. May be I can provide spiritual care, once in a while, or when patient needs it [pause], especially [to those] who are admitted for a long time, they need and ask for it."

Michael said that, "Spiritual care is provided to patients who are dying. . . . Even the sick patient, . . . you know, the normal sick patient. . . . But mostly we do apply this to most severe patients who are almost dying and persons who

are seen depressed." Celeste had a similar view, "During hard times in life, for example, sickness, family crisis, and in the end of life and [when] dying, people tend to turn to God or a Super Power that they believe in, for comfort and a peaceful end." Other than the health status of patients, the other indication that made nurses aware of spiritual needs was a patient's belief in witchcraft and devils.

Beliefs in Witchcraft and Devils

There were some participants in this study who stated that when their patients talked about witchcraft or devils, it was for them indicative of spiritual needs. For Fiona, this was the case when a patient was not responding to the questions asked or when a patient expressed being bewitched. She stated:

> Once the patient is there, you care for him, you go to the bed, you talk with the patient but the patient doesn't respond to anything, or she just responds slowly. . . . Some of the patients are shouting, "I am dying, dying, there is somebody who is following me," [nurse says] "what?" So we know that there is a spiritual need. They say that, "I am getting treatment, I am not going to be cured, I am bewitched." Interacting with patients, by asking, "Do you believe in witchcraft?" patient will tell you that, "I believe in witchcraft," then you ask your patient that we pray.

Few participants said that when their patients communicated to them about their beliefs of being possessed by devils or witches, they would consider it as a spiritual need. Natalia mentioned that the state of confusion and frustration presented by a patient indicated to her of her patient being possessed by the devil. Natalia narrated as follows:

> I can give you one example. I came across a woman in the pediatric ward whose baby was having diarrhea and fever. That mom was very confused, she was so confused. I remember that I went to her after doctor's rounds, I came to that mom, talked to her to know her problem. She told me that she

> had a problem with her husband and was also frustrated and that she had lots of stress. So we made an appointment with that mom and I visited her at her home after the baby was discharged. I talked to her, she explained to me that her husband had another wife and he was not taking care of her. I reassured her. That mom was a Christian and she [mom] was confused and she was possessed with devils, sometimes she had confusion. After discussing with her, she agreed that I could call a pastor, I mean to do prayers for her. So we discussed it and we made the arrangement. The pastor came and he started praying for her and at the end she was ok. That mom received spiritual healing, the confusion was ended.

Furthermore, Natalia mentioned that like her, her patient also believed in the existence of devils and how devils distract people and make them do wrong deeds. She illustrated:

> This is a kind of belief, she believed in devils and she thought that if she gets a prayer from a pastor, she will be set free. Yes, I am a Christian, I also believe in devils and there is a God. I see that mad people on the street, some of them are possessed by devils and they can do wrong things. Some of them, if they get prayers, it means that they can be set free.

Although Jumma did not believe in witchcraft or in the existence of devils he expressed that many people believe in them and attribute to them the cause of their misery and illness. He stated that devils control their victims and make people sick. Therefore, family members of the patients organize healing ceremonies with the assistance of a traditional healer to set the victim free of the devil. During this ceremony, the patient is asked questions by a healer or healers and apparently the devil in that victim is said to respond by demanding to fulfill his/her requests if wishing to set the person free of illness. Jumma said:

> Traditional healers say that they are talking to devils and the devil responds saying that the patient has this problem. The devil will reply that he is the problem and maybe he can remove it by this and this. “If you do this, I can remove the problem, the patient may improve.” So when the relatives do what has been said by the devil, the patient may be cured. However, I do not believe much in this kind of traditional practices.

The other major way described by participants for identifying spiritual needs was through close observations of patients which included presentation of uncomfortable emotions or feelings.

Close Observation of the Environment and Expression of Feelings

Many participants in this study believed that the diligent observation of their patient's environment and the expression of feelings by their patients significantly made them aware of the patients' spiritual needs. For example, Laurencia's patient with liver cancer was depressed and therefore, she thought that this patient required spiritual care. She said:

> The patient looked very depressed, after the rounds I had to go back. During the rounds she called me, I said, "ok, I will come" and I went back to her room and I took a chair and sat with her. She asked, "Sister how do you see me? Am I going to be cured? What is my problem?" I explained everything to her.

Karen experienced that her patient was sad and hopeless and therefore needed spiritual care. She said:

> This patient was alone in that room. I went in and I found her crying, I asked, "what's happening?" I took her hand and asked, "What is wrong? Why are you crying?" She went on sobbing. I stayed still, it is good to let somebody cry. At times, you can be with the patient and you may think that there is a need to encourage this person because this patient has lost hope. So those are the moments where we have planned for that spiritual care.

Ghanima described a patient's bedside environment which was indicative of spiritual needs. She stated that:

> She [patient] was very old, she had had a CVA [cerebrovascular accident] for a long time, almost a year. She had been hospitalized many times. This lady was not speaking, [she] was a bed ridden patient. We cared for her in the ward and always when you went in her room, [where] you would find a candle, you would find a picture of Jesus around her bed. Whenever we

> did bed making or whatever, we placed everything as the relatives wanted it to be. They said that she felt better when we put things around her.

Fiona pointed out that a patient's silence would also suggest a spiritual need. Anxiety in patients was also assumed to be a reason of providing spiritual care. Esther mentioned that:

> There was a patient in the ward, in the surgical ward, he was admitted for an operation. This patient was so worried. As I entered the room, I found anxiety on his face, I said, I don't know this person, but there is a need, he needed someone because he is very anxious, he is so worried so I talked to this person.

Ombeni also thought that the facial expressions on patients faces alerted her of spiritual needs. She said, "she [patient] is getting medicine but her facial expression is very sad, nurse you know we are going for counseling for HIV." Likewise, Angelina thought that by reading a patient's face one can recognize spiritual needs but she was mindful that at times patients may hide their feelings. Therefore, she believed that it was important to develop a rapport and demonstrate a caring attitude whereby patients can share his/her inner feelings:

> Some, you can see it from [their] face but some of the clients, you find that they show good face, but deep inside they are not happy. While caring for them, while doing other procedures you can go through a procedure and at the same time go through spiritual issues as well.

Thus far, the spiritual needs were said to be identified by two way communication between nurses and patients. These needs were identified either through direct expression by patients or by patient's relatives, or indirectly through patients giving clues to nurses. Other indications of spiritual needs included when patients were terminally ill or the nature of medical and surgical diagnosis, long term hospitalization, and beliefs in devils and witchcraft.

Interventions to Respond to Patients' Spiritual Needs

Having described the ways through which participants recognized the spiritual needs of their patients, this section illustrates spiritual care interventions used by participants to address the spiritual needs. Participants were asked to describe their experiences of providing spiritual care. They used clinical situations to indicate spiritual interventions utilized when providing spiritual care. Overall the analysis revealed that the nurse participants have used religious resources to support their patients when addressing a variety of spiritual needs. Also, they described some of the common interventions which they believed would address the spiritual needs of non-religious people.

Religion-Based Spiritual Care Interventions

Participants in this study belonged to Christianity and Islam. In both cases they believed in God and it seemed appropriate for them to talk about God explicitly and without hesitation. In addition, participants' understanding of spirituality in relation to religious beliefs may have influenced their conception of spiritual interventions because data revealed that they incorporated religious practices when providing spiritual care. Provision of spiritual care included: encouraging patients to trust God/Supreme Being/Creator, facilitation with prayers, Holy Scripture readings, and pastor/imam consultations. The following description will illustrate each of these interventions.

Encouraging patients to trust God/Supreme Being/Creator. It was expressed by many participants that by trusting in God and being submissive to the wishes of God, a person gains strength to overcome the miseries and

sufferings of life. The following excerpts demonstrate responses of participants in relation to trusting God in all matters of life including health and illness. Bora said, "Believe that there is a God, and God will solve this problem because it is now out of your capacity, explain your problem to God and He will solve it." The following excerpts further illustrate how nurse participants in this study encouraged their patients to have trust and faith in God.

Angelina mentioned, "When providing spiritual care, maybe I say to a patient, "don't worry, God will take care of all these things, just believe that God will take care of people at home and God will take care of you here." Likewise, Fiona expressed that patients coming to the hospital are distressed probably due to anticipating death and that trust in God reduces their fears:

> You talk to them about their beliefs in God, that God is there who will do everything for them [pause]. Although we are providing nursing care God will help them. So to remove the stress which they are having we talk to the patient.

Jumma, also had a similar view:

> For example, in our religion, when a person has a health problem, he needs reassurance, so when you are reassuring the patient, you can reassure the patient through religious beliefs. For example, you may tell the patient, "this is the work of God, no problem, you will be healed. You are the creature of God, the problem has been provided by God Himself, don't worry you will be cured." When you are saying this you are relating the problem with religion. When you are reassuring the patient this way, he will believe that the problem is coming from God and it will be resolved.

Receiving this kind of reassurance from a nurse is likely to be helpful for some patients but it may create problematic issues too. Jumma said that when he provided reassurance to one of his patients, he refused to accept any treatment

from the hospital and insisted that God Himself should assist him. The way this participant responded to this patient was noteworthy. He said to his patient:

> Ok, your problem is granted by God Himself. He is the one who has created you, no one gave you the food, you are the one going around getting your food. Similarly when you are sick you have to act, to pray, to ask him to recover you. So now you are in the hospital, how are we applying God? This is how we are applying God [referring to the treatment given]. You should agree. Then we started to give him treatment, he agreed, really. He agreed and second day he improved, the third day I didn't see him, he was discharged.

Ombeni also provided spiritual care by encouraging patients to have faith in God. She said:

> As you know, everyone has a belief that God is the only one who gets us sick or gets us better. When you tell someone, "don't worry, God is with you, you will be ok," the patient will be ok. When one is un-well, needs special attention, [or needs] more than medication, [we help them] to be close to God by telling him or her about his or her religion.

As stated by Angelina, "Christians or Muslims, discuss with them that our God is one and God always loves people and I tell them [patients] that." Likewise, Jumma said, "In both religions, . . . Christians and Muslims both believe that there is a God. So when you tell them this is the word of God, they believe this is the word of God and you may help them accordingly."

For participants, an individual's trust, devotion, and love for God was promoted through prayers that were believed to sustain the human soul. In this study, prayers were either performed independently by patients, by patients' relatives, or facilitated by nurse participants and clergy people. Following are excerpts related to performance of prayers as one of the significant spiritual care interventions.

Facilitation of prayers and conducting prayers. All participants in this study strongly expressed that prayers were the most common way of providing spiritual care. Celeste believed that, "Prayers help in strengthening one's faith and spirituality; they help in enhancing hope and bringing harmony between mind, soul, and body, and consequently in attaining serenity and inner healing." In addition, she expressed that prayers can bring a state of peacefulness despite the presence of physical suffering and pain. Fiona said that, "We don't pray for oneself only, everybody can pray for anybody." She shared a clinical experience where her patient was distressed due to her husband's extra marital affair. She encouraged this patient to pray regularly and apparently prayers helped. This is what she said to her patient:

> You just pray to God, because you are married and it was a Christian marriage. One day he will come back home. She started praying. The patient said, "I am so comfortable with your suggestion, I have started praying." The whole week when she was in the ward we were praying. I took only five minutes and went to pray with that lady, she was cured, she went home. One day she came to hospital and said, "You know what? My husband came back home.

All the participants indicated that prayers were part of spiritual care and therefore, they either prayed for their patients or assisted with prayers as per patients' and relative's requests. In this study, nurse participants represented multiple hospital units. The following are views of nurse participants who worked in operation rooms (OR) and intensive care units (ICU). Jumma stated:

> Some patients when [they] come there [to the OR], they are praying so, of course, we are leaving them to pray until their prayers are finished. Then they are praying on the operation table, we are doing nothing to the patient until he finishes. Providing the chance for your patient to pray is spiritual care. We are letting him do each and everything spiritually first.

Although Isaac thought that OR in itself could be an obstacle for providing spiritual care, he still provided spiritual care by using encouraging words and reassurance. He said:

> Of course when a patient comes to us, he fears the worst. The most I can do is just to reassure him or her, "please don't worry, everything will go right. If you have any faith you just pray but don't worry much. We will do our best, the anesthetist will give you the drugs, we have the best surgeons and the most experienced nurses, so you are in good hands" and that is the best I can do to relieve fears.

Karen expressed the importance of prayers as follows:

> In the ICU, a patient may be able to hear although he may not be able to talk. While you are giving care to that particular patient, why not speak to that person about God? Why not say that God cares about his or her life and that He will be there to rescue him or her. If I speak to that person like that, although he may not be able to speak, he can signal to you. Say that prayer for a client, maybe, by that prayer God from heaven will hear and get touched. Is healing a part is us? No, it's God, therefore, it is important to integrate spirituality into health.

Karen further referred to an example from a patient, who was in severe pain. She mentioned that in her prayers for such a patient she would ask God to work on that drug so that it can have an analgesic effect on the patient's body: "One of the prayers was actually for God to interplay with the medication to have an effect in the body to relieve him of the pain he was having." Also, when relatives visit their patients in ICU, she would provide them with ample time for prayers. Karen stated:

> The time when I am at the bedside of the ICU patients, even the relatives of some will come and say, "I would like to say prayers for my patient." "Ok, go ahead," so they would come to the bedside. At such time you also collaborate with them by letting them [have] ample time to pray. If you are invited you go with them and if not invited you stop other activities you have been doing. Usually we give them time when we are not busy. If they come at the time when we are doing something, we tell them, "please

> maybe come after five minutes." They accept that. We also take time to connect with them because we are respecting the patient's choice or rather they [relatives] make the choice on behalf of patients because patients are unable to speak.

Angelina said:

> There are some staff who believe in Jesus and sometimes we get patients who also believe in Jesus, so patients can say, "I believe in Jesus, sister can you pray for me?" So we, nurses and doctors, do pray. Also, when asked by a relative, "where can I pray? You just find a private room or a vacant room and tell them to sit and pray. I respect their beliefs and respect the time of prayers. I do not disturb my patients while they are praying.

Ghanima believed that patients have a right to pray and therefore it should be respected in a hospital setting. Like Angelina she too would find a space and time for patients' prayers. She said, "You can go into the room, and the patient may say, "Can you give me five minutes because I want to pray?" We allow them. She further stated:

> In case, like I am a Muslim, if someone comes here [hospital], there is no proper mosque within the premises, but when one wants to pray we will accommodate them. We can show them a space or find a quiet room for them because they have a right to pray. I know that it is part of healing also.

She also added that, if she was with the patient and the imam came to visit her patient, she would join in the prayers, "He [imam] came and he said that he wants to pray for our patient and then they make dua (prayer) there. And we were all there, praying with them" (Ghanima). Like Celeste, she too believed that prayers may change the health status of patients for the better. Even if there was no change, she said, "Spiritually prayers keep somebody believing that at least we did something for our patient."

Similarly, Karen stated:

> Encourage patients to have faith in whatever faith they have or if they are ready to have some prayers with you, . . . do it. Or if they want to conduct their prayers, let them do it themselves. Be there, listen, and help them and if they have asked you to perform prayers for them then, do it.

If patients' religious backgrounds were different from the participants, then the participants depended on their colleagues with backgrounds similar to the patients for assistance. However, some patients did not mind participants praying for them despite belonging to a different religious background. Bora stated that, "we have staff members who are Muslims, they can help him or her, or I can contact somebody who can help her." Likewise Jumma said, "In [this] hospital there are many nurses of different religions. If patients are in need of spiritual care, we can call people of their religion because what we need is the improvement of a patient's health condition." Christian nurse participants when asked by their Muslim patients to show them the direction to face when praying, would guide them and if they were not aware of the direction then they would not hesitate to contact a Muslim colleague. Angelina said:

> Many patients and their relatives say that they want to pray and ask, "Where I can pray sister? Where can I sit? Where is kiblah?" I can call a Muslim staff to show kiblah because I don't know. So you call a Muslim nurse to show them direction.

Likewise, Laurencia said that when she receives a Muslim patient, she too would facilitate with the prayers by providing the direction and the space for prayers. She mentioned, "Sometimes Muslim patients want to pray and you know sometimes they ask for space to pray and some of them ask us, "where is the

kiblah?" We do give them the direction and provide space in the ward." Fiona said:

> You talk to the patient and if he agrees that you pray from your religion, we pray for them and if somebody [nurse] who I know belongs to the same religion as the patient's, you just call that nurse to help the patient.

Nevertheless, Fiona believed that it is appropriate to pray through her religion if a patient is found in critical condition. She stated:

> I can pray for every patient and any patient. I will pray, although the patient may not believe, be a Muslim, once the patient is in danger just pray, "for the sake of this patient please God I am praying with my religion but help this patient."

However, some participants thought that it was a challenge to incorporate spiritual care if patients belonged to a different faith. Dorothea said, "If there is a Muslim patient, I can't go deep, if somebody is a Christian, I can go deep, I can advice him, maybe I [will] call somebody who can help him spiritually." Jumma also expressed a similar concern:

> But if there is a specific prayer from this [Islam] religion and specific from the other religion [Christianity], in that case I can't do [it] because I am coming from one side of the religion, I can't provide spiritual care directly to a patient because I don't know how to pray for them.

Karen believed that she could provide spiritual care to all her patients but it was easier for her if the patient belonged to the same faith as hers. She said:

> When it comes to spiritual care everybody needs the spiritual care. Maybe for me it will be very easy to communicate with a Christian patient because I know what to tell her or him according to the Bible but for Muslims, I will talk to them but I won't have quotations from the Quran.

From the above excerpts it appeared from participants that they may find it difficult to provide spiritual care if they belonged to a different religion than their

patients. Therefore, a question was asked about the quality of spiritual care provided to patients. There were a few participants who said that the quality of spiritual care would differ based on the nurse's religion whereas the majority of them denied that. For example, Karen expressed:

> The quality of care for people of different faiths won't differ because I see everyone the same. You should be open, maybe you will figure out that we are the same. The only difference is color of skin but we are all one, we breath the same kind of air, so whatever faith they have, I just take it and I will do what I have to do. If there is something which he might ask me, for example, which is contradictory to my faith, I will try in a very polite way to request that I can't do this but if there is any possibility of having a colleague of the same faith, I will call that person to do that. We are able to serve, we are able to respect, and we are able to communicate something which will be useful to somebody.

Ghanima also mentioned, "We do receive people of different religions and we take care of everyone, I take everyone as an individual, regardless of his or her religion." But Jumma and Ombeni had different views. Jumma said:

> Of course, of course the quality of care will be different. Because some patients may not believe that [pause], when you go to a patient and if you are a Christian and going to ask maybe to pray for him, he won't like it. When you are going to pray for him, maybe, his condition will become worse.

Ombeni thought Christian patients were receiving good spiritual care when compared to Muslim patients. She said:

> Yes, the quality of spiritual care is very different, us as Muslims, let me tell you from the bottom of my heart, we are very behind in such kind of care. Christians have tried giving good spiritual care, even the sacrament they give them in the ward but us no no. Also, there are many Bibles on the ward, but no copies of the Quran.

In the case of Humphrey, he denied giving spiritual care to his patients based on his understanding that he did not incorporate prayers in his care.

Humphrey said, “I can say I am practicing or continue practicing spiritual caregiving half way or I don’t give complete care. I am saying this because I love my patient and forgive them but praying for others I don’t think I am doing.” It is Humphrey’s opinion that prayers are the only way of providing spiritual care so his perception is that prayer is the only way of expressing spirituality.

It was evident from the participants in this study that prayers formed the major component of spiritual intervention. Hence, many participants fully supported their patients by respecting their prayer timings, providing quiet space for prayers, and many times praying along with their patients. Also, participants worked in collaboration with an interfaith group of nurses in meeting the specific religious needs of their patients. However, few participants thought that having a different religion from their patients sometimes impacts the quality of spiritual care.

The participants, when discussing prayers as one of the spiritual interventions, also mentioned reading Holy Scriptures as another important spiritual activity. The following illustrations demonstrate that reading Holy Scriptures was seen as a significant part of spiritual care intervention.

Holy scripture reading. To promote recovery from disease or be able to bear the disease, reading verses from the Bible and the Quran was believed to be an important spiritual practice. Some nurse participants thought that reading Holy Scripture promoted hope and peace amongst their sick patients. Celeste shared one of the clinical experiences where she came across a woman who was suspected to be HIV positive but was not willing to go for HIV testing. During the

counseling sessions with her, Celeste referred to prayers and reading verses from the Bible. As per Celeste, this woman gained courage and agreed to go for HIV testing. Celeste said:

> After discussing with her, talking and encouraging her, and giving her a reference to verses from the Bible, she reached a point where she recovered. She became very strong and eventually she came up and she told me, "I think if you people can assist me, I can get my blood checked for HIV and I will appreciate that. Then I have to ask for forgiveness from my husband and children because I have been torturing them."

Bora also illustrated the importance of reading Bible:

> If we believe in those words from the Bible, automatically it can change somebody spiritually. I have to communicate with her or him and try to use the polite words, and try to speak to them about words from the Bible, and to reassure her or him according to his or her problem. Usually I walk with my Bible in the ward and patients can use the copy of my Bible. I tell them, "read here this line it will help you" and I think that is spiritual care.

Similarly, for Dorothea, receiving the words of God was important and that meant "if somebody can give me the message or can tell me to read this verse, or that attending church is the way to receive the word of God. Also, reading the Bible, or the book where God's thing is written." During the interviews, I sometimes felt that some nurses were imposing their beliefs upon patients but when questioned about this concern, they denied that and mentioned that only after getting consent from their patients would they either read the Bible or perform prayers. Celeste narrated another clinical experience where reading certain verses from the Bible, along with prayers, had a profound impact on one of her distressed patients. Her patient was distressed because she came to know of her HIV status during the antenatal check up. My participant was given this patient's phone number as she was not able to meet with her when the result for

HIV was disclosed. During the late evening, my participant called and instructed this patient as follows:

> I asked her, "Do you have a Bible? Do you read the Bible?" She said, "Yes." I asked her to read a specific verse from the Bible and told her, "We can't discuss anything now due to your state of mind and emotions, but just read this verse and read [it] as many times as you can and say your prayers and try to rest."

Two days later when she met with this patient, my participant shared what her patient had told her:

> She told me, "You know what? First I have to thank you for saving my life. When you had called me I had put 40 tablets of chloroquine and a glass of water beside me. I had decided that I am going to end my life but after speaking to you and reading verses from the Bible, that you told me to read, I felt so peaceful. I just realized that I was about to do something very wrong, so I am very thankful to you.

The participant continued:

> Actually after discussing, my patient just settled down, she was calm, and she was peaceful. She told me, "I think I have prayed, and now I think I am strong enough to even share the information with my husband, whatever decision he is going to take that is up to him, but I am ready, because I am going to protect this child." Thank God this child was born and was not HIV positive.

Laurencia mentioned that when she finds time, she sits with her Christian patients and reads from the Bible. She said at times she also relies on the priest. She promotes hope in her patients by referring to the examples of sick people mentioned in the Bible. Celeste's and Laurencia's experiences suggest that some nurse participants may have extensive knowledge of the Bible. Interestingly, during the interview, it was found that Laurencia was a church leader and was knowledgeable with the content and context of the Bible. She also used to conduct

sessions for people of her Church. Regarding reading the Bible for her patients she stated that:

> Can't say always but sometimes I sit with the patient, read the Bible, Christians reading the Bible. Sometimes when reading the Bible you ask the patient, "Have you read about Jesus Christ? Do you know what Jesus Christ did?" And then I use sympathetic words and then, I mean use comforting words, words of God and give some example from the Bible if a Christian, "you remember this one was sick?" There are many examples given in the Bible were people were sick and I give those examples. Then we pray [pause], now and then I go and remind him about that, that's what I do. Sometimes if I can't do that I will call somebody, for example, pastor or imam or I even involve relatives, because sometimes I have no time but patients need spiritual care so I arrange with relatives, so that a pastor or imam can come on the ward and give the spiritual care.

One of the reasons for reading the Bible for another participant was to relieve stress. Natalia expressed, "Maybe some patients when they have stress they need to read the Bible. I give them the Bible if they want [laughs]." Celeste also stated that:

> If it is a Christian patient, sometime I encourage them, I can even quote advice [verse] from the Bible to give them encouragement and hope and if it is a Muslim also, there are many verses in the Bible that are also in Quran. Reading makes you stay in peace. Or I ask them to recite from their own religious books the verses or whatever someone feels comfortable to do.

The majority of the participants in this study were Christians, therefore there were more illustrations in relation to reading the Bible. The participants seemed to encourage their Muslim patients to read the Quran but bringing them a copy was difficult. During the interview, some of the participants mentioned that there were no copies of the Quran available in the ward. This may have prevented nurses from utilizing this resource in times of need despite being aware of its importance. As mentioned earlier Ombeni raised this concern and said, "There are

a lot of Bibles in the wards, but there are no copies of the Quran." She further stated that Muslim patients were not receiving adequate spiritual care. She believed that Christian patients were benefitting more in terms of spiritual care because Christian nurses made sure that their patients had access to pastoral services and to Bible whereas, Muslim nurses were paying less attention to such things. Besides having copies of the Bible in the ward, some of the nurses in this study also kept their own copies with them while on duty.

From the above illustrations it appeared that participants in this study were comfortable encouraging their patients to read Holy Scriptures because they believed that reading Holy Scriptures promoted comfort, hope, and peace in people. The following section highlights the role played by pastors or imams in providing spiritual care along with nurses.

Pastor/Imam consultation. Organizing a visit from a pastor or an imam was considered part of spiritual care intervention for the majority of the participants. Angelina said that, "I can ask for permission from a patient and consult the priest. I have seen many patients bringing a priest to the hospital for praying for them. Celeste also described how priests visit and pray for patients on the ward:

> When a priest is visiting patients he greets them and introduces himself. He says "I am so and so and I am here to pray, would you like me to pray for you?" Some of the patients will say, "Yes, please." Even Muslim patients will say, "yes, please pray for us," so the priest prays and goes.

If patients refuse, then the priest will respect their wishes. This was indicated by Esther as well. She said, "Priests talk to the patients, they say hello to them, if they wish he can pray for them and if someone says "no," then they don't

force. If someone says “yes,” whether a Muslim or a Christian they pray.”

Ghanima mentioned how an imam can be included in patient care. She said:

> And sometimes you may find a patient very sick, and relatives may come and say that we want an imam to come and pray for our patient, may be our patient is in his last minutes. They believe that if we pray, something can change. Maybe, it might change nothing but we do allow, we do allow. Sometimes if you are there, you can participate in prayers also. Sometimes you are doing some activity there and they start praying, you won’t leave because they are praying. If you have time, be with them.

Priests not only pray upon patient’s request but also baptize patients and assist with confession when the need is identified. Catholic nurse participants in this study have also baptized newborns and have assisted priests with the process. Bora mentioned:

> There is somebody who is very sick, so the parents may request for the Father from his or her church to come and baptize the child there, so we can arrange this. We phone and ask the priest to come and do the service when a request is made by the patients or the patient’s parents, you take care of it.

Dorothea said:

> I am a Catholic, the Catholic church allows us, you can baptize somebody who is in danger or in emergency, you can baptize. So one day when I was working, the mother give birth to a premature baby, and he was in critical condition, was dying, so I baptized the child and then called the Father, who then registered the name in the church.

Similarly, Fiona stated that “if a kid is dying, for example, the mother is having fetal distress, once the body comes out, as nurses we are allowed to baptize the kid, you just baptize.” The other religious practice besides baptizing is confession, which is facilitated in the ward by nurses. Fiona said, “Sometimes patients want to confess and ask nurses to call a priest.” In another example of

spiritual care intervention, Isaac mentioned how he sought the assistance of a pastor for his critically ill patients:

> In Christianity, when a person is critically ill or loses consciousness, you may call a pastor who can give him/her [pause] what do you call? [pause] prayers and of course he will give him some sort of water, blessed water and [he will] bless the patient.

He also added that, in other religions similar kinds of rituals are practiced. He said:

> The patient's relatives in some religions usually keep certain type of water near an elderly patient and they might say, "if he dies and we are not present, please put a drop of this water here, drop this bit of water somewhere here [pointing to the tongue]." They believe it will save life, eternal life.

Fiona shared an incident where she came across a male patient who seemed not to be recovering despite all the treatments. She thought that patient was suffering due to not having a proper Christian marriage. Apparently this man was not married but was living with a woman. After counseling the patient, she called her priest to come and officiate at the marriage. She narrated this as follows:

> I asked myself, this patient has got all the medications, doctors were there. It came suddenly in my head (smiling), "oh did you get married as per Christian procedure because you said that you are a Christian? He said, "No madam, is that the reason why I am suffocating yeah?" I said, "umm, I am just asking you this question." Patient said, "So we didn't get married, could you call a Father for me?" I called a Father from the church, it was my night duty, he came there, the woman was there, and they got married in the ward. They got married there. The Father sanctioned the marriage. That man was so calm, after that he was so calm. The Father went, [he] must have just reached downstairs, and that man passed away.

All the nurse participants mentioned that priests would visit patients regularly in the hospital and could also be contacted upon patients' request; whereas imams visited patients only when called by patients' or patient's relatives. Contact details for priests were available in the ward but for imams there were no readily available lists of contacts. Therefore, patient's relatives were sent to a nearby mosque if services were required. Ghanima indicated that:

> We do give patients the telephone number, the priest's telephone number who is visiting us regularly. We also give his cell number whenever they want so that they can communicate directly with the priest. We don't have the imam's phone number to contact him but whoever needs him [his services] we direct them to Upanga mosque.

To provide comfort to his patients, Michael would look for priests and imams to visit them. He said, "For Christians, we find a priest and he can go and pray for the patients, and if it is a Muslim, we can find an imam to visit a patient because the patients are to be satisfied." Karen mentioned that, priests would also perform Holy Communion for patients in the units. She said, "For Catholics, the priest would come and visit clients and give them Holy Communion. For Muslims, you find that some people from the Ismaili community [a minority sect of Shia Islam] would come to give them some spiritual care."

As seen from the above illustrations, the role played by a priest or an imam in a hospital setting was the performance of prayers, facilitating confession, baptizing the critically ill, and sometimes performing Holy Communion in the ward. This section continues further with the descriptions of some common spiritual care interventions.

Common Spiritual Care Interventions

Many study participants thought that the following spiritual care interventions are common to all people irrespective of the religion one followed. These spiritual care interventions include: demonstration of love, compassion, and forgiveness, maintaining and demonstrating moral and ethical behaviour, and counseling and reassurance.

Demonstration of love, compassion, and forgiveness. The majority of the participants in this study expressed that they demonstrated love and compassion in their care. These are also the doctrines deeply rooted in the world's major religions. As participants in this study belonged to two major world religions, that is, Christianity and Islam, these principles were evident in their expression of spirituality and spiritual care. For example, Dorothea said, "What I understand, God needs us to love each other, to be patient with each other, and give care." She further stated that:

> I am a nurse, I am attending a patient with love, with care, and if he needs more spiritual care, I can tell him or advice him where to go and get spiritual help. I say love and caring, that is a general way, everybody understands it, and everybody can provide it. Yes, I can show [this] to all patients.

Similarly Angelina stated:

> We all believe in God, whether that God is a tree, or what, we call that tree a God. All believers believe in love, compassion, assistance, and helping others. This love is God's love and because of this love, everybody helps each other, sees another human being as you see yourself.

For Dorothea, patients represented God and therefore, caring for patients was equated to serving God. She mentioned:

> Patients represents God, so when attending anybody which means of course, you are attending to God, because we are not seeing God, the one you are seeing is representing God, so you must show him love, he needs care and you need to be patient towards him.

The love towards the patients is demonstrated through certain actions. Natalia, elaborating on such action, said:

> The action you use to show this is love, first of all you regard a person as a human being. Every human being has a right to be loved, ok, so for example, the religion teaches people or children to love each other because God loves people. If God loves people, so we also have to love each other. So you have to love people, patients have to be loved as human being, they are human beings, they have a right to be loved. You respect them, you value them, and you give them dignity.

Esther believed that when she expresses love for her patient, it encourages patients to share issues and problems more openly: "So if I love my patient, of course, my patient will feel like talking, they see in you the charm, the charm coming from you, coming from me, then they feel the freedom of talking." She explained the term charm as, "What I mean by the word charm is approaching a patient with a positive approach, maintaining a good interpersonal relationship so that a patient can open up and talk freely about the problems he or she is facing."

In relation to forgiveness, Laurencia said:

> I can ask you how you feel about having done something not good to somebody. You need to ask for forgiveness because these are common things. If I do something bad to you and I don't come to you to apologize or to ask for forgiveness from you [sighed], I know that there is a thief in me, something bad in me. If I fail to contact you, at least contact someone else who has been given that mandate. For example, in our Christianity, if you can't face somebody, maybe that person, you can at least confess to a pastor or a priest that you did this and this.

Celeste mentioned how her patients felt that she had sinned and through a nurse's support she was able to find courage to resolve the issue. Celeste said:

> One of our patients was a lady; she had put herself in a miserable state. She thought that she had made a mistake and that she was totally helpless, completely useless, and that she had no hope at all. But upon several sessions with her, giving her care, she just opened up, she started speaking, and she started telling about her life. She believed that she had sinned and that's why she was very ill and she might die because of this. But after discussing with her, talking and encouraging her, and giving her references for verses from the Bible, she reached a point where she recovered, she became very strong and eventually she came up and she told me, "I think if you people can assist me I can get my blood checked for HIV and I will appreciate that, then I will ask for forgiveness from my husband and children because I have been torturing them." Her blood was tested. The report was negative; she just recovered (smiling). Actually she was not even given any more medication for HIV. It was possible through encouragement.

Similarly, Isaac expressed that some patients, during the time of terminal illness, realize that they have sinned and would like to confess. Patients will request nurses to call clergy persons to facilitate the process. Isaac mentioned:

> On the spiritual side, I mean a patient may have a certain spiritual anxiety or fear or alienation. It means that there were things he didn't do right in his life, he was not working well, and not following his faith properly and that is now put aside from God. He now fears that if he dies, certainly he is not going to see God, he is going to get punishment. For instance, a person may say to you, "I know I am critically ill and I know I am not going to get cured of this illness, if I get an opportunity to get this resource, my religion is so and so, please if you can help me in getting someone, a chaplain, a pastor or an imam, maybe they can come and see me. I can share with him or her my feelings so that at least I can be healed, I can be helped."

It may be possible for nurses to think about and be aware of patients' needs about confession due to their own religious belief. When Isaac was asked to state his understanding regarding spiritual care, he responded that a nurse uses religion as a resource during patient care. The above excerpts from different participants demonstrate that nurses can play a role in assisting patients to repent and seek ways for forgiveness. Celeste stated that, "Forgiveness gives one inner

peace and calmness. In order to forgive one has to have a religion or some kind of faith. Forgiveness sets people free spiritually for both the forgiver and the one being forgiven."

The other way that Esther believed that she demonstrated spiritual care intervention was as follows:

> At the end of the day someone will say, "I have served this patient, had good interaction and communication, maintained the interpersonal relationship, and showed love to that patient." If I go to a patient and I have a frown on my face or I don't talk to this patient, and only impose what I want to do, it won't even touch the patient, the patient will say, "What is this? Am I an object or a human being?"

She further stated that taking interest in patients was also part of spiritual care intervention. Thus, in the above descriptions, the participants have indicated and emphasized about love, compassion, and facilitating the forgiving process to resolve guilt and hurt as interventions when providing spiritual care to patients irrespective of religion.

Maintaining and demonstrating moral and ethical behaviour. Being moral and ethical is considered an important part of human interactions. Some of the moral and ethical behaviours such as being polite, honest, faithful, and respecting individuals regardless of religious beliefs were expressed as part of spiritual care interventions. It was interesting to note that participants, when conveying their understanding about spirituality had mentioned spirituality as an "inner-self" guiding a person's ethical or moral conduct. When they were sharing their views about spiritual care, they included demonstrating moral or ethical behaviours as part of spiritual care interventions. This suggests that what they believed to be

spirituality had a direct relation to their actions in terms of spiritual care interventions. Bora said:

> I can go to the patient and talk, because sometimes we get the patient with social problems, so I stay there, talk with her and listen to the problem. I have to communicate with her or him by using the polite words and to reassure her or him according to his or her problem.

Celeste said:

> The first step that I use is just showing that person that I care for you, I respect you as a human being, you are a unique person and I care for your needs, and I am open to listen to you and to help you as much as I can. And in the process while talking to the patient, what I do is to see whether there is something that I can help through listening and dialogue or just help a patient to decide . . . to make a decision on his care. If there are things that I can't do (smiles) then, for those who belong to a specific group or cultural group or religion, I inquire. If interested, I can arrange for a spiritual leader from their denomination to come and talk to them.

She further stated that, "I show them respect by listening, by connecting with them, at the same time giving them personal space, remaining non-judgmental and giving them help when needed." For Ombeni, human interaction in terms of honesty and faithfulness to patients was counted as spiritual care. She said:

> Because when we are doing our daily activities, we are supposed to be very faithful to our patients. Being faithful is spiritual because when the doctor writes the order let's say injection Rochephen and you are giving water for injection [distilled water used for dissolving parenteral medications]. . . . So being honest with patients is considered spiritual. Also, putting a patient in a conducive environment, making sure that the technology is working properly in ICU [intensive care unit], and there are enough lights. This is considered as providing spiritual care. In addition to providing religious care, our day to day activities are spiritual care.

Angelina believed that providing moral support to a patient was her moral responsibility. She mentioned that the primi-gravida women in the labour and

delivery room were scared of the experience and she would provide them moral support. She expressed this as follows:

> I take time to sit, discuss with them and discuss normal things, what is labour? What is delivery? So through talking and talking I come to understand that this person is scared, this person needs moral support so through talking I start giving moral support. For example, women in labour, who are in pain and are afraid be they Christian or Muslim I discuss with them that our God is one and that God always loves people. I tell them you will manage to go through this, you will manage. God is always there to assist you, you just pray in your way, the way you pray everyday, you will succeed and you will make it.

Isaac said that listening to a patient actively and being present were important aspects of human interaction. He said, "One must listen to a patient, always remain present when caring for a person. Also, one needs to communicate very well when a patient comes with some fears and be present during the time of sorrowfulness." Michael believed that demonstrating empathy and sympathy towards patients helps them to cope with an illness. One of the examples where he was empathetic was assisting a financially less fortunate person accessing welfare funds. He said:

> You may find that some patients are not doing financially well so the help you can provide is to inform the authority that this patient is not having enough money to pay for his own treatment and then the authority can decide about giving welfare. If you have sympathy in giving care to a patient then she would not think about the disease much.

Celeste believed that through combining ethical behaviours and religious practices one can raise hope of patients:

> Hope can be provided by availing oneself to others in need, being sympathetic and empathetic; use of quotations from the Bible, the Quran or other religious book; providing comforting words, touching, listening attentively, and being in silence when needed. Also by exercising patience and being non-judgmental or non-discriminative; being honest but

> sensitive; poem writing and reading; showing interest and confidence in care provision through verbal and non verbal communications.

The other general interventions indicated by the participants were counseling and providing reassurance to patients.

Counseling and reassurance. Many participants in this study considered counseling and providing reassurance to patients as another significant element of spiritual care interventions. In addition to counseling, reassuring patients to minimize patient's fears related to procedures and raising hope was considered as spiritual care. Michael mentioned that, "Providing reassurance to patients, making a patient pain free through getting a prescription order from a doctor, reducing patient's fear related to surgery are part of spiritual care." He gave an example of a patient who was too anxious for having a hysterectomy and the way he provided reassurance to reduce fears. He said:

> In the theater [OR] I welcomed her by using her name, and told her that, "in this theater we are doing many operations, don't fear, we have the surgeon who is an expert, (name of the anesthetist) the anesthesiologist who is expert, I am an experienced nurse, I will handle the instruments nicely and I have been there with the surgeon for years, he has operated nicely, no patient had a problem. Your problem will be removed today, you may go back home soon, doing normal activities without bleeding unnecessarily.

He further stated that, "sometimes we go and see patients in the wards before surgery so that they can relate with us and to reduce fears" (Michael). Like other participants, Natalia also mentioned that reassurance and counseling were part of spiritual care. She said:

> Spiritual care is reassuring and counseling the patient. If you do not do counseling you won't know that this patient has a spiritual problem. Also providing reassurance allays the anxiety. Sometimes when you do

> counseling the patient himself or herself solves the problem. So you help him or her through counseling.

Esther believed that through reassurance hopeless patient's hope can be restored. She stated:

> Sometimes you lose hope, but if someone comes and talks to you, you will feel that it is not only me but other people may also be facing more problems, they are coming across more severe problems than myself, so I believe that there is something, there is someone who can see, there is a Creator, there is someone who will lessen my problem or after this illness, something good will happen.

Jumma related to reassurance as part of spiritual care because he believed that, "When you are talking to a patient you can provide spiritual care. For example, in our religion, when a person has a health problem, he needs reassurance, you can reassure a patient through religious belief." Also for Ombeni, reassurance was a spiritual intervention because while reassuring her patient she would state, "Don't worry, God is with you." While providing reassurance she would say some prayers as well. Dorothea thought that it is through counseling that a person opens up and can be assisted. She said, "Usually it is counseling, talking to a patient, maybe the patient opens up to you and tell you everything. Also, that is the point you can start advice." Karen believed that counseling helps with behaviour change and health promotion. She said as follows:

> Let me give you an example of people who are alcoholics and are suffering from diabetes or renal problems. The goal of the counseling is to reduce the intake of alcoholic drinks. If you used the spiritual part of knowledge in this counseling they may actually think, "Why am I doing this? This may be wrong." There are some religions in which it is prohibited completely and there are other religions [where] it is allowed but minimum.

From the above excerpts it appeared that many participants in this study associated psychological intervention with spiritual intervention. A question was asked to differentiate between psychological and spiritual care. The majority of the participants believed that psychological and spiritual dimensions are tightly interlinked. They also indicated that counseling and reassurance were spiritual as well as psychological interventions. Esther mentioned, "These psychological and spiritual aspects go together." Similarly Fiona stated, "Psychological and spiritual is just, you can say, they are almost equal. In physical aspects you are dealing with the body and treating with nursing care but psychological and spiritual they are almost the same." Laurencia also had a similar view. She said, "Psychological care and spiritual care goes together because if somebody is well prepared psychologically [pause] yes, even spiritually they are well prepared. If I prepared you spiritually, I think it is even preparing you psychologically."

Celeste said:

> Psychological and spiritual care [pause] they are things that you can't quantify, you can't measure but the aspect of showing you that I care, the dialogue, listening to you, helping you to open up and speak up, that takes care of your psychological aspect. When it comes to spirituality, it is where you find peace and hope and that is possible even if you are very ill. You will carry on, you will have peace, you will have inner peace, so these are spiritual things, you can't quantify, but when a person reach that point you can say, yes, now she is calm, now she has come to terms, she has peace.

From Celeste's response it appeared that listening, having a dialogue, and helping a patient were psychological interventions but they affected people spiritually by having inner peace. Whereas, Humphrey and Angelina believed that listening and talking, which is part of the counseling process, were spiritual

interventions which affected patients psychologically and physically. Humphrey said:

> When you talk with your patient and you do counseling, that counseling itself is included in spiritual care, if I am not mistaken (smiles). In counseling we spend time with the patient and we talk with this patient. When you counsel a patient, he is affected psychologically. This counseling helps this patient to be well psychologically and also physically. I can say that this counseling is like I help this patient to come off this problem.

As described before, these responses indicate the tight link between spiritual, physical, and psychological aspects of human being. Angelina said:

> I know that when you respect or reassure the person spiritually or you talk to people spiritually according to their faith, I say this affects psychological part of a person. It means psychologically she is getting better. According to my understanding, spirituality and psychological aspects are related, they go together.

Thus findings suggests that some participants believed psychological and spiritual aspects were more closely related to each other than to the physical aspects and it was difficult to separate them. But Karen demarcated psychological care from spiritual care by stating that psychological care involved no mention of God or religious practices. Once a nurse introduces religious beliefs or refers to God during the counseling process or during nursing care, it would be termed as spiritual care rather than psychological care. She said:

> In psychological care, you are just talking to somebody or you are just talking about something until the person starts to understand you, without incorporating anything in relation to God or belief, it is a psychological care. But if you relate it to religion, you can call it as spiritual care.

She elaborated further on the above difference by giving an example of a person having fear:

> Eradicating the fear of the patient is both psychological and spiritual intervention. Psychologically I have to remove that fear from his mind. Spiritually, I have to sit and talk with him. [pause] . . . Also, this is psychology, but I will use some verses from religious books. I can look for those verses and tell things or refer to God, that God who is the final decision maker. Psychologically we have removed that fear from his mind but most of the time when we talked, we talked about spirituality in reference to God.

The above illustrations suggest that all aspects of a person, physical, psychological, and spiritual, though they appear different, are strongly intertwined. Moreover, participants felt that the psychological dimension was more closely linked with the spiritual dimension. Therefore, when describing counseling and reassurance as strategies, participants had mixed views about them being spiritual as well as psychological interventions.

Conclusion

In this chapter I have presented findings related to identifying and responding to spiritual needs. The ways through which nurse participants recognized spiritual needs were by paying attention to cues given by patients and their relatives, the medical and surgical diagnosis of patients, patient's belief in witchcraft and devils, and observing patient's bedside environment and facial expressions. In response to the identified spiritual needs several spiritual care interventions were implemented by participants. The spiritual interventions were based on religious practices and non-religious practices. The religious practices included encouraging patients to have faith in God, performing prayers, reading Holy Scriptures, and consulting clergy people. The participants believed that along with medical interventions, integration of religious practices would help their patients heal rather than only cure. They referred to religion and God when

describing some of the common spiritual interventions such as love, compassion, and forgiveness, maintaining and demonstrating moral and ethical behaviours, and counseling and reassurance. They believed that these interventions could be applicable to non- religious people. Having discussed the recognition of spiritual needs and spiritual care interventions from the perspective of my participants, the next chapter illustrates the challenges faced by them when identifying and providing spiritual care.

CHAPTER SIX: FINDINGS RELATED TO CHALLENGES IN ADDRESSING SPIRITUAL CARE

All the participants in this study expressed that they faced challenges when providing spiritual care. The participants believed that spiritual needs were hidden or deep inside a person so a nurse is required to spend additional time with patients to uncover and access spiritual needs. Secondly, participants associated spiritual care interventions with religious practices, for example, performing prayers, reading Holy Scripture, organizing a visit from clergy personnel, and providing counseling and reassurance which required nurses' time and presence. This chapter will illustrate the challenges faced by nurses, such as the intangible nature of spirituality, the lack of time and shortage of nurses, the lack of spiritual nursing care education, attitudes of nurses, organizational/institutional characteristics including salary structures for nurses, and patients' attitudes.

Intangible Nature of Spirituality

The majority of the participants stated that identifying spiritual needs and the provision of the spiritual care required extra time and vigilance of nurses as these needs were not obvious. For example, Angelina stated, "Spiritual needs are sometimes hidden in such a way that you need to spend time [getting] to know that person, to get used to that person, come closer so that person so that he can express his feelings." Similarly, Jumma said:

> But spiritual needs can't be seen by naked eyes because it is inside one's heart, yeah. It is hiding. If you go without talking to somebody, you won't identify the need. You should go there and ask, maybe through assessment you will find it, because some patients hide it.

Fiona also had a similar view, she said, "Assessment of spiritual needs is difficult because some patients are hiding their needs." Natalia also believed that spiritual care needed nurse's time:

> Taking care of the physical body doesn't consume much time but taking care of psychological and spiritual aspects is time consuming. It is something which is inside, it is an inner part. Sometimes patients don't want you to know their issues so you need to spend time talking with them until they tell you what is hidden inside. So it needs time.

Esther expressed that, "Someone will not open up unless you take time to assess their spiritual needs." Celeste stated, "Physical needs can be seen, the needs like, fever and pain, but spiritual needs you can't just see them like that." In addition to a similar view Laurencia mentioned that nurses needed additional skills if they were to identify spiritual needs. She stated, "Identifying physical needs is easier than identifying spiritual needs because that is something which is inside somebody [pause] so to dig it from inside of somebody is difficult. You need all the skills (laughs), it is not easy." Laurencia elaborated her point further:

> Physical needs are something which you identify by assessment, you physically examine. For example, you observe a patient for cleanliness. But identifying spiritual needs is possible only through communication and it depends on how the person brings up the questions.

Like other participants, Natalia also believed that it was difficult to assess spiritual needs compared to physical needs. She said:

> To provide physical care is not difficult but to provide spiritual care is difficult [laughs] because spiritual care is something that touches the inner feelings of somebody. But for physical care [pause] there is a patient who is sick, comes to the hospital, he has a wound, has pain, you give medication, he sleeps, if it is a wound, you apply a dressing. It is simple like that but when it comes to touching the inner feelings, you know, sometimes I don't want to tell you my inner feelings, I don't want to tell you what is inside me so it is difficult.

The intangible nature of spirituality and the hidden aspect of spiritual needs required nurses' time and additional human resources. But participants expressed that they do not have adequate time or the required number of nurses to address the spiritual needs of their patients. The following excerpts highlight their concerns.

Lack of Time and Shortage of Nurses

Bora stated:

> Spiritual care is good to give to every patient but with the shortage of time, the shortage of staff, you can't give it to every body in every shift, so it means others can go without any spiritual care. I think time is a challenge.

Esther thought that having a heavy patient load made it difficult for nurses to take out time for spiritual care. She said:

> We don't have enough nurses in the areas, a nurse [pause] one nurse taking care of about, leave alone the Aga Khan hospital, other government hospital, about 40 patients, it is hard to sit and talk even for 5 minutes with a person, talking about the spiritual part of the person. And most of the time I find that the nurses are taking care of the body more where treatment is concerned.

Humphrey expressed the following in relation to the lack of time:

> But nurses, they don't deal with this spiritual care because you see these nurses most of the time are busy, they don't have any time to spend with these patients to pray individually. They are dealing with nursing care itself, providing the medications, maybe cleanliness or providing body hygiene to the patients, they do ward rounds and they care for other nursing part but spiritual care I don't think.

He further stated in relation to the shortage of nurses:

> If we can manage then we can give it to all patients because all patients need spiritual care, but with the shortage of nurses, one nurse may be

> caring for 10 patients and it is not easy for her to provide spiritual care to all patients. We have many patients and we have two nurses or three nurses.

Jumma said that providing spiritual care meant to take on an extra load in addition to the nurse's assigned workload. He said:

> Nurses think that if I am going to ask that, maybe I will have more work. I should have time to talk, maybe God words [pause], while others are waiting for me, lots of patients waiting for me, 19 patients are waiting for me. . . . What I think is that the spiritual care needs time. You need to talk with your patient, at least one hour talking to a patient. If it was compulsory to find out spiritual beliefs of a patient, then you would provide care, but I think you are going to use almost [pause], you know, one hour; . . . one hour of course you can't afford.

Jumma further elaborated on the workload of nurses:

> Maybe you have a very sick patient in the same ward but when your time is only six hours to work, you have a lot to do, excluding spiritual care. You may have to care for 20 patients on a surgical ward, where 15 of them need dressing of wounds. Between the time you are entering the ward at eight a.m. and leaving the hospital at two p.m., there are dressings to be done, maybe there are medications. . . . Yeah, and there are also injections to be given [pause] until we finish these things I don't think we have time to even take our break.

Karen also thought that the current workload of nurses prevented her from providing spiritual care. She said, "Maybe one is busy with so many activities although we know that it is a very important part of patients' beliefs while in the hospital." Laurencia had a similar understanding, she said, "too much work because of which I fail to do that, I admit." In addition, she said, sometimes she gets so busy that she forgets to provide spiritual care but remembers after going home:

> When I go home I remember, "oh my God, I didn't go to see the patient." Sometimes you go the next day, when I go I may find that the patient has

> died [pause], you see, but at least there is this feeling, it was not that I didn't plan to go but I was too busy.

Michael believed that for a patient to share his/her inner feelings with a nurse, the nurse needs to ensure to make time. However, to make time for patients from his busy schedule seemed difficult. He said:

> To give spiritual care, you need time and you can't come and go and say you have given the spiritual care; . . . you have to set a time. You have to stay with a patient before he shares his feelings, it needs time. I can't come to you and ask, "What is inside you?" it is impossible, you have to sit and talk, talking and talking till he understands you. Now, for that particular time, two nurses in the ward preparing almost six patients for the surgery, shaving, giving enemas, finding and signing consent forms, it costs you time and of course it is impossible to give spiritual care.

Moreover, Michael emphasized the lack of time and the shortage of nurses as being the hindering factors in meeting patient's spiritual needs. He said:

> Maybe here I can say time matters [pause], time matters. Someone will be able to give spiritual care and physical care but first of all you have to know what he is supposed to do today, administering medications, another one is waiting for a nurse. He runs with a time, time is limited. You have six hours and you have to work for 20 patients. If you have two patients then one can manage. Spending half an hour with one patient? It is impossible.

Natalia's response was similar to Michael's. She mentioned:

> We need time to sit with the patients and talk, reassure, do counseling, you see. If you don't do counseling, it means you would not know that this patient has a spiritual problem. We don't have time to sit with patients to reassure [them]. . . . So the challenges which many nurses face, I think, is time; even for myself time is a challenge. Also, we are running short of staff. For example, if I sit and talk with one patient for 20 minutes or half an hour, it means that the other patients are waiting for me. So I can't spend [pause] maybe 30 minutes counseling my patient [laughs] while other patients are waiting for me. So you see I can't care while I am rushing and saying to the patient, "you don't worry, God will help you, you will be ok," I am rushing.

Ombeni too thought that despite her desire to provide spiritual care she cannot do so due to the workload and the time constraints. She said, “Too much workload, I do not provide spiritual care because we are very busy, so many patients at a time, so even if you want to give but the time is not enough.” Beside the lack of time and shortage of nurses, the other contributing factor preventing nurses from providing spiritual care was a lack of spiritual care education.

Lack of Spiritual Care Education

All the participants in the study indicated that the nursing schools did not focus on the spiritual component in their curriculum. They mentioned that their education had prepared them well to deal with physical and psychological aspects of patient care but very little or almost none on spiritual aspects. Angelina expressed this matter clearly, she said, “psychological care we were taught, physical care was also taught, but the assessment and care of the spiritual needs was not taught.” They also said that there was no content on assessing patients’ spiritual needs or identifying spiritual care interventions in their curriculum. Only a few participants stated that in their nursing education, the importance of spiritual care was mentioned verbally but the content and the skills related to the topic were not included. Therefore, they found it challenging to deal with the spiritual matters concerning their patients. The spiritual care that they had demonstrated in their clinical practice was based on their own value system, the way they were brought up in their family, and the influence of the faith based institutions from where they had received nursing education.

Esther stated that she saw her nurse teacher demonstrating the spiritual care in the clinical area and thereby she learned about it. She said:

> In my training, we were told how to care for the body, the mind, and the spirit. The spiritual area [pause], my tutor told me was the way you attend a person, the way you talk to a person. Also, you can talk to this person and ask if they need any other person who they feel comfortable to talk to or to address their spiritual needs, the inner most needs, according to their beliefs. But there was no component on spirituality which I can say I had in the course. That is why I am saying that the majority of nurses are not practicing this spiritual care because we were not taught any method, no method. It is something that is there [pause], it is mentioned as a very important component of nursing but you don't know how and what steps to follow.

Laurencia believed that her nursing education through the mission institution contributed to her understanding of spiritual caregiving. However, the topics such as the last office [rights] and the care of the dying patients were covered in the curriculum which helped her and other nurses learn about spiritual care giving to some extent. On recalling the content on spirituality in the nursing curriculum, she said:

> I remember it was there because we were taught about the last office, we were taught how to prepare this patient, somebody who is almost dying [pause] even if not talking but you can still pray. Also, in the newborn baby care we were taught [pause], let's say you deliver a baby and if you see that this baby may die at any time, we were allowed to contact parents and baptize the baby.

Karen expressed:

> In my training, I learned about the definition of health, WHO's definition of well being, taking care of physical well being, spiritual well-being. . . . Through that definition I learned about spiritual care. I am also required to ensure that the spiritual well being of my client is taken care of if I am to believe that my client is healthy. So that definition made me integrate that kind of knowledge into my daily practice but I don't remember any content in relation to spirituality in my nursing program. Yeah, during the diploma [in nursing] we used to have pastoral lessons where the pastor

> would come and we were learning. For example, within our school time, every Wednesday we would have an hour of pastoral lessons. We didn't have it in the nursing curriculum.

Natalia, while answering the question, "did your nursing education prepare you to practice spiritual care?" said, "No, actually not in my nursing program, they did not teach us as a subject or as a course but I learned it from church." She also mentioned, "Most of the nurses who come from a mission hospital, if you compare them with the nurses from non-mission schools, like government schools, there is a big difference in provision of spiritual care." Michael also alluded to mission schools' focusing on spiritual studies in addition to following the nursing curriculum. He said, "We were following the curriculum from the Ministry of Health but in addition, we studied spiritual studies. I don't know if the Ministry of Health has a curriculum on things like that but it was offered by the missionary school." Fiona too said there was no content specific to spiritual care in the curriculum but she learned it through the mission hospital.

Laurencia in her description about missionary schools indicated that:

> A priest would come [pause] and would give us words of God in the classroom, yeah, but it was not in the curriculum. I don't think it was in the curriculum offered by the Ministry of Health but it was part of the mission training. I don't know what they do in other training institutions. . . . I think training in the mission school helped me. The sessions given to you reminded you about what you are supposed to do and what is good for you. When you go to a ward you see the patients, patients who are in need, patients who are sick [pause], come to the other side [school], you meet a priest who is teaching you the same.

Jumma said that in his diploma education they were told, "To provide care to patients' according to their beliefs, if the patient is following the same religion like you. If a patient is from a different religion then you cannot provide spiritual

care directly but you can provide it indirectly." However, when he was asked about the content of such care, he said:

> No, I don't think we had any content on spirituality or spiritual care. We were only told that when a patient gets sick, he would have many problems including spiritual problems so you should go and ask the patient, maybe you should assess the patient's spiritual needs, then give spiritual care. The spiritual care is like giving a point of reference related to religion.

Isaac also mentioned that one of the challenges of providing spiritual care was the lack of spiritual education. He said, "we do not know [pause], we are not learning much about spiritual care. It was not there in our syllabus when we were in schools and so it becomes very difficult to do it." Humphrey also highlighted a similar concern:

> I can say that it is a problem of the Ministry of Health because they don't put this as a part of the curriculum from the beginning in the training school. These things should be implemented in the training, that is, in the nursing school. When you are practicing nursing this care should be included. We didn't have these things during the training so it is not easy for us to practice spiritual care. I can suggest that they can start training now and then we can practice.

Celeste was aware of the different needs of a person including spiritual needs but due to lack of education, she too felt that it was challenging to address spiritual needs. She expressed:

> You have to be aware that human beings have a spiritual self, a physical self, a psychological self, and a social self, so you try to address all these areas but how do I address the spiritual needs? In my experience I have never been taught to identify and address the spiritual needs [pause] so that is a challenge.

Bora also experienced the same challenge but she said that the teaching from her church had helped her to integrate spiritual care in her practice. She

mentioned, “Actually we haven’t been trained specifically in the spiritual care aspect but what you have been taught is from the church and what you believe sometimes helps.” She further stated that:

> It was emphasized in training to address the spiritual needs of the patients [pause], just verbally stating that giving spiritual care to the patients is good but the actual content on the spiritual care was not found in the curriculum.

From the above excerpts of the participants, it can be summarized that the lack of integration of the spiritual care component in the nursing curriculum made it difficult for the nurse participants to address the spiritual needs of their patients despite it being an important aspect of holistic care. Nurse participants who were educated through the mission institutions felt that they were better equipped to address the spiritual needs of their patients compared to those who had not been educated in such institutions. In addition, religious teachings allowed them to incorporate spiritual care aspects in their clinical practice. The other challenge in addressing the spiritual care of their patients was the attitudes of nurses.

Attitudes of Nurses

The nurse participants in this study described the attitudes of nurses as another challenge in meeting patients’ spiritual needs. What Dorothea meant by attitudes of nurses was, “They [nurses] are not interested in their patient care, they don’t want to know more about their patients, they just provide the care, the physical care. Most of the time, we are providing physical care.” Fiona thought that nurses have become insensitive when providing care and therefore they are neglecting the spiritual care component. She said:

> I am sorry to say that but now a days nurses are saying that they are so busy, so they go to the patient and say, "I want to give you an injection" and [she/he] gives [the] injection and moves on, that's all. They don't even ask patients how they are feeling.

Laurencia also expressed her thoughts about the attitudes of nurses and said:

> Sometimes you can see the attitudes of these nurses, . . . because to recognize somebody is in pain or in depression, nurses need to have a positive attitude towards patients. If the nurses or doctors are doing their duty to just cure, of course they give the medication and go.

Ghanima believed that patients do not feel comfortable sharing their feelings with the nurses as nurses are maintaining a distance from their patients. She said:

> We as nurses are supposed to be closer to our patients so that we can identify their needs. In order to identify needs we should be talking to the patients, communicating with them. If you talk to your patient he will become closer to you and at least he will tell his feelings about what he wants. But if you give him the medication and then you go [pause] when will he tell you maybe I need to pray or need somewhere to pray? If you are closer to them, if you are talking to them, communicating to them, and listening to them then you will get lot of information about their needs.

Moreover, Ghanima mentioned that the nurses are treating their patients like objects rather than approaching them as human beings. She believed that nursing is a vocation but nurses are joining the profession for some other reasons which make it difficult for them to actively engage in practicing nursing. She said:

> You know with this scarcity of jobs, people sometimes tend to come into nursing [pause], they don't have anywhere else to go. Only because they couldn't get other opportunities, they ended up doing nursing but in their heart there is no nursing attitude, they are just there maybe for the money. With bad attitude you won't have time to ask someone to have access to a priest. But if you have a good attitude or if you are caring, you will find your way, you have to ask others, you see, maybe this person needs a

> priest. You will ask your colleagues or find a way of helping your patient but if one has a bad attitude he/she won't have time with a patient, he/she won't take that time looking for a priest or finding a place to pray.

Karen also elaborated more on the aspect of care provided by the nurses who have their heart in nursing and those who are forced into the profession. She illustrated:

> There are some nurses who are nurses because they really like nursing. They were not pushed into the profession. These are two different nurses. There are those who are pushed into the profession because there was not any other place where they could go for schooling but there are others who liked nursing since he or she was young. There is a difference in nursing care in general and spiritual care in particular when such nurses join the profession.

Angelina expressed that some nurses do not understand the importance of spiritual care therefore they are ignoring it. She said, "Maybe because nurses don't understand that the spiritual care is also needed in our daily nursing care, so they don't see the importance of it. It also depends from one nurse to the other nurse." She further mentioned that, "It helps patients and relatives if they think about giving spiritual care." Esther wished nurses spent more time with their patients in providing the spiritual care. She stated that, "most of the time I find that the nurses are taking care of the body more and there are only few who are considering the spiritual part of this people. I wish every nurse would give time."

Isaac shared that some nurses think that time spent on spiritual care is wasted. He said:

> Sometimes a nurse thinks it is waste of time, which is not right actually. Secondly, you know, people [nurses] think that the spiritual care is something so difficult to accomplish though there are benefits. Also, you cannot see the benefits of helping a patient spiritually [pause] I mean physically you can't see the benefits while you are doing something very

> important to the patient. Sorry to say, but in most cases, in Tanzania, we are not much concentrating on that.

The participants in this study considered nurses' attitudes as a major challenge. They expressed that to provide spiritual care, nurses were required to have a positive attitude towards their patients. Nurses' attitude of ignoring patients' spiritual needs or considering provision of spiritual care as a waste of time had an impact on nursing practice in general and spiritual care in particular. The other challenge voiced by some participants was related to organizational/institutional characteristics.

Organization/Institutional Characteristics

In regard to organizational or institutional characteristics, participants expressed that not having a prayer place within the institution makes it difficult to implement spiritual care. When describing spirituality and spiritual care, most of the participants highlighted prayers as the most important spiritual intervention and maybe that is one of the reasons for expecting to have a place to prayer in the hospital setting. The other reason maybe that hospitals in which these nurse participants have worked or were trained before joining the Aga Khan Hospital, had a chapel or a mosque within the hospital premises. Fiona said:

> Why can't they [the hospital management] keep a small chapel so that people can use this for proper praying? You know, sometimes people ask you, "Where should I look when I am praying?" You just tell them I have seen people doing like this and looking this way. If there is a mosque it is better for them.

Ghanima expressed her thoughts as follows:

> The hospital or the institution itself is a challenge. The institution should provide at least a place for prayers because in the other hospitals you can

> find a mosque or a small church around where those patients who can walk can go and pray or they can go in the mosque and pray. But in my institution, actually, we don't have such a facility. You can find people praying on the grass there on the ground. Yeah, they go there and pray, it is because we don't have a proper area for prayers. Because he or she doesn't see any place to pray then he just say, "Oh! where can I go now?" They just stay in bed unless you pass by and talk to them, they say, "Oh! I didn't know I can pray here."

Isaac believed that the environment of the hospital can promote spiritual caregiving practices. He said that:

> Very important, the environment of the hospital matters the most. If the hospital is built in the most dominant religious faith then maybe that can help. We are saying that these private hospitals, in most cases, do not integrate spiritual care, that is one of the challenges.

He said that once he left the mission hospital, the motivation for providing spiritual care in a private hospital was reduced. Laurencia expressed that the working environment in the mission hospital enhanced nurses' ability to integrate spiritual care. She said:

> It depends on how somebody is brought up. Why am I saying that? I have been trained in a mission hospital and worked in a mission hospital and now I am working in a faith based hospital you know, I think even this contributes to the provision of spiritual care.

Jumma also believed that the hospital system has a lot to contribute if spiritual care is to be implemented. He said that the current system does not mandate nurses to integrate spiritual care. He said:

> Because it is not in our system we do not provide spiritual care. It should be in the system that our nursing care should be this, this, this and this, you must ask a patient, you should find out his spiritual belief but [currently] it is not mentioned in our system to do this.

Jumma thought that if the hospital system made it mandatory for the nurses to incorporate spiritual care then nurses would practice it. He mentioned:

> They will do it, I too must do this. When I am leaving the hospital, I can tell the next nurse that, "I have done this to this patient since I came and I have reached to this point, you should continue from here." But for now if I am going to do that it is only me, I don't think I will get a chance to focus on it properly. If you can provide spiritual care, it will help the patient but I don't think any nurse is forced to do that.

But Natalia and Michael had different views about the organization of the hospital. They raised a concern about the salary structure and mentioned that unless and until the nurses are paid an appropriate salary, it will be challenging to practice spiritual care. Because nurses are under paid they have to look for additional jobs after finishing their regular duties in the hospital. Therefore, they said that nurses mostly focus on the physical care aspects of a patient in order to complete their duty quickly. Natalia said:

> Most of the nurses are not happy. You know why? The problem is salary. Most of them are there working but they are thinking how can they meet their family needs? When they finish their duties they have to rush home or to work somewhere to find money to increase their income.

When asked how salary was related to spiritual care practice, Michael replied:

> To give proper spiritual service, you have to prepare yourself, you have to settle your mind [pause] and then to identify patient's needs. Then make up your mind and decide to give spiritual service. If not I will give physical service so that at least I can go and find some good pastures. This is distorting the nursing profession, first, at colleges the nursing teachers are not teaching proper lessons, secondly, the working area is not encouraging proper practice.

Some of the participants in this study have voiced their thoughts about the important role that hospitals or institutions can play to enhance spiritual care practice by health care professionals in general and by nurses in particular. Last but not the least of the challenges faced by the nurses in implementing spiritual care was patients' attitudes.

Patients' Attitudes

Only a few participants have expressed patients' attitudes as a challenge in providing spiritual care. Fiona said:

> Some patients do not want; you can't even provide the general nursing care. You go to the patient and the patient say that I do not want you to do this procedure and I am not ready for this now so we also agree on this. . . . Sometimes patients themselves refuse.

Laurencia stated:

> Sometimes, the patient themselves pose a challenge. For example, I say that this patient needs this spiritual care but [he/she] is not ready. And you can't force somebody. My duty is to advice and do whatever I can to change him or her. But if he or she refuses you can't force. But I feel bad if somebody dies without preparing for her life, future life, I feel bad but I can't help it. If somebody doesn't see value or doesn't agree you can't force. You advice and then the patient decides.

Like Laurencia, Ombeni also faced similar challenges. She said, "It was very difficult. When you tell him about God, he says there is no God. They [patients] are here in the hospital only for the medication and they say they will be ok." Jumma believed that if the nurses were to perform prayers for their patients belonging to a different faith than their own, then it may cause more harm to patients than doing good. He said:

> Because some patients may not believe that [pause] if you are a Christian and you are going to ask maybe to pray for him, he doesn't like it. When you are going to pray for him, maybe his condition will become worse. So when you go with a different religion and you are going to pray for him, he doesn't believe and he doesn't agree and if you do it you may cause more problems.

The challenges addressed by the participants in providing the spiritual care were the intangible nature of spirituality, the lack of time and the shortage of nurses, lack of nursing education related to spirituality and spiritual care, attitudes of nurses, the set up of an organization, and lastly, the attitudes of the patients. The following section addresses the factors that have positively influenced nurse participants in practicing spiritual care.

Factors That Positively Influence the Provision of Spiritual Care

It was interesting to note that the nurse participants in this study were also exposed to the above challenges but still it appeared that they managed to provide spiritual care. Therefore, a question was asked, "How have you learned about spiritual caregiving?" Under the subtheme "the lack of spiritual nursing education," nurse participants have indicated, to some extent, the ways through which they learned about spiritual caregiving but the following section will further elaborate. Awareness of self as being spiritual, having religious values, having family values, and having commitment to the nursing profession were said to have influenced the study participants' spiritual caregiving approaches. The responses of participants cannot be put into individual headings as they gave responses that include multiple factors at once. Celeste expressed:

> My spirituality will give me my values in care, how I value, how I look at another person as a human being, how I think of others, how I handle

> them, respect them, and everything else. So it all starts with the nurse who is going to provide care. So if this nurse is spiritually healthy, her way of approaching other beings will be very different from someone who is spiritually unhealthy. And that is why I am saying that in spirituality there is that caring attitude that shows your patients that you care, that you respect them, you know. It all starts with the nurse's self.

She further added that:

> Those are my values, I am spiritual, I believe in God and I believe that I did not become a nurse accidentally, but it was destined. God wanted it. The first contract I had signed was not with the employer but it was with God. This is the direction I am going to take; it is a mission to take care of human beings. It helps me in having called me for this mission. Most of the times it helps me when we are working in a very frustrating situation, I still manage because that is what keeps me going, that I have a mission to accomplish (smile) and I have to take care and help as much as I can to these people who need help.

Dorothea said, "No, I was not taught about spiritual care giving, it is according to my spiritual life, I understand that everybody needs spiritual care."

Esther also mentioned that for providing spiritual care one has to recognize his/her spiritual self. She said:

> One cannot provide spiritual care unless it is within you. There were times we had this fellowships with workers, we sat with workers and talked to them, we had this system in our hospital in those years. We used to sit once per week and say that there is this spiritual part that we are missing in our care. This is the only chance to provide the spiritual care to people who come under our care.

In addition to being aware of the spiritual self, Esther acknowledged her tutors for teaching her spiritual caregiving. She mentioned:

> When I started as a nurse, I saw my tutors in clinical practice, the way they were talking and the way they were trying to see the needs of a person. And there is also the thing called mission which is touching that part of the body which is the spirit.

Ghanima believed that spiritual caregiving was a natural act and being a committed nurse allowed her to address those needs. She mentioned that:

> It comes by itself. Like myself, I am a committed nurse; I know that I am taking care of an individual person, a person who is unique with physical and spiritual needs. This I know in my heart, though it was not taught in our program.

Similarly to Ghanima, Karen too believed that her commitment as a nurse and being aware of her inner self permitted her to provide the spiritual care. She illustrated:

> I think it is a personal thing depending on how you take it. Because, if you have a passion for caring for others then you will feel responsible to studying and to taking care of that thing when you see something is wrong. If you didn't have that kind of a passion you might ask, "Should I get involved with this person? Why should I talk?" You know, you feel responsible when you see somebody is suffering and you know that something will change in this person's life when you are going to tackle the issue and you feel that you need to. I am supposed to be leaving in the next 10 minutes but no, I should not leave before attending to that person. You feel it in yourself; you should go and do it.

Humphrey also indicated that such caregiving comes from within. He said, "Yes, I didn't learn this from the school, but you know there is something that you learn, maybe from experience, or just from yourself. I think these things will come from the person himself or herself." Fiona expressed that her religious teachings had helped her to incorporate spiritual caregiving in her nursing practice. She stated that:

> Once you see a patient dying and if you are a Christian you know this patient is not baptized, that sin will be on you, the one who knows it, in that way I believe that I must do something for the sake of the patient. This was taught in my religion.

In addition to working in the missionary hospital setting, Isaac believed that the nurses' understanding of their own religion influenced spiritual caregiving. He said:

> These are some of the values acquired through working in the missionary hospitals. Because I am a Christian, I have worked in a missionary hospital, so all the time we must help our patients. You know, we believe in Jesus Christ, so a patient represents Jesus Christ. If you help this person you will help Jesus Christ. You think so much in religious terms that it motivates you. In this missionary hospital the salary was not big, it was such small salaries, but still you felt comfortable helping the sick because ultimately you thought you were helping Jesus, you would be paid at the end. You believe in Jesus but you can't see Jesus, you can't touch Him but if you do any good or if you help this person then you help Jesus. That was our religious thinking (laughing).

Laurencia also said that "I think the training in mission school helped me, we were given sessions, every time the pastor reminded you about what you are supposed to do and what is good for you." She also added that, "it depends on how somebody is brought up because somebody may come from a family where this is not taught." Like many participants, Natalia too learned spiritual caregiving from her church:

> I learned it from my Church. I had nursing education from a college which was under the church. I remember, before we went to class or before going to wards to take care of the patients we had to go to the church every morning for prayers. All the students had to hear the words of God, how to take care of patients, how to love them, and how to support them.

She also acknowledged the role played by a family in instilling those spiritual values. She elaborated on family values as follows:

> Even from your family, because some families they are spiritually well, maybe your parents were spiritual. I mean when you were growing they were teaching you things such as how to love others, care for others, then you know how to love others. When you are taking care of your patients

> you will love them and you will take care of them spiritually also. So you learn from the family.

Jumma said that his approach towards spiritual caregiving was influenced by his religion and the way he was brought up at home. He said:

> I got experience from home. I was born Muslim, as Muslims we are asked to pray to God first, yes, to pray especially when there is a sudden onset of a problem, also, when a person is ill or gets sick.

Michael also indicated that his religious and family values taught him to take care of people spiritually. He illustrated:

> Because of my background, you pray first and then start working. I am doing this for my soul. I have worked with these missionaries, we have studied a lot with them. We have been taught how to behave with different people, how to accept others. If we understand them then we can work with them without a problem. We can apply the same principles to the work place. You are told that all these things should come from yourself, you have to think, your soul will tell you this is good or not good and you behave accordingly if it is good.

In relation to family values, Michael further stated:

> Nurses lack that awareness, maybe due to the environment sometimes [pause] where he is living or coming from and how he was brought up. You know, sometimes the family thing makes somebody good or bad. I tell you some families live in this world for a living without thinking about others.

From the excerpts above it may be stated that nursing education did not prepare the participants well to provide spiritual care but the value systems instilled through religion, families, and missionary based institutions helped them acquire knowledge and skills to practice spiritual care. Also, some participants said that it was part of their inner self which motivated them to address the spiritual needs including their commitment to the nursing profession.

Nursing Care versus Spiritual Care

Some of the participants in this study expressed that nursing care to them meant providing physical, psychological, and social care but not spiritual care. Also, spiritual care was a non-obligatory task of nurses. Some participants used the term nursing care to indicate any care given to a patient excluding spiritual or religious care. However, there were other participants who said that nursing care included spiritual aspects though their focus was mainly on physical care. There were two participants who mentioned that nursing care did not include spiritual care although theoretically they knew it was part of nursing care. For example, Humphrey stated:

> Spiritual care is mostly done by the pastor from St. Peter Church; he comes in the evening hours for Christians but if Muslim patients wish, they can pray together. They provide this care to the patients but nurses they don't deal with this spiritual care. Because you see [pause] these nurses most of the time, they are busy, they don't have any time to spend with these patients to pray individually. They are dealing with nursing care itself, providing the medications, maybe providing cleanliness or body hygiene to the patients, they do ward rounds, and they care for other parts of the person but I don't think they provide spiritual care.

Isaac had mixed feeling about spiritual care being part of nursing care. He said, "Sometimes nurses spend time talking about religious matters while there are so many other things to do [pause] . . . executing official duties." He expressed that any nursing activities other than spiritual or religious care activities were the responsibility of the nurses and he said, "that's our mentality, that's what most nurses think." Yet he stated:

> In most cases, nurses are very rarely providing spiritual care. Sometimes maybe [pause] I may be providing it unknowingly, it is not documented, that is very rare. I do not remember providing the spiritual care. It is not

> actually part and parcel of nursing to concentrate on spiritual care although that is one of the mistakes we are making. We usually take care of the body, social needs, and psychological needs but leave the needs of a soul.

Responses from Humphrey and Isaac suggest that nurses in general may be providing spiritual care but it may not be known to them as spiritual care interventions. Also, it is possible that nurses are concentrating more on physical care than the spiritual aspects of human care due to the challenges described above. Many participants have indicated that nurses including themselves were concentrating more on the physical aspects of care than spiritual care despite realizing that the spiritual part was important. For example, Esther expressed:

> Spirituality is incorporated when you are caring for someone as a whole person but this part [pause] spiritual is left [out] because there is no one who is making a follow up on this. There is no follow-up on this. The physical part is there, there is medicine, "did you take the medication?" "Oh yes." "Did you receive injections?" "Was your dressing done?" "Yes." But someone will not come and talk to you or use any word that comforts you.

Furthermore, Esther made some distinction between nursing care and spiritual care. She said:

> There is a difference between spiritual care and nursing care. In nursing care I will go to a patient and say, "I am taking your vital signs," maybe the patient has a wound and I say, "I have come for your dressing." When I do a dressing that is considered nursing care and then I leave. The spiritual care, most of the time, is not incorporated into nursing care. Although there is no need to make it a different thing as it should be included whenever you are providing any care. When you are providing nursing care, you are providing spiritual care, you are providing mental care, and physical care. Nursing care itself as nursing care has all these components but it depends upon a nurse how she considers it.

One of the conclusions that can be drawn from the above illustrations is that for participants the nature of health care is more geared towards providing

physical than psychological care and spiritual care. Also, depending upon the nurses' understanding of the meaning of spiritual care, some participants' think that they are providing spiritual care and some deny providing it. It also appeared that some of them are considering clergy or church/mosque people to be responsible for the spiritual aspect of the human care.

Impact on Patients' Receiving Spiritual Care and Evaluation of Spiritual Care Interventions

Evaluation of nursing care is a vital step in the nursing process as it provides a benchmark for improvement of care. One way of evaluating the spiritual care provided by nurses was to ask them the reaction of the patients upon receiving such care. It would have been ideal to ask the recipients of the care also but this study was limited to nurses only. Therefore, the following section will describe the perceptions of the nurse participants about the impact spiritual care had on patients.

Angelina said that usually nurses do not document the spiritual care provided but they see it. She said:

> Everybody appreciates receiving spiritual care and you can see their faces. When we are talking you can see their faces becoming brighter and they smile. They have not been happy before, you may find that they were frowning before but now you see their faces smiling and smiling.

Ghanima's patients also appreciated her care. She said, "Usually they do appreciate [it] very much. For example, if I provide someone with a place for prayers, they do appreciate very much." Isaac said his patients would also value his care and would maintain contact with him after discharge from the hospital.

He said, “At times patients relate so well, even after their discharge, they might even remember your name . . . and sometimes keep in touch with you if you have done good things [spiritual care].”

Similar to Isaac, Karen said that some patients would remember the name of the nurse who provided spiritual care and would make an attempt to visit upon discharge sometimes. In addition, she said that the emotional changes in patients would show her the outcome of spiritual care provided. She illustrated:

> For example, this person has been very much low, and may request, “can you call my religious leader for this and this?” So after receiving whatever care from the religious person, later on you will see this person’s mood is lifted and not like before, maybe this is part of evidence. Maybe you have taken up a photo of this person and you will find something, . . . flat mood. Later on you take another photo and you will see this person at least not having a flat mood. These can be considered as evidences.

Celeste mentioned that her patients would be more at peace after receiving spiritual care interventions. She said, “And once they recite verses from the Bible or the Quran, they say that, “yeah, I now feel peaceful.” Esther indicated the difficulty evaluating the care provided but by reading the facial expressions she would assess the impact of spiritual care. She mentioned:

> So it is something that you cannot measure because it is inward but the outward thing you can see. You see the face of this person, the change that you see, this person maybe was very anxious, worried before, but now after receiving [spiritual] care this person remain calm, and this is how you measure the outcome.

Celeste further expressed that after receiving spiritual care, patients are:

> more comfortable, more hopeful, you find people who are not ready to even eat, because they had lost hope, when you sit with them and encourage them, they start eating, and take medicines. Some of them may say, “I had decided not to swallow the tablets because I thought that I had

> not any worth" but if you sit and talk to them they feel that they have someone who is thinking of them as a total person.

Laurencia narrated an incident whereby her patient converted to Christianity after receiving some prayers from her. What other factors might have contributed to this change was difficult to understand but the nurse participant said that this lady was in a difficult labour and after receiving prayers from her, she delivered the baby normally. The lady was discharged after a few days but during the follow up visit, the husband, of that lady, who was a Christian, came to Laurencia and said, "My wife now has become a Christian because of you."

Natalia believed that it may not be difficult to document the outcome of spiritual care. She mentioned:

> If you provide spiritual care to the patient, he or she can say, . . . "Maybe I am experiencing like this and like this," or say that "I feel like this . . ."; give evidence maybe through his feelings. He can talk or he can write.

The majority of the participants believed that the provision of spiritual care interventions had a positive outcome. Some of them mentioned that usually such kind of care does not get documented but it is possible to evaluate the care provided. It appeared from the above responses that the outcome criteria focused mainly on emotional changes rather than physical changes or overall change in a person. The majority of the participants indicated that their patients felt more happy, peaceful, calm, satisfied, and hopeful after receiving the spiritual care from nurses.

Traditional Healing Practices

During the interview, a question was asked of all the participants, "Do you work with chaplains, priests, spiritual care givers, traditional healers, or divine healers when dealing with patients' issues while in the hospital?" Almost all participants mentioned seeking the assistance of and collaborating with priests and imams but most did not state working with traditional healers or divine healers while in the hospital. The participants' responses related to working with priests and imams have been covered under spiritual care interventions section in Chapter Five. This section will highlight the participants' beliefs and understanding about the role of traditional healing practices in health and healing.

There were few participants who saw the need for spiritual interventions based on the patient's beliefs about witchcraft and possession by devils. The method described by participants to set the person free from the possession of devils or witches was either through traditional healing practices or by prayers and they opted for prayers to deal with the issues. None of the participants said that they have worked with traditional healers, witch doctors, or divine healers. But it is worth describing their views about traditional healing practices in Tanzania. Traditional healing practices included using herbs prescribed by traditional healers, consulting a witch doctor, performance of rituals, and belief in divine healing.

Traditional Herbs

Some participants, like their patients, believed in traditional practices and there were others who did not believe. The participants who did not believe in

such practices tried to influence their patients to stop using them as they thought they causes more harm than good. The following section describes their positive and negative perceptions of using herbs as part of traditional healing practices:

> You can find that people are having that belief and the important thing is that we should respect that kind of a belief. There are some traditional medicines which are used and they are very vital. For example, the Neem tree, they say that you can collect the leaves and boil it in water and maybe somebody having fever takes a bath with that water and they believe it heals, . . . but I don't know how it works. (Karen)

Esther also believed in using traditional herbs. She mentioned:

> Yes, I believe in traditional healing or traditional medicine. . . . I do say yes, it is because it has touched someone and someone says this healing came after using this medicine. . . . I will not say to someone not to believe in something. That is his belief and I have to respect it.

Angelina too believed in using traditional herbs but denied believing in traditional healers. She said:

> Yeah, I have some faith, because when I was brought up in a village, there were some herbal medicines which were used for abdominal discomfort. When we chewed this we were cured so I believe in few things but traditional healers are not fine. My faith doesn't allow me but there are some medicines, leaves and roots of some plants which are useful.

She further stated that as a nurse she has been trained not to mix hospital based treatment with traditional medicines. She said, "we have been taught not to mix these things, other medicines [allopathic] and traditional medicines because we don't know their strength and action." Therefore, Angelina advised her patients to avoid using traditional medicines. It is possible that due to the healthcare professional's attitude towards traditional healers, some patients may hide having consulted traditional healers. Angelina realized this and said, "They

[patients] don't talk about it much because you come to the hospital when you are sick, visit doctors, you don't talk about these men [traditional healers], we are not advocating traditional medicines."

On the other hand, Celeste did not criticize her patients for using traditional medicines but convinced her patients to follow doctor's treatment while at the hospital. She said:

> I usually see such patients, I can't tell them that they are wrong, because that is how their belief is, that's where they belong. The most I can do is to tell them what we have and what we can do for them . . . and tell them, "You have come here in the hospital, try to believe that the doctors and nurses, whatever they are telling you is to help you recover. We don't condemn your treatment, but share [information] as much as possible, what was going on, how they treated you and what did they tell you."

Some participants had raised a concern about using traditional herbs given by traditional healers as it caused complications and at times death of people. Celeste said:

> They [patients] believe and some of them after going to so many traditional healers, and not recovering and they end up in the hospital. Sometimes, women in labour stay home, they are given some herbs, they come with severe contractions, some of them end up getting ruptured uterus and what not, but if you are blaming, you won't get their cooperation. . . . You take the opportunity and tell them the dangers of herbs that they are taking, you explain so that they don't get confused.

In addition to traditional herbs, the participants expressed that their patients sought the assistance of witchcraft doctors. The following description illustrates their views about witchcraft practices.

Witchcraft

Jumma said, "So when a person believes in something, . . . maybe he believes that the problem coming from devils, this is his spiritual belief, yes he

can be cured." He believes that traditional healing practices can cure people, therefore, he supports his patients in obtaining such services outside of the hospital. He said, "They [traditional healers] are healing through maybe by using herbs from trees, plants, sometimes treating people possessed by devils; . . . sometimes it works." Isaac too believed in traditional healing practices but stated that in the hospital setting it should not be integrated. He said, "I believe in traditional healers to some extent, but that should not be done within the hospital setting." He also mentioned that some of his patients do not like to discuss this topic with healthcare professionals, "Most patients usually don't want to talk when they are in the hospital. They don't want to talk to you about traditional healing. . . . They feel you are spying on them, but in some diseases traditional healing helps" (Isaac).

Fiona did not believe in witchcraft and totally condemned the practice of witchcraft. She said, "When you start praying with them, tell them not to believe in witchcraft where by they may abolish that belief. It is good to change their belief because patients will be stressed due to witchcraft, which is unnecessary." Fiona realized that changing someone's belief is not easy but it was important. Similarly, Laurencia also thought that it was not right to believe in witchcraft as witchcraft practitioners take advantage of people and rob them of their money and do not treat the cause of the illness. According to her, people who believed in witchcraft are illiterate people. She explained:

> They are not literate people; . . . some places they are not educated. . . . To educate them, to make them change or and know that if somebody is having a high temperature, take them to the hospital and do not to go to the traditional healers or to witch doctors. I don't believe in them, . . .

> because I think those people, of course, they have to earn their living, so they use that chance to get money from people. . . . When they [patients] come to hospital, they get cured, . . . but most of the time they go to them [witch doctors].

She shared that when patients come to the hospital after a failure in treatment by a healer, it takes time to treat the person in the hospital. In one of her examples, she mentioned about a child who died of complications of malaria. Apparently this child was treated by a witch doctor. After a few days when the parents saw the condition of their child deteriorating, they brought him to the hospital but it was too late to treat him and he died. Therefore, Laurencia said she is raising awareness in the public about changing the belief in witchcraft. She said:

> We speak to them and visit them at home to change them. It is not an easy thing to change them at once; . . . it is difficult. But they have started to change, . . . not only from listening to the messages from nurses but also from the messages from churches and mosques.

Michael also had a similar view point as Laurencia. He said:

> In Tanzania, there are some people who believe in witchcraft and they get cured. We have so many witch doctors and they treat many people. Some patients come to the hospital and some of them go to the witch doctors. After some time some people see the consequences of following the witch doctors. There are delays in patients coming to the hospital for treatment, causing lots of complications and many diseases.

Ombeni shared the following experience and her reaction to the situation. She stated:

> There was a woman with a baby with so many bandages around it and telling that she is having the influence of satan [devil] so there is this defensive mechanism. We [nurses] are going to tell the facts that this is not true. . . . Although it is very difficult to change somebody's beliefs, . . .

> we try our level best to raise awareness through conducting special sessions and sharing of knowledge.

Rituals

Ghanima and Isaac were the only participants who spoke about rituals when discussing traditional healing practices. Ghanima shared a personal example of how in her tribe they practice traditional ways of healing someone or to overcome a crisis in the family. She termed this practice as a ritual and said:

> Like in my tribe, I am a Chaga, when we have something bad happening in the family like death or anything that is not normal, my aunt, because she is elder to my father, she came to the family and we had to slaughter a sheep. She took a thin skin of a slaughtered sheep and everyone had to wear it on [their] hands. Then she took milk, a little fresh milk and poured it on the ground and prayed . . . to remove the bad feeling in the family or to wash out the bad things happening in the family. And again the meat is cooked and everyone eats it, something like that.

When Ghanima was asked about the influence of religion on the above practice, she said:

> Many religions have different ways of [incorporating] these ancestral rituals and it gives the family the satisfaction that ancestors are now happy, we did this and now our ancestors are happy. Also, they [family] will say that our patient or our son will be in a good position, will get healed, will feel better, though sometimes, it may not happen but at least it gives them satisfaction.

Ghanima clearly indicated incorporating religious prayers as part of rituals whereas Isaac mentioned that there was no relation between tribal beliefs, which includes rituals, and religion. He said:

> There is no connection between tribal beliefs and religion, . . . though religion is incorporated in one way or the other. It helps in some ways in treating people during those ceremonial performances, for example, circumcision. Within our tribe, there are commonalities, for instance we believe in circumcision of boys. Because it is done once in a year, we get

> so many boys; we circumcise them in one day, maybe 100 to 200 boys in one day. It is a very big ceremony. It is not related to religion but it is related to tribal beliefs you see. They are playing different types of dances, wearing a number of costumes, decorating themselves in different fashions and things like that.

From the above excerpts, it may be mentioned that except for a few participants, most believed in traditional herbs as part of the traditional healing practices but not in witchcraft. They did not encourage their patients to mix such therapies with hospital treatment. According to participants some patients felt comfortable sharing the information about traditional healing practices with healthcare professionals. Few participants expressed their negativity towards patients who believed in witchcraft. They discouraged their patients from following witch doctors as it caused complications and delayed treatment.

Divine Healing

For some participants divine healing meant getting rid of health problems without seeking medical treatment. Although none of the participants had worked with divine healers, some of them believed in divine healing. For example, when Angelina shared her personal experience where she said she was healed of severe body pain and immobility. According to her, the pain started in her neck, radiating to the whole body, and was followed by immobility of joints and legs. The pain was so severe that she had to use the bed cradle to prevent the bed sheets from touching her body. During her hospitalization, she was given various treatments including strong analgesics and antibiotics. She said nothing worked for her and one day a group of nursing students working in that hospital proposed her to conduct some prayers for her at the bed side. At the end of those prayers, she said:

> The pain was so unbearable, so after praying for sometime, I just felt that the whole body was so heavy like a big stone lying on the bed. Then I shouted to the young boys who were praying, "Oh my God, I don't have any pain." It was a pleasant feeling. The students asked, "What? You don't feel any pain?" I said, "No, remove the bed cradle, sit on my bed," so they were sitting there and touching my legs but there was no pain.

She further stated that, "It is through that faith, through those prayers that I was healed. I was cured. So I believe in God and that God can heal, can cure." When I asked her whether she believed in miracles, she mentioned:

> Miracles do happen and it has happened to me [laughs]. Those with strong faith, they talk about miracles. Even my church believes in miracles. Many people come to church, some have no children, they come to say that, "I prayed, I prayed, priest prayed for me, and now I have one child.

There were several participants who believed in miracles and it was hard to differentiate between divine healing and miracles. Esther said, "yes, I believe, I believe in miracles, I do (smile)" and she gave an example of a lady whose ultra-sound report showed the signs of abnormal growth in a baby but when the baby was born, it was healthy and normal. Even Natalia said she believed in miracles. But Ghanima raised a concern about divine healing practice. She said her driver suffered from HIV but was reluctant to take antiretroviral medications (ARVs). His driver believed in divine healing and continued to go for prayers but died within a short period. Ghanima said:

> My driver joined a prayer group. Whenever I talked to him he couldn't agree for the medication. He told me that, "I am going for the prayers and for 37 days we will have prayers. They were praying. Later I told him, "Look boy, I know that prayers are good for you but you need medication because you already have an infection." He said, "No, there are people coming there with certificates whereby they are showing that they were HIV positive and now after prayers they are negative."

She further stated:

> If at all he took ARVs with prayers it would have extended his life. People are going for prayers but at the same time they need to take medicines, take your medicine and God will help you, not just praying.

Humphrey shared an incident of his grandfather who had epilepsy and he too had stopped taking medications because he relied on prayers only. Unfortunately his grandfather died because of complications after having a seizure and he said, "Prayers and medications both play a part in the treatment. . . . When you give medication you can treat the cause, solve, and control many problems. Prayers and treatment go together." From these descriptions it can be stated that people who are practicing and following divine healing, need to combine medical treatment along with divine healing strategies.

At the end of each interview, every participant was given an opportunity to add or to suggest their views on spirituality and spiritual care. The majority of them felt that spiritual care was a highly important aspect of nursing care but much neglected component of the nursing care. They requested me to incorporate their suggestions in my research. The following section illustrates their suggestions.

Recommendations for Enhancing Spiritual Caregiving Practice

Recommendations for the Management

Few participants gave the following suggestions which are applicable to management of the hospital. Bora stated:

> It would be good if the hospital administrators organized for clergy people from church and mosque to come and talk to the patients and to give them support. Also to talk to the staff and to impart proper knowledge, spiritual knowledge so that they can talk with their patients to reduce tension, stress, and give psychological support.

Fiona asked:

> Why can't the hospital management keep a small chapel in the hospital premises so that people can use the space for proper praying? You know, sometimes people ask me, "Where should I look when I am praying?" For Muslim prayers I don't know anything. You just tell them I have seen people doing like this and looking this way. If there is a mosque it will be better for them.

Ghanima said:

> In the unit if you can have few copies of a Bible and a few copies of a Quran for patients to access it. Muslim and Christian patients will appreciate having and reading the Quran and the Bible. Sometimes it can help.

Ombeni suggested subscribing to a television (TV) program on spirituality so that the patients in the units can view the program if they wished. Like any other country, Tanzania also has access to TV programs on religious practices and spirituality. She said, "Maybe to have a TV in the ward which shows program on spirituality."

Continuing Educational Sessions

Some of the suggestions given were to enhance spiritual care knowledge and skills through continuing professional education sessions and adding content on spiritual care in the nursing curriculum. Bora suggested:

> Nurses' knowledge about spirituality and spiritual care is to be upgraded. I think if knowledge is given to them, all of them, then they can implement it because they are close to the patients.

Celeste also thought that nursing education would assist in enhancing nurses' knowledge and skills:

> I think nursing education will help. It can help in many dimensions. It will prepare a nurse on how to approach the patients, how to pick the cues

> when assessing their spiritual needs, and how to deal with the patients; . . . it is not an option.

Esther said, "I think adding content on spirituality and spiritual care is very important, it is very important." Fiona also suggested having "lectures on spirituality should be included in the syllabus." Isaac suggested that the environment in the hospital can be created by making a task group to foresee the implementation of the spiritual care. He said:

> The environment to provide spiritual care in the hospital can be created. We can organize ourselves, we can create a special team to foresee that everything is going on well and of course we will have our objectives and action plans. We can do it. Yes, we can do it. We need spirituality and spiritual care in nursing though we are not much implementing it . . . as it is not well defined and the boundaries are not there; but these are the things we need to incorporate in nursing if we really want to help the sick, . . . the body and the soul, which is my thinking. It is a high time now that we start; as Tanzanian nurses we lack that incorporation and because of which we nurses behave so differently.

Jumma thought that currently nurses are considering spiritual caregiving as an option but it should be made mandatory to address the spiritual matters of the patients. He suggested as follows:

> We should be asked to go to the patients and we should set a time to talk to our patients in order to find out their spiritual needs. Sometimes, maybe a patient is suffering spiritually and that is causing the psychological problem. So we should have time to talk to our patients so that we can find out this. . . . If the problem is spiritual we should ask them about their beliefs. As I said health includes these aspects, spiritual, psychological, and physical. . . . So if one aspect among them may be a problem the whole system will be affected.

Karen recommended that:

> I say that spiritual care is very vital in patient care. It is a neglected part and we need to uplift it so that we can realize what it is and we can practice it. When we have nurses' meeting we could study [discuss] about

> spiritual care. We should be taking care of that part. If we check [follow up] on these things, people will take interest and be attentive.

Laurencia's suggestion was no different from others. She said:

> I think content on spiritual care should be included in the nursing curriculum so that at least every nurse can implement it. Of course there are many patients who are in need of this care but we do not do it. Sometimes you may find that nurses don't even know how to care for a dying patient or about the last office although they have been taught.

Ombeni had a somewhat different opinion about enhancing spiritual caregiving practice. She recommended that, 'As nurses we can make a schedule, let's say every Friday maybe after 2 pm, we make a ward round and check on Muslim patients and on Sundays for those who are Christians" although she understands that spiritual care is required each day or any day. Furthermore, she suggested, "introducing content on spiritual care in the nursing schools."

The above suggestions presented by the participants were very valuable in terms of enhancing spiritual caregiving practices in the hospital setting. To having a proper prayer space in the hospital premises and having copies of the Bible, the Quran, and the other Holy Scripture in the units would certainly add to the existing level of care provision. Secondly, raising nurses' knowledge and skills about spirituality and spiritual care was crucial if nursing claims to be providing holistic care to their patients. Therefore, the nurse participants' recommendation about raising this awareness through continuing education sessions or through adding the content in the nursing curriculum was highly appreciated.

Conclusion

In this chapter, the views of the study participants related to the challenges in addressing spiritual care, the factors enhancing spiritual caregiving, and the impact of the spiritual care received by patients were presented. In addition, the beliefs of participants in traditional healing practices were also included. When describing the challenges, participants expressed that the intangible nature of spirituality made it difficult to assess spiritual needs. To assess the hidden aspect of spiritual need, nurses required time and human resource. All the participants felt that the time and the number of staff were not adequate to meet their patient's spiritual needs.

Lack of spiritual care education in nursing curriculum was voiced as another challenge. They expressed that the insufficient knowledge related to spirituality and spiritual care during their nursing education hindered their spiritual care practices or their ability to respond to their patients' spiritual needs. Nurses attitudes, set-up of an organization, and patients' attitudes were expressed as additional challenges. In relation to nurses' attitudes, the participants voiced out that nurses were less committed to nursing profession and ignored incorporating spiritual care into their practice. The lack of prayer place in hospital premises and the lack of emphasis on spiritual care by hospital administration were said to create confusion amongst nurses, patients, and families. Lower pay to nurses was also considered to hinder the implementation of spiritual care. In patients' attitudes, the participants expressed that some patients would refuse

receiving spiritual care as they would not value it or believe in receiving medications and medical treatment only.

The enabling factors for the integration of spiritual care into nursing practices stated by the participants were: awareness of self as spiritual, having family values, having religious values, and having a commitment for the nursing profession. The patients receiving spiritual care appreciated their nurses and they felt peaceful, calm, hopeful, and satisfied compared to patients not receiving spiritual care. The participants' views regarding traditional healing practices revealed that, they believed in traditional herbs and divine healing but not in witchcraft. However, they voiced their concern when patients depended on traditional practices leaving aside medical treatment.

Lastly, participants suggested the hospital management to organize for a clergy to visit patients on a regular basis and to set up a prayer place within the hospital premises. The other suggestion given by them was to effectively plan and conduct continuing education sessions for nurses and other staff to enhance knowledge and skill related to spirituality and spiritual care. Also, to include content on spiritual care in nursing education to enhance nurses' ability to respond to patients spiritual needs.

CHAPTER SEVEN: DISCUSSION AND IMPLICATIONS

The discussion of findings in this chapter relates to the research questions posed in the study and the themes that emerged during the analysis of data. The themes discussed are: meaning of spirituality, meaning of spiritual care, recognition of spiritual needs, interventions to respond to spiritual needs, challenges addressing spiritual care, and factors positively influencing the provision of spiritual care. The meaning of spirituality is discussed under sub-themes: spirituality is belief and faith in God, spirituality is religion, spirituality is morality and being ethical, and spirituality is inner self. Additional themes identified in the findings such as spiritual care versus nursing care, impact of receiving spiritual care, and the traditional healing practices to deal with spiritual matters are incorporated within the above themes. As I discuss the findings, other relevant scholarly work and a broader body of literature is compared and contrasted in order to illustrate how these findings relate to and add to the body of nursing knowledge. The discussion of findings is followed by implications for the practice, research, and education regarding spiritual care. At the end of the chapter, the strengths and limitations of the study and recommendations are presented.

Before discussing the themes of this study the analysis of demographic data is presented. When comparing the content of the transcripts of participants it did not appear that there was difference in the depth of understanding and expression of spirituality in relation to participants' age, their education, or their clinical experience. This however was not a study that set out to determine such

correlations. Vance's (2001) exploratory survey findings also did not reveal significant correlations between nurses spiritual care delivery and education, years of experience, or nurses graduating from a religiously affiliated nursing school. However, Hood (2004), referring to some studies, mentioned that age and exposure in clinical practice including years of clinical experience, influences spiritual perspectives of nurses.

The difference that was noticeable in this study was that the male nurses required more probes compared to female nurses during interviews to describe their understanding about the phenomena under study. Also, half of the male nurses did not think they were providing spiritual care when the interview began but as the interview progressed they themselves identified that they were providing spiritual care but had not been aware of it. However, I am mindful that the scope of my study was not to compare the level of understanding based on age or clinical experience but in future, comparative or correlational research studies may be carried out to examine these aspects.

This study was conducted to answer two main research questions: "How do Tanzanian nurses describe/understand the concepts of spirituality and spiritual care?" and "How do Tanzanian nurses practice spiritual care?" The following discussion is organized around these research questions. First I will consider "How do Tanzanian nurses describe/understand the concepts of spirituality and spiritual care?"

Spirituality is Belief and Faith in God

The findings from this study show that the nurse participants understood spirituality in relation to God, religion, and moral and ethical values. From their perspective spirituality appeared to be their belief in the existence of God and that religion brings them close to God. Having faith in God, conviction or trust in God was considered to be a central aspect of spirituality. The participants' description of faith is consistent with Clark and Olson's (2000) description of faith as "being in relationship with" and to have an "allegiance, commitment, trust, or loyalty" (p. 19) with deity or revered objects.

The participants in the Mahlungulu and Uys (2004) study also indicated the importance of faith in God when describing spirituality. According to Mahlungulu and Uys, for a transcendent relationship, this kind of faith is a prerequisite. For Mauk and Schmidt (2004), faith is a multidimensional concept which, although not observed directly, allows people to find meaning in life. Some of the general themes of spirituality mentioned in the literature corroborates participants' descriptions of spirituality. Though the terms appearing in literature were not exactly those used by participants, they had similar meaning. For example, in the literature spirituality is "non-material", "intangible", (Burkhardt & Nagai-Jacobson, 2002; Mira, 2004) and without a "physical dimension" (Burkhardt & Nagai-Jacobson, 2002) while participants described spirituality as "intangible nature" and "eternal life". In the literature, spirituality involves a "vertical relationship with God," "ultimate power," "Supreme Being" (Buck, 2006; Burkhardt, 1989; Carson & Koenig, 2008; Dyson, Cobb & Forman, 1997;

Mahlungulu & Uys, 2004; Reed, 1992; Tanyi, 2002), participants referred to spirituality as "belief in God/Supreme Being" and "feeling God's presence deep in the soul". The term "source of life" in the literature (Buck, 2006; Burkhardt & Nagai-Jacobson, 2002; Mira, 2004; Tanyi, 2002) may be considered similar to the "ability doing everything including breathing" as described by participants. The "horizontal relationship" involving connection with other people described in the literature (Buck, 2006; Burkhardt, 1989; Carson & Koenig, 2008; Dyson, Cobb & Forman, 1997; Mira, 2004; Reed, 1992; Tanyi, 2002) was expressed by participants as "being good to others". The findings imply that there are some aspects of spirituality that are rather universal.

All the participants' descriptions of spirituality were related to belief in God or the Divine and were not related to anything else other than the sacred. However, Carson and Koenig (2008) and Hollins (2005) indicate that many current definitions of spirituality tend to shy away from any connections to God or religion and focus more on the materialistic level but this was not the case in this study. The following discussion further reaffirms the relationship between the concepts of spirituality and religion.

Spirituality is Religion: Conceptual Confusion on the Part of Nurses

The participants believed in a reciprocal relationship between religion and spirituality. Many of them saw no difference between spirituality and religion. Religion was defined as a group of people commonly believing in a certain kind of God and having a certain set of practices and rituals. In addition, for participants, religion was a guide to show them what is right versus what is

wrong; a guide to relate to others; a framework for moral codes and socially acceptable values; and a path by which to reach heaven. Similar definitions were used by participants when defining spirituality. For a number of participants, religion worked as a link between the person and God. For participants, on one hand, religion enhanced proximity to God and on the other hand, spirituality facilitated internalization of religious values and motivated them to practice it in their everyday life. For example, some of the religious values they stated were love, compassion, forgiveness, being honest, and valuing others in a dignified and respectful manner. These religious values guided them to behave in a moral and ethical manner.

Although some of the participants regarded the broadness of spirituality over religion, their descriptions of spirituality did not cross religious boundaries in general. Hence it may be said that the participants' worldview of spirituality was close to a prescribed religious perspective rather than a non-religious perspective. One of the reasons may be the context of African religion in which these nurses are brought up. Or as stated by Rassool (2000), many religious believers do not comprehend any form of spirituality outside of religion and this is probably true for Tanzanian nurses.

This approach to spirituality is considered traditional or historical (Anderson, 2006). Within nursing literature and practice, a number of scholars have indicated that Western staff nurses interchangeably or synonymously use spirituality and religion (Burkhardt & Nagai-Jacobson, 2002; Davis, 2009; Greenstreet, 1999; Malinski, 2002; McSherry, 2007). This means, many nurses in

the West also consider spirituality in a religious context and they are unable to distinguish between the two concepts as are Tanzanian nurses. The participants in this study stated that it was easier to assist a person with spiritual needs through religion but many health care professionals caution viewing spirituality within a religious framework (Baldacchino & Draper, 2001; Buck, 2006; Burkhardt & Nagai-Jacobson, 2002; Emblen, 1992; Hamilton, Crandell, Carter, & Lynn, 2010; Harrington, 1995; McManus, 2006; McSherry, 2007; Narayanasamy & Owens, 2001).

The contradictory issue that arose from participants' discussion about spirituality was a description of pagans having spirituality, yet a being non-religious group of people. Pagans are recognized to have African Traditional Religion (ATR) but participants did not think they had a religion. Pagans' beliefs include a particular worldview about the universe, God, spirits, human life, and witchcraft (Mbiti, 1991; Magesa, 1997). Based on some of these beliefs, participants in the study described pagans as spiritual beings but non-religious people. So, on one hand participants said religion and spirituality are the same, on the other hand they contradicted their own understanding. It may be implied that nurses are confused about the difference between spirituality and religion.

Emblen (1992), by following a concept analysis procedure, identified major differences in the definitions of spirituality and religion. Based on these differences she cautioned healthcare professionals from using the terms interchangeably as it may lead to misinterpretations of meanings. However, Hollins (2005) and Koenig (2008) reminds us of spirituality's inherent link to

mainstream religions and how western society has moved away from shared and common belief and worship including rituals, towards more individual belief patterns and secular contexts. Hollins draws our attention to neglected aspects of religions by stating that, "It is rarely acknowledged that each of the main religions has, as it were, long tap roots that reach deep down into ancient wells of spirituality, which continue to nourish and inform their communities and their believers today." (p. 24). Nevertheless, appreciating the relationship between spirituality and religion is one aspect but using these concepts synonymously may inappropriately represent the meaning of spirituality.

Belzen (2010) mentioned that the word "religion" seems to refer "to something different in different contexts and in different discourses." (p. 332). Understanding of the context, the culture, and the inherent nature of spirituality is very important. In Tanzania, based on the findings, it seems viewing spiritual matters as religious matter is culturally appropriate; however, spirituality is distinctive from religion. Confusing spirituality and religion could have impact on holistic care. Tanzanian nurses' perspective of limiting spirituality only to those with religious affiliation is problematic (Burkhardt & Nagai-Jacobson, 2002; Emblen & Halstead, 1993; Tanyi, 2002) because it runs the risk of ignoring the spirituality of those without religion (McEwan, 2004). Likewise, when regularly connecting religion and spirituality, some important spiritual interventions may be missed because a nurse believes she/he knows the foundational religious beliefs of a patient before doing a careful spiritual assessment. Also, the confusion that the nurse participants have regarding spirituality and religion needs clarification.

Nurses are to be educated to differentiate between spirituality and religion and therefore widen their horizon of understanding of spirituality. Nurses' exposure to different worldviews of spirituality will assist them to reach out to diverse groups of people under their care.

Spirituality is Being Moral and Being Ethical

Nurses in this study have explicitly highlighted the need and the importance of morals and ethics when expressing the meaning of spirituality. For them, spirituality was a way of life as it has to do with peoples' day to day affairs in life. Due to its influence on all activities of human life, Mbiti (1991) has referred to African religion as the "African way of life" (p. 11). According to Mbiti there is no distinction between spirituality and religion so when he mentions religion as a way of life, it explains spirituality.

There have been many definitions of spirituality in nursing and non-nursing literature but indication of moral and ethical values as part of the definition was not clearly evident. For example, in the list of definitions generated by Buck (2006) and Emblen (1992) through concept analysis of the nursing literature on spirituality, published between 1963 and 2005, only one definition included morals or/and ethics as part of the definition. Few other definitions on the list implicitly cover the moral component of a person when defining spirituality. However, a number of definitions of religion encompass codes of ethics and morals (Emblen, 1992; Hollins, 2005; McManus, 2006). According to Narayanasamy (1999) the Christian theological position on spirituality has influenced modern nursing ethics.

It is interesting to note how the participants in this study related to morality and ethics in relation to spirituality and also how they described morality and ethics as an essential component of nursing practice. In Tanzania, besides having a code of ethics for nurses, the Tanzania Nurses and Midwives Council (TNMC) has made it a requirement for nursing schools/institution to ensure that applicants seeking admission in nursing program have good character (TNMC, 2007). Although TNMC expects nursing schools to have processes in place for assessing applicant's character, to what extent this is implemented is not clear. One would also note, reading Nightingale's account, how she placed emphasis on moral and ethical standards of nurses (Macrae, 1995). According to Taylor (2002), Nightingale was a deeply spiritual and religious person and she attracted women of considerable moral and upstanding status in their communities to join nursing and educate themselves. The characteristics of a good nurse have also been a focus of ancient writings and according to Paul (2000), this description is "remarkably similar to those written in the early twentieth century" (p. 61). Is it again time to think seriously about the significance of having people of "good character" in the nursing profession and to do whatever possible to follow the legacy of Florence Nightingale in this regard?

The participants in this study also asserted that, to attain closeness to God, one has to perform moral and ethical actions which include being good to others. How is ethical orientation linked to spirituality? What is the relationship between spirituality and moral-ethical values? Although there is a distinction between morality and ethics, they are often used interchangeably. Since participants

discussed morality and ethics in terms of spirituality/religion, I too discuss this from a similar perspective.

Shah-Kazemi (2007), when interpreting Ali's[3] Islamic perspective of spirituality, discusses the link between spirituality, moral values, and a code of ethics. Interestingly, he mentions that Ali's perspective is similar to Aristotle's and Plato's conception of ethics. He states that when moral agents' understanding of the meaning of life is derived from the concept of the "Good" then that "Good" functions as the basis "of the one's ability to act ethically, on all levels" (p. 77). Shah-Kazemi contends that before a person does any good, one has to be good and the way to remain good "is to be at one with the Real" (p. 77).

Burkhardt and Nagai-Jacobson (2002) assert that as embodied souls, one behaves and acts within spiritual selves and not outside that realm. One of the nurses in Anderson (2006) study also mentioned that the premises of nurse's action are spirituality. Simington (2004) in a book chapter "Ethics for an evolving spirituality" writes that many people in Western Europe [Western world] would see no difference between the sacred and the secular or between spiritual and physical. This fusion of the sacred and the secular understanding results in the conception of "Every act of daily living is a sacred act. Every act of worship is a sacramental re-enactment of their oneness with the spiritual world." (p. 468). The participants in this study have also related their everyday actions as being an important aspect of living and nursing practice. This is the aspect which makes life sacred and meaningful.

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[3] Cousin and son-in-law of the Prophet Muhammad, fourth caliph of Islam and first in the line of Shi'i Imams (Shah-Kazemi, 2007, p. 11)

Spirituality is Inner Self

Another view of spirituality that was commonly mentioned by participants was a person's "inner self", metaphorically referred to as "heart" or "soul." The terms used by participants are similar to the ones referred by nursing theorists like Watson and Newman. For example, Watson (1988) has used the terms "inner self," "spirit," or "essence of the person" when describing "the concept of soul" (p. 46). According to Watson, the concept of soul allows an individual to expand human capacities for "true human growth" and "to become more fully human" (p. 47). In participants' words, spirituality was something "internal" or "something from the heart." According to the Islamic perspective of spirituality, the 'heart' has a capacity of seeing God due to it's' "inmost mode of perception" (Shah-Kazemi, 2007, p. 29).

Newman (1995) has used "embodied consciousness" when describing spirituality which I interpret to mean "heart". It is the "heart" or "embodied consciousness" or "soul" which "can see God, not using eyesight but insight, that spiritual insight which is generated by 'verities of faith'" (Shah-Kazemi, 2007, p. 29). As per a reductionist paradigm, one may have difficulty accepting Shah-Kazemi's above description but interestingly 'science and reason' (Pesut, 2008) has a role to play in understanding spirituality. Shah-Kazemi's writes that in the worldview of Ali, "a spirit that surpasses, while comprising, the activities of the rational mind, as well as encompassing domains not nowadays associated with intellect, domains such as moral comportment and aesthetic sensibility." (p. 22).

Translating the Latin and Greek meanings of the word ‘intellect’ and ‘reason,’ Shah-Kazemi (2007) says, with intellect, the person “is able to contemplate or ‘see’ the Absolute;” while “with the reason, one can only think about it” (p. 23) because reason works with logic and forms mental concepts of those realities or Absolute. However, Ali did not disregard the role of reason in conceptualizing spirituality but considered it as one of the facets of the intellect. Similar views were expressed by Florence Nightingale, though she said it differently. According to Nightingale, there is no clash between science and spirituality, rather science is needed to develop “a mature concept of God.” (as cited in Macrae, 1995, p. 9).

Burkhardt & Nagai-Jacobson (2002) have used the term “spiritual core” which may denote heart or embodied consciousness. These authors contend that the more we are close to our spiritual core, the more we come to realize our “soulfulness as the source of our connection to and sense of communion with all aspects of our planetary life . . . and experience our oneness with God or the Sacred Source within us and beyond” (Burkhardt & Nagai-Jacobson, 2002, p. 10). The exploration of terms “heart”, “embodied consciousness” or “spiritual core” are important because they are seen to guide moral and ethical conduct of a person. Regardless of religion, race, or ethnicity, each individual must have moral rules and ethical values.

Some of the participants in this study, besides defining spirituality, categorized spirituality as positive and healthy or as negative and unhealthy. The description of positive and healthy spirituality included positive indicators of

personality such as hopefulness, humility, peacefulness, kindness, forgiving, and caring. The negative and unhealthy spirituality included hopelessness, arrogance, uncaring attitude, and many other negative side of a personality. In the case of one participant, she indicated a person experiencing a painful death as experiencing negative spirituality. The nurse thought of seeking spiritual support for this person but did not think of seeking psychological or social help. Although, in some cases, some participants considered the provision of psychological care and spiritual care as the same, the perception of nurses in relation to positive and negative spirituality raises a concern because they may overlook the holistic aspects of care. The experiences of people or coping strategies related to spirituality may be perceived of as positive or negative but to label the term spirituality as negative may be inappropriate. Various researchers have measured positive (healthy) and negative (unhealthy) spiritual coping strategies or positive or negative links between religion/spirituality and health behaviours (Malinski, 2002; Park, Edmonson, Hale-Smith, & Blank, 2009) but have not described spirituality on its own as being positive or negative. Further exploration of nurses' perceptions of negative spirituality is required as it may be connected to nursing care implications.

In summary, the participants defined spirituality as belief and faith in God, being moral and ethical, and inner self. Also, the concept of spirituality was used interchangeably with religion when describing spirituality. This view of confusing spirituality with religion is similar to Western staff nurses who also have difficulty differentiating between spirituality and religion. The implications of this

conceptual confusion may result in depriving people who do not see spirituality within a formalized religious context. In both cases there is a need to understand the difference between these two concepts. Having a broader understanding of spirituality has a direct impact on the meaning of spiritual care. The following discussion addresses the second part of the first research question where participants were asked to share their understanding of the meaning of spiritual care.

Meaning of Spiritual Care

The participants described spiritual care in a wider perspective than they described spirituality. Their descriptions included respecting people's belief in God, their religion, and providing care according to their spiritual beliefs and faith. Also, spiritual care related to relieving psychological stress, touching the inner aspects of a person which in turn provides hope, worth, positive outlook on life, and will power to tolerate suffering or difficulties encountered in life. One participant expressed that spiritual care involved preparing patients not only to accept illness but to prepare them for life after death.

Participants' definitions of spiritual care are congruent with definitions presented in the literature. Literature consistently highlights nurses' perception of spiritual care as religious care and the focus of spiritual care is supporting faith or religious needs (Davis, 2009; Emblen, 1992; Tanyi, 2001). However, when participants perceive spirituality synonymously with religion and spiritual care as religious care, it is possible that they will consider not providing spiritual care to patients. For example, when male participants in this study were not able to pray

for their patients they believed they were not providing spiritual care to them. Also, one of these male participants believed that spiritual care fell in the domain of a pastor or an imam but not nurses.

From these findings it is implied that many participants do not recognize that they are providing spiritual care through relational context (Emblen & Halstead, 1993; Tiew & Creedy, 2010). For example, participants have said that they were compassionate with their patients, respected them, fulfilled their needs as per request, and listened to them. It is possible that spiritual care continues to be a part of their nursing care in either an unconscious or an unrecognized form (Goldberg, 1998; Hood, Olson, & Allen, 2007). Anderson (2006) mentioned that everyday nursing practice is a reflection of spiritual care. She contends that spirituality is infused in nursing behaviours such as being present, being non-judgmental, respecting, listening attentively, touching (healing touch), and, advocating patients and families based on their needs. Failure to recognize or being unaware of these behaviours further prevents nurses from providing holistic care.

Although not stated by many, a few participants expressed that spiritual care consisted of providing physical, psychological, and social care in addition to incorporating religious practices. This approach to spiritual care is consistent with literature (Burkhardt & Nagai-Jacobson, 2002; Davis, 2009; McSherry, 2007). This view of spiritual care encompassing all dimensions of human beings falls into the scope of holism or holistic care. Although many participants viewed spiritual care as different from physical, psychological, and social care, they

acknowledged all aspects being intertwined or interrelated as found in literature. They explicitly mentioned that disturbances in one of the aspects will have an impact on other dimensions of a person. Narayanasamy (1999) also contends that an individual is comprised of body, mind and spirit, which are inseparable and alteration to any one of the three components will affect the other two and ultimately the whole person. Nursing theorist, Watson, describes harmony between body, mind, and soul as the highest function of health and the goal of nursing care (Watson, 1988).

For participants, spiritual care consisted of providing holistic care which also included not only curing but also a healing purpose. Historical accounts of the nursing discipline's legacy of spiritual care indicate that since primordial time, nurses have been integrating spiritual care into holistic nursing practice (Carson & Koenig, 2008; Narayanasamy, 1999; Tanyi, 2002; Taylor, 2002). Florence Nightingale also advocated for holistic nursing care and contended that integrating spiritual care is essential to healing as spirituality is the core component of an individual and the most important healing resource (Macrae, 2001; Taylor, 2002). However, in modern times, positivist thinkers in the fields of medicine and nursing have promoted Descartes' notion of mind and body as separate from the spiritual dimension. Because nursing has followed the medical model of care and the evidence-based practice movement, it has been suggested that spiritual care has become marginalized (Burkhardt & Nagai-Jacobson, 2002). The participants in this study also expressed that the main focus of nurses is on physical care rather than spiritual care. Anderson (2006) and Tiew and Creedy

(2010) also acknowledges this trend of nurses paying more attention to physical care.

Anderson (2006) mentioned that the demanding jobs of nurses have made them experts in the physical dimension of care and there is an effort toward developing the emotional (psychological) dimension and this author stressed that "more needs to be done in the area of addressing the spiritual dimension" (p. 25). This view of Anderson is revealed in this study as well. Participants in the study have said they value providing holistic care but the demands placed on them enable them to focus mainly on physical aspects of care compared to psycho-social and spiritual care. It may not be realized by healthcare professionals but the problem with the biomedical model of care is that it certainly looks for curing or eliminating disease without focusing on the cultural and social factors that contribute to health (Martin, 2009). Therefore, Martin proposes incorporating holistic care instead of biomedical care because the holistic approach is all encompassing, that is, it takes care of bio, psycho, social, and spiritual dimensions of a person.

Study participants expressed that curing mainly dealt with providing medical treatment, for example, giving medications, doing dressings, providing hygiene care, and nurses following doctor's order. On the other hand, healing occurred by reaching out to people and leaving an impact on their heart or soul. Malinski (2002) described healing as a part of spirituality which involved "being aware of, sensitive to, and cherishing wholeness for self, others, and the environment apart from disease conditions, traumatic situations, or the like"

(p. 284). According to study participants, healing action provided hope, a positive outlook, and reassurance to people to deal with the illness or suffering. Olson (2000) defined healing in terms of personal growth and development. According to her, healing "is an integration or balance of the physical, mental, emotional, and spiritual dimensions of oneself that leads towards personal growth and development" (p. 38-39). The healing process requires active involvement of a person but it can be facilitated by others including nurses. Accepting someone without any prejudice and judgment allows the flow of energy between beings which may promote healing. There is this human-to-human connection that also promotes healing (Galek et al., 2005; Watson, 1988).

Nightingale's view about the person's innate ability for healing supports the above perspective (Macrae, 2001). Healing strategies included spiritual care interventions which are discussed later in this chapter. Participants believed that some life-threatening illnesses were not curable but likely to be healed. Healing in such circumstances occurred by accepting the illness and being submissive to God's will. Malinski (2002) also contends that "cure may not be possible in all situations, but healing is the potential inherent in all situations" (p. 284).

The participants believed that spiritual care strengthened an individual's faith in God and allowed them to endure physical or psychological suffering with much hope. Newman's expansion of consciousness and Reed's self-transcendence helps explain the positive impact of sufferings. Newman believed that human suffering offers transcendence and transcendence allows people to embrace that experience and leads to expansion of consciousness (as cited in Malinski, 2002).

Similar to expansion of consciousness, Reed (1992) in her theory of self-transcendence mentioned expansion of self-boundaries in life-threatening situations which provides an opportunity for growth and seeking meaning. Schmidt and Mauk (2004) have described suffering as one of the concepts of spirituality and have interpreted the meaning of suffering from different religious perspectives. It is between the complexity of human suffering and aspirations, that growth and motivation for life are promoted (Malinski, 2002).

From the above accounts of the participants, it is implied that spiritual care was understood from a religious framework as well as from a holistic perspective. However, some of the participants defined spiritual care from a religious perspective only. As was the case with the concept of spirituality, the concept of spiritual care also needs to be clarified. Respecting and addressing clients' spirituality and religious practices are not only important, but are expectations when nurses practice holistic care (Canadian Nursing Association, 2005; Cavendish et al., 2007; Hodge, 2006). Having discussed the meaning of spirituality and spiritual care from Tanzanian nurses' perspective, the following discussion highlights their way of practicing spiritual care. This also leads to answering the second research question.

How Do Tanzanian Nurses Practice Spiritual Care?

For professional nursing practice, nurses have to follow the nursing process. Planning, implementation, and evaluation of care are dependent on accurate nursing assessment (Olson & Clark, 2000). Much like doing a physical and psycho-social assessment for assessing physiological and psycho-social

functions, nurses must carry out a spiritual assessment (Alpert, 2010). In this study, nurse participants mentioned assessing spiritual needs of their patients before providing spiritual care. The following discussion entails recognition of patients' spiritual needs and implementing spiritual care strategies to respond to spiritual needs. In addition, the challenges to the provision of spiritual care and the factors positively influencing spiritual care practices are discussed.

Recognition of Spiritual Needs

One of the professional roles of registered nurses nationally and internationally is to care for the spiritual needs of clients and families. Providing appropriate spiritual care is possible when individuals' spiritual needs are identified. Burkhardt (1989) sees spiritual assessment as an "art of 'being with' another with the intent of coming to know who the person is and facilitating the person's coming to a fuller understanding of self within the context of all of his or her life experiences" (p. 75). All the participants acknowledged the importance of assessing spiritual needs before implementing spiritual care. Some of the ways through which participants recognized spiritual needs included communication, patients' diagnosis, beliefs in witchcraft and devils, and close observation of the environment and expression of feelings. From the examples shared by the nurse participants it implies that identifying spiritual needs was a mutual process. Patients' relatives also played a major role in requesting of nurses' spiritual services for their sick family member. Nurse participants respected their patient's family's wishes and requests related to spiritual needs and care. Interestingly, the process of finding spiritual needs was similar to some of the spiritual

interventions identified in the literature. For example, communication, paying attention to the needs of patients and relatives, close observation of the environment, and being open to inquire about spiritual needs count as spiritual interventions (Anderson, 2006; Burkhardt & Nagai-Jacobson, 2002).

The study participants mentioned that ideally every patient requires spiritual care but patients who are terminally ill, are undergoing surgery, have HIV/AIDS, depression, and have been in the hospital for a long term need spiritual care more than others. Nurses in Narayanasamy and Owens's study also indicated that the severity of their patient's diagnosis promoted them to provide spiritual care (2001). Some authors have stated that a life-threatening situation gives rise to some of the most complex spiritual questions related to illness, death, and dying (Cotton et al., 2006; Ellis, Campbell, Detwiler-Breidenback, & Hubbard, 2002). Clients may wish to address these needs with nurses, who are therefore required to be prepared and knowledgeable about the spiritual dimension of care in order to support their clients in times of distress.

The cues given by patients and their families were picked up by participants through focused communication on patients' belief systems and by careful listening skills. A number of participants believed that nurses' assessment of patients' inner feelings required additional skills in relation to communication and counseling. This finding further emphasizes the need and importance of therapeutic communication including listening skills in nursing education. Although none of the participants mentioned using spiritual assessment tool/s to

assess patient's spiritual needs, it is suggested that nurses may make use of such formal instruments (Alpert, 2010).

The participants in this study mentioned that their patient's spiritual needs included a request for privacy, space, and time to pray, organization of a visit with a pastor or imam, and being provided with /or being read Holy Scriptures. Also, participants said that when their patients expressed feelings of hopelessness, fearfulness, and depression, it indicated to them a spiritual need. The literature on spiritual care has highlighted more than these stated spiritual needs as a pre-requisite to providing spiritual care (Alpert, 2010; Taylor, 2002; Weinberger-Litman, Muncie, Flannelly, & Flannelly, 2010). For example, Taylor (2002) has stated that patients' spiritual needs include the need to have purpose, hope, to express feelings, the desire to relate to and worship an Ultimate, desire to forgive and be forgiven, and to love and be loved by others and so forth. The other ways through which patients can manifest their spiritual needs are: "receiving care and support; experiencing God's presence; have opportunity to pray; gain sense of purpose and meaning in life; and receive visits from and engage in prayer with a chaplain" (Taylor, 2002, p. 21).

In addition to the above requests of patients, patients' relatives, and expression of feelings, the participants in this study also mentioned that patient's bedside environment (rosary, picture of Jesus Christ, bottle of holy water) provided them with a clue to the need providing spiritual care. In Narayanasamy and Owens's (2001) study, symbolic aspects such as a cross, crucifix and other religious artifacts led to recognition of religious need and all these identifiers

prompted nursing attention. Hence it implies that patients may manifest the need for spiritual care in diverse forms and as health care practitioners we are required to develop competency in and comfort with conducting spiritual assessment.

The patients being possessed by devil or satan also indicated to study participants the need for spiritual care. Identifying spiritual needs by a clue given by a patient or patient's family regarding being possessed by devils is consistent with Murray and Zentner (1993). Not many other articles, that I have come across on spiritual needs and spiritual care in nursing, have discussed this aspect of spiritual care. However, there are articles and texts which include roles and functions of traditional healers and some of them have specified the role played by a healer in warding off evil spirits (Mbiti, 1991; Mngqundaniso & Peltzer, 2008; Peltzer & Mngqundaniso, 2008).

Some of the participants themselves believed in the existence of a devil and possession of a devil causing harm or illness to a person. It is therefore not surprising that they would have believed patients who shared being possessed by devils. The study participants indicated that the performance of rituals is a powerful means of overcoming devil's power. In relation to rituals, Wane (2005) stated that the subtle invisible energies that are present in the natural environment are harnessed by performing rituals for healing purposes. Furthermore, he stresses the Western world should not see these concepts from a Eurocentric framework or ridicule this perspective but view them from an African indigenous knowledge perspective.

One participant mentioned the role of traditional healers in performing a ritual to de-posses a devil's influence on one of the patients. Mbiti (1991) also has mentioned the role of the divine or a medicine man in the performance of religious rituals and ceremonies. Another participant believed that shared prayers and prayers performed by a pastor would heal and set the person free of a devil. It is also mentioned by Murray and Zentner (1993) that "counsellors and psychiatrists and some ministers and priests have had to deal with devil possessions in treating clients" (p. 100). They further contend that in scientific terms these things are not spoken about but they require attention by health care professionals as they may be a recurring theme in a client's self-diagnosis. Nurses are also required to address this need in a holistic perspective rather than limiting their actions to performing prayers and consulting a priest. This topic should also be examined in the context of mental health, and required mental health interventions.

In summary, nurses are required to recognize patients' spiritual needs, which may be presented in a diverse manner and then provide spiritual care. Nurses need to combine mental health aspects along with spiritual care interventions when dealing with patients. Thus providing spiritual care is a part of holistic health care and must be addressed in a comprehension manner. In the next section I discuss the interventions used by the nurse participants to address spiritual needs.

Interventions to Respond to Spiritual Needs

Spiritual interventions identified by nurse participants in this study included religious-based interventions and non-religious based interventions. Religious-based interventions included encouraging patients to trust God/Supreme Being/Creator, facilitating prayers and conducting prayers, reading Holy Scripture, and seeking a pastor or imam's consultation. Demonstrating love, compassion, and forgiveness, maintaining and demonstrating moral and ethical behaviour, and counselling and reassurance were identified as non-religious based or common spiritual interventions. The source or the doctrines of these interventions lies in world's religions, however due to universality of these values, participants may have believed that these interventions were applicable to people regardless of their religion.

In the Davis (2009) study, the patient participants, residing in the United States, described spiritual interventions in ways similar to participants in this study, in terms of religiosity, prayer, meeting with clergy, and relationship to a higher power. In addition, some of the caring behaviours reported in a number of studies, like empathy, sympathy, and being available, were identified as part of spiritual care by participants in this study (Davis; Emblen & Halstead, 1993; Galek et al., 2005; Newshan, 1998). It may be implied that patients' and nurses' understanding of the spiritual care interventions coincide to a certain extent. However, it is important that nurses seek patients' views of spiritual care including spiritual interventions from the patients' perspective and from an African perspective rather than assuming interventions solely on their own.

It was found that the study participants' religious beliefs and practices assisted them to respond to their patients' spiritual needs. This is consistent with the findings of Narayanasamy and Owens's study in which they found that when nurses shared a similar religious background with their patients, it allowed them to provide spiritual care to their patients (2001). All the participants belonged to a faith community, 80% were Christians and 20% were Muslims. There was no information gathered in regard to different denominations of Christianity and Islam. Participants acknowledged being aware of their own spirituality and that this awareness allowed them to identify and address their patients' spiritual needs. The views described in this study are then limited to Christian and Muslim belief systems in general.

As Clark (2000) maintained, people "need to have and belong to a community. A person's . . . faith community can provide both a context and a container for sharing" (p. 25). Puchalski (2001) also mentioned that many people show less psychological distress if they find support in a spiritual or religious community. Hence it was not surprising to see nurse participants and their patients sharing respective faith community values and drawing support from these for patients' well-being. When the participants encouraged their patients to have faith in God it promoted hope in patients to endure illness with minimize distress. An accumulating amount of evidence supports the notion that spirituality and religious beliefs influence the outcomes of illness (Chiu, Emblen, Hofwegen, Sawatzky, & Meyerhoff, 2004) and help people to cope with serious illnesses and losses (Molzahn & Shields, 2008).

The findings revealed that participants unanimously indicated prayer, arranging a visit with a pastor/imam, or reading Holy Scripture (Bible and Quran) as a way of providing spiritual care. These findings generally are consistent with literature on spiritual caregiving practices (Anderson, 2006; Burkhardt & Nagai-Jacobson, 2002; Harrington, 1995; Mahlungulu & Uys, 2004; Murray & Zentner, 1995; McSherry, 2007; Reed, 1991a). When interpreting Ali's spirituality, Shah-Kazemi (2007) asserts that remembrance of God through meditation, prayers, or other sacred or divine practices "polishes the hearts" which in turn helps seeing God. It is important to discuss this point here because participants emphasized about prayers and remembrance of God when discussing the meaning and practice of spiritual care. Although participants did not extend their thinking in relation to the "expansion of consciousness" or "polishing of hearts", the act of prayer or remembrance of God was a meaningful practice.

This consciousness about God may not be measured by empirical knowledge but the anecdotes from the participants confirm God's presence in their hearts and minds. How does this consciousness about God translate to health of people and health care professionals' work? Puchalski says, "the relationship with a transcendent being or concept can give meaning and purpose to people's lives, to their joys and to their sufferings" (p. 32). God may be trusted for facilitating the process of healing and restoring hope in the midst of crisis (Doucet & Rovers, 2010). The nurse participants, as health care professionals, used their own religion and belief about God as a resource for providing spiritual care. They believed that encouraging their patients to remember God and by performing of

prayers they provided patients with mental assurance of God's presence in their times of difficulty.

According to Salman and Zoucha (2010), prayers bring people close to Allah (God) which in turn reduces the risk of depression, anxiety, and helplessness. However, Carson and Koenig (2008) warn that prayer should not be used as a substitute for health care provider's time or for meeting healthcare provider's needs or "to communicate a magical view of God that conveys a false sense of hope and expectation." (p. 146). Also, prayers in the case of few nurse participants were offered out of their own beliefs and religious perspectives rather than in respect and consideration of the patient's beliefs. Narayanasamy and Owens's have used the term "evangelical approach" to describe nurses imposing of their religious beliefs and interventions on patients (2001, p. 452). Furthermore, they said such actions may be perceived unethical and therefore should be avoided when providing spiritual care.

Another common spiritual care intervention expressed by participants was providing and/or reading Holy Scripture. This finding is consistent with the literature (Anderson, 2006; Burkhardt & Nagai-Jacobson, 2002; Davis, 2009; Harrington, 1995; Mahlubgulu & Uys, 2004; Murray & Zentner, 1995; McSherry, 2007; Narayanasamy & Owens, 2001). One of the Muslim nurses raised a concern that Muslim patients do not receive a copy of the Quran as compared to Christian patients receiving copies of the Bible when hospitalized. Also, she perceived that Muslim nurses do not frequently promote reading of the Quran in comparison to Christian nurses who promote Bible reading. One of the explanations of this

tradition maybe that there are many verses in the Bible which refer to healing and that Jesus (possessed healing qualities and he) performed healing in the areas of physical, psycho-social, and spiritual aspects (VanDan, 2004). As stated by Murray and Zentner (1993) "scripture references for various stated spiritual needs" (p. 107) may help patients. Also, as mentioned by Schmidt and Mauk (2004), "The gift of God's Words, the Bible, is also a means of grace, which explains the public reading of scripture during worship" (p. 11). Nelson (1995) also indicates that Christian doctrine promoted rigorous and precise training of nurses in the 19th and 20th centuries and he argues that though times have changed, many nurses have retained those values and it is likely that nurse participants in the study continued with these traditions including reading of the Bible.

However, the concern regarding the Quran surprised me because in my clinical experience as a nurse, working in Pakistan, I have found that copies of Suras (Chapters) from the Quran are provided to hospitalized patients and in fact, hospital units house multiple copies of such Suras. This discrepancy maybe due to Pakistan being a Muslim society and thus having a more religious influence compared to Tanzania though Tanzania has approximately a 50% Muslim population. I am also mindful that 80% of the participants in this study were Christians and only 20% were Muslims and therefore, it is possible that the intervention of reading the Holy Bible was more commonly heard during interviews than reading of the Holy Quran.

Like the Bible, the Quran is also considered "Word of God" and in the Quran, chapter 17, verse 82, God says, "And We reveal of the Qur'an that which is a healing and a mercy for believers…" (Translation by Pickthall, 1989, p. 232). Grundmann and Truemper (2004) suggest that nurses have a copy of the Quran at the patient's bedside within the patient's reach. Islam has also associated health practices in worshipping Allah (God) and Muslims are encouraged to read the Quran for physical and mental health (Salman and Zoucha, 2010). The nurse participant's concern is considered valid and it is suggested that Muslim nurses are to be made aware of utilizing this resource when providing spiritual care.

Meditation, incorporating music, art, and humour were found to be common spiritual interventions in some literature but these were not recognized by the study participants. However, interventions, not commonly addressed in recent literature, such as baptizing babies if critically ill, facilitating confession, seeking assistance from colleagues in providing spiritual care to patients with different faith, and counseling and reassurance were identified by nurses in this study. They worked closely with a pastor in carrying out these spiritual interventions. In one case, the participant facilitated legitimizing Christian marriage when she found that her critically ill patient was not married as per church rules with the belief that it would ease his death. The narrative accounts of my study participants revealed that they did not take a short cut to providing spiritual care by inviting a pastor or an imam but they provided spiritual care in collaboration with clergy. In the Narayanasamy and Owens's (2001) study,

nurses' involved chaplains to carry out some of the religious practices including baptizing babies similar to Tanzanian nurses.

However, nurses in this study mentioned that a pastor or imam's help was sought mainly for conducting prayers and for confession. It is likely that the participants have a limited understanding of the different roles played by pastors or imams. In Tanzania, pastors or imams are the primary spiritual care providers and the hospital from where the participants for this study were sought did not have chaplaincy services. Also, there is no literature available to confirm the availability of chaplain services in the hospitals of Tanzania.

In western countries, research studies and reviews have been carried out to explore the roles and functions of hospital chaplains and chaplains' perceptions of nurses as spiritual care providers (Flannelly, Galek, Buchhino, Handzo, & Tannenbaum, 2005; McClung, Grossoehme, Jacobson, 2006; Cavendish et al., 2007). According to Flannelly et al., the role of chaplains is increasing from the traditional roles of addressing concerns about death and dying, praying, dealing with grieving families, and attending to religious and spiritual needs of patients. They are involved in patient safety and advocacy, ethical consultation, and many more functions. Developing understanding of the role and functions of chaplains and pastors (imam) will allow nurses to work in collaboration with them for improved patient spiritual outcomes (Cavendish et al). It is not known if pastors or imams who visit hospital patients in Tanzania have any education related to the chaplaincy role. Perhaps the whole aspect of chaplaincy in Tanzania needs to be further examined.

In countries such as the USA, Great Britain, and Canada the number of people who claim themselves as having no religious affiliation is increasing (Creel & Tillman, 2008). However, there is not a corresponding decrease in the number of people who claim to believe in a higher power or the Divine. In fact, Alpert (2010) has mentioned that spirituality or being spiritual outside of a formalized religion is on the rise. The nurse participants in this study said that in Tanzania it is difficult to find a person without a religion and if they are identified, they are considered "pagan," though pagans do believe in God and they have other beliefs. To provide spiritual care to patients who do not ascribe to a formal religion requires non-religious based spiritual care interventions. The following is the description of such non-religious based spiritual care interventions applicable to all patients regardless of religion.

The study participants stated that demonstrating ethical behaviour was part of such spiritual care intervention. They also indicated demonstration of love and compassion towards patients and addressing concerns for resolutions of pending issues including forgiveness. According to Galek et al. (2005) and Newshan (1998), love, belonging, and respect create a sense of connectedness with others, and it is possible that these attributes of spirituality contribute to patients, regardless of religious base, sense of comfort and healing. When nurses demonstrate compassion, presence, and listen during each encounter, these attributes are important for spiritual assessment and spiritual care and not only lead to a more meaningful, trusting, and deeper relationship, but also have optimal

potential to heal within all dimensions of being (Emblen & Halstead, 1993; Puchalski, 2001).

The character of forgiveness is considered as a positive spiritual coping mechanism. According to Johnstone and Yoon (2009) forgiveness intervention is likely to improve mental health. They stated:

> Learning to forgive, or accepting that one can be forgiven, may help individuals move beyond their anger and improve their emotional and physical health. It will also be important to evaluate the efficacy of forgiveness interventions delivered in religious (e.g., chaplains, religious based counseling) versus nonreligious contexts (e.g., traditional psychotherapy)" (p. 430).

Counseling and reassurance were other spiritual care interventions identified and commonly used by participants. In this study, they said that these strategies are applicable for religious and non religious groups of patients. One of the participants in Davis's (2009) study mentioned reassurance as an informal component of spirituality (formal was religious component of spirituality) along with empathy and sympathy. Murray and Zentner (1993) also considered counseling as part of spiritual care. They contend that when counseling and mental and spiritual methods are combined it will lead to healing traumatic experiences, forgiving self and others, resolving grief, and enhancing healthier relationships. VanDan (2004) mentioned that one of the roles of a pastor is counseling which helps in detecting and intervening in spiritual distress. Hence, like stated by some participants, it is imperative that communication and counseling skills of nurses be improved.

Under the theme of spiritual care interventions, nurse participants also included the role played by traditional healers, divine healers, and witch doctors.

Research reports show that people turn to traditional healers due to a lack of appropriate medical treatment options (Popper-Giveon & Ventura, 2008). In addition, healers pay attention and respect to patients' culture and spiritual matters (Mngqundaniso & Peltzer, 2008; Peltzer & Mngqundaniso, 2008). None of the participants believed in witchcraft but some of them believed in traditional herbs prescribed by traditional healers or self-prescribed. They discouraged their hospitalized patients from using traditional herbs.

A major concern raised by the majority of the participants about traditional healers was that the herbs prescribed by them had no description of action, side effects, or adverse effects and sometimes herbs may interact with allopathic medications and may cause harm to patients. The concern related to divine healers, as stated by participants, was that they prohibited their patients from using medical treatment. For example, participants narrated how their two patients died of complications of HIV/AIDS and epilepsy due to avoiding medical treatment when under the care of divine healers. The participants' perceptions about witchcraft were totally negative. They believed that witch doctors were taking advantage of local people to make money and were least trained to save lives or provide healing.

It is important to capture these perceptions because, in Africa, many people go to these healers for different health-related problems. In fact, the ministries of health in different countries of Africa are making an effort to tap skills and knowledge of these resources in providing safe, effective, and quality services to African people (Mngqundaniso & Peltzer, 2008). So the question here

is how can nurses in Tanzania contribute toward the health ministry's effort when they have negative perceptions about healers? There is certainly a need to curtail incorrect practices but there is another whole aspect of traditional healing which needs to be understood, appreciated, and utilized. African people have been dependent on indigenous ways of healing and curing for centuries and if nurses are disregarding, undervaluing, or condemning these practices for the above mentioned reasons, they may not be providing holistic care. The findings of this study suggest a need to examine the whole aspect of healing practices from a cultural and indigenous knowledge perspective. Perhaps this is an area which requires further research because Wane (2005) argued that

> what indigenous Africa offers to the modern world is a renewed understanding of the concepts of healing, ritual, and community. Healing is central, the fulcrum on which we turn, because it was learned very early that human beings are vulnerable to physiological and spiritual breakdown, and that this general instability touches all human existence. (p. 34).

Having discussed the spiritual care interventions, it was important to know the perceptions of participants in regard to the impact on patients' receiving spiritual care. All the participants stated that their patients and patients' families appreciated receiving spiritual care from them. They perceived that patients, after receiving spiritual care, were more at peace, were happy, and compliant with treatment. This finding is consistent with the findings of Mahlungulu and Uys (2004). They too described the consequences of spiritual interventions as inner peace, hope, and finding meaning in illness and in death. In this study, there was one nurse who indicated that praying for a patient belonging to a different faith from his own faith may cause harm and therefore should be avoided. A similar

view was expressed by one of the patient participant in Davis's (2009) study, who said that because of not sharing specific religious beliefs, the nurse "may pray for the wrong thing" (p. 111). Therefore, it is important that nurses validate the appropriateness to pray for their patients (Murray & Zentner, 1993). A further research may be conducted to explore the impact on patients and their families who are receiving spiritual care. In the current study, I did not ask nurse participants about their reaction to or impact on them when providing spiritual care but it is important to explore their views in this regard too. The responses of patients as recipients of spiritual care and nurses as providers of spiritual care could guide the nursing discipline in harmonizing spiritual nursing care interventions which could lead to improved quality of care.

The participants in this study have described religious and non-religious based spiritual care interventions. A religious based spiritual interventions involved the desire to pray, read Holy Scripture, and consult clergy. Demonstrating ethical behaviour, love, compassion, and providing counseling and reassurance was part of non-religious based spiritual interventions. They also discussed the role of healers in providing spiritual care to people. Providing spiritual care to patients was not without challenges. The following discussion highlights some of the challenges expressed by participants in this study.

Challenges in Addressing Spiritual Care

The participants in this study identified a number of challenges that hinder them from providing spiritual care. For example, they mentioned: the intangible nature of spirituality, lack of time and shortage of nurses, lack of spiritual care

education, attitudes of nurses and patients, and the set-up of an organization/institution. It was also perceived by some participants that nurses were not taking interest in identifying spiritual needs of their patients as they feared it would add to their workload. It appeared that there were no new or different challenges identified by study participants in comparison to the challenges or hindering factors found in the literature. For example, the participants in Vance's (2001) study identified three greatest barriers, from a list consisting of nine barriers, which hindered nurses from providing spiritual care. The first barrier perceived was lack of time, followed by insufficient education related to spirituality and spiritual care, and the third one was the perception that spirituality matters are private for an individual and it is outside the role of nurses.

Similarly, confusion over the concepts of spirituality and religion outside the domain of nursing discipline, time constraint (Molzahn & Shields, 2008), and lack of education (Olson, Paul, Douglass, Clark, Simington, & Goddard, 2003) were identified as hindering nurses from integrating spiritual care. Molzahn and Shields (2008), McManus (2006), and McSherry (1998) also stated that many nurses think that they are unable to address spiritual issues in clinical areas because they were not adequately prepared in their education. In Harrington's (1995) descriptive study with Australian nurses, hindering factors such as fear, spiritual unawareness, confusion, failure to heal, practice setting, and nursing education were reported. Nurses have reported that they acquired the skills and resources to meet the spiritual needs from various personal and professional experiences,

during or even before their formal nursing education began like participants in this study (Harrington; Hood et al., 2007).

The other challenge that participants raised was the difficulty of assessing spiritual needs due to the intangible nature of spirituality. It was interesting to note that despite viewing spirituality as intangible, participants believed that fulfilling spiritual needs had an impact on the physical, the psychological, and the social dimensions of a person. However for many, physical needs were easier to assess than psychological and spiritual needs. The participants stated that psychological and spiritual needs are unseen and that time is required to obtain the information from "inside the heart of the patient". Where as, physical needs are seen with the naked eyes and can therefore be addressed easily. A few participants differentiated between psychological and spiritual care aspects by stating that when providing psychological care, there is no mention of God or religion whereas, God and religion are the basis of spiritual care. Again this finding is indicative of conceptual confusion. As discussed earlier, spiritual care is not confined to a religious framework, it also encompasses being moral, compassionate, and being human. In addition, it is possible for nurses to confuse the sign and symptoms of spiritual distress with problems psychological in origin and vice versa, therefore it is complex and difficult to separate psychological care from spiritual care and vice versa (McEwan, 2004). The important and necessary step is to maintain a person's sense of worth and personhood (McEwan), which may be impaired due to spiritual distress or mental health problems, through holistic approaches.

It is possible that when nurses perceive spirituality synonymously with religion and spiritual care as religious care, they may feel challenged to initiate a discussion on the topic of spirituality. In addition, as nurses may not be taught about world religions their fear of being misunderstood may stop them from integrating spiritual care, especially if religion and spirituality are equated. Also, because participants believed that spiritual care interventions such as praying, reading scriptures for patients, and calling a priest or an imam and facilitating their visit are time consuming, participants found it difficult to find time for these activities. Issues related to the shortage of nurses and heavy workloads were identified as barriers to the provisions of spiritual care. Some of the participants in the study voiced that they did not even have time to take their breaks due to workload. However, a few nurse participants thought that time was not an issue for them because providing spiritual care was not different or separate from physical care. They were of the opinion that during the clinical procedures, they talk, they listen, they show respect, and they show interest in their patients and this can be considered as providing spiritual care.

It remains however, that the issue related to shortage of nurses requires serious attention as it has a direct impact on spiritual care practices. For example, the essence of spiritual care is relational, nursing shortage limits nurses from developing personal interactions with patients and/or their family to identify their spiritual needs (Tiew & Creedy, 2010). Like many other countries, Tanzania is also facing a shortage of nursing staff (McIntosh & Stellenberg, 2009; TNMC, 2007). Health care organizations are required to take measures to deal with the

issue of shortage of health care professionals. Research has shown that when staffing is reduced due to an employer's budget cuts, it leads to unsafe patient care (McIntosh & Stellenberg, 2009). It is a vicious circle. Evidence suggests that when staff numbers are reduced, it not only cause negative patient outcomes but also leaves an impact on staff retention and recruitment (McIntosh & Stellenberg, 2009).

Modern healthcare systems must promote a balance between biomedical and spiritual approaches (WHO, 2008). It is unfortunate that the biomedical model of healthcare is propagated or publicized to an extent that the patients under the care of nurses do not see nurses providing spiritual care as much as physical and psychological care. For example, nine out of eleven patients in Davis's (2009) study did not expect their nurses to provide spiritual care to them because they perceived that nurses lacked time due to shortage and heavy workload. Patients in Cavendish et al., (2006) study also did not perceive nurses role to be providing spiritual care. They viewed clergy or family members as spiritual care providers. On some occasions, patients also create barriers to the provision of spiritual care. As stated by a few participants, some patients do not appreciate receiving spiritual care and prefer to receive only biomedical care. Again these findings highlight that, like nurses, patients may also be confused about differences between religion and spirituality. Perhaps another future study could be conducted to know what these patients see as spiritual care. One wonders however if nurses can still claim to be providing holistic care when the spiritual component of care is missing? Staff nurses alone cannot be blamed for this

deficit, the healthcare system and nurse leaders are equally responsible (Jenkins, Wikoff, Amankwaa, & Trent, 2009; Tiew and Creedy, 2010). Jenkins et al., in their study found that nurse leaders had lack of clarity between spirituality and religion and were inadequately prepared to direct or advocate for spiritual care.

The participants in this study perceived that providing spiritual care meant to take on an extra load in addition to a nurse's assigned workload when there were other important tasks to complete. According to Tiew and Creedy (2010), nurses' "view of spirituality as an added burden" is promoted by the organization's business model approach to services (p. 18). This approach towards spiritual care delivery was labelled by participants as a negative attitude of nurses and lack of commitment to the nursing profession. Nurses in other studies have also expressed similar perceptions (Anderson, 2006; Davis, 2009). For example, in Anderson's narrative inquiry study, one participant stated that nurses working in psychiatric and surgical units feel that they do not have time for spiritual care or that they have "more important things to do" (p. 86). Is spiritual care seen as a regular duty of nurses, by patients, hospital administrators, and employers? Further research in this area is necessary if the nursing discipline is to seriously consider spiritual care as part of nursing domain and not an optional extra.

The participants in the study also identified that not having a prayer place or a quiet space for mobile patients and their family members in the hospital settings was another challenge. The participants who had worked in other hospitals in Tanzania, before joining the current hospital, had seen built-in prayer facilities or

chapels and believed that the hospital environment has an impact on spiritual care. The other problem that was identified by participants in relation to institutions was the low salary structure. Although only two participants out of fifteen raised this concern, it is worth discussing this issue as it directly impacts nursing care in general and spiritual care in particular. Although a clear correlation has not been established, there could be a link between salary structure and spiritual care. Mutahaba (2005), in a seminar presentation on 'potential for public service pay reform to eradicate corruption among civil servants in Tanzania,' explicitly indicated that organizations which pay low salaries to their employees sustain harm insidiously before it can be noticed. He further stated that when employees' salaries do not meet their basic needs and they can not leave the organization, they tend to adopt a deviant work ethos. Some of the examples of such deviant behaviours include decreased good will, increased ill feelings, engaging in counterproductive behaviours, theft, and corruption. McCoy et al., (2008) also states that pay and income affect motivation, morale, performance, and retention. Like Mutahaba, they contend that poor pay motivates staff to privately engage in earning supplementary income through informally charging patients and many other activities that are harmful for any organization. Mutahaba in his report indicated that, "teachers, nurses, and registry clerks are often accused of taking bribes" (p. 23).

This is indeed a serious matter as participants in my study also indicated that when their own basic needs are not met and when they are struggling to supplement their income by rushing in order to be on time for additional work

they are stressed and they tend to concentrate on technical aspects of nursing tasks which do not include spiritual care. The chances of them providing spiritual care is lowest on their priority list. Secondly, spirituality was mentioned to be related to moral and ethical principles. How can spiritual care be offered if nurses are unethical? Organizations should revisit their salary structures and pay their employees in accordance to their qualifications or efforts made (Mutahaba, 2005).

As mentioned in a WHO regional office for the Western Pacific's report of 2008, "the whole organization ("the whole elephant")" (p. 10) needs to become people-centered to be able to provide quality care which includes spiritual care. Organizations are expected to be taking care of their employees too. Also, it was mentioned that the physical structure of the organization must promote a healing environment. Spiritual care is an integral part of nursing care and it would be unethical if nurses ignore spiritual care (Wright, 1998, as cited in Davis, 2009). The practice environment should be such that nurses and other health care professionals feel supported in the provision of spiritual care. Currently, it seems that the provision of this care is low on healthcare organizations' priority lists. For example, in the hospital from where participants were recruited, spiritual care was not explicit in their vision or mission statements although it did include compassion and ethics as core values. Health care organizations and nursing leaders have to develop guidelines to promote spiritual practice in hospital settings.

What astonishes me about the challenges or difficulties faced by nurses in implementing spiritual care is that there continues to be no resolution to issues

that were identified more than a decade ago. It is unfortunate that only a few steps have been taken to address some of the challenges. For example, the lack of education related to spirituality has led nursing education institutions to integrate the spiritual component of care into their curricula. Nursing schools in western countries have started including modules on spirituality but for the most part it is not addressed adequately (Callister et al., 2004; Mitchell, Bennett, & Manfrin-Ledet, 2006; Narayanasamy, 2006; Olson et al., 2003; Wallace et al., 2008). In Tanzania, most of the nursing schools implement the curriculum prescribed by the Ministry of Health and Social Welfare (MoHSW). The interviews with participants revealed that there was no content pertinent to spirituality and spiritual care in their curriculum. However, the faith based nursing schools added extra components related to spiritual matters.

Education modules on holistic care that encompasses the spiritual dimension are expected to help nursing students to develop sensitivity and the capacity to nurture the human spirit in their day-to-day practice (Beckman et al., 2007; Callister et al., 2004; Olson et al., 2003; Wallace et al., 2008). The Tanzanian diploma nursing curriculum has seven program objectives but none is related to spiritual knowledge. Applying "the knowledge of physical, biological, psychological and social sciences to the practice of nursing" (Department of Human Resources for Health Development, 2003, p. 3) is emphasized. Hence, the program includes content on physical, psychological, and social care but no content on spiritual care.

In light of the above, it is interesting that nonetheless the TNMC's nursing standards suggest that nurses "undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities" (TNMC, 2007, p. 3). There is a discrepancy between the national curriculum and the TNMC's standards for proficiency in nursing. It is unrealistic to expect nurses to be proficient in providing spiritual care when they are not taught about it in nursing schools. The findings from this study will be shared with the TNMC in Tanzania with the hope that components of spirituality and spiritual care will be included in the nursing curriculum in the near future.

McManus (2006) also suggests addressing spiritual and religious beliefs in nursing education and practice. Furthermore he states that health practitioners require working knowledge of the significance of spirituality in people's lives and methods through which spirituality can be developed and supported in nursing practice. He also stressed the importance of developing nurses' interpersonal skills and self-awareness. Harrington (1995) also emphasized the importance of spirituality education to promote clarification of nurses' own values and to help them learn to appreciate other values and beliefs.

Despite the above challenges, participants in this study still managed to provide spiritual care to their patients. In the following section I discuss the factors positively influencing spiritual care practice of study participants.

Factors that Positively Influence Spiritual Care Practice

The participants own awareness of spirituality, the way they had been brought up at home, having family values, and having religious values positively influenced their spiritual care practices. In addition, having studied in religious affiliated institutions and their commitment for the nursing profession motivated them to integrate spiritual care into their practice.

The individuals' awareness of spiritual self and faith traditions influences on spiritual care is consistent with the literature on spirituality and spiritual care (Anderson, 2006; Cavendish et al., 2007; Davis, 2009; Flannelly, Galek, Buchhino, Handzo, & Tannenbaum, 2005; Hood, 2004; Mauk and Schmidt, 2004; McClung, Grossoehme, Jacobson, 2006; McManus, 2006; McSherry, 2007; Molzahn & Shields, 2008; Reed 1992). These authors believe that nurse's awareness and understanding of spirituality is necessary to the provision of spiritual care. Some authors assert that when nurses have experienced spiritual awareness, they are better prepared to address their patients' spiritual needs, as they may be less apprehensive by beliefs and values of others (Lundberg & Kerdonfag, 2010; Murray & Zentner, 1993; Stranahan, 2001; Tanyi, 2002).

Lundberg and Kerdonfag (2010) have highlighted more factors that influence the provision of spiritual care than what has been stated by the participants in the study. For example, they included "nurse's age, experience, spiritual involvement, …, time, cultural factors, and education." (p. 1122). Hood et al. (2007) have concluded from their study that nurses acquire knowledge related to spiritual care either during, or even before their formal education

through experiential learning. They contend that nurses should "recognize the value of experiential learning for personal spiritual health as well as in assisting patients to explore spiritual issues" (p. 1205). However, Vance (2001) did not find any influence of age, education, or years of clinical experience on the provision of spiritual care. Further research in Tanzanian context need to be carried out to find the impact of the above factors on the provision of spiritual care.

In summary, nurses' positive attitudes towards spirituality and awareness would enhance spiritual care practice. Because nurses' spirituality significantly influences practice of spiritual care, it is imperative that nurses not only value experiential learning but also undertake spiritual education. Spiritual education should improve nurses' understanding and awareness of spiritual issues and prepare them to address person's spiritual needs (Lundberg & Kerdonfag, 2010).

Implications for Research, Practice, and Education

The findings from this research have implications for research, practice, and education.

Research

Future research studies to exploring spirituality and spiritual care must be carried out by involving diverse participants such as patients, patients' families, chaplains, physicians, social service care providers, and spiritual leaders of different faiths. It is important to study not only patients' and their families' perspectives of spirituality but also to explore their expectations of spiritual care from healthcare professionals. Families play an important role in African community and they are the primary caregivers. Therefore, knowing their

perspective is equally important. In addition, spiritual care ideally requires a multidisciplinary approach and the interventions used by the multidisciplinary team must be evaluated through on-going research to know if spiritual care needs are being met appropriately (Vance, 2001).

In this study, the views about spirituality and spiritual care were captured from nurse participants working in a private hospital. The nurse-patient ratio, availability of human and material resources, socio-demographic characteristics of patients, and method of supervision is usually different in different hospitals. It would be beneficial to explore and compare perceptions of nurses of the same phenomena but working in a government, private (faith-based and non-faith based), and semi-private hospitals. It is possible that nurses' perceptions of spirituality may not be much different but implementation of spiritual care and challenges of providing care may differ. Understanding these challenges is necessary to promote spiritual care practices regardless of the type of hospitals.

Another area which requires further research is exploring the role and functions of pastors and imams. If they are assuming chaplaincy roles, as described in western literature, then nurses and other health care professionals need to have clarity of these roles and functions so that chaplaincy resource can be effectively utilized.

Practice

If nurses claim to be holistic care providers, they have to make sure that spiritual care is integrated into their practice. In this study, nurses considered spiritual care as an important aspect of holistic care but their main emphasis was

on physical care rather than of spiritual care. Also, likely related to the confusion over spiritual care interventions versus religious care interventions, some of the participants did not think they were providing spiritual care. Expanding nurses understanding and knowledge related to spirituality and the difference between spirituality and religion, through continuing education sessions, could have a direct impact on spiritual care practice. The participants identified behaviours such as listening to patients, taking interest in them, and showing empathy, sympathy, and compassion as part of spiritual care interventions. Therefore, nurses demonstrating these behaviours when interacting with patients is essential.

The findings from this study suggest that some nurses have a negative attitude towards the provision of spiritual care. The underlying causes of these attitudes need to be explored by supervisors or nursing leaders and necessary steps should be taken to modify the behaviours so that spiritual caregiving practice is improved. To do this successfully, two way communication between the management and the staff is imperative. The study analysis also highlighted that nurses' may not be integrating mental health interventions when dealing with patients who believe being possessed by devils. It is imperative that nurses be able to address both mental health and spiritual care interventions.

Education

The findings from this study have highlighted nurses' confusion over the concept of spirituality and spiritual care. Nurses and nursing students must gain a wider perspective on spirituality and understand the difference between spirituality and religion. The Tanzanian nursing curriculum must develop and

implement content on spirituality and spiritual care. Understanding of spirituality from a cultural perspective is equally important hence content related to an African or Tanzanian perspective of care must be explicitly included in the curriculum.

In addition, nurses in this study did not mention integrating knowledge related to mental health when dealing with distressed, depressed, suicidal patients, and patients complaining of being possessed by devils or satan. Their main focus geared towards implementing religious care interventions and occasionally counselling a patient. Hence there is an implied need of providing education to nurses to view such cases not only in relation to religion or spirituality but also in the context of mental health.

For possible content on spiritual care including information on spiritual assessment instruments and specific teaching strategies, nurse educators may refer to various studies and text books in nursing and outside of nursing (Beckman, Boxley-Harges, Bruick-Sorge, & Salmon, 2007; Burkhardt & Nagai-Jacobson, 2002; Callister et al., 2004; Carson & Koenig, 2008; Greenstreet, 1999; van Leeuwen, Tiesinga, Middel, Post, & Jochemsen, 2008; Lovanio, & Wallace, 2007; Narayanasamy, 1999; Wallace et al., 2008).

Strengths and Limitations of the Study

The interpretive description (ID) approach used for this study allowed me to obtain an in-depth understanding of the phenomena of spirituality and spiritual care from Tanzanian nurses' perspective. Also, the design of the study enabled capturing knowledge beyond the expected research questions. Due to interpretive

description method's inclination to clinical context, the study generated spiritual care related findings which can be directly applied in the assessment and implementation of patient care. On one hand, the flexibility in study design in terms of data collection and data analysis strategy assisted me in broadening my perspective of qualitative methodology but on the other hand it was a challenge. As a novice researcher, I found it difficult to analyse data due to the openness left in choosing steps from generic qualitative research designs. However, this was not a limitation for me as my supervisors, who were experts in qualitative methodology, guided me through the process of analysis. The steps laid out in ID for rigor of a study facilitated in maintaining credibility of the study by following described criteria.

This study has contributed to the existing literature in important ways from the Tanzanian perspective. Tanzanian nurses' perspectives of spirituality and spiritual care is similar in some ways but distinctively traditional in comparison with Western perspective of spirituality. The knowledge and experience shared by the participants in identifying spiritual needs and responding to these needs may be utilized in developing a module on spirituality and spiritual care to enhance nurses' spiritual care practice and in guiding curriculum development.

Like any other research study, this study also has several limitations. It is possible that the participants who volunteered to take part in this study may have been particularly interested in the phenomenon of spirituality and the findings regarding spirituality and spiritual care might differ from those who did not participate in the study. As the participants in this study were Christians and

Muslims, it is possible that their perception of spirituality and spiritual care might not have captured perceptions of people following other faith traditions, having no religion, or belonging to different denominations within Christianity and Islam. The participants in this study self-identified their religious affiliation but did not state their denomination and as a researcher I did not inquire the specific religious groups. Having this information may have brought additional insights.

Recommendations

The participants in the study had some recommendations for enhancing spiritual care practice. Hence, the recommendations presented below include views from them as well as my own. Recommendations are presented in two categories: hospital services and nursing education.

Hospital Services

1. It would be advisable for hospitals to include spirituality and spiritual care in their vision or mission statements. This could potentially encourage employees to integrate spiritual care in their practice. Literature indicates that nurse leaders may play an important role in influencing hospitals to alter their mission statements, especially if they are themselves well educated about spirituality and spiritual care (Jenkins, Wikoff, Amankwaa, & Trent, 2009).

2. It would be advisable for hospitals to formalize chaplaincy services which can cater to the spiritual needs of patients, patients' families, and staff. Currently, the hospital where the study was conducted has informal clergy services, mainly meeting the religious needs of Christian patients. Chaplains have important roles to play in hospital settings and in Tanzania, if chaplaincy services

are not available then the role and function played by pastor and imam need to be explored by management and nurses. This endeavour will assist nurses in seeking their support to meet patients' spiritual needs.

3. It would be desirable for hospitals to allocate, within their premises, a quiet or a private space for prayer or for contemplation for patients and patients' families. Such facility can be used by patients and patients' relatives regardless of religious affiliation.

4. It would be desirable for hospitals to ensure that copies of the Bible and the Quran are made available for all patients.

5. The hospitals that have televisions for patients may want to consider subscribing to religious/spiritual television programs. Thai nurses in intensive care units provided their patients with such interventions and many families of these patients appreciated nurses efforts and felt comfortable and happy with them (Vance, 2001). The hospitals where televisions are not available, they may use radio for the same purpose as these programs are locally relayed on television and radio.

Nursing Education

1. To enhance knowledge and skills related to spiritual care, it is necessary that continuing education sessions be held for nurses and also for the multidisciplinary team. This strategy would also help in understanding the role and functions of each member in the multidisciplinary team to provide spiritual support. Teaching sessions should include the difference between spirituality and religion.

2. One of the concerns raised by some participants was improving communication and counselling skills of nurses. Developing and offering continuing education on counselling skills to nurses would be helpful. In addition to acquiring those skills, nurses could also be encouraged to use an appropriate and culturally sensitive tool or a combination of tools for spiritual assessment for their patients. It would be desirable that nurse managers identify and adopt a tool for spiritual assessment which could be used by nurses.

3. It is important and necessary that faculty teaching students and nurses have a broad understanding of spirituality and health, if they lack that understanding, they also should be offered additional education.

4. The nursing curriculum should be revised, as needed, to include content on spirituality and spiritual care and provide nursing students with an opportunity to learn and practice it in clinical areas with the assistance of faculty. Available literature on spirituality and the provision of spiritual care in nursing could be used to develop specific course content and teaching and learning strategies for integrating these topics into the curriculum.

5. It is also recommended that when implementing a course on spirituality and on the provision of spiritual care, cultural context should be integrated when teaching these topics. Lundberg and Kerdonfag (2010) states that spiritual needs are expressed based "on ethnic, religious and cultural backgrounds. Therefore, nurses should understand religious practices to be able to reduce patients' distress and enable them and their families to cope with illness and suffering." (p. 1127).

6. It is important for nurses to remain aware that, signs of anger, sadness, anxiety, or agitation, displayed by patients of this study participants, were behaviours that may have been reflected as psycho-social issues and not only as spiritual ones. Therefore, it is recommended that in teaching a course on spirituality and spiritual care, should discuss the relationship between psycho-social and spiritual issues. This will enable student nurses and nurses to address both mental health and spiritual care interventions.

Conclusion

The purpose of this study was to learn from Tanzanian nurses about their understanding of spirituality and their way of providing spiritual care to their patients in a clinical setting. Data analysis has revealed some interesting findings. For the participants in this study spirituality was considered an integral part of a person's wholeness and it carried implications for health and illness. The participants' understanding of the meaning of spirituality was similar to western nurses' views. Nurses are required to have clarity between spirituality and religion and must avoid limiting spirituality within an organized religious framework. The other important facet of spirituality highlighted in the study was moral and ethical conduct. Participants in this study often equated religion and spirituality. However, understanding spirituality beyond religious considerations is important to provide holistic care to patients and also to avoid excluding people who do not affiliate themselves with any organized religion. If care is to be holistic, nurses must integrate the psycho-social and spiritual dimensions as well as physical aspects of human beings.

Communication, patients' belief in devils and witchcraft, and patients' medical diagnosis and emotional responses were used as clues for participants to address spiritual needs of their patients. The participants in this study identified religious based and non-religious based spiritual interventions to respond to patients' spiritual needs. The participants incorporated patients' religious beliefs in their care and helped them maintain a relationship with a Higher Being/God through prayers, reading Holy Scripture, and consultation of pastor or imams. Non-religious based spiritual care interventions identified were demonstrating love, compassion, ethical behaviours, and providing counseling and reassurance. The importance of facilitating with the process of forgiveness was also emphasized. The participants believed that spiritual care promoted patients hope, inner peace, comfort, and happiness.

However, the participants faced a number of challenges when addressing spiritual care. Some of the challenges addressed were: shortage of time and staff, intangible nature of spirituality, lack of spiritual education, organization set up, and patients' demands. Despite those challenges, participants in this study said that they provided spiritual care. The positive factors that influenced spiritual care practices were their own awareness about spirituality, having religious values, and having commitment to the nursing profession.

It is hoped that the recommendations proposed in this concluding chapter will be useful for nursing practice and education. I believe that implementing them could lead to enhanced patient care. The findings of this study also have implications for research. In this chapter I have included a number of potential

research questions that have arisen from this study and I hope to have the opportunity to begin examining them as I embark into a new phase in my career.

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APPENDIX A: RESEARCH APPROVALS

Health Research Ethics Board

308 Campus Tower
University of Alberta, Edmonton, AB T6G 1K8
p. 780.492.9724 (Biomedical Panel)
p. 780.492.0302 (Health Panel)
p. 780.492.0459
p. 780.492.0839
f. 780.492.7808

APPROVAL FORM

Date: June 16, 2009

Principal Investigator:	Pauline Paul
Study ID:	Pro00005246
Study Title:	Tanzanian nurses understanding and practices of spiritual care

Expiration Date: June 15, 2010

Thank you for submitting the above study to the Health Research Ethics Board (Health Panel). Your application, along with revisions submitted June 8, 2009, has been reviewed and approved on behalf of the committee.

- Approval is granted with the understandig that a copy of the local ethics approval will be attached to this application once it has been obtained.

The ethics approval is valid until June 15, 2010. A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Health Research Ethics Board does not encompass authorization to access the patients, staff or resources of Capital Health or other local health care institutions for the purposes of the research. Enquiries regarding Capital Health administrative approval, and operational approval for areas impacted by the research, should be directed to the Capital Health Regional Research Administration office, #1800 College Plaza, phone (780) 407-1372.

Sincerely,

Glenn Griener, Ph.D.
Chair, Health Research Ethics Board (Health Panel)

Note: This correspondence includes an electronic signature (validation and approval via an online system).

UNIVERSITY OF ALBERTA Alberta Health Services Covenant Health

The Aga Khan Hospital, Dar es Salaam

An Institution of the Aga Khan Health Service, Tanzania

Ocean Road, P.O.Box 2289
Dar es Salaam, Tanzania
Telephone: 2115151/3, 2114096
Fax: 2115904/2115156
Email: agakhan@akhst.org

August 11, 2009

To whom it may Concern,

Reference to letter from the Ethics committee dated 14th July 2009; we here wish to confirm that Ms. Khairunnisa Aziz Dhanani can proceed with data collection at Our Institute.

Yours sincerely,

Dr. Jaffer Dharsee
Medical Director
Aga Khan Hospital
Dar es Salaam

THE UNITED REPUBLIC OF
TANZANIA

National Institute for Medical Research
P.O. Box 9653
Dar es Salaam
Tel: 255 22 2121400/390
Fax: 255 22 2121380/2121360
E-mail: headquarters@nimr.or.tz

Ministry of Health and Social Welfare
P.O. Box 9083
Dar es Salaam
Tel: 255 22 2120262-7
Fax: 255 22 2110986

NIMR/HQ/R.8a/Vol. IX/878

28th August 2009

Khairunnisa Dhamani
Aga Khan University –TIHE
Ufukoni Road
P O Box 38129
DAR ES SALAAM

CLEARANCE CERTIFICATE FOR CONDUCTING MEDICAL RESEARCH IN TANZANIA

This is to certify that the research entitled: Tanzania Nurses' Understanding and Practice of Spiritual Care (Dhamani K *et al*), has been granted ethics clearance to be conducted in Tanzania.
The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is made available to the Ministry of Health and the National Institute for Medical Research, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine.
5. Approval is for one year: 28th August 2009 to 27th August 2010.

Name: Dr Mwelecele N Malecela

Signature

ACTING CHAIRPERSON
MEDICAL RESEARCH
COORDINATING COMMITTEE

Name: Dr Deo M Mtasiwa

Signature

CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH, SOCIAL
WELFARE

CC: RMO
DMO

APPENDIX B: INFORMATION SESSION

Title of Research Study: Tanzanian Nurses' Understanding and Practice of Spiritual Care

Investigator: Khairunnisa Dhamani, RN, MSN, PhD (C)

Co-Supervisors: Pauline Paul, PhD, RN & Joanne Olson, PhD, RN

I am a doctoral student in the Faculty of Nursing at the University of Alberta, Canada. I am an employee of Aga Khan University. Currently I am at home in Dar es Salaam to collect data for this study.

I am conducting a study to learn from Tanzanian nurses about how nurses provide spiritual care to their patients.

You can participate if you:
- are a working with patients as a registered nurse
- have more than 1 year of clinical experience, and
- are willing to talk with me in English.

If you agree to participate we would have a conversation about your views on providing spiritual care to your patients. This conversation would take around 1 to 2 hours of your time. It would take place at Aga Khan University-Tanzania Institute of Higher Education at a time that is good for you.

Your participation in the study is voluntary. You may withdraw from the study at any time without giving me a reason. Participation in this study will not affect the conditions of your employment and your employer will not know that you are participating. You are free to say yes or no to any part of the study. You can stop the interview at any time by just telling me, and you may refuse to answer any question.

You will be reimbursed for your transport costs and telephone calls soon after the interview is complete.

To find out more about the study, you can call me at 0784479048 or e-mail dhamani@ualberta.ca. After we have talked, you can decide to take part in the study.

Note for ethics reviewers:
Flesch-Kincaid Grade level: 8.3

APPENDIX C: RECRUITMENT ADVERTISEMENT

Title of Research Study: Tanzanian Nurses' Understanding and Practice of Spiritual Care

Investigator: Khairunnisa Dhamani, RN, MSN, PhD (C)

Co-Supervisors: Pauline Paul, PhD, RN & Joanne Olson, PhD, RN

Looking for Registered Nurses

Views about Spiritual Nursing Care

I am a doctoral student in the Faculty of Nursing at the University of Alberta, Canada. I am an employee of Aga Khan University. Currently I am at home in Dar es Salaam to collect data for this study.

I am conducting a study to learn from Tanzanian nurses about how nurses provide spiritual care to their patients.

You can participate if you:
- are a working with patients as a registered nurse
- have more than 1 year of clinical experience, and
- are willing to talk with me in English.

If you agree to participate we would have a conversation about your views on providing spiritual care to your patients. This conversation would take around 1 to 2 hours of your time. It would take place at Aga Khan University-Tanzania Institute of Higher Education at a time that is good for you.

You will be reimbursed for your transport costs and telephone calls soon after the interview is complete.

To find out more about the study, you can call me at 0784479048 or e-mail dhamani@ualberta.ca. After we have talked, you can decide to take part in the study.

Note for ethics reviewers:
Flesch-Kincaid Grade level: 9.4. However, if "Aga Khan University-Tanzania Institute of Higher Education" is removed the reading level becomes 8.3.

APPENDIX D: QUESTIONS AND PROBES

Title of Study: Tanzanian Nurses' Understanding and Practice of Spiritual Care

For the interviews I will use open-ended questions related to spirituality:

1. What does spirituality mean to you?
2. What does spiritual care mean to you?
3. How do you recognize the spiritual needs of your patients?
4. How do you respond to patients' spiritual needs?
5. Tell me about a time when you practiced spiritual care.
6. Do you have chaplain services in the hospital to deal with patient's spiritual matters or spiritual issues?
7. Do you work with chaplains, priests, spiritual care givers, medicine men, or divine healers when dealing with patients' issues while in the hospital?
8. What are some of the challenges in addressing the spiritual dimension of care?
9. How have you learned about spiritual caregiving?
10. Did your nursing education prepare you to assess and provide spiritual care?
11. How are spirituality and religion related?

APPENDIX E: INFORMATION LETTER FOR INTERVIEWS WITH

REGISTERED NURSES (RNs)

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Title of Research Study: Tanzanian Nurses' Understanding and Practice of Spiritual Care

Investigator: Khairunnisa Dhamani, RN, MSN, PhD (C)
Aga Khan University – TIHE, Ufukoni Road, Plot # 42
P.O. Box 38129, Dar es Salaam, Tanzania
dhamani@ualberta.ca
(255) 22 212-2740

Co-Supervisors:

Pauline Paul, PhD, RN
Associate Professor, Faculty of Nursing
3-134, Clinical Sciences Building,
University of Alberta
Edmonton, AB, T6G 2G3
pauline.paul@ualberta.ca
(780) 492-7479

Joanne Olson, PhD, RN
Professor & Associate Dean, Undergraduate Program
Faculty of Nursing, 3-134, Clinical Sciences Building
University of Alberta, Edmonton, AB, T6G 2G3
joanne.olson@ualberta.ca
(780) 492-6252

THE STUDY:

One of nurses' duties is to care for the spiritual needs of patients and families. Most studies on this topic have been done in western countries. We would like to study this topic with Tanzania nurses.

We would like to know Tanzanian nurses' views about spiritual nursing care.

If you decide to participate in this study I will interview you about your views on providing spiritual care to your patients. It will take around 1 to 2 hours of your time. It will take place at Aga Khan University-Tanzania Institute of Higher Education at a time that is good for you. I will also ask you to give me some basic information about yourself (e.g. age range, gender, clinical experience).

The interviews will be audio-taped and then typed. I may contact you if I need clarifications after I have typed your information. You will have the option of seeing the typed version and of changing things in it if you wish.

Sometimes people who participate in a study remember important information after the interview has been completed. I am interested in all of your views on spiritual nursing care and would be happy if you shared these thoughts with me. If you wish to do this you could mail or email me.

There are no direct benefits to you for participating in this study. However, you may find our discussion on spiritual nursing care useful to you.

There are no known risks to taking part in this study. However, some individuals may feel uncomfortable talking about their experience. If you need to take a break or stop completely you will be able to do so.

All information will be kept private. Only I and my co-supervisors will have access to the data. However, only I will know your name. I will identify you in the reports of the study using a false name.

Data will be stored in locked cabinets. I will keep your records for at least five years after the study has been completed and one of my co-supervisors in Canada will keep an electronic copy of the data for the same period of time.

The information collected for this study might be looked at again in the future to answer other questions. If this happens, the ethics board will first review the new study to make sure that your information is used ethically.

Your participation in the study is voluntary. You may withdraw from the study at any time without giving me a reason. Participation in this study will not affect the conditions of your employment and your employer will not know that you are participating. You are free to say yes or no to any part of the study. You can stop the interview at any time by just telling me, and you may refuse to answer any question.

You will be reimbursed for your transport cost (TSh 20,000) for each visit and telephone calls (TSh 5,000).

If you have any concerns about your rights as a study participant, you may contact Dr. Christine Newburn-Cook, Research Office, Faculty of Nursing, University of Alberta (780-492-6764) or Mavis Yengo, Academic Head, Advanced Nursing Studies Programme, Aga Khan University (2122740/2122744). This office has no direct affiliation with the study investigators.

If you have any questions about the study, contact Khairunnisa Dhamani at 0784-479048 or e-mail dhamani@ualberta.ca

Please keep a copy of this letter for reference.

Participant initials: _____ Witness initials: _____

Note for ethics reviewers:

Flesch-Kincaid Grade level is 8.1.

APPENDIX F: CONSENT FORM

FACULTY OF
NURSING
UNIVERSITY OF ALBERTA

Part 1:

Title of Project: **Tanzanian Nurses' Understanding and Practice of Spiritual Care**

Principal Investigator: Khairunnisa Dhamani Phone Number: 0784-479048

Co-Supervisors: Dr. Pauline Paul Phone Number: (011) 780-492-7479

Dr. Joanne Olson Phone Number: (011) 780-492-6252

Part 2 (to be completed by the research subject):	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting conditions of your employment?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to the research information?	☐	☐
Do you agree to have the interview audio-taped?	☐	☐

Who explained this study to you?

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Participant_____

(Printed Name) _____ Telephone Number _____

Date _____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator _____ Date _____

APPENDIX G: DEMOGRAPHIC DATA SHEET

Title of Study: Tanzanian Nurses' Understanding and Practice of Spiritual Care

Please provide me with some of your personal information. It will take about five minutes to complete this data sheet. I will handle all information provided in a confidential manner.

May I thank you in advance for completing this data sheet.

Code # _____ Gender: Female _____ Male _____

Age range in years: 20-25 ☐ 26-30 ☐ 31 – 35 ☐ 36 – 40 ☐

41 & above ☐

Highest qualification: Diploma Nursing ☐ BSc Nursing ☐

Advanced Diploma ☐

How long have you been qualified as diploma nurse? Please state number of

years: _____

How many years of clinical experience do you have? Please state number of

years: _____

Have you worked outside of Aga Khan Hospital since your graduation? Yes ☐

No ☐

If yes, please tick in the box provided the type of the hospital in which you have

worked:

Public: ☐ Private for profit ☐ Private for non-profit ☐ Faith based ☐

Others _____

Please state the current unit/ward of your clinical practice: _____