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Hospital-based Spiritual Care for Mothers of Neonates at RMBH in Eldoret, Kenya: A Situational Analysis

Eunice Kamaara

Moi University, Department of Philosophy, Religion, and Theology, Eldoret, Kenya
ekamaara@gmail.com (corresponding author)

Paul Nyongesa, Hazel O. Ayanga, Emily J. Choge-Kerama, Dinah Chelagat, Joseph K. Koech, Mohamed Mraja, Edith K. Chemorion, Joseph Mothaly, Lucy Kiyiapi, Joseph Katwa, Jack Odunga and James Lemons

Abstract: Although the World Health Organization defines health holistically (WHO 2016), and although a positive relationship exists between spirituality and health, maternity care globally focuses on physical and psychological care while excluding spiritual care. In Kenya, spiritual care in hospital settings has received little attention. Yet, cross-culturally, childbearing and motherhood are perceived to be highly spiritual events, but which may be traumatic especially if obstetric complications, postpartum depression, and death occur. Spiritual care is positively associated with patients' ability to cope with negative experiences but also with a healthy birth process with optimal outcomes. Towards improving obstetric care by integrating professional clinical pastoral care in hospital settings in Kenya, we carried out a baseline study to explore the birthing physical, psychological and spiritual experiences of mothers of neonates admitted at the Neonatal Intensive Care Unit of the Riley Mother and Baby Hospital (RMBH) in Eldoret, Kenya. This article presents the results of the study.

Keywords: Spirituality; maternity care; hospital-based; clinical pastoral care.

Introduction

United Nations Millennium Development Goal 4 focused on reducing mortality of children under 5 years by two-thirds, while Goal 5 targeted to reduce maternal mortality ratio by more than half and also to realize universal access to reproductive health by 2015 (Vaught 2015). However, by the end of 2015, maternal and child mortality was still a global health burden.

This burden is not evenly distributed across regions. Sub-Saharan Africa suffers the brunt with an average of 13,000 deaths of mothers and babies occurring daily. Sub-Saharan Africa alone makes up half of the world's deaths among mothers, neonates, babies, and children (World Health Organisation 2016). Combinations of many factors are responsible for this but lack of provision of holistic and quality reproductive health remains key. Following the Millennium Development Goals, Sustainable Development Goal 3.1 and 3.2 seek to reduce global maternal mortality ratio to less than 70 per 100,000 live births, and to end preventable deaths of neonates and children under five, respectively, by 2030.

In Kenya, one of the sub-Saharan African countries, although the maternal mortality rate has reduced from 488/100,000 (Kenya Demographic and Health Survey [KDHS] 2008/2009) to 362/100,000 live births (KDHS 2014), and while this is below the sub-Saharan average of 640 deaths per 100,000 live births, it is still considerably high. Child mortality too remains high with the infant mortality rate at 39/1,000 (KDHS 2014). Most maternal deaths are caused by obstetric complications: postpartum haemorrhage (PPH), obstructed labour, pre-eclampsia/eclampsia (PE/E), puerperal sepsis, postpartum depression, and complications of unsafe abortion; while the majority of neonatal deaths are the result of infections, birth asphyxia, birth trauma, or complications of prematurity (WHO 2008). Improving the quality of obstetric care can directly reduce maternal and neonatal deaths. The following section focuses on how religion and spirituality may improve the quality of obstetric care and reduce maternal and neonatal deaths.

Religion, Spirituality and Maternal Health

Although the World Health Organization (WHO) defines health holistically, maternity care globally, and more specifically in Kenya, has tended to focus on the physical aspects of care, occasionally giving attention to the psychological aspects while excluding spiritual care. Holistic care which includes the environment, culture and spirituality have received little or no attention at all (Wilson 2014: 4). Yet, evidence suggests a significant positive relationship exists between religion/spirituality and health (Barletta & Witteveen, 2007; Koenig 2008a; Koenig *et al*. 2001; Puchalski 2001; Puchalski *et al*. 2014; VanderWeele, Balboni & Koh 2017; VandeCreek & Burton 2001). Although spirituality is not necessarily about religion, Ammerman (2013), Callister and Khalaf (2010), Carey & Cohen (2009), as well as Levin and Vanderpool (1989), suggest that religious practices positively affect physical and spiritual health by increasing health education, awareness and

practices. Solanke *et al.* (2015) argue for inclusion of religion into the social determinants of health framework.

The relationship between religion/spirituality and maternal and neonatal health seems significant. According to Callister and Khalaf (2010), as well as to Crowther and Hall (2015), childbearing and motherhood provide ideal contexts for spiritual care because they are highly spiritual events. Moloney (2007: 1) affirms: "cross-culturally and throughout history, pregnancy and childbirth have been perceived as spiritual events because of the miraculous processes involved". Besides, childbirth may be a traumatic experience especially if it involves obstetric complications. Spirituality would therefore be effective in helping mothers cope with the experiences. For example, spiritual care would address post-partum depression since religious and spiritual beliefs are positively associated with patients' ability to cope with stress (Koenig 2008a). Other discourse considers birth a healthy physiological process through which a mother, with adequate emotional and spiritual support, would secure optimal outcomes (Hirst 2005).

Mbiti (1969) observes that religion permeates all aspects of life in Africa, especially in critical moments of life. Religious and spiritual beliefs around pregnancy and childbirth are rife in Africa and these events are treated with many prohibitions and taboos towards safeguarding the health and life of mother and baby. Consequently, many women associate religion and spirituality with positive birth experiences and outcomes.

Adanikin *et al.* (2014) found that most women in Nigeria (75.8%), believed that there is a need for spiritual care during pregnancy and childbirth. They noted:

> About half (48.5%) were currently seeking for help in prayer/mission houses while another 8.6% still intended to. Overwhelmingly, 281 (70.8%) felt it was needful for health professionals to consider their spiritual needs. Most respondents, 257 (64.7%), desired that their clergy is allowed to pray with them while in labour and sees such collaboration as an incentive that will improve hospital patronage (Adanikin *et al.* 2014: 1).

Another study in Ghana investigated the beliefs, doctrines and practices of the Twelve Apostles Church and their impact on maternal and child health. The study found a strong correlation between religious beliefs and maternal and child mortality (Kwarteng, n.d.).

Google searches for literature on spirituality and health in Kenya returned no results. But anecdotal evidence suggest some religious and spiritual beliefs and practices are associated with health and healing. A doctoral study on Ameru women in Kenya suggests Christian women seek out

spiritual practices during their life crises such as pregnancy and childbirth (Muketha 2016).

These studies suggest a relationship between religion/spirituality and maternal and child health and therefore the importance of providing spiritual care in hospital settings. Even if this relationship is a matter of perception, perceptions matter.

Spirituality and Maternal Health at the RMBH

Whereas Clinical Pastoral Education (CPE) and the resultant professional service, Clinical Pastoral Care (CPC) or simply spiritual care, are fully developed in the United States and in many European countries such as Belgium, Ireland, Netherlands, Norway, and Sweden, this is lacking in nearly all Sub-Sahara African countries. In Kenya, nearly all chaplains serving in hospitals are not trained to provide clinical pastoral care. The tendency has been to pick any ordained Church ministers and second them to work in hospitals as chaplains with no training whatsoever. Additionally, many evangelists, with no training in theology or hospital care, volunteer as chaplains in hospitals across the country. These do not meet the minimum capabilities or commissioning requirements of health care chaplains expected by most Western countries, nor seldom do such volunteers practice holistic spiritual care that is person centred (Carey, Swinton and Grossoehme 2018).

Against this background, Moi University (MU) in partnership with Indiana University (IU), and the Christian Theological Seminary (CTS) both in Indianapolis, IN, US, set out to introduce training in Clinical Pastoral Education and integrate Clinical Pastoral Care at the Riley Mother and Baby Hospital (RMBH) of the Moi Teaching and Referral Hospital (MTRH), Eldoret. CPC, a professional holistic person-centered care, complements biomedical care while paying particular attention to spiritual health for healing, guiding, supporting, reconciling, nurturing, liberating, and facilitating self-empowerment of people in whatever health situations they find themselves.

The Department of Philosophy, Religion and Theology, in collaboration with the College of Health Sciences at Moi University, implemented a curriculum for a Postgraduate Diploma in Clinical Pastoral Education in September 2015. The curriculum is approved by the University Senate and consequently by the Commission for University Education in Kenya.

Teaching and training involves not just theoretical study of the clinical settings and of health and healing perspectives and how to spiritually care for those in need, but it primarily and necessarily involves study of the "living human document" a term coined by the founder of CPE, Anton T.

Boisen (1922-1965) to refer to intensive study of human experience (Asquith 1982). Therefore, student chaplains spend many CPE practicum hours at the bedside listening and learning from the "living human document" as they offer spiritual care with direction and guidance from a CPE supervisor. The CPE Project takes place at the RMBH and involves providing spiritual care services to mothers admitted in the facility.

The RMBH, opened in 2009, is a 500-bed state of the art maternity facility in Kenya. It is funded by generous donations from the Indianapolis community, co-ordinated by the globally renowned neonatologist, Jim Lemons. The RMBH provides a continuum of comprehensive family-focused services to mothers and neonates. The hospital serves as a referral centre for prenatal and postnatal care for women and their infants to a population of about 20 million throughout the western region of Kenya. About 60 babies are delivered every day at the facility. The RMBH Neonatal Intensive Care Unit (NICU) can care for 100 babies at a time. Countless lives are saved and countless families nurtured in the hospital. Continuous improvement of quality of care (including medical education, training and research on obstetric and gynaecologic care) at this facility is provided by the Reproductive Health Division and the Academic Model for Providing Access to Primary Health (AMPATH).[1]

Graduates of the CPE program comprise the pioneer team of trained hospital chaplains in Kenya to offer spiritual care in hospital settings. Spiritual care services include, but are not limited to, visitation, ministry of presence, listening, as well as use of spiritual resources in care such as touch, prayer, anointing, music, and laying of hands. Care involves reading and interpretation of the patients' spiritual needs, clarification of beliefs and values that may be standing in the way of healing, and, sharing love and compassion.

Baseline Situational Analysis

Before implementation of CPE at Moi University and CPC at the RMBH, we conducted a baseline situational analysis of the RMBH. This was imperative to provide an understanding of the holistic experiences of mothers of neonates towards identifying and meeting their holistic needs. The situational analysis sought to answer the questions: "What is the Quality of Care services at the Riley Mother Baby Hospital in Eldoret, Kenya?" What are the experiences of mothers of neonates admitted at the RMBH with regard to physical, psychological and spiritual needs and are these needs met? This article presents and discusses the results of the baseline study.

1. See www.ampathkenya.org

Research Methodology

This was a cross-sectional mixed method study. Primary data was collected between June and July 2015 across a population sample comprising mothers of neonates admitted at RMBH NICU during the time of fieldwork, care providers at and administrator of the facility, as well as birth companions, relatives, and friends of the mothers. All participants consented to participate in the study.

The quantitative component came before the qualitative component to allow the findings of the quantitative component to inform the latter. The American validated Spiritual Assessment Tool, the CHIPS Surrogate Enrolment Interview was customized to the Kenyan setting. A total of 124 mothers were accessed. In addition to the survey, an observation checklist was used to access information on available facilities and equipment at the RMBH and their quality.

Quantitative data was managed using the Statistical Package for Social Sciences (SPSS version 25.0). Descriptive analysis and cross tabulations helped identify the physical, psychosocial and spiritual experiences of the mothers. Descriptive statistical data is presented as frequencies and percentages. P-values of 0.05 were considered significant. Statistical inferences were done using X^2 and predictions using multiple logistic regression modelling. All the data was interpreted and tabulated for quick reference, comparisons, and cross checking before presentation.

In the qualitative component, mothers of neonates admitted at the Neonatal Intensive Care Unit (NICU) over June – July 2015 and their significant others (birth companions, relatives, and friends), paediatricians, neonatologists, nurses, midwives, and other staff at the RMBH were sampled purposively into a sample size of 18. Individuals in the sample population were approached and interviewed using an unstructured interview guide, towards exploring their life worlds. Data collected from mothers were complemented with those collected from other categories of participants.

To complement electronic data management using NVivo software, data were managed and analysed manually at two levels: (i) systematic transcription, cleaning and keying in of data into a computer in categories by source, reading the transcripts, making line-by-line identification and highlighting themes and ideas relating to each of the study objectives. Manual data analysis allowed for analytic (*etic)* coding which was compared with *in vivo* coding, and, (ii) data collected from mothers were compared and contrasted with those collected from healthcare providers, hospital administrator, and from the significant others to bring out different perspectives to experiences of mothers and of other categories of participants.

Scope and Limitations of the Study

This study mainly focused on the birthing experiences of mothers of neonates admitted at the RMBH without regard to the surrounding communities. We acknowledge that other deliveries occur outside this hospital but these were outside the scope of this study. Also, the number of mothers admitted over the months of June and July 2015 turned out to be small and therefore the findings of this study may not be generalized on experiences of mothers across hospitals in Kenya. Moreover, even though there now exists consensus on the definition of spirituality, and there are measures of spirituality (see, for example, Puchalski *et al*. 2014; Austin *et al*. 2018) defining spirituality and empirically measuring "spirituality" for the Kenyan context in this study was problematic. But this is not unique to Kenya. Other studies on other contexts have reported a similar experience (Koenig 2008b; Koenig 2008c; Moberg 2002; Moloney 2007). For example, it seems difficult to separate religion and spirituality in Kenya. We relied largely on self-reporting by study participants.

Nevertheless, the findings of this study provide useful insights on the birthing experiences of mothers at the RMBH. They may not only be used to guide delivery and review of the teaching/training, research and service components of the CPE project, but may also guide similar situations across Africa. Triangulation by method and source of data allowed for validation, while thematic saturation and use of an independent data analyst checked for study validity.

Ethical Considerations

The research protocol for this study was reviewed and approved by the Institutional Ethics Review Committee of the Moi Teaching and Referral Hospital and Moi University College of Health Sciences (FAN: IREC 1547).

Presentation and Discussion of Results

The aim of the study was to investigate the physical, psychological and spiritual birthing experiences of mothers of neonates admitted at the RMBH towards comprehensive health care provision. While current literature uses the bio-psycho-social-spiritual model (Sulmasy 2002), this study adopted and modified the biopsychosocial (BPS) model of health care developed by Drs. George Engel and John Romano (Engel 1977). According to the model, human health is determined by the interaction between the body, the mind and the environment and therefore good or ill health is a combination of biological, psychological and social factors This contrasts with

the biomedical model of medicine which suggests that disease processes can only be explained by an underlying deviation from normal function such as a virus, gene, developmental abnormality or injury (Sarno 1998). The BPS model was advanced to include spiritual and religious perspectives to health: the BioPsycho Social Spiritual and Religious (BPSSR) model.

The psychological, biological, and spiritual factors do not operate independent of each other but are complexly intertwined into a holistic whole: poor spiritual health, for example, would manifest in physical health and vice versa. However, for simplicity and clarity, we categorized holistic health into three broad areas: (i) physical experiences, (ii) psychological experiences and (iii) spiritual experiences. This section presents and discusses the findings of the study along these categories. But first, we present participants' socio-demographic characteristics to enable the reader to better interpret the results of the study.

Table 1: Socio-demographic characteristics of Mothers of Babies in the Neonatal Intensive Care Unit

No of participants		124
Mean age		24.81
Age Range		16-40
Age	Age below 18	8%
	Age below 25	60 %
Gender		Female 100%
Ethnicity	Kalenjin	52.4%
	Luhya	26.6%
	Kikuyu	7.2%
	Luo	4.0%
	Others*	6.4%
	Unknown	3.2%
Education	None	3.2%
	Primary	30.6%
	Secondary	38.7%
	Tertiary	29.0%
Marital status	Single	75.8%
	Married	22.6%

Religion	Christian	99.2%
	Islam/other	0.8%
Christian denomination	Protestant	54.2%
	Pentecostal	22.6%
	Catholic	21.8%
Household Income	<KES. 5000	48.3%
	KES 5000-10000	20.1%
	KES.10001-20000	16.1%
	>KES. 20000	8.0%
	Not Sure	8.8%
Transportation to hospital	Public/Ambulance	83.1%
	Private cars	13%
First Admission		94.4%
No of days in hospital	< 5 days	52.4%
	>5 days	47.6%
Caretaker's health	Good	99.2%
	Poor	0.8%
Nature of admission	Unexpected	76.6%
	Expected	20.2%
	Unsure	3.2%

* Others included Embu, Kamba, Kisii, Pokot, Somali and Teso, with one or two persons.

Table 1 suggests that 8% of mothers at the RMBH were below 18 and 60% below 25 years. The 8% are among the global 7.3 million births by girls under age 18, the great majority of whom are from developing countries (United Nations Population Fund [UNFPA] 2015). Surprisingly, over 75% of the participants reported that they were not married but probing over qualitative data collection suggested that majority of these were living with their partners without legal marriage certification or customary marriage rites.

Over 60% of the participants had a secondary level or less education and only 29% had a post-secondary level of education. Moreover 3.2% of participants had never gone to school. This compares with national statistics on level of education of the Kenyan population (KDHS 2014). As expected of the region that the Hospital serves, over 99% of all participants were Christians.

The majority of the participants were of Kalenjin ethnic group, the indigenous population of Uasin Gishu County where the RMBH is located. The Luhyia border Uasin Gishu and were the next big ethnic community at the Hospital. Although RMBH is a national referral hospital, most clients are often not referred; they simply present at the Hospital. Since onset of labour and childbirth are emergencies, self-referral clients are not denied access to services (Kilonzo *et al*. 2017). This is unlike in the other sections of the MTRH which deal largely with referral cases.

Approximately 48% of all participants reported a monthly family income of less than $50; 20% had a monthly family income of between $50 and $100; and only 6.5% had a family monthly income of between $101 and $200. These characteristics are not surprising because western Kenya is largely a resource poor setting. The RMBH, a public hospital with free maternity services, generally has a low-income clientele.

The quantitative data suggest that communication between mothers and health care providers was of good quality. Most mothers were clear on what was important in decision-making concerning their baby's health. Using the distrust scale, nearly 75% of the caretakers had a positive attitude and trusted the health care system. The conflict scale was used to measure conflict with health care providers. It was found that participants generally agreed with the doctors' diagnostic and treatment decisions.

The depression scale showed that 40-60% of mothers did not show any signs of depression. However, nearly 20% of all mothers felt tired and depressed. About 30 to 60% of the mothers felt worthless, anxious, restless and sometimes hopeless. Using the Brief RCOPE, a 14-item tool for measuring religious coping with life stressors, it emerged that up to 80% of the caretakers depended on almighty God for strength in order to cope when they had problems.

Between 80 and 90% of participants worshipped in churches, mosques or a private place at least once a week. It was notable that more than 80% of mothers studied believed in miracles. Approximately 40-60% felt they received spiritual support from their religious communities, the medical system, and from the untrained chaplains within the Hospital. However, probed to explain exactly what spiritual care they had received, nearly all of them reported that a religious leader had prayed for or preached to all of them together in the ward, which is not professional pastoral care. 30 to 50% had received none or very little spiritual/pastoral care.

The revised scale of the Functional Assessment of Chronic Illness Therapy-Spiritual well-being (FACIT-Sp NI) showed most caretakers were at peace with themselves, even in times of difficulty, and could find meaning, purpose, comfort and strength in their faith or spiritual beliefs.

Table 2: Clinical (cognitive, emotional and spiritual) characteristics of Mothers of Babies in the Neonatal Intensive Care Unit

Variable	Percent
Are involved in Decision-making (Moderately agree)	13/16 (81%)
Consider Decision-making principles (Extremely important)	33%
Consider Decision-making principles (Very important)	37%
Distrust of healthcare system	Mode (Agree) 9/9
Agree or disagree with Healthcare providers	Mode (Agree) 3/3
Have Conflict with healthcare providers	Mode (Disagreed) 1/1
Depression (Not at all depressed)	40-60 (50%)
Feel tired and depressed	20%
Have Distress and anxiety	30-60%
Brief RCOPE score	80%
Religious index	84.6% worshiped at least once a week
Belief in miracles	83.1%
Get spiritual support by religious community	79%
Get spiritual support by medical system (Doctors/Chaplains)	63%
FACIT Score	50-80%
Has anyone prayed for you since admission	79% (Yes)
Do you believe there is need for spiritual help during pregnancy?	96.8% Yes)
Are you currently seeking spiritual help?	79.8% (Yes)

Experiences of Mothers

Data collected using the observation check list, the American validated tool, and unstructured interview guide with mothers of neonates admitted at the NICU were triangulated with data collected from other categories of participants to address the study objectives. The findings on physical, psychological and spiritual experiences are presented and discussed in this section.

Data collected both qualitatively and quantitatively suggest that, by and large, mothers and their neonates admitted at NICU receive good physical biomedical care. They reported that this is marked by the following:

i. *Availability of various health care providers*

The RMBH is part of a national and referral hospital –which is the highest tier of public health service system in Kenya – and is part of a university teaching hospital. Therefore, the hospital has adequate consultant experts, including gynaecologists/obstetricians, paediatricians, and neonatologists, a rare group of specialists in many hospitals in Kenya. The hospital also has nurses, some of them specially trained in midwifery, and a hospital administrator. Additionally, there are numerous clinical officers, interns and registrars from the Moi University College of Health Sciences and from the nearby Kenya Medical Training Centre. Qualitative oral interviews with all categories of participants confirmed this. One female health care provider observed that the hospital has all high quality specialist consultants since most of them serve as teaching staff at the Moi University School of Medicine, while a male client whose wife was admitted at the RMBH said: '*There is very good care here. The doctors are the best around here. There is no need to go to a private hospital as the same doctors you find there are found here.*'

ii. *Availability of necessary facilities and equipment*

To collect data on facilities and equipment at the RMBH, we reviewed available literature including the RMBH website (*rileymotherbabyhospital.com/)* and also did observation using a checklist of all necessary facilities and equipment for a maternity hospital. The RMBH is one of the finest hospitals in Africa, with state-of-the-art equipment. The hospital had all the basic equipment necessary in a mother and baby hospital. At the hospital, about 20,000 babies are born every year. It had capacity for 16 caesarean deliveries every day and has one of the largest functioning NICU throughout East Africa. The NICU cares for about100 critically ill neonates at any one time. Unlike any other hospital in Kenya, the RMBH has hostels for mothers who have babies in NICU. This means that mothers can spend time in hospital with their neonates and with other mothers with babies in NICU.

In concurrence with data collected through observation, healthcare providers indicated that all necessary equipment was available and generally in good working condition. One health care provider added that the Hospital has good working relations with many private hospitals in Eldoret town, all of which are within a radius of one kilometre from the RMBH. These include Mediheal, Reale, the Eldoret Hospital, Elgon View Hospital, Fountain Hospital, and St. Luke's Trauma and Orthopaedic, among others. She indicated that when RMBH has more demand for intensive care facilities than they can offer, they transfer clients to the private hospitals.

iii. *Clean environment*

The environment was clean and well kept. There was running water in the hospital and an adequate number of staff to keep the place clean. As we walked around the hospital at various times of the day during data collection, we found different persons cleaning floors, services, and equipment. The smell associated with public hospitals in Kenya was absent in this Hospital.

iv. *Committed staff though some are overworked*

The staff seemed committed though the nurses appeared overworked. It would seem that Devolution of Health Services (DHS) has led to a huge increase of patient self-referral putting a lot of strain on staff (Kilonzo *et al.* 2017). But the cadre of staff matters: one gynaecologist/obstetrician observed:

> For the doctors, most of us who are teaching with Moi University, we like it when there are many patients because we want our students to learn. And as you know our learning method is problem based (PBL) so the more cases the better for us. Our students are able to encounter all the different kinds of emergencies that a mother or a neonate can have. Actually, in this hospital you find more doctors than nurses. You can find that you are doing a ward round with 6 doctors but there is only one nurse (Medical doctor, RMBH).

According to this doctor, the solution lies in enhancing 'down referral' where expertise from the national hospital is posted to train staff in lower level hospitals and also in improving facilities and equipment and enhancing medical supplies in lower level hospitals. However, it would seem that the country in general had a serious shortage of nurses, partly because of out-migration of nurses (Gross *et al.* 2011). While the WHO recommended ratio of nurses to patients is 25:10,000, Kenya national ratio is 10.4.: 10,0000 and the ratio in Uasin Gishu, one of the counties with lowest ratios, was at 8.5: 10,000 (*The Nursing Workforce Report* 2012).

v. *Food*

Food which mothers and their companions described as "nice but little" was served at the RMBH. While Devolution of Health Services, the national free maternity care policy, as well as the Beyond Zero Campaign, have enhanced access for maternal care, RMBH was grappling with the challenge of inadequate and delayed funding from the National Government. The "little" food that mothers of neonates admitted in NICU received may be associated with this delay and inadequacy. We observed however that some mothers had relatives who brought them food from home on regular intervals but a few did not, probably because they are from far or their families are resource poor.

vi. *Tired mothers*

Although mothers and their companions reported that they appreciate that there are hostels for mothers at the RMBH, a facility that is not found in any other hospital in Kenya, they expressed dissatisfaction with their location in relation to the NICU. The hostels are on the 3rd floor while the NICU is on ground floor. There is no lift so mothers have to walk down to NICU to breastfeed their babies every 3 hours. Most of the mothers complained that they were tired and lacked sleep because by the time they came back from NICU, they were reflecting on the condition in which they saw their babies. They reported that they often got anxious about how they would find their baby when they go down again. They observed that by the time they dozed off to sleep it was nearly time to go back to NICU. One mother, visibly looking tired, said: "…we have to go down to breastfeed the baby every 3 hours. One has not slept and it is time to go down. And it is far. I wish the baby's place (NICU) was on this floor (meaning on the 3rd floor near the hostels). I am always very, very tired."

The research team however appreciate the location of the hostels since NICU has to be near the labour ward and it would not be appropriate to put the mothers' hostels next to the almost always noisy labour wards.

vii. *Lack of privacy and congestion*

Some mothers complained of lack of privacy at the RMBH. Closely associated with lack of privacy, mothers cited congestion. This was observed during data collection. Some beds had two or three mothers.

According to health care providers, the increased demand for care is associated with the free maternity care supported by a national government policy and Kenya's First Lady's 'Beyond Zero' campaign: the number of deliveries in the hospital had increased from 30 per day to about 60 per

day. It would appear that the facility had been stretched beyond its capacity. As mentioned earlier, as the second national and referral hospital in Kenya, the hospital serves the entire western region of Kenya and although it is supposed to be a referral facility, it is not possible to send mothers away when they come without referral because of the nature of their health need – which is always an emergency.

This study concurs with Kilonzo *et al.* (2017) that the Free Maternity policy coupled with Devolution of Health Services had increased demand for maternal and neonatal care. As Kilonzo *et al.* (2017) did, we observed many ambulances bring patients and we could tell they were from different counties across western Kenya by the writings on the ambulances.

In terms of psychological experiences, again, overall, there was relatively good psychological care for mothers of children admitted at NICU even though it was not as good as the physical care. This was marked by:

(a) ***Availability of clinical counsellors and social workers***

There were psychological care providers on the same level of the hospital with the mothers' hostels. We were informed that there are two psychological counsellors and two social workers serving the RMBH. We met with the psychological care providers but not with the social workers who were often working away from the hospital.

(b) ***Availability of room for counselling***

There was a quiet room for counselling located on the same floor as the mothers' hostels. However, the room served as the office for not just the psychological care providers but also the social workers and we observed that other care providers kept coming in and out because there was no room for health care providers to sit when they were not in the wards.

(c) ***Good communication and use of Language by Health Care Providers***

One mother and one companion reported that health care providers are generally courteous and use friendly language but another mother reported that there is poor communication. One nurse and one care provider indicated that use of language could be improved for more respectful care to mothers. The nurse said:

> Sometimes some nurses are tired and they get impatient with the mothers, especially the younger nurses. To be a good nurse you need to have a calling. It is a vocation, hard work, you must have a desire to help, a desire to care.

But psychological care providers are few (two serving a population of at least 100 mothers every day). Yet, demand for psychological counselling and social support is high: mothers reported that they felt isolated from their families and they also felt lonely.

As noted earlier, there is a significant relationship between religion/spirituality and health (Koenig 2012; Powell *et al.* 2003; Reeve & Basalik 2011; Gyimah *et al.* 2006). Specifically, religion/spirituality has both negative and positive implications for maternal and neonatal health. Miller and Rubin (2011), for example, suggest that faith communities can play a major role in healthcare communication in and outside hospital settings. While there have been no studies on this in Kenya, studies from other parts of Africa suggest that religion/spirituality not only affect health seeking behaviours and therefore health utilization, but they also affect health outcomes of the birthing experience. In Ghana, for example, as has already been noted in this article, members of the Twelve Apostle Church reject modern medicine to emphasize faith healing, in line with their doctrine of God as healer of all illness and diseases (Kwarteng, n.d.).

Human beings not only have physical and psychological needs: they also have spiritual needs. Professional spiritual care would counter the spiritual needs of patients that are often ignored by biomedical care providers to provide focused pastoral care in guiding, nurturing, sustaining and liberating individuals by facilitating self-empowerment.

Spiritual care was found to be generally lacking at RMBH. This was unanimously reported by mothers and their companions as well as by consultant doctors, psychological counsellors, nurses/midwives, and support staff. This compares with the results of a study carried out in Nigeria (Adanikin *et al.* 2014). Yet, demand for this kind of care seemed high among mothers.

Mothers at the RMBH and their companions indicated that health care providers were mechanical and seemed to want to finish with the patients as soon as possible. One mother said:

> Physical care is very good care here. The doctors are there and they are good and these days we don't pay for services. They are free. The nurses seem to be very busy but they too do a good job. However, they do not talk to us about our spiritual needs. Sometimes I want to talk to someone about how am feeling but the nurses are too busy. And the doctors come for a few minutes, get reports from the nurses and then they go away very fast. Like I wanted to pray before theatre because I was very anxious because I lost my baby last time but nobody seemed interested.

The self-report by mothers of their need for, and unmet, spiritual care services compares with the results of a systematic review on unmet

demand for spiritual care by parents after still birth or neonatal death in the UK as well as with a study by Adanikin *et al.* (2014) of Nigerian women. As with Ghanaian women (Kwarteng, n.d.), some Kenyan women feel vulnerable when pregnant for fear of witchcraft or evil eye, which they associate with high maternal mortality and therefore they feel the need for spiritual protection. But this is not unique to African women: women in developed countries also believe in the influence of higher spiritual powers in positive outcomes of childbirth (Callister & Khalaf 2010).

Given the extremely low ratio of nurses to patients, lack of time to meet spiritual needs of mothers may be understood. A midwife working at the same hospital confirmed that health care providers do not take time to meet the needs of each client. However, she dismissed the idea of overworked staff, attributing this to poor attitude of nurses:

> "I don't think we explain why we are doing what we are doing. It is all in our attitude. We do VE (vaginal examination) and we don't tell them how far they are. We are ignoring them completely…we are very rude".

This situation of overworked nurses who lack spiritual care skills is not desirable since spiritual care is critically important to nursing and it has already been established that attending to the spiritual needs of patients may be positively related to improved health outcomes (Timmins & Caldeira 2017; Rogers & Wattis 2015; Zehtab & Hajbaghery 2014).

Biomedical care providers, including consultants, concurred that spiritual care is lacking at the RMBH. A biomedical consultant reiterated:

> …most of the time we run away from that element of how to give hope and support the mother… It gets a bit challenging. Sometimes we end up telling the mother that we have done our bit and now we leave it to God… and sometimes you don't know if the person you are talking to is a spiritual person or not so we don't dig too much in the element of spirituality but when you hear the mother saying "we leave it to God" you encourage them and tell them to just pray as we continue the treatment… we rarely come out and build them up on that kind of spirituality…

Professional spiritual care in hospital settings is not offered only to patients but also to hospital staff and relatives, companions and friends of patients. It was therefore not surprising that, even though our study did not focus on the needs of health care providers, biomedical care providers indicated their own need for spiritual care. A female paediatrician observed:

> Sometimes we require spiritual support because loss of a baby is very painful and our unit is quite erratic. You might find one day a very calm unit but the next day you find a lot of babies gasping. So you might end up losing four babies in a night and on the corridors the four mothers are screaming and crying and at some point you feel like I have failed them – what did you not do right? And you still have to admit other patients. By the time the night shift or day shift is over you have been strained, depressed, and you wonder: did I really choose the right career …

This finding compares with other findings from other settings that care providers are profoundly affected physically and psychologically by negative outcomes, especially prenatal death and that their needs are often unmet (see for example: Nuzum *et al.* 2015; Nuzum *et al.* 2016; Nuzum *et al.* 2017; Shorey *et al.* 2017). Provision of spiritual care was lacking at the RMBH and yet demand was high.

Conclusions and Recommendations

While WHO defines health holistically, and while a lot of literature suggest that there is a positive relationship between spirituality and maternal health, globally, little or no spiritual care at all is provided in hospital maternity settings. A baseline study of the situation at the Riley Mother and Baby Hospital, the biggest mother and child hospital in western Kenya, suggests that there is a need to integrate Clinical Pastoral Care (CPC) in hospitals in Kenya,

The quality of physical care at the RMBH was generally high, even though it was jeopardized by high demand for care. In a low-resource setting where many mothers do not seek prenatal and postnatal care, this is a good problem to have: it indicates accessibility of care. However, the Government of Kenya and the Uasin Gishu County government should seek ways through which they can maintain and enhance the quality of physical care at the RMBH. This may mean employing more care providers, especially nurses and midwives.

We appreciate that psychological counselling and social services are offered at the RMBH. But there is a need to employ more psychological counsellors and to provide more private spaces for offering this service. The ratio of counsellors to patients at 2:160 was unacceptably low and the availability of one room which is used as an office by all health care providers translated to lack of space for this service.

Professional CPC was lacking at the RMBH yet demand was high. This indicates a need to support integration of competent spiritual care at RMBH through employment of professionally trained chaplains, in-service training workshops for hospital chaplains, and sensitization workshops for all healthcare providers on the importance of spiritual care. This would

improve Quality of Care (QoC) in all spheres because all the dimensions of health are intertwined.

This study, the first of its kind in Kenya, faced some challenges, as discussed under scope and limitations. While the results may not be generalizable to other contexts, they provide invaluable insights for the introduction and integration of spiritual care at the RMBH, including the need to define spirituality in the western Kenya context. The study findings also provide a strong foundation for future studies.

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About the Authors

Eunice Kamaara is Professor of Religion. She holds a PhD in African Christian Ethics and a Master of Science degree in International Health Research Ethics. She currently serves as a member of the Ethics Review Board of Médecins Sans Frontières. She is interested in research on religion/spirtuality and health.

Dr. Paul Nyongesa is a Senior Lecturer and Tutor in the Dept. of Reproductive Health at Moi University, Eldoret Kenya and also a Consultant Obstetrician and Gynecologist with Clinical Duties in the Division of Reproductive Health, Moi Teaching and Referral Hospital, Eldoret, Kenya.

Hazel O. Ayanga is Associate Professor of Religion. She obtained her Bachelor's and Master of Arts degrees from the University of Nairobi. Her PhD is from Moi University and her post-doctoral is from Yale University, New Haven, US. Her current research interests include religion, culture and social change; science and religion dialogue and Clinical Pastoral Education.

Emily J. Choge-Kerama (PhD) is Associate Professor. She teaches Old Testament studies and Christian Ethics. She also prepares pastors and leaders in the ministry through the work of Africa International University, is co-chair of the Uasin Gishu Children's FORUM and founder member of African Christian Initiation Program (ACIP).

Dinah Chelagat is Senior Lecturer in Nursing and the current Dean of the School of Nursing at Moi University. She holds a PhD in Midwifery from University of the Free State, South Africa. Her research interest is in religion/spirituality and beginning/end of life healthcare.

Joseph Koech is the current Chair of the Department of Philosophy, Religion and Theology at Moi University. He holds a Doctor of Philosophy degree in Religion from Moi University. His research interest is in New Testament Studies, Contemporary Theology, and also Religion and Science.

Mohammed Mraja is Senior Lecturer in Islamic Studies and the current Dean of the School of Social Studies and Education at Bomet University College of Moi University. He received his PhD from Albert Ludwigs University, in Freiburg, Germany.

Edith K. Chemorion is a Lecturer of Religion, Science and Society, and a Clinical Pastoral Educator. She holds a Master of Theology degree in Clinical Pastoral Counselling from Stellenbosch University and is currently a PhD Candidate.

Joseph Mothaly holds a Bachelor of Theology degree from the Presbyterian University of Eastern Africa, Kikuyu, Kenya. He is a Clinical Pastoral Educator. He received his CPE training at Harris Methodist Health System, Fort Worth Texas.

Lucy Kiyiapi is the Head of the Department of Public Health Management & Promotion in the School of Public Health at Moi University. She holds a PhD in Counselling Psychology, is trained as a behaviour change expert, with a special interest in adolescents and youth. She is an addictive behaviour counsellor, a health promotion and education trainer, and a trauma counsellor.

Joseph Katwa is the Chaplain in the School of Medicine. He holds a Master of Science in International Health Research Ethics and a Master of Theology in HIV Counselling. He is a PhD candidate in Medical Education.

Jack Odunga holds a Bachelor of Science degree in Computer Science from the University of Nairobi and a Master of Science degree in Epidemiology and Biostatistics. He works in the Department of Reproductive Health.

James Lemons is Emeritus Professor of Paediatrics, Indiana University School of Medicine and a consultant neonatologist at Riley Children Hospital in Indianapolis. Previously he served as Director, Section of Neonatal-Perinatal Medicine, Department of Paediatrics, Indiana University.

References

Adanikin, A., U. Onwudiegwu and A. Akintayo (2014) "Reshaping Maternal Services in Nigeria: Any Need for Spiritual Care?" *BMC Pregnancy and Child Birth* 14(196). https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-196 (accessed 24 January 2018). https://doi.org/10.1186/1471-2393-14-196

Ammerman, N. T. (2013) "Spiritual but Not Religious? Beyond Binary Choices in the Study of Religion". *Journal for the Scientific Study of Religion* 52(2): 258–78. https://doi.org/10.1111/jssr.12024

Asquith, G. (1982) "Anton T. Boisen and the Study of 'Living Human Documents'". *Journal of Presbyterian History (1962–1985)* 60(3): 244–65. http://www.jstor.org/stable/23328440 (accessed 24 January 2018).

Austin, P., J. Macdonald and R. MacLeod (2018) "Measuring Spirituality and Religiosity in Clinical Settings: A Scoping Review of Available Instruments". *Religions* 9(3): 70. https://www.mdpi.com/2077-1444/9/3/70/pdf (accessed 5 March 2019).

Barletta, J., and K. Witteveen (2007) "Pastoral Care in Hospital: An Overview of Issues". *Australian Journal of Primary Health* 13: 97–105. https://doi.org/10.1071/PY07013

Callister, L. C., and I. Khalf (2010) "Spirituality in Childbearing Women", *Journal of Prenatal Education* 19(2): 16–24. https://doi.org/10.1624/105812410X495514

Carey, L. B., and J. Cohen (2009) "Religion, Spirituality and Health Care Treatment Decisions: The Role of Chaplains in the Australian Clinical Context". *Journal of Health Care Chaplaincy* 15(1): 25–39. https://doi.org/10.1080/08854720802698491

Carey, L. B., and B. Mathisen (eds) (2018) *Spiritual Care for Allied Health Practice: A Person-centered Approach*. London: Jessica Kingsley.

Carey, L. B., J. Swinton and D. H. Grossoehme (2018) "Chaplaincy and Spiritual Care". In *Spiritual Care for Allied Health Practice: A Person-centered Approach*, ed. L. B. Carey, and B. Mathisen. London: Jessica Kingsley.

Crowther, S,, and J. Hall (2015) "Spirituality and Spiritual Care in and Around Childbirth". *Women and Birth* 28(2): 173–78. https://doi.org/10.1016/j.wombi.2015.01.001

Engel, G. L. (1977) "The Need for a New Medical Model: A Challenge for Biomedicine". *Science* 196(4286): 129–36. https://doi.org/10.1126/science.847460

Gross, J. M., M. F. Rogers, I. Teplinskiy, E. Oywer, D. Wambua, A. Kamenju, J. Arudo, P. L. Riley, M. Higgins, C. Rakuom, R. Kiriinya and A. Waudo (2011) "The Impact of Out-migration on the Nursing Workforce in Kenya". *Health Services Research* 46(4): 1300–1318. https://doi.org/10.1111/j.1475-6773.2011.01251.x

Gyimah, S. O., B. K. Takyi and I. Addai (2006) "Challenges to the Reproductive-health needs of African Women: On Religion & Maternal Health Utilization in Ghana". *Social Science & Medicine* 62(12): 2930–2944. https://doi.org/10.1016/j.socscimed.2005.11.034

Hirst, C. (2005) Rebirthing: Report of the review of Maternity Services in Queensland. Brisbane, Australia: Queensland Health, Queensland.

Kenya National Bureau of Statistics, and ICF MACRO, (2014) *Kenya Demographic and Health Survey.* Calverton, MD: KNBS and ICF Macro.

Kilonzo, S., E. Kamaara and K. Magak (2017) "Improving Access to Maternal Health Care through Devolution in Western Kenya". *IDS Bulletin* 48(2): 91-108. https://doi.org/10.19088/1968-2017.118

Koenig, H. G. (2008a) *Medicine, Religion and Health: Where Science and Spirituality Meet*. West Conshohocken, PA: Templeton Foundation Press.

—(2008b). "Concerns about Measuring 'Spirituality' in Research". *The Journal of Nervous and Mental Disease* (196)5: 349–55. https://doi.org/10.1097/NMD.0b013e31816ff796

—(2008c) *Is Religion Good for Your Health? The Effects of Religion on Physical and Mental Health*. London and New York: Routledge Taylor & Francis Group.
—(2012) "Religion, Spirituality, and Health: The Research and Clinical Implications". *ISRN Psychiatry* 33(2012): 12–23. https://doi.org/10.5402/2012/278730
Koenig, H. G., M. E. McCullough and D. B. Larson (2001) *Handbook of Religion and Health*. Oxford: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195118667.001.0001
Kwarteng, G. (n.d.) Religious beliefs, Spirituality and Health: Implications for Maternal and Child Mortality in Ghana. Department of Women and Children's Health, Uppsala University, Norway. https://www.academia.edu/9404765/Religious_beliefs_Spirituality_and_Health_Implications_for_Maternal_and_Child_mortality_in_Ghana (accessed 29 June 2019).
Levin, J. S., and H. Y. Vanderpool (1989) "Is Religion Therapeutically Significant for Hypertension?" *Social Science & Medicine* 29(1): 69–78. https://doi.org/10.1016/0277-9536(89)90129-9
Mbiti, J. S. (1969) *African Religions and Philosophy*. Nairobi and London: Heinemann.
Miller, A., and D. Rubin (2011) *Faith Communities and Health Care Communication*. Ontario: Hampton Press.
Moberg, D. O. (2002) "Assessing and Measuring Spirituality: Confronting Dilemmas of Universal and Particular Evaluative Criteria". *Journal of Adult Development* 9(1): 47–60. https://doi.org/10.1023/A:1013877201375
Moloney, S. (2007) "Dancing with the Wind: A Methodological Approach to Researching Women's Spirituality around Menstruation and Birth". *International Journal of Qualitative Methods* 6(1): Article 7. https://sites.ualberta.ca/~iiqm/backissues/6_1/moloney.htm (accessed 25 January 2018).
Muketha, D. K. (2016) "Ameru Women's Spirituality: Negotiation of Spiritual Practices Among Methodist and Pentecostal Church Christian Women in Igembe Constituency". DPhil dissertation, MF Norwegian School of Theology.
Nuzum, D., S. Meaney, K. O'Donoghue and H. Morris (2015) "The Spiritual and Theological Issues Raised by Stillbirth for Healthcare Chaplains". *Journal of Pastoral Care & Counseling* 69(3): 163–70. https://doi.org/10.1177/1542305015602714
—(2016) "The Provision of Spiritual and Pastoral Care following Stillbirth in Ireland: A Mixed Methods Study". *BMJ Supportive & Palliative Care* 6(2): 194–200. https://doi.org/10.1136/bmjspcare-2013-000533
—(2017) "The Spiritual and Theological Challenges of Stillbirth for Bereaved Parents". *Journal of Religion and Health* 56(3): 1081–1095. https://doi.org/10.1007/s10943-017-0365-5
Powell L. H., L. Shahabi and C. E. Thoresen (2003) "Religion and Spirituality: Linkages to Physical Health". *American Psychology* 58(1): 36–52. https://doi.org/10.1037/0003-066X.58.1.36
Puchalski, C. M. (2001) "The Role of Spirituality in Health Care". *Proceedings Baylor University. Medical Center* 14(4): 352–57. https://doi.org/10.1080/08998280.2001.11927788
Puchalski, C. M., R. Vitillo, S. K. Hull and N. Reller (2014) "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus". *Journal of Palliative Medicine* 17(6): 642–56. https://doi.org/10.1089/jpm.2014.9427
Reeve, C. L, and D. Basalik (2011) "A State Level Investigation of the Associations among Intellectual Capital, Religiosity and Reproductive Health". *Intelligence* 39(1): 64–73. https://doi.org/10.1016/j.intell.2010.09.007
Rogers, M., and J. Wattis (2015) "Spirituality in Nursing Practice". *Nursing Standard* 29(39): 51–57. https://doi.org/10.7748/ns.29.39.51.e9726

Sarno J. E. (1998) *The Mind-Body Prescription: Healing the Body, Healing the Pain*. New York: Warner Books.

Shorey, S., B. André and V. Lopez (2017) "The Experiences and Needs of Healthcare Professionals Facing Perinatal Death: A Scoping Review". *International Journal of Nursing Studies* 68: 25–39. https://doi.org/10.1016/j.ijnurstu.2016.12.007

Solanke, B. L., O. Oladosu, A. Akinlo and S. Olanisebe (2015) "Religion as a Social Determinant of Maternal Health Care Service Utilisation in Nigeria". *African Population Studies* (29)2: 1868–1882. https://doi.org/10.11564/29-2-761

Sulmasy D. P. (2002) "A Biopsychosocial-spiritual Model for the Care of Patients at the End of Life". *The Gerontologist* 42(3): 3–24. https://doi.org/10.1093/geront/42.suppl_3.24

The Nursing Workforce Report (2012) Prepared by the Kenya Ministry of Health (MOH), the Nursing Council of Kenya (NCK), the Kenya Health Workforce Project, Emory University, and US Centers for Disease Control (CDC). http://www.health.go.ke/wp-content/uploads/2015/09/Kenya%20Nursing%20Workforce%20Report.pdf (accessed 1 February 2019).

Timmins, F., and S. Caldeira (2017) "Understanding Spirituality and Spiritual Care in Nursing". *Nursing Standard* 31(22): 50–57. https://doi.org/10.7748/ns.2017.e10311

United Nations Population fund (UNFPA) (2015) *Girlhood, not MotherHood: Preventing Adolescent Pregnancy*, http://www.unfpa.org/publications/girlhood-not-motherhood (accessed 31 January 2018).

VandeCreek, L., and L. Burton (2001) "Professional Chaplaincy: Its Role and Importance in Healthcare". *Journal of Pastoral Care & Counseling* 55(1): 81–97. https://doi.org/10.1177/002234090105500109

VanderWeele, T. J., T. A. Balboni and H. K. Koh (2017) "Health and Spirituality". *The Journal of American Medical Association* 318(6): 519–20. https://doi.org/10.1001/jama.2017.8136

Vaught, M. (2015) Training Nurses to Save Mothers and Babies in East Africa. Rotary Report. http://reliefweb.int/report/kenya/training-nurses-save-mothers-and-babies-east-africa (accessed 5 March 2019).

Wilson, D. R. (2014) "Holistic Ethics". *International Journal of Childbirth Education* 29(4): 4.

World Health Organization (2008) *The Global Burden of Disease: 2004 Update*. Geneva: World Health Organization.

—(2016) Maternal mortality, Fact sheet Updated November 2016, http://www.who.int/mediacentre/factsheets/fs348/en/ (accessed 4 December 2018).

WHO (2016) Constitution of WHO – Principles: Definition of Health? Geneva: World Health Organization, http://www.who.int/about/mission/en/

Zehtab, S., and M. Adib-Hajbaghery (2014) "The Importance of Spiritual Care in Nursing". *Nurse Midwifery Studies* 3(3): e22261. http://dx.doi.org/10.17795/nmsjournal22261