CHAPLAINCY IN SOUTH AFRICAN GOVERNMENT HOSPITALS: A HOLISTIC APPROACH TO CARE

By

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DECLARATION

I am hereby declaring that the study titled "Chaplaincy in South African government hospitals: a holistic approach to care" submitted to the University of Pretoria for the degree of Doctor of Philosophy in the subject of Practical Theology and Religion has not previously been submitted to any other university or institution. It is my own work in design and execution. In addition, the references used or quoted therein have been duly acknowledged.

………………………………………….. ……………………………………………

SE Mabe Date

DEDICATION

I dedicate this work to God the Father, God the Son, and God the Holy Spirit Who gave me compassion to care for the sick and the hospitalised, and the wisdom and strength to undertake this project with passion.

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ABSTRACT

The consumers of health care (patients) want their religious and spiritual needs to be addressed within the South African Government Hospitals' (SAGH) settings. Similarly, the providers of health care (doctors, nurses, and other clinical staff in the multi-disciplinary health care teams) are not religious and spiritual experts to respond to these needs in the health care settings. Therefore, this challenge can be resolved by the Department of Health (DoH) by recognising and embracing the health care chaplaincy. On the same vein, the DoH must employ a holistic and patient-centred medical model in its clinical approach to care. This will translate into the patients' religious and spiritual needs being provided by the religious and spiritual experts in the SAGH settings. This approach ensures that these services are not counter-productive to the medical approach. The other challenge is lack of trained and licenced providers of religious and spiritual care to practice in the clinical setting by employing the methods which are supported by scientific evidence.

The purpose of this research is to investigate a need for the possible establishment of chaplaincy in South African Government Hospitals for holistic approach to care which includes the patients' religious and spiritual dimensions of being, with a view to develop a chaplaincy model that is responsive to the patients' religious and spiritual needs. The DoH is expected to provide a well-balanced, holistic and patient-centred health care to all the SA citizenry which resonates with the Constitution of the RSA (1996), the NPRC, the WHO (2010) principles, and global health care norms, standards and principles on addressing the patients' religious and spiritual needs through the practice of the professional health care chaplaincy.

The study employed a qualitative research designs of ethnography (participant observation), to gather first-hand information (data) at the research field, that helps to describe how the religious and spiritual needs are addressed in the SAGH settings; phenomenological approach, to gather information (data) that describe the meaning of the lived experiences of the caregivers and patients in the health care settings; and grounded theory, by analysing and interpreting data from research interviews, in order to explore theory of health care chaplaincy in the SAGH settings with a view to understand its phenomenon.

The study followed Osmer's four task of Practical Theological Interpretation (PTI) as a framework and plan to guide the process of the study, and on how to interpret and respond to the challenges of this research project. The researcher was a participant observer at the PHC research field, purposively sampled and conducted semi-structured interviews with 30 research participants at the PHC research field who consented. The researcher employed a computer spreadsheet to capture, code, analyse and interpret data

from the research interviews. The researcher applied a collective social scientists' approaches from Babbie (et al.), Corbin and Strauss, Flick (et al.), Neuman, Osmer, and Ritchie (et al.).

The researcher followed the Limpopo Provincial Department of Health's (LPDoH) approval letter, applied the ethical principles as prescribed by the University of Pretoria's Research Ethical Committee (REC) in tandem with the World Medical Association Declaration (WMA) of Helsinki (2013), and the PHC protocol from the DoH and Social Development (SD)/ abbreviation DoHSD, during the entire course of this project.

The findings of this research show that there is a need for the establishment of chaplaincy in South African Government Hospitals, and that the DoH need to review its health policy and the medical model with a view to embrace a professional chaplaincy, as experts to respond and address the patients' religious and spiritual dimensions of being in the clinical health care settings, as member of a multi-disciplinary health care team. The findings provide recommendations towards addressing the patients' religious and spiritual needs to ensure that the SAGH provides the holistic-patient-centred needs.

KEY WORDS: *Chaplain, Chaplaincy, Holistic approach, Religious, and Spiritual Dimensions of Being*

LIST OF ABBREVIATIONS

ACRP	:	Association of Christian Religious Practitioners
APC	:	Association for Professional Chaplains
BPS	:	Biopsychosocial
BPS-S	:	Biopsychosocial-Spiritual
CBO	:	Community Based Organisation
CEO	:	Chief Executive Officer
COHSASA	:	Council for Health Service Accreditation in South Africa
CRL	:	Culture, Religion and Language
DCS	:	Department of Correctional Service
DENOSA	:	Democratic Nursing Organisation of South Africa
DoH	:	Department of Health
DoHE	:	Department of Higher Education
DoHSD	:	Department of Health and Social Development (DoHSD)
EMS	:	Emergency Medical Services
FBC	:	Faith Based Communities
FBO	:	Faith Based Organisation
GDP	:	Growth and Development Plan
HCC	:	Health Care Chaplaincy
ICU	:	Intensive Care Unit
IOM	:	Institute of Medicine
JCAHO	:	Joint Commission on the Accreditation of Healthcare Organizations
LoGS	:	Letters of Good Standing
LP	:	Limpopo Province
LPDoH	:	Limpopo Provincial Department of Health
LPG	:	Limpopo Provincial Government
LPGH	:	Limpopo Provincial Government Hospitals
LPH	:	Limpopo Provincial Hospitals
MEDUSA	:	Medical University of Southern Africa
NHS	:	National Health Service
NPRC	:	National Patients' Rights Charter
OPD	:	Out Patient Department
PHC	:	Pietersburg Hospital Campus

POWH	:	Prince of Wales Hospital
PPT	:	Planned Patient Transport
PT	:	Practical Theology
PTI	:	Practical Theological Interpretation
REC	:	Research Ethics Committee
RHT	:	Refuse Hospital Treatment
RSA	:	Republic of South Africa
SA	:	South Africa
SADoH	:	South African Department of Health
SAGH	:	South African Government Hospitals
SAHCP	:	South African Health Care Policy
SAHCS	:	South African Health Care System
SAHS	:	South African Health System
SANDF	:	South Africa National Defence Force
SAPS	:	South African Police Service
TVBC	:	Transkei, Venda, Bophuthatswana, Ciskei
UPFS	:	Uniform Patient Fee Schedule
WHO	:	World Health Organisation
WMA	:	World Medical Association
WMAD	:	World Medical Association Declaration
ZCC	:	Zion Christian Church

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CHAPTER 1

BACKGROUND AND INTRODUCTION OF THE STUDY

1.1 BACKGROUND OF THE STUDY

Studies show the increase recognition within contemporary Western medicine of the significant links between religion and health, and the need for health professionals to understand their patients' spiritual/religious beliefs and practices (Rumun, 2014:39). Spirituality and religion are seen as a core aspect of life, and patients want physicians to address issues of spirituality in the context of medical care, (Kliewer, 2004:616). Conversely, physicians and nurses feel inadequate to address patients' religious and spiritual needs (McDowell, 2017:1). Therefore, this study aimed at investigating the need for the establishment of chaplaincy in the South African Government Hospitals (SAGH) to address the patients' needs in a structured and a professional approach within the hospital settings.

The patients' spritual needs are posing global challenges on how to address them in the health care settings. VandeCreek and Burton (2001:82) agreed that the "*spirit is a natural dimension of every person,*" and that spirituality demonstrates persons are not merely physical bodies that require mechanical care. People find that their spirituality helps them maintain health, cope with illnesses, trauma, losses, and life transitions by integrating body, mind and spirit. There is increasing evidence that the patients rely on their spiritual and religious beliefs to help them cope with loss, stress, and illness (Galek et al., 2007; Taylor at el., 2015). They are becoming the center of care and take more active role in planning what treatment they receive. Therefore, there is a growing body of evidence showing a relationship between religion, spirituality, and health (Orton, 2008:114), and a concern about the importance of addressing patients' faith needs in the health care context (Timmins et al., 2017:2). In a hospital context, Sheikh et al. (2004:2) highlight that spiritual care is often coordinated and provided by chaplains. Ideally, hospital chaplains do not seek to displace local religious leaders, but rather aim to work synergically with their community colleagues in filling the specific requirements involved in delivering care in an often intense medical environment (Gibbons & Miller, 1989). While spiritual care is usually regarded as patient focussed, chaplaincies also have a role to play in assisting and supporting staff in their dealings with patients, and in coping with their ethical complexities of modern health care. Chaplains are often regarded as neutral figures, outside the usual staffing hierachies and thus as sources of help and support that can be accessed without risk of negative repercussions. Chaplains may also play an important role in helping

staff members cope with personal problems. Their supportive consultation can enhance morale and decrease staff burnout, thus reducing employee turnover and the use of sick time.

The researcher served in the South African Police Services (SAPS) as a chaplain for twenty-five (25) years, and was tasked among others, to visit the hospitalised SAPS employees and their families for pastoral care and support. However, the following challenges were prevalent at government hospitals: Most often than not, permission to visit patients was not granted if those visits were not conducted during the scheduled visiting hours. Sometimes a special permission to visit patients would be granted by health care authority only during emergency cases. Be that as it may, the interactions with patients would lack privacy because of the hospital settings (hospital ward accommodates six patients), or visitors who may be visiting in the same ward. However, the interventions would generally not be confidential, monitored or supervised by the health managers, nor assessed or evaluated to determine the impact they might have on the patients. Sometimes the visiting times would lapse even before the pastoral care or counselling was provided. These situations would create discomfort among the patients who requested the chaplain to perform sacred ceremonies in the hospital wards, those who opted not to take any part, and the caregivers who might be disrupted to perform health care procedures or routine duties.

From a bird's eye view, the developed countries are advanced and have set global trends and best practices in health care chaplaincies which resonate with the World Health Organisation's (WHO, 2010) components of a well functioning health system. However, the African context, more especially in South African health care settings, the phenomenon of health care chaplaincy is not well understood nor embraced. Similarly, when zooming closer to South African health care settings, chaplaincy is non-existent, or it is still in its infancy, and yet, few current studies were conducted on the involvement and role of the church, Community Based Organisation (CBO) and Faith Based Organisations (FBO) in the health care settings. However, no study was conducted in the South African Government Hospitals (SAGH) settings on the need for the establishment of a hospital chaplaincy for a holistic approach to care.

From an African context, South Africa (SA) in particular, there are chaplaincies in the law enforcement agencies (the army, the police and the prisons). However, research has shown that the patients' religious and spiritual care in the health care settings are not structured as compared to the law enforcement agencies. Secondly, religious and spiritual care in the health settings are provided from the multi-faiths, multi-religious and traditional backgrounds. Thirdly, there are no hospital chaplains appointed as professional experts to address the patients' religious and spiritual needs in the health care settings. This poses the question of 'What is the South African Department of Health's (SADoH) policy position

regarding the organisational structure of the SAGH, since the specific challenge in the SA health care settings is the exclusion of health care chaplaincy (religious and spiritual experts) to provide spiritual care to the patients?' This translate into the patients' religious and spiritual needs being provided voluntarily by lay members from the religious and spiritual communities, or by the unprofessional religious and spiritual leaders, or by the representatives of faiths from the diverse cultural and religious and spiritual backgrounds.

This approach is problematic in that patients are vulnerable to those who provide religious and spiritual care in the SAGH settings through unconventional methods. It can be argued that their services are not substantiated or supported by any scientific evidence, to ensure that they are ethical, and do not violate the rights of the patients. Again, this approach is also counter-productive, and it is the antithesis of the professional medical approach. Similarly, these practices are not regulated, assessed, monitored nor supervised. Furthermore, there is no institutional oversight mechanism to evaluate what value and impact they have on the patients' health. However, there is no professional body in South Africa to ensure that the religious and spiritual care is regulated for the religious and spiritual caregivers to practice in the South African Health Care (SAHC) settings. Based on these realities, it can be argued that the South African Health Care System (SAHCS) continues to operate on the model of care that is not responsive to the patients' religious and spiritual needs. The above challenges need to be addressed within the context of the SAGH settings to provide a holistic health care in tandem with the patients' rights charter.

The study seeks to investigate this question: 'Is there a need for the establishment of chaplaincy in the SAGH for a holistic approach to care that includes the patients' religious and spiritual dimensions of being?' Unless this study is conducted, the SAGH would continue violating the patients' right to considerate care. When the researcher complexify the SAHC settings, the inconclusive evidence is that the patients' religious and spiritual needs are not catered for, nor embraced in their health care and treatment plans. Why is there no chaplaincy to address the patients' religious and spiritual needs? Why is chaplaincy so insignificant, unrecognised, and unimportant in the health care settings? According to Swinton (et al. 2006:13-14), *"to complexify something is to take that which at first glance appears normal and uncomplicated and through a process of critical reflection at various levels, reveals that it is in fact complex and polyvalent."* Hence the study unpacked these challenges by employing Osmer's (2008:4) approach for the purpose of this research: 'What is going on? Why is this going on? What ought to be going on? and How might we respond?' Puchalski (2001:1) highlights that man is not destroyed by suffering; he is destroyed by suffering without meaning. The religion and spirituality form the basis of meaning and purpose for many people, including many patients. Louw (1994:61) concurs, and Koenig

(2001:98) agrees that only religion can answer the question of the purpose of life. The idea of life having a purpose stands and falls within the religious system. Without purpose there is no direction. Purpose driven, holistic health care intervention, is very critical to respond to what is going on in the SA hospitals regarding the patients' religious and spiritual needs.

1.2 RESEARCH METHODOLOGY

The researcher explores the research design, methodology, and methods which were employed with a view to conduct the empirical research study to answer the research questions. The researcher has further triangulated the qualitative research methods, such as observations (ethnography) and interviews with the research participants at the Pietersburg Hospital Campus (PHC) settings, with a view for: the investigation into the need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being.

1.3 RESEARCH DESIGN

Myers et al. (2014:82) agree that any research has a design, and this includes qualitative research. Research design is defined by Selltiz et al. cited in Mouton and Marais (1993:32) as follows: *"A research design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure."* The objective of the research design is *"to plan, structure and execute the project concerned in such a way that the validity of the findings is maximized"* (Mouton & Marais, 1993:193). This is in tandem with Osmer's (2008:47-64) four steps that are basic to the research design which are highlighted below:

- Clarity about the purpose of the project;
- Choice of a strategy of inquiry;
- Formation of a research plan and execution of it; and
- Reflection on the assumptions informing a particular project.

According to Osmer (2008:47-49), clarity about the purpose of the project, implies the specific reasons for carrying out research and a clear statement of which questions are designed to be answered. However, the reason for this study is to investigate the need for the possible establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes patients' religious and spiritual dimensions of being.

1.4 PROBLEM STATEMENT

There is no health care chaplaincy in the South African Government Hospitals (SAGH) as part of the health care teams, which translates into a lack of professional experts on the teams to look after the patients' religious and spiritual needs. This makes the rendering of a holistic approach to care impossible, because the patients' religious and spiritual needs are not addressed at the South African health care settings. This is compromising the patients' rights to considerate care which embrace their religious and spiritual needs in the health care treatment plans. According to Rumun (2014:47), *"incorporating spirituality or religion into healthcare requires the same skills that competent practitioners already use in the delivery of person-centred care. These skills are underpinned by the principles of respect and collaboration."* Hence the study sought to answer this research question; Is there a need for the establishment of chaplaincy in the South African Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being? Conversely, the SA health caregivers (doctors, nurses, social workers, psychologists and others) are not trained and skilled to respond to the patients' religious and spiritual needs. This problem is compounded by the medical model of care which does not embrace the religious and spiritual needs of the patients in the multi-disciplinary health care teams. Similarly, the services of the religious and spiritual leaders who provide the patients' religious and spiritual care in the SAGH settings, are not structured nor integrated into the health care teams. Therefore, the religious and spiritual practices are voluntary, fragmented, not regulated, not monitored, not supervised nor documented to evaluate its value and impact on the patients' health care.

Nevertheless, the patients and health caregivers (doctors, nurses, social workers, psychologists and others) at the SAGH settings, are faced with challenges which are related to the religious and spiritual dimensions of being human. The SAGHs do not have a structural approach to address the holistic needs of the patients which embrace the spiritual dimension of being. On the same vein, the health care chaplaincy as professional experts, who are skilled to provide the patients' religious and spiritual care as members of the health care teams, are not recognised. This situation has resulted in many patients struggling to cope with their illnesses because the SAHCS employs a medical model which does not embrace the patients' religious and spiritual needs in their treatment plans. On the contrary, many patients refuse hospital treatment (RHT), and are discharged from the SAGH since the current medical approach is not responsive to their religious and spiritual needs. This practice, however, compromises the patients' rights to considerate care when they are treated in the SAHC facilities. On the same vein, the patient-centred approach is not employed in that the patients are not at the centre of their health care, and do not take active role in planning how they are to be treated, what are their needs, wishes and

expectations. Similarly, the holistic approach is not employed in that all the patients' dimensions of being (body, soul and spirit) are not embraced when planning for the patients' treatment and care in the SA health care facilities.

The global studies show that it is critical in a patient-centred approach to care, to understand the patients' worldviews in the provision of a holistic care. According to Haynes et al. (2007:2), *the concept of a 'spiritual worldview' incorporates religion and spirituality, as well as many other philosophical or popular beliefs and reference points that make assumptions about the larger context of human existence*. Haynes et al. (*ibid*) further state that for many people, their worldview is the most important thing in their lives with a deciding role in directing behaviour; guiding attitudes to health, work and relationships; and strongly influencing how they regard themselves and others. Haynes et al. (*ibid*) argue that understanding religious and spiritual as dimensions of a person's 'spiritual worldview' helps the caregivers to be responsive to the complex and diverse ways in which people personalise their beliefs.

According to Woodward (2010), the health care chaplains know and understand the medical as well as the religious and spiritual worlds. Similarly, chaplaincy can become a critical member of the health care teams from a non-medical approach since the practices of the health care chaplains are regulated and supervised within the health care settings, to ensure that the diverse patients' religious and spiritual needs are met (Chung, 2009; Galek et al., 2007; Handzo, 2006; Haynes, 2007; Mowat & Ryan, 2202; Puchalski, 2001; VandeCreek & Burton, 2001). However, it is very critical, in the context of SAHC, to investigate this research question; Is there a need for the possible establishment of chaplaincy in the South African Government Hospitals for a holistic approach to care that includes patients' religious and spiritual dimensions of being? in response to the patients' holistic needs.

1.5 RESEARCH OBJECTIVES

This empirical research sought to investigate further professional experts (the primary source) who are within the SAGH multi-disciplinary health care teams, who can provide the patients' religious and spiritual care through a holistic approach to care. The researcher reviewed literature (secondary sources) to explore the global health care trends and practices which embrace the patient-centred approach to care, and the modern health care chaplaincy who are expert to provide the religious and spiritual care to the patients throughout their health care journeys. Therefore, there were three critical objectives covered by this empirical research study:

- To explore why chaplaincy is excluded from the SAGH settings for patients' religious and spiritual dimensions of being, with a view to investigate a need for the establishment of chaplaincy
- To explore chaplaincy roles and values (within health care teams) in the SAGH settings
- To develop a chaplaincy model that embraces a holistic approach to care in the SAGH settings

1.6 RESEARCH QUESTIONS

According to Corbin et al. (2008:25), *"the research question in a qualitative study is a statement that identifies the topic area to be studied and tells the reader what there is about this particular topic that is of interest to the researcher."* Corbin et al. (2008:19) further state that research question is the specific query to be addressed by the research. The question sets the parameters of the project and suggests the methods to be used for data gathering and analysis. The study sought to answer the following research questions in tandem with the research objectives:

- Why there is no health care chaplaincy in the SAGH settings?
- Why it is imperative to establish health care chaplaincy in the SAGH settings?
- What are the values and the roles of health care chaplaincy in the SAGH settings?
- What model of health care chaplaincy will be effective in the context of the SAGH settings?

The researcher has grounded the above research questions on the Constitution of the Republic of South Africa (RSA) of 1996, with a view to advance a health policy change towards a patient-centred, and a holistic approach to health care in the SAGH settings. This approach has illumined, elucidated and tested the applicability and relevance of the Constitution of the RSA in relation to the religious and spiritual needs of patients in health care, and how the SAGH can effectively and efficiently address them in tandem with the global health care chaplaincy trends and practices. This is in resonance with the relevant prescripts of the Constitution of the RSA (1996) on Chapter 2 of the Constitution on the Bill of Rights, Section 15, (Freedom of religion, belief and opinion) and Section 27, (Health care, food, water and social security).

According to the Constitution of the RSA (1996):

> *Everyone has the right to freedom of conscience, religion, thought, belief and opinion. Religious observances may be conducted at state or state-aided institutions, under certain provisions; and that everyone has the right to have access to- health care services, including reproductive health care.*

This is in tandem with the contents in the Constitution and Public Health Policy, Section 27. VandeCreek and Burton (2001:83) highlight this concerning the patients' rights. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 1998) makes clear that the patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychological, and spiritual values. Therefore, these fundamental patients' rights are very critical in determining the patients' provision of health care.

The researcher has collected data by observing and interviewing the Respondents (highlighted below) in their natural settings (SAGH environment), in response to the research questions and the research objectives.

- The PHC management;
- The PHC health care professionals (doctors, nurses, social workers, psychologists and other clinicians); and
- The PHC patients over the age of 18 and not mentally or legally incompetent.

1.7 RESEARCH METHODOLOGY AND METHODS

According to Omer (2008), research methodology is a particular methodology guiding a research project, connecting the methods used to the desired outcome. The methodology was explored by the researcher in relations to the strategic enquiries. The researcher employed the qualitative research methodology to guide this study in order to address the research topic. According to Creswell (2007:37), *"qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of a research problem inquiring into the meaning individuals or groups ascribe to a social or human problem."* To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is inductive and establishes patterns and themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, and a complex description and interpretation of the problem and it extends the literature or signals a call for action. The assumption on the role of chaplaincy in health care, the belief system and spiritual worldview of the patients, and the meaning they ascribe to their health resonates with the qualitative research methodological approaches of phenomenology, ethnography and grounded theory. "*They are relevant strategies of inquiry to explore the meanings of the patients' experiences, values and beliefs, religious and cultural practices"* (Literature Review, 2010:69; Swinton & Mowat, 2006:33).

Mouton and Marais (1993:155-156) state that quantitative approach may be described in general terms as *"that approach to research in the social sciences that is more highly formalized as well as more explicitly controlled, with a range that is more exactly defined, and which, in terms of the methods used, is relatively close to the physical sciences."* In contradiction, qualitative approaches are those approaches in which the procedures are not as strictly formalised, while the scope is more likely to be undefined, and more philosophical mode of operation is adopted. According to Osmer (2008:49-50), "*quantitative research gathers and analyses numeric data to explore relationships between variables*." Qualitative research seeks to understand the actions and practices in which individuals and groups engage in everyday life and the meanings they ascribe to their experience. Quantitative research is especially helpful in discovering broad statistical patterns and relationships. Qualitative research is better suited to study small number of individuals, groups, or community in depth.

De Vos et al. (2011) highlight that Denzin and Lincoln (2005) prefer to call methodologies such as ethnography, phenomenology and the biographical method 'strategies of enquiry, or tools' that can be used to design qualitative research. Swinton and Mowat (2006:29-30) emphasize this view by stating that *"qualitative research is a multi-method in focus, involving an interpretative, and naturalistic approach to its subject matter."*

This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. It is noteworthy that the operative words in this qualitative study are many methods, multi-method, or variety of methods. The researcher's view in employing these strategies of inquiry was to ensure the maximisation of data collection.

According to Swinton and Mowat (2006:29-30), *"qualitative research involves the utilisation of a variety of methods and approaches which enable the researcher to explore the social world in an attempt to access and understand the unique ways that individuals and communities inhabit it."* It assumes that human beings are 'interpretive creatures;' that make sense of the world and their experiences within it involve a constant process of interpretation and meaning-seeking. Qualitative research assumes that the world is not simply 'out there' waiting to be discovered. Rather, it recognizes 'the world' as the locus of complex interpretive process within which human beings struggle to make sense of their experiences including their experiences of God. The researcher's task is to tell the story about the situation accurately; creates evidence convincingly and brings that evidence before the 'judge' who will read the report and pronounce the final verdict. Thus, contrary to what is often assumed, good qualitative research, like good

detective work, is rigorous, painstaking, exciting, complex and difficult, requiring a wide range of technical skills including the ability to collect and analyse data using informed and multi-disciplinary frameworks, the ability to interview, and to transcribe and accurately interpret data, and a deep and thorough knowledge of the theory and practice of hermeneutics and interpretation. It is noteworthy that qualitative research methods and approaches are relevant to undertake a process of inquiry or exploration in the social world of the individuals and community.

The researcher highlighted that the strategy of inquiry is a particular methodology guiding a research project, connecting the methods used to the outcomes desired. But what is methodology and methods in qualitative research? Corbin and Strauss (2008:1) define methodology as *"a way of thinking about and studying social phenomena. Methods are techniques and procedures for gathering and analysing data."* This is in tandem with Osmer's (2008:54) definition of methods of research when he reiterates that it is the specific procedures used to gather and record data. The methods are determined, in part, by the strategy of inquiry you have chosen for your study (e.g. interviews; participant observation; demographic analysis).

Similarly, Swinton and Mowat (2006) put it that methods are specific techniques that are used for data collection and analysis. They comprise a series of clearly defined, disciplined and systematic procedures that the researcher uses to accomplish a task. Methodology is connected to method, but in a way and formally, it relates to the study of methods. More broadly, the term methodology should do with an overall approach to a particular field. It implies a family of methods that have in common philosophical and epistemological assumptions. Methods are carried out within a particular set of methodological assumptions. This resonates with Myers et al. (2014) in that methodologies are categorised by the purposes that they are meant to serve.

The researcher has triangulated the phenomenological, ethnographical and grounded theory approaches or strategies with a view to maximise the quality of research. Triangulation can be defined as a powerful technique that facilitates validation of data through cross verification from two or more sources. In particular, it refers to the application and combination of several research methods in study of the same phenomenon. [1] Flick (2007:81) highlights for example, triangulation of interviews with other qualitative approaches like ethnography (interviews become a part of the 'master' strategy of ethnography) or with methods like participant observation or focus groups. The researcher's view is that triangulating data collection on the same topic will ensure data validation. The researcher will further triangulate the

research Respondents at PHC (the health care managers, caregivers who includes among others physicians, nurses, clinicians, and the patients) to maximise the quality of data collection.

The reason for employing ethnographical inquiry is that ethnography is hermeneutically grounded in that it takes account of the inter-subjective nature of understanding the role of language in constructing meaning, and the role played by the participant observer's own horizon in the hermeneutical conversation. The ethnographic method gives the best possible chance to understand the participant in their own setting, (Swinton & Mowat, 2006). Similarly, phenomenological and the grounded theory strategies were also employed by the researcher to study the meaning of patients' experiences (Literature Review, 2010).

These approaches suite well with the Practical Theological research methodological approach. The researcher's view was that, since chaplaincy in health care is unknown or not recognised in the SAGHs, it is imperative to employ many strategies or approaches of inquiry to enhance the outcome of this research study. The researcher has explored the patients' needs by gleaning information from the collated data to describe how the patients understand the phenomenon of religion and spirituality in their experiences of health care. This process has further shared the light on the relevancy of chaplaincy in the provision of the religious and spiritual care in a hospital setting.

Myers et al. (2014:60) highlight the content analysis, phenomenology, grounded theory, and ethnography as qualitative methods, and state that:

- *They can be used to answer descriptive questions;*
- *Are useful for exploring a phenomenon about which little is known and developing theories that can be tested through quantitative means;*
- *Are also useful when trying to understand something from someone else's perspective (Bradley, 1991) and finally,*
- *They can be valuable for bringing quantitative results 'to life.'*

The phenomenological, ethnographical and grounded theory approaches are in tandem with the three types of knowledge that bear reference for the Practical Theological research as cited by Swinton and Mowat (2006:33) below:

- *Knowledge of the other: It occurs when the researcher focuses on an individual or group and explores in-depth the way in which they view and interact with the world. The researcher has focused on the PHC research Respondents (health care managers, caregivers and patients) with a view to understand how their spiritual worldview experiences are impacting them in the context of the provision of care in a hospital setting.*

This knowledge of other will highlight the views of the research Respondents on how they interact with the world on health care in relation to their religious and spiritual dimensions in a hospital setting.

- *Knowledge of phenomena: It relates to the research done on categories of event such as, for example, the manifestation of the Holy Spirit within a church congregation, methods of discipleship, and the impact of change on communities. Here we can gain understanding of the meaning of phenomena and various complex processes involved within them. The researcher has focused on the value and meaning of the phenomenon of chaplaincy in the provision of a holistic care to address the patients' religious and spiritual dimensions of being.*
- *Reflective knowledge: It occurs when researchers deliberately turn their attention to their own processes of constructing the world, with the goal of saying something fresh and new about that personal (or shared) world. The researcher focused on the art of hermeneutics to generate or construct meaning from the views of the PHC research Respondents. This resonates with the view of Woodward (2010) in that, a chaplain is among those who can help interpret and listen to the experiences of the patients. A chaplain's role is to develop and interpret a theological understanding of health, healing and suffering, and is perceived to be the human and divine link. This reflective knowledge highlighted the expertise of a professional chaplaincy in constructing the patients' world with a view to interpret and listen to their experiences, and thereby to propose the contextual chaplaincy model for care.*

The health crisis and life-threatening incidents either have a positive or a negative impact on the patients (Holst, 2006:8). These crisis and incidents require the relevant skills to provide quality care (Osmer, 2008:83). The researcher's Theological background was critical in the understanding of the respondents' spiritual worldview since the researcher's spiritual worldview is also shaped by the belief system that is grounded in the four basic questions of human existential need; Why do I exist? What is the purpose and meaning for my existence? How do I respond to ethical or moral issues? What happens to me after death? These critical questions shaped the religious and spiritual worldview of many people and they might require a special, expert and professional intervention to enhance their wellbeing in the health care settings (Cook, 2004:61; Handzo, 2006:664; Haynes et al., 2007:2; NHS Chaplaincy Guidelines, 2015:27; Puchalski, 2001:1; Taylor et al., 2015:92; Willemse et al., 2017:62; VandeCreek & Burton, 2001:83-84).

Swinton and Mowat (2006:75) agree that Practical Theology (PT) utilises a variety of methodologies and a wide range of accompanying methods to conduct research with a view to gain the required knowledge in an area of social interest. Hence the researcher has gained knowledge in this study using both the nomothetic and ideographic strategies. According to Swinton and Mowat (2006:40-43):

> *Nomothetic knowledge is knowledge gained using scientific method. Knowledge must meet the three criteria before it can be considered scientific truth. It must be falsifiable, replicable and generalizable. Ideographic knowledge is of a different order from*

nomothetic knowledge. It presumes that meaningful knowledge can be discovered in unique, non-replicable experiences. Hence ideographic truth is important from the perspective of PT because it is integral to the language of scripture and tradition. God reveals God's self in and through knowledge that is profoundly ideographic."

Science is an evidence-based practice (Literature Review, 2010:15; Mowat, 2008:16; Myers et al., 2014:31) where knowledge is gained through scientific methods. On the contrary, ideographic knowledge employed the hermeneutical skill and knowledge as opposed to the scientific approach. There are, however, limitations in scientific research in that ethical/moral problems and people's experiences cannot be answered through this approach. However, it is asserted that there are shortcomings in all the research projects.

Mouton and Marais (1993:48) highlight further that Wilhelm Windelband proposed the distinction between nomothetic and ideographic research strategies or methodologies as captured in this statement:

In their quest for knowledge of reality, the empirical sciences either seek the general in the form of the law of nature or the particular in the form of the historically defined structure. On the one hand, they are concerned with the form which invariably remains constant. On the other hand, they are concerned with the unique, immanently defined content of the real event. The former disciplines are nomological sciences. The latter disciplines are sciences of process or sciences of the event. If I may be permitted to introduce some new technical terms scientific thought is nomothetic in the former case and ideographic in the latter case.

Simply put, nomothetic knowledge seeks the general knowledge in the form of a constant form of the law. Conversely, ideographic knowledge seeks the particular in the form of historically defined structure, unique, and immanently defined content of the real event. Therefore, ideographic knowledge is in contradiction with the nomothetic knowledge in relations to their scientific approach.

The researcher's perspective in this way of thinking and the overall approach to this study was informed by the 'spiritual worldview' as valuable resources to the patients' spiritual health care. Similarly, researching chaplaincy role in health care is in tandem with the approaches of PT. Ideographic knowledge resonates with the patients' belief system in that when miraculous healings happen, it may seem impractical to can test such through nomothetic process of enquiry. According to Heitink (1993:6), *"a theory of action in PT is the empirically oriented theological theory of the mediation of the Christian faith in the praxis of modern society."* Heitink (1993:151) states that:

praxis is understood as the actions of individuals and groups in society, within and outside the church, who are willing to be inspired in their private and public lives by the

> *Christian tradition, and who want to focus on the salvation of humankind and the world. Theory is understood as a comprehensive hermeneutical-theological statement that relates the Christian tradition, to experience, to the life and actions of modern humans."*

The researcher has put this theory in operation during the conduction of the empirical research through semi-structured interviews of the PHC participants to understand the patients' meaning of their experiences in the health care.

1.8 THEORY DESIGNS

Gray (2014:98) highlight that a comprehensive literature review serves among others, the presentation of the kinds of research methodologies and tools that have been used in other studies which may guide the design of the proposed study. The researcher highlighted the qualitative methodology as the strategy of enquiry that was employed to guide this study, and the different methods connected to it which are used to the desired outcomes. The researcher broadly discusses the relevant qualitative research designs and cites the reasons for their suitability in this empirical study. However, quantitative methodology was employed to gather the demographic data (for example, race, gender, age group, faith group, and population) with a view to profile the PHC Respondents.

1.8.1 Phenomenological design

Phenomenology is a qualitative research design or strategy which is characterised by the studies of the meaning of patients' experiences (Literature Review, 2010; Taylor et al., 2015). This resonates with Alfred Schultz. According to de Vos et al. (2011), phenomenology originated from the work of Alfred Schutz who aimed to explain how life world of subjects is developed and experienced by them (Scwandt, 2007). The authors define phenomenology as "a qualitative research design or approach aims to describe what the life world consists of, or more specifically, what concepts and structures of experience give form and meaning to it (Schram, 2006). Smith & Shinebourne (2012) states that phenomenology is used to understand how individual interpret their own experience of a phenomenon of interest. First, participants are selected and recruited who can report in detail on their experience; next, one-on-one interviews are conducted with these individuals; and finally, the transcripts of these interviews are reviewed closely for themes and patterns.

The researcher has employed this strategy at the PHC setting in tandem with Myers et al. (*ibid*). The researcher has observed and conducted semi-structured interviews to gather data from the PHC managers, caregivers and patients (research participants) with a view to describe the phenomenon of

the religious and spiritual care in the SAGH settings in response to the patients' needs, expectations and wishes. The describing skill is critical for capturing what is seen and heard from the research participants' thinking and feelings within the context of the hospital setting as the natural environment (Osmer, 2008). The researcher has described the meaning of their experiences from their own views on the religious and spiritual dimensions of being in the health care. According to Osmer (2008), triangulating observation, among other things, is critical from the side of a good observer, and might include the range of many things. The effective observation can be from the outsider's or insider's viewpoint. According to Glesne and Peshkin (1992:7), an 'etic' approach is from an outsider's point of view, and an 'emic' approach is from an insider's point of view. Swinton and Mowat (2006:166-167) assert that *"the researcher becomes part of the setting and in so doing begin to understand that setting, sometimes in ways which challenge and confront those who are 'natural' to the setting. The researcher is required to hold both the position of outsider and that of insider within the particular setting."*

1.8.2 Ethnographical design

According to de Vos et al. (2011), ethnography originated from studies in anthropology. The authors broadened its definition in that it is a qualitative research designed to study everyday human behaviour which is characterised by participant observation and description of the action of a small number of subjects and the meanings that they attached to their actions. This is in tandem with Creswell's (2007) definition. Myers and Roberts (2014:62) agree in that *"ethnography involves the observation of a culture or group by a researcher who seeks to 'embed' him or herself in that culture or group"* (Edmonds & Kennedy, 2012; Fetterman, 2009). The goal is to develop in-depth understanding of the culture or group, with focus on in-group members' perspectives of their own experience. This methodology was originally developed to understand other cultures, but can be applied to other contexts or groups as well. Ethnography is a qualitative research design or strategy which is characterised by the studies of the patients' values, beliefs, and cultural practices, (Literature Review, 2010:69). Therefore, this approach was relevant for participant observation and the description of action in human behaviour.

Dowie (2002) cited in Swinton and Mowat (2006) makes the point that ethnography is a form of hermeneutics which is grounded in that it takes account of the inter- subjective nature of understanding, the role of language in constructing meaning, and the role played by the participant observer's own horizon in the hermeneutical conversation. According to Swinton and Mowat (2006:166-167), *"the ethnographic study seeks to capture the strange in the familiar. Its purpose is to challenge and complexify situations and accepted views of the nature of truth reality and, in so doing, to render the familiar strange."*

The researcher's view was that ethnographic strategy is most appropriate data gathering tool to understand the provision of the religious and spiritual care in the South African health care settings. The skills of observing and describing the behaviour of the patients and the caregivers in PHC settings (natural environment) would enhance chances of better understanding their values, beliefs, and cultural practices on the religious and spiritual needs in health care.

The describing, observing and interviewing skills are crucial in the collection of data from the research participants' natural environment (Osmer, 2008). The field notes should be detailed in description. The researcher should know what to observe and to describe (for example, the actions as naturally as possible in the actual sequence to establish a pattern in behaviour; the individuals or group as they appear, what they do and why, what they are wearing, the items they have and for what purpose; the physical state of the environment and the time of the event, the date, the name of researcher if so, and the pseudonyms of those present). However, according to Myers et al. (2014), observation is an underused and highly valuable method to collect data.

1.8.3 Grounded theory design

According to Denzin and Lincoln (2013), Grounded Theory is a method of qualitative inquiry in which data collection and analysis reciprocally inform and shape each other through an emergent interactive process. The term 'Grounded Theory,' refers to method and its product, a theory developed from successive conceptual analysis of data. Researchers may adopt grounded theory strategies while using a variety of data collection methods. Grounded Theory studies have frequently been interview studies, and some studies have used documents or ethnographic data. It is often difficult, however, to discern the extent to which researchers have engaged grounded theory strategies (Charmaz, 2007, 2010; Timmermans & Tavory, 2007).

Literature Review (2010:69) defines Grounded Theory as *"a research design or strategy which is characterised by the studies of the patients' experiences over time."* Myers et al. (2014:62) confirm that Grounded theory is a procedure used to generate theory from qualitative data (Glaser & Strauss, 1967). First, the qualitative data are examined and categorised. During this process, each new instance of a category is continually compared to the previous instances of that category to reassess the nature of the category and the need for another category. As the researcher continues to carefully review data, at some point comparison of new instances to previous instances yields little new insight, at which point the categories are considered 'saturated' and the data analysis is complete. The researcher may then reflect

on the categories to identify themes and patterns and formulate a theory. Theory emanates from the qualitative data.

Charmaz (2006) cited in de Vos et al. (2011:319) explains that the testing of the emergent theory is guided by theoretical sampling. Theoretical sampling means seeking pertinent data to develop an emerging theory. The main purpose of theoretical sampling is to elaborate and refine the categories constituting a theory. Strauss and Corbin (1990:23) comment further that a grounded theory is discovered, developed and provisionally verified through systematic data collection and the analysis of data pertaining to that phenomenon. Therefore, data collection, analysis and theory stand in a reciprocal relationship with one another. The researcher does not begin with a theory, then prove it; rather begin with an area of study, and what is relevant to that area is gradually allowed to emerge. A systematic set of procedures is used for data collection and analysis. Data are collected by means of interviews with individuals who have participated in a process about a central phenomenon to 'saturate' categories and detail a theory. The researcher's view was to explore the theory of chaplaincy in the SAGH settings.

Corbin and Strauss (2008:1) confirm that Grounded theory is a specific methodology developed by Glaser and Strauss (1967) for the purpose of building theory from data. Birks and Mills (2015:2) highlight that in 1967, after the completion of 'Awareness of Dying,' Glaser and Strauss published 'The Discovery of Grounded Theory.' Together they made their scholarly motivation for this publication quite clear, stating that *"we would all agree that in social research generating theory goes hand in hand with verifying it; but many sociologists have been diverted from this truism in their zeal to test either existing theories or a theory that they have barely started to generate* (1967:2)." This correlate with de Vos et al. (2011:318) in that grounded theory was developed by Glaser and Strauss (1967) and is based on two concepts, namely constant comparison and theoretical sampling (Suddaby, 2006). De Vos et al. (2011:318-319) broadened the definition of Grounded theory as a qualitative research design which employs the method of constant comparison where new data gathered, actions observed and perceptions recorded of the subjects are constantly compared with those of new subjects to generate a theory. The researcher thus constantly asks: 'How does what I already have differ from what I now found?' The aim is to look for similarities and differences in the data, with a view to reach a state of saturation.

The researcher's aim to employ the Grounded theoretical strategy was to develop a chaplaincy theory from the data. The strategy is best suited to collect data by using a multi-method approach, (such as the semi-structured interviews, the Constitution of RSA, the ethnographic and phenomenological strategies) and to analyse data until it is saturated into prevalent set categories, (for example, studying the

experiences of the research Respondents or participants over time). The researcher concluded the process of constant data collection and analysis with a view to identify the developing themes and patterns. The guiding principles in this process are the theoretical sampling and constant comparisons, (for example, collecting, recording, transcribing, analysing, collating and comparing data until saturation) to establish the prevalent themes and patterns.

1.9 FORMATION OF A RESEARCH PLAN AND EXECUTION

Formation of a research plan is about how the project will be carried out in a specific time frame, including decisions about what or who will be investigated, who will conduct the research, and the methods to be used to gather and analyse data (Osmer, 2008). The researcher has highlighted a synoptic scheduled plan on how the project will be executed in practice. The researcher has undertaken an investigation into the need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being. However, the scheduled plan which is described below was operationalised in this study:

1.9.1 Research time frame (schedule) and setting

The researcher has put an operational plan in place on how to conduct this empirical study. The plan was a process that involves the submission of an application for an ethical clearance certificate from the University's Research Ethics Committee (REC). The next step was the submission of an application for permission from the Department of Health (DoH) in Limpopo Provincial Government to grant access to conduct research at the hospital setting. The following steps set the scene by purposive sampling Respondents, the completion of the consent letters by the sampled Respondents, and the commencement of the semi-structured interviews at the hospital setting. The time frames were envisaged to be from 08:00 to 16:00 on Mondays to Fridays for a period of three months with a view to collect and analyse data by using a multi-method approach. The researcher's view was that this scheduled time frames were reasonable to achieve the study's aims and objectives. The researcher has conducted this research as planned (a student or primary investigator) and within the available means and the resources.

1.9.2 Research Respondents from the population

The researcher highlighted that the research Respondents would be sampled purposively with a view to glean for honest answers from the research questions that would address the research problem. The researcher has triangulated the research Respondents to maximise the validity and reliability of the

research with a view to understand the role of chaplaincy in health care. This further enhanced the development of a credible chaplaincy theory and a contextual model that can be implemented in a hospital setting for a holistic approach to care. The scheduled semi-structured interviews with the PHC management has been conducted with a view to investigate why chaplaincy is excluded from health care teams. This target group was key informants to determine the need for the review of the SA health policy that embraces chaplaincy in SAGH. The group was also critical to inform the researcher of the need for the establishment of health care chaplaincy in the SAGH's multi-disciplinary health care teams.

The second research Respondents scheduled for semi-structured interviews were the PHC health caregivers, (physicians, nurses, clinicians, social workers, psychologist and relevant team members). This target group was key in the understanding of the role of chaplaincy in health care within the multi-disciplinary teams as experts in the provision of the religious and spiritual care to the patients. This target group played a crucial role in a holistic approach to care that includes patients' religious and spiritual dimensions of being human. This group was also critical in informing the researcher concerning the need for the establishment of chaplaincy in the SAGH settings.

The third and final research Respondents scheduled for semi-structured interviews were the patients who had been admitted at the PHC, over the age of 18 and meet the set requirement criteria by World Medical Association Declaration of Helsinki, Ethical Principle for Medical Research (WMA,1964). The researcher also followed the prescribed requirements as set by the policies of the University of Pretoria. This target group was key in determining the relevant health caregivers who provided the professional care in addressing the patients' religious and spiritual needs in the SAGH. This target group was key informants on how the patients' right to health care are protected and addressed by the DoH as enshrined in the Constitution of the Republic of South Africa. The research questions were grounded in the Constitution of the Republic of South Africa (1996) in tandem with the patients' rights.

1.10 METHODS OR INSTRUMENTS OF DATA GATHERING

The researcher comprehensively discussed the various methods employed in gathering data. The synoptic methods and a theoretical framework employed, are summarised and discussed below.

1.10.1 Synoptic methodological approach

The research approach was qualitative (empirical) in nature and participants were identified through purposive sampling. Instruments for data gathering (semi-structured interviews and participant

observation) were guided by Osmer's (2008) approach to Practical Theological Interpretation (PTI) by answering these four questions: 'What is going on? Why did this incident take place? What ought to be going on? How might we respond in ways that are faithful and effective?' The purpose of this approach was to achieve four tasks discussed below:

1.10.1.1 The descriptive-empirical task which is achieved through priestly listening

The researcher has gathered data to determine patterns and dynamics in the SAGHs in addressing the patient's religious and spiritual needs in their treatment plans. The perception was that the religious and spiritual leaders, the representatives of different faiths and lay caregivers had access to the patients during the hospital visiting times. However, they are not part of the health care teams. It was further assumed that their religious and spiritual care services are neither evaluated nor researched in order to establish what value or impact they have on the patients' treatment and recovery plan. In order to verify these assumptions, the sampled research Respondents has been interviewed. According to Kvale and Brinkmann (2009:1; 2015:3), 'the qualitative interview attempts to understand the world from the subjects' point of view, to unfold the meaning of their experiences, to uncover their lived world prior to scientific explanations. The researcher assumed the role of participant observer in PHC milieu with a view to observe first hand (Swinton, 2006:166-167), what was going on during the treatment and care of the patients. This study was of national relevance in holistic approach to care, but it was delimited to Limpopo Provincial Government Hospital (LPGH) due to its intensity, time and financial constraints. The gathered data were intended to describe the patterns and dynamics when providing the patient's religious and spiritual care in the SAGH settings.

1.10.1.2 The interpretive task which is achieved through Sagely wisdom

The gathered data were interpreted and utilised to develop the chaplaincy theory and practices from 'Grounded theory.' This process addressed these research questions: 'Why did this incident take place? Why does SADoH not recognise the role of chaplaincy as experts in the multi-disciplinary health care teams? Why are the patient's needs and expectations not considered in their health care treatment plans at SAGHs?' The collated data were analysed and interpreted in order to determine patterns and themes that describe health care practices in SAGH.

1.10.1.3 The normative task which is achieved through prophetic discernment

This normative task was achieved through the employment of theological concepts to interpret gathered data from the interviews and participant observation within the health care setting. This process enabled the construction of what should be the norm in a well functioning health care system as espoused by WHO (2010). The researcher was in a position to benchmark good practices on health care chaplaincy as a norm in the holistic approach to care. The recommendations emanating from the research findings determined how to align the South African health policy in order to resonate with the person-centred approach as a norm to address patients' holistic needs.

1.10.1.4 The pragmatic task which is achieved through servant leadership

The pragmatic task approach was used to guide the researcher in achieving the aims and objectives of the study. This task has been directed by the forms of researcher's leadership (competent, transactional and transforming leaders) Osmer (2008) when communicating the research findings. This task answers the question: How may we respond? The researcher has reflected on the analysed and interpreted primary data (observation and interviews) and the secondary data (literature review) to address how to respond to the needs of patients.

1.10.1.5 The workflow process

The researcher was guided by the conceptual workflow process (Chart 1) below, when conducting this research. Myers et al. (2014:79) highlight that if the research is guided by a strong theoretical or conceptual framework, it can be helpful in identifying the issues to look around a question. Myers et al. (*ibid*) differentiate between the two schools of thought in qualitative work *"whether or not you need a framework."* However, the researcher subscribed to the view that going into a research field, the researcher must have a thought or ideas about a subject, particularly if you care a lot about it, and a framework is needed to guide a research process. Notwithstanding, Myers et al. (*ibid*) are agreed that having a conceptual framework is not required, not forbidden, but optional.

The researcher developed the workflow process (Chart 1) to indicate how the qualitative research was conducted. The health care system was the focus of the study from the workflow process to explore what was going on? The researcher has employed a descriptive-empirical task to gather data to determine the need for chaplaincy. This process reciprocated with the next enquiry on why is there no chaplaincy? The researcher has employed the interpretive task to understand and explain reasons that informed the

exclusion of chaplaincy in SAGH. The workflow processes to explore both these enquiries were grounded in the qualitative research methodology. The chart below reflects:

- The triangulation of the phenomenological, ethnographical and grounded approaches for data collection.
- That knowing what was going on and why, informed what ought to be going on? This workflow process was to direct the investigation into a need for chaplaincy with a view to find the effective solutions for intervention. The researcher's perspective was therefore to benchmark the research findings with the global norms and standards, trends that informs the practice of the professional health care chaplaincy in the context of the institutional health care settings.
- The pragmatic task of how might we respond? The researcher made recommendations from the research findings to benchmark the model of chaplaincy for good practice in the context of the SAGH health care teams.

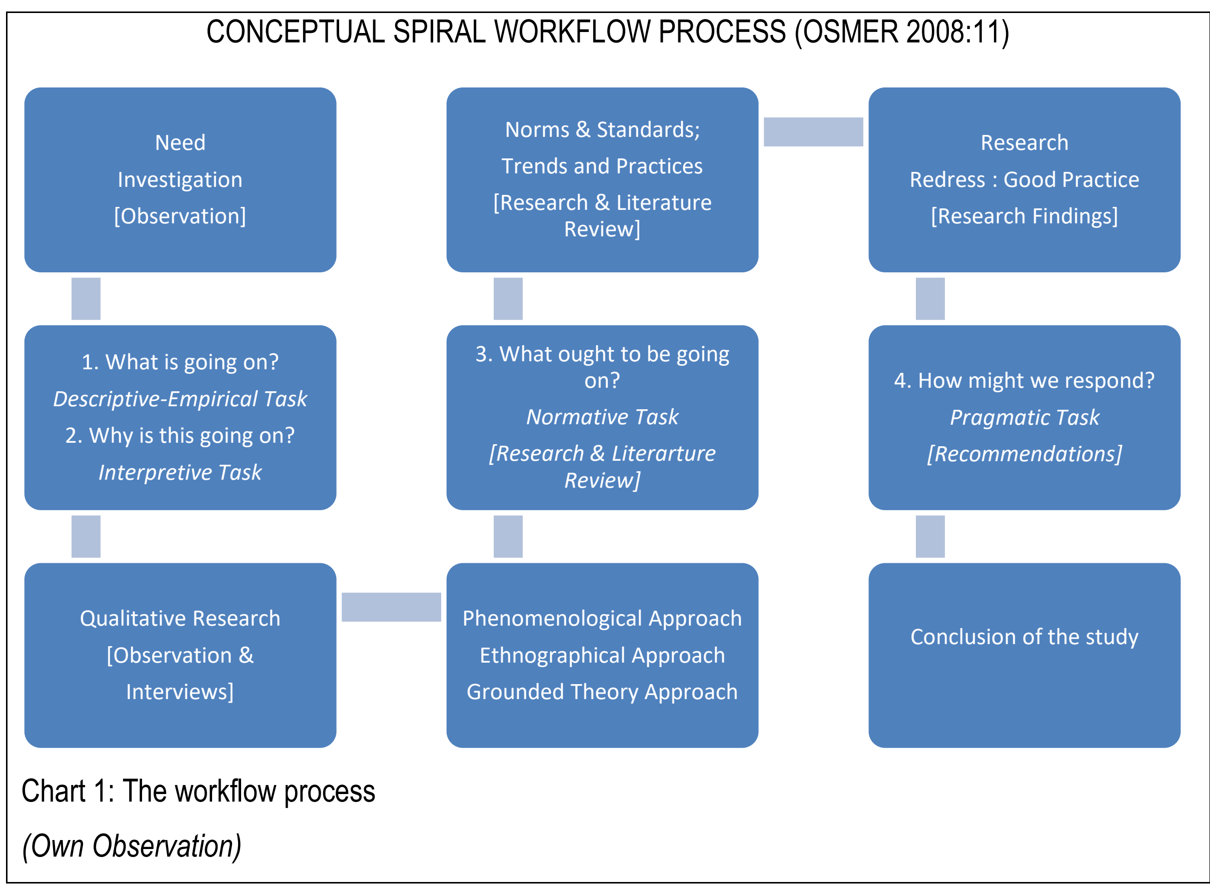


Chart 1: The workflow process

(Own Observation)

According to de Vos et al. (2011:327), qualitative researchers create the research strategy best suited to their research during the research process, or even design their whole research project around the selected strategy. De Vos et al. (*ibid*) highlight further that the process whereby qualitative research is designed follows a cyclic path to allow for critical reflection on one stage before proceeding to the next. The qualitative researchers typically employ a wide range of strategies or frameworks of inquiry from which researcher should make selection. Therefore, the workflow process (Chart 1) was in tandem with this cyclic path process for critical reflection as indicated by the arrows. However, this workflow process did not reflect any form of a linear process.

1.11 REFLECTION ON THE ASSUMPTIONS

Reflection on the meta-theoretical assumptions informing the project, including assumptions about the nature of reality, knowledge, human beings, and the moral ends of life (Osmer, 2008).

The researcher's experience in the SAPS chaplaincy services was very critical in that it has shaped his frame of reference in terms of understanding the phenomenon, roles, value and impact of chaplaincy in law-enforcement. Therefore, the researcher did not come with a mind free from any background knowledge nor experience, but was influenced one way or another by such encounters with the shared

experiences of the then hospitalised SAPS members and their families. Similarly, the researcher's horizon of health care chaplaincy resonated with the values, beliefs and attitudes of the patients in terms of what he viewed as chaplaincy care and support, and this experience played a critical role in this research process. However, reflexivity has assisted the researcher to deal fairly with these thoughts. This exercise was critical to limit the researcher's subjectivity in the qualitative research, to ensure credibility in the research outcomes in relation to the choices and assumptions which might be made in the study.

The researcher was of the view that reflexivity was key to deal with such bias in a research study because it provides an effective and impartial research outcome. The researcher was self-aware, self-conscious and self-reflecting in respect of the study relationships within the context of the research inquiry that he brought to the process. Self-reflection was critical to navigate any thoughts and actions that dominate research in a bias way. However, it must be stated that the researcher's experience of chaplaincy has always been from an *etic* (outside) approach in the health care settings.

The researcher highlighted one of the important ingredients in qualitative research methodology as the reflexivity of the researcher. *(*Creswell, 2007:37). Osmer's (2008:57-58) view is that meta-theoretical perspective is composed of the assumptions about reality, knowledge, and science that transcend research projects and theories. The network of beliefs and values justifies why researchers work the way they do on a project. Hence reflexivity in contemporary social science is, according to Osmer (*ibid*), the by-product of the double crisis of empirical research. The researcher discussed this double crisis (representation and legitimation) below.

1.11.1 Representation crisis

According to Osmer (2008:57) it is no longer assumed that *'facts'* are formed through direct observation of phenomenon. Rather, observation is theory-laden and dependent on the research practices and technologies used to gather data. Thus, Osmer (*ibid*) makes any direct correspondence between phenomenon and scientific representations of that phenomenon problematic. On the same vein, Taylor, et al. (2015:93-94) employ interpretive phenemenology of Heidegger (1962) which focuses on describing the meanings of individuals' being in the world and how these meaning influence the choices they make (Lopez & Willis, 2004). Therefore, Taylor at al. (2015) confirm that phenomenology is descriptive and a dynamic interplay occurs between the participant and researcher as the essential themes begins to surface (Colaizzi, 1978). Similarly, Taylor et al. (*ibid*) further highlight that Heidegger (1962) asserted that people are entrenched in their world to such an extent that subjective experiences are intricately linked

with social, cultural, and political contexts. Notwithstanding, Taylor et al. (*ibid*) choice of the interpretive phenomenological design (Colaizzi, 1978) was motivated by the fact that participants provided new information about their world and experiences, as well as the meanings they ascribe to them.

1.11.2 Legitimation crisis

Osmer (2008) highlights that the classical experimental criteria used to judge the adequacy of scientific research (i.e., validity, reliability, and generalisability) are now viewed as too narrow. Such criteria are not universal. As Osmer (*ibid*) puts it, generalisability, for example, is relatively unimportant in qualitative research, which studies a few cases in great depth and rarely makes claims that can be generalised to a broader population. This twofold crisis (representation and legitimation) led social scientists to become more reflexive about the choices and assumptions guiding their work. This means that they must reflect on and articulate for others their own perspective on the ontological (what is the nature of reality?) and epistemological (how is the nature of reality known?) questions. Hence contemporary researchers draw on a variety of philosophical (meta-theoretical) perspectives to answer these questions based on the scientific claims and their justification.

On the same vein, Mouton and Marais (1993) state that the term ‘ontology’ refers to the study of being or reality. This is in tandem with Omer’s (2008) perspective in that ‘ontology’ is the nature of reality, and ‘epistemology’ is how reality is known. The term ‘epistemology’ relates to the branch of philosophy connected with the theory of knowledge. In essence it seeks to ask and to answer the question *“How do we know what we know?” indeed, “How can we know at all?’’* (Swinton & Mowat 2006:32). Similarly, philosophy is *“a view of the world encompassing the questions and mechanisms for finding answers that inform that view,”* (Birks & Mills, 2015:2). According to de Vos et al. (2011:309), *“the ontological and epistemological”* branches of philosophy would guide the methodological approaches to explore the patients’ episodes, situations, or contexts in the hospital setting with a view to investigate the need for the establishment of chaplaincy in South African Government Hospital for a holistic approach to care.

1.12 PURPOSE OF THE STUDY

The purpose of this study was to investigate the need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes patients’ religious and spiritual dimensions of being. Similarly, this study was also aimed at developing an effective, contextual model of chaplaincy within the SAGH settings that would respond and address religious and spiritual needs of patients and health caregivers.

1.13 THE KNOWLEDGE GAP

There are global studies which has been conducted on health care chaplaincies. However, very few research studies undertaken in the African and South African contexts do not address the question, *'Why health care chaplaincy is excluded in the SAGH settings to address the patients' religious and spiritual needs in their treatment plans?'* Therefore, this study is aimed to fill this knowledge gap, and to ensure that the phenomenon of a contemporary global health care chaplaincy is understood and embraced in the SAGH settings. The study further sought to:

- Close an existing knowledge gap on the literature of chaplaincy in the South African health care context.
- Contribute to how the practice of the religious and spiritual care in the SAGH settings can be conducted.
- Contribute towards Theology, and more specifically, the field of Practical Theology, through research driven, evidence-based, professional practice of the health care chaplaincy in the SAGH settings.

1.14 SIGNIFICANCE OF THE STUDY

Firstly, the significance of the study was well articulated in the abovementioned knowledge gaps. This is in tandem with Myers et.al. (2014:viii) in that chaplains are in a position to make a contribution to a body of evidence which reveals that caring for a person's emotional and spiritual needs in a health and social care environment improves their wellbeing and personal outcomes. Similarly, chaplains may (among others) need to work with health care colleagues to institute some method of screening for spiritual risk or need in order to facilitate early identification and referral of these patients, (Fitchett et. al., 2000:186) for the religious and spiritual care in the treatment plans.

Secondly, the future studies or research on the health care chaplaincies may be conducted by sourcing this study as a point of reference from the perspective of the health care chaplaincy in the context of the SAGH settings.

Thirdly, the study has recommended effective, efficient and relevant solutions that would respond and address the religious and spiritual needs of patients, health caregivers and the hospital management in the SAGH settings.

1.15 DEFINITION OF OPERATIONAL TERMS

1.15.1 Chaplain, chaplaincy, and chaplaincy care

Health care chaplaincy literature review defines a chaplain as "a cleric (such as a minister, priest, pastor, rabbi, or imam), or a lay representative of a religious tradition, attached to a secular institution such as hospital, prison, military unit, school, business, police department, fire department, university, or private chapel." [2] A Chaplain is defined as *"a priest who is normally not in charge of a parish, but rather provides church services for the armed forces or in such institutions as schools, hospitals, and prisons"* (Collins & Farrugia, 2013:38).

Chaplaincy is, according to Oxford Dictionary, "the office or position of a member of the clergy attached to a private chapel, institution, ship, regiment, etc." [3] According to Loewy and Loewy (2007:6) the Encyclopaedia Britannica dates the concept of chaplaincy to early centuries of the Christian church, and describes a chaplain as *"originally a priest or minister who is in charge of a chapel, an ordained member of the clergy who is assigned to a special ministry... appointed to serve in a variety of institutions and corporate bodies, such as prisons, hospitals, schools, and universities."* The board-certified chaplaincy is designated to provide specialised spiritual care, (HCC, 2010:2).

1.15.2 Clergy

A clergy is the collective body of men and women ordained as ministers of the Christian church (Collins, 2004).

1.15.3 Dimensions of being

According to the Oxford Dictionary, dimensions of being refer to the aspect, feature, element, facet, or side of human, being a body, soul and spirit. For the purposes of this study, the dimensions of being refer to the spiritual side of human. [4]

1.15.4 Health, health care, and hospital chaplain

Health is "the condition of being sound in body, mind, or spirit; especially: freedom from physical disease or pain." [4] Another definition of health "is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity." [5] Further, health is "a relative state in which one is able to

function well physically, mentally, socially, and spiritually in order to express the full range of one's unique potentialities within the environment in which one is living." [6] Health care is "the organised provision of medical care to individuals or community." [7] "A hospital chaplain is a clergy member ordained to assist residents in their religious and spiritual pursuits. Chaplains are usually required to have a degree in counselling, theology, or another major pertinent to their line of work." 8]

1.15.5 Holistic approach

"A holistic view means being interested in engaging and developing the whole person. You can think of this as different levels, physical, emotional, mental and spiritual. It is the concept that the human being is multi-dimensional. We have conscious and unconscious aspects, rational and irrational aspects." [9]

1.15.6 Minister

Collins (2004) defines a minister as a clergyman, especially in Presbyterian and some Nonconformist churches.

1.15.7 Multi-disciplinary team and multi-disciplinary approach

"A multi-disciplinary team will mean different things to different services." [10] This care is best delivered by a multi-disciplinary team who can support patients and families who may have physical, functional, emotional, psychological, social and spiritual needs. The multi-disciplinary approach is "a term referring to the philosophy of converging multiple specialities and or technologies to establish a diagnosis or effects a therapy." [11]

1.15.8 Pastor and pastoral care

A pastor is defined as a clergyman or priest in charge of a congregation. A person who exercises spiritual guidance over many people. A pastor is an old word for shepherd. And a priest is a person ordained to act as a mediator between God and man in administering the sacraments, preaching, blessing, guiding, etc. (Collins, 2004).

Pastoral care is the discipline of providing a focussed deliberate intention of caring for the resiliency of the human soul within the other's theological context and understanding, particularly when the other is faced with challenges beyond their usual ability to cope (Harding et al., 2008:112).

1.15.9 Patient, patient care, and patient-centred care

A patient is any recipient of health care services. The patient is the most often ill or injured and in need of treatment by a physician, advanced practice registered nurse. [12] Patient-care is the services rendered by members of the health professionals for the benefit of a patient. [13] The Institute of Medicine (IOM) defines patient-centred care as providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. [14]

1.15.10 Religion

Tovar-Murray (2011) states that the word religion comes from the Latin root *religio,* which describes the interaction between humans and a universal unifying force that touches upon all aspects of existences (Hill et al., 2000). According to Kliewer (2004:616), *"religion is seen as focusing more on prescribed beliefs, rituals, and practices as well as social institutional features, and on the undertaking of a spiritual search using specific means or methods (i.e. rituals or behaviours) within an identifiable group."*

1.15.11 Spiritual, spirituality, and spiritual care

Spiritual is defined as "relating to the spirit or soul and not to physical nature or matter; intangible; or relating to sacred things, the Church, religion, etc." *(*Collins, 2004). HCC (2010;2) states that:

> *Spirituality in health care is that part of a person that gives meaning and purpose to the person's life. Belief in a higher power that may inspire hope, seeks resolution, and transcends physical and conscious constraints.' Spiritual care in nursing is an important part of overall health care." [15] According to the medical dictionary, spiritual care is "that aspect of healthcare that attends to spiritual and religious needs brought on by illness or injury." [16] Spiritual care refers to "interventions made by any caregiver that address patients' spiritual needs.*

1.16 DELIMITATION OF THE STUDY

Although the purpose of the study was to investigate the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care, the scope was delimited to Pietersburg Hospital Campus (PHC) in the Capricorn District of Limpopo Province. The researcher could not broaden this study to other South African hospitals due to time and financial constraints. However, the results or the findings of this qualitative study may not be generalised to the wider health care communities since the health care contexts and the experiences of the research subjects are not the same.

1.17 OVERVIEW OF THE STUDY

The study consists of the following six (6) chapters:

CHAPTER 1: INTRODUCTION AND BACKGROUND OF THE STUDY

This chapter presents the background and introduction of the study, as well as the methodology employed to investigate the need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being.

CHAPTER 2: PARTICIPANT OBSERVATION AND LITERATURE REVIEW

This chapter presents the researcher's participant observation in the PHC settings, detailed with the literature review on the global trends and practices of health care chaplaincy in responding and addressing the patients' religious and spiritual needs in the hospital settings. The chapter also captures the purpose of the study, the knowledge gap to be filled, the significance of the study, the definition of operational terms, and the delimitations of the study.

CHAPTER 3: DATA COLLECTION PROCEDURE

This chapter outlines the research plan for data collection (interviews, observation, field notes), data analysis and data interpretation employed from the interviews conducted by triangulating the research participants.

CHAPTER 4: DATA PRESENTATION AND INTERPRETATION

This chapter presents the research findings from the empirical data analysis and interpretation from the interviews.

CHAPTER 5: REFLECTIONS ON THE STUDY FINDINGS

This chapter presents the reflections on the research findings, and the proposed chaplaincy model that can be employed in the SA hospital settings with a view to respond and address the patients' religious and spiritual needs.

CHAPTER 6: EVALUATION OF THE STUDY, RECOMMENDATIONS AND CONCLUSION

This chapter provides an evaluation of the study. The chapter also captures the recommendations and the conclusion of the study.

1.18 PRELIMINARY CONCLUSION

This chapter presents the background and introduction to the study on the need for the establishment of chaplaincy in SAGH for a holistic approach to care, outlines the methodology which embraces the research design, the methodology, and the methods as strategies of enquiry, namely: phenomenology, ethnography and grounded theory. The methodology serves the purpose of a strategic direction of the research inquiry and the execution plan which will be undertaken in the next chapter. The purpose of the study, the research objectives, the research questions, the knowledge gap, the significance of the study and its delimitation are well captured in this chapter.

CHAPTER 2

PARTICIPANT OBSERVATION AND LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the literature on the health care chaplaincy, and captures the researcher's observations for data gathering at Pietersburg Hospital Campus settings for three months. An ethnographic approach was employed as one of the data gathering instruments, to explore and describe the subjective experiences and viewpoints of the doctors and nurses in this research field. The ethnographic method gives the best possible chance to understand the participant in their own setting, (Swinton & Mowat, 2006). Creswell (in de Vos et al., 2011:314-316) define ethnography as *"the study of an intact cultural or social group (or individual or individuals within that group) based primarily on observations over a prolonged period spent by the researcher in the field."* According to de Vos et al. (*ibid*), the ethnographer listens and records the voices of informants where the interaction happens, with the intention of studying the cultural concepts and generating a cultural portrait. However, the researcher's view was to have an insight into the SAGH caregivers' (doctors, nurses, social workers, psychologists, other clinicians) responses to the patients' religious and spiritual needs in the hospital settings, and thereby to maximise the outcome of this empirical research in tandem with the approved research's ethical code. Therefore, in order to collect data, the researcher employed Osmer's (2008:4) Practical Theological Interpretation, as a methodology of Practical Theology which includes a descriptive-empirical, interpretive, normative and pragmatic tasks with a view to guide this research study by applying these fourfold questions:

- What is going on? Focus area was on what was happening in Pietersburg Hospital Campus.
- Why did this incident take place? Focus area was on why is chaplaincy excluded in the SAGH.
- What ought to be going on? Focus area was on the importance of the patient-centred approach.
- How might we respond? Focus area is on the interviews with the Respondents, (Chapter 4).

The four aspects cited below, are in tandem with the overall methodology. They give an insight into what was going on in the PHC settings in relation to the global health practices when providing the patients' religious and spiritual care:

Firstly, chapter 2 presents the participant's observation on what was going on (Osmer, 2008:4) in the SAGH with regard to responding to the patients' religious and spiritual needs in the health care settings,

and more specifically, in Pietersburg Hospital Campus as a field of the study. The observation was aimed at exploring whether there is a need or no need for the establishment of chaplaincy in the SAGH settings. The reflection on the Limpopo Provincial background, highlight the context in which the health care was provided during observations. Therefore, the researcher's perspective on answering this research question, *'Is there a need for chaplaincy in SAGH?'* was buttressed on the participants' views within the PHC settings; admitted patients, (consumers of health care), the providers of health care (caregivers), and the hospital management (explored fully in Chapter 4).

Secondly, this chapter explores the rational as to, *'why the South African Department of Health (SADoH) excludes chaplaincy in the health care settings, for a holistic approach to care that includes the patients' religious and spiritual dimensions of being?'* Hence, the researcher observed how the caregivers at PHC settings addressed the patients' religious and needs without the professional expertise of the health care chaplaincy. Similarly, what were the patients' experiences at the PHC settings with regard to their religious and spiritual needs, wishes and expectations during the period of the researcher's observation.

However, the review of literature (secondary source) was conducted in order to unpack, clarify, explain, expound, demonstrate, and get insight into the value and benefits of global health care chaplaincy as opposed to how the SAGH respond to the patients' religious and spiritual needs with a view to highlight the global health care response to the patients' holistic needs.

Thirdly, the researcher reviews the global health care chaplaincies' current trends and practices as the practical responses to what ought to be going on, (Osmer, 2008:4) in the context of the SAGH settings, regarding the provision of the patients' religious and spiritual care. According to Pera et al., (2005:97-98) *"as new developments take place in the medical field, the rights of patients are becoming a major issue."* Conversely, Pera et al. (*ibid*) agreed that:

> *During illness, the human rights of patients gain greater prominence, as does the importance of human rights in the nurse-patient relationship. The state of illness itself, and the proportions which it may assume, make the patient vulnerable to abuse. Furthermore, illness gives rise to new needs that must be met so that the patient's integrity as a unique individual is retained* (p.97).

And lastly, in Chapter 4 of this study, the researcher will explore how might the SADoH respond to address the challenges of the patients's needs, expectations and wishes in the SAGH settings in tandem with the National Patients' Rights Charter (NPRC), espoused by Mulaudzi et al. (2001).

2.2 BACKGROUND

South Africa has a national and nine (9) provincial parliamentary systems of government established on 27 April 1994. However, this background serves to highlight the context from which health care is provided in the Limpopo Province (LP) as a system of government. It has a total area of 125,754km^2 (48,554sq m), and its capital city is Polokwane. It is ranked 5th in GDP from the nine provinces in SA. Limpopo has the highest level of poverty to any South African province, with 78.9% of the population living below the national poverty line. In the 2011 census, 74.4% of local dwellings were in a tribal or traditional area, compared to a national average of 27.1%. [17]

POPULATION GROUP	PERCENTAGE	LANGUAGES	PERCENTAGE
Black African	96.7%	Northern Sotho	52%
White	2.6%	Xitsonga	24%
Indian / Asian	0.3%	Tshivenda	16.7%
Coloured	0.3%	Afrikaans	2.3%

Table 1 The population groups in Limpopo and languages: [17]

Generally, Curtain and Flaherty (1982:105-114) state that *"the patients come from a variety of cultural backgrounds from where they derive their belief system. These cultural beliefs influence how health care is to be provided with a view to meet the distinctive needs of the patients."* This resonates with the South African context in that SA is a secular state with diverse religious population. [17] According to 2019 statistics South Africa, in terms of religions across the population, 81.2% of South Africans are identified with Christian based faith, 3.7% identified with other faiths, and 15% are not affiliated with any faith in particular. [18] It is reported further that African Independent Churches 25.4%; Pentecostal & Evangelicals 15.2%; Roman Catholics 6.8%; Methodists 5%; Reformed Churches 4.2%; Anglican Churches 3.2%; Pentecostal Churches 5.3%; and other Christian Denominations 8.4%. [19] However, Limpopo Province has a predominantly Christian religious society, but there are other traditional religions such as Islam and Hinduism. [20]

The Zion Christian Church (ZCC), based outside Polokwane at Moria, is the largest African-initiated church ever founded in Southern Africa and now claims at least five million members. The ZCC, which fuses African traditional belief with Christianity, was officially founded by Engenas Lekganyane in 1924, based on a vision he had from God 14 years before. Many other African churches, mainly Apostolic or Pentecostal, exist throughout the province, as well as a predominance of Catholic and Lutheran churches.

Many people regularly seek the help of traditional healers to protect themselves against witchcraft or to undo a witch's curse. Ancestors are very much part of consulting a traditional healer, which most people in Limpopo do from time to time or even regularly. The spirit world, of which the ancestors are the core, is almost more real than the physical world to many people in Limpopo. People there vary in their dedication to their ancestors, both in the ritual attention they give them and in their beliefs in their power. Many scoff at the notion of witchcraft, but for many in Limpopo, both are terrifying real. [21] However, Christianity and ancestor worship both hold sway in Limpopo, and co-exist comfortably in many worldviews. Therefore, this background information contextualises the patients' religious and spiritual needs in the PHC, because a large percentage of the Limpopo population use the services of the LP government's health care.

2.3 PARTICIPANT OBSERVATION

The researcher observed (in the context of the above background) how the patients who were admitted at PHC settings received the religious and spiritual care and support from their religious and spiritual leaders or clergy. These observations were focused on an investigation into the need for the establishment of chaplaincy in the SAGH for a holistic approach to care that includes the patients' religious and spiritual dimensions of being. During these observations, the researcher discovered that the visits were targeted at the patients attached to the faith groups of these religious and spiritual leaders and or clergy. On the same vein, the patients' family members and or relatives who visited them, provided the required support which, most often than not, included the request for divine intervention. This resonates with Ferngren (2014:1) in that, *"physicians and patients alike pray for divine help and healing, especially when they have exhausted all the avenues of modern science and medical knowledge."* However, the researcher's horizon on what was going on, was broadened during the open day session at the PHC.

The researcher describes the PHC open day session which was held on 28 March 2019 by the PHC management to give an account on the challenges and successes faced by the hospital. Therefore, this provides a helicopter view (in tandem with the research questions: *'What was going on? Why was this going on?'* regarding providing the health care services in the PHC settings. The researcher discovered that, during the presentation which was done by the acting CEO, there were no plans to embrace and incorporate the patients' religious and spiritual needs in their treatment plans. This is problematic because the current SA health care system is not responsive to the patients' religious and spiritual needs in the SAGH settings. The CEO's presentation covered some of the following:

Pietersburg Hospital Campus is a tertiary hospital situated in the Capricorn District in Limpopo Province. It serves a population of 5.8 million people in the Province. The hospital has a total of 701 approved beds and about 516 usable beds and 17 wards. It is a training institution which runs in collaboration with Sefako Makgatho Health Sciences University. It is stated that Pietersburg Hospital Campus is committed to provide holistic, secondary and tertiary health services. [22] Table (2) below indicates all the services provided at PHC, as a tertiary hospital which operates on a referral system. The table (3) captures the referral levels of health care within this system. Table (4) highlights how the patients are admitted for treatment and care at the PHC as a tertiary hospital.

Firstly, the CEO's presentation on the plans for the improvement of the PHC health care system, detailed the provision of quality health care, the structural upgrading and the enhancement of the resources (human, physical and financial). Therefore, the manager's presentation covered all the aspects and dimensions of health care in the PHC as prescribed by the SA health system. However, the researcher discovered that the CEO's presentation did not highlight how the patients' religious and spiritual needs would be addressed in the PHC settings in view of the background as highlighted above in 2.2.

Secondly, the researcher discovered that the CEO's presentation on the provision of health care did not embrace nor incorporate the establishment of the health care chaplaincy. Therefore, the focus areas of the presentation were on improving quality of care, increasing access to tertiary services, reducing referrals outside Limpopo, and the implementation of the sustainable outreach programs. Similarly, the challenges which were highlighted from the CEO's presentation, included the financial (inadequate funding, obsolete laundry equipment), the pharmaceutical supply (lack of constant supply of pharmaceutical and surgical sundry), the information technology and records management (manual records management, inadequate records storage space), the infrastructure (old and dilapidated structure, infrastructure not appropriate for the services), the health care technology (obsolete medical equipment) and the human resource (shortage of appropriate skills or scarcity of specialists). However, the scarcity of the health care specialists did not include a need for the religious and spiritual experts in the PHC health care teams. Therefore, the question of *'why is this going on in the South African Health Care System (SAHCS) to exclude chaplaincy in SAGH settings?'* can be viewed as a lack of understanding the phenomenon of health care chaplaincy with a view to provide the holistic care.

Thirdly, the presentation highlighted the achievements of the PHC, which among others, covered the appointments of the critical positions, including the hospital board (Table 5), the renovations done at the PHC environment, the purchasing of the critical health care equipment/s, the refurbishment of the

mortuary and other critical wards. This information broadened the researcher's horizon (from the context of the SAGH) on the challenges faced by SAGH management on how to manage, maintain and provide quality health care within the limited budget and the budgetary constraints. The researcher discovered during this presentation, that there are plans in place to build a new hospital in Polokwane with increased capacity, to ensure that the people of Limpopo would access the quality of health care needed with minimal outside referrals. However, this presentation was confined to the *modus operandi* of the SA health care system which does not recognise the value of the patients' religious and spiritual care in the SAGH settings. The challenges faced by the providers (for example, doctors and nurses) and consumers of care (patients) about their religious and spiritual needs in the hospital settings were not covered by the presentation nor highlighted for future health care plans which are aimed to enhance the health care quality. Therefore, the CEO's presentation was broad enough to cover all the relevant information that is captured below:

There is lack of health care facilities and shortage of personnel in the Limpopo Province. This translates into the Limpopo Provincial Department of Health's (LPDoH) usage of the referral system to those patients who access the health care services at the two tertiary hospitals of Mankweng and Pietersburg. However, it is the responsibility of the referring hospitals to arrange transport to and from the tertiary hospitals by Planned Patient Transport (PPT).

Pietersburg Hospital Campus is one of the tertiary hospitals in Limpopo which provides services highlighted below:

TERTIARY HOSPITAL SERVICES
Anaesthesiology, Clinical Emergency, Cardiology - General, Cardiothoracic Surgery, CAT Scan, Clinical Engineering, Colorectal Surgery, Craniofacial Surgery, Dietetics, Dermatology, Emergency Medicine, Forensic Pathology, Gastroenterology, General Surgery, High Care Services, Hepatobiliary Surgery, Internal Medicine, Intensive Care Unit, Medical Otorhinolaryngology, Orthotic and Prosthetic, Medical Oncology, MRI, Scan, Nephrology, Neonatology, Neurology, Neurosurgery, Nuclear Medicine, Obstetrics and Gynaecology, Paediatrics and Child Health, Pharmaceutical Services, Oral Health, Occupational Therapy, Optometry/ Oral Pathology, Orthodontics, Orthopaedics, Plastic and Reconstructive Surgery, Physiotherapy, Podiatry, Prosthodontics, Psychiatry, Psychology, Public Health Medicine, Radiology, Radiation Oncology, Renal Dialysis, Respiratory Medicine (Pulmonology), Rheumatology, Speech, Language and Audiology, Social Work, Urology, Vascular Surgery

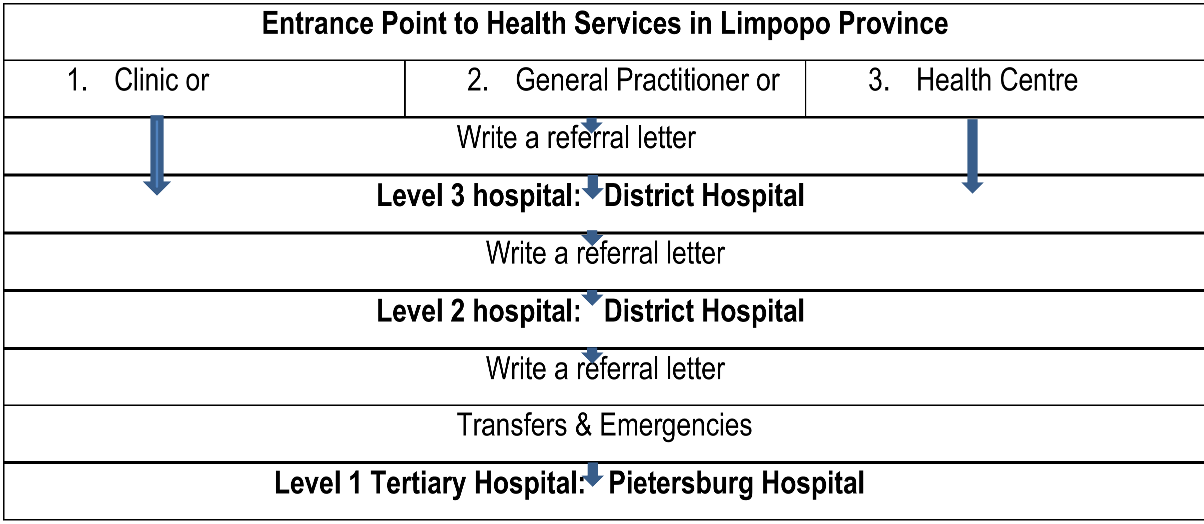
Table 2. Tertiary hospital services

The patients are referred to the PHC settings through these levels of health care:

Referral System: Levels of Health Care
Level 1= Primary Health Care Clinics, Community Health Care Centre, District Hospital
Level 2=Regional Hospital
Level 3 =Provincial Tertiary Hospital (Pietersburg Hospital)
Level 4= Central Hospitals, Specialised Hospital

Table 3: The referral system: Levels of heath care services

The patients referred or enter in the PHC facilities must follow these procedures prior to being admitted:



Entrance Point to Health Services in Limpopo Province		
1. Clinic or	2. General Practitioner or	3. Health Centre
	Write a referral letter	
	Level 3 hospital: District Hospital	
	Write a referral letter	
	Level 2 hospital: District Hospital	
	Write a referral letter	
	Transfers & Emergencies	
	Level 1 Tertiary Hospital: Pietersburg Hospital	

Table 4: Entrance point of health services in Limpopo Province

However, this background paints a vivid picture of despair among the underprivileged patients (from 5.8 million population) who are channelled by the LPDoH's referral system to access the health care services at these designated tertiary hospitals. Similarly, researcher observed that many patients in Limpopo have become frustrated and impatient due to this referral system in that they purported to be subjected to the inhuman approach of having to be wait-listed for the availability of a hospital bed. Therefore, some of the patients claimed that they were wait-listed for a period of six months before they could be admitted at the PHC facility! They purported that this referral system, as an approach which is employed by the Department of Health (DoH) before the patients are admitted at SAGH, had a negative impact on the patients' religious and spiritual dimensions of being in that they had to seek an alternative treatment (religious and spiritual care or traditional medicine) elsewhere, instead of waiting for their admissions into the hospital facilities for the Western medical treatment. According to Kruger et al. (2009:7);

> *Humans seem to have a need to escape the everyday realities of life. Their spirits constantly seek further, deeper, higher, beyond the limitations of suffering, deception and the banality of everyday life. Human beings have a strong inclination towards the mysterious depths and outer horizons of their existence, and an immense capacity for wonder, reverence and awe.*

Hence, the patients sought divine intervention as an effectively coping mechanism.

2.3.1 What is going on?

The researcher observed what was going on (Osmer, 2008:34) during the admission, treatment and care of the patients in the PHC facility - with specific focus on the provision of the religious and spiritual care - since there is no hospital chaplaincy in the PHC multi-disciplinary health care teams. Similarly, the researcher captured critical moments and the challenges (from March to May 2019, between 07:30-16:00) faced by the PHC caregivers on how they responded to the patients' religious and spiritual needs, values, beliefs and cultural practices within the health care system, especially if the doctors and nurses had the experiences of being brought up short (Osmer, 2008:21).

2.3.2 Observing the daily routines at PHC setting

The researcher observed that there were security personnel stationed at the hospital entrances and designated hospital wards (children and maternity wards) assigned for access control at the PHC facility, to ensure safety and security of the hospital staff and the patients. Every person had to pass through these security systems.

The researcher observed that it was a common practice for the PHC personnel (+90% employees: hospital management, caregivers and staff) to wear the green golf-shirt (green colour) on Wednesdays. The domain specific units wore their own golf-shirts on specific days of the week (for example, the blue uniform or golf-shirts were worn on Mondays for TB awareness, the caregivers worn white uniform or golf-shirts on Tuesdays. The pink uniform or golf-shirts were worn on Fridays for cancer awareness). The doctors and nurses normally wore their hospital coats and uniform respectively. The personnel were expected to have name tags for identification and security purposes.

The researcher further observed that there were patients who arrived at the PHC casualty by private transport, or EMS ambulances or helicopter in emergency situations. The other category of patients came to the hospital without any formal referral. The patients had to report at the help desk, underwent a triage

process before being taken to the consultation rooms in the hospital casualty. The patients were diagnosed and referred to the domain specific medical unit for the provision of the required services or the interventions. There are different treatment clinics within the PHC settings where the patients were treated by the health care providers. The patients' medical history or health care related information were captured in their personal files (even electronically) for administrative and medical purposes, and thereafter the porters took those who were admitted to their respective hospital wards. The patients who were scheduled for appointments, treatment procedures and care with their services providers in the PHC were transported by the PPT, (Table 5) and always accompanied by the Emergency Medical Service (EMS) personnel. The patients were expected to report at the Out-Patient Department (OPD) before 07:30 for administrative purposes and retrieval of their personal hospital files, before consulting the PHC doctors.

The researcher also observed that it was a common practice among the PHC nursing staff to assemble in the mornings (between 07:00-07:30) at their respective nursing stations for briefings (reporting on and off duty) and divine intervention sessions (normal joint-singing and prayer) before they could attend to the patients in the wards. The team of medical doctors normally arrived at the wards after 07:30 to perform their routine duties, they were sometimes accompanied by the medical students. The personnel from the kitchen staff brought meals to the wards between 07:30 and 08:00 and 12:30 and 13:00 before the patients could take their medication. A battery-operated golf cart (attached to steel containers or trailers) was normally used to distribute food to the hospital wards. The researcher observed that there was a cleaning staff assigned for the tidying of the hospital wards, passages, casualty, and outside the hospital premises. There were others who were assigned to the hospital laundry services.

The researcher observed that there was a hospital ministry at PHC where lunch-prayer meetings were held under a tree or in the hospital hall if it was not booked for use. The hospital employees usually assembled for prayer services between 13:00 and 14:00 during lunch times. This hospital ministry created a platform for the employees at the PHC facility to come together for mutual encouragement, inspirational messages and for sharing their testimonies. The researcher observed that these prayer sessions were conduits of enhancing the faith and hope of the attendees.

The pictures in tables (5-8) below, were shot during the observation at the PHC facility. The first picture (A) was taken during the open day accountability session with some members of the PHC board and management. The second picture (B) is the PPT used to transport the patients from the district hospitals to PHC.

PICTURES CAPTURED DURING THE RESEARCHER'S OBSERVATIONS AT PHC	
A. PHC Open Day Session	B. LP Planned Patient Transport
A PHC Management & Board Members	B LP Planned Patient Transport

Table 5: PHC open day session and planned patient transport

The third picture (C) is a battery-operated cart used to distribute food in the PHC wards for the patients. The fourth picture (D) is a battery-operated golf cart which is usually used to dispose of the deceased bodies of patients within the PHC facility.

PICTURES CAPTURED DURING THE RESEARCHER'S OBSERVATIONS AT PHC	
C. Motrec Cart	D. Paramedic Golf Cart
C	D
Motrec Cart (used to distribute food to the PHC wards)	Paramedic Golf Cart (used to dispose deceased bodies)

Table 6: Mortrec cart and paramedic golf cart

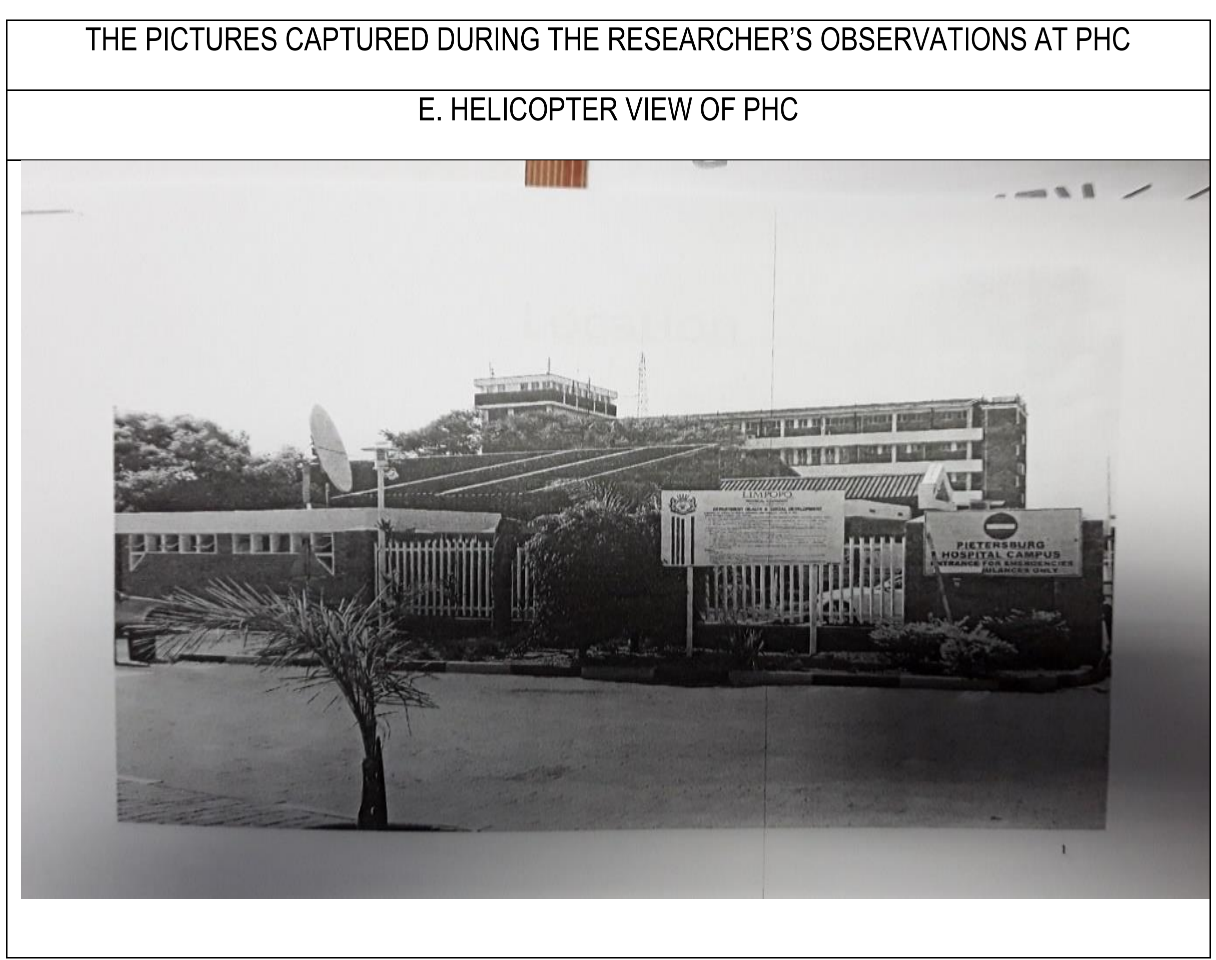
THE PICTURES CAPTURED DURING THE RESEARCHER'S OBSERVATIONS AT PHC
E. HELICOPTER VIEW OF PHC


Table 7: Helicopter view of PHC

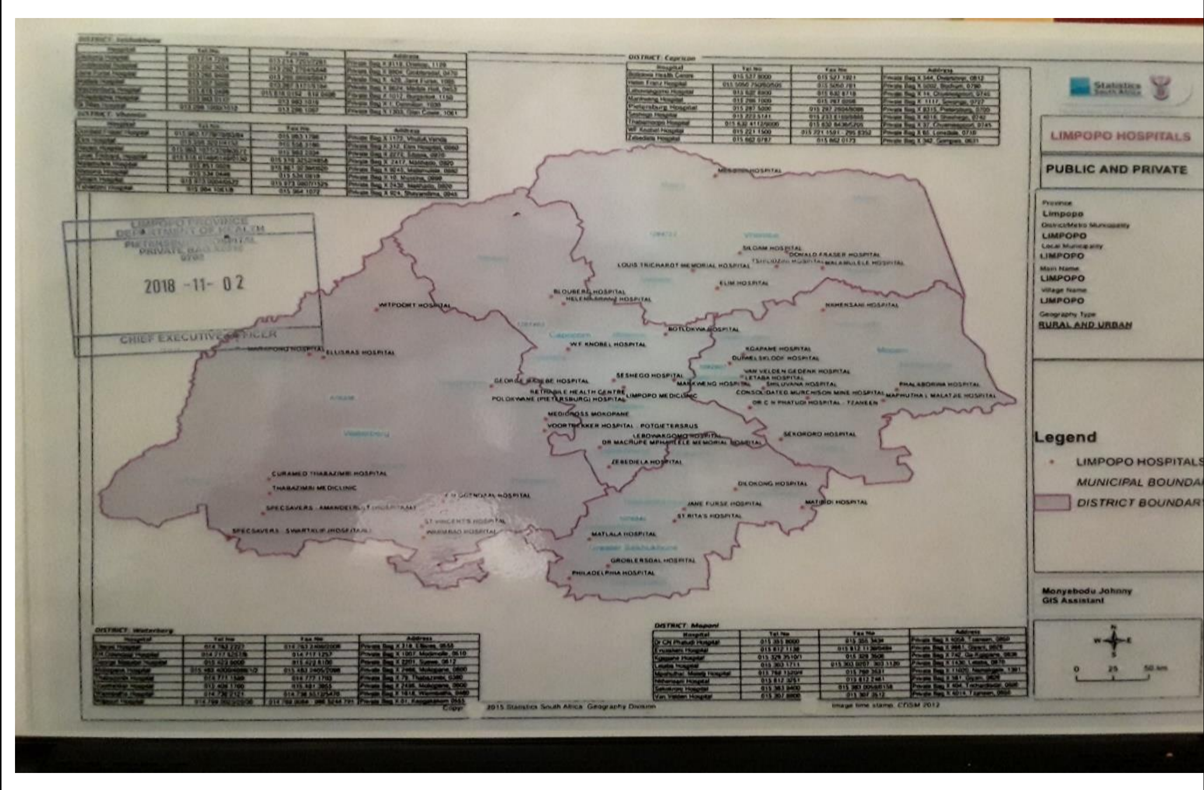
THE PICTURES CAPTURED DURING THE RESEARCHER'S OBSERVATIONS AT PHC
F. THE HELICOPTER VIEW OF THE MAP OF LIMPOPO HOSPITALS (FROM STAS SA)
 LP Hospitals Map (Stats SA)

Table 8: Limpopo hospitals map

2.3.3 Observing the provision of religious and spiritual care

The PHC gatekeeper introduced the researcher to the hospital management and to the Orthopaedic and Forensic departments with a view to foster relations and to build a rapport. The researcher further underwent the security clearance process through the PHC's risk management unit to be provided with an identification card for the duration of the research study. Thereafter, the researcher was granted access to conduct routine observations in the PHC settings in line with the proposed research schedule. However, the researcher noticed that the caregivers were very sceptical about his presence in the hospital settings, even though he had a hospital identification card and a protocol letter from the relevant authority that allowed the research study to be conducted.

The researcher encountered challenges with some of the PHC caregivers and managers to access the patients in the wards without an approval letter signed by the Chief Executive Officer (CEO). According

to Neuman (2006:397-398), *"serendipity is important in field research. Many times, a field researcher does not know the relevance of what he or she is observing until later."* During the PHC's accountability session, one of the pastors told the researcher that he was providing the religious and spiritual care to the oncology patients at ward Q. However, he was instructed to discontinue rendering these services. Similarly, the pastor of the PHC ministry confirmed that she was also prevented from praying with and for the patients at PHC settings. Notwithstanding, the PHC caregivers were reluctant to allow the practice of the religious and spiritual care at the hospital settings because they maintained a very strict protocol. Therefore, when the researcher noticed that the patients at PHC settings were protected by regulating religious and spiritual care practices, he requested management assistance. (Appendix A: CEO letter ref: 10/7/2 dated 13 March 2019).

The CEO gave the researcher an approval letter that allowed him access to the PHC wards to build rapport with the caregivers and the patients. During the planned visits, the researcher noticed that most patients relied on their religious and spiritual belief systems to cope with their treatment. Some patients would listen to the radio stations' religious and spiritual programmes. Others would view their cell phones for the religious and spiritual messages, or listen to the gospel songs for inspiration as a coping mechanism. When the researcher visited the wards, he met two women who were admitted in ward O, and he introduced himself and informed them about the purpose of his visit. One of these women started crying as the researcher was talking to them. The researcher noticed through her face that she was experiencing severe pains. After he has engaged her to determine the cause of her emotional state, she responded by saying that he (the researcher) was Godsend, as a confirmation for her prayer request. She purported that she was praying to God that morning for divine strengthening during her hospitalisation, and to protect her before she was taken for X-ray tests. Thereafter, the researcher led the two women in a word of prayer. The women thanked the researcher for pastoral support and divine intervention, and noticed that the face of the woman who was crying earlier on was glowing with hope. And later that day, about 09:00 am, the researcher met with the woman at the hospital passage, awaiting to be taken in for her X-ray test. When she saw the researcher, she smiled and said: "*Ke lebogile thapelo moruti!*" Loosely translated: "I thank your prayer pastor."

The researcher further noticed two elderly male patients sitting on the PHC coach near the entrance door of ward C, and approached them to build a rapport. After greetings, the researcher explained the purpose of his visit. One of the patients voluntarily shared this health care experience. The patient purported that he had an accident in 2011, and was admitted and treated for seven months at a private hospital. He stated that he has experienced severe kidney pains after being discharged. This was the reason for his

referral to PHC. The health caregivers had run some tests to diagnose the cause of the pains, and the results of the tests confirmed that his previous operation was the cause of his medical condition. However, the patient purported that he had to wait for six months before the hospital bed was available. Hence, it was during that trying times when his faith was challenged. He further purported that the Bible was his source of hope, and that the Bible tracts that he read at the private hospital has assisted him in coping with his medical condition. According to his view, there is a need to provide the patients' religious and spiritual cares during their treatment and health care, and provide the religious and spiritual tracts.

2.3.4 Applying the priestly listening skills

The researcher's view was that, to have an insight into the PHC setting, patience was needed when doing observations on the caregivers' daily routines (rhythm) in the performance of their duties, and how they reacted when faced with a challenge, or a situation, or an episode in the context of their workflow. According to Neuman (2006:397-398), *"novice need to learn that wait time is a necessary part of fieldwork, and it can be valuable."* You need to learn the rhythm of the setting, to operate on other people's schedules, and to observe how events occur within their own flow of time. During these episodes and situations, the researcher would apply his priestly listening skills (Osmer, 2008:35-37) as a form of attending and data gathering tool. Neuman (2006:398) reiterates that *"a good field researcher listens carefully to phrases, accents, and incorrect grammar, listening both to what is said and how it is said or what was implied."* The researcher captured these observations: The next episode took place during the researcher's observation when the forensic pathologist personnel were called to the hospital wards to dispose of the deceased patient's body (Table 5) by using battery operated golf cart designed for this purpose, to carry the deceased patient from the hospital or casualty wards to the hospital mortuary. The deceased family members or relatives were contacted by the caregivers for identification and the administrative purposes. The doctor was the responsible caregiver designated to write the death reports that explained the cause of death. Similarly, members of the deceased family or relatives who were called to the hospital, because of the death incident, appeared to experience pain of loss and bereavement, and needed the religious and spiritual supports.

The researcher noticed during the routine visits to the hospital wards (as part of data gathering process), a pregnant young African woman sitting on the hospital bench, facing the nursing station. She portrayed (just by mere observation) a sad face, with very deep thoughts. There were two other men (young and elderly) sitting next to her. The researcher surmised that perhaps they might have come together. After the researcher has greeted and introduced himself to them, this woman's face was down, and she did

not respond. The researcher then prompted why they have come to the hospital. The two men confirmed that they were father and son, and the latter was about to be discharged from the hospital. The pregnant young African woman told the researcher that she received a phone call to come quickly to the hospital. When the researcher probed to enquire why she was called to the hospital, she cried, and with a staggering voice she said: "*Ba re moratho waka o hlokofetse*." Loosely translated; *"They said that my sister is deceased."* The doctor was busy with the completion of the death report. At that very moment, the researcher asked her if she needed bereavement counselling. And she agreed. After that her face brightened up, she wiped her tears and she thanked the researcher for the spiritual support. On the same vein, the researcher further observed that the curtain to her deceased sister's bed was closed. Other patients in the ward appeared to be in shock and saddened by the experience of losing one of them.

The other episode observed at Ward M was about a young man who was limping with one foot towards the nursing station. One of his legs appeared to be numb, and his hands were tightly holding to the movable hospital trolley as he motioned forward. When he arrived at the nursing station, he greeted and answered the landline phone call. Someone was phoning to enquire about his medical condition, and the researcher overheard him saying that he was fine. The caller might be insisting to visit the patient at the hospital, and that bothered the patient: "*Ga ke nyake o tla mo! Ke sharp! Ke sharp! Ke tla go bona tomorrow ge ba-ndischacha.*" Loosely translated; *"I do not want you here! I am fine! I am fine! I will see you tomorrow when I am discharged."* The next day, the researcher saw the same young man on a wheelchair. He was waiting in a queue to be taken for X-ray tests so that the extent of his medical condition could be assessed. The researcher greeted and introduced himself to the patient, and he asked him how he was coping, because he had observed how he struggled to walk to the nursing station yesterday. "*Oho, ke wena moruti? Yes, ke go bone maabane. Hai ke sharp.*" Loosely translated; *"Oh it is you pastor. Yes, I saw you yesterday. I am fine."* The researcher explained to him that he was doing research at PHC and requested his permission to participate in the study. He agreed, but he explained that he might be discharged immediately after the X-rays test. Therefore, the researcher engaged him to establish what brought him to the hospital. The patient then opened and told the researcher how he found himself at the Pietersburg hospital. This is what happened:

The patient purported that he was brought to PHC by an ambulance from one of the villages in Limpopo Province. According to his memory, he found out that his girlfriend was cheating with his best friend. After he discovered their secret affair, he decided to commit suicide, and he drank brake fluid. The nurse told him he passed out and was rushed to the nearby hospital, and he was transferred immediately to PHC because of his serious condition. It was on Sunday when he arrived at PHC Intensive Care Unit (ICU),

and he purported the he was in a coma for three to four days before he regained his consciousness. And thereafter, he was stabilised and transferred to ward M. He asserted that he had enough time to think about this episode, and he concluded that God has given him the second chance to live again. He said that he drew his strength from higher source, and he resolved to stop drinking. He told the researcher that he was working in one of the companies, and he admitted that he was a heavy drinker. He spends at least R100-00 per day and more than R500-00 per week on alcohol alone. He asked the researcher to pray for him: "*Moruti, ke kgopela o nthapelele ke lese go nwa.*" Loosely translated; "Pastor, I ask you to pray for me so that I can stop drinking." This patient's story and the request created an opportunity for a brief spiritual support. The researcher's experience of his SAPS chaplaincy guided him on how to render spiritual support to the patient.

The other episode was observed during the researcher's visit to the PHC settings, at the oncology ward Q. The researcher saw four young mothers who were sitting outside the hospital premise enjoying the sun. He approached them, introduced himself and explained the purpose of his visit. The young mothers were willing to be interviewed. But the formal interviews could not be conducted since the interview process was already concluded. However, as the researcher interacted with them, he discovered that they were there to support their children who were admitted for cancer treatment. During the probing, the researcher discovered that these young mothers had established the support group for mutual spiritual support and encouragement. One of them said that her child was gravely ill and in the advanced cancer stage. The doctors had already informed her that there was nothing else they could do to save her child, and she had to prepare for the worst. However, she appeared to be strong in faith and ready for her child's palliative care and support. Thereafter, the researcher provided intercessory prayers for all of them. The next day, the researcher coincidentally met this faithful mother. She expressed her words of thanks and gratitude for God's intervention, and purported that her child's medical condition has improved due to the prayers. This episode was corroborated by PHC allied hospital worker. She attested to the researcher about this woman's child whose health has improved after their prayer, and she asked why the hospital does not appoint the chaplains.

The following situation was experienced during the researcher's observations: The researcher was visiting the PHC casualty to observe how the patients were admitted and treated by the caregivers. The researcher noticed that one of the personnel from Emergency Medical Services (EMS) was not feeling well. The researcher approached and introduced himself to him, and he was keen to hear that the researcher was a minister. He expressed his willingness to be one of the research participants, and asked the researcher to pray for him. The researcher rendered a word of prayer. However, the situation was not

conducive to conduct an interview. After few weeks (four or less), the researcher met the same personnel at the hospital premise. During their informal discussion, the personnel purported that they are not receiving the necessary support needed from the management regarding the demanding duties. He said that they are expected to save lives in their line of duty, and they sometimes encounter gruesome scenes which impact on their wellbeing. He expressed his wish to have a religious and spiritual support at the workplace. The researcher again heard that in one of their situations, the community of Northam in Limpopo Province attacked the EMS personnel. The personnel were under the impression that it was an emergency. However, they discover later that it was a booby trap which was set by the residents due to the protests. He said the personnel (male and female) were stopped by the mob during that night. The road has been blocked by rocks, and the ambulance could not escape on either side of the road. The community stopped the hospital ambulance, searched the personnel and confiscated their valuable items. They then tied them up and torched the ambulance. The personnel managed to escape, and the female colleague reported this incident because she has hidden her cell phone in her breasts. The personnel purported that this situation was very traumatic, and there was minimal management support. Hence they dealt with this trauma their own way.

2.3.5 Observing health caregivers' experiences of being brought up short

The researcher observed that PHC caregivers' experience of being brought up short (Osmer, 2008:21-23) was challenged when the caregivers' pre-understanding of the provision of health care to the patients is through a non-responsive medical model. Osmer (*ibid*) further states that:

> *We can shrink back and deny the challenges these experiences present, attempting to buttress and repair our already-established patterns of interpretation. Or we can embrace the challenge they present to our way of being in the world, learning from them and accepting responsibility for creating new interpretive patterns* (pp.21-22).

Conversely, there were times when the patients would refuse hospital treatment (RHT) for religious and spiritual related reasons, other times the patients would refuse blood transfusion due to their belief system. Sometimes the patients would like to be provided with the religious and spiritual support (rituals or form of prayer or scriptural messages) before the surgical operational procedures are conducted in the hospital theatre. However, there were no systems in place to embrace these challenges and to respond effectively to the religious and spiritual needs of the patients. It became evident that there was a gap in this regard.

The first episode happened after the researcher held a special service on Good Friday 19 April 2019 at the PHC casualty section for the on-duty doctors and the nursing staff. Thereafter, the researcher visited few hospital wards after conducting the service to encourage patients and the on-duty caregivers. The researcher observed that some patients were demotivated because they could not be granted permission to go home and be part of the Easter celebrations at their respective places of worship. The researcher's view was that it was crucial to experience first-hand how the patients are coping with their health challenges, and more especially during Easter. These actions were motivated by the participant observation's approach the researcher employed with a view to gather data. Secondly, these actions were informed by what the researcher overhead from the PHC management regarding the Easter hospital plans in order that they can deal with any challenges which may need their prompt responses and interventions. It is common knowledge that there are millions of people who annually come to Limpopo Province to attend the Easter service at Moria, outside of Polokwane city. It is during these heightened periods that there are many road accidents which are experienced, partly due to the high traffic volume and the reckless driving. Therefore, all the relevant Departments in Limpopo Province (SAPS, Departments of Health and Traffic, Roads and Infrastructure) are expected to have their plans in place to intervene and respond to these anticipated challenges.

The researcher reported at the PHC casualty on Tuesday 22 April 2019, to determine the caregivers' experiences during their special Easter duties. Their reception was very warm and welcoming, and most of them expressed words of thanks and gratitude for the special Easter service which the researcher has conducted. They purported that it served as a motivation and inspiration. They further confirmed that 2019 Easter was not as busy as before. However, it was during this interaction between the caregivers and the researcher when he was requested by one of the nursing sister to assist them with a patient at the casualty who was requesting the services of a religious leader before any treatment procedure could be done on her. She was lying on a hospital bed at the casualty consultation room. They purported that she refused that her blood could be drawn before she talked to her minister (religious and spiritual leader). After the nursing sister introduced the researcher to her, the researcher greeted her and explained that he was a minister, and that he was at the hospital to conduct research. When the researcher probed to determine what was her problem, she responded by saying that she knows her rights. She said that no caregiver can draw blood from her without her consent, pre-counselling and explaining the reasons for that process. The researcher reassured her that he is also trained as a counsellor, and that he was willing to assist her in this regard. But she insisted that she must first talk to her minister and receive the relevant instructions (*ditaelo*) for her informed decision. Therefore, the researcher asked her if she would be comfortable if he prayed with her, she consented. After the prayer, the researcher tried to probe why she

was refusing that her blood be drawn so that the caregivers can determine what kind of interventions were needed. She responded and said that she knows that, and it was her right to agree or disagree. When probing further, she confirmed that her brother went to fetch her minister. However, this incident demonstrated that the patients' religious and spiritual dimensions of being human in the SA health care settings, is a practical challenge that need to be addressed through the institutional health care system.

The researcher observed how the PHC managers managed the episodes and situations when confronted with the experience of being brought up short. The first incident observed was when the two officers (detectives) from the SAPS arrived early in the morning of March 2019 to investigate the case of a missing child. It was alleged that the child went missing during hospitalisation at PHC, and the officers came to meet with the hospital manager for the investigation of the missing child. The researcher further noticed that there were many doctors who came to meet the hospital manager for work-related matters, and they waited until the police left the manager's office. After the officers interviewed the manager they were referred to the office of risk manager for the hospital video recordings. This incident highlighted one of the challenges which are faced by the mangers in the SAGH settings. There are many incidents of reported cases of the babies who are stolen from the SAGH facilities. The hospital mangers are expected to put measures in place in the running and management of the hospitals to secure the patients' safety. The researcher observed that in PHC settings, there were security guard personnel posted at the entrances of the hospital, including the maternity and the children's wards. There was also a security system for the video recordings. However, the experiences of being brought up short in a health care system, affect the hospital management, the caregivers and the patients alike. Hence most of the believers would rely on their belief system when they are faced with the spiritual challenges.

The other incident that happened was when the SAPS officers came to the Government Mortuary (PHC Forensic Department) to investigate the death of a suspect. The researcher observed that the family of the deceased was accompanied by the SAPS officers as well as the officer from the Department of Correctional Services (DCS) from Mokopane, so that they can identify the body of the deceased patient. The researcher overheard the officers alleging that the suspect was released on parole, and was staying with his family. However, when he got sick and was admitted for treatment at the Government hospital, he used a fake Identity Document (ID). Therefore, it was a challenge to trace the deceased suspect's family after he died in the hospital. The purpose of coming to the government mortuary was to identify the deceased suspect to verify and confirm his identity. The researcher overheard the father of the deceased telling the officers that his son was using an identity of his other brother when he was admitted for hospitalisation so that the DCS could not trace him. However, this incident resonates with many similar

reported cases of unidentified patients who are admitted and treated at the SAGH. Therefore, it is only when these patients experience health complication or related challenges that the hospitals are unable to trace their families and or relatives for support. Hence this incident was a highlight on this grey area.

The third incident happened on March 2019 when the researcher was supposed to interview one of the hospital managers. The researcher noticed that the manager was uneasy because of the reported situation of a leaking hospital steam pipe which had to be fixed on that Friday. The researcher had to postpone the interview with the manager so that he could attend to this problem. However, the researcher noticed that the PHC had an old structure which needs to be maintained to provide the health care services in a conducive health environment. Conversely, lack of maintenance of these structures and hospital environment would impact on the managers of health care, the caregiver of health care and the recipients of health care alike. This translates into old, unused and dilapidated hospital structures (buildings) that has become obsolete for the provision of quality health care. Similarly, this result in hospital space shortage, and thereby wait-listing the patients who access the health service. Finally, these affected and frustrated the functioning of an effective health care system in providing quality health care.

The fourth incident was observed by the researcher on March 2019 after the instruction from the higher authority (the political head) was issued to the PHC management to secure a bed for a patient. The relevant manager had to enquire for the availability of a hospital bed as opposed to the functioning of the hospital referral system. This experience of being brought up short resonate with many impatient patients who are subjected to being wait-listed and not getting the kind of help as expected from the Government hospitals. Therefore, this incident painted a picture of a political system which was meddling with the health care referral system in the admission of the patients in SAGH. This is problematic because everyone has the right of access to health care services as prescribed by the Constitution of the RSA (1996). However, this and many other similar incidents highlighted the political challenges facing the managers of health care, health caregivers and the consumers of health care in the SAGH settings.

2.4 HOPE IN THE MIDST OF THE HEALTH CARE CHALLENGES

According to Holst (2006:8), *"a hospital is a place of paradox, of contradictions and blurred realities."* Therefore, an institutional health care chaplaincy becomes very critical role player in the health care teams in that, it brings hope in the challenging health care settings, and, also relates the meaning of illnesses to those in distress. However, the exclusion of the health care chaplaincy, firstly, translates into the religious and spiritual services' approach that is inconsistent, unstructured, unsustainable,

unmonitored, unevaluated, and unresponsive to the patients' religious and spiritual needs as grounded in the RSA's Constitution of 1996, and encapsulated in the Patients' Rights Charter. Secondly, the exclusion of the health care chaplaincy translates into a lack of result-orientated, value-driven, research-oriented, and professional expertise in providing the religious and spiritual care within the multi-disciplinary health care teams. The researcher observed that the managers, the caregivers and the patients in the PHC settings, would benefit greatly if there was an institutional chaplaincy that was providing the religious and spiritual care.

2.4.1 Human beings

According to Hodge (2005), human beings are viewed as an integrated entity, consisting of body (*soma*), soul, and spirit. The researcher observed that the religious and spiritual needs of the patients and caregivers at PHC settings were innate. Therefore, they appreciated the messages of hope and encouragement which the researcher was providing, especially to those whose hopes were deferred during the health care crisis. They embraced a belief in the supernatural being that generated hope in a hopeless, helpless and hapless health care challenges.

2.4.2 Optimal functioning

According to WHO (2010), health system responds in a balanced way to population's needs and expectations. McDowell and South (2017:1) say that *"the practitioners of holistic care agree that spiritual care must be included to address fully the needs of clients." Hence "holistic nursing care incorporates the needs of body, mind, and spirit,"* (*ibid*). Therefore, caregivers need to be mindful about tailoring interventions to more closely to fit the needs and preferences of patients from more collectivist cultures- e.g., involving family members and patient's cultural group in the treatment process (Cook, 2004:62-63).

2.4.3 Provision of care

The researcher observed that when the religious and spiritual care was driven by hope, it enhanced the conditions of the patients' well-being. According to Ferngren (2014:1-2);

> *A belief in God often quietly motivates a physician or health-care worker to provide compassionate care for those who are ill, or to help the sick endure pain and suffering, or to give spiritual consolation to the dying. Physicians and patients alike pray for divine help and healing, especially when they have exhausted all the avenues of modern science and medical knowledge. Faith today still offers the hope of some relief to many*

> *who experience chronic or untreatable diseases. And it provides a comfort that modern medicine and science do belief that there is divine purpose in suffering some meaning in all the pain one bears.*

2.4.4 Expectations

The researcher observed that expectations were mutual in that the managers of health care, the providers of health care and the consumers of health care all had common expectations to save lives. According to Pera et al. (2005:176), *"religion is an all-inclusive value system which governs a person's existence in the world and, indeed, in the universe."* The researcher further noticed that the PHC caregivers and the patients who had strong religious and spiritual beliefs, would normally portray high hopes and expectations (when everything else seemed to be failing).

2.5 MEANING IN THE MIDST OF THE HEALTH CARE CHALLENGES

According to Haynes et al. (2007:5):

> *The core issues that are likely to affect patients relate to meaning (how we make sense of what is happening to us, e.g. how we tackle questions like 'Why?'), and coping (spirituality is a resource that transcends personal, social and material circumstances and so can offer sustenance in the face of all mortal adversity). Understanding and supporting these needs is not an addition to clinical care but an integral part of it.*

Therefore, Haynes et al. (2007:10) reiterate: *"nurses, doctors, allied health and ward clerks are there to support. Spirituality is part of that. It is not medical treatment, but it is something that nourishes and helps to heal a person's spirit."* The patients who are spiritual orientated may utilise their beliefs in coping with illness, pain, and life stresses. Studies indicate that those who are spiritual tend to have a more positive outlook and a better quality of life. Kliewer (2004:620) states that *"spirituality and religion benefit patients by helping prevent illness and increasing ability to cope."*

2.5.1 Meaning of life

The meaning of life is critical, VandeCreek and Burton (2001) agree that, approaching death can engender serious spiritual questions that contribute to anxiety, depression, hopelessness and despair.

2.5.2 Emotional and social support

Tovar-Murray (2011) agrees that religious behaviours and spiritual beliefs provide individuals with social and emotional support that contributes to a person's sense of meaning.

2.5.3 Acceptance

According to Puchalski (2001:1), *"one of the challenges physicians face is to help people find meaning and acceptance during suffering and chronic illness."*

2.5.4 Need for genuine warmth

Chung (2009:11) mentions that "*independent of their faith or lack of faith, most people do not want to be alone, unseen, unheard in a hospital or at the end of their lives, and would derive much benefit from being attended to by spiritual care practitioners capable of providing the most essential of services, the genuine warmth and presence of a fellow human being, attentive listening without judgment or need to manipulate."*

2.5.5 Illness

VandeCreek and Burton (2001:82) state that when the patients are faced with illnesses, they usually raise questions, to find meaning; *"Why do I exist? Why am I ill? Will I die? What will happen to me when I die?"*

2.5.6 Negative or positive meaning

Koenig (2001) says that religious beliefs provide a positive worldview that gives experiences - whether positive or negative - *meaning*. Meaning, in turn, provides purpose and direction in life.

2.5.7 Goal or purpose

Koenig (2001:98) reiterate that *"religion could provide a worldview that gives meaning to life."* Furthermore, Koenig (*ibid*) is of the view that *"only religion can answer the question of the purpose of life. One can hardly be wrong in concluding that the idea of life having a purpose stands and falls within the religious system."* Willemse et al. (2017:64) agrees with this view.

2.6 WHY IS THIS GOING ON?

According to Haynes et al. (2007:5), studies suggest that *"patients want clinicians to incorporate spirituality into their treatment and care."* Similarly, McDowell and South (2017:1) reiterates that *"holistic nursing care incorporates the needs of body, mind, and spirit."* On the same vein, Puchalski (2001:5) advocates for the physicians to serve the patients by *"being sensitive to all dimensions of patients and their families: body, mind, and spirit."* Hence Kliewer's (2004:621) view is that physicians need a model that encourages *"to treat the patient person, addressing not only physical, but also social, emotional, and spiritual issues."* Therefore, Hodge (2005:316) is relevant to suggest that human beings are to be viewed as an integrated entity of body, soul and spirit, (Figure 1).

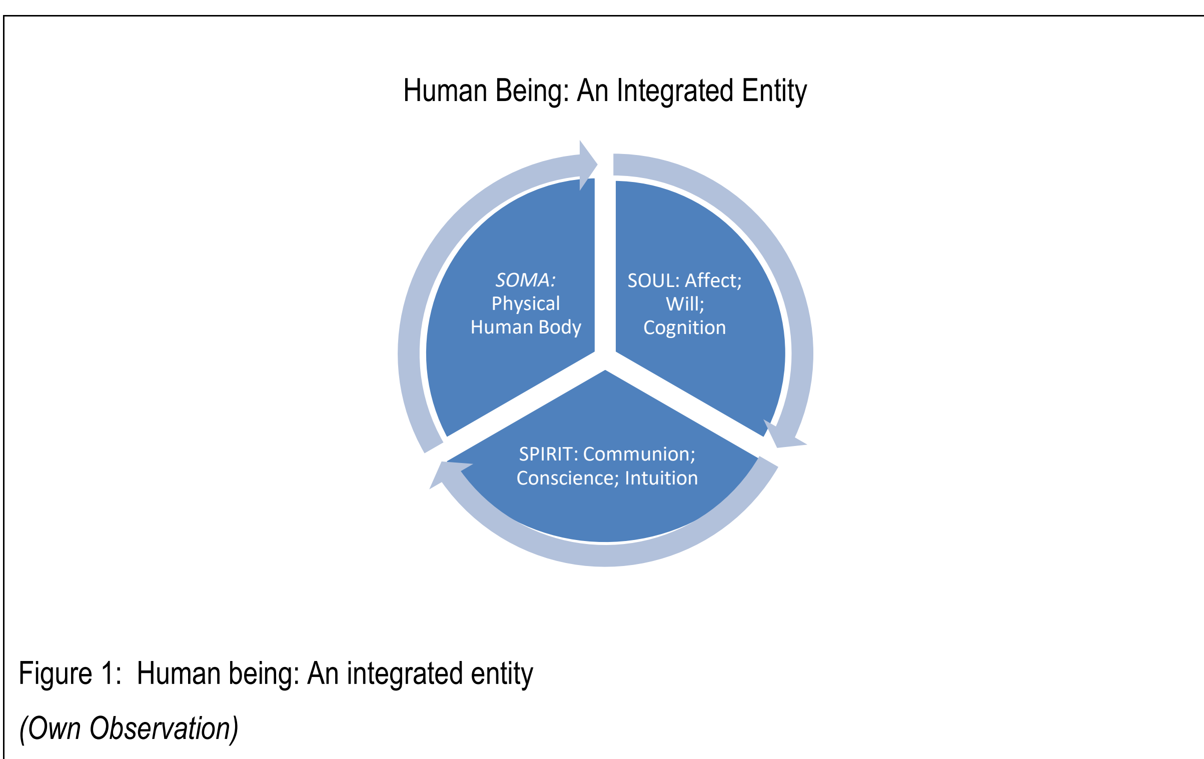


Figure 1: Human being: An integrated entity

(Own Observation)

However, the SAHCS does not embrace the religious and spiritual systems to respond to the needs of the patients. This is problematic because the patients' health care needs are addressed from the separate, yet parallel systems of care. On the one hand, there is a health care system, and on the other hand, there is a religious and spiritual belief systems. This translates into autonomous health care systems which do not streamline the patients' health care needs, and thereby operate in silos, (reflected in Diagram 1 below). Secondly, the patients' right to participate in the decisions that affect their treatment plans is not exercised in that the religious and spiritual needs are not addressed nor considered in the SAGH settings. This demean their human dignity during their hospitalisation. See Figure 1 above.

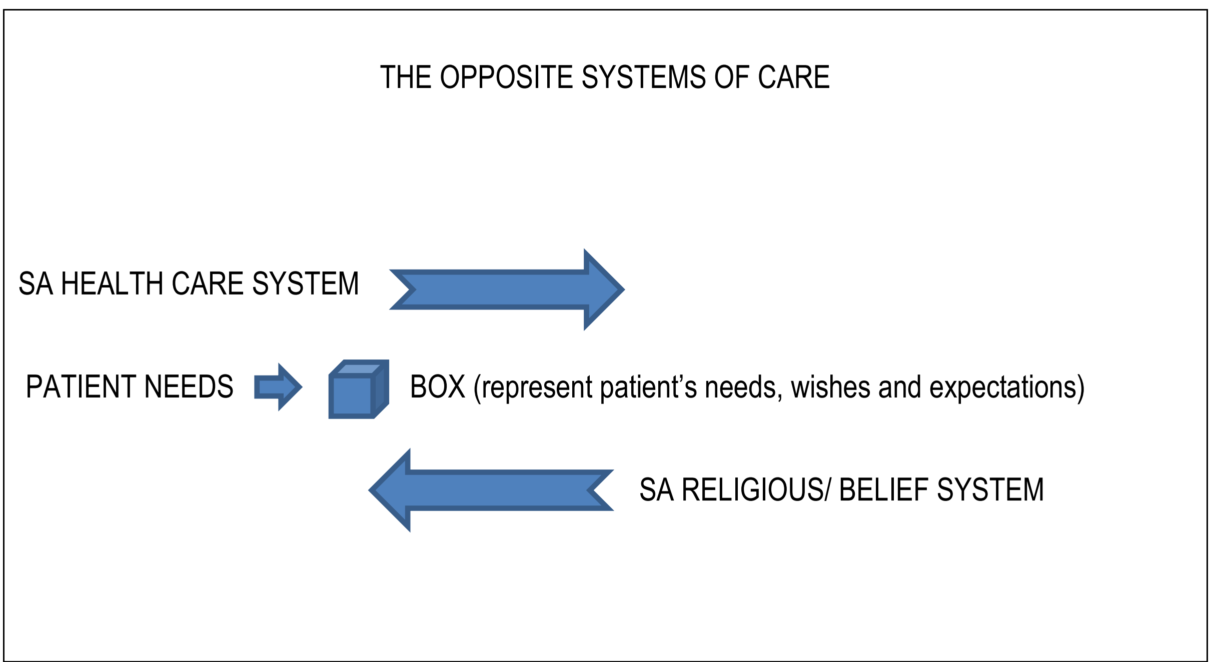


Diagram 1. The opposite systems of care

The foundation of any structure or system is very critical for sustanance. This applies to the SA health system. Why is this going on in the SA health care system is not cryptic, or a conundrum. It is in the public domain. There are buckets of challenges that directly and indirectly affect the consumers of health care as provided by the South African Government. It is public knowledge that the state capture [23] has affected the consumers of health care in the SAGH, compounded by spate of corruption, [24] labour disputes, [25] poor working conditions, [26,28,29] poor health care management, [22] unqualified managers who are deployed to run the health institutions, [27] low morale among government employess, [28,29] disregard for the Constitution and the health policies, [27] as well as the health care functions that are delegated to the provincial and district levels, [27,28,29] These are some of the causal factors that are attributed to the South African health care crisis. This is problematic in that the managers of health care, the health caregivers and the consumers of care are directly or indirectly affected by these challenges. Hence it is a mamoth task for the health care managers and caregivers to manage and provide the quality health care under these challenging health-related conditions, as expected by the patients in the SAGH.

Similarly, the historical background on a structural approach to the provision of health care in the South African context is traced from 1652 when the first temporary hospital was started at Cape of Good Hope, and later followed by the permanent one which was completed in 1656. It is further highlighted that the demands of health care from 1807 due to developments in mining, industry, trade and related commercial activities, created a need for church involvement (Roman Catholics, and later Anglicans from Europe) in

nursing duties at those missionary hospitals, and provided training of black nurses at Lovedale from 1902. The recognition of nursing in military in 1912 and the academic training at tertiary institutions elevated it to a professional status. The establishment of independent states and homelands in South Africa (Transkei, Venda, Bophuthatswana, and Ciskei, abbreviated as TVBC states) under Apartheid regime also created independent Nursing Councils, and Nursing Associations under these TVBC states. Under the post-Apartheid dispensation in 1994, these Councils and Associations were all merged to form one organisation called the Democratic Nursing Organisation of South Africa (DENOSA). Most of these missionary hospitals became the South African Government hospitals. [30] [33] However, these excludes religious and spiritual care.

The SA health care is provided through the medical approach which excludes the patients' religious and spiritual needs. There are currently more than 400 public hospitals managed at district and regional levels (tables 3 and 4), and more than 200 private hospitals in South Africa that do not provide the services of health care chaplaincy. [30] However, the involvement of the church to provide the religious and spiritual care to the patients is practiced on adhoc basis and unregulated. In South Africa the church played a crucial role in health care, expanding the nursing services to the South African military. [30] It can be argued that the services rendered by the church in hospitals were not on the physical needs of the patients only, but embraced a holistic approach to care which considered the religious and spiritual dimensions of human being. Therefore, it may be surmised that the church-state partnership shared the mutual responsibility to cover the financial health care costs. Similarly, it can be argued that the patients' religious and spiritual needs in the SAGH are directly or indirectly affected in terms of the health infrastructure, (delapidated hospital buildings, unused hospital equipments, and others) staffing, shortage of funds, admission and other hospital fees, and similar health related challenges (HIV/AIDS treatment, TB and others). [30]

2.7 WHAT OUGHT TO BE GOING ON?

The global health care is evolving in the first and developed countries such as Australia, Canada, England, Scotland, United State of America, Wales and other countries which embrace people-centred and a holistic approach to care, (Haynes et al., 2007; Myers and Roberts 2014; NHS Chaplaincy Guide, 2015; Orton, 2008; Swinton et al., 2006; Taylor et al., 2015; Timmins et al., 2017; Woodward, 2010). The studies on the evolution of health care has shown that these trends and practices are as a direct response that is targeted at meeting the changing needs, expectations and wishes of the patients. This is to ensure that the religious and spiritual dimension of being human are addressed in tandem with the patients'

fundamental right to considerate care, (VandeCreek & Burton, 2001:83). The researcher explores patient-centred care, a holistic approach care, and chaplaicy.

From the South African context, the proponents of the public health care argue that:

> *Biomedical interventions in health will not be effective without being complemented by modification in behaviour. It is clear that a drug will not be effective if the right dosage is not taken and if there is no adherence to dosage guidelines. Certainly, the latter supportive interventions are behavioural rather than biomedical. To cite one example, the realisation that behaviour has to change has given impetus to combination prevention discourse in HIV prevention* (Magezi, 2012:1).

Similarly, Manala (2005:897) argues that *"HIV/AIDS in South Africa demands a specific approach to the Christian ministry in which the African world-view is acknowledged."* Therefore, from the view of De la Porte (2016:3);

> *"Research has demonstrated robust links between spirituality and health. What is emphasised throughout is the importance of integrating spirituality into the practice of healthcare. A multi-disciplinary approach is needed with the person at the centre, making room for the distinctive perspectives and practices of social sciences, health professionals, chaplains, and clergy. The availability of spiritual and pastoral workers trained to work in healthcare is emphasised throughout the research.*

However, these views do not address the current challenges of why is the health care chaplaincy excluded in the SAGH settings to address the patients' religious and spiritual needs. Conversely, a proponent of pastoral care in a health care setting, Atherstone (2011) argues that the hospital chaplains can form part of the broader medical team as competent religious and spiritual health care professionals.

The researcher's observations highlighted that the SAHCS does not provide the religious and spiritual care to the patients who are admitted and treated at the PHC settings. Notwithstanding, there is no professional health care chaplaincy in the SAGH's health care teams as institutional experts in rendering the religious and spiritual care. However, the ressearcher's view is that what ought to be going on in the SAGH settings is to provide the quality health care that is responsive to the needs of the patients, and addresses all dimensions of the patients' being. This imlplies that there is a need for a new synchronised health care system which embraces the patient-centred care, (which encapsulate the patients' needs, expectations, wishes, worldviews, and rights). Secondly, this system must employ a holistic approach to care (body, soul spirit), and thirdly, this system must translate into a model of health care that address the patients' religious and spiritual needs. Therefore, since the health care chaplaincy knows both the

worlds and systems of caring (health and religious systems), it has evolved as a critical player in a holistic approach to care that is effective to address the patients' religious and spiritual needs, (Diagram 2 below).

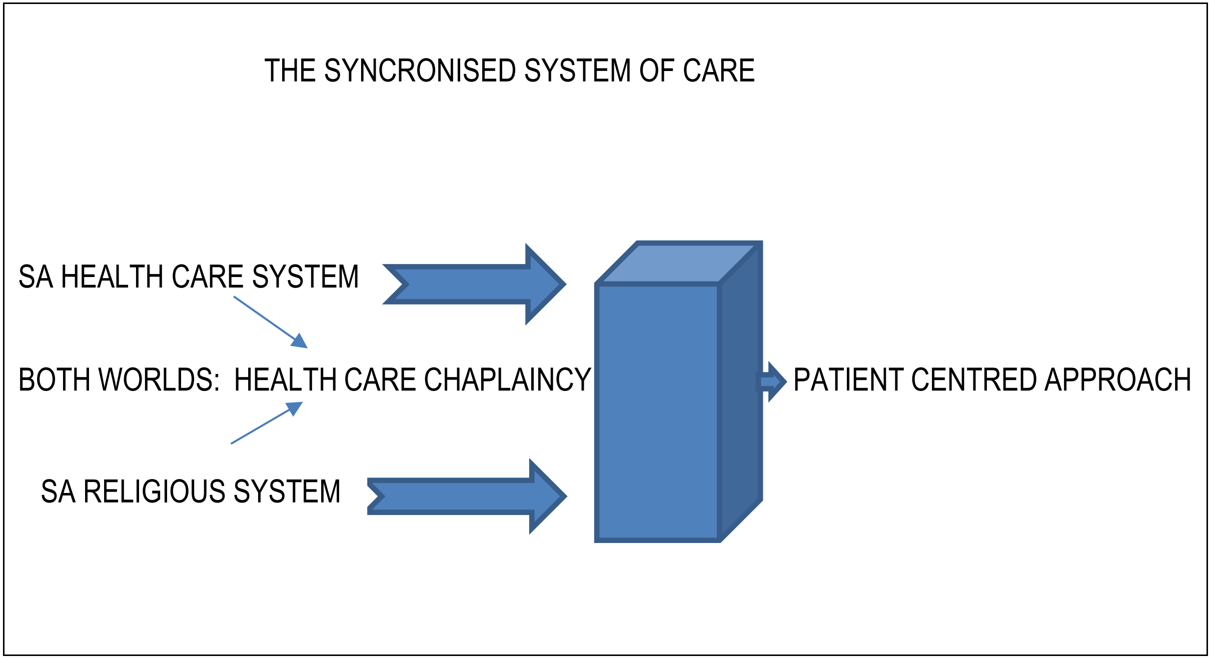


Diagram 2: Health care and religious systems

2.8 PATIENT-CENTRED CARE

According to Chung (2009:24),

> *"In a patient-centered holistic approach, the belief systems and attitudes, resources and relationships, and other aspects of the person in the body are acknowledged to significantly impact healing and recovery. It is more important to know who has the disease than to know the disease the person has.*

Hence the patient-centred care requires health care professionals to acknowledge and accommodate patient's beliefs, practices and wishes (Haynes et al., 2007). This implies that there is a need for a holistic approach to care in response to the patients (as human beings), and thereby employ the patient-centred health care model which includes the patients' religious and spiritual needs when planning and providing treatment and care in the SAGH facilities. The evolution of health care into the patient-centred, holistic and wellness focussed (HCC, 2010:6) resonates with the patients' fundamental rights to considerate care (VandeCreek & Burton, 2001). Similarly, the South African consumers of health care are also becoming more aware of their rights through the Constitution of the Republic of South Africa. The National Patients' Rights' Charter (NPRC) embraces among others, that the patients participate in decision making and the choice of health service. The patients who use the public health services have rights which include among

others: participation in decision making, access to health care, choice of health service, and to complain about health service, (Mulaudzi et al., 2001). This is in tandem with WHO (2010) in that one of the key components of a well-functioning health system is making it possible for people to participate in decisions affecting their health and health system. Therefore, Pera et al. (2005) are of the view that the following fundamental rights cannot be violated by the government in that rights such as the right to life, the right to human dignity, the right to privacy, the right to language and culture, the right to freedom of religion, and others are people-centred. However, Curtain and Flaherty's (1982) argument is that to begin to meet the needs of the whole public, institutional reorganisation and reform are necessary in health care.

2.8.1 Patient's world view and expectations

A world view is a view that is used worldwide. A world view is a mental model of reality- a comprehensive framework of ideas and attitudes about the world, ourselves, and life, a system of beliefs, a system of personally customised theories about the world and how it works - with answers for a wide range of questions like: What are humans, why we are here, and what is our purpose in life? What are your goals for life? When you make decisions about using time – is it the stuff life is made of? What are your values and priorities? What can we know, and how? And with how much certainty? A person's world view is affected by many factors such as their inherited characteristic, background experiences and life situations, the values, attitudes, and habits they have developed, and more and these vary from one person to another." [31] The patient-centred care embraces the patient's world view which is key for meaning, purpose, coping, and wellness. According to Haynes et al., (2007:2-7), "*the people's world view is the most important thing in their lives with a deciding role in directing behaviour; guiding attitudes to health, work and relationships, and strongly influencing how they regard themselves and others*." Hence identifying 'spiritual and religious needs in the hospital context assist in gaining and understanding patients' beliefs or practices and their wishes. It is therefore imperative that patients are to be engaged in order to understand their world views and respond appropriately to their needs. Willemse et al. (2017) mention that life-threatening disease may lead to existential crisis that lead to questions related to beliefs and worldview. Spiritual caregivers can play a complementary role in meeting the spiritual needs within whole patient care. The world view concerns basic beliefs, key values and perception of life that enables the patients and families to make decisions when necessary, also at an ethical level. Thus, room for various world views in the ICU is extremely relevant for both quality of life and care.

2.8.2 Patient's religious and spiritual needs

The researcher observed that the patients' health care records were captured manually and electronically at the PHC for administrative purposes. These records contained the patients' information which included among others, their religious or faith backgrounds. However, the SA health care system does not embrace the religious and spiritual care in the SAGH settings. Therefore, it seemed very strange and naive, (from the researcher's perspective) that the patients had to be subjected to these procedures of providing their personal beliefs' information, knowing good well that this will not translate into any screening or assessment of their religious and spiritual needs so that it can be addressed through their health care and treatment plans. Similarly, it is absurd to exclude chaplaincy as experts to address the patients' religiopus and spiritual needs in the SAGH. Howell et al. (2017) agree that addressing the spiritual and religious needs of hospitalised patients has become increasingly important in the last two decades.

Since religion and spirituality are key resources in providing meaning and understanding patient's world view, an instrument (tool) to screen and assess patient's needs in the health care setting is required. It is important to have an instrument to screen and assess patients' needs during their admission and treatment. According to Hodge (2005:314), *"assessment provides a method of identifying spiritual assets that can be operationalised in treatment and discharge planning."* Chung (2009:21,23) reiterates that *"an assessment is a statement of perception and a process of information gathering and interpretation."* Spiritual assessment is considered a prerequisite for effective spiritual care. The chaplain ought to understand the needs, strengths and particular issues relevant to the individual patient, so that care can be provided where it is most needed. This protocol and procedure is vital in ensuring that evidence-based approach is practiced in chaplaincy to provide quality service as religious and spiritual experts. The nurses, social workers and the other health care staff need training to administer screening and assessment.

According to Puchalski (2001:1),

> *Spiritual or compassionate care involves serving the whole person, physically, emotionally, socially, and spiritually. Such service is inherently a spiritual activity. Serving patients may involve spending time with them, holding their hands, and talking about what is important to them. Patients value these experiences with their physicians.*

As POWH Nurse puts it that *"nurses, doctors, allied health and ward clerks are there to support. Spirituality is part of that. It is not medical treatment, but it is something that nourishes and helps to heal a person's spirit"* (Haynes, 2007:10). Therefore, Kliewer (2004) argues that it is all about the patient's spirituality, not the caregiver's or physician's, and about supporting the patient's spiritual beliefs, working within the framework of those beliefs, (unless clearly pathological). Providers can collaborate with 'spiritual specialists,' such as the patient's spiritual leader or the hospital chaplains, social workers, mental health specialists, psychologists, or even a group of some sort. However, the researcher observed that some of the caregivers (nurses and doctors) in the PHC settings, were providing the compassionate care from their own convictions and volitions, which is contrary to the current South African medical approach, since it does not embrace the patients' religious and spiritual needs.

Haynes et al. (2007) state that predominant biomedical position has been to leave spirituality out of medicine. However, research, together with the increasing emphasis on a biopsychosocial model, strongly suggests that this is no longer acceptable in contemporary patient-centred health care, and patients want clinicians to incorporate spirituality into their treatment and care. Conversely, Kliewer (2004:622) reiterates that the process of learning how to integrate medicine and spirituality is not an easy one, nor will it be accomplished without struggle. But it is a process vitally important for modern medicine. The issue truly is one of caring, both when cure is possible, and when it is not. It is a matter of focusing on part of what makes us truly human, and supporting a healing process that often transcends the biomedical agenda. However, Puchalski (2001:5) argues that it is important for physicians to understand professional boundaries when providing in-depth spiritual counselling, unless it is under the direction of chaplains and other spiritual leaders, as they are the experts in the religious and spiritual care and counselling.

2.9 HOLISTIC APPROACH TO CARE

According to Dreyer et al. (1993:7), health is the well-being of the body, the psyche and the spirit, and that it includes the harmonious integration of a person with himself/herself, the community and the environment (*ibid*). Health should therefore be viewed within the specific community's socio-political, cultural, religious and interactive framework, and never in isolation. Health is a dynamic that encompasses the promotion of optimal physical, psychological and spiritual functioning (*ibid*). However, the researcher observed that in the PHC settings, the caregivers are employing or operating on the skewed, stereotype, one dimensional, regressive, old fashioned, and unresponsive medical model of health care that excludes the patients' religious and dimensions of being human. Therefore, the patients who refuse hospital treatment (RHT) based on their religious and spiritual needs, are discharged from

the hospital because the SA health care system cannot address their religious and spiritual needs. However, Pera et al. (2005:176) argue that *"religion is an all-inclusive value system which governs a person's existence in the world and, indeed, in the universe."* Hence it is appropriate to employ a holistic approach to care.

On the same vein, Chung (2009) is of the view that the holistic (etymologically the same root as whole, health, heal, holy) perspective, akin to systems theory, emphasizes the relationship between parts and whole. Holistic medicine sees the physical body (Greek: *soma*) as one integral system within the higher-level system, the wholeness of a human being. As in psychosomatic medicine body and mind are recognised as affecting each other, corresponding to the common element of all systems, which is knowing that one part of a system tells us about another part. Treatment cannot only be aimed at a set of symptoms, psychosocial, spiritual as well as behavioral and environmental factors impact disease and well-being of a 'patient' (etymologically 'the bearer of suffering').

Holistic approach has been traditionally defined as a philosophical theory that states that the determining factors in nature are wholes which are irreducible to the sum of their parts and that the evolution of the universe is the record of the activity and making of such wholes. More generally, it is a concept that wholes cannot be analyzed into parts or reduced to discrete elements without unexplainable residuals. Holism may also be defined by what it is not synonymous with organicism; holism does not require an entity to be alive or even part of living processes. And neither is holism confined to spiritual mysticism, unaccessible to scientific methods of study. [32]

2.9.1 Multi-disciplinary healthcare teams

The term, 'multi-disciplinary' is defined as combining or involving several academic disciplines or professional specialisations in an approach to a topic or problem. [33] The impeding problem is how to address the patients' world views in the SAGH multi-disciplinary health care teams. The current approach to provide the religious and spiritual care to patients in the SAGH is problematic in that there are many religious and spiritual structures, organisations and churches which are not regulated nor trained to provide the religious and spiritual care as part of the multi-disciplinary health care teams. However, the relevant approach requires the expertise of the professional health care chaplaincy as experts in the religious and spiritual care within the multi-disciplinary health care teams. Therefore, this resonates with the researcher's observations at the PHC settings which excludes chaplaincy services, but includes the professional services (for example, the social workers, psychologists, and other therapists and clinicians)

as part of the multi-disciplinary health care teams. Conversely, this translates into all the dimensions of care being provided in the SAGH settings, except for the religious and spiritual dimensions.

The researcher's view is that the misunderstanding of the phenomenon of health care chaplaincy in the SAGH settings can be cited as one of the many reasons to justify its exclusion in the SAGH health care teams. On the contrary, the antagonists of chaplaincy, Loewy and Loewy agree that religiosity is merely one expression of spirituality, yet claim that, because all patients are spiritual beings, they should routinely be visited by a chaplaincy service because chaplains have 'special expertise' in all spiritual matters. Even if such a claim to special expertise were proven (which it is not), having all patients routinely visited by a chaplain would be equivalent to having all patients seen by a cardiologist; after all, the argument is the same. We all have spiritual needs and we all have hearts. A chaplain, like a cardiologist, may-or may not-be an important member of a health care team for a patient. To claim otherwise requires compelling evidence that, thus far, has not been provided. Loewy and Loewy reiterate that hospital chaplains may, in appropriate cases, serve a critically important function in a patient's care. However, we are deeply concerned about the demands on the part of some chaplains and chaplaincy associations to be treated as full-fledged members of every patient's health care team and or to have complete access to patient's medical records whether to gather patient information or to make notations of their own. Loewy & Loewy further argue that chaplains are no health care professionals and, arguably, not even allied health care professionals for three rather important reasons:

- Chaplaincy has no biomedical foundations.
- Chaplains (qua chaplains) have no unique biomedical specialty training, and
- Chaplains would presumably reject the idea of being closely supervised by the patient's physician.

Therefore, the proponent of chaplaincy Chung (2009:8), asserts that *"critics argue against chaplains becoming full-fledged members of health care teams or have full access to medical files and contend that spiritual care is but the emperor's new clothes."* According to Chung (*ibid*), *"overcoming historical confrontations, science and spirituality can converge in a chaplaincy model that is a higher synthesis with patients being the beneficiaries."* Similarly, Timmins (et al. 2017:15-16) further argue that some changes are to be considered such as increasing access to patient's records, including chaplains on multidisciplinary teams. Therefore, chaplaincy is a specialised skill that provide a different dimension of care (non-medical) within the health care professionals' holistic approach to care.

Ali et al. (2013) further argue that the need to work as part of a multi-faith team within an institution characterised by religious diversity is often noted by chaplains as an intrinsic taken-for-granted part of their role. The description of the multi-faith reality of chaplaincy work may be positive, 'neutral' or negative, but it is clearly seen as part of the wider social context of the institution and of the society more broadly. On the same vein, the need to work as part of health care professionals in hospital setting is equally important to chaplain's role in the holistic approach to care. Ali et al. *(ibid)* confirm that a hospital chaplain is a very important part of the health care team and offers spiritual counselling and emotional support to the sick, recovering, and dying patients. If the patient does not have his or her own minister, the chaplain often serves as a trusted friend and pastoral figure. He/she is often available to the emergency room, intensive care unit, and hospital staff to help with the distressed family or a critically ill or dying patient. He/she functions as a very important part of the health care team. He/she must not only be able to intermingle with the other professionals but to interrelate and interact with them. Hence hospital chaplaincy is a specialised ministry with many demands. On the contrary, there are some things about hospital environment a chaplain can't know and will never know. However, basic knowledge of the hospital environment is and always will be critical part of a hospital chaplain. Conversely, chaplaincy is not valued as a critical part of the SAGH settings.

Research shows that there is a growing body of consensus that health care professionals should be at least aware of their patient's spiritual needs and concerns (Neumann & Olive, 2003; Olive, 1995). King and Wells (2003) go further suggesting that it is not enough to just address these issues, but that professionals should convey their patient's beliefs and values to the other members of the treatment team, Galek et al. (2007). Every team member has a special and specific role to play. The team should portray team dynamics, like for example, '*espirit de corps*.' "Espirit de corps is a feeling of loyalty and pride that is shared by members of a group who consider themselves to be diferrent from other people in some special way." [34] On the contrary, how do you ensure '*espirit de corps'* among members of the team if there is no information sharing nor access to information (files)? Similarly, why the nurses and the social workers are called to administer spiritual screenings or assessments (if they are not trained theologians)? Are they not members of the same team who strive to achieve the same goal? The researcher's perspective is that this view is narrow in that it does not consider the dynamics of a team. Therefore, "team dynamics are the unconspicuous, psychological forces that influence the direction of a team's bahavoiur and performance. They are like undercurrents in the sea, which can carry boats in a diferrent direction to the one they intend to sail." [35] The researcher's view is that every team has its own vision, mission, approach (action) and strategies to achieve its goal: To work in tandem and to their professional

abilities so as to provide the quality health care. The researcher explores the concept of holistic approach through the notion of how an airballoon work.

2.9.2 Concept of holistic approach through air balloon

The researcher explores the idea of a health care team in Figure 2. This can be conceptualised through the picture of an air balloon. It is stated that "a hot air balloon is lighter than aircraft consisting of a bag, called an envelope, which contains heated air. Suspended beneath is a gondola or wicker basket, which carries passengers and a source of heat, in most cases an open flame." [36] The researcher's view is that in order to understand the holistic approach to health care, the concept of an air balloon can be borrowed in this example. The picture shows that air balloon is composed of three important parts which form an indivisible whole (team) as highlighted below:

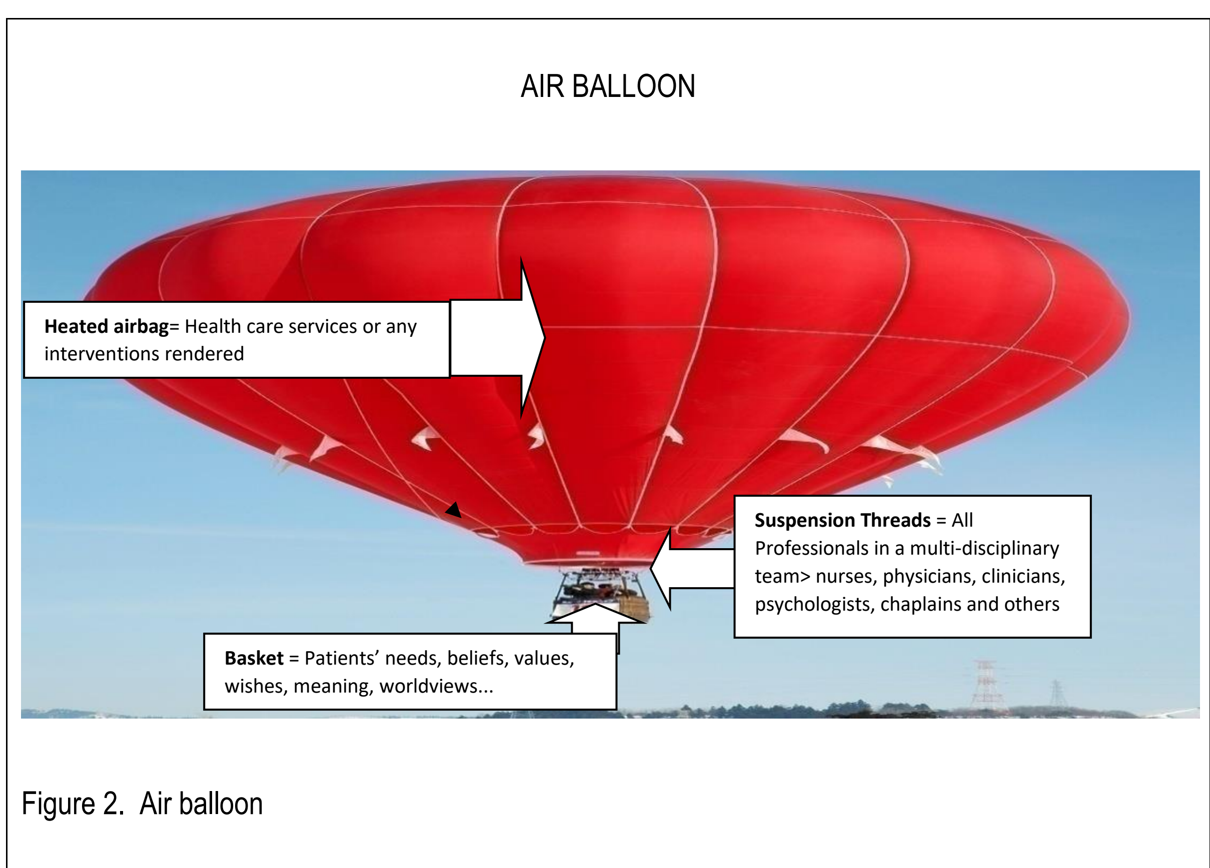


Figure 2. Air balloon

2.9.3 The lower part of air balloon

The lower part called gondola/wicker basket (which carry passengers and is a source of heat) is associated with the patients, their needs and expectations (world views, religiosity, spirituality, beliefs, values, meaning and others) from hospitalisation, treatment and discharge process. Like an air balloon, the patient is taken on board (for treatment, care and support) with the hope of recovery, healing, and achieving a state of wellness. Therefore, the patients are assured the provision of the quality of professional health care by the health care team in the hospital settings through their health care journey. However, the patients must give consent and their rights be respected.

2.9.4 The middle part of air balloon

This middle part representing threads (or cords) joining the gondola/wicker basket and the bag/envelope is associated with the inputs (expertise) of the health care professionals (nurses, physicians, clinicians, chaplains, psychologists and others) in a multi-disciplinary health care teams who are appointed to render a holistic care in order to treat the patient as a whole person, thereby addressing not only the physical, but also the social, emotional, and spiritual issues, (Kliewer, 2004). However, the strength/resilience of each thread/cord depends on the equitable weight sharing (expertise) of other members of treating and

caring team. Therefore, the patients' needs, expectations, wishes and beliefs are provided from a holistic approach through the multi-disciplinary teams.

2.9.5 The upper part of air balloon

The upper part called bag/envelope *(*which contains heated air*)* is associated with the services or interventions provided by the health care teams in a holistic approach, from the day of admission through the processes of their treatment and care in the hospital settings. The discharge epitomises the anticipated destination. The impact, value and success of the services which are provided by the health care teams can be measured through the client satisfaction instrument in order to indicate the level in the quality of service (on the scale of very poor to very good).

The concept of air balloon can be globally understood from the patient-centred and a holistic approach to care. However, in the context of the SAGH settings, the current medical model employed for the patients' treatment and health care, does not embrace the provision of the institutional religious and spiritual care. This is problematic because the patients' right to choose other dimensions of their health care in their treatment plans are not respected. This implies that the patients who use the services of the SAGH, consent that their religious and spiritual needs can be placed at the periphery. This translates into the SA health system disregarding the patients' religious and spiritual dimensions of being. Therefore, the patients' health care journeys are predetermined by the SA health care institutions without any due regard to all their needs, wishes and expectations. Similarly, the patients who use the services of the SA health care facilities, compromise their right to the freedom of choice, specifically the freedom of religion, belief and opinion which are covered in Chapter 2, Bill of Rights, from the Constitution of RSA (1996).

2.10 HEALTH CARE CHAPLAINCY

The expertise of chaplaincy in South African health care is a profession which provides the patients' religious and spiritual care in the hospital settings, is misconstrued as a kind of a religion or a faith group or a church. This is problematic in that the concept of chaplaincy in the SAGH settings will continue to remain a foreign concept in the health care system as long as it is misintepreted and misunderstood. The researcher spent three months at the PHC settings in order to collect data with a view to investigate the need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being. However, modern health care chaplaincy is a service and profession working within the National Health Service (NHS) that is focused on ensuring that all people, be they religious or not, have the opportunity to access pastoral,

spiritual and religious supports when they need it (NHS Chaplaincy Guide, 2015:6). Hence it is critical to ensure that the patients' religious and spiritual needs are provided through a structured approach. Therefore, the researcher clarified this phenomenon of the health care chaplaincy with a view to broaden its understanding by exploring its etymology and theory, roles and benefits, and its context in the health care settings.

2.10.1 Etymology and theory of chaplaincy

There are challenges which are experienced by the caregivers (for example doctor and nurses) in the SAGH settings who are expected to respond to the patients' religious and spiritual needs through the medical approach. These caregivers were not trained to deal with the religious and spiritual needs of the patients in tandem with the South African health care system as it is embraced in the current protocols, ethical code of practice, norms and standards. Therefore, the available option at the doctors' disposal is to grant the patients who refused hospital treatment, permission to be discharged from the health care system in order to seek the religious and spiritual care elsewhere. This practice is problematic in that the patient's health and right to the freedom of religion in the hospital settings is compromised. Therefore, in view of the above, it is critical to explore the etymology and theory of chaplaincy in modern health care in order to broaden its understanding on how to address the patients' needs in SAGH settings.

According to Chung (2009), the etymology of chaplaincy can be understood from this historical background that Saint Martin of Tours (319-397 AD) aspired to serve God when still in his childhood. However, it was required of him to join the army at age 15 and he remained a soldier until he was 20 years old. In the winter of 337 AD, riding near the city gates of Amiens, Gaul, he noticed a beggar destitute of clothing. He cut his military cloak into two equal halves and gave one to the shivering beggar. As Severus (360-425 AD), his friend and biographer, writes further, "Martin, that man full of God, had nothing except his arms and his simple military dress. Some bystanders laughed at him because the cloak was now an unsightly object. Those of sounder understanding groaned because they had done nothing similar." The following night Martin was rewarded with a vision of Christ wearing his half cloak and making known to the angels his act of mercy. St. Martin was acclaimed Bishop of Tours in 371 AD. Cappellanus (Latin) denoted a cleric who was the custodian of the sacred cloak of St. Martin under the Frankish kings. The first chapel was a santuary to preserve St. Martin's cloak. Later, clerics officiating in the chapel of a sovereign or in settings where the people did not have free, frequent access to a regular cleric, such as in hospital, were called chaplains. Prior to the appointment as chaplain, a cleric first has to thoroughly train and serve in his own faith community. The use of the word 'chaplaincy' probably only began when

General Orders issued in 1776 provided a chaplain for each US regiment. The traditional chaplain ministered and sought to guide others to his own faith group.

However, chaplaincy care has historically not been, in general, theory driven. Where theory is used at all, it is generally borrowed from other professions. Many chaplains resist the idea of theory outright, considering it an infringement on the sanctity of their relationships with their patients, (Literature review, 2010). This is in tandem with the views of Chung (2009:22), that spiritual care practitioners of any faith tend to feel that numbers, data and statistic are alien to the way of functioning and have little to do with their ministry. Conversely, Mowat (2008) asserts that theory and empirical research are required to work together to produce evidence for practice.

In the same vein, Chung (2009) agrees that a new paradigm of chaplaincy has emerged which embraces scientific research. Chung (*ibid*) is of the view that science has become an ally providing empirical evidence for the efficiency and value of spiritual care. This new development and evolution in the health care is progressive because it brings the scientific evidence of chaplaincy to the fore. Therefore, the researcher's objective is, firstly, to contribute to theoretical and practical body of evidence through an emprical study on the establishment of chaplaincy in the SAGH settings. Secondly, to develop a contextual and a holistic chaplaincy model that will be effective to meet the religious and spiritual needs of patients who are admitted and treated in the SAGH settings.

The evidence-based health care is the cornerstone of modern approaches to health, although chaplaincy has minimal amount of evidence for effectiveness of interventions. Therefore, Timmins, et al. (2017) highlight that the empirical research related to the chaplain's role, skills and competencies of health care was found to be limited. Furthermore, there was very little empirical data on chaplaincy service provision, and other systematic reviews found similar empirical gaps but claimed that *'absence of evidence does not mean evidence of absence.'* On the contrary, this does not mean that chaplaincy is not valuable or valued but rather that its proof is difficult due to its lack of visibility. The health care chaplains can provide strategic assistance within the clinical environment by providing plethora of services, from pastoral care, support, counselling, education to benefit patients and families; assist patients, families and clinical staff to relieve them of emotional stress; they are key professionals within health care context to help ensure that any health care treatment decisions are holistic; can provide expert religious and spiritual supports to patients and families during difficult times. Similar studies further confirm that chaplains are often invisible and not always fully integrated within the multi-disciplinary team.

2.10.2 The roles and benefits of health care chaplaincy

The researcher's point of departure is that the institutional health care chaplaincy has a very critical role to play if a holistic approach to care is to be achieved in the SAGH settings. It is of utmost importance to clarify the roles of chaplaincy in health care from global trends, and how chaplaincy has evolved from its conception, birth, infancy, and into a modern patient-centred-holistic care. These trends and changes do not necessarily imply that the researcher applied 'a cut and paste' approach which does not resonate with the institutional chaplaincy in the SAGH settings. However, the researcher undertook this process with a view to learn from the experiences of others (managers, caregivers and patients), to glean for information on best practices, and thereby not reinvent a new wheel. Therefore, the researcher explored among others, the plethora of the roles and the importance of professional health care chaplaincy services as articulated by VandeCreek and Burton, (2001:82-92) below:

2.10.2.1 The meaning and practice of spiritual care

According to VandeCreek and Burton (2001:82-84), a chaplain (spiritual care provider) is a professional who provide spiritual care in health care settings. Spirituality demonstrates that persons are not merely physical bodies that require mechanical care. Chaplains' support for their efforts is appropriately thought of as spiritual care. Institutions who ignore the patient's spiritual dimension of being become like 'biological garages where dysfunctional human parts are repaired or replaced' (Gibbons & Miller, 1989). Such 'prisons of technical mercy' (Berry, 1994) obscure the integrity and scope of persons. It is imperative for health care organisations to respond to patient's rights for spiritual needs as a holistic approach to their well-being. Professional chaplains are key in addressing spiritual crisis through spiritual care, even in the absence of cure. Chaplains play a critical role in health care teams by caring for staff members in distress and when encountering difficult ethical decisions. The researcher concurs with these views because the patients' right to access health care and be treated with dignity and respect, even during his or her treatment journey is unparalled. The patients' religious and spiritual care has to be insourced and aligned through chaplaincy in tandem with the SA medical model of care in the SAGH settings. This will adress the holistic needs of the patients admitted and treated in the SA government hospitals, and to restore their rights and human dignity in the provision of quality religious and spiritual health care through a professional and reliable approach.

2.10.2.2 Who provides spiritual care?

The question of who provides spiritual care is critical in the context of the SA multi-faiths and multi-religions. VandeCreek and Burton (2001) advance this argument that a variety of persons may provide patient with basic spiritual care. Be that as it may, professional chaplain does not displace local religious leaders, but fills the special requirements involved in intense medical environments (Gibbons & Miller, 1989). The following reasons why professional chaplain is key to provide spiritual care are cited:

They are in and understand health care environment, patient might not notify their religious and spiritual leader of their hospitalisation or do not have a religious and spiritual community nearby. The positive aspects as to why a professional health care chaplain is key to provide spiritual care are that they offer spiritual care to all, maintain confidentiality, are accountable, are sensitive to diverse ethnic and religious cultures and are theologically and clinically trained to discharge holistic care. The researcher concurs with these views in that the professional health care chaplain is an expert to provide the religious and spiritual care in the hospital settings. They are familiar with the health care environment and serve as conduits of creating the 'sacred space' to ensure a holistic approach to care is responsive to the patients' needs.

Therefore, since the researcher has been in the SAPS chaplaincy for over two decades, he has experienced that the institutional law-enforcement chaplaincy provides religious and spiritual services to all the inhabitants of SA. The law-enforcement chaplaincy is trained and equiped to address all the needs of the diverse ethnic and religious cultures in partnership with their religious and cultural leaderships. However, the approach by SAPS chaplaincy differs from a medical model in the institutional health care system whose approach excludes the other opposite systems of belief.

2.10.2.3 The functions and activities of professional chaplains

The South African Department of Health has not considered the competencies of professional chaplaincy as opposed to the Department of South African Police Service (SAPS), Department of Correctional Services (DCS), and the South African National Defence Force (SANDF). However, VandeCreek and Burton (2001) argue that the professional chaplaincy is critical to:

- Unwind tight religious beliefs.
- Not proselytise.
- Provide empathic listening.

- Serve in health care teams from non-medical perspective.
- Lead religious ceremonies.
- Participate in ethical issues.
- Professional chaplains are experts in religious and spiritual matters.
- Render advocacy for patient/families.
- Professional chaplains are research driven professionals.

Therefore, the researcher's view on the functions and activities of professional chaplains is that they are indispensable in a holistic approach to care, in the SA context of its multi-faiths and multi-religions. The chaplains can add value if they could participate in the health care teams to address the religious and spiritual needs of the patients. However, the exclusion of chaplaincy in the health care teams can be viewed as a disservice to the health institution, the health care professionals, patients, their families, community and the religious and spiritual communities of SA who have the right to access such services.

2.10.2.4 The benefits of spiritual care provided by professional chaplains

VandeCreek and Burton (2001) agree that the benefits of spiritual care provided by professional chaplains increasingly demonstrated by empirical research studies are for the patient and families in that religious and spirituality impact emotional and physical well-being. The benefits are for health care professionals (staff) who experience stress in their workplace. The benefits are for the health care organisations in meeting patients' expectations/needs through holistic approach, maintaining relationship between organisation and local clergy/community, acting as gatekeepers from spiritual abuse/proselytising, advocacy, enhance organisational vision, mission, assist organisation in fulfilling a variety of accreditation standards including patient's rights and provide cost efficient spiritual care; and are for the mutual benefit of the community.

However, the benefits of providing spiritual care in the SA health care settings (by a professional chaplaincy) would be for the mutual benefit of all the stakeholders in the SAGH. The contemporary chaplaincy is very critical to address the religious and spiritual needs, including plethora of other related patients' expectations. The researcher summarised how modern chaplaincy has evolved and the relevance of the health care chaplaincy in the context of the developing SAHC.

The following are a summary of the predominant contemporary health care needs for many patients who require the services of a professional expert in the religious and spiritual care in the hospital settings.

Table 9 below summarises the critical role of health care chaplaincy in the contemporary hospital environment. These includes among others, the religious care, the pastoral care, the spiritual care, the pastoral counselling, the pastoral and emotional support, the ethical and moral decisions, the bioethical issues, the visits by chaplains, the advocacy by chaplains, and the cultural aspects. The modern health care has evolved globally and embraces all the dimensions of the patient's being human.

Therefore, the concepts of patient-centred approach to care and the holistic approach to care are not foreign when health care is planned and provided. Similarly, modern health care chaplaincy has also evolved as a critical member in the multi-disciplinary health care teams to provide the religious and spiritual care in the institutional health care settings. The researcher summarises these contemporary health care chaplaincy roles in Table 9 below in tandem with the researcher's comments (as encapsulated from the studies on global health care chaplaincy from the different researchers).

Role of Chaplaincy	**Authors**	**Comments**
Religious care	Cook, 2004; Galek et al. 2007; Harding et al. 2008; Haynes et al. 2007; Kliewer, 2004; Koenig 2001; Orton, 2008; Swinton & Mowat, 2006; Taylor et al. 2015; Timmins et al. 2017; Tovar-Murray, 2011; VandeCreek & Burton, 2001	Most religious patients use religion as a coping mechanism. Hence religion is viewed as important dimension of holistic approach to care. Religious rituals and ceremonies play a very critical role during the treatment of most patients. Religion is critical in the well-being of most patients, and forms the basis of meaning and purpose to them, and people-centred care considers it in holistic approach to care.
Spiritual care	Cook, 2004; Frierdich, 2015; Galek et al. 2007; Harding et al. 2008; Haynes et al. 2007; Hodge, 2005; Howell et al. 2017; Kliewer, 2004; Koenig 2001; Mack, 2004; Mowat & Ryan, 2003; Orton, 2008; Puchalski, 2001; Swinton & Mowat, 2006; Taylor et al. 2015;	In the same vein, most patients use spirituality as a coping mechanism. They want their spirituality addressed in the treatment plan. Hence many nurses view spirituality as an important part of holistic treatment. Spirituality can play a critical role as an alternative therapy. Likewise, spirituality forms the basis of meaning and purpose for most patients and tends to enhance recovery from illness and surgery. Trends in health care show spirituality having an increase in interests from many patients. Be that as it may, holistic approach to care embraces spirituality

	Timmins et al. 2017; Tovar-Murray, 2011; VadeCreek & Burton, 2001; Willemse et al. 2017	as key dimension of being human with spiritual needs, and part of treatment plan, and patient's spiritual worldview cannot be ignored.
Pastoral care	Handzo, 2006; Harding et al. 2008; Orton, 2008; Taylor et al. 2015; Timmins et al. 2017; Woodward, 2010	Trends in health care studies show that there is steady decrease in pastoral care and conversely an increase in spirituality. However, it is the patient who must indicate whether pastoral care is needed. Pastoral care may be provided when it is needed.
Pastoral Counselling	Taylor et al. 2015	Similarly, trends in pastoral counselling like pastoral care seem to be in decline. This does not mean that the services of pastoral counselling are insignificant to everyone.
Pastoral and Emotional support	Mack, 2004; Taylor et al. 2015; Timmins et al. 2017	Trends from research that involved the pastoral support seem to reflect similar findings on decline. On the contrary, most patients may not decline support on the basis of it being pastoral or emotional. Support in health care is needed by many patients.
Ethical and Moral Decisions	Taylor, et al. 2015; Timmins et al. 2017	Chaplains play a key role in assisting the patients, families and even the health care team members and the institution in taking ethical and moral decisions. Chaplain's perspective and viewpoint is grounded in the theological or related relevant training.
Bioethical Issues	Atherstone, 2011; Timmins et al. 2017	Like ethical and moral decisions, bio (life) ethical decisions and issues need a different opinion and perspective from that of the medical background (e.g. chaplain).
Visits by Chaplain	Atherstone, 2011; Handzo, 2006; Howell et al. 2017; Orton, 2008; Timmins et al. 2017	Visits by chaplains are critical in the health care environment. The referrals by other professionals are evidence of the patients' needs and the value of chaplains in visits.

Advocacy by Chaplaincy	Atherstone, 2011; Taylor et al. 2015; Timmins et al. 2017, Woodward, 2010	Chaplains can play a critical role to speak on behalf of the patients and their families (including church communities) in matters and issues that need advocacy in healthcare. Chaplaincy has proven to be the key partner in this aspect of advocacy.
Cultural Aspects	Cook, 2004; Haynes et al. 2007; Swinton & Mowat, 2006; Timmins et al. 2017	The other critical role of chaplaincy involves the cultural aspect. The health care professionals, the institution and the patients and their families can mutually benefit from chaplaincy in this regard.

Table 9: The predominant contemporary health care chaplaincy roles

2.10.3 The context of health care chaplaincy

The South African context (as a secular state), is pluralistic and diverse in nature. This context embraces the diverse and multi-faiths, religions, and cultures which influence the provision of health care in the SAGH settings. However, the context of modern health care chaplaincy is critical to determine the clinical approach when providing the patients' religious and spiritual care. According to Woodward (2010), a former health care chaplain, it is important to understand chaplaincy from two broad framework of the church culture in relation to the world: by not appreciating health service, and secondly, the uncertainty or security of chaplaincy in the current health service in providing spiritual care. Woodward confirms that this 'ministry beween two worlds' is created by the financial and pluralistic, multi-faith and multi-cultural contexts. On the same vein, we cannot build a healthy hospital community without attending to the context within which it exists. This is in tandem with the views of Atherstone (2011), who reiterates that the hospital chaplains experience two vastly different worlds - a medical world and a religious world. According to Atherstone (*ibid*), chaplains are members of two professions. Firstly, their own faith tradition, and secondly, their professional registered body. Therefore, chaplaincy is a critical player in the context of SA health care to provide the expert, clinical, and professional service in the multi-disciplinary health care teams.

2.11 HOW MIGHT WE RESPOND?

The researcher's view on how to respond to this investigation into the need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes the

patients' religious and spiritual dimensions of being, was by means of participant observations and the interviews with the managers of health care, the health caregivers, and the consumers of health care (patients) at the PHC settings. This approach ensured that data is gathered, and insight into the provision of the religious and spiritual care is gained. However, since the health care providers throughout the world are addressing the spiritual dimension when assessing and planning care for clients, (McDowell et al., 2017), the above Respondents' views (in the context of this study), provided a rich and detailed description from their own religious and spiritual experiences in health care.

Firstly, the managers are responsible for protocol, financial control, training and quality improvement, (Handzo, 2006:663-664) in the health care settings. Similarly, Mowat and Ryan (2003:65) reiterate that the managers deal with policy and practice implications. Therefore, without strong policies and leadership, health systems do not spontaneously provide balanced responses for the challenges which are underpinned by the needs and expectations of the population, (WHO, 2010). However, the PHC managers as the research participants are critical.

Secondly, the PHC caregivers, as participants were equally critical in the context of this study in that, the clinical providers such as physicians and nurses agree that it is important to address the spiritual needs of their patients, (Howell et al., 2017:157). According to Pera et al. (2005:71):

> *A nurse can play a key role in creating a climate in which the rights and needs of patients are recognised and respected. As advocates for patient, a nurse can make decisions to protect the rights of patients. Patients are often defenceless and nurses based on their knowledge and experience, support and assist patients in making decisions.*

Similarly, McDowell and South (2017) agree that spirituality has been recognised as a human needs throughout the history of nursing. Spiritual care, though not fully understood by all care providers, is a necessary component of holistic nursing practice. Conversely, the people long for their physicians to sit with them and to support them, (Puchalski, 2001).

Thirdly, the PHC patients, as the consumers of health care, are equally critical to participate in this study. However, why is the fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values (VandeCreek & Burton, 2001) not exercised from a people-centred approach when responding to their religious and spiritual needs in the context of the SAGH settings? Similarly, why are the patients' religious and spiritual needs not embraced in their treatment plans when hospitalised at the SAGH settings? Conversely, the Constitution of the Republic of

South Africa, Chapter 2: Bill of Rights, section 15(1) and (2) gurantee the freedom of religion, belief and opinion, and are embraced in the NPRC (Mulaudzi et al., 2001).

2.12 PRELIMINARY CONCLUSION

The researcher provided an insight into what was going on in the PHC settings regarding the provision of the religious and spiritual care. The researcher shared his observations on why this is happening (in respect of the exclusion of health care chaplaincy) by not providing a holistic approach to care that includes the patients' religious and spiritual dimensions of being in the SAGH. However, the researcher observed that what ought to be going on is that including chaplaincy in health care (hospitals) would bring a different dimension of care from that of a non-medical perspective (global trends and practices), and can be mutually beneficial to the health care managers, the caregivers and the patients in the SAGH settings. The researcher highlighted how might we respond to address the patients' religious and spiritual dimensions of being in the SAGH settings. However, the researcher explored this topic further, in this study from Chapter 4, by interviewing the managers, caregivers and patients at PHC setting.

CHAPTER 3

DATA COLLECTION PROCEDURE

3.1 INTRODUCTION

The focus of this chapter is to deal with data collection, analysis and interpretation of data as guided by Osmer (2008:4). The researcher has personally collected, analysed and interpreted the empirical data gathered at the PHC research site in tandem with the workflow process (Chart 1) as highlighted in Chapter 1. The researcher has further triangulated the qualitative research methods with a view to elicit knowledge and to understand the phenomenon of health care chaplaincy in the provision of a patient-centred approach to care (as embraced by the multi-disciplinary health care teams) for the patients' needs in the treatment plans. The researcher employs the research plan as proposed by Osmer (2008:53-57), which involved decisions about the following:

- The people, program, and setting that were investigated,
- The specific methods that were used to gather data,
- The individuals or research team that conducted the research, and
- The sequence of steps that were followed to carry out the project in a specific time frame.

3.2 THE RESEARCH PLAN

The people, program, setting that were investigated. The research plan encapsulated the people (population), the program and setting as discussed below:

3.2.1 Research population

Myers et al. (2014) describe population as a brief description of the participants. Mouton (1996:134) states that a *"population is a collection of objects, events or individuals having some common characteristic that the researcher is interested in studying*." The population is the aggregate of all the cases that conform to some designated set of specifications. Neuman (2003:232) cited in de Vos et al. (2011:224) asserts that the larger the population, the smaller the percentage of that population the sample needs to be, and vice versa. For the purpose of this study, the researcher was of the view that the kind of information needed and the potential sources of the information were to be gleaned from the above target research population (managers, healthcarers and patients in the SAGH).

Therefore, the research population which was sampled for this study (Osmer 2008) comprised of all the hospital managers, the serving medical staff/caregivers (doctors, nurses, psychologists, social workers and other health care clinicians/professionals) at the PHC setting in the Limpopo Province, and the patients who were admitted and treated (scheduled appointments) at the same facility during the period of January 2019 to May 2019.

3.2.2 Research sampling

It is asserted that sampling is part of our everyday life and is pretty much equivalent to 'selection', (Mouton, 1996). The selection criteria for identifying and recruiting key participants were in tandem with a sampling strategy employed by Swinton and Mowat (2006) in that the researcher predetermined who could answer the research questions to achieve the research product by solving the research problem. The primary purpose of sampling is to collect specific cases, events, or actions that can clarify and deepen understanding. *"Qualitative researchers' concern is to find cases that will enhance what the researchers learn about the processes of social life in a specific context"* (Neuman, 2006:219-222). The researcher was of the view that these research participants were in a context and an environment that was relevant for the study. The researcher employed a non-probability sampling strategy to understand the population, guided by the questions cited by Swinton and Mowat (*ibid*):

- How to choose the research participants?
- What kind of sample was needed?
- How the participants were to be sampled?

3.2.3 Research sample size

According to Myers et al. (2014), a sample size is the number of participants. Sandelowski's view (1995:179) cited in Taylor et al. (2015:94) is that determining adequate sample size in qualitative research is ultimately a matter of judgment and experience in evaluating the quality of the information collected against the uses to which it will be put, the research method, purposeful sampling strategy employed, and the research product intended. Hence, qualitative samples according to Ritchie et al. (2014:113-133),

> *Usually small in size because of data saturation. The statements about incidence or prevalence are not the concern of qualitative research, the*

> *qualitative studies yield rich detailed information, and the qualitative research can be highly intensive in terms of the research resources it requires.*

According to Corbin and Strauss (2008) saturation is usually explained in terms of ‘when no new data are emerging.’ It is more than a matter of no new data. It also denotes the development of categories in terms of their properties and dimensions, including variation, and if theory building, the delineating of relationships between concepts. For the purpose of this empirical study, the researcher continued with the process of recruiting the research participants until data saturation was achieved.

3.3 RESEARCH SETTING

The researcher highlighted in Chapters 1 and 2 that the setting for this study was at PHC in Limpopo Province for a period of three months. Firstly, the researcher was granted an ethical clearance certificate by the University of Pretoria’s Research Ethics Committee (REC) as a prerequisite to conduct this research. Secondly, the Department of Health (DoH) granted permission for the study to be conducted. Finally, Clinical Research: University of Limpopo – School of Medicine approved the application for permission to conduct the research within the PHC setting.

3.4 RESEARCH METHODS

The researcher employed the phenomenological strategy to gain insight into the meaning of the patients’ experiences and their impact on coping with health problems. The researcher further employed the grounded theory strategy to gain rich, detailed description and insight into the emotional, religious and spiritual changes that the patients experienced during their treatment. Lastly, the researcher employed the ethnographic strategy to study the rich, detailed description and insight into the patients’ religious and spiritual values, beliefs, and practices and their role in coping with illness and medical treatment (HCC, 2010).

3.4.1 Triangulation of research participants

The researcher triangulated the research participants which included the hospital managers, caregivers and the patients (Chart 2 below) at PHC setting, to maximise the validity and reliability of the empirical research study. It was critical to explore the phenomenon of health care chaplaincy with a view to understand its roles and value in the health care teams from the perspectives of the research participants. Secondly, the researcher’s aim was to develop a contextual chaplaincy model that can address the patients’ religious and spiritual needs in SAGH.

PARTICIPANTS' TRIANGULATION (PRIMARY DATA COLLECTION PROCESS)

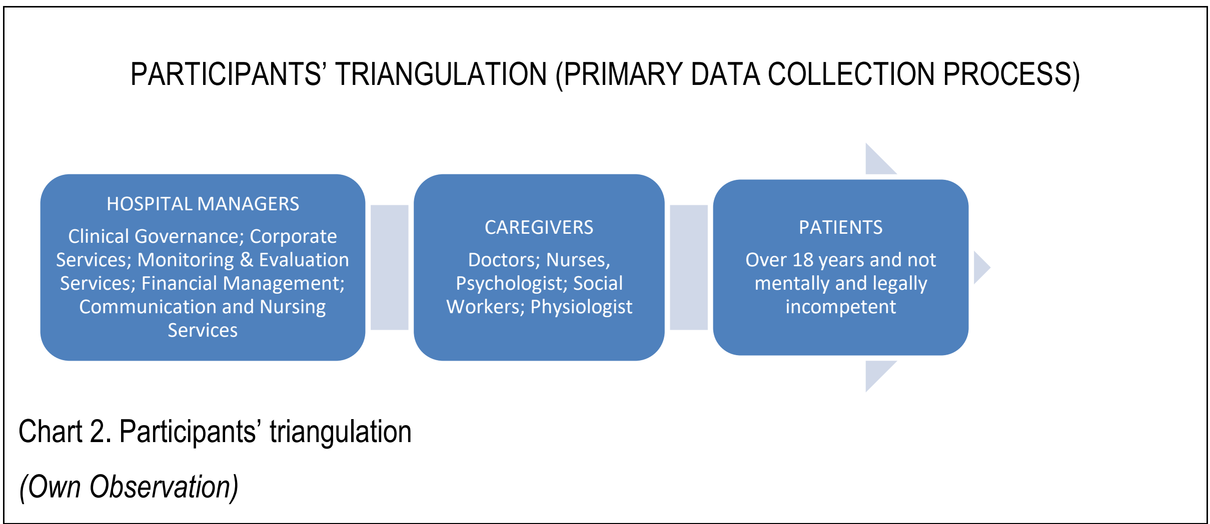


Chart 2. Participants' triangulation

(Own Observation)

3.4.2 Research instruments

A research instrument is a testing device for measuring a given phenomenon, such as a paper and pencil, a questionnaire, an interview, a research tool, or a set of guidelines for observation. [39] The researcher employed firstly, participant observation (field research) as an instrument for gathering primary data that addressed the research topic. Secondly, the researcher personally conducted interviews with the participants (audio taped by a voice recorder) in the PHC setting. The researcher's experience (as an instrument of research), resonate with the challenges of laborious process of recruiting the research participants, preparing, arranging and conducting the interviews with the participants. This is in tandem with Ritchie et al. (2014:178) in that the qualitative research interviewers are themselves considered research instruments and as such can influence the interaction. The process of interviewing is a demanding one - cognitively, intellectually, psychologically and emotionally (Kvale & Brinkman, 2009; Rubin & Rubin, 2012; Silverman, 2012).

3.5 THE INDIVIDUAL OR RESEARCH TEAM THAT CONDUCTED RESEARCH

The researcher was personally involved in conducting the research as highlighted above.

3.5.1 Establishing rapport

According to Mouton and Marais (1993), the advantage of a solid interpersonal relationship between researcher and participant is that it acts to neutralize initial distrust. It is also clear that it can act as a control for the role of selection effects. The establishment of good rapport can also serve as a control for the context effects. The researcher's view in establishing a rapport or interpersonal relationship with the participants at the PHC setting (managers, health caregivers and the patients) was to enable the building

of trust, the gaining of access and data gathering within the research milieu. Ritchie et al. (2014:185) are of the view that establishing a good rapport also comes from the researcher displaying confidence in what they are doing. Trust is strengthened where researcher appears to be comfortable with the interview situation, and with everything the interviewee should say. Interviewees also respond positively where the interviewer displays a sense of 'tranquillity'- an inner stillness which shows they are comfortable with the interviewee and with the interview situation, and which communicates interest and attention. The researcher's experience as former chaplain and clergy was key in establishing rapport with the participants.

3.5.2 Ethical considerations

The World Medical Association Declaration (WMAD) of Helsinki Ethical Principle for Medical Research stipulates that any research that involves the human subjects must comply to certain principles, minimise risks, protect vulnerable groups and individuals, follow scientific and research protocols, exercise the right to privacy, confidentiality, and ensure that informed consent is given by subjects in medical research. The researcher signed the WMAD as a prerequisite for the granting of an ethical clearance certificate by the University of Pretoria's Research Ethics Committee (REC). The researcher applied the prescribed requirements as set by the policies of the University of Pretoria (REC) in tandem with the WMAD of Helsinki and cited sources accordingly (Table 10 below).

THE CRITICAL ETHICAL PRINCIPLES THAT ARE KEY FOR QUALITATIVE RESEARCHERS' GOOD ETHICAL PRACTICE	
ETHICAL PRINCIPLES	SOURCES
Anonymity	Babbie et al. 2010:520-525; Long and Johnson, 2007:9-19; 37-38; Pera et al. 2005:152-154.
Confidentiality	Babbie et al. 2010:520-525; Long and Johnson, 2007:9-19; 37-38; Mulaudzi et al. 2001:4; Pera et al. 2005:152-154; WMAD.
Considerate and Respect	Long and Johnson, 2007:9-19; 37-38; Pera et al. 2005:152-154.
Informed Consent	Henning et al. 2011:73; Long and Johnson, 2007:9-19; 37-38; Mulaudzi et al. 2001:4; Neuman, 2006:135-136; Pera et al. 2005:152-154; WMAD.
No Deception	Babbie et al. 2010:520-525.

No Harm	Babbie et al. 2010:520-525; Long and Johnson, 2007:9-19; 37-38; 61-62; WMAD.
Privacy	Henning et al. 2011:73; Pera et al. 2005:152-154; WMAD.
Right to Receive Payment	Long and Johnson (2007:15).
Right to Withdraw	Long and Johnson (2007:9-19; 37-38).
Sensitivity	Henning et al. (2011:73).

Table 10: Key ethical principles of health care chaplaincy roles

According to Long and Johnson (2007), the 'human rights' perspective has been prominent for more than 60 years since World War II, when it became clear that human beings had been tortured, mutilated and killed for 'scientific' purposes by both military and civilian health workers. It is not surprising that many codes of conduct grew up to prevent such abuses in future (WMA, 2005). Babbie et al. (2010) concur that ethical issues arise out of interaction with other people, other beings (such as animals), and the environment, especially where there is potential for, or a conflict of interests. Neuman's (2006) view is that codes of ethics and other researchers provide guidance, but ethical conduct ultimately depends on the individual researcher. The researcher has a moral and professional obligation to be ethical, even when research subjects are unaware of or unconcerned about ethics. Ethics begin and end with the researcher.

3.6 THE SEQUENCE OF STEPS FOLLOWED IN THIS PROJECT

The researcher employed Carol Warren's (2002) [cited in Henning et al. 2011] three phases in the process of the research interviews (March to May 2019) in tandem with the six stages proposed by Ritchie et al. (2014). The aim of this structural approach was to ensure that the interviews were practically, systematically and logically followed by the researcher. Carol Warren (2002) proposes these three phases in the research interviews:

- Finding the Respondents and setting up the interview in accordance with the overall research design.
- Conducting and recording the interview.
- Reflecting on the interview and working with, or analysing and interpreting data.

The researcher followed this sequence of steps (for data collection, data analysis and data interpretation) in tandem with Osmer (2008), and applied the proposed six stages of an interview as advocated by Ritchie et al. (*ibid*):

- Arrival and introduction (the process begins when researcher and participants meet),
- Introducing the Research (the researcher introduces topic with a view to move into the research mode),
- Beginning of an interview (opening questions by researcher to kick-start the process),
- During interview (researcher guides participants to key themes),
- Ending interview (researcher can signal the approach of the end of the interview), and
- After the interview (researcher thanks the participants and move them out of the research mode).

3.7 DATA COLLECTION

The researcher explained broadly in Chapter 1 the specific methodology that was employed for data collection. According to Corbin and Strauss (2008), data collection methods are techniques and procedures for gathering and analysing data. This is in tandem with Osmer (2008) in that methods of research are specific procedures used to gather and record data. Mouton (1996) is of the view that a first general principle in data collection is that the inclusion of multiple sources of data collection in a research project is likely to increase the reliability of the observations. Denzin (1978) coined the term *triangulation* to refer to the use of multiple methods of data collection. However, the researcher employed the phenomenological, ethnographic/participant observation and the grounded theory strategies (Figure 3) through semi-structured interviews process (audio taped) and field notes.

The researcher requested the sampled participants who agreed to take part in the study to complete consent forms (Appendix B), and to be interviewed (Appendix C: research questions for the managers, caregivers and patients), and demographic background (Appendix D) to gather quantitative data that confirmed the participants' gender, age, ethnicity, occupation, faith group (religious and spiritual preference), language and their residential areas. This process was done prior to conducting the interviews with the sampled research participants in the PHC setting.

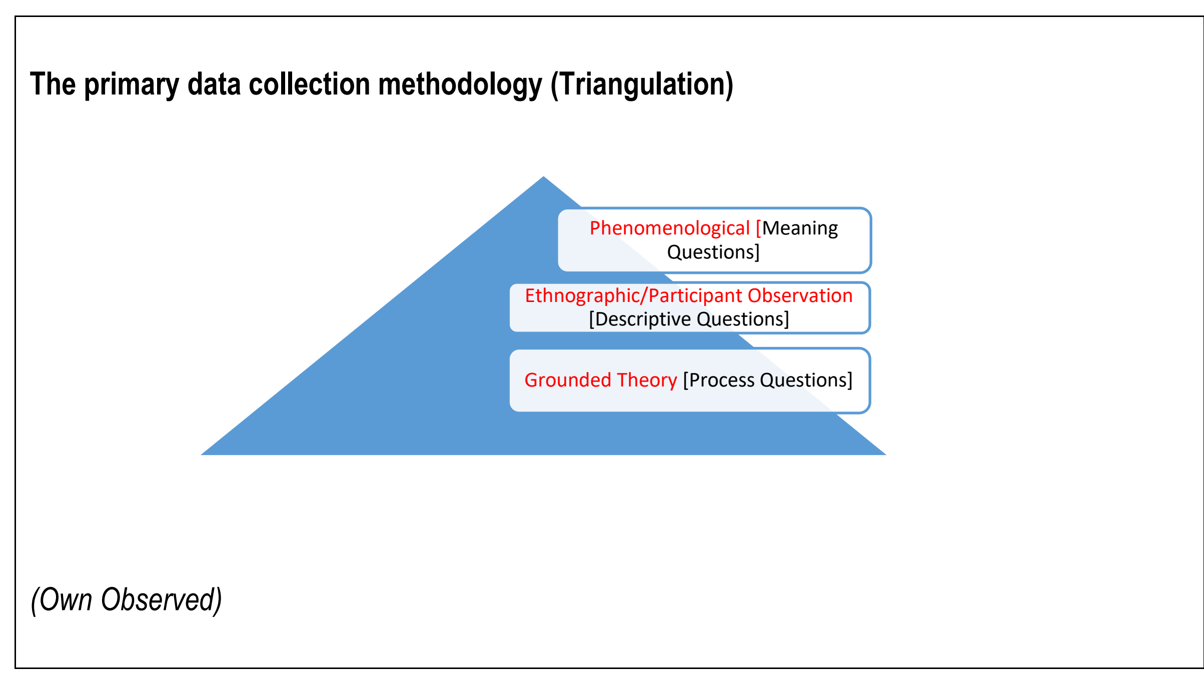


Figure 3: The primary data collection methodology (triangulation)

In this empirical research, the researcher employed the semi-structured interviews, the observation and the field notes as the key strategic data collection techniques to ensure the enhancement of the reliable data. The table below highlights the synoptic overview of the threefold purpose of the 'interviews, observation, and field notes.

PURPOSES OF INTERVIEWS-OBSERVATION-FIELD NOTES		
PURPOSE OF INTERVIEWS	PURPOSE OF OBSERVATION	PURPOSE OF FIELD NOTES
1. To understand the world from the subjects' point of view, (Brinkmann and Kvale 2015:3); 2. To gain a detailed picture of a participant's beliefs about their spiritual worldviews, (de Vos et al. 2011:351); 3. To undertake a search-and-discover mission, (Henning et al. 2011:55);	1. To see as well as to observe with the other senses, (Henning et al. 2011:82); 2. To observe behaviour, social interaction, and characteristics such as gender, number of individuals, physical locality, non-verbal behaviour and stature, (Mouton 1996:142); 3. To establish a link between reality and the theoretical	1. To record the event, knowing that it takes more than a single interview to gain an impression of a participant's feelings, thoughts and knowledge, (Henning et al. 2011:79); 2. To use for direct observation, inference, analytic and personal journal, (Neuman 2006:399);

4. To seek information from the other for a particular purpose, (Omer 2008:61-62); 5. To seek knowledge and sharing experience and knowledge, (Ritchie et al. 2014:178; Rubin and Rubin 2012:); Swinton and Mowat 2006:63-64); 6. To be employed as useful technique for conducting systematic social enquiry, (Silverman 2004:140).	assumption, (Mouton and Marais 1993:162); 4. To provide direct access to this setting, (Osmer 2008:60); 5. To systematically watches, listens and records the phenomena of interest, (Ritchie et al. 2014:267).	3. To use in capturing observed data, containing comparable detailed descriptions of settings, activities and interactions as well as a researcher's interpretation of what occurred, (Ritchie et al. 2014:267, 171).

Table 11: Purposes of the interviews, observation and field notes

3.7.1 Purpose of interviews

The researcher captured the purpose of interviews in Table 11 above. It must be noted that there are a plethora of views on what is the purpose of an interview. However, the researcher is of the view that these views can be encapsulated into one thought nerve: 'A technique used for social enquiry to understand a phenomenon or something. The researcher steered the conversation with prompts and probes during the interviewing process. According to Ritchie et al. (2014) probes are responsive, follow-up questions which elicit more information, description or explanation, and prompts is when researcher introduces ideas into the interview and seeks the interviewee's view of them. Similarly, Osmer (2008:62-63) reiterates that prompts signal to the interviewee where you are in the interview. Therefore, probes build on the interviewee's response and ask him or her to go further.

The semi-structured interviews were conducted by the researcher at PHC setting. These interviews were tape recorded for the duration of the interview and transcribed verbatim by the researcher at a later stage. According to Henning et al. (2011), the transcription of the conversation should commence as soon as possible. It is advisable to transcribe as much of the data as you can yourself, and are convinced that working closely with the data assists in the analysis that would come later. Henning et al. (*ibid*) further assert that for interviews to be trustworthy and credible utilising the tools of data capturing, it is important

that craftsmanship or creativity be built into their conceptualisation and their design as well as in their implementation, recording and transcription.

According to Corbin et al. (2008:19) the research question is the specific query to be addressed by the research. The question(s) sets the parameters of the project and suggests the methods to be used for data gathering and analysis. Corbin et al. (2008:25) reiterate*: "The research question in a qualitative study is a statement that identifies the topic area to be studied and tells the reader what there is about this particular topic that is of interest to the researcher."* Myers and Roberts (2014) advocate for the nature of researchable questions that are feasible (the question is small enough for researcher to carry out the study with the available resources) and meaningful (the question is big enough for the results to contribute enough new knowledge to make change). According to Myers and Roberts (2014) grounding your research question in a conceptual model will help you focus your question, suggest possible methodologies for carrying out your study, and enable conversations with colleagues by giving you a common language and concepts with which to talk. Therefore, in view of the above, the researcher grounded these questions on the Constitution of RSA (1996) in tandem with National Patients' Rights Charter (Mulaudzi et al., 2001).

The scheduled interviews with the PHC management (first research Respondents) were conducted with the objective of determining their views on why chaplaincy is excluded from health care teams for a holistic approach to care. This target group was ctitical informants in the review of the health policy for inclusivity so as to address the religious and the spiritual needs of the patients in the multi-disciplinary health care teams. Secondly, this group was key to inform the researcher of the need for the establishment of chaplaincy in the SAGH settings.

The second research Respondents scheduled for interviews were the PHC health caregivers, (doctors, nurses, social workers, psychologist and other clinicians). This target group was key in the understanding of the role of chaplaincy in health care teams (as experts) in the provision of the religious and spiritual care to the patients. This target group plays a crucial role in that they face the challenges of responding to the patients' religious and spiritual needs in SAGH settings, and are relevant in this study, to investigate the need for the establishment of chaplaincy.

The third and final research Respondents scheduled for interviews were the patients who were admitted at the PHC settings, over the age of 18 and met the set requirement criteria as discussed under 3.2.

(Ethical considerations). This target group was crucial to determine their needs and who must provide the religious and spiritual needs in the SAGH settings.

3.7.2 Purpose of participant observation

Henning et al. (2011) are of the view that in general, observation implies seeing as well as observing with the other senses. Depending on the research question, observation may be brief and serve only as a discrete research tool for gathering information within a study that is not ethnographic. Observation may involve much more, though. It may mean participating in the actions of the people in the research setting and getting to know their ways of doing very well. The hallmark method of ethnography stems from this social participation and is known as participatory observation. In this study, the researcher observed the actions and reaction of the participants in the PHC settings for a period of three months, with a view to get first-hand information on how the respond to the related matters in the research topic.

This resonates with Osmer (2008) in that, in qualitative research, first hand participation in the field under investigation is crucial. This takes the skill of observing. Osmer (*ibid*) is of the view that this provides direct access to this setting, rather than relying on the selective impressions of others. It allows you to discover things that participants might not notice or might be unwilling to share. The researcher employed the participant observation as a direct method to study behaviour of research participants in the natural setting while it was taking place with a view to establish a link between reality and the theoretical assumption, (Mouton & Marais, 1993).

3.7.3 Purpose of field notes

The purpose of field notes is symmetrical to observations. This is affirmed by Ritchie et al. (2014) in that field notes are traditionally used to capture observed data, containing comparable detailed descriptions of settings, activities and interactions as well as a researcher's interpretation of what occurred. Neuman's (2006) view is that a great deal of what researchers do in the field is to pay close attention, watch, and listen carefully. They use all the senses, noticing what is seen, heard, smelled, tasted, or touched. The researcher becomes an instrument that absorbs all sources of information. A good field researcher listens carefully to phrases, accents, and incorrect grammar, listening both to what is said and how it is said or what was implied. Hence, serendipity according to Neuman (*ibid*), is important in field research. Many times, a field researcher does not know the relevance of what he or she is observing until later. This has two implications. First is the importance of keen observation and excellent notes always, even when 'nothing seems to be happening.' Second is the importance of looking back over time and learning to

appreciate wait time. However, for the purpose of this study, the researcher was prepared to enter the research setting with an inquisitive open mind. The researcher used research notes to capture, describe and gain an understanding of the participants with the aim of illumining the unseen information (describe behaviour, routine daily activities, conversations, expressions, interactions, date, time and location) in the PHC research setting. The researcher captured field notes in the diary.

3.8 DATA TRANSCRIPTION AND ANALYSIS

According to Osmer (2008), if individual interviews are audio-taped, then the interviewer might later listen to the tape, writing down significant themes and transcribing only key comments word for word. However, for the purpose of this study, the researcher listened to the audio tapes and transcribed the interviews verbatim (word for word).

Analysis involves, in the view of Corbin and Strauss (2008), examining a substance and its components to determine their properties and functions, then, using the acquired knowledge to make inferences about the whole. Analytic tools are thinking devices or procedures that if used correctly can facilitate coding, Corbin and Strauss (*ibid*). The analysis is always the heart of any research project. It is that point in the research process where the mass of data that has been generated begins to be formed into meaningful units which will illuminate the complexities of the situation. The process of analysis is not a once-only event. It would be an error to assume that within qualitative research the method of data collection is in some way sequential to the process of analysis. The analysis should always be firmly linked to the research question and carried out simultaneously with the collection of the data. The actual process of analysis of data starts from the moment that data collection commences. Indeed, it could be argued that the analysis process starts earlier than this. A primary task of analysis is for the researcher to read the data and become very familiar with its content; to immerse herself in the data. The analysis is only as good as the analyser (Swinton & Mowat, 2006).

According to Osmer (2008:56), the researcher begins to review all the field notes, transcripts, and interview notes to gain a sense of the whole and to spot recurrent language, issues, or themes. Researchers then begin to code the data, chunking it into smaller units for analysis and gradually forming categories that allow these chunks to be organised and compared across different data sources. Osmer (2008:4-5) reiterates that gathering information that helps us discern patterns and dynamics, episodes, situations, or contexts is the descriptive-empirical task of practical theological interpretation. However, Swinton and Mowat (2006) state that when reflecting theologically, God and the revelation that God has given to human beings in Christ is the true starting point for all Practical Theology. Practical theology

seeks to understand practice, to evaluate, to criticise; to look at the relationship between what is done and what is said or professed.

3.9 DATA INTERPRETATION

De Vos et al. (2011:416) state that *"interpretation involves making sense of the data, the 'lessons learned."* According to Osmer (2008), Gadamer argues that all interpretation begins in an already-interpreted world. Swinton and Mowat (2006) concur in that qualitative research takes place within what has been described as an interpretative paradigm. All research is interpretative; it is guided by a set of beliefs and feelings about the world and how it should be understood and studied. However, for the purpose of this study, the researcher aligned with the views that data interpretation refers to the process of critiquing and determining the significance of important information, such as survey results, experimental findings, observations or narrative reports. Researchers use similar but more meticulous process to gather, analyse and interpret data. In qualitative data interpretation, researchers seek new knowledge and insight into phenomena. [38] Similarly, data interpretation refers to the implementation of processes through which data is reviewed for the purposes of arriving at an informed conclusion. The interpretation of data assigns a meaning to the information analysed and determines its signification and implication. When interpreting data, an analyst must try to discern the differences between correlation, causation and coincidences, as well as many other bias-but should also consider all the factors involved. [39] Therefore, the participants' views (beliefs, experiences in health care) were key in data interpretation.

DATA COLLECTION	DATA ANALYSIS	DATA INTERPRETATION
The researcher collected data from the sampled Respondents (hospital managers, caregivers and patients) who consented to the study and were willing to be interviewed at Polokwane Hospital Campus (PHC) setting with a view to investigate the need for the establishment of chaplaincy in SAGH for holistic approach to care that includes patients' religious and spiritual	The researcher used non-variable ideas, concepts, categories and themes as analytical tools grounded in empirical data through a structural approach (use of spreadsheets). The researcher analysed the collated data from the tool of in-vivo coding to elicit meaning, gain understanding and develop empirical knowledge regarding the	The objective of the data interpretation was to elicit knowledge with a view to ensure respect for the right of the patients' religious and spiritual (worldviews) during hospitalisation with a view to meet their inherent needs and thereby improve the quality of holistic care in South African Government Hospitals (SAGH) multi-disciplinary health care

dimensions of being. The interviews were tape-recorded and transcribed verbatim by the researcher. The researcher employed the strategy of triangulating the three qualitative research methods of phenomenology, ethnography / observation and grounded theory during the collection of data, and was guided by the ethical principles during the study as agreed upon with Research Ethical Committees (REC). The researcher conducted a field work study by employing an ethnographic/participant observation tool in the PHC setting for a period of three months with a view to illumine the unseen behaviour, activities, conversation, expressions, interactions, date, time and venue.	meaning of patients' religious and spiritual experiences and its impact on coping with health problems in SAGH. The researcher analysed the descriptive participants' questions about their values, beliefs, practices of cultural group as grounded in the Constitution of RSA and encapsulated in the patients' charter of rights. The objective was to gain understanding with the role it plays in coping with illness and medical treatment; and to finally process participants' spiritual experiences over time (religious/spiritual intervention) through the course of illness and medical treatment. The researcher analysed a phenomenon of chaplaincy in the multi-disciplinary health care team to reconstruct the inherent significant chaplaincy structure and the understanding of chaplaincy in health care.	teams. The researcher further interpreted analysed data with a view to understand the insight into the meaning that patients give to their illness and to spiritual healing experiences through their hospital journey. The object was to provide for the patients' religious/spiritual dimension of being. The researcher further more interpreted the rich, detailed description and insight into the religious and spiritual values, beliefs, and practices of patients in their treatment and to gain an understanding of the experts (chaplaincy) who can best provide care for these patients' needs in a multi-disciplinary health care team. Finally, researcher interpreted the emotional, religious and spiritual changes that patients experienced during their course of medical treatment and the value, impact and role of hospital visits by religious/spiritual leaders to provide care.

Table 12: The researcher's synoptic overview on the collection, analysis and interpretation

3.10 PRELIMINARY CONCLUSION

The purpose of Chapter 3 was to address the sequence of steps that were followed to carry out the collection, analysis and interpretation of the primary data, with a view to investigate the need for the possible establishment of chaplaincy in South African Government Hospital for a holistic approach to care that includes patients' religious and spiritual dimensions of being. The researcher described the triangulation of the research participants and how data was collected (interviews, observation, field notes), and the process of analysis and interpretation employed. The next chapter deals with the research findings.

CHAPTER 4

DATA PRESENTATION AND INTERPRETATION

4.1 INTRODUCTION

This chapter presents the collected data from the research interviews conducted among the consented PHC managers, caregivers and the patients with a view to address the research questions. The researcher collected data at the PHC setting by employing a purposive, non-probability sampling strategy (Osmer, 2008) to determine the composition of the research participants. The researcher was guided by these questions as cited by Swinton and Mowat (2006:69): (1) How to choose the research participants? (2) What kind of sample was needed? and (3) How the participants were to be sampled? The interviews were recorded and transcribed to ensure data reliability. It also presents the interpretation of data.

The scheduled semi-structured interviews were conducted by the researcher with PHC management as first research Respondents to tease for information, in order to hear their views on the patients' rights to considerate health care, and how they respond to the patients' religious and spiritual needs in a holistic approach to care within the multi-disciplinary teams. This target group was key informants to determine the need for the establishment of a professional, institutional health care chaplaincy in the SAGH (to address patients' religious and spiritual needs). This group was also critical to determine the need for the possible review of the current health care policy, towards an inclusive SA Government's Healthcare policy that embraces chaplaincy and the patients' religious and spiritual dimensions of being (resonating with the patients' rights charter, as grounded in the Constitution of RSA (1996): Chapter 2 of the Bill of Rights.

The second research Respondents scheduled for semi-structured interviews were the PHC caregivers, (doctors, nurses, social workers, psychologists, health care professionals). The purpose of interviewing this target group was twofold: Firstly, the researcher wanted to solicit information in order to hear their views on the patients' rights to considerate health care, their experiences, values, beliefs and ethical challenges they are facing when addressing the patients' religious and spiritual needs in SAGH settings. Secondly, this target group was also key to determine the need for the possible establishment of an institutional chaplaincy as the religious and spiritual experts within a multi-disciplinary health care teams.

The third research Respondents scheduled for semi-structured interviews were the patients admitted and treated at the PHC settings, between the period of March 2019 to May 2019. The purpose of interviewing

this target group was to solicit information in order to hear their views on exercising their rights to freedom of conscience, religion, thought, belief and opinion as the consumers of health care in SAGH settings. Similarly, to solicit for information with regard to their views on their religious and spiritual needs, their experiences of health care, the impact of their religious and spiritual values, beliefs and cultural practices on coping with illness and the medical treatment in SAGH, and the need for chaplaincy.

The participants were interviewed in a preferred language of their choice which were translated prior to the scheduled interviews. The researcher further observed the responses (verbal and non verbal) of the research participants during their face to face interviews. These interviews were tape recorded, and later transcribed verbatim, and colour coded for the purpose of data analysis and interpretation. Pseudonyms were used to profile the Respondents. A computerised spreadsheet with a view to identify the patterns, relationships, themes and sub-themes that emerged from the data with a view to address the research topic. The findings are categorised under these themes and sub-themes which have emerged from data.

4.2 RESEARCH POPULATION

Myers et al. (2014) describe a population as a brief description of the participants. Mouton (1996:134) states that a *"population is a collection of objects, events or individuals having some common characteristic that the researcher is interested in studying*. For the purpose of this empirical research study, the researcher was of the view that the kind of information which was needed, and the potential sources of this information would be gleaned from the target research population below.

Table 13 below reflects the PHC population statistics from January 2019 to May 2019 whose aim was to indicate the public sector occupational class ratio to patients from which the sample was drawn:

THE PHC POPULATION STATISTICS FROM JANUARY 2019 TO MAY 2019										
Public sector occupational class (medical, nursing, allied, admin and support) ratio-to-patients admitted										
Period	January		February		March		April		May	
Occupational Class	Ratio to Patients		Ratio to Patients		Ratio to Patients		Ratio to Patients		Ratio to Patients	
Medical	1	5	1	5	1	5	1	5	1	5
	291	1400	288	1322	289	1 515	291	1380	294	1437
Nursing	1	2	1	2	1	2	1	2	1	2
	704	1400	681	1322	680	1 515	677	1380	680	1437

Allied	1 / 166	8 / 1400	1 / 167	8 / 1322	1 / 165	8 / 1 515	1 / 164	8 / 1380	1 / 161	8 / 1437
Admin and Support	1 / 414	3 / 1400	1 / 410	3 / 1322	1 / 409	3 / 1 515	1 / 407	3 / 1380	1 / 405	3 / 1437
Patients										
Admitted	1 400		1 322		1 515		1 380		1 437	
Discharged	1 094		1 241		1 414		1 267		1 340	
Deaths	103		85		115		96		110	
T/F Out	17		30		23		24		18	
Days PTS	32		40		43		23		32	
INPTS DAYS	11 882		12 366		13 495		11 330		13 012	

Table 13: The PHC Population Statistics from January 2019 to May 2019

4.3 RESEARCH SAMPLE

Table 14 below reflects the occupational classification or categories which is comprised of a sample of thirty (30) research participants who were interviewed from a research population at the PHC settings:

RESEARCH SAMPLE						
Occupational Classification	**Number of Participants**					**Codes**
Managers	6					RR1M-RR6M
Caregivers	Doctors = 5	Nurses = 6	Medical Social Workers = 3	Physiotherapist = 1	Psychologist = 1	RRC1-RRC16
Patients	8					RRP1-RRP8
RR1M1 to RR6M represent the managers: From Research Respondents 1 to 6		RRC1 to RRC16 represent the caregivers: From Research Respondents 7 to 22		RRP1 to RRP8 represent the patients: From Research Respondents 23 to30		

Table 14: Research sample

4.4 DEMOGRAPHIC CHARACTERISTIC

The researcher applied the principal strategy in the study, with a view to embrace the demographic characteristics of the research participants in tandem with Long and Johnson (2007:78): *"A principal strategy for health and nursing research is the collection of data about people. The data may include personal, biographical and demographic information that should normally be used for this purpose only."*

The Table 15 below encapsulates the PHC demographic characteristics of the research population.

PHC DEMOGRAPHIC CHARACTERISTICS OF THE RESEARCH POPULATION (YESNUARY 2019 TO MAY 2019)							
Characteristic	**Managers**	**Caregivers**					**Patients**
		Doctors	*Nurses*	*Psychologists*	*Social Workers*	*Physio-therapist*	
Gender							
Male……………….	[3]	[3]	[1]	[0]	[1]	[0]	[4]
Female................	[3]	[2]	[5]	[1]	[2]	[1]	[4]
Age							
18- 31…………..	[0]	[1]	[0]	[0]	[0]	[0]	[0]
31- 41…………..	[0]	[2]	[2]	[0]	[0]	[1]	[1]
41-51…………..	[4]	[1]	[2]	[1]	[3]	[0]	[2]
51+………………	[2]	[1]	[2]	[0]	[0]	[0]	[5]
Ethnicity							
African…………….	[6]	[4]	[5]	[1]	[3]	[1]	[4]
Asian……………..	[0]	[0]	[0]	[0]	[0]	[0]	[0]
Coloured…………	[0]	[0]	[0]	[0]	[0]	[0]	[1]
Indian…………….	[0]	[1]	[0]	[0]	[0]	[0]	[2]
White…………….	[0]	[0]	[1]	[0]	[0]	[0]	[1]
Occupation							
Managers………..	**[6]**	[0]	[0]	[0]	[0]	[0]	[0]
Doctors…………..	[0]	**[5]**	[0]	[0]	[0]	[0]	[0]
Nurses…………..	[0]	[0]	**[6]**	[0]	[0]	[0]	[0]
Psychologists……	[0]	[0]	[0]	**[1]**	[0]	[0]	[0]
Social Workers….	[0]	[0]	[0]	[0]	**[3]**	[0]	[0]
Physiotherapists….	[0]	[0]	[0]	[0]	[0]	**[1]**	[0]
Patients…………..	[0]	[0]	[0]	[0]	[0]	[0]	**[8]**
Faith Group							
African Traditional...	[0]	[0]	[0]	[0]	[0]	[0]	[0]
Christian…………..	[6]	[5]	[5]	[1]	[3]	[1]	[7]
Hindu………………	[0]	[0]	[0]	[0]	[0]	[0]	[0]
Muslim…………….	[0]	[0]	[1]	[0]	[0]	[0]	[1]
Non-believer………	[0]	[0]	[0]	[0]	[0]	[0]	[0]

Other………………	[0]	[0]	[0]	[0]	[0]	[0]	[0]
Language Afrikaans………… English…………… North Sotho……… Tsonga…………… Venda……………. Other………………	 [0] [1] [4] [0] [1] [0]	 [0] [1] [2] [1] [1] [0]	 [1] [2] [1] [0] [1] [1]	 [0] [0] [1] [0] [0] [0]	 [0] [0] [1] [0] [1] [1]	 [0] [0] [0] [1] [0] [0]	 [2] [2] [2] [0] [1] [1]
Residential Area Capricorn District…. Mopani District…… Sekhukhune District Waterberg District… Vhembe District…. Other……………….	 [5] [0] [0] [1] [0] [0]	 [4] [0] [0] [0] [1] [0]	 [6] [0] [0] [0] [0] [0]	 [1] [0] [0] [0] [0] [0]	 [3] [0] [0] [0] [0] [0]	 [1] [0] [0] [0] [0] [0]	 [3] [0] [1] [1] [2] [1]
TOTAL = [30]	**6**	**5**	**6**	**1**	**3**	**1**	**8**

Table 15: The PHC demographic characteristics of the research population

4.5 PRESENTATION OF THE RESEARCH FINDINGS

The study answered these research questions: Why there is no chaplaincy? Why it is imperative to establish chaplaincy? What are the values and roles of chaplaincy? and propose a model of chaplaincy, in tandem with these research objectives: The exploration on why chaplaincy is excluded in SAGH, and the chaplaincy roles and values. The researcher interviewed Respondents with a view to elicit knowledge and to understand the research topic by posing the research questions to the managers, the caregivers and the patients (Appendix C).

Why is chaplaincy excluded from SAGH multi-disciplinary health care teams?	Why it is imperative to establish chaplaincy in SAGH?	What role can chaplaincy play in multi-disciplinary health care teams? Can chaplaincy add any value (need)?	What contextual model of chaplaincy will be effective?
Exclusion of Chaplaincy?	Need for Chaplaincy?	Role and Value of Chaplaincy?	Model of Chaplaincy?
Questions posed to:	Questions posed to: Managers: 1,2,3,4,5,6,7,9,10	Questions	Questions Managers: 1,2,3,6,8

Managers: 4,5,6,7,8,9 Caregivers: 1,2,3,4,5,6,7,8,10 Patients: 1,2,3,9,10	Caregivers:1,2,3,4,5,6,7,8,10 Patients: 1,2,3,4,6,7,8,9	Managers: 1,2,3,4,5,6,7,9 Caregivers: 1,2,3,4,6,7,8,10 Patients: 1,2,3,4,6,7,8,9	Caregivers: 1,2,3,4,6,7,8,10 Patients: 1,2,3,4,6,7,8,9
Questions to address *Exclusion of chaplaincy if there is a need.	Questions to address *The importance of the religious / spiritual dimensions of being.	Questions to address * The role and value of chaplaincy in health care.	Questions to address *The contextual model of chaplaincy.

Table 16: Summary of the research questions

According to Collins (2004), a theme is *"an idea or topic expanded in a discourse, discussion, etc.*" Henning et al. (2011:107) alludes that *"when a researcher is satisfied that the themes represent a reasonably researched chunk of reality, each theme can be used as the basis for argument in a discussion around them."* Processed data do not have the status of findings until the themes have been discussed and argued to make a point, and the point that is to be made comes from the research question(s). The following ten themes emerged from interviews with the research participants at PHC:

- The right to freedom of conscience, religion, thought, belief and opinion during hospitalisation.
- Embracing, assessing and responding to the patients' religious and spiritual needs.
- Embracing, supporting and conduction of the religious observances in the SAGH settings.
- *The need for chaplaincy as the religious and spiritual experts in a holistic approach to care.*
- The establishment of chaplaincy (recruitment, appointment and regulation) and health policy.
- The views of the managers, caregiver and patients on health care services and ethical challenges.
- The patients' meaning of the religious and spiritual healing for coping with illness in SAGH settings.
- The patients' value and role of the religious and spiritual beliefs in coping with the medical treatment.
- The patients' experience of the religious and spiritual needs during the medical treatment.
- The views of managers, caregiver and patients on the importance of health and health care.

4.5.1 Theme 1: The right to freedom of conscience, religion, thought, belief and opinion during hospitalisation

According to Pera et al. (2005), the fundamental rights such as the right to life, the right to human dignity, the right to privacy, the right to language and culture, the right to freedom of religion, and others, cannot be violated by the government. Therefore, the Constitution of RSA (1996), Chapter 2: Bill of Rights, stipulates under Section 15(1) states that: *"Everyone has the right to freedom of conscience, religion, thought, belief and opinion."* On the same vein, the SAGH embrace the National Patients' Rights Charter (NPRC) to address the complaints regarding hospitalisation and treatment at health care centres in general (Mulaudzi et al., 2001:49). Hence the research questions were grounded in the RSA Constitution of 1996.

The researcher interviewed the patients to elicit their views on exercising the right to freedom of conscience, religion, thought, belief and opinion during hospitalisation in SAGH settings. These views resonate with VandeCreek and Burton (2001:83) in that: "patients have a fundamental right to considerate care that safeguards their personal dignity and respect their cultural, psychological, and spiritual values."

Respondent 26 confirmed this viewpoint that *"That one, I feel like those rights must be exercised."* Respondent 30 reiterated similar view with Respondent 26: *"Yes I will exercise the rights."* Respondents 24 and 29 agreed also to exercise this right during hospitalisation in SAGH. Respondent 23 was of this view, regarding the exercise of the rights during hospitalisation: *"It should be fair and reasonable."* Respondent 18's response embraced the view of Respondent 23: *"Yes, I think it is possible, that this rights can be exercised, in a way that, if it does not impinge on the right of other people, or other patients. But I think that it is possible."*

However, Respondent 25 was of this view:

> *"Yes it seems here, this one, according to the way I feel, I wish that when you enter the hospital, it must, firstly, those that I will meet at the hospital, it might be the nurses, they must introduce themselves to me. And then from there, I must also introduce myself to them. And then from there, they must continue to orientate me to all the hospital sites, like for instance, the restrooms, the place where I can get water. And then if there are anything which I might need, they may approach me humbly, as in the hospital we have mutual respect. Yes, I am a patient, they must also support my illness, so that I must not talk about stress, yes. Another thing, to ask if I feel pain, what I must do according to them, in line with my illness. They work according to a protocol. They tell you, 'we are expecting a doctor.' Whatever the procedure a doctor prescribes, it will be the procedure they need to follow according.*

The view of Respondent 25 resonates with the view of Haynes et al. (2007:7) of using patients' admission form information is a potential starting point to understand their worldview and its implications for health. Similarly, Puchalski (2001:1) states that *"compassionate care calls for physicians to walk with people during their pain, to be partners with patients rather than experts dictating information."*

However, when the caregivers were asked to share their views on the patients who want to exercise the right to freedom of conscience, religion, thought, belief and opinion during hospitalisation in SAGH,

Respondent 22 mentioned this thought-provoking view:

> *I think it's possible, but there are instances where it really… it might not be feasible. But they are well within their rights to want to exercise their religion or their belief background, more especially patients who have like terminal diagnosis, terminal illnesses. What I always realise is that, even if you refuse or you don't consider their religious aspect, you are most likely going to fail in terms of treatment, because they will probably be lost to follow-up. They will just disappear and go and fulfil whatever they want to fulfil. And by that time for an example, if a patient has cancer, you have a cycle for chemotherapy, which must not be interrupted. So, if you are not considering that she believes that if my pastor prays for me, I will be healed, or she believes that I'm bewitched, I must go and consult- if you don't take into consideration, they will disappear for a good six months. And then, by the time when they come back, they are like in terminal stages where there's absolutely nothing that you can do. So, I think they are well within their right if we had such services, and we are managing together. People who are in the chaplaincy office, I'm sure they will be able to bring into perspective, because from our point, patient don't believe us. I don't know if you get me? They don't have that rapport in terms of, maybe they think we have their best interest, in terms of their religious beliefs. They already- before they can even voice it out- they already think we are going to refuse. So, I think if there's an office that is more experienced in that, then we can have a holistic approach, where we say: 'This is your diagnosis, this is what we are going to do.' And then, if these services' there, then we don't have to interrupt treatment. We can treat you and then whoever can come to the hospital, whatever your belief is. But if they are not going to be giving concoction thing. I don't know, that's why I'm saying, somewhere it might not be feasible, because some, especially traditional things. Okay, and even some churches, they give things nowadays. So, you do not know exactly what it is in that thing. And even some herbs have been shown. We have patients who will have complications. So, when it comes to that it might not, but in instances where it's just about uplifting the spirit, of the patients, I don't think there's anything wrong in that. I don't think there's anything wrong, Yes.*

Respondent 21 shared this viewpoint:

> *Well my personal view regarding this question? I think every patient who walks into the hospital, besides being a patient, it is a human being. So, they also have the right*

to their religion, their own belief. So, the question it's, or sometimes I think it becomes a problem, when they walk into a facility, because here- as much as you want or we always want to treat the patient holistically, our focus it is treating the problem, which is most of the time is the physical ailments. But I believe, I think my personal view is that: 'everyone has the right to exercise their own religion or belief in the hospital institution.'

Respondent 20 agreed with Respondent 21 on the focus of a holistic treatment:

So, as a health care worker I think it's quite important that they have the, firstly, have the right to this freedom of religion. And I think also it, being integrated into health care will help a patient a lot, because many of the times, you know you're not just treating a patient's organic or pathological problem, you know you deal with their sub-conscious, their conscious, their religious beliefs. And a lot of what they expect out of health care systems also revolve around what they belief in. And you know, sort of their spiritual connections with whatever divine being they belief in, yes.

Respondent 7 expressed the reality of the caregivers' challenges in this viewpoint:

My view is that, is becoming complicated, complex and is not, is actually complicated because, you find that the doctor is referring this way, say maybe the patient need to take the treatment, and you find that the patient wants to exercise his belief, you find that he doesn't want to take treatment, it's not his belief, he believes that if I go somewhere else, if I see my pastor, if I, you know, and then it's becoming difficult to trace them because they end up giving wrong information. When you trace them, they are no longer to be found, because they are running away from treatment. They think that the treatment is not doing any good. It's like maybe when you are saying: 'Molwetsi [pseudonym] you are diabetic, take treatment,' then I say: 'No, but if I can see my pastor or my (inyanga) [traditional healer] or my religion, it will be much better than that.

Respondent 19 concurred with Respondent 7 in this manner:

I think patients do have this rights, even during hospitalisation. However, it's kind of limited, in which way? During hospitalisation patients still have their rights to believe religion and opinion. So, if they feel during hospitalisation they want to consult with any of their belief, their religion, so the hospital will not prevent them from doing so. They will be allowed to consult with such. However, during hospitalisation, I think to bring their religion, the spiritual dimension, spiritual domain, spiritual belief into the hospital, that's the one that will bring complexity in terms of treatment, management and care of the patient.

However, according to Sheikh (et al., 2004:1), the legislation on human rights makes clear that all individuals have the right to practice their religion. In the context of hospital care, where individuals are

frequently highly dependent on others, fulfilling this right and, more importantly, gaining access to spiritual help in times of serious illness or death, may be problematic for patients of faiths other than Christianity.

Respondent 10 shared this personal observation:

> *Yes, I think according to me, every patient has that right, but during my observations in the health sector, these rights are not being exercised. The hospital is mainly focussing on medical issues and regardless of the religion or a thought or the belief and the opinion of the patients. When I can give an example of the thought, and the religion: these people they come, they have their different, religions, but we're not asking them their belongings, and we're not asking them, what do they think it can help to uplift their health.*

Haynes et al. (2007:5) confirm the view of Respondent 10 that: *"The predominant biomedical position has been to leave spirituality out of medicine."* Similarly, Willemse et al. (2017:62) state that *"naturally, doctors and nurses give priority to maintenance of the clinical aspects. However, the primary focus on the treatment of clinical symptoms may impede the understanding of the spiritual needs of patients."*

Respondent 13 expressed similar view to Respondent 10 that:

> *It will be, a good thing to have, to have this exercised because patients now, they don't have access to this. So, most of the time, they ask for discharge, of which they end up giving them. What is this? Refuse hospital treatment, so they can go and receive spiritual counselling at their respective churches.*

Respondent 17 mentioned that: *"Everybody's got the right to do that. If you are well informed about your diagnosis, and your care, you can make honest decision if you are mentally stable. So, I do believe that you have got the right."*

Respondent 14's argument resonates with those of Respondent 20 and 21 above:

> *Yes, in terms of freedom of religion, I do believe you pastor that, it will benefit the one whose ill at that particular time. Isn't, remember they're saying the human being is composed of physical, psychological and spiritual wellbeing. So, once you separate one from the other it becomes difficult. Do you see it?*

The views expressed by all the Respondents resonates with the contents of the patients' rights charter. According to Mulaudzi et al. (2001:50-60), the consumers of health care are also becoming more aware of their rights through the Constitution of the Republic of South Africa, Act 200 of 1993. The NPRC

embrace among others aspects such as participation in policy making, thereby building a trusting relationship and confidence in the health service. The patients who use the public health services have rights which include among others: participation in decision making, access to health care, choice of health service, and to complain about health service.

PATIENTS' RIGHTS CHARTER	
Every patient has the right to:	Every patient or client has the following responsibilities:
* Healthy and safe environment * Participation in decision-making * Access to health care * Knowledge of one's health * Insurance/medical aid scheme * Choice of health services * Treated by a named health care provider * Confidentiality and privacy * Informed consent * Refusal or treatment * A second opinion * Continuity of care * Complaints about health services	* To take care of his or her health * To care for and protect the environment * To respect the rights of other patients and health providers * To utilise the care system properly and not to abuse it * To know his or her local health services and what they offer * To provide health care providers with the relevant and accurate information for diagnostic, treatment and rehabilitation or counselling purposes * To advise the health care providers on his or her wishes about his or her death * To comply with the prescribed treatment or rehabilitation procedures * To enquire about the related costs of the treatment and/or rehabilitation and to arrange for payment * To take care of health records in his or her possession

Table 17: Patients' Rights Charter

4.5.2 Theme 2: Embracing, assessing and responding to the patients' religious and spiritual needs

According to Hodge (2005:322), "clients have diverse needs and interests, as do practitioners." Be that as it may, Howell et al. (2017) further state that:

> *Addressing the spiritual and religious needs of hospitalised patients has become of increasing importance in the last two decades. In fact, provisions for spiritual care have*

been added to the standards put forth by hospital accreditation bodies such as The Joint Commission (TJC) (Medicare/Joint Commission national hospital inpatient quality measures, n.d).

Therefore, when the researcher posed few questions to the Respondents to elicit their views on embracing, assessing and responding to the patients' religious and spiritual needs:

Respondent 19 shared this challenging view:

I think there will still be challenges to incorporate it into the medical model. What is it that we will be treating? Okay we've incorporated all these, so here what is it that we are treating? So now Okay incorporating the other regimen, on which level? On which level, we incorporate? On the support level or on care? Because if it's care still it's not going work, it's still going be contrary and maybe counter- productive. So, if it's TB and then we've incorporated the model into the care, and I'm a traditional believing in the traditional domain, my people would have to come and burn some things as per our practices. I'm TB or I'm asthmatic, so will the medical practitioner allow it? This person already has lung issues, now you come and subject this patient in concentrated smoke and so, how are we going to work about it? And remember by the era we are in; it will make it even more challenging. The credibility, authenticity of our traditional healer-practitioners, of our spiritual caregivers. So, having to incorporate it in the treatment plan, so it means, I'm not sure how are they going to authenticate these practitioners. Remember here we're talking: it's either cure or management, that's the model. So how are we going to cure this TB? or how are you going to care and manage this TB from a traditional perspective, from a spiritual perspective? Remember like I'm saying, the person's spiritual domain is very strong. I think it's almost central. So, if my spiritual or my whoever, my spiritual practitioner says: 'Okay, you can do away with this, we have spoken to your ancestors, you are healed. So, I am going to put my tablets away, and belief my ancestors are seeing me through, and this illness it's gone. And when I complicate, I still run to the old model now), the medical model. When you come, you have complicated, maybe you have even developed resistance. You are no longer treat-able, you are no longer responding to the treatment. So, having to incorporate them in the treatment plan it might still be, not feasible... So, here the model is very easy to authenticate: 'Doctor Ngaka [pseudonym], let's see, you are a senior psychologist, are you registered with- you satisfied the requirements of the board that you are an authentic psychologist?' Yes, I have proof and documents to authenticate. So now, having to incorporate all these religious practitioners, so, how are we going to authenticate them?... And still, within the same domain, it's public knowledge we have false practitioners, either spiritual practitioners or traditional healers. So now, how are we going to deal with that? (mm mm). We have authentic and non-authentic? So, still with the religious domain, there are some issues that needs to sorted out, which we don't know how we are going to sort them out. So, having to bring the domain that itself it's having challenges and dilemma, and you bring it into- not that model- the medical model is absolute and ultimate. So, now we have incorporated it in the treatment plan, we have our wonderful pastors, we have our wonderful traditional healers, how are [we] going to regulate them? And we also need to stipulate on which

level are we bringing it on. So, as a psychologist in the hospital I am not primary. A patient can still be treated.

According to Hodge (2005:314), *"it is increasingly recognised that health care professionals should consider conducting a spiritual assessment as part of holistic service provision."* Cook (2004:60) asserts that *"for most people, although certainly not all, both religion and spirituality serve important roles and both are important for caregivers to assess."* Hodge (*ibid*) highlights that "assessment provides a method of identifying spiritual asserts that can be operationalised in treatment and discharge planning." Rumun (2014:39) agrees that:

> *In identifying 'spiritual or religious needs' in the hospital context, health professionals are attempting to gain an understanding of two broad issues: Firstly, beliefs or practices which are significant to the patient's health that can affect decision-making, coping, support networks, commitment to treatment regimens, use of complementary health practices and general wellbeing. And secondly, patients' wishes about the way beliefs and practices are acknowledged and supported while they are in hospital.*

Similarly, McDowell and South (2017:1) say that clients' assessment and planning of health care must include the spiritual dimension. De la Porte (2016:4) confirms that *"an assessment of spiritual concerns includes, but not limited to meaning, purpose, beliefs, guilt, forgiveness and unfinished life tasks."*

Respondent 3 highlighted this on assessment:

> *Eh, maybe, maybe there is a need because now, we do not assess them, whether on their religious or spiritual need. But I think people are spiritual beings, and therefore it might be important at times, the best part of administering them into our system, we understand those kinds of belief that they have. So, it might be necessary at times we assess them. Look, we have a situation in hospital, obviously in hospital, you admit a lot of people who would have different beliefs, who would have, who will believe in that, others will in that. We have a situation of people here, who wants prayers from your Christian priests. We have people who come here and want to perform some traditional, you would know, that they want to do those kinds of things. Therefore, maybe it might be important for hospitals at times to, as part of profiling their patients, to also understand people that they admit as far as their spiritual issues are concerned.*

Respondent 17 expressed this view:

> *There is a form that they fill on admission. It is a kind of the demographics of the patient. His name, his date of birth, ID number and what {what}, and religion is included in that questionnaire. And also, the nurses do phone pastors on patients' request. I know in my own capacity if I see one of our Church members, I even call my own dominee and say, 'listen, so and so is admitted, come see the patient. So, I think we*

should put more emphasis on the patient's spiritual being, because as I said before, if you are sick, and your emotional and spiritual aspect is neglected, your healing will take so much longer. And patients will just be sick for long times.

Respondent 20 shared this view that embraces chaplaincy:

> *Alright, so again like I am very supportive of it. I think it's one aspect that gets neglected a lot, and I mean like you have mention as well there is no chaplaincy currently in our government hospitals. And I think it is something that can- you know- their assistance, will assist our patients because at the end of the day- you know- we don't treat a leg or an arm, you know- we are treating a patient. And the patient comes with their religion, you know- and comes with their beliefs and comes with their, you know- everything, that they are a holistic person, with different dimensions, you know- and, us as health care provider obviously, our aim is to treat the organic problem, you know. But I think for a person to be, to feel that they've benefitted from hospital will need an engagement in all kinds of levels, and the establishment of chaplaincy can assist in that regard.*

Respondent 8 concurred with the view of Respondent 20:

> *Okay, with my view on this issue is that, I think, it is good for this chaplain to be there for this patient, because sometimes we may found that we treat the patient, is it not so? But after treating the patient, you can see that out-part we have done our part (alright) with the medication and everything, but spiritually this person (mm) is still suffering inside. But there is nothing that we can do since we don't offer the chaplain services around. So, I think the best thing we can have that service, it can be of help in this situation.*

Respondent 11 stated this concerning religion as part of treatment:

> *Yes, I think it's important for a person, to have a freedom of a religion and belief, because, each {an} every person, have got origin, and background, and religious, background (alright). And the religion, is also part of the treatment. If you don't believe in something, which means that thing cannot happen. So, if the patients, have got a religion where this person believe on, and it's excluded, medical team cannot be able to achieve. I think, the patient has got the right, to have the religion which he falls in, to be exercised.*

Respondent 1's response was more on the religious and spiritual support:

> *Well it is expected of every health care worker to ask the patient about their religious belief or their spirituality. Mainly for us is to find that area if it can help as a source of support for the patient, because when you treat the patient you might have a limited contact. But as the patient goes out to their usual lifestyle, you need to find certain aspect in their lifestyle that will support your treatment, and it will be continuous, and it*

will be beneficial to the patient. Otherwise you might end up with patient who relapse because they did not follow on.

Respondent 4 expressed lack of religious and spiritual provision in the hospital settings that:

> *Yes, it is necessary. Is it not, in terms of the bill of rights, it says all citizens of South Africa, they've got freedom of religion? So, it's like, if the person is admitted in the hospital, then you find that some believe in that, my pastor can come and pray for me. But you realise that, is not provided in the set up now. So, that's why I say it is important for this to be, yes.*

Respondent 14's view strongly supports addressing the patients' needs "Yes, I strongly support that, if there's religious and spiritual needs. Whilst they are being hospitalised it should be adhered to. If there is a need being observed, why don't you address it because you have seen there is a need?" Respondent 12 mentioned this regarding nursing plan that:

> *Definitely it is important. In nursing, they do plan. Sometimes, you know it's just that it's not been done like constantly so. But sometimes it gets included in planning, to say: 'you know we need a spiritual care.' But it is important that a person gets that only, because now you cannot separate a person. You need to look at physical, psychological, spiritual, everything, where the person comes from, community you know, social part of it.*

Respondent 21 shared this progressive viewpoint:

> *Yes, like now like in this, I think where we are now, I've probably maybe in the private health sector, where I think there is a place, or if ever you're sick, some few private hospitals, have some chaplaincy. But in our public sector, in my experience, I've never, or else the old hospitals, where we used to have missionaries, and so on, but they are no longer there. So, you don't- you hardly see these services. You hardly see a place where we embrace this. So, I think this should come up in the planning, in the health care system plan when we plan system and so on. Chaplaincy should be part of, Yes, because it's very crucial, it forms the basis of everything. I think it should be part," Respondent further stated: "In private hospitals you see there, there and there. But what I've noticed, I don't know whether it is chaplaincy or they belong to a specific religious, but at least they provide a type of... when they built those facilities, there's also, what do we call that? A chapel. There's a chapel there. Their plan provides there's a chapel. Now we are looking at the plans- they want to build the hospital, the tertiary hospital, the Limpopo Tertiary hospital. So, they showed us the architectural plans and so. I didn't see a chapel. I didn't see an office where they say: 'this is a chaplain's office,' Yes. So, I think when they are doing the planning, the future planning or whatever they do in their planning for the governmental structures when it comes to health, think about it, and include it, to be part and parcel of the health care system.*

Respondent 16 expressed similar view that chaplaincy address the religious and spiritual needs:

> *Yes, yes, we can include them, yes because we are dealing with people who have their own beliefs, yes. And, that is why I say problem of patients is that, if s/he is in the hospital, even if there is progress but slow progress, somebody comes stating that somewhere it appears they... s/he will sign RHT forms and leave. And you cannot refuse him/her permission. But later they come back to the same system. So rather, everything must be, their needs must be addressed by chaplaincy in the same system.*

Respondent 22 subscribed to this view that embraces all the dimensions of being human that:

> *I think it's something that has been missing for the longest of the time. We need to include it, and it should be part of the plan of management everywhere, because patients are the same, whether you are here, whether you are in another province, whether you are in another country, you'll still be a patient, I mean a human being with three dimensions, that need to be taken care of. We need to feed your soul, we need to take care of your body, and as spiritually we need to be taken care of… so I think it will play a big role. It will also limit a defaulting, in terms of treatment of the patient. It will play a very, Yes, key role.*

4.5.3 Theme 3: Embracing, supporting and conduction of the religious observances in the SAGH settings

The NHS Chaplaincy Guidelines (2015:27) is propagating that in terms of the modern health care:

> *The provision of suitable areas for worship; prayer; contemplation; reflection; meditation, stillness and peace is required for human rights and equality to be observed. It is also a positive incentive in recruitment to have areas available close to clinical practice which staff can attend without difficulty.*

The Respondents were asked to share their views on conducting the spiritual and religious observances in SAGH settings, as grounded in the Constitution of RSA (1996) Chapter 2: Bill of Rights, section 15(2). Respondent 4 shared this affirmative view:

> *As it's indicated in section 15 (2), I think if this process can be controlled, then the policy be laid down, or this is how the process must unfold, then it can assist, even the patient. But if it is not prescribed, the hospital can have a lot of challenges around it. But if it can be controlled, documented, and assessed very well, then it doesn't have any problem.*

Respondent 8 asserted in this view:

> *In fact, there is a need of this religious and, so that we can work holistically so, we can work medically, you do your spiritual part, so that those people, can get help, because now people are being discharged to the hospital, they are still suffering, though medically wise they can say: 'No the patient is better,' but medically lot of patients you can see that, they are not suffering this medical conditions. They've got the problem deep inside, but we will discharge, saying 'you are fine you can go.' So, this thing of this religious being, and if it can be conducted, at least even though they cannot do the office inside, but they make a contract with someone, like a priest somewhere to say, no, you will receive a call, if there is a need.*

The Respondent further stated:

> *Yes, we really embrace it, because really we need their support, because if we keep on like neglecting this, we are killing our people spiritually so, because they need deliverance really.*

Respondent 1 shared an institutionalised service in this view that:

> *Yes, if the services are in the hospital, then you don't have to have the scenario where time is wasted by patient who want to go away to consult their spiritual leaders, they will be able to, as you speak to them they will tell you: 'I need to consult,' and then you tell them their services are free and available in our hospital. They will go there, consult and come back to you, even on the same day, and you decide for further intervention and appointment.*

Respondent 11 shared this interesting view:

> *I think it's feasible, because if you haven't, you believe in something, your belief can also have good consequences on your treatment. If you know that, it's Christmas, if you know that Okay, it's, Good Friday, you know that Okay, Good Friday is the time when Jesus was crucified. So, if I provide something to other people, which means that thing can also have good things in return on me. I think it's good.*

Respondent 5 mentioned this challenge:

> *The patient can request, but it's difficult to address their request as I said earlier, that we have different beliefs and yes, and the patients are all in one place and then now trying to cater for all of them in one setting, it becomes a bit difficult… I think if we, they can come up with ways on how to address them, it will make it easier because as health care workers, then it becomes difficult for them because even that person s/he also has his/ her own beliefs. So, implementing others, we may vary in attending to*

> *them. But if there is a person with, what do you call it? Rules or whatever, that is put into place, yes, that can be followed.*

Respondent 21 shared this complexity in this view:

> *This one I think it is tricky. I think it is tricky because well- it will depend on what observances, like you've mentioned here. The observances should follow the rules that are made by the authorities, conduct- you know- on equitable basis and like they should be voluntarily. This one can be tricky because, for instance, I will talk about experience. When you work in neonatal ICU you are admitting a new born baby with critical issues and so on. There's this belief, let's say, you've got twins that are born, and one twin die. So, according to some beliefs, the other twin, they should bring like a branch, a branch of tree, into the hospital facility, into the ward, and then perform that ritual there. So, that one for instance, it can be tricky because in a certain- like ICU we try not to bring- you know- in the- because of, you're worried about the risk of infections, and so on. And then there's also this one where the same twin, the alive twin the remaining, should be taken, be put into the grave- you know- I've seen that. So, it's feasible, I think this one it depends on the extent of the observance, and if it's not going to be counter- productive to the medical approach, and it won't pose any risk, any health risk- you know- or things like that. Yes, if it's about a pastor coming and conduct the service for his group of his religion's patients, those are easy. But there are certain ones that will be very challenging.*

Respondent 23 summed it thus: *"No problem"* While Respondent 6 simply confirmed that: *"That can be done."*

Respondent 25 suggested this alternative approach that:

> *Yes, according to my wish, I say let the religious observances be conducted. It is the one that, it is religion according to its variety. But the other important thing, my suggestion is, how would it be that in the hospitals- because other people are religious others not, concerning religion, there must be tracts that can be put inside the lockers so that when any patient is admitted, will be able to pass time and read about what religion say. What does my care at the hospital mean because the Bible is the one that will teach us about love, how to treat each other well, and to respect each other?*

Respondent 29 conversely shared this view that, *"Because you see, then, I was here, admit, I was also praying, and other people they were doing with me, they were busy with me, so I don't think so.*

4.5.4 Theme 4: The need for chaplaincy as the religious and spiritual experts in a holistic approach to care

The NHS Chaplaincy Guidelines (2015:7) reiterates that *"chaplaincy has evolved in response to changing needs with increasing professionalism"* It is crucial to highlight from the context of this study that the position of the chaplain in the hospital is based on historical precedent and pre-dates the setting up of the NHS in 1948. Typically, hospital chaplains have been Christian ministers and have either been employed to work full time for the hospital or take some part time sessions as part of their parish ministry. The management was shared between church and hospital and their role as representative of the church in the organisation went largely unquestioned. *"The way chaplaincy was configured in any hospital tended to be a consequence of local circumstances"* (Mowat, 2008:14).

The researcher interviewed the Respondents to determine what are their views on the need for chaplaincy as the religious and spiritual experts in a holistic approach to care in a health care setting.

Respondent 17 stated this viewpoint:

> *I should think it should be, like that, I mean chaplains are trained. They are trained how to read the Bible, how to interpret it, they also know how to pray for patients, they also did a bit of psychology, when they know that social needs of the patients, the physical needs, the emotional needs. So, I do think they should oversee this.*

Respondent 1 shared this affirmative view:

> *Yes, I am pro, the provision of chaplaincy services. You know we have health care providers in hospitals, but it seems like places like airports, they see that it is necessary to have chaplaincy services or to have a chapel where people can go and do their religious observances without hindrance, so even here, it should be. It should go without say because it's part of health.*

Respondent 10 shared this viewpoint:

> *Another role that I think chaplaincy can do is to also visit the patients' families in their homestead, maybe before or after discharge, so that the families can also be, brought on board to assist the patients. Because, for example, if somebody we realise that, spiritually that person needs assistance, and the person is being discharged, go back home, but you find that he doesn't get the necessary support, it's where I think chaplaincy can, also intervene.*

Respondent 10 mentioned the importance of holistic treatment:

> *Yes, like I said, it will help because, so far it will assist in treating our people holistically, because now we are treating them, but the issue of their religious beliefs, it's lacking far, far, far behind. And of course, it will bring too much improvements in their lives, and even to the hospitals staff, yes."*

Respondent again confirmed this:

> *It will help very, very, very much. Like I said previously according to my observations, most of the ailments are related to spirituality, yes. And that's why medically we sometimes, it's not, medically people are not unable to get… because spiritually some boundaries that needs to be reached, before, yes.*

The view of Respondent 10 is captured by VandeCreek and Burton (2001:85) in that *"professional chaplains offer spiritual care to all who are in need and have specialised education to mobilise spiritual resources so that patients cope more effectively. They maintain confidentiality and provide a supportive context which patients can discuss their concerns."* Therefore, modern chaplains have moved from a situation of 'assumption of presence' to a need to affirm a 'case for chaplaincy,' (Timmins et al., 2017:4).

Respondent 8 shared this perspective that:

> *Okay, another thing here, isn't that we've got, let's say, this one, I don't want to talk, dwell much on casualty alone. I want to talk for the hospital as a whole. With this one I think, it will play a major role because, let's say, we've got a chaplain office, is a staff member, who is having a problem, others they don't like to share the problem with the... Others they don't go to church at their homes, but you can see this person is having a problem, can I say 'my colleague, since you have come to me and decide to open, even though you cannot open, can't you go to reverend and tell your problem, maybe they can pray with you, and have deliverance on whatever, you are suffering from?' Another thing is the patients in the units, Yes, there are patients that are there, they've seen them, they've tried everything, but they see that, we are failing, we have tried lot of things, but what she needed that patient, it's only God's help. Then if you are there, they can call: 'Reverend we've got this patient in the unit, can you come at least pray for our patient, or talk with our patient?' Sometimes, things they don't need these medical things.*

Respondent 14 highlighted this interesting view on chaplaincy that:

> *If, as we've said, the chaplain is going to be doing whatever that he will be doing in terms of the Constitution of the Republic, meaning that, you won't be enforcing a certain religion, but will be observing all the religions, and then my answer will be, my*

view, it will help. They can facilitate if they will be doing it according to the manner that it should be done, not enforcing, Yes, they can facilitate.

Respondent 11 stated this viewpoint on chaplaincy that:

I think is to remind, the caregivers or the employees, of the purpose and reason why they are called. I think even spiritual counselling. I think even to help, to coordinate all the employees, with different professions to come in one boat. And also, to the chaplain can also help to make each worker, to realise that human being has got origin, and have got Creator, Yes.

Respondent 22 mentioned this critical role of chaplaincy that:

Yes, I think, I probably think they are the right people to do it, because they are not focussed at a certain religion. So, if you ask me to do it, I will look at what I belief in, and I will provide for that. And sometimes due to- I don't know- that's why you are a staunch believer in what you believe in, or you don't have information about other religions, you tend to want to judge others and think that this is not the right thing. So, if it's done by the chaplaincy, who knows the broad-spectrum categories or types of religions that we have, I think it will be fair. That's what I think, and it will be able to cater for a bigger spectrum of patients.

4.5.5 Theme 5: The establishment of chaplaincy (recruitment, appointment and regulation) and health policy

According to NHS Chaplaincy Guidelines (2015:17), *"effective chaplaincy depends on the quality of appointments and it is expected that every effort is made to recruit candidates of the highest calibre*." On the same vein, (Howell et al., 2017:157) are of the view that the establishment of a professional chaplaincy would requires guidelines, professional board-certified chaplains in hospitals, policies and protocols to determine how chaplains should best provide spiritual care in the inpatient and critical care settings.

When the researcher posed the question of appointing the patients' spiritual and religious leaders in the multi-disciplinary health care team to meet their spiritual and religious needs in the context of SAGH, Respondent 23 had this to say: *"I see no problem with it."* Respondent 24 confirmed the need for the establishment of chaplaincy: *"We do actually need somebody. We're supposed to have these people long time ago. We all need God obvious."* Respondent 25 highlighted the view that chaplaincy will bring synergy:

The need for religion is only that, there must be regular visits from the ones that have knowledge of the word of God, to inspire us that, yes this are the ways of God, this is how they apply to us, yes. These will give us strength that, even if you are ill, you must remember others then remember the revelations of the words of God that it will save you. My view is that it is a good thing, because it will bring the families- those groups will be doctors, yes, all religions, speaking one thing that will assist them to know how to treat these people of God.

Respondent 26 mentioned this concerning the appointment of chaplains: *"Yes let there be clergy." The Respondent further reiterated: "We had, I had that understanding that the clergy must come and teach."* Respondents 27, 28 and 29 were of this viewpoint that: *It is good to appoint the spiritual and or the religious leaders in the multi-disciplinary health care teams to meet their spiritual and or religious needs.* Respondent 30 reiterated similar view with other Respondents: *"Yes. I am awaiting this appointment."*

When the researcher interviewed the PHC management to elicit their views on the recruitment and the appointment of chaplains as the religious and spiritual experts in the SAGH multi-disciplinary health care teams; secondly, to share their views on the adoption of health care policy that embraces chaplaincy, and thirdly, to share their views on the regulation of the practice of chaplaincy in the SAGH settings. Respondent 1 shared this principle view;

On the same principle that we have, you know doctors and nurses who are taking care of the physical aspect of the body, we have psychologists who are taking care of the mental or psychological aspect of the body, including eh psychiatrists as well, and we have social workers who are in the hospital attending to social needs of the person. It goes without say that there should be spiritual attention for the people's soul, such spiritual caregivers, must be appointed same as the other people.

The Respondent further stated:

Yes, I am pro, the provision of chaplaincy services. You know we have health care providers in hospitals, but it seems like places like airports, they see that it is necessary to have chaplaincy services, or to have a chapel where people can go and do their religious observances without hindrance, so even here, it should be. It should go without say because it's part of health."

Furthermore, the Respondent reiterated:

The services should be open to all, because being a service provider does not mean you don't have spiritual needs. You may, at some point in your life become a patient, so those services should be open to you, same as you know it's along the principles that, in a work environment there should be a place for health for the workers, like in

the hospital we have the occupational health services which is for the workers. So, that place must also accommodate the workers, the patients and their relatives.

Respondent agreed on regulating the practice of Chaplaincy that:

Because they are going to be employees, they need to be governed by the laws of South Africa, including labour laws.

Therefore, the Respondent is of the view that:

Like all employees, the employment procedure or process must take place, advertisement, shortlisting, interview and in that panel of interview there must be relevant people, relevant stakeholders will be able to question this person, lest we fall into a trap of getting somebody who is narrow minded and want to only advance their spirituality or religious way of doing things. Chaplaincy must be open to all. It must be non- discriminatory.

Respondent 5 mentioned this view that there is a need: *"I don't see anything wrong with that, because the need is there. So, when there's a need there must be somebody appointed to look at, or to administer or to yes to direct that particular need."* Respondent agreed that chaplaincy practice must be regulated nationally. The Respondent's view is this;

Yes, I think it is important to have it, a chaplain in hospital, because, isn't that it embraces all the religion's body? It's neutral?"

Similarly, on the practice of Chaplains in SAGH, the Respondent confirmed that:

Definitely, it needs to be regulated. So, that it's practiced within certain directives on the recruitment and appointment of chaplaincy as religious and spiritual experts.

Respondent shared this view:

My understanding is, as we say according to those levels, it depends on where we need. If there's a need for the, at the hospital level, like in any other need at the professional need, at that level, it will follow the same route. If it's a national one like we said, obviously, we need a person regulating and managing it up there, it will also be just to follow the same. I don't think it needs anything different, yes, from what is happening now.

Respondent 6 briefly pointed this view: *"There is no problem, to appoint chaplains. And that: Yes, in terms of the policy I can, yes we will have a recruitment policy. On the same vein on regulating the practice of*

chaplaincy in SAGH: "They must be regulated." Respondent 4 shared this view on the need for chaplaincy:

> *Yes, it is needed. The chaplains are very important. Isn't that when a patient is admitted, what we believe it is that a human being is not only physical, but there is a spiritual part and it also needs attention. But currently when a patient is admitted, we are looking only for the body, but we don't care about the soul. So, it is necessary for chaplains to be appointed in the health system.*

The Respondent agreed in that:

> *Yes, there must be a policy, and it must be adopted. The practice of health care chaplaincy to be regulated." However, on the recruitment and appointment of chaplains stated that it will have first start with the reviewing of the structure, which means the organisational structure needs to be amended, and this section be included in the organisational structure. And if these people can be recruited and appointed, they must be regulated like all health teams that are operating.*

Respondent 2 put it this way:

> *I think it is very much necessary, considering our past I think some of the things it's a work in progress, there is a need to redress on this one. To me where I am, I think it's a very necessary need, and it needs to be considered as early as possible. It is my view and it is very much necessary. I can say, where I am, I can say it is long overdue."*

He further reiterated that:

> *Anything without regulation pastor, what I've observed is that Okay, it leaves the room for people to do as they wish. And once there's regulation it assists in terms of managing whatever needs to happen within a country. And I think it is important that we adopt such kind of a policy, so that it can be able to assist in terms of managing the delivery of the spiritual needs of our patients. Yes, I think that responsibility will be given to the health care managers for them to administer, just because there will be regulation that assist in terms of guiding, in terms of how it should be implemented.*

Respondent 3 mentioned this view from the experience of working with SAPS chaplaincy:

> *I am sure, I'm sure in my response so far, look, I've worked with chaplaincies in the police service, and I've seen it work very well. Secondly, I know in the hospital you know, in the hospital it's even worse. You have a lot of, I mean people who come here are sick, obviously, the chaplaincy will assist us, because you see you would know that for a person to be well and to be cured and all those kind of things, it has, at times, it's a psychological thing, you know. You have at times, you should accept that I am sick, you know those kinds of things. Therefore, chaplaincy and pastors and all those*

people can be able to assist us to deal with that component, of trying to get this person to, you know, when a person is here, I mean doctors don't just come to you and give you medication. At times, it will be social workers here, they talk to people, we have psychologists who talk to people, and at that point we try to deal with the psychology, with the mind of a person. And therefore, chaplaincy, can assist us to take that further, can help us to engage with those things and get people in a positive mental frame, when they get assistance here. And I think it's something that can be able to work for us.

The Respondent was convinced on the establishment of chaplaincy in SAGH that:

If anyone would have to ask me that question, my view will be: 'Let's have them.' Look this is just a summarised. 'Let's have them.' In the hospital, like I said, all people who come in this hospital are somehow psychologically affected. You could be a patient, you could be a patient, obviously, you are a patient, you are sick, you are bound to have some psychological problems. You could be a staff member, you know the things that you see, the patients that you interact with, can also cause you some psychological problems. And therefore, at the presence of a chaplain, can assist the two people, both the patient and the staff member, the caregivers. It can assist both of them. And therefore, it can be a very necessary, you know, I know this people might be trained from the schools and from so on, but they're still human beings. You, we got to see things here, yoh u get to see rude patients, or rude staff members. So, either way, when you are a staff member who want to assist this patient, and this patient is rude, tell you whatever they want to tell you, they create those psychological problems that I am talking about. You could be a patient and the kind of care you receive, it might threaten you, you know those kinds of things. And at times for a speedy recovery, you might need to be in a, like I've said, in a positive state of mind. And chaplaincy can assist us to achieve that, both for the patient and for the staff members.

Similarly, on regulating the practice of Chaplaincy, the Respondent said that:

"If you can't regulate it you will have problems, your background says, 'I would dare.' In the public people believe in different things. You would not want to bring them in the hospital and force them into a corner. So, in regulating them, you must then have an acknowledgment that patients who come here, they will come from, you know, different background. And therefore, somebody who is in that position, a chaplain, would need to have that understanding, that these people are coming from diverse background. But having said that, once we regulate it, it's that, I've said it must not be forced on patients. So, it must be patients agreeing that, you know, 'I need to talk to a priest,' you know, 'I think this, that priest can come to talk to me.' Which is what I think should happen. A priest comes, wants to talk to people in a ward, my view is: 'Let's not just take this priest to that ward. Let's get the consent of this patient. Let's have this patient agreeing, {the patients}, the priest can come,' so that if there are those who are saying: 'no I don't want to listen to that man,' we're able to respect their wishes. So, like I'm saying, you don't bring a patient here from home, and you're forcing them into things that they don't want to. Therefore, if a pastor wants to come, talk to patients, let's get

the consent of the patient. Let's regulate in a manner that still protect the patient's right. In a manner that still listen to the patient, what the patient wants must still be respected.

Simply put, the Respondent confirmed that this need to be a 'patient-centred approach.' The response highlighted this concerning the recruitment and appointment of chaplains as religious and spiritual experts:

Look the chaplain must do it. Look, if I'm saying, the person that you appoint as a chaplain, it would have to be somebody who would need to have that understanding, how the environment in the hospital works. And I've already said one of things that happens is that patients have got the right to be informed. So, the process to these, appoint chaplains, must acknowledge that the people who come here to be chaplains, they must be having that understanding. They themselves must be coming from a background. They should either be pastors, you know, or they should be, Yes, they should either be pastors or they should be people who have got that authority, to talk on certain issues, Because, obviously, it's not just anybody who've got authority to talk about these things. So, it must be somebody who have got some kind of, I believe when you are a pastor, who've got authority to talk to issues, chaplains, and all those kinds of things. And this person would need to understand that patients must be informed of their rights.

4.5. 6 Theme 6: The views of the managers, caregiver and patients on health care services and ethical challenges

According to Puchalski (2001:1), medical ethicists have reminded us that religion and spirituality form the basis of meaning and purpose for many people. At the same time, while patients struggle with physical aspects of their disease, they have other pain as well: pain related to mental and spiritual suffering, to an inability to engage the deepest questions of life.

These are the views which were expressed by the PHC managers, the caregivers and the patients during the interviews, to elicit knowledge on how they address ethical challenges they faced with the patients in relation to their religious and spiritual needs. Respondent 16 stated this viewpoint as a solution to the challenge:

Yes, it helps because the challenges that we face at the hospital it's, because you have a person who want to go to the church saying that she/he want to enquire, yes, that may I continue with eh, not only with reproductive, any procedure in theatre. Eh they want to sign eh, RHT going to enquire, and then, until they receive confirmation that: 'You can carry on or you can't.' So, at least, if it is here, even the doctors will be able to talk to chaplaincy about the procedure. But if they should fetch them somewhere, the doctor won't even tell the importance of this procedure to their priest outside. But if chaplaincy is on site, doctors will be able to explain the emergency of the procedure, and the importance of doing this procedure in the patient.

Respondent 1 pointed out this holistic view:

> *Yes, these are choices of individuals and they should be respected, because health is not just the absence of disease. It should have a spiritual and financial connotation to it, because we are not seen as a single dimension people. People indeed need access to whatever that can help their health.*

Respondent 2 mentioned this view on the obscurity on the health care structure:

> *From where I am, I think it is very much necessary. The way our health care system is streamlined, I think it's obscured. Maybe it's because of our historical past. What I think needs to happen is that, patients need to be given a choice, in terms of how they want their needs to be cared while they are in the hospitals. Often, you find that's okay, our medical practitioners, they only come to the hospital to offer that little medical care, and the bigger chunk, which to me as the issue of serving the spiritual needs of the patients, has been neglected. And that remember it plays a major role in term of making sure that's okay, the physical being of a human being is attended to. So, where I am I think such kind of choice needs to be given to patients, and it will go a long way in making sure that the delivery of our health care system is a fully-fledged package.*

According to Mc Cormick (2014), research indicates that the religious beliefs and spiritual practices of patients are powerful factors for many in coping with serious illnesses and in making ethical choices about their treatment options and in decisions about end-of-life care. Respondent 3 highlighted the importance of embracing the religious and spiritual needs;

> *Look, South Africa it's a country, it's a religious or spiritual country. I would believe that majority of our people, if not all our people, participate in a religious or a spiritual arrangement, all of them would do that. And therefore, it becomes important that you can embrace their- those kinds of needs in the in the South African health policy. The many different health policies we have in the hospital should be able to talk to these things. I think it's just a matter of relevance, like I'm saying a lot of us you know we either go to Church, we want our priest to come see us when we are hospitalised, or we perform certain whatever thing that we perform. But at the end of the day I would believe that majority of South Africans are Church-goers. And when they are in the hospital here, I mean, I know that a lot of them would want to be seen by their priests, and therefore, these kind of things needs to be covered as part of the policies that we have in the institutions.*

Respondent 4 shared this challenge on shortage of personnel:

> *This one, it can have a challenge currently, if you consider the shortage that we are having as a national department of health. We are running short of some medical specialists, then you realised that if a person is admitted here, and my wish is, as a patient, that if a health care can be from my religion, then you realise in terms of the current situation, the shortage that we are having now, there is no one on it, it*

means the patient won't get any help. So, when coming to this one I say, when coming to health professionals, let them assess all the patients, yes.

Respondent 13 raised this holistic view in tandem with the view of Respondent 1:

> *I think it's good for the patients, because it's for their own benefits. Healing process doesn't take place looking at one dimension, so the spiritual need is also important. There are those who believe that, whatever the spirituality they believe in, like it will be able to cure them of their sicknesses. And if they are deprived of that, it delays their healing process because it tends to affect their psychology. They end up depressed, they end up not healing at all because they were not offered the opportunity to practicing those spiritual or to get someone to come and counsel them spiritually.*

Hodge (2005:316) share the view of Respondents 1 and 13 that human beings are viewed as an integrated entity, consisting of body (soma), soul, and spirit. Respondent 10 mentioned this practical approach to the ethical related challenge;

> *I think involving other stakeholders in this one is very much good. And I'm going to be honest about this one, for example the case of abortion, usually they refer cases to us. According to my religious belief I usually tell them that, I'm unable to give them counselling regarding abortion. And usually I suggest to the nurses the other side, and the doctors to say: 'Can't we refer them back to their spiritual people that can assist them before you do any procedures?' Because with me, it's, I'm unable to do counselling on them, and I think even us, a staff, we need such kind of help to. We need assistance to say: 'how can we go about such kind of cases?' Yes.*

Respondent 6 confirmed the importance of the patient's choice: *"I'll allow the patient to have his own choice, mm.* Respondent 12 shared this view when faced with the dilemma to resolve ethical challenges;

> *I think it will help in the great deal because remember, when patient come, you know to do such things, they are not afforded that opportunity, I think it will also save a lot of babies that, you know are being aborted before, without their consent, mm, because now a person will think, and rethink again, you know, if there is somebody who is going into that area of spirituality which is not happening now, mm.*

Respondent 8 highlighted this personal viewpoint that:

> *I don't know whether I'm getting this right? Isn't that we say the patient has got the right to have access to health care services, including reproductive health care? When we talk of reproductive health care, reproductive health care includes lot of things, small eh, like the termination of pregnancy, those things. So, I don't know whether we are, going there to those terminations of pregnancy and stuff? Okay, Okay. On my side with this one, yes? of*

embracing spiritual, concerning that side, isn't that the person includes this reproductive health, let's say, the person came to me, want to terminate the pregnancy, she's got the right. But myself, as a Christian to me to perform that, it's not easy for me. And I'll be undermining her rights. So, I think, maybe, if we do some counselling with this people, because others, they terminate because like, others they terminate because of the situation she is in. Maybe if this spiritual dimension, this spiritual, what can I say? This portion of this, spiritual counselling side is there, maybe if we can refer that person before you can take this decision: 'Can I send you to someone who can talk to you? Counsel you, talk to you spiritually and holistically, so that you can take the decision after seeing this people? So, you can come and take the decision that: 'No I finalised, I have the priest saying this, I have the psychologist saying this, I have this one saying this, but the decision is final sister, I want this, I think it's alright.

Respondent 17 reiterated a similar view to that of Respondent 8:

> *Eh, personally I have an issue with termination of pregnancy. It's a personal thing. I think when there is a baby with severe abnormalities, it's justified, or where it was due to sexually brutal attack, it can also be justified. But just to terminate to me it's a problem. And, I usually ask one of the pastors or spiritual leaders that I know, to intervene with the patient. Because I feel it's not my place, and I might say something that is not needed. So, to me to have somebody who can talk to the patient without judging the patient, that is where spiritual leader comes in. You are not there to judge, but you are there to lead the patient into the right direction. So, to me I think that is very important that there is somebody who can assist the patient with the process. Remember there's a lot to work through, by, in this type of situation.*

The views expressed by Respondents 3, 8, 10, 16 and 17 resonate with the view of Timmins et al. (2017:12) in that: (a) Chaplains can represent a theological, spiritual, and/or religious viewpoint on ethics committees. (b) Chaplains can provide a non-scientific point of view; and (c) Chaplains can provide an advocacy role at ethics committee meetings on behalf of patients and their families.

Respondent 18 shared the view on the challenges experienced by some patients:

> *Yes, I think eh, I support that the spiritual thing should also be addressed to that patient, should have access to that, because some of them they do these things. Later, then they feel guilty for the rest of their lives. Some of them then they even think of committing suicide. They said should I have met a man of God or a woman of God before I do these things, I would have done otherwise. But I did it out of total ignorance. And now I'm praying, I'm paying a fatal price.*

This viewpoint expressed by Respondent 18 is in tandem with what Saad and Madeiros (2016) captured in this adage by Samuel H. Golter, author of 'The City of Hope, 1890-1971: "There is no profit in curing the body if in the process we destroy the soul.

Respondent 7 shared this view on the patients deciding to embrace spiritual dimensions only:

> *Mm, they are- these patients they will need health care services? Yes? At the same time, they want to embrace spiritual dimension? I don't think there's any problem, they can go hand in hand, but if these people, they maintain health care. In the hospital, we are having problems with the people who doesn't want to embrace health care. They only want to embrace... they only want to embrace spiritual dimensions. When any- it's a problem that we are facing. They don't want to embrace health care. When you are talking to them, it's like: 'You are telling me about the pills?' Eh, and... some they can be able to correlate, and there's no problem they can correlate, but let them not leave health care out.*

Respondent 21 shared similar holistic viewpoint with those of Respondents 1 and 13:

> *Okay. Yes, like holistically, like the patient is the spirit, I mean spirit, body, soul. So, as much as you want to take care of the one part, you also want to take care of the other part, the spiritual part. So, I think, Yes, I think it's their right. So, each health care services should provide- at least there should be these services that embrace spiritual dimensions, Yes. And I think people are more conscious and aware and more- how can I say it? I think before, compared to know, I think, people are more conscious about their beliefs. And they are more open about their beliefs and their spirituality such that, even when they visit or accessing health care facility, they bring that with them, because it is part of their life, it's who they are. So, I think the health care system should be mindful of that, should have that awareness, and try and embrace it, because I think people- that's how people are nowadays. They are more comfortable exercising their spirituality or religion openly than before. I think before they used to hide. And they would- even used to sign RHT just to go and perform a ritual. Here they say no, no, no, no, no we want discharge, but if you interrogate further, you find that the main reason why they want to discharge this patient, because they want to go perform something. But nowadays they openly say, 'we want to go perform this.' So, but I don't think the health care system has the place for that. You know I don't think we are at the point where we openly say: 'Yes, we understand that a person it's spirit, body and soul.' They need to take care of those part, or they need to exercise their religious belief. So, health care facilities should have these services, mm.*

Respondent 19 shared this viewpoint on addressing complex ethical challenges:

> *So, this is health care service that require spiritual dimension, for instance we given an example of a termination of pregnancy as an example? I think it's all about what I've just said that, they're accessing the relevant service for a relevant cause. So, if perhaps you have, you're pregnant, one is pregnant and they're struggling with issues of conscience, they need to clear that with their spiritual caregiver first, before they even land into the hospital, because here it's all about what it is? It's care. Okay, what are you here for? And Okay, then, you need to be assisted in terms of... So, it means you should have made peace and you have taken a conscious decision that: 'Okay, now I'm going to terminate?' So, but if you're still battling, therefore it means you need to seek help with your spiritual caregiver, and then deal with the issue first. And if it's*

here, let's take for instance, it's a patient who is in hospital and they feel, Okay, maybe let's involve all the stakeholders: the spiritual dimension, the medical... So, let's take an example of a minor. So, and let's take an example of a Christian perspective. That's a minor pregnant, let's take for instance even from rape. The patient is a twelve-year minor, has been raped, now pregnant. When you look at the psychosocial background, maybe she is an orphan, there's no income, no parents, pregnant, been raped, maybe even have contracted HIV during the rape. Now when you look at the holistic background of this patient, it would be self-defeating for the patient to keep this baby, when we look at all the factors. But now what would the spiritual model say? 'You cannot kill,' for instance. So, now if we say: 'Okay, now we will take the spiritual model: 'Though shall not kill,' so now what will happen eventually to the wellbeing of this child? This child would be alive but dead, given the circumstances that she would have to live in. You got pregnant from rape, you still should deal with rape itself, the pregnancy, you are a minor, what would you do with the child? Okay, if I had parents maybe they would assist in terms of bringing up and care and advice of bringing about of this child. I do not have parents, there is no income, so how am I going to sustain this child? So, it means that now I would have to be out of school even, so now holistically, where would this child end up being? So, it's involving all the aspects like social, political, religious, economic, personal, psychological.

Respondent 20 shared this contrasting view from that of Respondent 19:

I think it is a good way of support, also in terms of reproductive health care- you know- certain issues are quite ethical. For an example- you know- like terminations, or you know- the end-of-life situations where spiritual sort of dimension- you know… impeccable view on that, and I think if there is a team dedicated to supporting them with that aspect, it will help them to- you know- sort of decide as well. Sometimes they… you know… agree from organic point of view that something needs to be done, but spiritual side does not allow them to engage on such. I think that integration will help, yes.

According to Puchalski (2001:1), *"helping, fixing, and serving represent three different ways of seeing life. When you help, you see life as weak. When you fix, you see life as broken. When you serve, you see life as whole. Fixing and helping may be the work of the ego, and service the work of the soul."* Therefore, it is critical to take note of how the caregivers (Respondents 19 and 20) view the life of the patients when they are expected to provide care and support services in response to the needs of the patients in SAGH settings when they are confronted with the dilemma of ethical choices.

Respondent 25 shared this personal experience as a patient: *"Yes at the hospital, according to my own observations, I did not notice anything wrong happening, except the thing which I do not accept, is this one that a person can perform abortion."* Respondent 22 highlighted this critical scenario from the viewpoint of the caregiver:

Mm, that will play a very important role. One of two, of the most ethical issues that or challenges that we meet, or on a day to day, although I am no longer at reproductive health, but one of the termination of pregnancy, more especially when it's not even suggested by the woman, it's suggested from a medical point of view, that this pregnancy is dangerous to your health. And to save your life we must terminate the life that you are carrying. Because in other religions they believe a foetus, is a life. We will say, 'it's a foetus,' but the woman will be believing this is a life, and you are asking me to kill this patient. And the other dilemma that we will have is the Jehovah's Witness in terms of blood transfusion. The child is dying there, and we need to transfuse, and in government hospitals sometimes we don't have a lot of alternatives that we can offer due to, I don't know that's budget constraints or what. So, you find that we are stuck, she is telling you that I can't allow my child to get blood from any other person, or just to get blood altogether. So, I think they should be allowed to get the spiritual part be addressed, because all these ethical dilemmas have got spiritual connotation and psychological long term psychological effects. We can sit down and convince you, and force you to address the spiritual part. But what you remain with it as a parent or a woman who feels guilty for the rest of their life. So, I believe that they should be allowed to exercise that spiritual dimension. And also, medical personnel must also be trained, because sometimes we dictate, we just feel like hey, these things we are telling you, 'it's going to kill you.' And we don't consider that this can have long term psychological repercussions, and belief repercussions. Because when you feel guilty, in terms of your religion, then psychologically we've caused you problems, like for a long, for probably the rest of your life, if we don't have to come around and deal with the situation, mm.

Respondent 5 was of the view that there is a need for assisting patients with the spiritual aspect:

I think yes if there is a person, then the patients will at least have the access to somebody whom they can assist in that regard. We are looking at the health aspect, so if there is somebody who is looking in the spiritual aspect, and we are able to cater for them.

The views of Respondents 5, 8 and 17 resonate with Mc Cormick (2014) in that the chaplain is a helpful resource in providing or arranging for rituals that are important to patients under circumstances. On the same vein, the NHS Chaplaincy Guide (2015:7) further stipulates that:

Chaplaincy provides highly skilled and compassionate pastoral, spiritual or religious support for patients, carers and staff facing situations which are at times harrowing and stressful. These include: sudden infant death; psychosis; diagnosis of life-threatening conditions; end of life care; and various kinds of self-harm. There is a growing body of evidence that appropriate spiritual care has an immediate and enduring benefit for those utilising chaplaincy in these situations.

4.5.7 Theme 7: The patients' meaning of the religious and spiritual healing for coping with illness in SAGH settings

According to McDowell et al. (2017:1) *"the spiritual dimension, in bio-psycho-social-spiritual model, considers a person's values and meaning in life; and may include the concept of transcendence, which suggests a guiding force outside of self and a belief in God or higher power."* Similar studies confirm that individuals who find meaning in God and participant in religious activities with community of believers tend to have an increased in their general happiness, (Tovar-Murray, 2011:188-189).

When the researcher asked the Respondents to share their views on the meaning of the religious and spiritual healing for coping with illness in the SAGH settings. Respondent 30 highlighted that healing occurs when trusting in God: "Isn't that the reverend will pray for you? And you get help? And get well? You must also trust in God, yes, and then you will discover that you are healed, yes." Respondent 29 reaffirmed that religion and spiritual healing is helpful: *"Yes, it is helping."* Respondent 27 agreed with Respondent 29 on the religious and spiritual healing: *"It helps to heal our spirits."* Respondent 28 shared this personal belief:

> *I believe on the, Yes, I believe on the spiritual/ religious believing, because even when I am sick, when somebody comes to help me, I am feeling better, everything will change because spiritual/ religion healing, is more powerful for others. Yes, so I need it. It helps me even. Yes, even when I'm illness, when I'm, have religions healing, everything is going well. Yes.*

Respondent 26 shared this viewpoint: *"Eh it is alright, spiritual healing or religious healing, it all depends from that particular person that, do I believe in the spiritual belief or in the…? Yes."* Respondent 24 mentioned the power of joint prayer: *"We must all pray and stand together."* Respondent 23 shared this view on the need for care and support: *"I don't see any problem with it either. Lots of people don't have people that stands by them, so they turn rather to somebody that can stand by them."*

The views of Respondents 23 and 24 resonate with Puchalski's view (2001:2) in that *"people long for their physicians as well as their families and friends to sit with them and support them in their struggle."*

4.5.8 Theme 8: The patients' value and role of the religious and spiritual beliefs in coping with the medical treatment

Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing process. The value such as spiritual elements in health and quality of life has led to more holistic view of health that includes a non-material dimension, (Saad & Madeiros, 2016).

When the researcher asked the Respondents to share their views on the value and role of the religious and spiritual beliefs in coping with their medical treatment at the SAGH settings. Respondent 23 confirmed in this viewpoint: *"It has value, yes, definitely."* Respondent 28 reiterated: "Yes." Respondent 27 stated that: *"It helps."* Respondent 30 highlighted the value of belief in healing: *"Yes the faith that I will believe in, is when they treat me and I get healed, it is when I will believe. But if I don't get healed, I will not be able to believe."*

According to Haynes et al. (2007:13), the valued beliefs of patients and families should not be refuted; this will only widen the chasm between clinicians and patient, leading to greater tensions and increased likelihood of entrenched, polarised positions. The goal is to engage in exploratory conversation which elicits better understanding of beliefs, and encourages expression of the ambiguity and dilemmas that many people experience when trying to reconcile their beliefs with the demands of secular contexts.

Respondent 26 confirmed the role of chaplaincy: *"Yes I will gladly receive it because the teachers will be nearby."* Respondent 25 highlighted this viewpoint: *"Spiritual treatment in illness implies that you must surrender yourself, that the way I am sick, I will be healed."*

According to VandeCreek and Burton (2001:83), *"persons frequently attend to spiritual concerns within religious communities using traditional religious practices, beliefs, and values that reflect the cumulative traditions of their religious faith."* They may pray, read sacred texts, and observe individual or corporate rituals that are to their tradition.

Respondent 24 shared this view: *"Eh, what will I say? It's all about the feelings, the praying, Yes."* Respondent 29 agreed that medicine comes first, and then religion: *"Yes, it has. First, I think eh first, of medicine, you are doing your treatment, and then religion."*

4.5.9 Theme 9: The patients' experience of the religious and spiritual needs during the medical treatment

Saad and Madeiros (2016) are convinced that a contemporary orientation of the hospital experience model must encompass the clients' religious-spiritual dimension. A person's confrontation with serious illness or injury and the looming possibility of death raises primary spiritual questions. Notebly, the inpatient is more vulnerable, since he/she is away from his/her pillars of faith, such as community resources and daily ritual. The hospital should provide religious/spiritual resources in order to promote the most effective coping strategy to their patients. Therefore, Mowat and Ryan (2003) argue that spiritual need is patient led, and based on the subjective experience of the patient.

When the researcher asked the Respondents to share their views on their experience of the religious and spiritual needs during their medical treatment at SAGH settings. Respondent 28 shared the same view with Respondent 24 below:

> *Yes, I need, I need it, Yes, I need somebody to pray because you, I have strange ways somebody prays for me even when I have in bad situation, everything will be changed, so I need somebody to pray for me, because the prayer is more powerful.*

Respondent 27 mentioned the view on the primary support of the church: *"Honestly speaking, the support of the church is the primary one. We were supposed to try, so that even God can heal us. Isn't that everything we should be asking from Him? Also for the sickness to heal, you must ask from God."* Respondent 26 shared this viewpoint on the chaplaincy's daily service:

> *Eh it's the role of faith, it's preaching that comes to me, or that is delivered to me. I must be waiting in anticipation because there it is coming every day. It is not something that I receive that particular day. It is something that is always there. And even myself I believe in that."*

Respondent 25 highlighted the view on the experience as grounded on the treatment approach:

> *Yes, according to my view as I explain further, yes I do not persevere to continue, to say anything further, except faith and treatment that you will be experiencing. Isn't- you will be believing what you will be seeing, the way they treat you well, this way I am not treated well? Yes, this is the what you will be able to differentiate. But that you will imagine that yes they will treat me this way, or they did not treat me this way, the way they treat you, is the one that at the end, I will not be able to explain it.*

Respondent 30 said: *"No."* And Respondent 23 further reiterated the viewpoint of Respondent 30: *"No. I was praying myself the whole time that I can stay alive."* Respondent 24 in contrast to Respondent 23

and 30 reaffirmed the need for chaplaincy: “We do actually need somebody, we’re supposed to have these people long time ago, Yes. We all need God obvious.”

4.5.10 Theme 10: The views of managers, caregiver and patients on the importance of health and health care

According to Dreyer et al. (1993:7), most literature indicates that health is the well-being of the body, the psyche and the spirit, and that it includes the harmonious integration of a person with himself/ herself, the community and the environment. Health should therefore be viewed within the specific community’s socio-political, cultural, religious and interactive framework, and never in isolation. Health is a dynamic that encompasses the promotion of optimal physical, psychological and spiritual functioning.

The researcher asked the Respondents to share their views on the importance of health and health care as key everywhere in the world, and to ensure that the people get the health care they need in the SAGH settings. Respondent 3 shared this critical viewpoint on the need for an effective health care system:

> *Yes, look everywhere, I mean, for us to have, to access better health care, we would need amongst the things you would need everywhere in the world, would be that, you would need to have you know, professional caregivers. You will need to have infrastructure that talks to that. You would have many things. If a person comes into this hospital, for this person to receive proper health care, there must be people, there must be medicine, there must be infrastructure, there must be everybody else. So, I think everywhere in the world, if I understand your question, I’m saying there are few things that you need to consider for any patient walking in the hospital to receive a proper health care, either there should be basic things that must be met. If people come here there are no nurses, there are no doctors, there’s no medication in pharmacy, there’s no bed that they are going to sleep on, you will not expect them to get proper health care. But for them to get proper health care there should be basic things that needs to happen. Some of them are the ones that I have indicated. There should be a relation. You see in the hospital you have two kinds of staff members. You have, remember in the hospital we are, our core-business is the patients. Our core-business is the provision of the service to the hospital. Therefore, your core-staff are your nurses and your, and your doctors. These are your core-people that you must have, direct providers of the health care service. But there should be millions of others who must provide what I call supportive kind of activity, to ensuring that these ones deliver their services. Remember, when a doctor should see this patient, I mean there could be administration that must be done. There must be somebody who does that administration. There are fund issues that is involved. There’s, that person might need a physiotherapist or any other allied-like kind of a services. Therefore, that integrations of things must actually happen if you are to provide a proper health care.”*

The Respondent further reiterated when asked about chaplaincy in SAGH:

> *Look, we have the same country. We must provide same service. I always say: 'There's no reason to have, a different kind of an arrangement that, if you have to go to… look government hospitals must actually provide same services. I can't go to a hospital in Kimberly and be told no, we don't have chaplaincy. And you go to Bushbuckridge and find one. These are all government institutions. They must be able to provide same services, and it must happen, in fact it must happen in all government hospitals.*

Respondent 1 articulated this critical viewpoint in tandem with the view of health by WHO:

> *Every country that does not give attention to health and health care, they drive their own people into poverty, because health care has a way of being expensive, and it can cause you everything that you have, and at the end you still even lose your health. So, if preventative type of health is used in a country, then you won't have to suffer a huge burden of disease. Because we are all acting and are governed by the WHO or coordinated by WHO, there is a definition of a world health care about health, 1944/ 1945/ 1946 there. It says: 'Health is not just the absence of disease,' but it puts in, 'spiritual things', they put in, 'financial things there,' so bringing in spirituality will help, but when we get to using, doing everything that is needed, we will see the effects of proper health care because we have not even started to touch on financial things of health. But when we get to spirituality we will be getting there to providing a total health care package.*

Magezi (2012:7) reaffirms the viewpoint of Respondent 1 in that, according to WHO (1948), health refers to *"a complete state of physical, mental, spiritual and social wellbeing and not merely an absence of disease."*

Respondent 2 shared this viewpoint on the importance of providing a uniform service:

> *Eh, one thing that I have observed, within our country is that, the issue of provinces, is the one that is creating a problem. It is a fact that when we are measured, we are measured as a collective, and not as provinces. And all the citizens of the country, were supposed to be getting the uniform health care services. You find that there are services that are only offered in Western Cape in Gauteng, which means that some of our patients, for them to access such kind of specialised kind of services, they need to be transferred to provinces like Gauteng and Western Cape, which is unfair to the patients. Because as the country we vote for the same government all of us, and then we are supposed to be getting the best and uniform health care irrespective of where you stay. So, where I am I feel that it is necessary that, maybe we do away with the provinces and then we serve the people of the nation as the collective without any segregation."*

The responded further shared this view:

> *What is important in life is that, when we want to introduce something new, we need to be able to involve other stakeholders, and have their views. However, what is important here is that whether the patient is from KwaZulu Natal or is from Limpopo, when they've got spiritual needs, it doesn't matter where they come from. Their spiritual needs will always be the same. And my feeling is that I don't think there's any province that will drag its feet, because what is important is that the patient will be involved in the entire process of developing policies that addresses their needs. And I think there won't be any other policy-makers who will try and have objections just because it is not them, it is the patient, whom, my feeling is that Okay, whether the patient is in Western Cape, is in Gauteng, they have got the same needs.*

Respondent 5 agreed with Respondent 2 that:

> *What happens here, I believe that it's happening everywhere. What we need, it's needed, even in other provinces we are the same people. We are living this side and sometimes I may move, next week you find me in Pretoria, I mean Gauteng. The challenges are the same, they can just differ with magnitude, but the challenges and the needs are the same.*

Respondent 4 highlighted this view on the need for chaplaincy:

> *I believe what is happening in Limpopo is what's happening in KZN or Free State, every province. So, if there is a need in Limpopo for chaplains to be part of the health care, it means all South Africans we need the service." The Respondent further stated: "But what I can say, really it is needed to have a Chaplain in the hospital environment, because you will realise people have got a lot of issues. Some are admitted because of social problems, and then it ends up affecting their physical or their body. Then they end up admitted in the hospital. Then you realise our health care practitioners, they will be busy dealing with the physical, but the root cause of the problem we're not attended to. But if chaplains can be here, then people can be free to voice out that thing that are in their heart that can cause stress, that can cause the depression, all those things. Because what we believe is that, before the person can have physical problem, most of the problems started from the spiritual, or the soul. You realise the person has got a problem at home, then person can be depressed. Then, when the person come to the hospital, the doctors will be dealing with depression, but when the person goes back home, the root cause is still there. But this services are important. I wish, the government can accept this, or maybe it can be me, but there is a serious need. We dwell much on the physical, but we left the spiritual behind. And most of the things that are happening in the physical, they come from the spiritual.*

The views shared by Respondents 1, 4, 7, 8, 16, 17, 19, and 20 resonates with Maxwell's (1990:5) view, in that illness is physical, emotional, and spiritual. This can be conceptualised in figure 4 below:

HOLISTIC APPROACH TO CARE

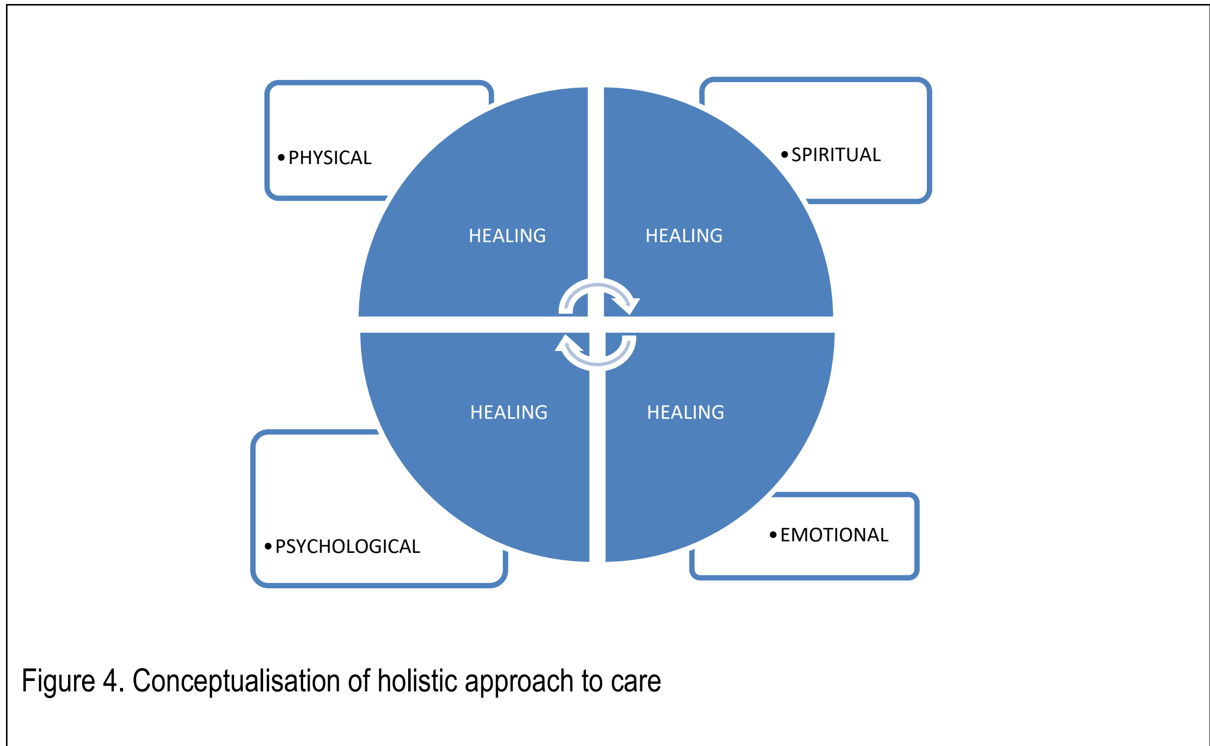


Figure 4. Conceptualisation of holistic approach to care

Respondent 7 raised this concern on lack of resources to address the patients' needs:

> *This is, little bit more complex reverend. That's the thing. People are not getting what they need. People are not getting what they need, especially in health care, Yes. They lack resources, mm. They do lack resources.*

Respondent 8 shared this viewpoint on chaplaincy as the supplement to health care:

> *Okay, right, with this one? Since the health care is the core, to everyone, so it means, when I take the above statement, what we have talked about, and relating it to the health care, that is been needed, to each and everyone, not to Mpumalanga or not to Gauteng, it's, we call it one. So, it means what we are, we we're talking about, with the chaplain. If we can implement it to everywhere, it will help the whole of the country because, we are no longer going to have those, nowadays if you can look, there are people that they say, there is this word that we use: 'The patients are relapsing,' with this word 'relapsing thing,' it's when the patient has decided that: 'No, I've been taking this for a long time, so enough is enough, I'm no longer going to take this treatment.' So, we've got lot of those people that have relapsed. Since the health care is more important to everyone in the country, so let the chaplains be another, the supplement to our health care, so that we can work together as a whole. So, that we can help this people, because maybe we can reduce the lack, the stat, the amount of this relapse, because you know, I've been counselled spiritually, if the treatment-wise and the psychological-wise they failed, at least I've got the support of the pastor. The, because I, if the pastor, I know that if the pastor see that this thing is being difficult, he also*

consults with their colleagues and stuff, then they pray for that matter. So, I think it will be better, concerning the health care around the world. And so, that we can, our people, the health care is a core, so if we can have the supplement to what we are doing.

Respondent 11 agreed on the productive healthy workforce:

> *Okay, I think health and health care, is a key, because the world or the country, cannot be the country without the people working. And we cannot be able to work if we are ill. And we cannot be able to be productive if we are ill. And I think, there must be working together of different provinces or different stakeholders, to achieve this.*

Respondent 6 agree with Respondent 11. Respondent 19 shared the view that health care needs are universal:

> *Eh, health care needs are universal. Patients in Limpopo, the needs would be similar needs of patients in KwaZulu Natal. So, we cannot say maybe for Limpopo this is the health care needs that they need and then maybe in Cape Town, so it's universal. So, for instance if we say: 'Yes, we deem it fit to incorporate chaplaincy in the health care system, it means- it would be applicable to all provinces and regions. And if it is not feasible and practical it would still not be practical and feasible in all the provinces, because anyway the model that is used is the same, patients' needs, health care needs are the same. So, what is deemed necessary here and appropriate, is universal across all the provinces.*

Respondent 9 raised this issue of budget:

> *It does differ, eh, does differ. It's key everywhere, though we may differ in how we implement our services. Even the budget that the government gives is not equal. They depend on the demographics of the provinces.*

Respondent 12 share the same sentiments expressed by Respondent 9 that:

> *Okay, yes, health care should be free, it's just that the resources are limited and we always, always running short of resources. And as such, now they try to have budget to say for this province we'll have so much. And as such, when you use these resources, you need to cater for your community, and, Yes, it is difficult because now you know, some people are poor. But in a state hospital, people are being categorised according to affordability- 'means test,' how do you afford. Are you working, are you not working? So, for those who are working, they compensate the ones that are not working. So, those who are working, they expect, they are expected to put something so that the health system should not be overloaded. And those who are not working, they get the free services, they are subsidised fully by the government, yes. So, I do not think anyone should be denied any health services, it should be free services mm.*

Respondent 20 reiterated the same approach in addressing the patients' needs:

> *Okay, well I agree with that as well in the sense that- you know. Health care is not only specific to a province or region per se. But- you know- it encompasses health condition, and this is everywhere, not only in our country, but everywhere in the world. And at the end of the day- you know- peoples' concerns in health care are always the same, you know. The pathologists can be different but- you know- people always need support. They always need that spiritual sort of engagement, and there's always certain expectations that they have, out of, and hospital admission people always want to get better. And I think, there aren't necessarily any differences in different environments, apart from specific organic- you know- problems. But I think in general, the approach is the same. And I think that- you know- the support, engagement is the, is essentially the same, everywhere, yes.*

Respondent 17 highlighted the importance of health care:

> *Health care is very important, because if you don't look after health, how will you take care of your family? Because if you are sick, you don't have an income. So, your health care facility needs to look after your health. So, therefore you need trained professional nurses, doctors and spiritual people as well, because health is not only based on medicine. If your emotional state is not Okay, the best health care in the world will do nothing. So, they are all interlinking, and there's a place for everything. Health care cannot be separated with spiritual needs. So, to me I think that is quite feasible it can happen, and it should happen.*

Respondent 24 agreed with most Respondents that, *"Yes, but it need to be all over, not only at some places. That is the main problem."* Respondent 25 shared this view on the unity of the health care team:

> *Yes, according to my view you discover that these groups that need to unite, and observe that life is the most important thing, and to treat this nation is the most important thing, yes, it is very important if they are united to be one team, so that they are able to help this nation of South Africa.*

Respondent 14 shared this view on the caregivers' perspectives regarding public health care:

> *My view on health and health care as key everywhere in the world? What does this question mean exactly pastor so that I answer relevantly? But it's start pastor, from my view to ensure that people get the health care that they need before even it boils down to myself, and people of, like, I believe that it's starts with what we normally call the political will. What do I mean? In the health care, particularly in the public health care must be there. We can be hundred here, but if there are no resources, there is nothing that we can do. And unfortunately for me, it's good that we don't know each other, so that we are not playing politics. But unfortunately for me, I've been through quite a few South African public hospitals. And it's very few that are doing very good, honestly*

speaking, no wonder, the moment we, as particularly, you should ask yourself this pastor. Ask yourself this, you can through your research, ask all the people that you've researched, health care workers, they don't have medical aid, as a general question. I believe, if not all of them 90% of them will say, 'I have a medical aid.' I mean the ones who are working in the hospitals, that says something is wrong. Why I don't trust the system that I'm serving?" Respondent further again said: "I don't want to come here. I don't want to come here. I want to go somewhere. But I'm working here in this hospital. So, this tell you that I know that the service that I'm bringing to these people is not the service I want to get when I am sick. It's like a teacher who has a child at private school. It tells you that she doesn't trust the current system, she prefers system for just, to have that safety sake of mind. So, what I am trying to say, to try and shorten it, that's why I was making an example you have doctors, nurses, all types of categories working for the Department of Health that work with patient. They are all paying expensive medical aid just in case I'm sick, I don't want to be nursed where I am working, because I know the situation there. So, that's why I said the need starts with the political will. There must be resources, institutions must be up to date. Lastly, because this one is, once I can talk about this, it can strike twelve o' clock. But then, also again, at the end of the day, it's the hands of those because will be working, isn't it? But one thing I've seen, even the books say that. If you can check pastor, there was a study. I remember, somebody like you was doing a study about attitude. I was home at that time at Ermelo, that people are complaining about health care workers, cleaners have got attitude, nurses, they've got attitude, doctors, what's this story? The conclusion was that: 'these people are demotivated, they are demoralised, they are feeling neglected, the working environment where they work is just not conducive. So, they are with patients the whole day, so obviously, that's where they got to take out the frustration. So, you also need staff that is motivated, staff that is of good, and high positive spirit. And then these poor patients of God are going to access the good health care that they need as the question says. But currently we are far from that, I can promise you that.

Respondent 10 agreed with Respondent 14:

Okay. Yes, I think to my understanding and my views, the health care system is collapsing, day by day. There is shortage of staff, the staff is demoralised, and our people nowadays are looking for money beside giving care to the patients. And politics is also playing another role within health facilities, that frustrates the staff. So, according to me things are not in order. Yes, and there is lot of un-transparency regarding financial issues, and less training to the staff that should provide services. I think if they improve on giving relevant people, relevant job descriptions, it will, that will help. For example, our people are eating food which are prepared by just people that they hired long time ago, and people are going on pensions, others they pass on, there are no replacements.

Respondent 22 concurred that health and health care is key everywhere:

> *It's key everywhere! It's key everywhere. And we should ensure that all spectrum of people get the same quality of care everywhere, which will then prolong our life expectancy, and keep our people healthy and fit, for them to be productive. And it's very key that we give them the same right, and the same- we afford them the same quality of care, eh, across the whole world, not only across South Africa, mm.*

Respondent 28 shared the same views as Respondent 22:

> *Yes, the health care question is important, the key everywhere, because when there's no health, there is no life. So, when we find self but to preach us about our health, in the ward, everything will be going well. So, we need, that's why we need the health care.*

Respondents 30 and 23 agree with the view of Respondent 22 and 28 above. Respondents 16 agreed with Respondents 8, 16 and 19 on having chaplaincy:

> *Life is life, it is the same, so it should be universal, yes. You must not find out that health care from somewhere its better than from the other place. People will move to where they think, eh it is, they can be offered better health care than where they are staying. So, that's why it has to be the same. Yes, it can also apply to other provinces. You must not find out that somewhere it seems as if there is chaplaincy and then it is working very well, somewhere it is not on site. The people will move to where there are chaplaincies because, especially the believers, yes, yes.*

Respondent 26 shared the view that is aligned with the view of Respondent 14 in that the working environment and conditions are stressors that make them to take their frustration to the patients; *"It is good, very important." Respondent further said:*

> *Even that one I accept it. We want them to welcome us in an acceptable manner. We do not want when we arrive here, you find someone, it seems as if they treat you just like nobody. Let them accept us like human beings, especially the sick people. If you accept them, they will also be healed. They become healed even before they are healed, yes.*

4.6 CHALLENGES EXPERIENCED DURING COLLECTION, ANALYSIS AND INTERPRETATION OF DATA

4.6.1 Challenges experienced during data collection at PHC settings

The researcher had to commute daily to the research field (PHC settings) from Monday to Friday for three months, with a view to collect data. The researcher experienced during the first day at the research field,

the challenge of fostering relations with the PHC departments assigned to him (as proposed by the hospital's REC in the terms of the hospital protocol) to orientate and familiarise him with the PHC settings and to understand the hospital protocol. This happened because of the unavailable of the departmental heads and their reluctance to assist the researcher in that regard. However, after consulting with the hospital management, the researcher was assigned a gatekeeper who orientated him to the hospital settings. The gatekeeper further introduced the researcher to the PHC management, the hospital staff, and the relevant hospital departments and wards which fit the profile of the study. The researcher was also granted a temporary identification (ID) card after he was vetted by the PHC risk management office, with a view to conduct the research at the PHC settings (from March to May 2019).

Therefore, the researcher's ID card allowed him access to the PHC settings as a participant observer, with a view to collect data and to build rapport with the hospital staff and the patients. After spending few days at the research field, the sampled Respondents were recruited and given the consent forms to sign before participating in the study. There were some participants who were sceptical at first, to be interviewed by the researcher with the use of the voice recorder. However, the researcher assured the participants that he was subjected to apply and follow strict ethical principles (as embraced on the consent form and introduction in tandem with letters from the Limpopo Provincial DoH, the University of Pretoria and the hospital RECs). The researcher shared the purpose and importance of the research to all the volunteers who were willing to participate in the study. The researcher and the participants who consented to be interviewed, then signed, and each kept a copy of the consent and introduction form.

The researcher's active participation in the hospital activities that embraced and needed his expertise, (as a participant observer and a reverend: for example, during the PHC open day accountability session, morning devotions for the PHC caregivers, pastoral intervention and visits to the patients in the wards), were key enablers that affirmed his credibility as a research student, and thereby encouraged voluntary participation from those who were approached and sampled purposively for the research study. The participants experienced first-hand, the critical role and value of responding to the patients' religious and spiritual needs within the hospital settings through the researcher's involvement and willingness to assist when called out. The researcher also showed the Respondents who consented to participate in the study, the letters which were granted by the University of Pretoria's REC, the hospital's REC on protocol, the approval from the Limpopo DoH to conduct research at PHC, and the hospital's CEO introduction letter.

The other challenges which were experienced with the PHC managers were mainly due to their work-related duties. Therefore, some of the interview appointments had to be rescheduled with a view to

ensure that their availability for the next interview. However, there were interruptions experienced during the interviews with the managers because of work-related challenges (for example, urgent calls that needed attention, sometimes the hospital staff, colleagues, and the clients who wanted to see managers).

Similarly, the challenges experienced with the caregivers (doctors and nurses, social workers and psychologist) were mainly due to their busy work-related schedule, and therefore, the researcher had to rescheduled the interview appointments. Again, there were no suitable venues where the interviews could be conducted with minimal disruptions. The PHC is a referral hospital, therefore, the researcher observed that the patients were being attended by the caregivers from 08:00 to 14:00. The challenge to conduct the interviews with the caregivers and the patients could be done after 14:00.

However, the challenge with this time slot was that, most patients who were scheduled for these afternoon interviews, would by then be drowsy because of being medicated, others would be experiencing pain, whilst others would be tired and need to rest. This resulted in the patients' responses to the interview questions being answered very briefly and to the point. Similarly, the patients would prefer to be interviewed in the language of their choice (preferably in Sepedi language) after the researcher has enquired from them prior to conducting the interviews. Therefore, the researcher had to rewrite the research questions and conduct the interviews in the preferred language of the participant, and thereafter had to translate them to English language for data analysis and interpretation.

4.6.2 Challenges experienced during data analysis and interpretation

The researcher employed participant observation strategy, in tandem with the interviews, with a view to recruit the participants, and to collect data at the research field. However, from a total number of fifty (50) research participants recruited, only thirty (30) consented to be interviewed by the researcher, and those interviews were recorded by using a voice recorder. Similarly, most of the patients who gave consent to participate in the study, preferred to be interviewed in the language of their choice, (Sepedi). Therefore, the researcher had to translate the research questions, and to conduct the interviews in Sepedi language. Thereafter, the recorded interviews were later transcribed verbatim (word for word) by using a computer.

The researcher had to broaden his understanding and knowledge of the research topic by immersing himself with the collected data (written research field notes and the recorded interviews), in order to make sense of what was observed, what was said during the interviews, and thereby be able to draw reliable research findings. However, the process of listening repeatedly to the interviews, was tiresome in that, good listening skill had to be applied for comprehension. Again, the researcher had to read through data

(from the computerised spreadsheet) repeatedly in order to verify that the information which was transcribed, was accurately captured so as to determine the emerging patterns and dynamics from data. On the same vein, the other challenge was to apply priestly listening skill with a view to discern, (during the analysis and the interpretation of data) the relevance of the study from the participants' viewpoints.

The other challenge which was experienced by the researcher, was the organisation and classification of voluminous data into manageable categories or themes. However, the researcher opted to apply colour coding of the transcribed interviews from the computerised spreadsheet to manage data. The researchable patterns and relationships later emerged from the mass of collected data during this rigorous process of careful analysis and interpretation. The research findings, therefore, (as grounded on the analysed and interpreted data) confirmed that there is a need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being.

4.7 PRELIMINARY CONCLUSION

This chapter presents the research findings from data analysis and interpretation. The interviews were tape recorded and transcribed verbatim. The transcripts were collated for data analysis by employing a computerised spreadsheet. The research findings were organised and reduced into these ten categories or themes: the right to freedom of conscience, religion, thought, belief and opinion during hospitalisation; embracing, assessing and responding to the patients' religious and spiritual needs; embracing, supporting and conduction of the religious observances in the SAGH settings; the need for chaplaincy as the religious and spiritual experts in a holistic approach to care; the establishment of chaplaincy (recruitment, appointment and regulation) and health policy; the views of the managers, caregiver and patients on health care services and ethical challenges; the patients' meaning of the religious and spiritual healing for coping with illness in SAGH settings; the patients' value and role of the religious and spiritual beliefs in coping with the medical treatment; the patients' experience of the religious and spiritual needs during the medical treatment; and the views of managers, caregiver and patients on the importance of health and health care. However, the research findings elicited the knowledge and understanding of the need and importance of chaplaincy in SAGH settings as expert providers of the religious and spiritual cares to the inpatients. Secondly, the researcher highlighted the challenges experienced during the collection, analysis and interpretation of data. The next chapter presents the reflections on the research findings, and propose a contextual chaplaincy model that can be employed in the SAGH settings for a holistic approach to care to address the patients' religious and spiritual needs in health care teams.

CHAPTER 5

REFLECTIONS ON THE RESEARCH FINDINGS

5.1 INTRODUCTION

This chapter presents the reflections on the research findings that have been based on the research questions and the objectives of the study topic. The researcher reflects on the responses of the PHC managers, the caregivers and the patients from their interviews, (under themes discussed from the research findings in chapter 4) with a view to glean and elicit knowledge based on those responses that address the research questions and the objectives of the study. Therefore, those reflections were done in tandem with data collected from the observations, (Chapter 2) on how the patients' religious and spiritual needs were addressed at the PHC settings. This also presents a proposed chaplaincy model that can be implemented in the SAGH settings, with a view to respond and address the patients' religious and spiritual needs within the health care plans.

5.2 REFLECTION ON THE RESPONSES

The researcher reflected on what was going on during the participant's observations at the research field? This background assisted the researcher to understand the context of the research field from an *emic* perspective. The researcher reflected on why these things were happening? Why were the patients' religious and spiritual needs provided without embracing the religious and spiritual dimensions in the treatment plans? The researcher reflected further on what ought to have happened? What value would chaplaincy add if the religious and spiritual needs were embraced in the treatment plans? How might we respond? The latter reflections encapsulated the Theological; the ethical; and the good practice of a professional, modern chaplaincy, (as part of the multi-disciplinary health care teams) which ought to be established as experts, to respond and address the patients' religious and spiritual needs in the SAGH's health settings.

5.3 DISCUSSION ON THE RESEARCH FINDINGS AND INTERPRETATION

5.3.1 Theme 1: The right to freedom of conscience, religion, thought, belief and opinion during hospitalisation

5.3.1.1 Reflection on the responses of managers

The researcher interviewed six (6) PHC managers to share their views on assessing the patients' religious and spiritual needs, in line with their rights to the freedom of conscience, religion, thought, belief and opinion, with a view to ensure patient-centred care is rendered within the health care teams/ and or treatment plans. All of them agreed on the importance of assessing the religious and spiritual needs of the patients. However, one manager stated: *"It is expected to assess these needs to avoid any relapse from the patients."* Four (4) managers agreed the focus of assessment is on the medical approach. Conversely, one (1) manager said that the hospital does the assessments of the patients' religious and spiritual needs.

5.3.1.2 Reflection on responses of caregivers

There were sixteen (16) caregivers interviewed to share their views on the patients who want to exercise their rights to freedom of conscience, religion, thought, belief and opinion during hospitalisation. All of them agreed that the patients do have this right. However, two (2) mentioned that it is complicated and complex to exercise this right during hospitalisation. Another Respondent shared a similar view, but purported that the traditional approach will complicate the patient's treatment. Thirteen (13) shared the view that this right is critical and must be exercised to address the patient (as a human being) holistically. Similarly, another caregiver said that this right, when it is exercised, must not infringe on the others' rights.

5.3.1.3 Reflection on responses of patients

The researcher interviewed eight (8) patients to share their views on exercising their rights to the freedom of conscience, religion, thought, belief and opinion when admitted and treated at the SAGH settings. All of them agreed to exercise this right. However, one (1) said that it should be exercised fairly and reasonably. Another one (1) stated that it must be exercised with mutual respect among the patients and caregivers.

5.3.1.4 Comparison of the responses of managers, caregivers and patients

The researcher found that when these views are compared with each other, they share the same frame of reference that the patients' rights may be exercised during hospitalisation in the SAGH settings. However, the patients' religious and spiritual needs are neither screened nor assessed when the patients are admitted in the PHC, except the biographic background which is captured in the computer system.

Similarly, the patients' religious and spiritual needs are not embraced in the medical treatment plans during hospitalisation in the PHC institution. The inconclusive evidence is that a holistic and patient-centred care is not practiced in the SAGH settings. This implies that there is no provision made for the patients' belief system in the South African Health Care Policy (SAHCP), contrary to the fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychological, and spiritual values, VandeCreek & Burton (2001) agree that it is a good practice in global health care settings. Similarly, the researcher observed that the patients' religious and spiritual needs were not screened, assessed nor embraced in the medical treatment plans at the PHC settings. Timmins et al. (2017) share this critical point of view that in many countries, such as the United States, United Kingdom, Belgium, and Brazil, for example, spiritual and religious support while in hospital are deemed fundamental rights, not an optional add-on for care, and nurses, doctors and other healthcare workers report positively about chaplaincy roles in practice (Fitchett & Nolan, 2015). In the Netherlands and Belgium patients have a right to receive chaplaincy within healthcare." Therefore, it can be stated that the patients are within their rights if they refuse hospital treatment (RHT) which does not embrace the religious or spiritual care.

5.3.2 Theme 2: Embracing, assessing and responding to the patients' religious and spiritual needs

5.3.2.1 Reflection on responses of managers

The views of the managers on the assessment of the patients' religious and spiritual needs are captured on 5.3.1.1 above. On the same vein, the researcher asked the managers to share their views on the health policy that embraces and responds to the patients' religious and spiritual needs in SAGH. All of them agreed that the health policy must embrace and respond to these needs. However, one (1) manager shared this viewpoint:

> *My question becomes, I'm trying to relate the two with the health aspect per se, because it looks more to me like a social aspect, not directly related to health. But on the other hand, I'm thinking out, because we do have cases whereby sometimes people, their belief is that if they, we can get 1, 2, 3, then this person will be healed. So yes, I think it can be. I think they can make a room for that.*

Another manager stated that, *"Yes, if the policy can be there, then procedures will be laid down in line with the policy, this is how it must be implemented, then it will be fine."* Similarly, other manager agreed that the patients must be involved in decision-making regarding their religious and spiritual needs in the health policy. This resonates with the NPRC that the patients must also participate in decision making.

5.3.2.2 Reflection on responses of caregivers

The researcher asked the caregivers to share their views on embracing the patients' religious and spiritual needs in their health care plans. All, except one (1) Respondent, agreed that the treatment plans must embrace the patients' religious and spiritual needs for a holistic approach to care, and thereby offset the RHT and defaulting on treatment, if it does not infringe on the rights of others. On the same vein, one (1) caregiver shared this viewpoint:

> *We should embrace it. The religious and the spiritual needs of the person, will make our job lighter if we embrace it. It will help us, get through to the patients. And if we include it in our care plan, it will be of help to us as staff and even to the patients, yes.*

On the contrary, one caregiver highlighted this summarised viewpoint:

> *So, meaning it should now, maybe the plan should now be incorporated within the medical model? I think there'll still be challenges to incorporate it into the medical model. What is it that we will be treating? We are in a hospital? Okay we've incorporated all these, so here what is it that we are treating? It's all about what priority? Or maybe for lack of a better word, we're treating TB here. So now, okay incorporating the other regimen on which level? Because if it's care, still it's not going to work, it's still going to be contrary and maybe counter-productive… So now, having to incorporate all these- religious practitioners, so how are we going to authenticate them? And I might not be a pastor with documents, but I might be spiritually given and powerful to change spiritual life of people. But now how will I be authenticated? And still, within the same domain, it's public knowledge we have false practitioners, either spiritual practitioners or traditional healers. So now how are we going to deal with that?... So, having to bring the domain that itself it's having challenges and dilemmas, and you bring it into- not that model- the medical model is absolute and ultimate.*

However, one respondent shared this contrasting view:

> *Yes, of the hospital we embrace, but when we talk about religious and spiritual needs, they're able to, let me give, a person can ask permission to consult a healer, a traditional healer, we allow him/her. They come and receive treatment, a person will tell you that you know there is somebody who treat me with herbs. I want to go there. We will explain that and give him/her the certain things that we know.*

5.3.2.3 Comparison of responses on managers and caregivers

The views shared above indicate a dichotomy between fifteen (15) respondents who agree, as opposed to one (1) who disagree on the health policy which would embrace and responds to the patients' religious

and spiritual needs. However, what is happening is that the SAGH employ the medical model that is not responsive to the patients' religious and spiritual needs. Therefore, this translated into the caregivers not being able to address the patients' religious and spiritual needs (best global health care practice) in the SA health institutions through a holistic approach to care. Secondly, the other critical issue is the unregulated practices of the multi-faiths and traditional healers who might (purported by a caregiver) practice in the hospital settings with models that can be counter-productive to the current medical model. Therefore, there is a need to review health policy, to ensure that all dimensions of being are embraced.

5.3.3 Theme 3: Embracing, supporting and conduction of the religious observances in the SAGH settings

The researcher asked the managers, the caregivers and the patients to share their views on the request to conduct the religious and spiritual observances in the SAGH settings within prescribed requirements.

5.3.3.1 Reflection on responses of managers

The managers agreed that the religious observances can be conducted in SAGH settings, since these observances will follow rules, are conducted on equitable basis, and attendance is free and voluntary. Conversely, one manager shared this contrasting viewpoint:

> *"The patient can request, but it's difficult to address their request as I said earlier, that we have different beliefs and yes, and the patients are all in one place. And then now trying to cater for all of them in one setting, it becomes a bit difficult."*

5.3.3.2 Reflection on responses of caregivers

There were fourteen (14) respondents who agreed that it is feasible to conduct the religious observances. However, two (2) caregivers raised the concern that these observances are dominated by Christianity and other religious observances are not observed. Another caregiver mentioned this:

> *It can be done. I mean they don't need a lot. There are no, I mean like if they do that, it's just a matter of providing venue and the person who'll be conducting that. So, the possibility is there that it can be done. It's just that maybe they are not putting much focus on it. But if they want to do it, there's nothing wrong stopping them. And anyway, it is not, whoever who feels that wants to, he or she wants to attend will do so.*

Another caregiver shared this view:

> *It is possible because, well, I've seen there are some, I do not know that is Church services or what, that are being observed, even here they have something like this sometimes. And then also in Mankweng, I have seen something like that. I think that for as long, because we don't see these patients the whole day. There is a schedule for medication, for this and for that, for ward rounds. So, if the patient is stable enough, I don't see anything wrong really, because all these- what they are observing, you will be surprised there's power in spiritual upliftment. So, you will be surprised what a happy patient, how they can comply, how they remain positive about everything you are doing, just because they could also take part, because they sort of see those observances as a very important part of their life. Okay, in their patient care, in terms of the medical point of view, I do not think there's anything wrong, regardless of whatever religion, they will be coming from.*

5.3.3.3 Reflection on responses of patients

Six respondents agreed that it is a good thing to conduct the religious observances in the SAGH settings. However, two of the respondents shared these contrary views: *"I don't know but they must, if they can make it possible. Yes, there I am not sure."* Respondent 29 mentioned that during her hospitalisation, she used to have joint prayers with other people. However, she purported that, conducting the religious observances could not add any value to her belief.

5.3.3.4 Comparison of responses on managers, caregivers and patients

The comparison of these responses indicates the managers, the caregivers and the patients shared a common viewpoint in that the religious observances can be conducted at the SAGH settings, provided those observances meet certain prescribed requirements. On the contrary, one caregiver mentioned that: *"I think patients do have this rights even during hospitalisation. However, it's kind of limited, in which way?*

During hospitalisation, patients still have their rights to believe religion and opinion. So, if they feel during hospitalisation they want to consult with any of their belief, their religion, so, the hospital would not prevent them from doing so. They would be allowed to consult with such. However, during hospitalisation, I think to bring their religion, the spiritual dimension, spiritual domain, spiritual belief into the hospital, that's the one that would bring complexity, in terms of treatment, management and care of the patient.

However, the views of most participants supported the value, the importance and the impact of the religious observances on the patients' wellbeing. These views resonate with what the researcher

experienced when he conducted a devotion on Good Friday for the caregivers who were on duty, and when he visited and prayed with some patients who requested to be prayed for at the PHC wards. The biographical information of the respondents who were interviewed (Table 15), reflects that twenty-eight (28) were of the Christians faith, and only two (2) were of the Moslem faith. The researcher observed that most of the patients he has visited and prayed for, were of the Christian faiths, and who valued the religious observances like Good Friday, highly. However, the Limpopo Province is predominantly visited by millions of people during Easter, mostly are the ZCC members undertaking an annual pilgrimage to observe Easter in the city of Moriah. Therefore, it can be surmised that the patients' innate desires for divine intervention might have been heightened by the prevalent festive mood of Good Friday celebration.

Most of the views shared a common frame of reference, twenty-five (25) as opposed to five (5) Respondents, were in support of conducting the religious and spiritual observances in the SAGH settings within prescribed requirements. These responses support the research question as to why it is imperative to have an onsite health care chaplaincy in the SAGH settings. Therefore, the majority views of the Respondents affirmed that chaplaincy can play a critical role in ensuring that the patients' religious and spiritual needs (embracing the religious and spiritual observances) are addressed in the SAGH settings.

5.3.4 Theme 4: The need for chaplaincy as the religious and spiritual experts in a holistic approach to care

The researcher interviewed the respondents to determine their views on the need for chaplaincy as the religious and spiritual experts in a holistic approach to care in the health care settings.

5.3.4.1 Reflection on responses of managers

The six managers' views on the need for chaplaincy were common as that five agreed. However, three managers expressed a common view that the need for chaplaincy must be respected, and provided on the request of the patient or individual. They agreed that the patients or individuals must have access to whatever that can help their faith. The other three managers mentioned that the health system need to be streamlined to address these needs. However, one manager stated that the shortage of medical specialist and other health related resources were challenges which impact on the establishment of chaplaincy. On the contrary, this manager confirmed that the religious and spiritual leaders do visit the patients:

They just come and do the visit but it is not documented, it's not controlled at all. It means during the time of visits if my native doctor came to me, then he will talk to me and whatever, and that one is a Christian and the pastor can come and pray. But these are only done during visiting hours. But if it can be documented and programmed then it will be regulated and even the time frame will be set that this is time for what, and this is time for that. Then this will be time for health care professionals, and this will be time for the religious leaders then it will differ. But for now, it's just using the visiting time.

Therefore, this assertion of not monitoring, documenting or regulating the interventions of the religious or spiritual leaders during visits, was consistent with the researcher's observations as a participant observer.

5.3.4.2 Reflection on responses of caregivers

The researcher interviewed sixteen caregivers to share their views on the need for chaplaincy as the religious and spiritual experts in a holistic approach to care in the health care settings, and fifteen agreed that there is a need for chaplaincy. However, only one caregiver did not see any need for chaplaincy: *"So it would not address the patient's holistic aspects."* Conversely, most views shared by caregivers are that chaplaincy complement the other dimensions of being:

It will assist in treating our people holistically, because now we are treating them, but the issue of their religious beliefs, it's lacking far, far, far behind. Another role that I think chaplaincy can do is to also visit the patients' families in their homestead, maybe before or after discharge, so that the families can also be brought on board to assist the patients.

On the same vein, one caregiver reiterated that:

I think, it will play a major role because, let's say, we've got a chaplain's office, is a staff member, who is having a problem, others they don't like to share the problem... Others they don't go to church at their homes, but you can see this person is having a problem, can I say: 'my colleague, since you have come to me and decide to open, even though you cannot open, can't you go to reverend and tell your problem, maybe they can pray with you, and have deliverance on whatever, you are suffering from?' Another thing is the patients in the units, there are patients that are there, they've seen them, they've tried everything, but they see that, we are failing, we have tried lot of things, but what she needed, that patient, it's only God's help.

However, one caregiver mentioned that:

The chaplain is going to be doing whatever that he will be doing in terms of the Constitution of the Republic, meaning that, you won't be enforcing a certain religion,

> *but will be observing all the religions, and then my answer will be, my view, it will help. They can facilitate if they will be doing it per the manner that it should be done, not enforcing.*

5.3.4.3 Reflection on responses of patients

The researcher interviewed eight patients to share their views on the need for chaplaincy as the religious and spiritual experts in a holistic approach to care in the health care settings, and seven patients agreed that chaplaincy can play advocacy role for their needs. This is encapsulated in this view of one patient:

> *I want to have a chaplain in the hospital because some other things they need the prayers of the chaplain to help us in the hospital. So, it's important for us to have a chaplain in the hospital because we need to help, for the God to help us. So, it's somebody, he is telling us about God and he is praying for us because other spiritual diseases they need for somebody for praying for us. So, I like that one.*

Similarly, other seven patients agreed that the chaplaincy can facilitate the religious and spiritual observances in a hospital setting. And lastly, that they will appreciate the appointment of chaplaincy. One patient stated that, *"We do actually need somebody. We are supposed to have these people long time ago."*

5.3.4.4 Comparison of responses on managers, caregivers and patients

Twenty-seven respondents agreed (i.e. five managers, fifteen caregivers, and seven patients) there is a need for chaplaincy as the religious and spiritual experts in a holistic approach to care in the health care settings. However, three were not sure/disagreed with the need for chaplaincy in the health care settings. These responses were critical in the context of the study, to answer the plum pie question: Is there a need for the establishment of chaplaincy in SA Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being?

5.3.5 Theme 5: The establishment of chaplaincy (recruitment, appointment and regulation) and health policy

5.3.5.1 Reflection on responses of managers

The researcher interviewed the PHC management to elicit their views on the chaplains' recruitments and appointments (as religious and spiritual experts in SAGH multi-disciplinary health care teams). Secondly,

to share their views on the adoption of the health care policy that embraces chaplaincy, and thirdly, to share their views on the regulation of the practice of chaplaincy in the SAGH settings.

The six managers agreed that the chaplains must be appointed in the SAGH multi-disciplinary health care teams. They also agreed that the health care policy should be reviewed and adopted with a view to embrace the practice of chaplaincy. They further agreed that the practice of chaplaincy in the SAGH settings must be regulated. Therefore, one manager mentioned that:

> *On the same principle that we have, you know doctors and nurses who are taking care of the physical aspect of the body, we have psychologists who are taking care of the mental or psychological aspect of the body, including eh psychiatrists as well, and we have social workers who are in the hospital attending to social needs of the person. It goes without say that there should be spiritual attention for the people's soul, such spiritual caregivers, must be appointed same as the other people.*

Another manager mentioned that there is no problem to appoint chaplains, and said that: *"in terms of the policy I can, yes we will have a recruitment policy."* One manager echoed the same viewpoint: "*Yes there must be a policy, and it must be adopted."* On the same vein, this manager concurred in that the practice of health care chaplaincy must be regulated.

5.3.5.2 Reflection on responses of caregivers

When the researcher interviewed the PHC caregivers to share their views on the establishment of chaplaincy to address the patients' religious and spiritual dimensions of being, fourteen agreed, and two were not sure or disagreed on the establishment of chaplaincy for the abovementioned task. However, one caregiver highlighted that:

> *We need this kind of expertise because health care facilities- I mean are run by health caregivers who are trained in looking after the body, the physical side of things, or maybe the psychological. But the spiritual and the religious part of it is most- of the time- it's neglected.*

On the same vein, another caregiver mentioned: *"It's only us social workers,"* who are addressing the religious and spiritual needs of the patients, and stated that: *"it's not our part."* Conversely, one caregiver shared this viewpoint:

> *This one is a bit of a challenge for me. Remember pastor, earlier on I was covered by the fact that things must be done according to the Constitution of the Republic. But for an example, I know just to be precise on the question that, if the chaplains want to*

> *address the patient's religious and spiritual dimension of the patient, I say it be, let me state what I've said earlier on, if it can be done according to the Constitution because it covers everybody.*

5.3.5.3 Reflection on responses of patients

When the researcher interviewed the patients on the appointments of their spiritual or religious leaders in the multi-disciplinary health care team to meet their spiritual or religious needs in the SAGH settings, they all agreed. However, one patient reiterated: "*We do actually need somebody. We're supposed to have these people long time ago. We all need God obvious."*

5.3.5.4 Comparison of responses on managers, caregivers and patients

There were twenty-eight respondents (i.e. six managers, fourteen caregivers, and eight patients) who shared a common viewpoint on the establishment of chaplaincy in the SAGH health care teams. Therefore, the Respondents supported the view that health care policy should embrace chaplaincy, and that the practice of health care chaplaincy must be regulated in the SAGH settings.

5.3.6 Theme 6: The views of the managers, caregiver and patients on health care services and ethical challenges

5.3.6.1 Reflection on responses of managers

The researcher interviewed six PHC managers to share their views on the patients who request to access the services of a health care chaplaincy when they are confronted with making ethical decisions: The managers shared this common view: Firstly, the patients need to be given choices in terms of what they need. Secondly, the patients' choices need to be respected. Thirdly, these choices must be included in the health policies. However, one manager was of the view that all the patients must be assessed. Another manager stated that the existence of chaplaincy will enable the patients to access the religious and spiritual services. Similarly, one manager stated: *"people indeed have to have access to whatever that can help their health."* On the contrary, another manager mentioned that *"the way in which our health care system is streamlined, I think it's obscured."* However, one manager further stated*: "the many different health policies we have in the hospital should be able to talk to these things. I think it's just a matter of relevance."* Another manager agreed: *"I'll allow the patient to have his own choice."* Similarly, one manager shared that: *"When coming to health professionals, let them assess all the patients."*

5.3.6.2 Reflection on responses of caregivers

The researcher interviewed sixteen PHC caregivers to share their views on patients requesting health care services which embrace spiritual dimension, when confronted with making ethical decisions. These are some of the caregivers' views:

> *One of two, of the most ethical issues that or challenges that we meet, or on a day to day, although I am no longer at reproductive health, but one of the termination of pregnancy, more especially when it's not even suggested by the woman, it's suggested from a medical point of view, that this pregnancy is dangerous to your health. And to save your life we must terminate the life that you are carrying.*

One caregiver reiterated that:

> *I think it's a good way of support, also in terms of reproductive health care- you know- certain issues are quite ethical. For an example- you know- like terminations, or- you know- the end-of-life situations where spiritual sort of dimension- you know- impeccable view on that, and I think if there is a team dedicated to supporting them with that aspect, it will help them to- you know- sort of decide as well. Sometimes they- you know- agree from organic point of view that something needs to be done, but spiritual side does not allow them to engage on such. I think that integration will help, yes.*

Another caregiver shared this viewpoint: *"I support that the spiritual thing should also be addressed to that patient, should have access to that, because some of them they do these things. Later, then they feel guilty for the rest of their lives. Some of them then even think of committing suicide."*

However, one caregiver shared this viewpoint: *"But if chaplaincy is on site, doctors will be able to explain the emergency of the procedure, and the importance of doing this procedure in the patient."* The other caregiver mentioned that:

> *Healing process doesn't take place looking at one dimension, so the spiritual need is also important." On the contrary, one caregiver shared this viewpoint: "So this is health care service that require spiritual dimension, for instance we're given an example of a termination of pregnancy as an example. I think it's all about what I've just said, that, they're accessing the relevant service for a relevant cause. So, if perhaps you have, you're pregnant, one is pregnant and they're struggling with issues of conscience, they need to clear that with their spiritual caregiver first, before they even land into the hospital, because here it's all about what it is?*

Therefore, all the caregivers agreed and confirmed (except for one) that it was good to have the services of chaplaincy, to address the patients' religious and spiritual challenges, when faced with the critical ethical dilemmas and the crucial ethical decision making that affect the patients. Two caregivers shared the view that patients who want to access the religious and spiritual services sometimes sign RHT form to consult with their religious and spiritual leaders or traditional healers. However, some caregivers agreed that if chaplaincy is on site, their services will be of a great help to both the patients and the caregivers. Other caregivers reiterated that healing process doesn't take place at one dimension, so the spiritual need is also important in terms of holistic care. One caregiver said that chaplaincy is critical in that it subscribes to ethical principles such as confidentiality, and are non-judgmental. Therefore, the patients who are facing tough ethical challenges can be referred to chaplaincy.

5.3.6.3 Reflection on responses of patients

This is a singular view expressed by a patient when the researcher interviewed him to share his view on the experience of health care services from the day of his admission at the PHC settings: *"Yes at the hospital, according to my own observations, I did not notice anything wrong happening, except the thing which I do not accept, is this one that a person can perform abortion."* However, the other seven patients did not share any ethical challenges they have experienced during their hospitalisation at PHC settings, or any other challenges related to the need for chaplaincy based on the ethical decisions.

5.3.6.4 Comparison of responses on managers, caregivers and patients

The Respondents shared the common view that the patient who requests to access the services of a health care chaplaincy must be allowed to do so. However, other Respondents stated that they are not comfortable to deal with the ethical challenges, like termination of pregnancy, based on their beliefs.

5.3.7 Theme 7: The patients' meaning of the religious and spiritual healing for coping with illness in SAGH settings

5.3.7.1 Reflection on responses of patients

The researcher interviewed patients to get insight into the meaning that they gave to their conditions and to the healing experiences. One patient's response was this: *"I don't see any problem with it either."* Another patient's response was that spiritual healing or religious healing depends on that person's spiritual belief. The patient said the religious and spiritual healing depends on the person's belief system.

Conversely, the other patient shared this viewpoint that: *"We must all pray and stand together."* This resonates with Ferngren (2014:9) in that *"the religious or divine healing, which is broader than what we often call 'miraculous healing' seeks the assistance or the intervention of a divine power that transcends the normal course of nature."*

5.3.8 Theme 8: The patients' value and role of the religious and spiritual beliefs in coping with the medical treatment

5.3.8.1 Reflection on responses of patients

The researcher asked the respondents to share their views on the value and role of the religious and spiritual beliefs in coping with their medical treatment. The researcher found out that, of the eight patients interviewed, Respondents 23, 27, 28 shared similar views with Respondent 30. They confirmed that religion and spirituality have value and it also help. However, the view expressed by Respondents 25 and 26 are congruous. The former shared this viewpoint: *"Spiritual treatment in illness implies that you must surrender yourself, that the way I am sick, I will be healed,"* while the latter reaffirmed it in this way: *"Yes I will gladly receive it because the teachers will be nearby."* Similarly, Respondent 24 grounded the value and role of the religion and spirituality in coping with treatment on the feelings and prayer: *"It's all about the feelings, the praying."* Conversely, Respondent 29 highlighted that treatment precedes religion in terms of the sequence: *"You are doing your treatment, and then religion."*

5.3.9 Theme 9: The patients' experiences of the religious and spiritual needs during the medical treatment

5.3.9.1 Reflection on responses of patients

The researcher interviewed the respondents to share their views on their experiences of the religious and spiritual needs during the medical treatment. One respondent reaffirming the need for chaplaincy in SAGH: *"We do actually need somebody. We are supposed to have these people long time ago. We all need God obviously."* Another stated that:

> *It's the role of faith, it's preaching that comes to me, or that is delivered to me. I must be waiting in anticipation because there it is coming every day. It is not something that I receive that day. It is something that is always there. And even myself I believe in that." However, one (1) Respondent said: "Honestly speaking, the support of the Church is the primary one. We were supposed to try, so that even God can heal us.*

> *Isn't that everything we should be asking from Him? Also for the sickness to heal, you must ask from God.*

Another Respondent confirmed the need for religious and spiritual support: *"I need somebody to pray for me, because the prayer is more powerful."* According to Puchalski (2001:3),

> *A study of the 'placebo effect' has led to conclusions that our beliefs are powerful and can influence our health outcomes. Herbert Benson, MD, a cardiologist at Harvard School of Medicine, has renamed the placebo effect 'remembered wellness.' I see this as an ability to tap into one's inner resources to heal. Benson, myself, and others see the physician-patient relationship as having placebo effect as well, i.e., the relationship itself is an important part of therapeutic process. Benson suggests that there are 3 components that contribute to the placebo effect of the patient-physician relationship: positive beliefs and expectations on the part of the patients, positive beliefs and expectations on the part of the physician or health care professional, and a good relationship between the 2 parties.*

This study is corroborated by VandeCreek and Burton (2001) in that, it confirms prayer and other exercise of belief nourishes and heals the body. Therefore, *"all in all, placebos provide an excellent example of the interaction of mind and body by demonstrating the ways in which a person's beliefs about treatment can have remarkable effects on the outcome of that treatment"* (Bishop, 1994:34).

The religious and or spiritual healing means something to the patients for coping with illnesses. These are some of the viewpoints from the participants on having chaplaincy to address the religious and spiritual needs of the patients in the SAGH settings: Respondent 13 shared that:

> *I think it will be very relevant because it will be looking at the patient as a whole, not specifically on the physiological and the physical aspect of human being, as health involve also the spirituality of the patient. So, I think it will be of a benefit to the patient as well, and it will be very helpful for them, during the healing process.*

Respondent 21 shared that:

> *I think we need this kind of expertise because health care facilities- I mean are run by health caregivers who are trained in looking after the body, the physical side of things, or maybe the psychological. But the spiritual and the religious part of it is most- of the time- it's neglected. And I think personally there are certain things that, maybe they manifest physically, but the main roots are spiritual.*

The value or role of religious and or spiritual beliefs in coping with medical treatment is critical: According to Kruger et al. (2009:7),

Religions reconcile a human being to him-/herself and the world. One feels certain, has deep insight and acts correctly- so one believes. All forms of suffering, physical as well as emotional, become tolerable if one is liberated from the torments of meaninglessness and senselessness. The confidence generated in this way endows religious individuals and groups with enormous strength.

Respondent 4 mentioned that:

But what I can say, it is needed to have a chaplain in the hospital environment, because you will realise people have got a lot of issues. Some are admitted because of social problems, then it ends up affecting their physical or their body, then they end up admitted in the hospital, then you realise our health care practitioners, they will be busy dealing with the physical, but the root cause of the problem was not attended to. But if chaplains can be here, then people can be free to voice out that thing that are in their heart that can cause stress, that can cause, the depression, all those things, because what we believe is that before the person can have physical problem, most of the problems started from the spiritual, or the soul. You realise the person has got a problem at home, then person can be depressed, then when the person come to the hospital the doctors will be dealing with depression, but when the person goes back home, the root cause is still there. But this services are important. I wish, the government can accept this, or maybe it can be me, but there is a serious need.

The experience of religious and or spiritual needs during illness and medical treatment is critical: Respondent 10 shared this: *"According to my observations most of the ailments are related to spirituality."* Respondent 21 share this experience from a physician's point of view:

There are certain wards, for instance the ICU, that's where we've critically ill patients, and it's the area we need to minimise risks of infection. Sometimes you'll have a patient's mother saying: 'no I've come with oil, anointing oil, this pastor says, I should apply it to the child,' or water, or whatever it is, you know? So, these are the things that we are not saying: 'don't use them, but be mindful of the environment, and what we're dealing with.

5.3.10 Theme 1.10: The views of managers, caregiver and patients on the importance of health and health care

5.3.10.1 Reflection on responses of managers

The researcher asked the managers to share their views on the importance of health and health care as key everywhere in the world, and to ensure that the people get the health care they need in the SAGH settings. All the managers shared a similar view that health and health care is key everywhere in the world. They agreed that spirituality and chaplaincy are very critical to ensure provision of a holistic care.

One manager articulated that every country that does not give attention to health and health care, they drive their own people into poverty, because health care has a way of being expensive, and it can cause you everything that you have, and at the end you still even lose your health. So, if preventative type of health is used in a country, then you won't have to suffer a huge burden of disease. But when we get to spirituality we will be getting there to providing a total health care package. However, another manager stated that, all the citizens of the country, were supposed to be getting the uniform health care services. One manager shared this critical viewpoint on the need for an effective health care system:

> *To access better health care, we would need amongst the things you would need everywhere in the world, would be that, you would need to have you know, professional caregivers. You will need to have infrastructure that talks to that. You would have many things. If a person comes into this hospital, for this person to receive proper health care, there must be people, there must be medicine, there must be infrastructure, there must be everybody else. Our core-business is the provision of the service to the hospital. Therefore, your core-staff are your nurses and your, and your doctors. These are your core-people that you must have, direct providers of the health care service. But there should be millions of others who must provide what I call supportive kind of activity, to ensuring that these ones deliver their services.*

Another manager stated that:

> *But what I can say, it is needed to have a chaplain in the hospital environment, because you will realise people have got a lot of issues. Some are admitted because of social problems, and then it ends up affecting their physical or their body. Then they end up admitted in the hospital. Then you realise our health care practitioners, they will be busy dealing with the physical, but the root cause of the problem we're not attended to. But if chaplains can be here, then people can be free to voice out that thing that are in their heart that can cause stress, that can cause the depression, all those things.*

5.3.10.2 Reflection on responses of caregivers

The researcher asked the caregivers to share their views on the importance of health and health care as key everywhere in the world, and to ensure that the people get the health care they need in the SAGH settings. All the caregivers view health and health care as critical, and most agree on having chaplaincy.

However, six caregivers mentioned that the people are not getting what they need due to lack of resources and budgetary constraints. Similarly, the financial challenges impact negatively on the caregivers and the patients alike, compounded by the lack of chaplaincy services. One caregivers stated that:

The patients are relapsing, and since the health care is more important to everyone in the country, so let the chaplains be another, the supplement to our health care, so that we can work together as a whole. So, that we can help this people, because maybe we can reduce the lack, the amount of this relapse.

Similarly, two caregivers shared this view that:

There is shortage of staff, the staff is demoralised, and our people nowadays are looking for money beside giving care to the patients. And politics are also playing another role within health facilities, that frustrates the staff. So, according to me things are not in order. Yes, and there is lot of un-transparency regarding financial issues, and less training to the staff that should provide services. I think if they improve on giving relevant people, relevant job descriptions, it will, that will help.

Conversely, three caregivers agreed that we cannot be productive if we are ill, and there is no income. One caregiver shared that:

My view to ensure that people get the health care that they need before even it boils down to myself, and people of, like, I believe that it's starts with what we normally call the political will. What do I mean? In the health care, particularly in the public health care must be there. We can be hundred here, but if there are no resources, there is nothing that we can do.

5.3.10.3 Reflection on responses of patients

The patients shared a common view in that health and health care is very important and need to help all the people of South Africa. However, one patient shared the view that the caregivers and chaplaincy must be one team:

Yes, according to my view, you discover that these groups that need to unite, and observe that life is the most important thing, and to treat this nation is the most important thing, yes, it is very important if they are united to be one team, so that they are able to help this nation of South Africa.

5.3.10.4 Comparison of responses on managers, caregivers and patients

The managers and caregivers shared a common view that health and health care must be provided, and chaplaincy need to be included in the health care teams. However, they shared a common concern on the financial constraints which is experienced in the provision of quality health care, and thereby impacts

negatively on the service delivery. Therefore, many views expressed by the Respondents confirmed that the people should get the health care that they need, and that embraces the religious and spiritual needs.

5.4 WHAT IS GOING ON?

The researcher deepened his understanding of what was going on in PHC settings by becoming a participant observer with a view to investigate a need for the establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes the patients' religious and spiritual dimensions of being. The researcher employed priestly listening skills to understand the needs of the research participants in the health care environment, and to see first-hand how the patients' religious and spiritual needs are addressed within the South African Government Health Care institutions. The researcher observed what was going on, and interviewed the managers (management of health care), the caregivers (providers of health care) and the patients (consumers of health care) at the PHC settings to get insight into the research topic. However, findings of this study confirmed that there is a need for the establishment of chaplaincy in the SAGH settings. The participants wanted their existential need for divine intervention embraced in the hospital treatment plans.

The researcher observed that there was a hospital ministry where the caregivers (doctors and nurses) attend lunch-time prayers. However, the caregivers (professional nurses) were conducting their morning prayers before they attend to the patients. Hence some patients initiated their own support groups for joint-prayers and mutual support. The other patients were dependent on the support of their families and their religious or spiritual leaders during the regular hospital visits, whilst others preferred to listen to the value based religious programmes and gospel music for self-inspiration. The researcher prayed with the patients, (prior to performing the medical procedures), in response to their request for divine intervention.

The researcher found that there is no health care chaplaincy (as experts to address the patients' religious and spiritual needs) in the SAGH settings. Similarly, the patients were not screened or assessed to ensure that their religious and spiritual needs are addressed. By implication, the patient's participation in decision making and choice of health service's need, are very limited in that there is no need-led approach to health care. However, the researcher found that there were patients who refused hospital treatment based on their religious and spiritual needs. Therefore, during the interviews, the caregivers confirmed that the patients would sign the RHT form to discharge themselves from the medical treatments which are not responsive to their religious and spiritual needs in the treatment plans. One (1) caregiver shared the view that they are not able to refuse them this right, but most patients would default at the treatment, disappear for a very lengthy period, and they would come back to the hospital in the worse medical

conditions. This view was further corroborated by other caregivers that, when the patients come back for treatment, they would disclose to them that they had alternative treatment elsewhere.

According to Curtain and Flaherty (1982), the patients come from a variety of cultural backgrounds from where they derive their belief system. These cultural beliefs influence how health care is to be provided with a view to meet the distinctive needs of the patients. Similarly, Pera et al. (2005) mention that as new developments take place in the medical field, the rights of patients are becoming a major issue. During illness, the human rights of patients gain greater prominence, as does the importance of human rights in the nurse-patient relationship. The state of illness itself, and the proportions which it may assume, make the patient vulnerable to abuse. Furthermore, illness gives rise to new needs that must be met so that the patient's integrity as a unique individual is retained. However, the study by Mulaudzi et al. (2001) confirms that in SA health care institutions, the NPRC embraces among others, the patients' participation in decision making and the choice of their health service, (WHO, 2010).

5.5 WHY IS THIS GOING ON?

The researcher found that the South African Health Care System (SAHCS) employs a Western Medical Model to treat and care for the patients. This view was corroborated by the caregivers during the interviews with the researcher at PHC research field. This translates into the patients' religious and spiritual dimensions of being human not incorporated nor embraced in the SA health policy. According to Mowat and Ryan (2003), spirituality is an inherent dimension of being human. Hence valuing human is critical in a holistic health care system. Similar study by Puchalski (2001) further confirms that compassionate care means being fully attentive to all the dimensions of the patients and their families, in body, mind and spirit. Therefore, the challenge to respond to religious and spiritual needs is that bio-medically-dominated clinical tradition disregard spirituality as scientifically addressable, (De la Porte, 2016; Mowat & Ryan 2003). This challenge is compounded by the Religious and Spiritual fraternity (Belief System) and the Department of Health (Health System) working in silos (Magezi, 2012). Conversely, World Health Organisation (2010) states that:

> *Health systems are only as effective as the services they provide. These critically depend among others, standards, norms and guidance to ensure access and essential dimensions of quality: safety, effectiveness, integration, continuity, and people-centeredness.*

However, the acknowledgment of the importance of the religious and spiritual dimensions is imperative in the context of SAGH, to embrace chaplaincy with a view to be responsive to the patient's spiritual

needs (De la Porte, 2016). The chaplaincy can play a very critical role in the SAGH multi-disciplinary health care teams by dovetailing the systems of Health and Beliefs to be streamlined into a holistic approach to care, (Woodward, 2010). This holistic approach is conceptualised in Figure (5) below:

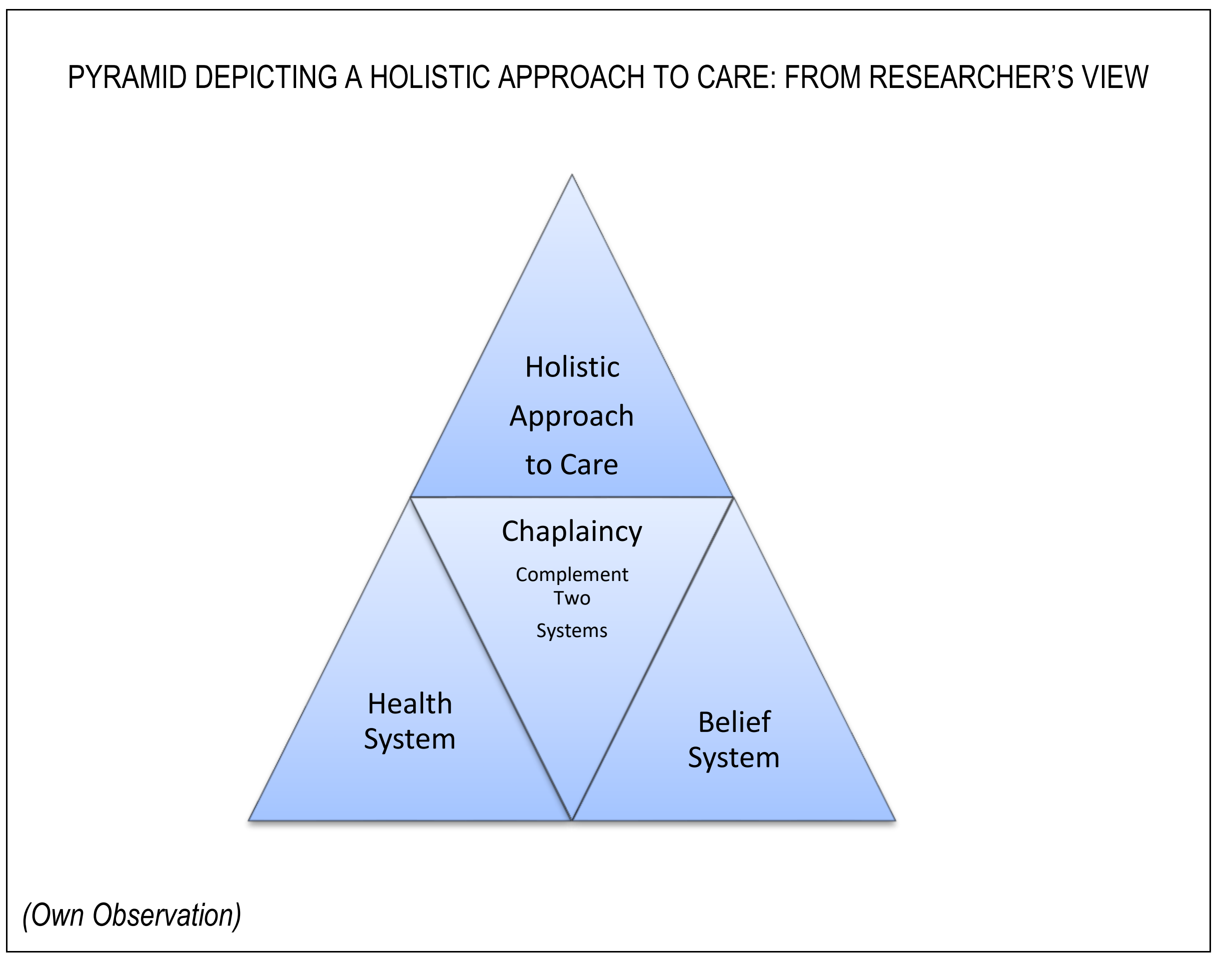


Figure 5. Pyramid depicting a holistic approach to care

The other reason why is this going on, according to De la Porte (2016), is a lack of *"statutory requirement or official system in place for accreditation and certification of spiritual and pastoral workers in healthcare."* This systemic challenge is an impediment for the establishment of chaplaincy in that it cannot be registered and practice as a profession, (without accreditation) within the SAGH health care teams.

5.6 WHAT OUGHT TO BE GOING ON?

5.6.1 Theological reflections

5.6.1.1 The ministry of Jesus

Osmer (2008) is of the view that an ethic of equal regard is grounded in the narratives of creation and Christ's ministry that point to the inherent dignity and worth of all human beings. In stories of creation, human beings are portrayed as created in God's image and, thus, as worthy of respect in personal relations and of fair treatment in social institutions. In narratives of Christ's ministry, he is portrayed as telling his disciples no less than eight times, 'You shall love your neighbour as yourself,' and follow the Golden Rule. The researcher found that both the caregivers and the patients need respect, love and care. Therefore, the ministry of Jesus through chaplaincy creates conduits for respect, love and commpassion.

According to Curtain and Flaherty (1982:87), *"comprehending human relationship in the professional context compels one to understand that disease magnifies universal needs, creates new needs, and renders an individual vulnerable to abuse."* Chung (2009) concurs that, every human being has needs which reflect a depth of being beyond mere physical concerns. To love, be loved, be connected and respected; to speak thoughts and feeling that are one's truth; to explore the meaning of one's life and disease and be supported in transformative healing, or simply to not be alone-these all are fundamental human quests to be honoured, especially at such a vulnerable and vital time as hospitalisation or dying. This view resonates with the view of Respondent 26 to caregivers:

> *We want them to welcome us in an acceptable manner. We do not want when we arrive here, you find someone, it seems as if they treat you just like nobody. Let them accept us like human beings, especially the sick people. If you accept them, they will also be healed. They become healed even before they are healed.*

On the same vein, the caregiver, Respondent 22, further echoed the same view to the patients that:

> *Oh, well I think they can also play a role, also in towards not only the patients, also towards the workers because for us to be able to work together, we must have the same understanding, and view things almost like understanding the views of each other. And as well workers in the system are also human beings. They are also human beings, and they face a lot of challenges. So, some of them don't even get time to go to their places of, however they worship or whatever. Some don't have that kind of support. So, I think if we are there to provide also those services we will build a strong and a healthy team, that will be able to care for patients in general. I think, Yes, they can play a role, even they are not there for patients.*

According to Lewis & Travis (1991:17),

> *The new reality to which Christians must adjust in today's world is that we live in a multi-religious context with followers of non-Christian religions pervading our*

> *heretofore exclusive Christian enclaves. The physical nearness of these non-Christian neighbours naturally calls us to learn about them and share the Gospel with them.*

However, on the surface, according to Swinton and Mowat (2006:9), the friendships of the church and the world *appear* to be the same, but when we reflect on them theologically we see that they are quite different. Jesus befriended everybody (including the outcasts) based on love and the principle of grace. The researcher is of the view that the Church of God is called to imitate God, (Ephesians 5:1-2) by loving one another, and to follow Christ, (John 13:12-17) by serving one another. Similarly, the ministry of Jesus impacted positively, among others, the sick and those with infirmities. Therefore, the church is called to minister to the sick and troubled by visiting and praying for them and with them, (Matthew 25:31-46) to touch their lives in resonance with the parable of the Good Samaritan (Luke 10:25-37): *"Who is my neighbour?"* Jesus concludes: *"Go and do likewise."*

Dreyer et al. (1993:7) are of the view that health is the well-being of the body, the psyche and the spirit, and that it includes the harmonious integration of a person with himself/ herself, the community and the environment (*ibid*). Health should therefore be viewed within the specific community's socio-political, cultural, religious and interactive framework, and never in isolation. Health is a dynamic that encompasses the promotion of optimal physical, psychological and spiritual functioning, (*ibid*). However, when the researcher conducted interviews, one caregiver and Respondent 21 shared this viewpoint that:

> *Okay. Yes, like holistically, like the patient is the spirit, I mean spirit, body, soul. So, as much as you want to take care of the one part, you also want to take care of the other part, the spiritual part. So, but I don't think the health care system has the place for that. You know I don't think we are at the point where we openly say: 'Yes we understand that a person it's spirit, body and soul.' They need to take care of those part or they need to exercise their religious belief. So, health care facilities should have these services.*

Respondent 22 mentioned this, concerning health care that: "*I mean a human being with three dimensions, that need to be taken care of. We need to feed your soul, we need to take care of your body, and as spiritually we need to be taken care of in terms of treatment of the patient. It will play a very- Yes- key role."*

The researcher's view is that the Church and the Religious communities are not sharing a common vision, mission and approach to respond and address the patients' religious and spiritual needs in the health care institutions. There is a lack of a uniform approach when providing the religious and spiritual care in the SAGH settings. This is impeded by non-existence of a statutory body for registration, licencing and

supervision of the practitioners of the religious and spiritual caregivers as professionals in the hospital settings. This translates into some religious and spiritual leaders using unorthodox methods in their approach, (which are not documented), when they address the patients' religious and spiritual needs in the SAGH. This view was corroborated by Respondent 21 during the interview that:

> *Let's take for instance the traditional belief system. They will be coming and doing their rituals which is very diverse. Some will cut, they use razor blades, some they burn things, some they use concoctions which according to the medical model they are not regulated, the concentration in it is unknown, and now having to bring that to the patient who is in the hospital, so that will bring some challenge in terms of care and management.*

Therefore, this view supports the researcher's finding that the phenomenon of chaplaincy, as the religious and spiritual experts, and a profession within the health care settings, was misunderstood by some of the caregivers.

According to VandeCreek and Burton (2001:87),

> *Professional chaplains design and lead religious ceremonies of worship and ritual such as: prayer, meditation, and reading of holy texts; worship and observances of holy days; blessings and sacraments; memorial services and funerals; rituals at the time of birth or other significant times of life cycle transition; and holiday observances.*

Therefore, the religious observances encourage the participants, strengthens their faith, bring relief and comfort. The participants find meaning and acceptance during suffering and chronic illness, (Puchalski 2001:1). One caregiver and Respondent 22 highlighted this critical view: *"So, you will be surprised what a happy patient, how they can comply, how they remain positive about everything you are doing, just because they were able to also take part, because they sort of see those observances as a very important part of their life."*

5.6.1.2 The ministry of Paul

The ministry of Paul is modelled and shaped by the ministry of Jesus in that, Paul urges the Congregants to follow his example, as he followed the example of Jesus Christ, (1 Corinthians 11:1). Therefore, Paul's ministry must be interpreted within the context of this text, (1 Corinthians 9:19-23): "*Though I am free and belong to no man, I make myself a slave to everyone, to win as many as possible. To the Jews I became like a Jew, to win the Jews. To those under the law I became like one under the law (though I am not under the law), to win those under the law. To those not having the law I became like one not having the*

law (though I am not free from God's law but am under Christ's law), to win those not having the law. To the weak I became weak, to win the weak. I have become all things to all men so that by all possible means I might save some. I do all this for the sake of the gospel, that I may share in its blessings." The ministry of Jesus was broad and embraced everyone. But Paul's ministry embraced the Gentiles. Similarly, health care chaplaincy must be understood in the same vein as the ministries of Jesus and Paul: It is broad enough to embrace everyone, and specific enough to embrace those in health care.

The researcher interviewed participants to share their views on chaplaincy: Respondent 21 stated: "I think chaplaincy it's very important. Like one of the role that we already spoke about, it's you'll be there looking after the religious beliefs and so on, and facilitating all these groups of bodies that are out there. And I think it's going to help a lot. It will improve in the outcome of these health care service that we provide for the patients. Because like I've explained, and other things, they just need religious intervention. They just need spiritual intervention. So, chaplaincy is very important. So, it's a service that is crucial that is going to add value in the holistic approach of managing a patient, because they teach us about holistic approach. When you look at the patient, look at the patient holistically. But they don't teach you in medical school to look at the religious, they don't teach you to look at the- you know- religion, the beliefs. Its' more of, okay, they will talk more of psychological approach. But beyond that patients have their own belief system, that governs who they are, and how they see these diseases. So, I think a chaplaincy will add value."

According to Meiring (1996:211-212): *"In the medical field, a considerable amount of so-called 'alternative medicine' is influenced by holistic thought, for example by the notion that the human spirit can bring about 'spontaneous' cures of grave illness like cancer"* (Muller, 1989:18) *"or that a person can be healed in a spiritualist manner by means of the beings with whom a medium can make contact."* However, Pera et al. (2005:177) state that:

> *If health personnel understand religion better, religion can be utilised to provide better care, especially in situations where religious practices have a detrimental effect on health care. At the same time, religious leaders can contribute towards the health, comfort and decision-making of believing patients. Because the course of illness and other forms of human suffering is uncertain, informed interaction between health-service personnel and religious leaders in providing care can only be to the advantage of the patient/client.*

Similarly, Kruger et al. (2009:7) reiterate that: *"All forms of suffering, physical as well as emotional, become tolerable if one is liberated from the torments of meaninglessness and senselessness. The confidence generated in this way endows religious individuals and groups with enormous strength. This*

role of religion may be called comprehensive integrating." However, chaplaincy in health care can provide the religious and spiritual healing and create the sacred space as soul doctors.

Therefore, Chung (2009:60) is of the view that a holistic framework ought to integrate science as well as a humanist, existentialist or even a secular way of ministering to the sick and dying in response to their changing needs. Nevertheless, chaplaincy complement both the health system and the belief system.

5.6.1.3 The ministry to patients

The ministry to patients within health care settings, is modelled and shaped by the ministries of Jesus and Paul in that, (John, 13:12-17; 34-35; Ephesians, 5:1-2, 6:7) providers of the religious and spiritual health care must imitate God and have a servant's attitude. Therefore, chaplaincy is a relevant ministry in the health care context, to minister to all the patients, whether they are believers or non-believers. During the interviews, Respondent 28 shared this view, on the experience of religious and spiritual needs during illness and the treatment plan that:

> *I want to have a chaplain in the hospital because some other things they need the prayers of the chaplain to help us in the hospital. So, it's important for us to have a chaplain in the hospital because we need help from the God, to help us, so it's somebody who is telling us about God, and he is praying for us because other spiritual diseases they need somebody for praying for us.*

Therefore, this view resonates with Jesus' instruction to his disciples, to 'heal the sick' (Matthew, 10:8).

According to Rumun (2014:39-40),

> *It is common for patients to have existential questions about their illnesses, and may inquire 'why me?' when given a devastating diagnosis. A sick person may feel that the medical illness is a punishment from God. This is so because, if devout religious faith is a pathway to good health and protection from diseases, then it is believed that illness/sickness results from lack of devotion to the said faith. This notion can be harmful to the patient in question because the patient believes that the illness has come upon him/her as a result of lack of devotion and thereby affect how the patient views the sickness, treatment modalities and gaining good health. In other words such questions as 'Why Me' may affect health outcomes.*

Therefore, having chaplaincy on site, may be the relevant response to address these existential challenges in the hospital settings, by ministering to those in need.

Similarly, Puchalski (2001:4) shares this experience with a 28-old year-old woman who was raped as a teenager and had an abortion. In her belief system, that was wrong. This was her exact words: *"I have been waiting for punishment, and this is it."* Therefore, Puchalski (*ibid*) is of the view that, it is critical that the physicians and health care providers listen to all aspect of the patients' lives that can affect their decision making and their coping skills. However, the chaplains are the religious and spiritual experts who are trained to address *"the part of the person that is most deeply concerned with feelings, with the need for meaning in life, with convictions, belief systems, values, dreams, interpersonal relationships, relationship to God, and so forth,"* Pera et al. (2005:18-19). Since the search for meaning, purpose, wholeness, and integration is constant, never ending task, (VandeCreek & Burton 2001) the ministry to the patients is imperative to respond to the religious and spiritual challenges in the health care settings.

However, Ferngren (2014:13) argues that, an imaginative gulf separates the medical world of previous historical ages from the modern world of advanced technology and sophisticated biomedicine. This gulf tends to render us unconsciously patronizing toward earlier cultures that struggled with the same problems that confront us in a medical crisis: how to alleviate or learn to live with our own pain and suffering; how to account for our illnesses by placing them in a meaningful context or a broader framework that depends on nonmedical categories for understanding; and how to respond to the suffering of those around us. Earlier societies than ours faced similar issues and responded in similar ways. Their response often involved religious answers to many of the questions they asked. To consider religious ritual, prayer, and vows a primitive approach to health and medicine are to be both presentism and unhistorical. Religion often gives answers that go beyond the realm of reason and logic, which are necessary but insufficient components of our self-awareness.

5.6.2 Ethical reflections

According to Osmer (2008), ethical reflection with universal ethical principles is particularly important, for it allows moral communities to test their present practices and norms against universal ethical principles. However, researcher's view is that in SA health care, service to humanity must be rendered within ethical principle of respect for human life. This must be in tandem with the consumers' health rights.

The researcher reflected on the Nurse Pledge of Service (NPS) to highlight the importance of universal ethical principles with regard to service for humanity in health care (captured on the wall at PHC ward Q). The content of this NPS reflects that a service to humanity is grounded on ethical principles. Therefore, any clinical decision must consider the patients' needs, preferences, wishes and expectations at the SAGH settings. The researcher's view is that these blocks are very critical to instil the NPS compliance:

- Health and health care system (infrastructure, funding, staff, providers, management). [Block 1]
- Uniform norms and standards (policy issues: regulations, principles and ethics, morality). [Block2]
- Mission (statement=aims and objectives), vision and action plans. [Block 3]
- Approach (holistic care), support system. [Block 4]
- Needs, expectations and wishes of patients. [Block 5]
- Integrated (all dimensions) model (competency). [Block 6]
- Treatment plans (screening/assessment needs). [Block 7]
- Your rights, (patients and caregivers). [Block 8]

PIETERSBURG HOSPITAL CAMPUS

Nurses' pledge of service

I……………… solemnly pledge myself to the service of humanity, and endeavour to practice my profession with conscience and with dignity. I will maintain by all means in my power the honour and noble traditions of my profession. The total health of my patients will be my first consideration. I will hold in confidence all personal matters coming to my knowledge. I will not permit considerations of my religion, nationality, race, or social standing to intervene between my duty and my patient. I will maintain the utmost respect for human life. I will make these promises, solemnly freely and upon my honour.

Frame 1: Nurses'pledge of service

The above eight (8) building blocks impact directly or indirectly on the service to humanity. The first block touches on the importance of a well-functioning health care system (WHO 2010). The second block touches on providing quality health to consumers of health care through uniform norms and standards. The third block reflects on what is the mission of providing health to the community. The fourth block reflects on what is the approach to provide holistic care, followed by the sixth block on the patients' needs, expectations and wishes which translates into an integrated model encapsulated in the treatment, without violating the rights of patients and caregivers. These blocks ensure a service builds on ethical principles.

Studies show that holistic nursing care incorporates the needs of body, mind and spirit, (Mc Dowell & South, 2017:1). According to Curtain and Flaherty (1982), nursing exists in response to a need of society and holds ideals related to man's health throughout his life span. Hence nursing is evolving with a view to meet the health needs of the members of the public. However, Pera et al. (2005) are of the view that a nurse can play a key role in creating a climate in which the rights and needs of patients are recognised and respected. As advocates for patient, a nurse can make decisions to protect the rights of patients. Patients are often defenceless and nurses can, based on their knowledge and experience, support and assist patients in making decisions. Similarly, studies show that chaplaincy play a critical role by representing a theological, spiritual, and/or religious viewpoint on ethics committees; provide a non-scientific point of view; and an advocacy role at ethics committee meetings on behalf of patients and their families, (Timmins et al., 2017). Therefore, it is critical to establish chaplaincy at the SAGH settings.

Wnhen the researcher interviewed the participants to share their views, when confronted with the choice of making ethical decisions, these were some of the responses from the nurses and the doctors at PHC: Respondent 16, a medical doctor, highlighted this challenging viewpoint that:

> *Yes, it helps because the challenges that we face at the hospital, it's, because you have a person who want to go to the church saying that s/he want to enquire, yes, that may I continue with eh, not only with reproductive, any procedure in theatre. Eh they want to sign eh, RHT going to enquire, and then, until they receive confirmation that: 'You can carry on or you can't.' So at least if it is here, even the doctors will be able to talk to chaplaincy about the procedure. But if they should fetch them somewhere, the doctor won't even tell the importance of this procedure to their priest outside. But if chaplaincy is on site, doctors will be able to explain the emergency of the procedure, and the importance of doing this procedure in the patient.*

Studies show that global health care has evolved to become patient-centred, holistic and wellness focussed, (Galek et al., 2007; HCC, 2010; McDowell et al., 2017). Similarly, other studies show South Africa is a country comprised of many different ethnicities with eleven official languages, and value religion and spirituality. Studies further show that South African culture recognise a holistic relationship between the emotional, spiritual and physical state of someone's condition, even when facing the challenges of health, illness and death. However, South African families seek out the support, guidance and advice of their religious community for spiritual healing, (HCC, 2013). Similarly, some patients are affected (positively or negatively) by unorthodox religious and spiritual practices which are unethical.

During the interviews, Respondent 10, a professional nurse, mentioned this practical approach to the ethical related challenge like abortion, at the PHC settings:

> *I think involving other stakeholders in this one is very much good. And I'm going to be honest about this one, for example the case of abortion, usually they refer cases to us." According to my religious belief I usually tell them that, I'm unable to give them counselling regarding abortion. And usually I suggest to the nurses the other side, and the doctors to say: 'Can't we refer them back to their spiritual people that can assist them before you do any procedures?' Because with me, it's, I'm unable to do counselling on them, and I think even us, a staff, we need such kind of help to. We need assistance to say: 'how can we go about such kind of cases? Yes.*

5.6.3 Reflections on good practice

According to Haynes et al. (2007:12), *"Good practice means that staff should clearly document patient needs, response to needs and outcomes; and should work collaboratively with the multidisciplinary team (and link with other agencies when required) to ensure needs are met."* This resonates with the view of Curtain and Flaherty (1982:148) in that:

> *Physicians and nurses who demonstrate what they profess, that is, participatory membership on a health care team, practice as colleagues- with respect for each other's expertise and contributions, consideration of each other's points of view in their decision making and genuine collaboration in the common goal of the promotion of functional competence in the recipients of health care.*

Similarly, Rumun (2014:47) also agrees that, *"patients spiritual or religious needs should be documented and all health care team members should understand them. This will enable these needs to be integrated into treatment planning and care."* Handzo (2006) captures the best parctice in professional pastoral care on accepted practice representing the highest quality in professional pastoral care including among others, Spiritual screening and Assessment Processes, and Quality Improvement.

These views serves as practical examples of good practice, and documenting the needs of the patients is critical in the treatment plans, and resonates with the view of Respondent 4, a manager, who highlighted this viewpoint:

> *I think if this process can be controlled, then the policy be laid down, or this is how the process must unfold, then it can assist, even the patient. But if it is not prescribed, the hospital can have a lot of challenges around it. But if it can be controlled, documented, and assessed very well, then it doesn't have any problem.*

Therefore, best practice implies assessing, documenting, and implementing. Rumun (2014:39) argues that:

> *In identifying 'spiritual or religious needs' in the hospital context, health professionals are attempting to gain an understanding of two broad issues: Firstly, beliefs or practices which are significant to the patient's health that can affect decision-making, coping, support networks, commitment to treatment regimens, use of complementary health practices and general wellbeing. And secondly, patients' wishes about the way beliefs and practices are acknowledged and supported while they are in hospital." However, the researcher (as a participant observer at the PHC research field) observed that there were patients and families who were in need of the religious and spiritual services in the PHC settings. The researcher observed that these needs were not forming part of the treatment plans.*

According to VandeCreek and Burton (2001:83), *"Professional chaplains respect and respond to patient values and beliefs, encouraging a more holistic approach to healthcare."* Similarly, Harding et al. (2008:100) state that trends in health care reveal professionals are interested to respond to spiritual need. However, during the research study, the researcher captured this view from Respondent 21, on the need for health care chaplaincy:

> *I think there's a great need for these services, in the health care system. So, talking from my experience as a health caregiver, I've had experiences where patients would like, request like sometimes they request for a pastor, or they want like an example you will be wishing that, before you're to perform certain procedures for especially before taking them to theatre, they will request that a priest should come, either pray for them, or give a go ahead. And the other one, the common one is the Jehovah's Witness. So, the Jehovah's Witness religious group of patients, those ones that we are those one that is the group that we commonly work with. And they specifically require that their religious leaders come in, or comes on board, to give advice or their views, regarding the management of their conditions. So, I think services like these are very crucial in health care system. We do need chaplaincy, if my understanding- like you've explained- is going to cater all religious groups.*

5.7 HOW MIGHT WE RESPOND?

How we respond to the outcome of this study must be informed by what was observed and gathered during the interviews at the PHC research field, and the study of literature. The response to the study is guided by a process of a five-fold R's (Review; Remodel; Register; Recruit and Regulate) aimed at transforming Health Care System, and to understand chaplaincy roles from the threefold levels of care.

5.7.1 Review of health care policy

Reviewing of health care policy is done to ensure that all dimensions of being human are embraced in the health care and are included in the treatment plans. This requires a strong leadership that will ensure

transformation in the health care sector takes place, that the rules, regulations, norms, standards and principles to guide health care provision in the policy are well captured, to ensure its proper application.

South Africa is a constitutional democratic state with a Constitution to govern the SA citizenry. Therefore, chaplaincies exist in the South African law enforcement agencies, (SAPS, SANDF, and DCS). However, the DoH does not make any provision for health care chaplaincy in the SAGH settings. This is the antithesis of the evolving global health care practices which embrace chaplaincies in the hospital settings. Secondly, this is the antithesis of WHO (2010) in its advocacy for a well functioning health system which responds in a balance way to a population's needs and expectations by among others, making it possible for the people to participate in decisions affecting their health and health system. The the NPRC makes provision for the patients' participation in decision making, (see Chapter 4, Table 17). However, researcher observed and confirmed during the interviews that, the decision making excludes the patients' religious and spiritual needs in the PHC treatment plans, and therefore were not embraced in the treatment model.

The participants were interviewed to share their views on the health care policy that embraces the religious and spiritual needs of the patients, and these were some of the responses from management: Respondent 4 mentioned that: *"Yes, if the policy can be there, then procedures will be laid down in line with the policy, this is how it must be implemented, then it will be fine."* Respondent 2 reiterated that:

> *I think it is necessary that the patients form part of the wider spectrum of the stakeholders that participate in the development of the South African health policies. And that in itself it will assist in making sure that, no one is left behind in terms of the development of the health policies. Because as it is now, yes there are various stakeholders, but one stakeholder that is amiss, in this spectrum is the patient, whom I think, where I am, it is the main player in the delivery of the health services.*

However, Respondent 3 stated that:

> *Look, South Africa its a country, its a religious or spiritual country. I would believe that majority of our people, if not all our people, participate in some kind of a religious or a spiritual arrangement, all of them would do that. And therefore, it becomes important that you are able to embrace their, those kind of needs in the, in the South African health policy. The many different health policy we have in the hospital should be able to talk to these things. I think its just a matter of relevance, like I'm saying a lot of us you know we either go to Church, we want our priest to come see us when we are hospitalised, or we perform certain whatever thing that we perform, at the end of the day I would believe that majority of South Africans are churchgoers. And when they*

are in the hospital here, I mean, I know that a lot of them would want to be seen by their priests, and therefore, these kind of things needs to be covered as part of the policicies that we have in the institutions.

Therefore, the PHC managers agreed that the patients must be involved in the decision-making processes on how the health policy will ensures that their religious and spiritual needs are responded to, and addressed within the SA institutional health care, such as the SAGH settings.

5.7.2 Remodel the current medical model

Remodelling is aimed at restructing the current SA medical model in oder to include chaplaincy in the SAGH settings. This model would be realigned so as to embrace chaplaincy in order to respond and address the patients' religious and spiritual needs in the multi-disciplinary health care teams. The researcher has broadly discussed the health system and belief system in Chapter 2 of this study. These two systems are existing independently from each other. They do not operate in symmetry, so as to provide the patients' religious and spiritual health care in the SAGH settings. However, the researcher observed and found from the interviews that these two systems were operating in silos, and were diametrically opposed to each other to provide a holistic approach to care that includes the patients' religious and spiritual needs.

This assertion was corroborated when researcher interviewed the participants to share their views on chaplaincy addressing the patients' spiritual worldview's needs in the health care teams. This was a response from one caregiver, Respondent 19:

> *They will be relevant in addressing the patient's spiritual worldview. However, the feasibility and the practicality of chaplaincy in the health care system might be a challenge, in which way? The hospital utilises the medical model, so now when we bring the chaplaincy which will be addressing a diverse religious belief system, so now it might be causing, some disruption, and maybe confusion, and even complexity in the management and care of the patient.*

When the researcher interviewed the participants to share their views on the patients requesting to access the services of health care chaplaincy in SAGH settings, this is one of the responses from a manager, Respondent 2:

> *From where I am, I think it is very much necessary. The way our health care system is streamlined, I think it's obscured. Maybe it's because of our historical past. What I think needs to happen, is that patient needs to be given a choice, in terms of how they want their needs to be cared while they are*

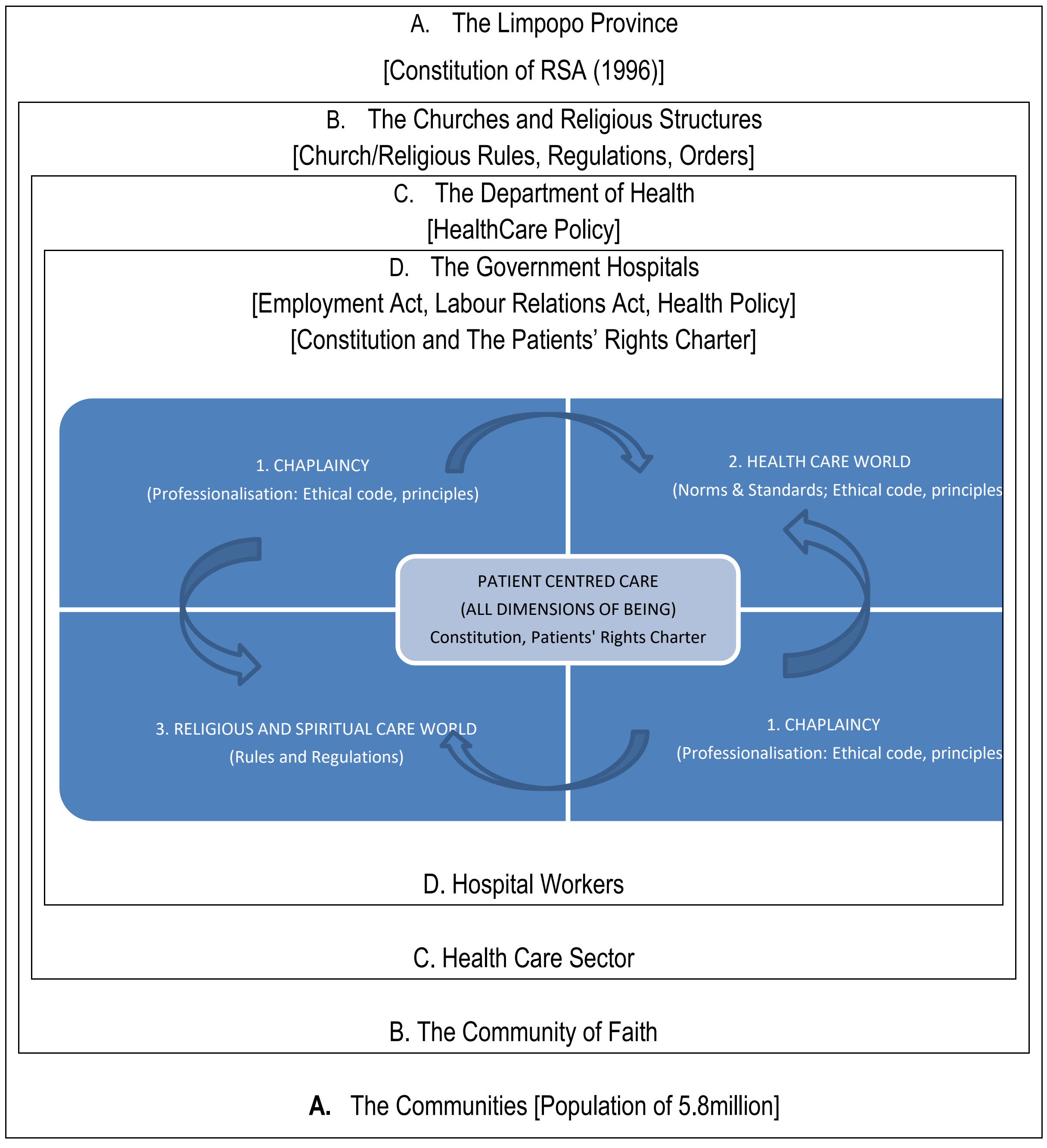
> *in the hospitals. Often you find that Okay, our medical practitioners, they only come to the hospital to offer that little medical care, and the bigger chunk, which to me as the issue of serving the spiritual needs of the patients, has been neglected. And that remember it plays a major role in term of making sure that Okay, the physical being of a human being is attended to. So, where I am I think such kind of choice needs to be given to patients, and it will go a long way in making sure that the delivery of our health care system is a fully-fledged package* (compare with Figure 5 above).

The researcher asked the caregivers to share their views on the embracing the patients' religious and spiritual needs in their health care plans. All, except one Respondent, agreed that the treatment plans must embrace the patients' religious and spiritual needs for a holistic approach to care, and thereby offset the RHT and defaulting on treatment, if it does not infringe on the rights of others. One Respondent stated that:

> *But when we talk about religious and spiritual needs, they're able to, let me give, a person is able to ask permission to consult a healer, a traditional healer, we allow him/her. They come and receive treatment, a person will tell you that you know there is somebody who treat me with herbs. I want to go there. We will explain that and give him/her the certain things that we know.*

However, the challenge with this approach was that, such treatment was not included in the medical treatment plans. Therefore, the researcher argues that if these systems are synchronised, then, the patients' religious and spiritual needs would be screened, assessed, documented and addressed within the institutional health care system. This would translate into a patient-centred model which employs a holistic approach to care embracing chaplaincy, in order to address the patients' holistic needs, expectations and wishes in SAGH settings. The chaplaincy model (below), may be explored to explain its application in the SAGH settings:

A CONCEPTUAL CHAPLAINCY MODEL IN THE SOUTH AFRICAN GOVERNMENT HOSPITAL SETTINGS



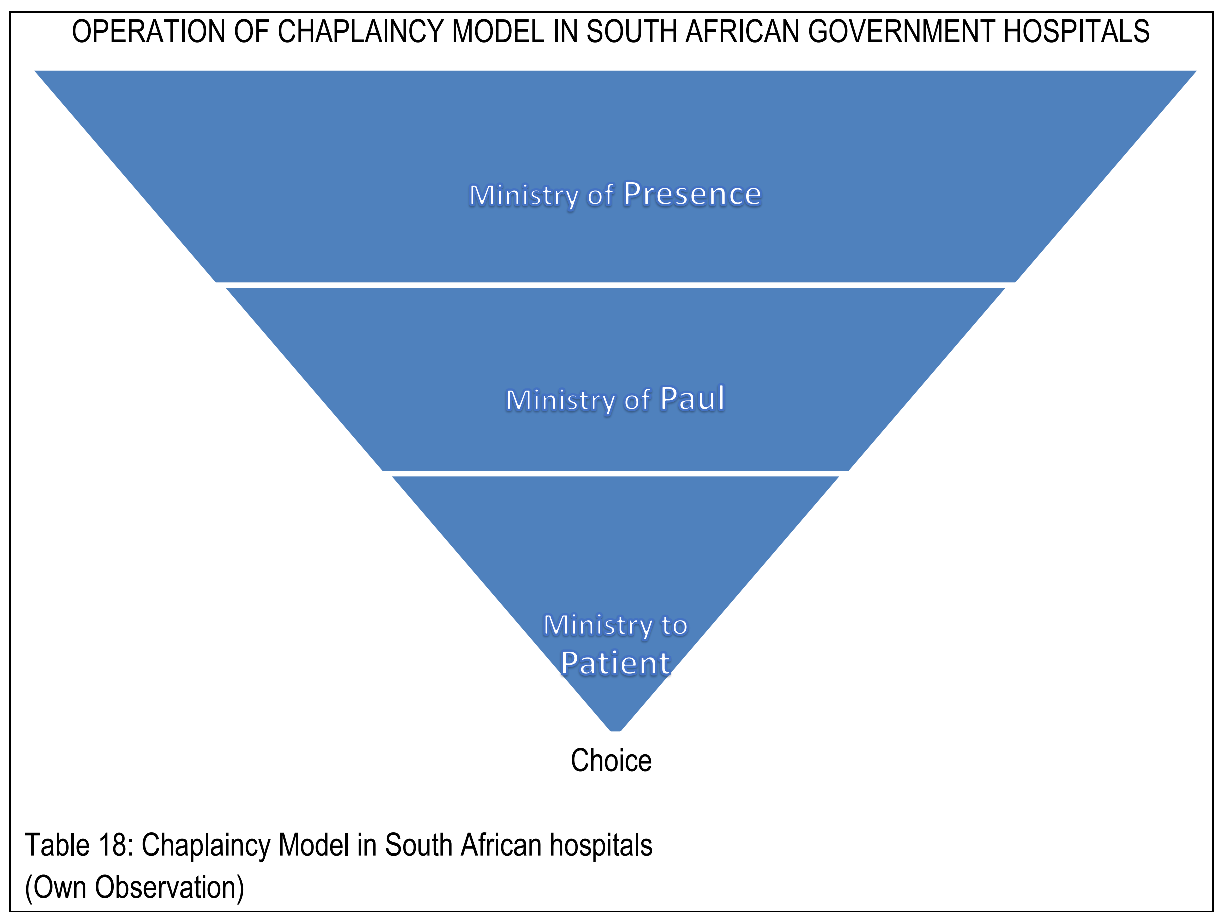


Table 18: Chaplaincy Model in South African hospitals
(Own Observation)

The composition or structure of a proposed chaplaincy model is explained thus: A. The LP is governed in line with the SA Constitution to serve the population of 5.8 million people. B. The Churches and Religious structures in the LP operate through their Church/ Religious rules, regulations and orders to serve their constituencies (believers). C. The DoH serves the population of LP by providing health care through the Government's HealthCare Policies in tandem with the Constitution of RSA. D. The SAGH renders the health care services in line with the Constitution, the Health Policy and the prescribed Health Care Acts. Therefore, the establishment of health care chaplaincy in the SAGH settings ensures that Health Care World and Religious and spiritual World are synchronised, realigned and streamlined with a view to respond, and to address all dimensions of being human. This is the primary focus: Patient-Centred Care encapsulated within the RSA Constitution, (1996) in tandem with the NPRC.

Similarly, the operation of chaplaincy model in SAGH settings, is to be conceptualised from the three-fold ministries of Presence-Paul-Patient (discussed above). The researcher provides this synoptic viewpoint:

5.7.2.1 The Ministry of presence is broad enough to embrace all the needs of the population in LP

The ministry of Presence highlights the role of chaplaincy as encapsulated in the ministry of Jesus Christ. Jesus befriended whosoever, everyone, anyone, someone. He travelled from place to place to serve the social outcasts, the sick, the lame, the rejected, the rich, the poor, the esteemed, the lowly in status. Therefore, the ministry of Presence through chaplaincy can add value and play a critical role in the multi-faiths communities (Matthew, 25). The professional chaplains, moving across multi-cultural, multi-faiths' boundaries, serve as an integral member of that community by ministering to all the communities. This was echoed during the interviews with the participants, Respondents 7, 9 and 10. Therefore, the chaplains make unique contributions by providing community service (VandeCreek & Burton, 2001).

5.7.2.2 The Ministry of Paul is specific enough to address the caregivers' needs in the SAGH settings

The ministry of Paul highlights role of chaplaincy as encapsulated in the ministry to Gentiles. The apostle Paul was sent specifically to minister to the non-Jews. Therefore, Paul related to the people by becoming all in all, (1 Corinthians 9:19-23). The chaplains are in the hospital environment to serve the caregivers by becoming caregivers, to serve and minister to them: *"The professional chaplains, moving across disciplinary boundaries, serve as integral member of healthcare teams as they care for staff members themselves who experience the stress of patient care. Chaplains not only help staff members cope, but empower them to recognize the meaning and value of their work in new ways"* (VandeCreek & Burton 2001:84,91). This was echoed during the interviews with the participants, Respondents 11,12, 13, 17,20 and 21. Therefore, the chaplains also minister to the patients, families and staff, (Timmins et al., 2017).

5.7.2.3 The ministry of patient is specific to respond to the religious and spiritual needs of the patients

The ministry of patients highlights the role of chaplaincy as embraced in the ministry to Patients (Luke, 10:25). The professional chaplain serves the patients by being patient with them! Chaplains minister with compassion to the sick and the frail: *"The professional chaplains offer spiritual care to all who are in need and have specialized education to mobilize spiritual resources so that the patients cope more effectively,"* (VandeCreek & Burton, 2001). This was echoed during the interviews with the participants, these Respondents 8, 9, 10, 13, 15, 17, 18, 19, 20, 21 and 22. However, secular institutions such as hospitals, are need-based and patient-centred in approach, (Harding et al., 2008) to provide care.

5.7.3 Register the religious and spiritual health caregivers

Registration of the religious and spiritual health caregivers with a professional recognised body or council or board is critical to ensure the practice of chaplains in the SAGH settings. Similarly, the modern health care has evolved, and global trends on the practice of chaplaincies in the hospital settings show that they are all registered and accredited, (Atherstone, 2011; Orton, 2008; VandeCreek & Burton, 2001). Cadge (2018) states that:

> *Chaplains, like professionals in a range of industries, have long sought to maintain and build occupational power by articulating their professional mandate and advocating for their work. I describe how leaders of the Association of Professional Chaplains and its predecessor organizations used multiple strategies to articulate and re-articulate their professional mandate between 1940 and the present to become a companion profession, one that comes alongside another without seeking to challenge its jurisdiction. I find chaplains seeking to develop an economic base, aligning interests across distinct segments of the profession and creating new professional associations, lobbying for legislative support, and offering their services in institutional voids. They further adopted the language of healthcare around questions of identity, charting, and accreditation and, chaplains used not just the frameworks but the methods of healthcare-evidence based research - to try to demonstrate their value. This history can help chaplains and chaplaincy leaders today to form a more comprehensive sense of their history and think more strategically regarding how to make the case for their profession going forward.*

The researcher interviewed the participants to share their views on embracing the patients' religious and spiritual needs in their health care plan, one caregiver, Respondent 19 said that:

> *And remember we are not discrediting the religious practitioners, either traditional. So here the model is very easy to authenticate doctor [Mardy (pseudonym)]. Let's see you are a senior psychologist, are you registered with, you satisfied the requirements of the board that you are an authentic psychologist. Yes, I have proof and documents to authenticate. So now, having to incorporate all these- religious practitioners, so how are we going to authenticate them? And I might not be a pastor with documents, but I might be spiritually given and powerful to change spiritual life of people. But now how will I be authenticated? And still, within the same domain, it's public knowledge we have false practitioners, either spiritual practitioners or traditional healers. So now how are we going to deal with that? We have authentic and non-authentic?*

According to De la Porte (2016:4),

> *The Council for Health Service Accreditation in South Africa was established in 1996 to assist healthcare facilities in developing countries to deliver quality healthcare to their clients through sustained improvement, using internationally recognised*

> *standards and based on patient safety principles and operational research. COHSASA is accredited by ISQua. The COHSASA HS (Version 6.6, June 2010-July 2014) currently does not have a standard for spirituality. However, the COHSASA Hospice Palliative Care Standards (1st edn., August 2010-July 2014) does include a standard for spiritual care which states: 7.3.1: The spiritual needs of patients and families are identified and addressed according to their religious and cultural beliefs and values.*

On a positive note, the Association of Christian Religious Practitioners (ACRP) held an Annual Conference and General Meeting at Pretoria on 25-26 August 2017 under the theme: "*Professionalization of (Christian) religious professions within the context of the South African regulatory framework*." The focus was on the process to establish ACRP as a professional body for religious professions in terms of the South African National Qualification Framework (NQF) Act (67 of 2008) in view of the report on Culture, Religion and Language (CRL) Rights Commission (constituted in terms of Section 9 of the Constitution of South Africa, 1996).

5.7.4 Recruit and reskill the religious and spiritual experts for chaplaincy

Recruitment, appointment and skilling (training) of the religious and spiritual experts as the health caregivers in the multi-disciplinary teams, is critical to ensure that the patients' religious and spiritual needs are addressed. The quality of the recruitment and skilling, enhances the chaplains' competencies.

According to Haynes et al. (2007:12),

> *Incorporating spirituality into health care requires the same skills that competent practitioners already use in their delivery of person-centred care... These skills are underpinned by the principle of respect. In practice, this does not mean we always have to feel respected for all patients and their beliefs and practices, but that we should always act respectfully towards them.*

However, Cook (2004:67) is of the view that integrating spiritual and cultural competency within health care chaplaincy, there should be provision of resources and structures established for skills' facilitation. This resonates with the researcher's experience in law-enforcement for twenty-five years in the SAPS chaplaincy. The researcher was recruited into SAPS chaplaincy, (after satisfying set criteria as standards required for appointment into the service). He was immediately orientated into the practice of SAPS chaplaincy, had to attend local and international training to ensure that he was equipped (skilled) to provide pastoral care and support to the SAPS members, their families and the community. The researcher was also involved in joint chaplaincy programmes (SAPS, SANDF and DCS) to support the members of the law-enforcement, their families and the community. However, the health care chaplaincy

in the SAGH settings can only be conceptualised, since it has never been experienced. And there are no relevant *emic* research studies conducted on the phenomenon of health care chaplaincy. Therefore, this study is very critical to ensure the establishment of health care chaplaincy in the SAGH settings.

When the researcher interviewed the managers at the PHC research field to share their views on the recruitment and appointment of hospital chaplains (as experts address the religious and spiritual needs of the patients in the SAGH health care teams), these were some of the responses: Respondent 1 said that:

> *I am pro, the provision of chaplaincy services. You know we have health care providers in hospitals, but it seems like places like airports, they see that it is necessary to have chaplaincy services, or to have a chapel where people can go and do their religious observances without hindrance, so even here, it should be. It should go without say because it's part of health.*

However, Respondent 6 shared this viewpoint: "*There is no problem… in terms of the policy I can, yes we will have a recruitment policy."* This is the viewpoint of Respondent 3 that: *"I've worked with chaplaincies in the police service, and I've seen it work very well. Secondly, I know in the hospital you know, in the hospital it's even worse. You have a lot of, I mean people who come here are sick, obviously, the chaplaincy will assist us."* And again, Respondent 3 reiterated this viewpoint that:

> *If anyone would have to ask me that question, my view will be: 'Let's have them.' Look, this is just a summarised… The person that you appoint as a chaplain, it would have to be somebody who would need to have that understanding, how the environment in the hospital work. They themselves must be coming from a background. They should either be pastors, you know, or they should be, Yes, they should either be pastors or they should be people who have got that authority, to talk on certain issues, Because, obviously, it's not just anybody who've got authority to talk about these things. So, it must be somebody who have got some kind of, I believe when you are a pastor, who've got some kind of authority to talk to issues, chaplains, and all those kind of things. And this person would need to understand that patients must be informed of their rights.*

5.7.5 Regulate the practice of chaplaincy in health care settings

Regulation of the practice of chaplains as experts to provide the religious and spiritual care in the SAGH health care teams is critical. However, in SA there is no official system for regulation, (De la Porte, 2016:4). On the contrary, according to the researcher's experience in the SAPS (regarding the practice of chaplaincy), appointed chaplains are regulated by (among other SAPS regulations), the Letters of Good Standing (LoGS) with their relevant Church Councils, or their Boards, or such commissioned

Authorities. When the researcher interviewed the managers to share their views on regulating the practice of health care chaplaincy in the SAGH settings, these were some of the responses: Respondent 1 said that:

> *Because they are going to be employees, they need to be governed by the laws of South Africa, including labour laws… like all employees, the employment procedure or process must take place, advertisement, shortlisting, interview and in that panel of interview there must be relevant people, relevant stakeholders will be able to question this person, lest we fall into a trap of getting somebody who is narrow minded and want to only advance their spirituality or religious way of doing things. Chaplaincy must be open to all. It must be non- discriminatory.*

Respondent 5 stated that, *"definitely it needs to be regulated. So, that it's practiced within certain directives."* Respondent 6 reiterated: *"they must be regulated." Respondent 4 said that, "Yes there must be a policy, and it must be adopted… the practice of health care chaplaincy to be regulated."* Respondent 2 said that:

> *Anything without regulation pastor, what I've observed is that Okay, it leaves the room for people to do as they wish. And once there's regulation it assists in terms of managing whatever needs to happen within a country. And I think it is important that we adopt such kind of a policy, so that it can be able to assist in terms of managing the delivery of the spiritual needs of our patients.*

According to the HCC (2010), in acute health care, board-certification is the standard for professional chaplaincy. The process of chaplains' certification is governed by Common Standards for Certification adopted by the leading professional chaplaincy associations in North America in 2004. These standards require a master's level degree in theology or a related field, endorsement by a religious community, 1600 hours of Clinical Pastoral Education (CPE) and an in-depth interview by a peer review committee. De la Porte (2016:4-5) reiterates that the international training for accredited and/ or certified spiritual and pastoral care workers is based on the principles and practices of the Clinical Pastoral Education (CPE).

Therefore, this intensive training and endorsement, in-depth interviewing by a peer review committee, are some of the key criteria to regulate the practice of chaplaincy in the health care settings, especially in the acute health care settings like the ICU. When the researcher interviewed the participants, this challenging point of view was shared by Respondent 21:

> *For instance, there are certain wards, for instance the ICU, that's where we've critically ill patients, and it's the area we need to minimise risks of infection. Sometimes you'll have a patient's mother saying: 'no I've come with oil anointing oil, this pastor says, I*

> *should apply it to the child,' or water or whatever it is, you know? So, these are the things that we are not saying: 'don't use them, but be mindful of the environment, and what we're dealing with.*

Similarly, Respondent 19 echoed this common viewpoint that:

> *Let's take for instance the traditional belief system, they will be coming and doing their rituals which is very diverse. Some will cut, they use razor blades, some they burn things, some they use concoctions which according to the medical model they are not regulated, the concentration in it is unknown and now having to bring that to the patient who is in the hospital, so that will bring some challenge in terms of care and management.*

However, the global health care chaplaincies' practices, are regulated according to agreed norms, standards and ethical principles.

5.8 THREE LEVELS OF CARE

The researcher applied grounded theory (from continuous analysis and interpretation of the primary data) to conceptualise the phenomenon of health care chaplaincy, with a view to understand what it means and how does it apply in the current context of South African hospital settings. Chaplaincy is, according to researcher's perspective, to be conceptualised as a compassionate care in a health care setting which is rooted in serving all human beings, by ministering to the soul and spirit of the patients in distresses, which are manifested by the religious and spiritual challenges, in order to address a deeper human need.

According to Puchalski (2001:1): *"the word compassion means 'to suffer with.' Compassionate care calls physicians to walk with people during their pain, to be partners with patients rather than experts dictating information to them."* This view resonates with the experience of the Respondent 21 that:

> *We can sit down and convince you, and force you a lot, address the spiritual part. But what you remain with it as a parent or a woman who feels guilty for the rest of their life. So, I believe that they should be allowed to exercise that spiritual dimension. And also, medical personnel must also be trained because sometimes we dictate, we just feel like hey, these things we are telling you it's going to kill you. And we don't consider that this can have long term psychological repercussions. And belief repercussions because when you feel guilty, in terms of your religion, then psychologically we've caused you problems, like for a long for probably the rest of your life, if we don't have to come around and deal with the situation.*

However, Puchalski, (*ibid*) reiterates that compassionate care involves serving the whole person-the physical, emotional, social, and spiritual. Such service is inherently spiritual activity. On the same vein, McDowell and South (2017:1) agree that: *"The spiritual dimension, in a bio-psycho-social-spiritual model, considers a person's values and meaning in life; and may include the concept of transcendence, which suggests a guiding force outside of self and a belief in God or a higher power."* Similarly, Kliewer (2004:616, 621) asserts that, *"an appropriate model for addressing patients' spiritual concerns should include active-listening skills, identification of spiritual/emotional issues, effective referrals to 'spiritual specialist,' and ongoing communication about this aspect of healing process."* However, primary data analysis and interpretation, shows the disjointed levels of care (Chart 3) on health care provisions in the PHC settings:

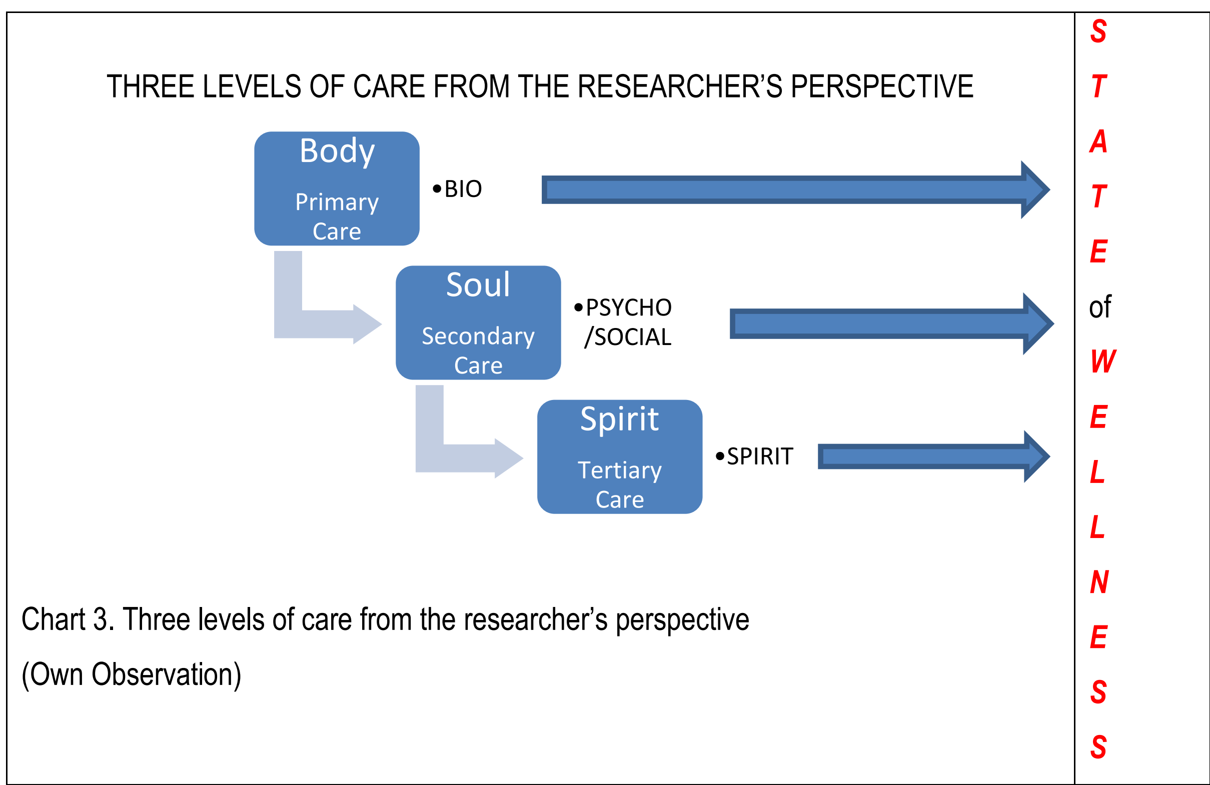


Chart 3. Three levels of care from the researcher's perspective

(Own Observation)

5.8.1 Primary care level

According to Haynes (2007:5): "Biomedical position has been to leave spirituality out of medicine." Similarly, Willemse et al. (2017:62) concurs that: *"The primary focus on the treatment of clinical symptoms may impede the understanding of the spiritual needs of patients."* The view of Respondent 10 resonates that:

> *The hospital is mainly focussing on, medical issues and regardless of the religion or a thought or the belief and the opinion of the patients. I can give an example of the*

> *thought eh and the religion. These people they come, they have their different, religions, but we're not asking them, their belongings, and we're not asking them, what do they think it can help to uplift their health.*

A similar view was shared by Respondent 13 that:

> *Like human beings are not only the physical of each, when they are in hospital we focus on this physical part of them, but they also have psychosocial issues and the spiritual dimensions attached to them and with their different beliefs it influences their health care as well, on their wellbeing. So, I think the chaplaincy will be a good idea because then it will also cater the spiritual part of the human being and not only focussing on one dimension.*

Therefore, this study confirms that the focus of the SA DoH is to address the patients' medical related challenges through primary health care.

Notwithstanding, the NHS (2015) states: *"Chaplains in primary care can have an important role in staff support, both individually and as a community of workers."* This view was echoed by Respondent 21 that:

> *I think we need this kind of expertise because health care facilities- I mean are run by health caregivers who are trained in looking after the body, the physical side of things, or maybe the psychological. But the spiritual and the religious part of it is most- of the time- it's neglected. And I think personally there are certain things that, maybe they manifest physically, but the main roots are spiritual.*

Similarly, Respondent 9 shared this view on professional chaplains: *"They are trained in this, they've got the knowledge, then it will be done in a, in a practical or a feasible way, because the chaplaincy will know exactly what to do."* Furthermore, Respondent 10 mentioned that:

> *Actually, there is a dire need, because, if we can look, 60% if not 80% of the conditions they are spiritually related. I can give example of such cases. People are admitted due to para-suicide, people are admitted due to psychiatric conditions, and people they have, stress related conditions, maybe a person has been diagnosed with diabetes, hypertension, but their conditions are not improving because spiritually they are not working, of which we can see, you can realise that we are working in circles, we are not helping at all. So, the chaplains, the chaplaincy in the institutions, will be of great, great, help to a patient.*

Therefore, this study (from the participant's observations and interviews) confirms that chaplaincy can play a critical role at the primary care level.

5.8.2 Secondary care level

Studies confirm that secondary care is rooted in a holistic treatment and a contemporary patient-centred care, (Cook 2004:63; Galek et al. 2007:364; Haynes 2007:5; Orton 2008:116). This view was shared by Respondent 7: "You find that the doctor is referring this way, say maybe the patient need to take the treatment, and you find that the patient wants to exercise his belief, you find that he doesn't want to take treatment, it's not his belief, he believes that if I go somewhere else, if I see my pastor, if I, you know, and then it's becoming difficult to trace them because they end up giving wrong information. When you trace them they are no longer to be found, because they are running away from treatment. They think that the treatment is not doing any good." However, this study confirms that the Health system and Belief system in SA, are asymmetrical and operating in silos, to provide a holistic health care to the patients.

Therefore, it would be best if the secondary care level is synchronised, as Respondent 9 shared this viewpoint: "I think, we will be nursing our patients in totality, comprehensively, if this is implemented because now we are lacking on that one, but if it is introduced then we will be looking in totality, comprehensively, because life is not about the physical being only, the spiritual being should be also entertained." This bring us to the critical question: "Why is chaplaincy excluded in the SAGH settings?"

The chart (3) above reflects a threefold level of care. However, the researcher observed and confirmed through this study, that the Health care in SAGH is provided on two levels: the primary and secondary levels. The first level, Bio (life) is focussed on the patients' medical conditions of care, and there are doctors and nurses appointed as core staff to respond and provide the required care. Similarly, the second level of care is focussed on the Psycho-Social needs of the patients, and there are psychologists, psychiatrists and the medical social workers who are appointed to provide such services. Therefore, this translate into a medical model which embraces the Bio-Psycho-Social (BPS) dimensions of care. Therefore, the Spiritual level of care is not embraced in the SAGH health care treatment plans. This approach can be comprehended through the concept of a bicycle (structure mounted on two wheels) in its operation. This notion of a bicycle implies that the Health system is structured and modelled in such a way that it only responds and addresses the patients' physical and psycho-social related challenges. Conversely, the patients' spiritual dimension of care which is rooted in a Belief system is not embraced.

This study found that the establishment of chaplaincy will translate into a tertiary care level, as a response to address the critical patients' religious and spiritual challenges in the SAGH settings. This approach which embraces all dimensions of being human, can therefore be comprehended through the concept of

a tricycle (structure mounted on three wheels) in its operation. This notion of a tricycle implies that the global modern health care model (BPS-S) that is currently employed in many developed countries as a response to provide a holistic, patient-centred care, must therefore be adopted in the SAGH settings, so that we do not reinvent the wheel. Therefore, a tricycle notion, brings a different dimension of care to ensure that the workload is shared equally (in a balanced way) without compromising the nature and character of the other dimensions. However, this study discusses a proposed contextual, applicable and effective model on how the SAGH health care teams can provide a holistic and a patient-centred care.

This resonates with the viewpoint of Respondent 21:

> *The medical fraternity doesn't have answers for everything. There are instances where they want to stop a patient from interacting or doing whatever they believe in, or practicing what they believe in, or else we've already told them sorry there's nothing that we can do, we are just palliative or buying time, so that you are comfortable. And other people as they take part into those, they get uplifted and some believe well I'm being healed. That's what they believe in.*

However, secondary care level is critical in that the patients may refuse or accept the hospital treatment. Therefore, Respondent 9 shared this viewpoint, on having the services of chaplaincy:

> *Eh my view is that, the patient then will have the, an informed decision because, sometimes patients take decisions, without proper guidance, and sometimes they will regret later, to say I shouldn't have done this. But if the spiritual part of it, is considered, then this patient will have an informed decision.*

No single profession can claim sole responsibility on the provision of a holistic, patient-centred care. Therefore, health care professionals must work together in the SAGH settings to provide quality health care to all the South African citizenry. This view was shared by a patient, Respondent 23: "*Yes, it is very important if they are united to be one team, so that they are able to help this nation of South Africa."*

5.8.3 Tertiary care level

The researcher asked the participants to share their views on embracing the patients' religious and spiritual needs in the treatment plans. The respondents shared a common view that they must be embraced. However, Respondent 19 shared this viewpoint as a concern: "So meaning it should now, maybe the plan should now be incorporated within the medical model? I think they'll still be challenges to incorporate it into the medical model. What is it that we will be treating? We are in a hospital. Okay we've incorporated all these, so here what is it that we are treating? …So now we have incorporated it in

the treatment plan, we have our wonderful pastors, we have our wonderful traditional healers, how are going to regulate them? And we also need to stipulate on which level are we bringing it on?" Similarly, Respondent 14 mentioned: *"Clinically I mean, medically you can only deal with a person to a certain extent. But spiritually our hands are tied. But in my view who can then assist that, to that particular level?"*

According to Howell et al. (2017: 157), *"Clinical providers such as physicians and nurses agree that it is important to address the spiritual needs of their patients, and health care chaplains are the primary spiritual care providers in hospital settings."* As Willemse (2017:62) puts it that: *"Integral care means that spiritual care is interrelated with physical and psychosocial care and not limited to spiritual rituals."* Harding (2008:112) highlights that: "The word 'spirituality' carries the connotation of an individual seeking connection with an 'other' being, greater than oneself and one's own relationship with the 'transcendent.'"

This study found that the establishment of chaplaincy in the SAGH settings is critical to bring synergy between the Health and Belief systems to ensure that a holistic patient-centred care is provided. Currently, the tertiary care level in the SAGH settings is not embraced in the patients' treatment plans. Respondent 12 highlighted this viewpoint:

> *Now most of the conditions, some diseases, you might find that they are from the spiritual part of it. If I'm not content, or there are other problems or I'm not getting you know, your spiritual is part of healing you also need that so that, you know some of the things, you just need that, and the person will be well. Things like your psychosomatic diseases, they need spiritual, they need psychological treatment. So, the treatment need to be holistic.*

Respondent 13 shared this critical viewpoint that:

> *It will be looking at the patient as a whole, not specifically on the physiological and the physical aspect of human being, as health involve also the spirituality of the patient. So, I think it will be of a benefit to the patient as well, and it will be very helpful for them, during the healing process.*

The researcher's understanding of the tertiary care level (Chart 3), is informed by the phenomenon of chaplaincy as a profession which is responsible to provide expert religious and spiritual care in the health care settings (within the multi-disciplinary health care teams). Therefore, this study shows that in global modern health care chaplaincy, there are specific qualifications and requirements which must be satisfied for the appointment and regulations of the practice of chaplains in the health care settings. For example, (HCC, 2010) highlights the process of certifying the professional chaplains; the level of qualification; endorsement by religious community; the number of hours in the CPE; and the interview with peer review

committee, among others. However, there is no health care chaplaincy in South Africa (save for law-enforcements). The researcher's five-fold critical stages, (Chart 4) below, explores a process which is aimed at the establishment of chaplaincy in the SAGH multi-disciplinary health care teams. These high global modern chaplaincy norms, principles and standards of practice are critical to ensure the chaplains do provide quality care. Therefore, these requirements for chaplaincy practice, if adopted, allay the respondents' fears of embracing the patients' religious and spiritual needs in the treatment plans. This study discussed five-fold critical stages towards the establishment of chaplaincy (Chart 4):

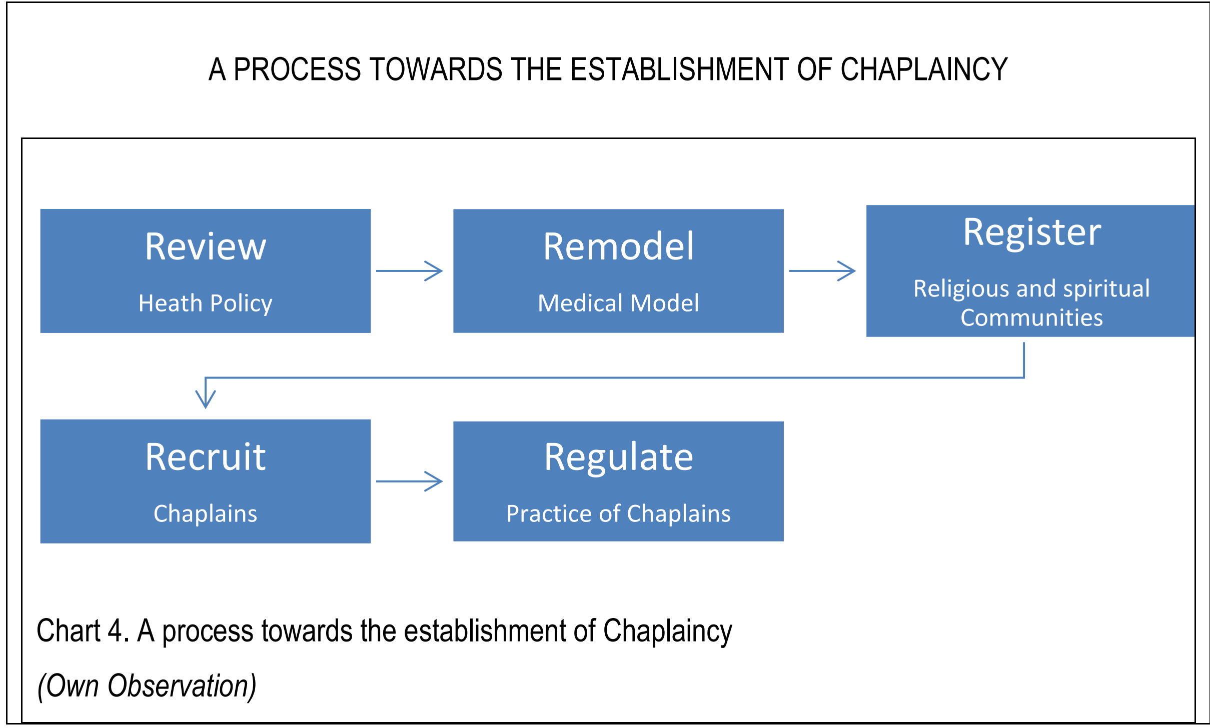


Chart 4. A process towards the establishment of Chaplaincy

(Own Observation)

According to Orton (2008:114-115), *"Religion involves an organized belief system with agreed practices and rituals."* And chaplains provide the religious and spiritual care. However, it is a misnomer to view chaplaincy through the prism of traditional healers. Chaplaincy should not be misconstrued with traditional healers. This study confirms that chaplaincy responds and address the patients' religious and spiritual needs through prescribed ethical principles, norms and standards of practice. During the interviews on regulating the practice of chaplaincy, this view was shared by Respondent 3 that:

> *Somebody who is in that position, a chaplain would need to have that understanding, that these people are coming from diverse background. But having said that, once we regulate it, it's that, I've said it must not be forced on patients. So, it must be patients agreeing that you know I need to talk to a priest, you know I think this, that priest can come to talk to me, which is what I think should happen. A priest comes wants to talk to people in a ward, my view is: 'Let's not just take this priest to that ward. Let's get the consent of this patient. Let's have this patient agreeing, the patients, the priest can come.' So, that if there are those who are saying: 'no I don't want to listen to that man,'*

we're able to respect their wishes. So, like I'm saying you don't bring a patient here from home and you're forcing them into things that they don't want to.

The researcher comes from a Christian background, is an ordained minister, and a former chaplain in the SAPS. The chaplaincy norms, principles and standards of practicing Christian ministry, resonates with the three-fold ministries discussed in this study: Ministry of Presence (Jesus), ministry of Paul, and ministry to Patients. The same principles encapsulated in these ministries applies even today in that Jesus confirmed that He came to do the will of His Father, and by Himself He can do nothing, (John, 5:19-30). Similarly, the ministry of Paul applies and subscribes to the same principles, by following the example of Jesus, (1 Corinthians, 11:1; Philippians, 4:13; 1 Corinthians, 9:19-23). On the same vein, the ministry to Patients applies and subscribes to the same principles, by imitating God, and following the examples of Jesus and Paul, (Ephesians, 4:4-5;5:1). Jesus said that He did what the Father told Him to do, Paul said that he was doing what the Holy Spirit told him to. Similarly, the ministers of God in chaplaincy, are also expected to do what the Holy Spirit tells them to do, (Ephesians, 5:1; John, 13:15; 1 Corinthians, 11:1), by responding to a deeper human need at the tertiary care level, a need for eternal salvation, (John, 4:1-42).

5.9 PRELIMINARY CONCLUSION

This chapter reflects on the findings from the research questions and the objectives of the study. The researcher observed how the patients' religious and spiritual needs were addressed in the PHC settings. The chapter also reflects on the observations and the responses of the managers, the caregivers and the patients at PHC settings. The chapter further reflects on the Theological, ethical, and good practice of chaplaincy in line with PTI (Osmer 2008): What was going? Why was this going on? What ought to be going on? How might we respond?

- The study found that there is no health care chaplaincy in the SAGH settings. The exclusion of chaplaincy in the SAGH settings may be attributed to the following challenges:
- The South African Health Care (SAHC) policy which does not embrace the religious and spiritual dimensions of care.
- The Medical Model which is not responsive to the patients' religious and spiritual dimensions of being human.
- The Health System and Belief System which are operating independently, in silos, and are not interfaced into a holistic, patient-centred health care model, and

- The non-existence of a Religious and Spiritual Statutory Body to ensure that chaplaincy is regulated, and the health care chaplains are registered with the aim of practicing in the SAGH's multi-disciplinary health care teams.

However, the researcher's view is that, the establishment of health care chaplaincy in the SAGH settings for a holistic approach to care is imperative, to ensure that all dimensions of being human are addressed. Therefore, professional modern health care chaplaincy may play a critical role in the SAGH settings by dovetailing Health and Belief Systems into a model that embraces all the patients' dimensions of being. Secondly, this chapter presents a proposed chaplaincy model that can be implemented in the SAGH settings, with a view to respond and address the patients' religious and spiritual needs within the health care teams. This model reflects an application of chaplaincy through the Ministries of Presence, Paul and Patients in health care. The researcher further discusses the role of chaplaincy in the threefold levels of care. The next chapter evaluates the study, makes some recommendations, and concludes the study.

CHAPTER 6

EVALUATION, RECOMMENDATIONS AND CONCLUSION OF THE STUDY

6.1 INTRODUCTION

This chapter provides an evaluation, recommendations and the conclusion of the study. The study answered the question on a need for the possible establishment of chaplaincy in South African Government Hospitals for a holistic approach to care.

Firstly, the evaluation of the study was done with a view to determine if the purpose and objectives of the study were achieved, from data analysis and interpretation, leading to the research findings (outcome).

Secondly, the recommendations are made from the research findings with a view to address a need for the possible establishment of healthcare chaplaincy in South African Government Hospitals (SAGH) for a holistic approach to care that includes patients Religious and Spiritual dimensions of being.

Thirdly, to conclude this study the following were to be revisited: (1) The research problem was based on why chaplaincy (as the religious and spiritual experts) is excluded in the South African Government Hospital settings, as part of the multi-disciplinary health care teams, responsible to address the patients' religious and spiritual needs in the health care and treatment plans? (2) The purpose of this research was to investigate the need for the possible establishment of chaplaincy in South African Government Hospitals for a holistic approach to care that includes patients' religious and spiritual dimensions of being. (3) The study was aimed at developing a holistic, patient-centred model of chaplaincy, that will respond and address the patients' religious and spiritual needs in the SAGH settings. (4) The objectives of this research were; To explore why chaplaincy is excluded from the SAGH settings for the patients' religious and spiritual dimensions of being, with a view to investigate a need for the possible establishment of chaplaincy, to explore chaplaincy roles and values (within health care teams) in the SAGH settings, and to develop a chaplaincy model that embraces a holistic approach to care in the SAGH settings.

6.2 SUMMARY OF FINDINGS

The findings of this study are based firstly, on the researcher's observations at the PHC research field. Secondly, the findings are developed from the gleaned views of the research participants through the analysis and interpretation of data, to address the topic of this research. However, the study achieved its purpose by confirming that there is a need for the possible establishment of chaplaincy in the South

African Government Hospital for a holistic approach to care that includes patients' religious and spiritual dimensions of being. The purpose of this study is in tandem with the achievement of the following objectives: Why chaplaincy is excluded in the health care settings to address the patients' religious and spiritual needs? What are the roles and values of chaplaincy in the SAGH settings? What kind of chaplaincy model can be developed to embrace a holistic approach to care in the SAGH settings?

The following points capture a summary of the researcher's participant **OSERVATIONS** at the PHC settings:

- **O**versight: The researcher observed that there were no oversight, supervision, and monitoring conducted at the PHC on the religious and spiritual leaders who provided care to their clients during the visiting times.
- **B**elief and health systems: The researcher observed that the patients' belief system operate independently from the health system, which is antithesis of a holistic, patient-centred approach to care.
- **S**piritual and religious needs: The researcher observed that the patients and the caregivers have spiritual and religious needs. However, the caregivers were conducting morning devotions when they report on duty, whilst the patients had their own way to empower themselves spiritually, for example, by prayers.
- **E**valuation: The researcher observed that the patients' religious and spiritual interventions (including traditional) were not evaluated to determine the impact it had on the treatment and health care journeys.
- **R**eferral hospital: The researcher observed that PHC is a referring hospital, and Mankweng hospital. Therefore, the patients used a common patient-planned transport to travel to, and from the hospital. However, the researcher observed that there was lack of religious and spiritual activities on site, since there is no chaplaincy to provide the patients' religious and spiritual care, and to render supportive care.
- **V**enue for religious and spiritual activities: The researcher observed that there are no designated venues (room or chapel) where the patients, the families and others, may perform their religious or spiritual rituals.
- **A**ssessments and screenings: The researcher observed that there are no religious and spiritual assessments or screening done. The hospital system only captures patients' demographics, which embraces beliefs.

- **T**reatment plans: The researcher observed that the treatment plans were done based on the Western medical approach. Therefore, the patients exercised their right to refuse hospital treatment, if need be.
- **I**nterventions: The researcher observed that there were patients who requested prayers for divine intervention before they can be taken for any procedure, more specifically surgery. Since researcher was a participant observer, some of the patients approached him to pray for them, others for their frail children.
- **O**bservances: The researcher observed that there were no religious or spiritual observances conducted at the PHC. However, when the researcher conducted Easter devotion at the PHC for the caregivers, and he visited the sick in the wards, the recipients (caregivers and patients), appreciated those services.
- **N**o religious or spiritual caregivers: The researcher observed that there are no religious or spiritual caregivers in the health care treatment teams at PHC settings. However, the researcher observed a need for chaplaincy, when visiting the wards.
- **S**upport groups: The researcher further observed there were support groups of mothers whose children were hospitalised for treatment and care at PHC settings. One mother confirmed that they encourage one another by coming together, share the Word of God, and conduct joint prayers on behalf of their sick children. In one incident, the researcher prayed with the mothers at the children's ward who were in a support group. Another group were mothers whose children were at oncology, and they had to be there to provide care and support to their children during the scheduled times. The researcher could offer intercessory prayers with this group of mothers, and they appreciated this supportive role. The third group were cancer patients at the oncology ward where the researcher provided pastoral support and devotion.

The following sub-topics captures the essence of the synoptic views from the research findings:

6.2.1 The Patients' Rights Charter

The patients in the SAGH settings are allowed to exercise the obsolete rights (not provided in the health care settings) as opposed to absolute rights (patient-centred approach) when they should decide on the type of treatment and care they would need, which does not embrace their religious and spiritual needs. Therefore, the patients accept or refuse hospital treatment (RHT) due to lack of an institutionalised religious or spiritual care. The study has shown that most of the patients treated at SAGH, when they come back to the hospital for further treatment, they are in a worse medical condition than when they left.

However, many views from the respondents confirmed that the people should get the health care that they need. On the same vein, the patients' right to choose the religious or spiritual care which is embraced in the treatment plans and care is imperative. Therefore, the study found that if these services are provided in the SAGH settings, it would address the institutional challenges of the patients who insist to be released, to seek for the religious or spiritual help which is provided outside the SAGH settings. This is the antithesis of a holistic, patient-centred care in that, the human spirits of the patients seek for inner peace which is beyond the limitations of suffering, with a view to cope with their everyday life challenges.

6.2.2 The Health Care Policy

The Constitution of the Republic of South Africa of 1996 is the supreme law of the country. The health law and health policy are derived and regulated from the RSA Constitution. Therefore, the right to access health care services is a basic human right. Section 27 of the Constitution of the RSA provides tools to ensure that, the health care policy and practices respond to the needs of the South African citizenry.

This resonates with WHO (2010) five key components of a well functioning health system:

- Improving the health status of individuals, families and communities
- Defending the population against what threatens its health
- Protecting people against the financial consequences of ill-health
- Providing equitable access to people-centred care and
- Making it possible for people to participate in decisions affecting their health and health system.

The study found that the Health and Belief systems in the SA health care context, are world apart in terms of providing a holistic, patient-centred care (which embraces all dimensions of being human) in the SAGH settings. This challenge is attributed to the SA Health policy not recognising the professional modern chaplaincy (as the religious and spiritual health care experts) and the religious and spiritual communities not having a statutory body responsible to register and monitor the practice of chaplains in the hospitals.

However, the study confirms there is an urgent need to begin a process of reviewing the SA Health policy. The critical role players must all be involved (including participation from all the consumers of care) in the decision-making, because these changes will affect their health care and treatment, directly or indirectly. Therefore, the review of Health policy is imperative to ensure that a common approach to health care and treatment is employed, to respond to the patients' religious and spiritual needs, and to provide a holistic, patient-centred care that embrace the services of health care chaplaincy in the SAGH settings.

6.2.3 The need for Chaplaincy

The study confirms that there is a dire need for the establishment of chaplaincy in the SAGH settings. The views expressed by the respondents confirmed that health care chaplaincy can play a crucial role to ensure that the patients' religious and spiritual care is addressed in the SAGH settings. Some views touched on the critical health care tangents which are evidenced from the patients' relapsing; disappearing without any trace from the health care and treatment; and refusing hospital treatment in the SAGH settings. This challenge is because of the SA medical approach not embracing the religious and spiritual needs of the patients in the health care and treatment planning. This translates into health care chaplaincy not being recognised by the DoH to practice religious and spiritual care in the SAGH settings.

However, studies show the evolution of a global, modernised, professional, research-driven, evidence-based health chaplaincy has moved from a situation of assumption of presence to a need to affirm a case for chaplaincy. Therefore, there is an ever-growing need to incorporate the religious and spiritual needs of the patients in the hospital treatment plans and care. Similarly, South Africa, as part of a global health care village, has no mechanisms that respond and address the innate human need in the SAGH settings.

6.2.4 The establishment of Chaplaincy

The researcher highlighted that there are chaplaincies in the South African law-enforcement agencies (DCS, SANDF, and SAPS). However, there is no chaplaincy in the South African hospital settings. Therefore, the focus of this study was to investigate a need for the possible establishment of chaplaincy.

The global health care trends have shown that in the hospital settings, the religious and spiritual care is provided and coordinated by the professional chaplains. Therefore, the responses of the participants at the PHC research field were critical in the context of this study, to determine whether there is a need for the possible establishment of chaplaincy in the SAGH settings. However, the study confirmed that there is indeed a need for chaplaincy, to provide the patients' religious and spiritual care in the SAGH settings. The interviewed caregivers shared a common view that the establishment of chaplaincy will be a response towards addressing the fundamental challenges of the patients' innate religious and spiritual needs in the SAGH settings. On the same vein, the inclusion of chaplaincy in the multi-disciplinary health care teams will play a critical role to address the challenges of patients' who refused hospital treatment; who relapse from the treatment; who are not having any visits from their families and friends, and therefore feel lonely; provide supportive care to the caregivers, among others. Conversely, the health care policy and the medical model do not embrace the religious and spiritual needs of the patients. Hence

the analysis and interpretation of gathered data, were employed as tools to guide a process towards the transformation of the Health Care System that would respond to the patients religious and spiritual needs.

Chaplaincy is about providing compassionate care to fellow human beings. It is a service of compassion. However, since the SAGH settings do not have chaplains in the health care teams to provide the religious and spiritual care, it was very crucial to explore the process towards the establishment of a professional health care chaplaincy. This process captures the following five-critical transformational changes or key points that ought to be addressed in order to achieve the aim of establishing chaplaincy: The review of Health policy; remodelling of the medical model; the registration of chaplains with the recognised statutory body; the recruitment of chaplains; and the regulation of the practice of chaplains in the SAGH settings.

6.2.5 The roles and value of Chaplaincy

The study confirms that the patients who request to access the services of a health care chaplaincy must be allowed to do so. However, other respondents stated that they are not comfortable dealing with ethical challenges like termination of pregnancy because of their own beliefs. Similarly, many views of the respondents affirmed that chaplaincy can play a crucial role to ensure that the patients' religious and spiritual needs (embraced in the hospital treatment plans) are addressed in the SAGH settings.

The hospital chaplains work synergically with the relevant stakeholders to provide a coordinated care to the patients. They assist and support staff in their dealings with patients and in coping with their ethical complexities of modern health care. Chaplains are often regarded as neutral figures, outside the usual staffing hierachies and thus as sources of help and support that can be accessed without risk of negative repercussions. Chaplains may also play an important role in helping staff members cope with personal problems. Their supportive consultation can enhance morale and decrease staff burnout, thus reducing employee turnover and the use of sick time. Chaplaincy complement the health and the belief systems. Chaplaincy plays the following five key roles:

- **R**eligious care and support: Chaplains provide diverse religious care as neutrals, and are not judgmental.
- **O**rganisational and community: Chaplains champion organisational and community needs in tandem.
- **L**ife or bioethical: Chaplains provide guidance in life and death situations as religious and spiritual leaders.

- **E**thical and moral: Chaplains practice within the confines of the ethical norms, standards and principles.
- **S**piritual care and support: Chaplains provide diverse spiritual care as neutrals, and are not judgemental.

Chaplaincy adds value by:

- **V**isits: Chaplains visit clients and provide support and therapy to the needy (without violating their rights).
- **A**dvocacy: Chaplains provide advocacy on behalf of the clients (patients, families and their relatives).
- **L**eadership: Chaplaincy provides leadership on the religious and spiritual matters in the clinical settings.
- **U**nwind tight religious and spiritual beliefs: Chaplains unwind tight beliefs that may be counter-productive.
- **E**mpathic listening: Chaplains provide priestly listening skills in response to the clients' needs (grief, loss).
- **S**taff support: Chaplains provide support to the hospital staff (personal, family or work-related challenges).

6.3 THE MODEL OF HEALTH CARE

The study found that the South African Health System (SAHS) employs a Western medical model to treat and care for the patients in the SAGH settings. This systemic challenge has become an impediment in the South African context to ensure the establishment of chaplaincy (as expert providers of the religious and spiritual care) to address the holistic needs of the patients. Similarly, chaplaincy is not registered as a profession, with a view to practice the religious and spiritual care in the SAGH health care teams. However, the Beliefs System (religious and spiritual communities) is operating independently to provide the patients' religious and spiritual care. The study highlight that these two Systems (Health and Belief) need to be synchronised into a model that embraces dimensions of being human (Body, Soul and Spirit).

6.4 SUGGESTIONS FOR FURTHER RESEARCH

The study focussed on the investigation into a need for the possible establishment of chaplaincy in SAGH for holistic approach to care which includes the patients' religious and spiritual dimensions of being.

Therefore, the study looked at an innate, intrinsic, inherent basic human need for the religious and spiritual dimensions of care which is not embraced in the health care settings for treatment and care. This need was critical to inform the possible establishment of chaplaincy, as religious and spiritual experts in the SAGH multi-disciplinary health care teams. However, the study focused on chaplaincy establishment.

Firstly, further research on a need for the establishment of chaplaincy, can be conducted in the broader SAGH context (all provinces), since this study was confined to the PHC settings and included a small research sample. Therefore, future researchers may explore the need to establish health care chaplaincy in the SAGH settings, aimed at addressing the patients' religious and spiritual health care needs, through the expert services of a professionalised, modern health care chaplaincy, as part of the health care teams.

Secondly, future researchers may explore the evidence-based chaplaincy practice in the context of the SAGH settings (after health care chaplaincy is established), to enhance the treatment and care of the patients. The purpose of such a study need to be on chaplains' empowerment with a view to ensure a research driven profession, that provides quality care to the ever-changing religious and spiritual needs, in tandem with the patients' rights, and in resonance with the ethical principles to provide such services.

Thirdly, future researchers may conduct empirical studies on the clinical approach to provide specialised spiritual care to the palliate patients, to the patients in the ICU, and other critical hospital units or wards that require such kind of services. Studies has shown that the health care is evolving, and the health care systems and models are adapted to respond to these challenges through innovative methods of treatment and care. However, the relevancy of chaplaincy as a profession in the multi-disciplinary health care teams, depends on its advancement, specialised and innovative empirical research studies, that will respond and address the spiritual needs of the patients in the context of the fourth industrial revolution. Swinton and Mowat (2008:18) employs a concept of 'techno-theology' in that, sources of information with other social sciences are combined, with a view to develop specialised techniques to ensure that the practice of chaplaincy is put into the service of God, with a view to maintain high professional standards.

Fourthly, future researchers may explore the modalities of a holistic health care that synchronises the traditional and the religious and spiritual healing in the health care settings, which are not counter-productive to, but complement the medical model. Studies show that South African cultures recognise a holistic relationship between the emotional, spiritual and physical state of someone's condition, even when facing the challenges of health, illness and death. However, the findings of this study confirmed that some patients sought alternative treatment outside the hospital settings, and have consulted with the

relevant healers for their religious and spiritual needs. Therefore, such a study need to explore how distinctive patient-centred needs are addressed (medical and traditional/religious and spiritual approaches) within the SAGH settings, to be proactive in responding to the cultural and religious and spiritual belief systems which influence the patients' decisions on choices of the health care and treatments they need or prefer.

Fifthly, further research may be conducted on the impact of the religious and spiritual care on the patients (patient-led) who are hospitalised and treated at the SAGH settings, after receiving such chaplaincy services. Therefore, the patients' health care records, (well documented and employing acceptable ethical principles, norms and standards) which embrace their religious and spiritual screenings, assessments and interventions done by chaplaincy, are properly analysed and interpreted to measure its impact.

6.5 RECOMMENDATIONS

The study found that there is a need to establish health care chaplaincy in the SAGH settings for a holistic and patient-centred care, with a view to address the religious and spiritual needs in the treatment plans and care. Therefore, the DoH and the Faith Based Communities (FBC), and all the stakeholders need to collaborate in drafting of a Health Policy that embraces all the dimensions of being human (body-soul-spirit).

The following ten recommendations are based on the research findings that the legislation on human rights provides for the right to freedom of conscience, religion, thought, belief and opinion. The patients' rights to considerate care in the SAGH settings need to be respected (embrace spiritual worldviews). Therefore, patients need to exercise their health care choices in tandem with the NPRC, which resonate with their South African democratic values and belief system.

- It is recommended that the workshops on human rights be conducted for the health caregivers at the SAGH settings, with a view to enhance their knowledge and understanding of the patients' rights to considerate care. These workshops will help the DoH from lawsuits, and empower the caregivers to be pro-active in responding to patients' rights as embraced in the health care policy.
- The Hospital Management needs to create a system that captures the screening and assessments of the patients' religious and spiritual needs, for the purposes of planning for treatment and care. It is recommended that the DoH develop the screening and assessment forms that will be used as tools or instruments to capture the patients religious and spiritual needs

in the SAGH systems. The caregivers (particularly social workers) need training to assist in the capturing process.

- The DoH need to adopt a holistic, patient-centred, more adaptable model of modern chaplaincy, to ensure that the patients' beliefs and practices are integrated into the SAGH treatment plans and care. The health care settings need to be conducive climates which embrace these beliefs. It is recommended that a one-stop (a holistic) approach be implemented in the SAGH settings, for the patients' consultation purposes, regarding their needs for their health care services.
- The Hospital Management and the Boards need to embrace a standard of practice (as prescribed by the envisaged regulatory religious and spiritual body, responsible for registration, certification and standardising of chaplaincy practice), when recruiting and appointing the chaplains in the SAGH health care teams, (guided by the prescribed policy directives). Therefore, a pilot project is recommended, to establish chaplaincy in the SAGH multi-disciplinary health care teams.
- The Hospital Management and the Boards need to make provisions (within the prescripts of the revised health care policy), for the designated rooms or office space to be used as chapels, which can be accessed by the caregivers, the patients and their families for the religious and spiritual practices or rituals. It is recommended that the DoH, in the plans for development and upgrading of the SAGH facilities, need to consider including such structures in the new plans.
- The patients and their families need to be allowed to participate in their religious and spiritual rituals and observances, (within the prescripts of the health care policy) in the hospital settings. It is recommended that the envisaged chaplaincy office be responsible to arrange, to organise, to facilitate and to officiate the religious and spiritual observances, in consultation with the religious and spiritual leaders, the patients and their families, provided there is such a need and their requests meet the prescribed requirements. Similarly, chaplaincy need to address other religious and spiritual needs, (need-led) for the patients, their families and the health caregivers, (for example, offering prayers, devotions and others) in line with the chaplains' job-descriptions.
- The Hospital Management and the Boards need to make provisions (within the prescripts of the revised health care policy) to create a desk for the religious and spiritual community of faiths in the SAGH settings. It is recommended that the DoH establish a religious and spiritual desk in the SAGH settings, and appoint a suitable candidate, who will be responsible to coordinate among others, the hospital visits, (in liaison with chaplaincy, for authenticating visitors) and the referrals of the patients. The aim of this desk will be the application of a standardised, structured and synergised approach to address the patients' needs, and the provision of professional services. This desk will also play a critical role to partner with the different hospital ministries for support.

- The religious and spiritual community of faiths need to work in synergy with chaplaincy with a view to provide the patients' religious and spiritual care and to ensure a harmless, synchronised application of ethical approach which is not counter-productive to the revised medical approach. It is recommended that the envisaged office of chaplaincy initiate and conduct awareness campaigns with the religious and spiritual communities of faiths with a view to enlighten and empower them on the purpose of health care chaplaincy in the SAGH setting, and how the faiths' communities can partner with chaplaincy and the SAGH to provide the patients' care and support.
- The caregivers (doctors and nurses as core staff) need to be trained (within the prescripts of the revised health care policy), with a view to broaden the understanding of the patients' customs and rituals practices, (for example: prayer, meditation, anointing, sacraments of holy communion and baptism). This training is aimed at equipping the caregivers and to enhance interdisciplinary perspective on religion, spirituality and chaplaincy; to be fully informed and more attuned to the patients' health care needs, expectations and wishes; and to be responsive to the complex and diverse needs of the patients' spiritual worldviews without being judgmental and prescriptive. It is recommended that the envisaged chaplaincy office be responsible to provide such training.
- There is a need for an institution that will train and develop the chaplains (as professionals) in the practice-guiding disciplines as required skills for clinical approach in the health care settings. It is recommended that the DoH consult with the Department of Higher Education (DoHE) and the religious and spiritual communities with a view to address this challenge of training chaplains. However, other independent training facilities who are accredited to provide such training and impart the relevant knowledge and skills to health care chaplains can be approach in this regard.

6.6 CONCLUSION

This chapter presents the conclusion of this empirical study, summarised the findings, proposed further research, make the recommendations on the outcome of the findings, and presents the conclusion. The researcher was a research participant during data collections from the observations on how the religious and spiritual needs were addressed at the PHC settings, and from the interviews conducted with the research participants to address the research topic: The observations were critical for the researcher to understand how chaplaincy can be established and function in the SAGH settings since there are no health care chaplains. Therefore, the researcher came to the research field (PHC settings) with an open mind, and he was willing to learn as much as possible from the study, without relying too much on prior knowledge and experience of over twenty-five (25) years in SAPS chaplaincy. However, this experience and knowledge came in handy. Similarly, the research interviews with participants were critical to provide

an answer on a need for the possible establishment of chaplaincy in the SAGH settings, which then informed the reasons for its establishment, with a view to address the holistic needs of the patients which embraces their religious and spiritual needs in the treatment plans.

The study findings touched on the tangents of the basic human rights related to the considerate health care which resonates with the patient-centred approach to health care. The patients are to be given the health care they need within the prescripts of progressive health care policy. On the same vein, the findings addressed the critical hurdles such as the SA health care policy and the medical model that need to be reviewed, to ensure that all the dimensions of human being, are addressed in a structural approach within the health care institutions. Therefore, the researcher conducted secondary research through literature reviews and studied relevant materials on the phenomenon of health care chaplaincy, the global trends on the provision of holistic care which embrace the services of modern, secular, professional chaplaincy in the health care settings, to address the religious and spiritual needs of the patients, and related printed and electronic sources. However, the researcher had to follow sound ethical principles, applied non-judgmental and unbiased approach to the research topic by being open minded, and purposively recruited the participants from all the beliefs' background.

The study achieved its purpose and objectives on investigating a need for the possible establishment of chaplaincy in SAGH settings for a holistic approach to care. The views of the secondary sources and the views expressed by the participants during the interviews at the research filed, were compared, contrasted and synchronised to address the contextual, patients' needs, (from the multi-faiths and multi-cultural backgrounds) in the SAGH settings. The study addressed the process that needs to be followed for the possible establishment of chaplaincy, and highlighted the roles and value of chaplaincy in unifying the Health and the Belief Systems with a view to work in tandem and synergy.

Therefore, should these recommendations be implemented, the patients' religious and spiritual needs could be addressed within the institutional health care settings. This would ensure that the SAGH settings follow and apply a model that is responsive to the patients' dimensions of being human, which includes the professional health care chaplains, as expert in clinical practice of the religious and spiritual care. However, the interviews were conducted on a sample size of 30 research participants. Therefore, this research may provoke a meaningful discourse on the possible establishment of health care chaplaincy in the SAGH settings for a holistic approach to care, among the academic world, the world of the religious and spiritual communities of faiths, the world of health care, and any other role players who might be interested in the phenomenon of healthcare chaplaincy.

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APPENDIX A: CEO LETTER REF. 10/7/2 DATED 13 MARCH 2019

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

PIETERSBURG HOSPITAL

REF: 10/7/2
ENQ: DR Victor S Matabane (Acting Clinical Executive Director)
EXT: 5009

DATE: 13 March 2019

INTRODUCTION OF CHAPLAINCY RESEARCH

PURPOSE
This letter serves to introduce Mr SE Mabe as a PhD student doing research.

BACKGROUND

He has been given the permission to do a study (research) on the feasibility of establishing chaplaincy services within the public hospitals of South Africa. The permission was granted by the University of Pretoria, the Provincial Department of Health and Pietersburg Hospital.

These services are non-discriminatory in nature.

MOTIVATION

In the spirit of being a Tertiary Institution that is driven by research evidence, it should come naturally for us to welcome the researcher into our working environment. This is for our own good and benefit.

The spiritual, legal and financial aspects of health have been neglected for a very long time in our societies. We should be pleased with one of our community members taking charge of this type of ground-breaking research.

He should to be able to produce whatever proof that may be required of him in any area of our hospital.

RECOMMENDATION(S)

I, therefore, recommend that every clinical area and every working area of the hospital should cooperate with this research process.

Dr NA Buys
(Acting Chief Executive Officer)

2019/03/14
Date

EXCELLENCE IS OUR PASSION | Page 1 of 1

APPENDIX B: LETTER OF INTRODUCTION AND INFORMED CONSENT FOR PARTICIPATION IN ACADEMIC RESEARCH

LETTER OF INTRODUCTION AND INFORMED CONSENT FOR PARTICIPATION IN ACADEMIC RESEARCH

Title of the study: AN INVESTIGATION INTO THE NEED FOR THE ESTABLISHMENT OF CHAPLAINCY IN SOUTH AFRICAN GOVERNMENT HOSPITALS FOR A HOLISTIC APPROACH TO CARE THAT INCLUDES PATIENTS' RELIGIOUS AND SPIRITUAL DIMENSIONS OF BEING

Researcher: Rev. Sello Edwin Mabe: PhD Student at University of Pretoria

Contact Number. 079 836 8536. Email address: sello.edwinmabe@gmail.com

Research Ethical Committee name: Manda Smith [Departmental Administrator]

Contact details: +27 (0)12-356 3085. Email address: manda.smith@up.ac.za

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You are cordially invited to participate in an academic research study due to your experience and knowledge in the research area, namely: **"An investigation into the need for the establishment of Chaplaincy in South African Government hospitals for a holistic approach to care that includes patients' religious and spiritual dimensions of being."** Each participant will receive, read, understand and sign this document *before* the start of the study.

Purpose of the study: The purpose of the study is to investigate the need for the establishment of Chaplaincy in South African Government hospitals for a holistic approach to care that includes patients' religious and spiritual dimensions of being. The results of the study may be published in an academic journal. You will be provided with a summary of our findings on request. No participant's names will be used in the final publication.

Duration of the study: The study will be conducted over a period of three months in a Provincial hospital setting (Pietersburg Hospital Campus) and the projected completion date is May 2019.

Research procedures: The participant observation and semi-structured interviews will be used by the researcher to gather data from the policymakers' / hospital management; health care professionals (physicians, nurses, clinicians and social

workers) and the patients who are identified, sampled purposively, and invited for the interviews (transcribed and coded for analysis).

What is expected of you: Participants are expected to be interviewed and to answer the research questions as honestly and openly as possible (interview expected to last between 20-30 minutes).

Your rights: Your participation in this study is very important to understand the research question why Chaplaincy is excluded in South African Government Hospitals' healthcare teams for holistic approach to care. You may, however, choose not to participate and you may also stop participating at any time without stating any reasons and without any negative consequences. You, as participant, may contact the researcher at any time to clarify any issues pertaining to this research. The Respondent as well as the researcher will each keep a copy of this signed document.

Confidentiality: All information will be treated as confidential and participants will be kept anonymous. Data will be used for the purpose it is intended for, and will be kept confidential. The researcher and university of Pretoria Department of Practical Theology will have access to raw data. The relevant data will be destroyed, should you choose to withdraw from the study.

Risks and Benefits: The are no risks in this study because the participants are expected to share their views on their experiences, values, beliefs and cultural practices in the SA Government health care. No participant will be reimbursed for participating in this study. However, the study will benefit the South African Department of Health (SADoH), Government Hospital Caregivers and Patients.

WRITTEN INFORMED CONSENT

I hereby confirm that I have been informed about the nature of this research. I understand that I may, at any stage, without prejudice, withdraw my consent and participation in the research. I have had sufficient opportunity to ask questions.

Respondent: ______________________________

Signature: ______________________________

Contact: ______________________________

Researcher: ______________________________

Signature: ______________________________

Date: ______________________________

VERBAL INFORMED CONSENT *(Only applicable if Respondent cannot write)*

I, the researcher, have read and have explained fully to the Respondent, named ____ and his/her relatives, the letter of introduction. The Respondent indicated that he/she understands that he/she will be free to withdraw at any time.

Respondent: ______________________________

Contact: ______________________________

Researcher: ______________________________

Signature: ______________________________

Witness: ______________________________

Contact: ______________________________

Date: ______________________________

APPENDIX C: RESEARCH QUESTIONS FOR MANAGERS, CAREGIVERS AND PATIENTS

THE RESEARCH QUESTIONS

This investigation seeks to explore two basic research questions:

1. Why is chaplaincy excluded from South African Government Hospitals' (SAGH) multi-disciplinary health care teams as religious and spiritual experts in a holistic approach to care?
2. Is there a need for the establishment of chaplaincy in SAGH for patient's religious and spiritual dimensions of being?

Building from the above two basic research questions

QUESTIONS FOR HOSPITAL MANAGERS

Health Policymakers and Hospital Managers.

These research questions are grounded in the Constitution of the Republic of South Africa (CRSA), 1996.

Chapter 2: Bill of Rights

Freedom of religion, belief and opinion

Section 15(1) "Everyone has the right to freedom of conscience, religion, thought, belief and opinion."

Question 1: What is your view on assessing the patient's religious and spiritual needs to ensure patient-centred care is rendered in the SAGH health care teams / and or treatment plan?

Section 15(2) "Religious observances may be conducted at state or state-aided institutions, provided that:

(a) Those observances follow rules made by the appropriate public authorities;

(b) They are conducted on an equitable basis; and

(c) Attendance at them is free and voluntary."

Question 2: What is your view on patients requesting their religious observances be conducted in the SAGH?

Health care, food, water and social security

Section 27(1) "Everyone has the right to have access to-

(a) Health care services, including reproductive health care

Question 3: What is your view on the patients requesting to access the services of health care chaplaincy in SAGH who are religious and spiritual experts as part of the multi-disciplinary health care teams?

Chapter 10: Public Administration

Basic values and principles governing public administration

Section 195 (1)(e) “people’s needs must be responded to, and the public must be encouraged to participate in policy-making.”

QUESTIONS FOR HOSPITAL MANAGERS

(Health Policymakers and Hospital Managers).

These research questions are grounded in the Constitution of the Republic of South Africa (CRSA), 1996.

Question 4: What is your view on embracing the patients’ religious and spiritual needs in SA Health policy?

Section 195 (2) The above principles apply to- (a) “administration in every sphere of government.”

Question 5: What is your view on SAGH responding to the religious and spiritual needs of the patients?

Section 195 (4) “The appointment in public administration of a number of persons on policy considerations is not precluded, but national legislation must regulate these appointments in the public service.”

Question 6: What is your view on appointing the chaplains in SAGH multidisciplinary health care teams?

Public Service

Section 197 (1) “Within public administration there is a public service for the Republic, which must function, and be structured, in terms of national legislation, and which must loyally execute the lawful policies of the government of the day.”

Question 7: What is your view on adopting Health care policy which embraces health care chaplaincy in SAGH for holistic approach to care that includes patients’ religious and spiritual dimension of being?

Section 197 (2) “The terms and conditions of employment in the public service must be regulated by national legislation.”

Question 8: What is your view on regulating the practice of health care chaplaincy in the SAGH?

Section 197 (4) “Provincial governments are responsible for the recruitment, appointment, promotion, transfer and dismissal of members of the public service in their administrations within a framework of uniform norms and standards applying to the public service.”

Question 9: What is your view on the recruitment and appointment of hospital chaplains as experts to address the religious and spiritual needs of the patient in the SAGH health care teams?

Quotation: “The MEC’s of the Mpumalanga and Limpopo Departments of Health, Gillion Pudumo Mashego and Dr Phophi Ramathuba, signed a Memorandum of Understanding (MOU) to agree to assist each other where it’s possible in terms of Primary Health Care in both provinces. Ramathuba said health and healthcare is key everywhere in the world

which is why it is so important to ensure the people of Mpumalanga and Limpopo get the health care they need...When our country is measured in terms of life expectancy, they don't say Mpumalanga or Limpopo is doing well, the country is measured as a whole. The provinces aren't separated, we are measured as a nation which serves as an indicator investors use when they decide whether or not to invest in our country." (PolOkaywane Review Bonus, page 4, dated 13-19 September 2017).

Question 10: What is your view on health and health care as key everywhere in the world and ensuring that the people get the health care they need?

QUESTIONS FOR CAREGIVERS

(Physicians, Nurses, Clinicians, Social Workers etc.)

These research questions are grounded in the Constitution of the Republic of South Africa (CRSA), 1996.

Chapter 2: Bill of Rights

Freedom of religion, belief and opinion

Section 15(1) "Everyone has the right to freedom of conscience, religion, thought, belief and opinion."

Question 1: What is your view on the patient who wants this right to be exercised during hospitalisation?

Question 2: What is your view on chaplaincy addressing patient's spiritual worldview's (comprehensive view or personal philosophy of human life and the universe) need in health care team?

Section 15(2) "Religious observances may be conducted at state or state-aided institutions, provided that

(a) Those observances follow rules made by the appropriate public authorities;

(b) They are conducted on an equitable basis; and

(c) Attendance at them is free and voluntary."

Question 3: What is your view on conducting the religious observances at the SA Government Hospitals?

Question 4: What is your view on chaplaincy facilitating and or/officiating religious observances in SAGH?

Question 5: What is your view on supporting and embracing the religious observances in the SAGH?

Section 27(1) "Everyone has the right to have access to-

(a) Health care services, including reproductive health care

Question 6: What is your view on patients' requesting health care services which embrace spiritual dimension?

Question 7: What is your view on having chaplaincy to address the patients' religious and spiritual dimensions of being?

Question 8: What other roles do you think can chaplaincy play in the SAGH health care teams?

Quotation: "The MEC's of the Mpumalanga and Limpopo Departments of Health, Gillion Pudumo Mashego and Dr Phophi Ramathuba, signed a Memorandum of Understanding (MOU) to agree to assist each other where it's possible in terms of Primary Health Care in both provinces. Ramathuba said health and healthcare is key everywhere in the world which is why it is so important to ensure the people of Mpumalanga and Limpopo get the health care they need...When our country is measured in terms of life expectancy, they don't say Mpumalanga or Limpopo is doing well, the country is measured as a whole. The provinces aren't separated, we are measured as a nation which serves as an indicator investors use when they decide whether or not to invest in our country." (PolOkaywane Review Bonus, page 4, dated 13-19 September 2017).

Question 9: What is your view on health and health care as key everywhere in the world and ensuring that the people get the health care they need?

Question 10: What is your view on embracing the patients' religious and spiritual needs in their health care plan?

QUESTIONS FOR PATIENTS

These research questions are grounded in the Constitution of the Republic of South Africa (CRSA), 1996.

Chapter 2: Bill of Rights

Freedom of religion, belief and opinion

Section 15(1) "Everyone has the right to freedom of conscience, religion, thought, belief and opinion."

Question 1: What is your view on exercising your right when admitted and treated in a Government hospital?

Question 2: What is your view on having a chaplain to advocate for this need in a hospital treatment plan?

Section 15(2) "Religious observances may be conducted at state or state-aided institutions, provided that

(a) Those observances follow rules made by the appropriate public authorities;
(b) They are conducted on an equitable basis; and
(c) Attendance at them is free and voluntary."

Question 3: What is your view on having your spiritual / religious observance conducted in a hospital setting?

Question 4: What is your view on having a chaplain to facilitate this spiritual / religious observance in a hospital setting?

Section 27(1) "Everyone has the right to have access to-

(a) Health care services, including reproductive health care

Question 5: What is your view on your experience of health care services from the day of your admission?

Question 6: What is your view on spiritual / religious healing? What does spiritual / religious healing mean to you for coping with your illness?

Question 7: Kindly describe the value or role of spiritual / religious beliefs in coping with your medical treatment?

Question 8: In your view did you experience any spiritual / religious need/s during your illness and the medical treatment?

Question 9: What is your view on having your spiritual / religious leader appointed in the multi-disciplinary health care team to meet your spiritual / religious needs?

Quotation: "The MEC's of the Mpumalanga and Limpopo Departments of Health, Gillion Pudumo Mashego and Dr Phophi Ramathuba, signed a Memorandum of Understanding (MOU) to agree to assist each other where it's possible in terms of Primary Health Care in both provinces. Ramathuba said health and healthcare is key everywhere in the world which is why it is so important to ensure the people of Mpumalanga and Limpopo get the health care they need...When our country is measured in terms of life expectancy, they don't say Mpumalanga or Limpopo is doing well, the country is measured as a whole. The provinces aren't separated, we are measured as a nation which serves as an indicator investors use when they decide whether or not to invest in our country." (PolOkaywane Review Bonus, page 4, dated 13-19 September 2017).

Question 10: What is your view from this quotation that health and health care is key everywhere in the world which is why it is so important to ensure that you get the health care you need?

APPENDIX D: DEMOGRAPHICAL BACKGROUND OF RESEARCH RESPONDENTS

DEMOGRAPHICAL BACKGROUND OF THE RESEARCH RESPONDENTS

(Please note that this information will only serve the intended purpose in the research study)

1. Indicate your gender.

Male	
Female	

2. What is your date of birth?.

Day	
Month	
Year	

3. Indicate your ethnicity.

African	Asian	Caucasian	Coloured	Indian	White	Other

4. Indicate your occupation [category or classification].

Caregiver	Physician	Nurse	Psychologist	Social Worker	Clinician	Other
Manager						
Patient						

5. Indicate your faith group.

Christian	Eastern	Hindu	Jewish	Muslim	Non-Believer	Traditional African	Other

6. Indicate your language

Afrikaans	English	North Sotho	Tsonga	Venda	Other

7. Indicate your residential area.

Capricon District	Mopani District	Sekhukhune District	Waterberg District	Vhembe District	Other

Student: ....

SE Mabe