Integrating Religion and Spirituality into Clinical Practice: the beliefs and practices of health professionals' in Addis Ababa, Ethiopia

Natnael Alemayehu

Advisor: Firehiwot Jebessa, PhD

A thesis submitted to School of Social Work of Addis Ababa University in partial fulfillment of the requirement for the degree of Master's in Social Work

Addis Ababa University

Addis Ababa, Ethiopia

February 2021

Integrating Religion and Spirituality into Clinical Practice: The beliefs and practices of health professionals' in Addis Ababa, Ethiopia

By: Natnael Alemayehu

Advisor: Firehiwot Jebessa, PhD

February 2021

Addis Ababa, Ethiopia

Letter of Declaration

I declare that this thesis entitled “Integrating Religion and Spirituality into Clinical Practice: A qualitative descriptive study of health professionals’ beliefs and practices” is my original work except as cited in the references. The thesis is submitted to the School of Social Work of Addis Ababa University in partial fulfillment of the requirement for the degree of Master’s in Social Work. Hence, the thesis has not been presented for candidacy for degree at a different university.

Student’s Name: Natnael Alemayehu

Signature: _____

Date: _____

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLEGE OF SOCAIL SCIENCES
SCHOOL OF SOCIAL WORK

Integrating Religion and Spirituality into Clinical Practice: A qualitative descriptive study of health professionals' beliefs and practices in Addis Ababa, Ethiopia

By: Natnael Alemayehu

Approved by Board of Examiners

Chairman, Department of Graduate Committee	Signature
Advisor	Signature
External Examiner	Signature
Internal Examiner	Signature

Acknowledgement

I praise God, who is able to do immeasurably more than I can ask or imagine. I am forever grateful for God who granted me eternal life and gave me much love, grace, hope, mercy, and energy through His son Jesus Christ and His Holy Spirit. This has been a great encouragement for me to start, continue, and complete my education.

I am also grateful for my parents Alemayehu Mammo and Simegn Assefa and my sisters Ephrata and Ruth, who have invested much on me by the grace, knowledge, and resources they have received from God. My prayer is that they would receive their rewards from God and the fruits of their labors in me. I want to thank my advisor Dr. Firehiwot for the insightful feedbacks, helpful guidelines, and patience in my demanding explorations. I want also thank Dr. Ashenafi Hagos and Dr. Abebe Assefa who have taught me a lot about research and practical ways of conducting one.

My gratitude is also for my friends and church families, who have advised, encouraged, helped, prayed, and supported me to work on this thesis. I would like to especially thank my friend Edlawit Wondimu for the transcriptions she did for this study, Maritu Seifu for the 'kicks on the head' to devoutly work on my paper and for doing the translation of the interview guide from the English language to Amharic, for Bemnet Alemayehu for his encouraging words, prayers and for doing the back translation of the interview guide, Ashenafi Tibebe for being an understanding co-worker, Garedew W/Tinsae and Pastor Michael Mengesha along with all the International Evangelical Church staffs and who have been a great blessing and help for me. And I would like to thank Dr. Alemseged Ketema for giving me constructive feedback on my final report. Thank you, and may God bless all of you.

Abstract

This study has explored the beliefs and practices of health professionals on integrating religion and spirituality into clinical practice. It has aimed to analyze health professionals' definitions of religion and spirituality, the ways in which they address religious and spiritual needs of their clients, their beliefs on whether religion and spirituality should be integrated and the challenges that they encounter in integrating religion and spirituality into clinical practice. To meet this objective, the study has utilized the qualitative description design which has helped generate a summarized description of participants' experience on the matter. The health professionals who participated came from the fields of nursing, social work, psychology, psychiatry, and medicine with various specializations. The data was collected using a semi-structured in-depth interview and then using thematic analysis. Accordingly, the study has found that the health professionals define religion as an organized system of beliefs which involve specific doctrines, institutions, practices, and rituals. On the other hand, spirituality was defined in terms of personal adherence to one's religion or aspects of life which relates to a person's development in life, passions of pursuit, and ways in which people build relationships. The participants believe that religion and spirituality play an integral role in the individual's well-being. Accordingly, it was found that they encourage their clients to use their religious beliefs and practices along with modern medical remedies. Fanaticism, sensitivity of the topic, and inclusivity were identified as factors which hinder the integration of religion and spirituality into clinical practices. The health professionals also reflected different opinions on issues such as provision of spiritual care, religion and spirituality in health education, and professional's refusal of service based on religious reasons. The paper concludes by discussing the findings with existing literature and presenting their implications for social work practice, policy, research, and education.

Keywords: *Clinical Practice, Integrated Practice, Health care, Religion and Spirituality*

Acronyms and Abbreviations

APA: American Psychiatric Association

AAU: Addis Ababa University

FDRE: Federal Democratic Republic of Ethiopia

ART: Anti-Retroviral Therapy

CSA: Central Statistics Agency

CV: Curriculum Vitae

DSM V: Diagnostic and Statistical Manual of Mental Disorders Fifth Edition

ENA: Ethiopia News Agency

ENT: Ear, Nose and Throat

FDRE: Federal Democratic Republic of Ethiopia

FMOH: Federal Ministry of Health

FMoST: Federal Ministry of Science and Technology

ICD: International Classification of Diseases

ICU: Intensive Care Unit

IRB: Institutional Review Board

NHS: National Health Service

NKJV: New King James Version

NRERC: National Research Ethics Review Committee

UK: United Kingdom

US: United States

WHO: World Health Organization

Contents

Chapter One: Introduction

1.1 Introduction

Spirituality is one of the most fascinating human experiences. A study conducted by Lomas (2019) shows that there are terms depicting it in numerous cultures around the world. Zinnbauer et.al. (1997) have stated that most people use the terms religiosity and spirituality interchangeably. The reason is that in previous times the concept of spirituality has been strongly associated with certain religious practices (Moberg, 2010). Recently, there has been a shift to a more secularized and individualistic way of thought, even in considering issues of religion and spirituality which has led people make distinctions between the two (Zinnbauer et.al., 1997; Lomas, 2019).

Religion and spirituality have been an area of interest for scholars since the beginning of the 20th century marked by the works of William James (Miller & Thoresen, 2003). It has been studied by professionals both in health and behavioral sciences (Hufford, 2005). Research have sought to determine the essence of spirituality (Mayhew, 2004; Chao, Chen & Yen, 2002) and its association with diverse issues (Moberg, 2010). There are multiple tools to understand the notions of spirituality, religiosity, and embedded practices (Austin, Macdonald & MacLeod, 2018). The complexity of people's view and practice of spirituality (Bender & McRoberts, 2012) as well as lack of clarity regarding its relation to their health (Miller & Thoresen, 2003) makes it a critical area of research.

Studies conducted in Ethiopia show that people often use religious/spiritual beliefs in approaching health issues. These beliefs have been used to explain the source of health problems and ways for recovery (Kahissay, Fenta & Boon, 2018; Selambizu Getachew, 2018; Hussein, 2016). It was also noted that religion determines the response of the community to receiving certain types of medical services like abortion (Addisu Tsegaye, 2018). Therefore, it is crucial for health professionals to know how to address the needs of their clients

accordingly. These studies in Ethiopia, however, have focused on understanding the patients', caregivers', and the general public's experience of religion/spirituality in relation with different health issues. And research on religion/spirituality from the perspective of health professionals is minimal.

Consequently, little is known about how health professionals in our country define religion/spirituality and how they address them in their clinical practice. The knowledge gap created by lack of research in this area makes it difficult to have a comprehensive view of the role of religion/spirituality in health and health service provision. The gap also creates a barrier for standardized clinical practice. The main reason for this is health professionals' decision on how to address the religious/spiritual needs of their clients or whether they should integrate religion/spirituality into their clinical practice would depend on their intuition rather than empirical evidence.

Hence, this study has explored the beliefs and practices of health professionals in the integration of religion and spirituality into clinical practice. It has analyzed health professionals' definition of religion and spirituality in health care provision and ways in which they address religious/spiritual needs and concerns of clients. The study has also investigated the stance of health professionals on whether religion/spirituality should be integrated into clinical practice. In addition, the study has examined the challenges that professionals face in integrating religion/spirituality into clinical practice. The details of the local studies on religion/spirituality are presented in the following section.

1.2 Problem Statement

Majority of the population in our country, Ethiopia, identify themselves with a certain religion, the major ones being Christianity and Islam (CSA Ethiopia, 2007). As mentioned above, several studies conducted on spirituality and religiosity reflect the notion that spirituality is commonly associated with certain religious beliefs and practices. The studies

conducted in our country show how health and psychosocial issues like abortion, social media use, and caregiving can have great influence on spirituality. In contrast, they have also considered the perceived roles of spirituality/religiosity in a person's health. A number of these studies are briefly presented below.

Addisu Tsegaye (2018), has conducted a qualitative study on fertility and abortion decision in relation to religiosity among 13 women residing in Addis Ababa, Ethiopia. Participants of the study were members of major religions in the country, Orthodox Christians, Protestant Christians, and Islam. His findings show that alongside legal and social implications, religious beliefs have intrapersonal and interpersonal impact on women making abortion decisions. The intrapersonal effects of religiosity in abortion, as indicated by majority of the participants in Addisu's study, relates to the fact they feel remorse and shock accompanied by self-judgment, while few indicated they felt a relief or had mixed feelings. Interpersonally, the religions condemn abortion, thus they contribute to the social stigma the women face.

Daniel Moges (2019) has conducted a study on the challenges and opportunities of using Facebook among 178 youths who have an Orthodox Christian background. His study has found that Facebook usage had the purpose of socialization as well as spiritual communication. The youths' spiritual activity on Facebook for the most part involved "reminding spiritual holydays, announcing the commencement of fasting, sharing news and events of the church and disclosing the maladministration of the church" (p.84). Conversely, the youth have identified wastage of time and weakening of spiritual life as the major challenges of using Facebook along with a certain level of addiction. (Daniel Moges, 2019)

Kahissay, Fenta and Boon (2018), have conducted a study on religion, spirits and healing among the *Tehuluder* Community, Ethiopia. Their study shows that members of the community strongly associate health with their religious belief. Both health problems and

recovery are thought to be given by God. While ill-health is thought to have natural, social, and supernatural causes, healing is thought to occur because of supernatural interventions which follow supplications and rituals (Kahissay, Fenta and Boon, 2018).

Selambizu Getachew (2018) has studied spirituality/religiosity's role in the recovery of patients from substance use disorder in Zewditu Hospital. Her findings show that patients have increased inclination towards religion and spiritual practices including praying, attending church, saluting the church, listening to sermons and spiritual songs. Participants have identified the spiritual practices as helpful for preventing relapse, abstaining from using the drugs and resisting craving. Accordingly, the study shows that spirituality and religiosity have positive contributions in the clients' recovery. (Selambizu Getachew, 2018)

Hussein (2016) has conducted a micro-ethnographic study on '*dhikr'*, a spiritual practice of reflection on Allah among Sufi Muslims, in Hararghe, Ethiopia. The study sought to explore the use of dhikr, as a Faith-Based Therapy, to treat psychosocial problems. The study shows that the client, a religious leader, family members, and significant others including neighbors and friends involve in the *dhikr*. While the therapy is solemnly led by the religious leader through recital of different religious texts, each of the individuals present is required to personally engage with God. The study has indicated that people in the community believe that such deep and personal encounter with the supernatural rejuvenates a person and the collective practice of *dhikr* can help participants gain a "sense of good connection with God" (p.44). (Hussein, 2016)

A quantitative study was conducted by Mulugeta Hussien (2014) on the role of spirituality on students' psychological well-being. The study was conducted among 153 undergraduate students who are protestant Christians. The study has found that increased spirituality, and involvement in worship services and regular prayer is associated with low psychological wellbeing. Mulugeta explained this finding by stating that students with

psychological problem use spirituality and active participation in spiritual activities as a gateway from underlying issues which threaten their psychological wellbeing.

Another study was conducted by Serkalem Tafesse (2015), on the use, application, and integration of religion/spirituality in clinical social service providers in Addis Ababa, Ethiopia. Her findings show that practitioners who participate in religious activities are in favor of integrating spiritual/religious practices with the services they provide. These practitioners were found to use spirituality/religiosity in 75% of their cases. Furthermore, exceeding number of professionals working in the field of childcare seem to consent to the use of the spirituality and religiosity among the three clinical fields included in the study: childcare, mental health, and HIV/AIDS (Serkalem Tafesse, 2015).

The above studies show that research on spirituality and religion have focused on understanding the way they influence people's view of health issues and their remedies. Even though the study by Serkalem Tafesse (2015) considered the integration of spirituality in clinical social service provision, it was not inclusive of other professionals who work in clinical/health settings. Moreover, it did not show how health professionals incorporate religion/spirituality into their clinical practice and the challenges they face in integrating religion/spirituality into their practice. Hence, this study will explore the beliefs and practices of health professionals in Addis Ababa on the integration of religion and spirituality into clinical practice with the objective to generate summarized descriptions. The study will critically investigate practitioners' definition of religion and spirituality and ways they integrate them into their clinical practice. It will also investigate the beliefs of the health professionals on whether religion and spirituality should be integrated into clinical practice, and the challenges faced in choosing to integrate religion and spirituality into clinical practice.

1.3 Research Questions

1.3.1 General Research Question

- What are the beliefs and practices of health professionals on the integration of religion and spirituality into clinical practice?

1.3.2 Specific Research Questions

- How do health professionals define religion and spirituality?
- What are the beliefs of health professionals on whether religion and spirituality should be integrated into clinical practice?
- In what ways do health professionals integrate religion and spirituality into their clinical practice?
- What are the challenges faced by the health professionals in integrating religion/spirituality into clinical practice?

1.4 Significance of the Study

The Ethiopian government has determined that religious/spiritual interventions as crucial for winning the battle against the CORONA VIRUS crisis. This has been expressed by the fact that the government has allowed religious teachings and worship services to be broadcasted in national television by adjusting the law which forbid such actions (Seleshi Tessema, 2020). This measure was taken partly to allow followers to continue prayer and worship in their homes since they cannot hold meetings. On the other hand, the fact that people can slack of in applying the preventive measures for CORONA VIRUS because of faith reasons was clearly addressed by the religious leaders in those programs.

This was not the first time that religion has played a role in the prevention of or protection against health problems at the state level. But Araya explains that the *Hidar Sitaten* movement which aimed to clear the terrible outbreak of the flu in the end of 19th century from Addis Ababa and the whole country was inspired by the Ethiopian Orthodox Church's

practice of burning incense. He also states that the burning of solid wastes which came as a result has played a significant role in the "effective elimination of the disease" (2020).

As would be seen in the next chapter, religion and spirituality are integral parts of clients' overall wellbeing. They have significant role in determining a person's health in every aspect and contribute to positive outcomes in healthcare service provision. All health professionals and social workers have the responsibility to attend to clients' health needs holistically, i.e., biological, psychological, social, and spiritual. However, literature on how to integrate religiosity/spirituality in clinical practice appropriately and effectively is yet to develop, especially in Ethiopia. These, among other factors, have presented health professionals with many challenges in dealing with religious/spiritual issues in their service provision.

Accordingly, the proposed study seeks to contribute to the advancement of literature on the area of religion/spirituality in clinical practice. The study hopes to inform educators and trainers on developing guidelines which equip health professionals with the necessary knowledge, skills, and values to competently address religious/spiritual issues in their clinical practice. Aside these direct outcomes, the study will encourage further research on religion, spirituality, and health.

1.5 Conceptual Definitions

Belief: "characterized as a propositional attitude … the mental state of having some attitude, stance, take, or opinion about a proposition or about the potential state of affairs in which that proposition is true" (Schwitzgebel, 2019).

Clinical Intervention: "any intentional action designed to result in an outcome and establish effects for specific clinical practices and programs, systems for the delivery of care, and even health related policies or legislation" (Eldh et.al., 2017; p.3).

Clinical Practice: "the agreed-upon and customary means of delivering health care by doctors, nurses and other health professionals" (Segen's Medical Dictionary, 2011).

Health care: "the various services for the prevention or treatment of illness and injuries" (Collins Dictionary, 2020).

Health Professionals: health workers which are "involved in the promotive, preventive, curative, palliative or rehabilitative health services licensed by the Ministry or regional health regulatory bodies" (FMOH Ethiopia, 2018; p.1).

Integrate (Integrating): "to incorporate into a larger unit" (Merriam-Webster, 2020).

Religion: "A unified system of beliefs and practices relative to sacred things" (Durkheim, 1912).

Religiosity: "An individual's conviction, devotion, and veneration towards a divinity … and encapsulates all dimensions of religion" (Gallagher & Tierney, 2013).

Spiritual Care: "Spiritual care is that care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener" (NHS Scotland, 2009; p.6).

Spirituality: "A personal search for meaning and purpose in life, which may or may not be related to religion. It entails connection to self-chosen and/or religious beliefs, values, and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being" (Tanyi, 2002; p.506).

1.7 Scope of the Study

As would be seen in the following section, the interaction between Religion/Spirituality and health has several implications for health care. It incorporates broad themes of defining concepts in Religion/Spirituality, determining their relationship with health, identifying its place in health care, exploring the thoughts and behaviors of the people

involved and the dynamics of health care thereof. This study will specifically examine how health care professionals integrate spirituality in their clinical practice.

1.8 Limitations

The use of a qualitative design in the study only allows a depth of understanding of the topic, integrating religion and spirituality into clinical practice, rather than cover the breadth of the topic which is expected more from a quantitative inquiry. The use of qualitative methodology also meant that the study findings are only generalizable to the research participants. The fact that only profession and sex were considered as the primary domains for variation among participants, most of the participants were found to be followers of the Christian religion with varying sects. And only one of the participants was from the Islamic religion. The snowball sampling used in the study could have also contributed to this outcome. Mainly because, people are likely to know people of the same socio-demographic and religious views. Although variety in participants' profession and sex was achieved, the use of the snowball sampling technique has led to the participants being followers of the Christian faith apart from one participant who is the follower of the religion of Islam. The proportional involvement of participants from both religions could have led to a different outcome in the study findings. The research only used semi-structured in-depth interviews for collecting data via local phone call. The reason for this is the protective measures taken by the government to minimize and avoid the spread of CORONA VIRUS. The research might have benefited more if naturalistic ways of data collection such as on field observation and focused group discussions were used to further enrich and validate the data. The spread of the virus has also limited the involvement of more participants which would have been available otherwise.

Chapter Two: Review of the Relevant Literature

2.1 Religion and Spirituality

2.1.1 Religions in the world

It is estimated that there are about 4,300 religions around the world (Popchavei, 2018). According to The Guardian, most people still esteem religion nowadays with 84% of the world's population identifying themselves with a certain religion (2018). The religious groups share varying numbers of adherents: Christianity (31.2%), Islam (24.1%), Hinduism (15.1%), Buddhism (6.9%) and other traditional or folk religions (6%). The remaining 16% of the world population does not have any religious affiliation (Hacket, Stonawski, Skirbekk & Grim, 2012).

2.1.2 Understanding Religion

Emile Durkheim, in his book *The Elementary Forms of Religious Life,* defines religion as "A unified system of beliefs and practices relative to sacred things" (Durkheim, 1912). He believed that religion is social by nature and its ultimate goals are identification and solidarity. He also described religious practices as meant to "excite, maintain, or recreate certain mental states in these groups" (Thompson, 1982; p.125). Of course, adherents themselves would have a different explanation for the origins and existence of their respective religions. But his definition encapsulates four key elements which comprise religion: beliefs, relation with the sacred, practices and a unified system. These elements are commonly found in all the major religions of the world.

2.1.2.1 Religious Beliefs

There are three beliefs identified by William James as being common among many prominent religions. Leuba (1904), presents these beliefs as followed:

"(1) a more spiritual universe of which the physical world is a part and from which it draws its chief significance; (2) in union or harmonious relation with that higher

universe as our true end; and (3) in prayer or inner communion with the spirit thereof-be that spirit "God" or "law"-as a process wherein work is really done, and spiritual energy flows in and produces effects, psychological or material, within the phenomenal" (p.323)

He also explains that religions share the notion that there is something fundamentally wrong with us, human beings, and relationship with the higher power will deliver us. (Leuba, 1904)

Adamason (2020), identifies Hinduism, New Age Spirituality, Buddhism, Islam, and Christianity as the major religions of the world. He provides a summary of their core beliefs consistently with Lebua (1904) framework; what is wrong with us, views on the divine and means of attaining freedom. The below descriptions provide an overview of the core beliefs of the religions irrespective of doctrinal differences among their sects and individual followers.

2.1.2.1.1 Buddhism

Buddhism is a religion which seeks to liberate adherers from the nonstop succession between life and death caused by a person's sensual desires. There is no specified divine being but rather a person, Buddha, who has gained this freedom which is sought by the followers. The way of deliverance is through self-discipline expressed through several religious principles.

2.1.2.1.2 Christianity

For Christians, God is the eternal creator who wants to have a personal relationship with people. All people themselves included are thought to be sinners. And they believe that it is by faith in Jesus Christ, who has died on the cross and rose again from the dead to pay for the penalty of sin that one can be saved.

2.1.2.1.3 Hinduism

For Hindus, the present life is an outcome of a previous life within the principle of reincarnation. The ultimate being is Brahman, who is represented through innumerable gods and goddesses. The goal of communion with the deity is to break the reincarnation cycle and be liberated from the law of karma so that the soul can rest.

2.1.2.1.4 Islam

In Islam, Allah is the transcendent and superior God who has created the universe. Both the good and evil in this world are thought to be his will. A Muslim will enter Paradise after this life if only he/she was a devote follower of the religion and has done many good works or died for the sake of Allah.

2.1.2.1.5 New Age Spirituality

New Age Spiritualists, on the other hand, believe in their own divinity or power, which is a state of higher consciousness. Negative experiences are thought to be illusions. And the goal of spiritual practices is to increase in one's belief of being sovereign over reality moving from the objective external reality towards the reality that the 'Self' creates.

2.1.2.2 Religiosity and Religious Practices

Gallagher and Tiemey (2013), define religiosity as **"**An individual's conviction, devotion, and veneration towards a divinity … and encapsulates all dimensions of religion". Depending on its goal, religiosity can be divided as intrinsic religiosity and extrinsic religiosity. Intrinsic religiosity is a religiosity which has the religion itself as its goal, while in extrinsic religiosity, religion is used to meet other needs rather than the religion itself. Thus, there is less concern for upholding the religion itself (Masters, 2013).

Each of the religions above has its own distinct rites. Nonetheless, Nita (2019), states that common religious practices may include "prayers, rituals, practicing mindfulness, taking part in religious observances, expressing feelings and displaying emotional literacy, talking

and connecting with others in a meaningful way" (p.1605). As one can observe, some of these rites can be done individually while others are practiced in group settings. Either ways, religious duties are often administered by the respective religious entities.

2.1.3 Defining Spirituality

Hacket, Stonawski, Skirbekk, and Grim (2012), state that atheists, agnostics, and people who generally do not associate with religion comprise 16% of the world population. They also mention that most of these group of people, maintain faith in the supernatural or higher power which may not necessarily be God. Moreover, the unaffiliated group often distinctively identify themselves as spiritual but not religious. They also tend to have a secular and subjective view of spirituality (Koenig, 2009). This contrasts with the fact that in past times spirituality was thought to be one aspect of religion (Moberg, 2010; Zinnbauer et. al., 1997).

Lomas (2019), in his lexicographical study, has found that 'the sacred', contemplative practices and self-transcendence are themes which characterize spirituality. He states that unlike the case in the definitions of religiousness/religiosity, religious customs and/or institutions are not necessary for defining spirituality. Tanyi (2018) asserts that although spirituality may or may not relate to religion, it has the aim of achieving an optimal state of functioning by attaining meaning in life through "connection to self-chosen and/or religious beliefs, values, and practices" (p.506). This assertion denotes the special emphasis given in definitions of spirituality to meaning/purpose of life (Yawar, 2001).

Zinnbauer et.al (1997), have identified that religiousness and spirituality share beliefs and practices; but differ in how people associate spirituality to more subjective and pleasant experiences. They also mentioned that people may claim to be either spiritual, religious, or both. There are also other groups, commonly found in the western society, who are neither spiritual nor religious (Cook, 2015). As a result of the obscurity of people's views and

practice, religion/religiosity and spirituality have become critical areas of investigation (Bender & McRoberts, 2012). Hill et.al. (2000) suggest that research should systematically and cautiously analyze the commonalities and differences between religion and spirituality.

2.1.4 Religion/Spirituality in Ethiopia

Christianity and Islam are the dominant religions in Ethiopia consisting 97% of the entire population while the remaining 3% consists of other religious groups (CSA Ethiopia, 2007). These religions have close ties with the country's culture and history. As a result, adherents' practice of the religions is different from other parts of the world. For example, Muslims in Ethiopia often use *Menzuma* for worship, practice *dhikr* accompanied with clapping and tongue trilling, and majority follow Sunni branch of Islam along with Sufism. The serious commitment of people to their religion is reflected in their observance of different religious rites. For instance, vast majority of Ethiopian Orthodox Christians value religion (98%), attend church meetings every week (78%) and engage in fasting (87%) in comparison with smaller numbers in Orthodox Christians in Europe (Diamant, 2017). It is observed that such devotion to own's religion symbolizes spirituality. Hence, it is possible to conclude that Ethiopia is a spiritual country with diverse religious heritage.

2.2 Religion/Spirituality and Health

Research indicates that there is a significant association between religious variables and physical, mental and substance use disorders (Miller & Thoresen, 2003). Religious practices such as church attendance, frequency of prayer and belief in eternal life were found to have positive relationship with both physical and mental health. Although positive relationship has been indicated between patients' spiritual practices and their health outcomes (Brémault-Phillips et.al., 2015), patients have also stated that disturbance in their religion/spirituality can aggravate their health issues especially their mental health (Koenig, 2009).

2.2.1 Religion and Physical Health

Powell, Shahabi, and Thoresen (2003), have conducted a review using the levels of evidence approach to determine the relationship of religious factors and physical health issues by testing common hypotheses. Evidence was ranked in descending order as persuasive, reasonable, some support, consistent failure and inadequate based on the presence of flaws or number of studies on the topic. Accordingly, they have found that the evidence for the claim that church attendance protects against death is persuasive. There is some evidence to support the claim that religion/spirituality is a protective factor for cardiovascular disease. Some evidence was also found to support improvement of physical recovery in acute illness in receiving prayer. The evidence supporting other hypothesis on the relationship between religion/spirituality and health issues like cancer mortality, death, disability, progression of cancer, life expectancy and acute illness was either inadequate or encountered consistent failure. (Powell, Shahabi, & Thoresen, 2003)

2.2.2 Religion and Mental Health

Ellison, Boardman, Williams, & Jackson (2001) have also conducted a review on religious involvement, stress, and mental health. They have found that church attendance and belief in eternal life had strong positive relationship with wellbeing while slight positive association was found between prayer and well-being. Contrarily, only church attendance had inverse association with distress. Prayer's relationship with distress was found to be positive and weak while belief in eternal life had no relation with distress.

Koenig, George, and Peterson (1998) have found that intrinsic religiosity had strong and positive relationship with remission time in older patients while church attendance and personal religious practices had no connection. Religion/spirituality provide a sense of hope, comfort, meaning, control, security, and self-confidence which can be resourceful when

people are dealing with depression, suicide, and anxiety. At times, they were noted to be a source of anxiety and complications in psychotic and neurotic disorders. (Koenig, 2009).

2.2.3 Mediators Between Religion/Spirituality and Health Outcomes

Depending on the study, factors which can confound or mediate between religion/spirituality and health may include demographic factors such as age, gender, ethnicity, education, income, marital status, employment status, and other factors like physical health, mental health, social support, healthy lifestyle, and treatment (Ellison et.al., 2001; Koenig et.al., 1998; Powell, Shahabi & Thoresen, 2003). There are two approaches which can be used to determine the actual relationship between religion/spirituality and health outcomes in statistical analysis. The first one is a Unique Variance Approach in which a factor will only be considered as having an independent contribution if it makes a considerable difference in prediction beyond existing risk or protective factors. The second one is Casual Modeling Approach which involves checking whether a certain variable like religion/spirituality still has a contribution in determining a certain outcome after other correlated predictors are entered. Nonetheless, it is noted that healthy lifestyle commonly mediates positive health outcomes which come as a result religion/spirituality. (Miller & Thoresen, 2003)

2.3 Religion/Spirituality and Health Care

Health care has pertinent difference depending on individuals' religious beliefs (Rumun, 2014). Religion/spirituality forms people's values and influence decisions related to treatment (Shinall, 2009). It often encourages adherents to adopt specific lifestyles. Accordingly, health professionals (Medics) should be aware of the implications that religious views have for their clinical practice including their own views as it determines their ethical and optimal competence (Meador, 2009). Moreover, patients express a desire that health care should address religious and spiritual concerns in part (Cook, 2015). The Alberta Health

Services confers that religions vary in the way they approach health and illness, the rituals they have for birth, the accommodation provided for death and grief related issues, commended diet, how issues pertaining to end of life are handled, and their stance in abortion, assisted suicide, birth control, blood donation, euthanasia, fertility interventions, psychiatric diagnosis, use of pain control medication, organ donation and organ transplantation (Cook, 2015).

2.3.1 Religious Practices in Daily Life

Religions guide how followers go about their clothing, diet, interaction with the opposite sex, rituals for worship and dates to be considered special. For instance, the Islamic faith does not allow people of the opposite sex to have a direct eye and physical contact (Attum, Wahdee & Shamoon, 2020). Muslims also prepare for prayer/worship by washing and cleaning themselves specifically their hands, face, and feet (Boucher, Siddiqui & Koenig, 2017). A Hindu may not eat meat because a vegetarian diet is commended by the religion (Swihart & Martin, 2020) while for orthodox Christians all sorts of meat and animal products are prohibited during fasting days and seasons (IES, 2020). Such religious needs and practices out to be respected and supported while caring for inpatients in the hospital (Swihart & Martin, 2020; Attum, Wahdee & Shamoon, 2020; Boucher, Siddiqui & Koenig, 2017).

2.3.2 Religious Practices and Major life Events

Religions shape beliefs over major life events like birth and death. Correspondingly, they dictate rites which are associated with the coming of a child into the world or a person leaving it. Some of these practices are ones which come after the event. For example, people who affiliate with the Abrahamic religions, meaning Christianity, Islam, and Judaism practice male circumcision (BBC, 2014). Although in most parts of Ethiopia followers of those religions practiced male circumcision, it is only in recent years that people in Gambella Region started to engage in Voluntary Medical Male Circumcision for its health benefits

(Teruwork Kebede & Jock Bol, 2016). On the other hand, there are religious practices which are meant to prepare the person and those around for those major life events. For instance, a Catholic person on a sick bed may choose to call on the clergy to ceremonial cleanse himself through rituals of settling confession, viaticum, extreme unction, blessings, and prayer in preparation for death (Delany, 1908). Once a person is dead there can be rituals to prepare the body for burial. '*Tahara'* is one of such rituals practiced by Jews. It involves purifying the body by washing it with water, covering it with shroud after it dries, placing the body in casket after being covered with big garment, putting on earth on the eyes and heart and in the bottom of the casket, and finally recital of prayers for forgiveness (PBS, 2004). Although family or community members may by default facilitate these activities, the hospital and health professionals would assume the responsibility of attending to these needs in their absence.

2.3.3 Religious/Spiritual Beliefs and Treatment Decisions

Dealing with religious/spiritual issues in health care can at times become more complex because of ethical and legal frameworks which dictate details of service provision. Health care professionals often face challenges in determining a course of actions which satisfies patients' needs in a manner that is consistent with agency policies, professional ethics, legal requirements, and their own conscience (FMOH, 2020). The situation presents a dilemma when a certain action is deemed to compromise any one of these areas. Although there are numerous instances in which health professionals face such difficulties, I will briefly discuss five common issues in which they need to carefully examine the interaction between religion/spirituality and health care.

2.3.3.1 Religion/Spirituality in Mental Health Problem Diagnosis

Determining the role of religion/spirituality in mental health problems can present health professionals with difficulty especially in cases of psychotic and substance use

disorders (Koenig, 2009). The DSM 5 incorporates religious and spiritual issues in addressing various mental disorders. It encourages professionals to recognize the role of religious and spiritual factors in shaping a person's identity, outlook, definitions of normative and deviant behaviors, and help seeking behaviors.

In most cases, the manual suggests that behaviors should be considered for diagnosis if they are involuntary, not accounted for religion and religious practices, supersede what is considered normal part of culture/religious practices, or accompanied by clinically significant impairments or distress. This is specifically applicable in diagnosing Delusion Disorders, Brief Psychotic Disorders, Schizophrenia, Dissociative Identity Disorder, Dissociative Trance and Persistent Complex Bereavement Disorder (APA, 2012). The DSM 5, unlike DSM IV, also contains a category, V.62.89 (Z65.8), that specifically addresses religious/spiritual issues which may be distressful like "loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values" (APA, 2012; p.725).

Abdul-Hamid (2011) asserts that the inclusion of such category in the coming ICD-11 like that of the DSM 5 would assist professionals with intricate differential diagnosis in dealing with mental health problems. However, Prusak (2016), criticizes this by stating that such approach "encourages pathologizing religious and spiritual problems" (p.175-176). Accordingly, health professionals should be aware of and sensitive towards individuals' religion/spirituality and the context in which they provide mental health services.

2.3.3.2 Refusal of Treatment Because of Religious/Spiritual Reasons

Studies show that people can have religious/spiritual explanations for the causation of health problems (Kahissay, Fenta and Boon, 2018; Tebaber Workneh et.al., 2018; Asare & Danquah, 2017; Elbarazi et.al., 2017). Their views have significant effect on their health care and treatment decisions. For instance, patients may believe that their ailment is a deserved punishment by God for wrongdoings; hence they may consider accepting it as a way of

paying back for what they owed. Patients' refusal of treatment because of religious and spiritual reasons can be challenging for health professionals especially when they believe the treatment is crucial for the patients' health. In this case, the health professionals should involve chaplains and patient's faith community in addressing religious/spiritual issues if the patients are willing. Their engagement can provide a deeper understanding of patient's beliefs and present alternative views for the patient in line with the basic teaching of the religion/spirituality which may help him/her better deal with the situation. (Frush, Eberly Jr & Curlin, 2018)

Tarpley and Tarpley (2009), in their commentary on a case which involved a 65-years old patient's refusal of a surgery based on religious and quality of life concerns, suggested that physicians should uphold patient's autonomy. They explained that the role and moral obligation of physician who does is to ensure that the adult patient is competent and well informed about the diagnosis, treatment options and possible outcomes by becoming "a source of requested information and advice" (p.762). Accordingly, they have stated that any doubts over the soundness of patient's decision should be addressed by "communicating clearly understandable data, answer questions honestly, and attempt to understand why the patient has made the choice" (p.763). Family members should have a consultation role based on the patient's preference; and the physician should not seek to manipulate a patient's decision for any reason including his/her family's persuasion. (Tarpley & Tarpley, 2009)

2.3.3.3 Religion/Spirituality in Parental Medical Decision Making

Even though, as seen in the above case, adults can refuse treatment on religion/spiritual basis regardless of its negative implications for their prognosis, whether parents can make similar decisions for their young children is a completely different story. Black (2006), states that parents' have the right to make decisions to choose suitable treatments for their children on religious basis if it does not endanger their child's well-being

both physical and mental. He explains that courts, in ruling over such cases, consider seriousness of the child's health problem, effectiveness of treatment, and quality of life issues with and without treatment. Parents' decision to withdraw treatment or use other alternatives on religious grounds are legally acceptable if the proposed medical treatment has less chances of succeeding and compromises quality of life as compared to other alternatives. In contrast, their actions may be taken as a medical neglect if the proposed medical treatment has higher probability of succeeding and pose less risk for the child's health; in which case the state will be given temporary custody and permission to proceed with treatment. Black asserts that appropriateness and best-interest are critical aspects of legally competent medical decision making. Moreover, he notes that "medical decisions are not always scientific … right to refuse treatment based on religious objection is not absolute" (2006; p.679).

2.3.3.4 Religion/Spirituality in Medical Decision Making Involving Incapacitated Patients

An Adult patient may at times be in a position where he/she is unable to make health care decisions. In such cases, it is recommended that health professionals should involve a surrogate decision maker. A surrogate decision maker is a person "who has the capacity and is willing to make medical decisions for the patient" (Markkula Center, 2017). The person can be a family member who is an adult or a person who has a close relationship with the patient and meets the requirement for medical decision making as assessed by a social worker or others (Markkula Center, 2017). However, not all patients in such a position have such a person who can make health care decisions on their behalf.

According to Schweilkart (2019), there are three groups of patients who are often unrepresented; these are patients "who are homeless or mentally ill, those who by "choice or life history" do not have family or friends who could act as a surrogate, and those elderly patients who have outlived their family and friends" (p.587). He proposes that decision

making for such patients should be made using multidisciplinary approach as opposed to the common unilateral approaches of ethics committees, physicians, or legal guardians.

The Bioethics Committee of Santa Clara County Medical Association has developed a policy to dictate health care decisions in the absence of surrogate decision makers by combining the ethics committee method with a multidisciplinary approach. The policy states that the Bioethics Committee of the hospital need to be consulted in matters involving incapacitated patients and/or those who cannot provide informed consent. The committee may also form a Sub-Committee which can play the role of surrogate decision maker. The Sub-committee will be multidisciplinary and can consist of a physician, ethics consultant, social worker, a chaplain, and palliative care. Representatives of patient's religion may involve in the team when it is found to be necessary. The policy mentions that patient's religious beliefs will be considered by the Sub-committee in determining health care goals to the possible degree and the specific cases to which the policy applies will be reviewed by the entire Bioethics Committee. (Markkula Center, 2017)

Based on the above, it is possible to conclude that the extent to which the religion/spirituality of an incapacitated patient will be considered in health care decision will be dependent on the surrogate's knowledge of patient's beliefs and practices. It is expected that default surrogates would have more awareness of these things and are in a better position than those who are assigned by an ethics committee or a board. Shalowitz, Garett-Mayer & Wendler (2007), however, suggest that timely population-based treatment indicators may provide information for predicting patients' preference regarding treatment with similar precision as to that of default surrogates, i.e., family and/or friends. But there are significant differences among definitions, laws and standards which require the awareness of the health care system, the service providers, and the patients themselves on this topic (DeMartino et.al., 2017).

2.3.3.5 Professionals' Religion/Spirituality and Medical Procedures

Like that of the patients, health professionals can also encounter medical procedures which contradict or compromise their religious/spiritual beliefs and moral standards. But whether they can refuse to carry out the procedure on such basis is a controversial issue. In the US, the Constitution and several Federal statues uphold the professionals' right to refuse participation in any kind of medical procedures which violate their conscience (HHS, 2019). The legislations provide protection against discrimination of health professionals by different entities because of their refusal to engage with such procedures. On the other hand, various segments of the population and some Federal Court Judges have rejected the statutes as being lopsided towards the professionals and health entities rather than keeping the balance with service users (Curlin, Lawrence, Chin & Lantos, 2007).

The Criminal Code of Federal Democratic Republic of Ethiopia (2004) states that health professionals cannot refuse providing service for people with serious needs "without just cause" and/or because of "indifference, selfishness, cupidity, hatred or contempt or any other similar motives" (Art. 537(1)). The ambiguity of what constitute 'serious needs' and 'just cause' can lead to the question whether religion/spirituality is a satisfactory reason for refusing service provision. Allen (2012) asserts that laws are above professional ethics; but recommends that the professionals should seek supervision in choosing a course of action. It is also recommended that health professionals should consult with attorneys to be informed on "relevant legal issues, cases and decisions" (Buehler, Divita & Yium, 1989; p.18/9).

2.4 Assessing Spirituality

There are multiple tools to understand the interaction between spirituality and health care services (Austin, Macdonald & MacLeod, 2018). Each of the spiritual assessment tools focus on patients' spirituality as it relates to different aspect of health care. LaRocca-Pitts (2012) makes a distinction between levels of spiritual assessment namely spiritual screening,

spiritual history, and spiritual assessment. The major difference in these categories is the depth of information attained, constancy in time and its use.

Spiritual screening involves asking clients one or two questions with the purpose of identifying clients' religious requirements in terms of specific aspects of client's stay in hospital (food, religious observance etc.) or appropriate chaplaincy. This information is relatively permanent throughout the health care service provision. Spiritual history is conducted to know more about a patient's beliefs and experiences, and their impact on the medical care. The assessment will be informative of the client's spiritual dynamics, well-being, and resources. These aspects of client's spirituality may change during medical care thus it may be done more than once depending on the client's health situation. Lastly, spiritual assessment involves deeper evaluation of clients' spirituality with the goal of having a patient's spiritual profile. This information helps determine client's spiritual needs based on which spiritual care/interventions can be planned. (LaRocca-Pitts, 2012)

2.4.1 FICA

FICA is one of the spiritual assessment tools commonly used for clinical purposes. 'F' stands for Faith/beliefs; the questions relate with patient's source of meaning and spiritual beliefs. 'I' stands for Importance/Influence; the questions relate with the importance of spirituality for the patient and the influence it can have on self-care and health care decisions. 'C' stands for Community; the question relates with patient's association with spiritual/religious community. 'A' stands for Action/Address; questions focus on how client's needs can be addressed based on this information. (Puchalski, 1996; cited in Puchalski, 2001)

2.4.2 SPIRIT

On the other hand, SPIRIT is a spiritual history tool which is a bit more exhaustive than FICA. Questions of 'S' relate with the Spiritual belief System of the patient. Questions of 'P' focus on the patient's Personal spirituality. Questions of 'I' are intended to know about

a patient's integration with a spiritual community. Questions of 'R' help determine specific Ritualized practices and Restrictions which a patient may consider significant. Finally, questions of 'T' are meant to address issues related with end of life and advance directives. (Maugans, 1996)

2.4.3 FACT

FACT is a spiritual assessment tool developed for use among chaplains. Its content is broader and more comprehensive than other tools like the ones above. 'F' stands for Faith; and it helps acquire information on a person's specific faith, his/her view own's spirituality and beliefs that give meaning and purpose in his/her life. 'A' stands for Active, Available, Accessible and Applicable; it is used to inquire of a person's involvement and activeness in a religious/spiritual community, access to things needed to apply beliefs and the existence of an individual or a group whom the client appreciates the presence and support in such a time. 'C' stands for Coping, Comfort, Conflicts or Concerns: it is used to ask whether the client can cope with his/her health situation, whether he/she is able to cope or gain comfort through his/her faith, whether there is conflict between his/her faith and medical treatment, and the presence of a specific concerns. Finally, 'T' stands for treatment plan which may involve direct spiritual intervention if faith/beliefs are similar, encouraging the patients to sort out their concerns with their respective clergy or referring him/her to the chaplaincy service in the hospital. (LaRocca-Pitts, 2012)

Rumun (2014), asserts that the assessments should be carried out with respect and sensitivity, in a way that is not offensive for patients. Accordingly, the focus of the assessment should shift from religious/spiritual beliefs to source of meaning, purpose, and support when it is found that a patient deems religion/spirituality as unimportant for him/herself. The professional may seek to openly discuss these issues if/when it presents difficulty for the patient as it can potentially alter his/her health and medical outcomes

(Koenig, 2007; as cited by Rumun, 2014). Congruently, Puchalski (2001) contends that spiritual assessments should be patient-centered and are not to be basis for "proselytizing and ridiculing patients' beliefs" (p.355).

2.5 Spiritual Care

Spiritual Care can be understood as a "care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener" (NHS Scotland, 2009; p.6). According to Puchalski (2001), it may involve:

1) *Practicing compassionate presence—i.e., being fully present and attentive to their patients and being supportive to them in all their suffering: physical, emotional, and spiritual; 2) Listening to patients' fears, hopes, pain, and dreams; 3) Obtaining a spiritual history; Being attentive to all dimensions of patients and their families: body, mind, and spirit; 4) Incorporating spiritual practices as appropriate; 5) Involving chaplains as members of the interdisciplinary health care team*. (p.355)

Culliford (2002), explains that the goal of spiritual care is healing not cure of symptoms which implies the "restoration of psychobiological integrity, with the implication of personal growth and a sense of renewal" (p.1434). This fits in with the holistic care model which is advocated for in contemporary clinical practice and significantly improves prognosis of patients (Culliford, 2002).

Saad and de Medeiros (2016) assert that the hospitals have various reasons for including spiritual care services. First reason is that patients insist that their health care service providers should consider religious/spiritual aspects. Secondly, it helps professionals better manage religion or spiritual based misconceptions which have implications for

treatment. Thirdly, such outlooks in health care services have become a requirement for accreditation (in USA). Lastly, the support patients receive form their religion, spirituality or faith communities have positive role in patients' health that it minimizes their demand from health care thus reducing the cost of such cares. (Saad and de Medeiros, 2016)

Spiritual care, though other professionals can incorporate it into their practice, is mostly provided by chaplains, nurses, and/or social workers. The professionals' decision to involve spiritual issues can show the client that the professional seeks to address not only the disease or ailment, but also, other aspects of his or her overall wellbeing (D'Souza, 2007). Nevertheless, professionals should be aware of their professional boundaries and power relation with patients while engaging in spiritual practices as it can unintentionally cause patients to conform to the professionals' faith. (Puchalski, 2001)

2.6 Challenges of Integrating Religion/Spirituality in Clinical Practice

Baldacchino (2015), states that the spiritual dimension of health is discounted by health professionals because of the medical model which predominantly focuses on health problems and their treatment. Other reasons for ignoring patients' religion/spirituality include "lack of education on spiritual care; lack of inter-professional education (IPE); work overload; lack of time; different cultures; lack of attention to personal spirituality; ethical issues and unwillingness to deliver spiritual care" (p.594). Culliford (2015) suggests that this can be addressed by prioritizing spiritual care and working on areas of "clinical governance and continuing personal and professional development" (p.1435) in accordance with the underlying cause. Personal spirituality is also known to increase the effectiveness of spiritual care as it helps the professionals develop "a trustful helping relationship" (Baldacchino, 2015; p.597) with patients. Examining the spiritual needs of oneself also helps the professionals provide support for others on similar areas (Jackson, 2004).

Chapter Three: Research Methods

3.1 Bracketing

Morgan (2014) states that the interpretation of a study outcomes will be subject to the beliefs and actions of the researcher, and those involved in the process. Bracketing is a technique used in qualitative studies as a means of acknowledging preconceptions which pose threat to the research and its rigor (Tufford & Newman, 2010). This research has utilized a qualitative descriptive method. Because of the use of qualitative design namely, qualitative descriptive design, the researcher has framed these individual factors which may have influenced the study namely his own faith and professional disposition.

As an Evangelical Christian, my views of spirituality and its relationship with health is predominantly dependent on what the Holy Bible teaches on the matter. The Holy Bible in general articulates that God determines a person's health. It presents various instances on which demons and evil spirits associated with health problems and diseases; Epilepsy (Luke 8:37-43), Wild behavior (Matthew 8:28-34; 15:22-28), Deafness (Matthew 9:32-33), Comorbid Visual impairment and Deafness (Matthew 12:22). The Holy Bible exhibits various instances of miraculous healing. Few of these involved a certain procedure; healing from leprosy by dipping oneself in a river seven times (2 Kings 5:14; NKJV); healing from boil by laying "a lump of figs" (2 Kings 20:7; NKJV); healed from visual impairment after being anointed with clay mixed with saliva (John 9:6-7; NKJV); drinking a little wine for stomach problem (1 Timothy 5:23; NKJV). But ultimately whether through such procedures, modern medicine, prayer or other instances, God is the one who gives and restores wellbeing.

The implication of my Christian faith for the study is that discussions on spirituality must recognize spiritual beings and related spiritual experiences as objective realities which have critical role in determining a person's health. Accordingly, the design and strategies in this study are inclined towards understanding how health professionals approach these pieces

of spirituality in their clinical practice. A researcher with a different view on spirituality may approach integration of religion/spirituality in clinical practice differently. For instance, a researcher with an atheistic worldview may give emphasis to the aspects of spirituality which are more related with meaning of life and self-transcendence. My beliefs may also influence the interpretations of the findings of the study and its outcomes.

As a social worker, I deem that the goal of any clinical and non-clinical intervention should aim for a holistic wellbeing of the client including spiritual wellbeing. The client centered approach commonly upheld by the profession contends that clients should be given an opportunity to actively engage in the process of health care delivery. This means that professionals should step into client's world and follow their lead in providing them with services. Clients should also be the ones who dictate the details of the care they receive including the one whom they receive it from. Although standards are not clear on the specifics of using one's religion and spirituality in practice, it is expected that such engagement should be for the purpose of serving the client's interest and must be based on his/her consent.

3.2 Research Paradigm/Worldview

Creswell (2009) describes worldview as the philosophical ideas held by a researcher which elucidate reasons behind choosing a certain approach to research. He explains that these notions may be molded by a student's field of study, views of advisers and faculty, and previous encounter with research. This research is oriented by the pragmatic paradigm. Morgan (2014) drawing from John Dewey's work states that pragmatism is mistakenly viewed to address the question of "what works?" (p.2). At the core of pragmatic philosophy is the idea that human experience incorporates beliefs and actions which mediated by interpretation yield one another in an endless cycle. In social science research, it gives rise to a new paradigm in which a research's focus shifts from "abstract philosophical beliefs" (p.7)

to beliefs with direct link to actions. Thus, research would investigate the process, meaning and outcome of choices made and "how these factors influence both the choices made and the ways we interpret the outcome of the choices". (Morgan, 2014; p.7)

The researcher believed that the integration of religion/spirituality into clinical practice can be best examined through the pragmatic lenses. The principles of pragmatism, unlike other worldviews, directly deal with practices without getting entangled with philosophical notions. This was helpful in dealing with the complex yet delicate issue of religion and spirituality which can only be understood in terms of people's beliefs, actions, and the relationship between the two. Similarly, clinical practice, as stated previously, denotes the actions of different health care professionals in accordance with their professional knowledge, values, and ethics. Moreover, the researcher chose pragmatism as a paradigm because unlike constructivism which seeks to "develop subjective meanings of the phenomena" (Kaushik & Walsh, 2019; p.2), the research only seeks to provide a description of participants' experience of the phenomenon.

3.3 Research Design

The research has utilized the qualitative description design to answer the research questions set forth in the first chapter of this document. Bradshaw, Atkinson, & Doody (2017) stated that qualitative description design can be used where data must be acquired directly from people who are experiencing the phenomenon of interest. According to Lambert and Lambert, (2012), qualitative descriptive design involves studying specific experiences of individuals in their natural state with aims to summarize the experiences in everyday terms (p.1). They have also explained that qualitative descriptive design, as compared to other qualitative approaches, is much less theoretical and complex.

The researcher chose the qualitative descriptive design because the research only sought to describe the phenomenon of interest, namely integrating religion and spirituality

into clinical practice. Lambert and Lambert (2012) have noted that qualitative descriptive design can have the overtone of any of the qualitative research methods and methodologies like phenomenology and grounded theory. This study has a phenomenological overtone specifically in sample size determination, data collection, and data analysis.

First, the phenomenological overtone is reflected in sampling and sample size determination in that emphasis is given to distinctiveness rather than data saturation. Bradshaw, Atkinson, and Doody (2017) have explained that, in phenomenology, "uniqueness of individual's experiences" is stressed and thus, it is argued that it is impossible to truly achieve data saturation. And second, the researcher has used bracketing as a tool to avoid "subjectivity during data collection and analysis" (Neubauer, Witkop, & Varpio, 2019; p.92). Third, the researcher has included direct quotes of participants' statements to show the rich details of the participants experience of the topic in discussion. However, this does not mean that the study is a phenomenological study as it does not intend to describe the meaning of lived experience as expected in phenomenology (Creswell, 2007).

3.4 Study Area

The study areas for this research are health institutions located in Addis Ababa, Ethiopia.

3.5 Study Participants

The participants of this study were health professionals who have experience in providing direct health services to clients. The health professionals came from governmental and private health institutions in Addis Ababa, Ethiopia namely Hayat Medical College, Tikur Anbessa Specialized Hospital (Addis Ababa University), Mental Health Society of Ethiopia, Gandhi Memorial Hospital, Eye Bank of Ethiopia, and other health centers. The health professionals are from the fields of Anatomy, Medicine, Nursing, Psychology, Psychiatry, Radiology, Sociology, Social Work and Surgery. The government of Ethiopia had set a partial lock down because of the Corona Virus outbreak. Institutions were encouraged to minimize

staff presence in their offices and look for means to provide services which does not involve physical contact. This has made it difficult to contact responsible agencies to determine specific institutions from which potential participants will be reached systematically. For this reason, the study participants were identified using personal social networks because

3.6 Sampling

Lambert and Lambert (2012) have stated that a descriptive qualitative design may utilize purposeful sampling technique so long as it is suitable to meet the objective of the study. Accordingly, the researcher has used a non-probability purposeful sampling technique namely criterion sampling technique. Criterion sampling entails that participants will be selected based on the anticipation of greater familiarity with the topic thus, can provide "both detailed and generalizable" information (Palinkas, 2016). The criteria for recruiting participants for this study were the following.

Participants:

- should be a health professional working clinical settings in Addis Ababa
- has a minimum of three years-experience in direct health care provision
- is available and willing to participate in the study.

Because of the difficulty in locating health professionals, who would be available and willing to participate in the study due to the Corona Virus outbreak, the researcher has used the snowball sampling technique to identify participants who meet the above criteria. The researcher has also used the maximum variation sampling technique to ensure that the participants have diverse experience of the phenomena. The traits considered for variation were profession, workplace, and sex. When it was found that the potential participants were similar in profession, years of experience and religion were considered as traits to decide inclusion.

3.7 Sample Size

Sim, Saunders, Waterfield & Kingstone (2018), explain that sample size determination in qualitative research is a debatable issue. Nonetheless, the analysis of different research shows that there are four commonly used techniques to determine sample size. These are rule of thumb, conceptual model, numerical guidelines, and statistical formulae. Among these methods, the conceptual model entails that the researcher determines the sample size by considering specific aspects of the study like the objective, theoretical framework, and the intended analysis (Sim, Saunders, Waterfield & Kingstone, 2018). Since the objective of the study was to have a deeper understanding of how various health professionals integrate spirituality in clinical practice, twelve participants were included in this study. The number of the participants was limited to that specific number because these were the participants who were willing and available to be part of the study during the time of data collection.

3.8 Data Collection

Bradshaw, Atkinson, and Doody (2017) have stated that qualitative description primarily uses semi-structured in-depth interviews as means to collect data. They have also explained that they use of such data collection "encourages depth and rigor, which facilitates the emergence of new concepts, and contributes to the richness of data" (p.5). The semi-structured in-depth interviews in this study consisted of questions which address professionals' view of the terms, religion and spirituality, and their thoughts on their relationship with health, health problem and health care provision. The participants were also asked questions in relation with the integration of religion and spirituality into clinical practice. The interview guide was prepared based on the literature review conducted by the researcher. The interview guide was then translated into the Amharic language by a well experienced translator. The Amharic interview guide was translated back to the English

language by another professional to ensure the accuracy of the translation. All interviews except for one, was conducted using the Amharic language. The final copy of the guides is annexed at the end of this document.

3.9 Data Analysis and Presentation

Qualitative data analysis basically entails analyzing the collected data for themes or perspectives (Creswell, 2009; p.171). Although there are variations among the different qualitative techniques, the overall qualitative data analysis can have four steps which are taken in between the data collection and the final output. The analysis steps included Data managing; Reading and Memoing; Describing, Classifying, and Interpreting; and Representing and Visualizing (Creswell, 2007). The data was organized and skimmed through in preparation for analysis.

The data managing process also involved transcribing the interviews verbatim. Since most of the interviews were conducted in Amharic, the transcribed files were translated to the English language by a professional who is informed of the research. The translation was checked for accuracy by comparing the final translation with the original language of the interview.Creswell (2009) has noted that data can be organized based on predetermined codes as well as codes which emerge from the study. Accordingly, both coding approaches were used in this study. Since data analysis goes hand in hand with the data collection and preparation process, the researcher has gone through the data carefully and repeatedly to structure and shape the themes/descriptions. In line with the study design, the researcher has presented descriptive summaries of participants' response. The descriptions were backed up by different quotes from the participants which either "signify different perspective, display a point, or convey more complex understanding" (Creswell, 2007; pp.182-83). Finally, the researcher has expounded on the major findings of the study in relation to the available literature.

3.10 Data Quality Assurance

The data quality of the research was primarily ensured by using rigorous research methods as well as by using certain procedures in the undertaking. Creswell (2009) recommends using several procedures to ensure the validity of the data and the findings. The procedures include Triangulation, Member Checking, Rich and Thick Description, Clarify Bias, Presenting Discrepant Information, Debriefing, and Using External Auditor. Accordingly, the researcher has applied these procedures to produce reliable and valid data.

Clarify Bias: The researcher has used the technique of bracketing to frame the bias he brings into the study.

Data Source Triangulation: the data was collected from different types of people who provide varying viewpoints (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014).

Member Checking: participants will be given an opportunity to reflect on the findings to be included in the final report.

Rich and Thick Description: the researcher has presented well-constructed themes backed up by vivid descriptions which reflect different perspectives found in the data.

Discrepant Information: unexpected and discrepant findings in the study are discussed in contrast to other findings within the themes.

Peer Debriefing: the researcher will identify a colleague/instructor who will review and ask questions regarding the data and the interpretation given.

External Auditor: at the end of the study, the final report will be given to another colleague/instructor who has not been involved in the study or with the researcher in any way to review the research.

In addition, the researcher has used the necessary interview skills such as paraphrasing and note taking to ensure that the responses are grasped with their intended meaning. And the use of member checking that

3.11 Ethical Considerations

Ethics is a critical part of any research undertaking. In Ethiopia, the National Research Ethics Review Committee, under the FDRE Ministry of Science and Technology, has the mandate to oversee research activities in the country. The committee is also responsible to design and provide guidelines on how ethical issues should be addressed at different levels. Accordingly, the researcher has considered the ethical principles and guidelines set out by the committee.

The eight principles stated in the National Research Ethics Review Guideline are Ethical Justification and Scientific Validity, Science and Social Value, Favorable Risk-Benefit Ratio to Participants and Their Communities, Fair Selection and Enrollment of Human Subjects, Privacy, Independent/IRB Review, Informed Consent Process, and Community Engagement (FMoST, 2014; p.16). These principles were upheld both in the design and undertaking of this research. The researcher has proceeded with the research after it was approved by the instructor and internal examiner assigned by the School of Social Work, Addis Ababa University.

Potential participants were provided with an online written informed consent. The informed consent contained:

- Information about the research topic, its purpose, expected outcome/s from the research and duration of the research process
- Role of the participants in the research, the type of data to be gathered from them and the time it will require, and their beneficence as well as potential losses

- Description of participants' unalienable rights to voluntarily participate or not, right to confidentiality and conditions in which it may be broken, right to anonymity, right to withdraw at any given time from the research without any precondition, right to be provided with any information about the research, its process or anything related, and their right to privacy
- Contact information of the researcher and School of Social Work, Addis Ababa University

The researcher only proceeded with the data collection once the potential participants gave their consent by submitting the form as directed arranged by the system.

The researcher has used pseudonyms to protect participants' anonymity, confidentiality, and privacy. Identifying information will not be shared with a third party or included on the report without an express consent from the participants. Confidentiality will only be broken without such a consent if the information is required by legal bodies or if the participants pose threat to self or others and the researcher has clear evidence to justify it.

The end of the research will be marked by the submission of the final report to Addis Ababa University School of Social Work. Interested participants may get a copy of this report by contacting the researcher or the institution. The findings may also be made available for the public using different mediums in accordance with regulations pertaining to decimation.

3.12 Safety Measures

Due to the current CORONA VIRUS crisis governments have taken various steps to ensure the safety of their people. During the data collection period of this research, the Ethiopian government has issued a state of emergency to prevent the spread of the virus under Proclamation 3/2020. During this time people were required to maintain physical distancing (2 meters), wear face masks in public places, wash or sanitize their hands frequently, meetings of more than four people are forbidden, use forms of greeting which do

not require physical contact, students were advised to stay at home and work using online platforms, and were to avoid any activity which may contribute to the spread of the corona virus (ENA, 2020; EthioEmbassy UK, 2020).

In line with these regulations, the researcher has used Google Forms as a platform for sending the informed consent to potential participants along with a socio-demographic information sheet via a link provided by google. The links were sent out using the email addresses obtained from the professional who recommended them. Participants were given the option to have the interview physically or virtually using various means namely Local Phone calls or Video Call using Zoom, Google Duo or Skype. In accordance with their choice, all interviews were conducted via local phone calls except for one which was conducted face to face. During, the face-to-face interview, the researcher has maintained social distancing, wore mask, and used a sanitizer.

Chapter Four: Findings

4.1 Participant's Sociodemographic Information

The participants of this study are health professionals who work in various clinical settings. A total of 12 professionals have participated in this study. Before the interview, participants were asked to provide several socio-demographic information namely, Name, Age, Sex, Marital Status, Profession, Workplace, Years of experience in Clinical Practice, and Religion. The responses of the participants are presented in the table below. For the sake of maintaining confidentiality, however, the participants are given pseudonyms.

No.	Pseudonyms	Age	Sex	Marital Status	Profession	Workplace	Years in CP	Religion
1.	Belaynesh	74	Female	Married	Nurse	Retired	48+	Orthodox
2.	Kidist	73	Female	Married	Anatomist	Hayat Medical College	32	Adventist
3.	Ketema	58	Male	Married	Surgeon/Teacher	Tikur Anbessa Specialized Hoslital/AAU	34	Protestant
4.	Tewodros	45	Male	Single	Sociologist	Mental Health Society - Ethiopia	6	Orthodox
5.	Berhane	27	Female	Single	Nurse	Mental Health Society - Ethiopia	5	Protestant
6.	Tassew	29	Male	Single	Social Work	Gandhi Memorial Hospital	4	Orthodox
7.	Demekech	30	Female	Single	Psychiatry Resident	Tikur Anbessa Specialized Hospital	6	Orthodox
8.	Kibrom	60	Male	Married	Radiologist	Unspecified Private Hospital	40	Orthodox
9.	Ayelu	58	Female	Married	Ophthalmologist	Addis Eye Clinic	36	Orthodox
10	Tringo	38	Female	Married	Medical Director	Eye Bank of Ethiopia	8	Orthodox
11	Gizaw	58	Male	Married	Medical Doctor	Unspecified Private Hospital	32	Orthodox
12	Abdi	37	Male	Married	Medical Doctor	Unspecified Government Health Center	15	Islam

The table shows that the participant's age ranged from 27 to 74 years old. Equal number of Male and Female professionals have participated in the study. Eight of the participants were married while the remaining four are Single. In line with the maximum variation sampling technique used in this study, each of the participants are from different professions except for three participants who are Medical Doctors and another two who are Nurses. Nonetheless, the participants differ in their Religion and Workplace. The health professionals' years of experience in clinical settings also ranges from 4 to 40 years.

4.2 Defining Religion and Spirituality

The health professionals in this study were asked how they define the terms Religion and Spirituality. Accordingly, they have explained that the two intertwine with one another but at same time have characters which make one different from the other. Belaynesh has mentioned that defining these terms is difficult because "it is a philosophical question which many people struggle with" (Belaynesh, , August 28, 2020). Notwithstanding the above, each of the participants has provided their own description of religion and spirituality. Their descriptions are presented here after.

Belaynesh described religion as an organized system of belief followed by a group of people; and has practices and rituals which are peculiar to that religion. The participants have mentioned that religion involves believing in the existence of something, either a God, a higher power, or a supernatural force, which is bigger than self. They have stated that religion involves following or leading our lives in line with a specific doctrine, guidelines, rules, and written beliefs which are specific to that religion. Tewodros stated, "religion answers the question we have about what happens to us after death" (Tewodros, , August 28, 2020). Additionally, Demekech said that religion is an institution … where you follow the rules, where you pray, and go to places where these activities are done" (Demekech, September 19, 2020).

The participants have described spirituality as one which relates with individuals' practice of their own religion. Tassew stated that there is a different side to spirituality which does not relate with religion. He said that spirituality is "the strength and patience we have to get to the goals we set for ourselves; it is the reason we have to pay sacrifice to achieve" (Tassew, , August 28, 2020). Similarly, Berhane explained that spirituality is living life according to the things we learn in everyday life. Ayelu has also stated that spirituality might be the way a person sees the world and the way he/she build relationships.

The participants have compared religion and spirituality and shared their reflections on how the two relate. They have stated that religion and spirituality relate with one another and go hand in hand with one another. The participants have described religion as something which is communal and spirituality as something which is personal. Some participants explained that spirituality is a means by which a person carries out the ordinances set forth in his or her religion. In explaining the relationship between religion and spirituality, Demekech stated that spirituality is a wider concept than religion since "it is more related to self-knowledge and the way we relate to religion" (Demekech, , September 19, 2020).

The participants have also explained that religion and spirituality may differ in the way they are exhibited in individuals' lives. They have stated that people who are spiritual may not necessarily be religious or belong to a particular religion. On the contrary, Tassew mentioned that he considers people who follow a specific religion to be spiritual as well. He explained that this is because religion leads to spirituality. But Demekech has stated that although a person follows a specific religion it does not necessarily imply that he or she is spiritual.

As mentioned above, the major distinction made by the participants between religion and spirituality is that the former refers to something communal while the latter is something personal. Tringo has mentioned that spirituality differs from person to person. She further adds, "spirituality can either weaken or strengthen your faith, the way you act out what you understand, or live-in harmony with what you believe in" (Tringo, , August 27, 2020). In conclusion, Berhane has stated that the reason the terms are linked with one another has to do with "the way we were raised, making sure those two go together" (Berhane, , August 28, 2020). In any case, Tassew has said that religion and spirituality are tools to achieve the things we deem important.

4.3 Personal Religiosity/Spirituality

The participants have expressed that religion and spirituality have a big place in their lives. They have mentioned that they have followed in the footsteps of their parents in their choice of religion. Berhane said that as children, people follow the religion of their parents. Once that person is old, he or she may choose to convert to a different religion based on what he or she think is right. She added that unlike religion, spirituality is something to be developed personally through time.

Each of the participants, though they come from different religious backgrounds, believes in God, and have their own ways of practicing their religion. In explaining his beliefs and practices Ketema said, "I believe in God, the God that came to this world to save us, that lost his life on the cross to save our lives…. and I have been spiritual, I follow all the rules and try to keep myself from making sins" (Ketema, , August 26, 2020). Other participants have also mentioned the specific things they do to demonstrate their devotion to their religion. Tewodros said that he and his family were not deeply religious; but they used to go to the church and attend sermons. Although he has stopped going to church when his mother got sick, he still fasts without missing a season and prays. On the other hand, Tringo stated that there is a reason she came to this world and she believes leading a very spiritual and religious life is important. She added that it is in such a manner that she has lived this far.

Belaynesh expressed that keeping her religion during her college years was difficult. She has shared the following story of how she has kept her religion and beliefs despite the challenges until now.

> *Well, I am from the old school. I am a very senior health professional. And when I grew up, I remember I had this experience where the university I attended in the 60s and early 70s allowed all sorts of expressions. There was even a group claiming that there was no God. Since I came from Ethiopia, which is a highly religious country,*

and parents who are very spiritual, I found such expressions to be exceedingly difficult to deal with emotionally. Especially because my mother was the most religious and spiritual person I knew, and her stance became part of mine during my childhood. As far as my clinical practice is concerned, I was trained as a nurse and later as a physician. I kept my own religion because of the variety. (Belaynesh, , August 28, 2020)

Belaynesh mentioned that her practice of her religion is primarily driven from her mother. She said that even as a doctor she still uses holy water when she gets ill and encouraged others to do the same because she believes that it has power that can make people well.

After all the challenges, I decided that I will keep my religion and that of my parents, especially my mother's. I have big respect for my mother. This made me stick to the religion she followed. Personally, I have used holy water for my family, and for my clients. My mother brought me up with holy water from Ziquala Abo… And my children used to drink that, I do not know how they believe in it now. … God is near whenever we seek him. And my experience is that time and again, people who are surprised to see me on the holy water site when I was ill and said, "she is a doctor, she is a doctor". But it has power. (Belaynesh, , August 28, 2020)

Belaynesh also believes that science and medicine are part of God's work and that they are a different way in which she sees the power and presence of God with her. This belief is shared by other participants. Gizaw and Abdi said that they believe it is because of the creator, God, and not in their efforts alone that they are able to have successful outcomes in the service they provide for their clients.

4.4 Relation of Religion/Spirituality with Health

The participants were asked to share their thoughts on how religion and spirituality relate with health. Accordingly, they have expressed that there is a strong relationship

between a person's religiosity/spirituality and health. Belaynesh explained that 'the spiritual' can be considered as one domain of a person's overall wellbeing. She has quoted the WHO's definition of health saying, "illness is defined not just as a physical wellness. Health is a general wellbeing. ... wellbeing which includes the physical, emotional, social and spiritual" (Belaynesh, , August 28, 2020).

The participants have conveyed spirituality in terms of a person's psychological condition. They have explained that a person's physical health is linked with their psychological make up and that both need to be addressed for the person to have full recovery. Ketema has stated, "we are trying to cure the illness on every level. So, when you try to heal their physical illness, we also need to make sure their psychological pain is also healed" (Ketema, , August 26, 2020). Demekech, who is a psychiatrist, said that the field of psychiatry or psychology does not only focus on the psychological and social, but it is also not only about the mind, the body, or the spirit. Rather she said that the professions focus on the interaction between these aspects of life. Demekech has further explained that religion can be a source of mental and emotional strength from which resilience is found. The participants were also asked if it is possible to make distinction between that which is spiritual from that which is psychological. They have stated that such a distinction is difficult.

4.5 Religion/Spirituality and Health Problems

The health professionals in this study have explained various ways in which religion and spirituality shape the way people understand the cause and nature of health problems. The participants stated that they come across clients who believe that their health problems are caused by evil spirits, lack of religious commitment, or punishment from God. Each of the participants have described different scenarios in which they have encountered such issues in their clinical practice and how they have dealt with it. Their descriptions are presented as followed.

Demekech stated that before diagnosing a patient with mental health problem, they ask their clients if they have an explanatory model for the cause of their illness. She said that this helps them understand their clients. She also stated that they ask their clients what got them to where they are and what they found helpful in dealing with their problem. After this, they give their own diagnosis and discuss with the clients what they think the treatment they get should be.

Tassew has stated that people can have either positive or negative religious interpretation of their health problems. On the negative side, he said that people, when faced with sever illnesses or traumatic accidents, may believe that their problem is caused by lack of commitment towards their religion. They may believe that the problem came as a punishment for the sins they committed, or they would simply blame God for what happened. Tassew explained that when clients have such attitude, they would reflect feelings of hopelessness which in return affects their immune system. In contrast, he has also observed that some clients are thankful that they survived a traumatizing car accident. In conclusion, he stated that most sever health problems lead to religious or spiritual thoughts. And other participants have also noted the relationship between clients' belief and their immune system.

Belaynesh mentioned that people are likely to believe that mental health problems are caused by evil spirits because mental health relates to the spiritual or emotional aspect of the individual. She stated that this was a real struggle especially 15 years ago because of the imbalance between the psychiatric service providers, who at that time were close 8, and the number of the population who needed mental health services, which consisted 10-15% of the 70 million people. Belaynesh explained that due to the accessibility issue caused by this imbalance, people preferred to go to holy water sites. The clergy on those sites, on the other hand, also believed that they are getting to the real cause of the mental health problem which they believed to be spirits. Belaynesh stated that much effort was required from the side of

the professionals to work together with the clergy to explain to them medical care works and that they needed to encourage their followers to take the necessary cautions and treatments. Both Belaynesh and Tringo have explained that there has been a real success on this regard even in dealing with people's perception of HIV/AIDS and the Corona Virus.

Ketema has also mentioned that he has had encounters with clients who believe that their health problems are caused by evil spirits. In such cases, Ketema explained that he makes sure to check whether the person's problem is not physical by conducting various tests. He stated that once he is 100% sure that the problem is not physical, he would refer the client to a psychologist or a psychiatrist because what the client is facing may be a psychological issue. He has also mentioned a case in which he referred a client to seek a psychological help because the person claimed to smell something funky and there was no clinical and physical cause for that smell. He said that while managing this case he even went to the length of going under his nose and smelling to prove to the person that he does not have a bad smell. Kibrom stated that he would also take similar measures while conducting thorough assessments and referring clients to psychiatrists.

Unlike the above cases, Berhane, who is a clinical nurse working in psychiatric institution, mentioned that although it is not acceptable by the society, she believes some health problems are caused by evil spirits. She said,

> *All the cases are the same for me. The reason for their illness might be different, I believe the way they see their illness and the cause depends on the individual. And I believe there are illnesses that are caused by evil spirit…. Not all of them but some. You cannot just tell them their problem or illness is caused by evil spirit; our society would not take it positively.* (Berhane, , August 28, 2020)

Berhane stated that since it will not be taken positively, she keeps it to herself and does nothing to help personally. Belaynesh also mentioned that there are times where her faith is

challenged because of the health problems she sees people face, especially during the time where she worked as a pediatrician. She said that there were times where she blamed the parents or even God because of the health problems of children.

Belaynesh shared her experience on this regard as followed.

> *Personally, I was not a strong practitioner. I was trained as a pediatrician. And I was already a mother with three children by the time I completed my training. For me, to see certain diseases like cancer and HIV broke me down. Before that I was really upset by malnutrition. And sometimes, I used to blame the parents and even God. Because you can imagine how difficult it is to accept anything happening to small children. They do not know even how to express their pains. So, I have been through a lot. How I managed to retain even this belief.* (Belaynesh, , August 28, 2020)

Belaynesh also explained that medical practice is not easy and that professionals face lots of horrible things that can blow their faith. But she suggested that when professionals, including herself, encounter such issues, "you just manage and hope to see better things" (Belaynesh, , August 28, 2020).

4.6 Beliefs on whether Religion/Spirituality should be Integrated into Clinical Practice

The participants were asked to share their opinions on integrating of religion and spirituality with clinical practice. Although most of them agreed religion and spirituality can have a positive outcome if practiced by the clients, the participants have reflected different stances on whether the professional should integrate it into his or her clinical practice.

Belaynesh has stated that she encourages and assists her clients to practice their religion if it does not do them harm. She has explained that the reason for her practice is that she believes religion, spiritual guidance, and spiritual support is part of each individual "because they are spiritual beings" (Belaynesh, , August 28, 2020). Ayelu has stated that the integration of the two has an incredibly good result because "God would be there for you and

support you every step of the way" (Ayelu, , August 28, 2020). Berhane also stated that believing in something will enable people to have more hope. However, she explained that this should not be the reason for not taking medicine. She said that God is the one who gives power and that clients need to believe in the ability of both religion and medicine in saving them.

Contrary to the above, other participants have stated that religion and spirituality should not be integrated with clinical practice. The major reason they gave for this is that religion/spirituality does not go together with science and modern medical practice. The other reason is that health professionals are mainly expected to provide medical treatment which does not require or need the professional to be neither religious nor spiritual. In explaining her stance, Demekech said,

> *We do encourage spirituality. But we do not address a patient's problem with spirituality, or we were never told to do so neither in trainings nor in any other way. Science is always evidence based, and the treatments we give, whether they are medications or psychotherapies, they are evidence based. All the pharmacological therapies went through different process including animal trials, human trial and maybe efficacy and many more. It is hard to have these trials on religion, the whole point of religion and spirituality is our ability to believe in the unseen, having faith blindly. But normally, when a patient is religious or spiritual, we make sure we encourage them to keep it up because it is helpful.* (Demekech, , September 19, 2020)

Kibrom, who also shares this belief, stated that he personally believes that there are traits which medicine and religion share, like the use of different herbs and plants to bring healing. But he explained the topic of religion should not be raised because such discussions would not have positive results. He also added that both religion and work have their places and as a health professional, he gives his professional opinion.

Ketema has pronounced that health professionals do not need to be religious or spiritual to provide appropriate services for their clients. He explained,

> *When it comes to clinical practice, the place we give to the life of a human being is huge. We do not need to be religious or spiritual to want to save lives. We have seen non-religious individuals give the right type of service, even better service than those of us who say are religious. So, it is hard for me to say that clinical settings and individual beliefs are related or go together…. It is hard to say that healing should be religious or spiritual because we all have our own religion; and we all have our own understanding of spirituality.* (Ketema, , August 26, 2020)

On this regard, Berhane states that his/her profession focuses on saving lives, helping individuals. She stated that helping should come from the heart "it should be because you know the person needs help and not because you want to show off or anything" (Berhane, , August 28, 2020). Overall, the participants agree that the integration of religion and spirituality with clinical practice is dependent on the practitioner and the willingness of the client.

4.7 Specific ways of Integrating Religion and Spirituality into Clinical Practice

Most of the participants have described specific ways in which they integrate religion and spirituality into their clinical practices. The first way of integrating religion and spirituality into clinical practice is by considering it as one area of inquiry while assessing the clients' condition and taking medical history. Kidist stated that whenever she finds her students in distress, she talks to them to identify whether their problem is physical, psychological, or spiritual. On the other hand, Abdi mentioned that he can identify the clients' commitment to their religion and concerning issues in regards by conducting a thorough medical history. Similarly, Tassew stated that he observes his clients' commitment to their

religion. He explained that this helps him determine how to use his clients' spirituality to reduce their stress and improve their time of recovery.

The second way in which the participants integrate religion and spirituality into clinical practice is by providing direct advices, specifically by encouraging or discouraging certain religious rites considering the clients' health condition. Belaynesh stated that although she believes fasting is important for orthodox religion followers, she explains to her diabetic patients that it is not advised for them. Kidist shared that there was a time where she advised one of her students, who is of a different religion, "to speak with God and tell Him your problems" (, September 19, 2020). She explained that the reason she did this was because the student had a problem but believed that she could not talk to anyone about it.

The third way in which the health professionals, who participated in this study, integrate religion and spirituality is by reorienting clients' perspective for them to have a positive outlook of their situation and use that as a tool for recovery. On this regard, Tassew shared the following.

> *There are times where they (the clients) see their situation negatively, as in blame God for what they are going through. So, we find ways for them to see other patients who are around them. We explain to them that they are not cursed, or God did not do this to them as a punishment. So, the thing is, we try to avoid the negative thoughts. … On the other hand, if they think whatever they are facing is a blessing, it shows you the strength they have, and you can use it as a tool to help them heal faster.* (Tassew, , August 28, 2020)

Similarly, Ayelu stated that consulting clients about their beliefs in a higher power makes it "easier to help them avoid negative thoughts and have a positive outlook" (Ayelu, , August 28, 2020), specifically during the times when they lose hope.

Another way the professionals integrate religion and spirituality is by showing their clients ways in which they can uphold their religious rites without abandoning modern medical treatment. Tewodros and Berhane stated that they encourage people with mental health problems to have psychiatric treatments while still using holy waters. The participants have explained that the effort of the professionals alone may not always be sufficient in such situations. They have stated the involvement of religious clergy is crucial to bring people into such an awareness whereby people uphold both their religious beliefs and modern medicine. The participants response has indicated that this is true both in public health issues like HIV/AIDS and in handling individual cases.

In the case of HIV/AIDS prevention and control, Belaynesh said the major success/breakthrough for saving lives from HIV/AIDS came about after the pope's declaration that medicine goes along with the holy water. The reason why this was considered a breakthrough was because people went to the holy water while not practicing the necessary cautions which led to the loss of many lives. She stated that, after the religious leaders learnt to convince others, people went to the holy water sites while using retroviral drugs which were discovered afterwards.

While handling individual cases, Tassew, who is a social worker, shared about a time where he needed to ask the assistance of clergy to convince a nun who had gangrene that she needs an immediate surgery. He explained that the reason the nun refused to have the surgery was because she believed that God would heal her and that she would rather wait on Him. Tassew mentioned that it took lots of effort from his side, from the side of the physicians, and the clergy to bring the woman to a place where she accepts the need for her to have a surgery. By the time she made the decision, the gangrene has affected her entire leg, so it had to be amputated. Tassew also stated that this is one of the reasons that the religious aspect should be considered and addressed.

Another health issue, which required the involvement of religious leaders, is organ donation. Tringo, who is a manager at the National Eye Bank, stated that people can sometimes face confusion as to why they should donate their organs or whether it is right for them to do so. She said that individual clients may ask, "why would I give something God has given me?" (Tringo, , August 27, 2020) or the clients may say that there is nothing written in the Bible about donating part of the body to another person. She explained that when such things happen, they would encourage their clients to consult with their pastors or religious leaders. Tringo has also mentioned that they are planning to work with religious institutions to help them understand the importance of such deeds from the religious point of view.

Belaynesh has noted that at times religious leaders can uphold harmful religious practices which cause harm to their followers. She said that she has recently observed such practices among protestant church leaders who use the name of the religion for something else. She stated that the reason patients prefer religious support over medical treatment is because the health system is weak and lacks accessibility. She further explained that when patients get hurt in trying to uphold the religious teachings, they are not sure where to go because they consider medical centers as their last option. Belaynesh suggests that new religious leaders need to teach the right ways and that everyone needs to be accountable. She mentioned that there was a guideline developed which restricts priests to use less or no physical harm. She suggested that such regulations should also be reinforced among church leaders. Additionally, she stated that it is up to the health professionals to create awareness.

The fifth way the professionals integrate religion and spirituality is by using their clients' beliefs to provide reassurance and comfort in difficult situations. Ketema, who is a surgeon said that telling patients that God will be with them and telling them that "we as professionals will do what we can" makes patients feel a lot better. He said,

> *Most patients see death and surgery as if they are the same thing. And we try to make sure they do not feel threatened. We will not be telling them how everything is going to be alright. Instead, we tell them that they should be stronger and that we will go as far as possible to save their lives. We do not directly say that God would save them. But since we know most patients believe in the existence of God, we tell them how he will be there for them and that they should leave everything to Him.* (Ketema, , August 26, 2020)

Integrating religion and spirituality does not always involve giving advises and informing clients what to do or not to do. Some of the participants mentioned that at times the integration involves listening to their clients and understand things from their perspective. Demekech stated that she tries to ask her clients some questions and have them explain why they think what they think. She explained that having the knowledge of different religions is helpful because it makes it easier to understand people who follow those religion. She stated that it is the easiest when the clients follow the religion as the professional. She said such an understanding helps ensure that the professionals explain things in the way that the clients will be able to accept it. Furthermore, Ketema mentioned that listening to what patients have to say is even a particularly good way of helping psychologically.

According to the participants in this study, integrating religion and spirituality can also mean providing appropriate services which consider the clients' religious requirements. Ketema gave an example for this saying that they avoid giving service to patients whom they know will lose blood in a surgery if the person is a follower of a religion that does not allow blood transfusion. He said that he never forces anyone to do anything against their belief. But he explained that if the blood transfusion is needed to go ahead with the surgery, he tries to explain how important it is. Ketema added that he will not go any further than that, but instead he refers the client to a psychologist since he believes that they have "a better

understanding of this and getting to the bottom of their issue" (Ketema, , August 26, 2020). Berhane also mentioned that she would refer her clients to other places or professionals who can better serve the clients after she has gone as far as possible.

The final way in which the health professionals integrate religion and spirituality in their clinical practice is by upholding both their own personal spirituality and professional ethics in service provision. In sharing how she upholds her personal spirituality and professional ethics while providing service, Ayelu said:

> *First, I must explain everything that could go wrong, all the risks and the reason for the procedure they are going through as the ethics requires me to do so. After that I make sure that they understand and sign a consent sheet … Our work is all about saving lives. But we need to understand that human power is limited. The solutions we give are not beyond this world. So, whatever I do, God needs to bless my work for me to succeed. There are times where I leave the operation room thinking the case is too complicated and the result, I expect, may not be good. But when I see the patient in a better state than I expected, I know it is God who has done that.* (Ayelu, , August 28, 2020)

Likewise, Tringo has also shared her experience on how her institution upholds professional ethics and religiosity. She said,

> *We try to explain the importance of their generosity from the religious point of view.… Some people express a desire to donate to a family member. The first thing we do is explain they cannot donate while they are still alive. And the second thing is they cannot say who they want to donate to.* (Tringo, , August 27, 2020)

4.8 Religion and Spirituality in Clinical Service and Clinical Education

Health professionals can integrate religion/spirituality into clinical either in direct clinical service provision or in providing clinical education for other practitioners. Integration

is implied in holistic assessments which consider spirituality, provision of spiritual care, clinical practice guidelines and ethical standards. The participants' have addressed each of those areas of integration.

4.8.1 Assessing Spiritual Needs

The participants were asked if they specifically assess their clients' religion and spirituality and whether they use specific tools to do so. The participants response show that they assess their clients' spirituality by using their own instincts, by observing the clients' actions, by having conversations with them either by their own initiation or with the initiation of the professional, and by making note of the clients' expressions. The participants have stated that they are not aware of any tools or guidelines that can help them conduct such an assessment. On the other hand, two participants have stated that they do not engage in such conversations with their clients or assess their spiritual needs.

4.8.2 Spiritual Care in Clinical Service

The participants in this study were asked what they think about the provision of spiritual care as part of the clinical services offered in health institutions. The participants' response to this related much with their stance on whether religion and spirituality should be integrated into clinical practice. Belaynesh and Gizaw, who believe in integrating religion and spirituality into clinical practice, said that they are in favor of spiritual care. They both shared that they remember such services in their early years of clinical practice during the Haile Selassie regime. The following is a narration of what spiritual care looked like during that time and the changes that led to its demise.

> *In the old time, there were priests assigned to each hospital. They visit the people in the hospital wards even those who are secular. That was before 50 years, before the revolution. For the faith-based organizations, there were prayers held for every service in the entire hospital. The Ethiopian Orthodox Church, the ancient one, had*

> *practiced some part of clinical work and curative work, in of assisting the weak. And when the missionaries came, the main services they offered were medicine and education. Even I know of many protestants, like the Seventh day Adventist Church who did such things in the old time* (Belaynesh). *But all these were nationalized in the revolution 40 years ago. And during that period, religion was not promoted nor was it acceptable. The missionaries left the country. Those who stayed, the Ethiopians, were harassed in many ways. So, that again affected the practice and the health workers because they were drawn from the same pool of society.* (Belaynesh, , August 28, 2020; Gizaw, , September 27, 2020)

Belaynesh stated that the clinical practice was more liberated after the Derg regime left 30 years ago. Nonetheless, the policies which were developed after that time, including the health policy, were designed to make the health and education services secular. She explained that these measures made health service provision to be dependent on the individuals' belief. So, thoughts on whether to integrate religion and spirituality or provide spiritual care was left to the individual practitioner.

The participants have stated that currently there are only few health institutions which provide services which consider clients' spiritual needs. The example they gave for this is that some institutions have prepared prayer rooms within the hospital (chapels). Another example, given by Belaynesh, is the prayers held in the Hamline Hospital. She said that both the Hamelin's were extraordinarily strong religious people, but they accepted staffs and clients from all kinds of religions. Even so, she said that prayer was one part of starting the daily routine in the hospital. And Belaynesh believes that this is one good way of providing spiritual care in clinical settings.

4.8.3 Guidelines on Addressing Religious or Spiritual Issues

The participants were asked whether they are aware of any guidelines, policies, or regulations which dictate actions to be taken in relation with religious or spiritual matters in clinical practice. The participants have in general expressed that they are not aware of any specific guidelines which address the integration of religion and spirituality with clinical practice or the provision of spiritual care. However, three participants have mentioned that although they do not recall the specifics, they said that there are guidelines and measures taken by the Ministry of Health on the topic of Religion and HIV/AIDS, Religion and FGM, and Religion and Adolescent Reproductive Health. Gizaw has also mentioned that there is a national standard which requires hospitals to be free from religious expressions. But in any case, the participants have affirmed that they always uphold professional practice.

4.8.4 Professionals' Refusal of Service

Belaynesh has mentioned that in her experience in working in WHO, she has encountered health workers who do not do according to the regulations of the organization because of their beliefs. She has stated that this is especially true on the topic of reproductive health service provision for young people. On this note, she shared the following.

> *There are new guidelines and new protocols within the organization that we follow. Especially when it comes to the provision of reproductive health services for the young people, I have heard pediatricians who have negative attitude towards young people using these services thinking that this is encouraging them to be more active sexually. While that is not the idea, we just want to save lives, avoid infection and unnecessary pregnancy.* (Belaynesh, , August 28, 2020)

Belaynesh asserted that she believes it is wrong to refuse to follow regulations or refuse services based on one's belief. She also stated that it is up to the client to decide and the professional to serve where assigned.

Based on the assertion of Belaynesh, two participants, Abdi and Gizaw, were asked their thoughts on professionals' refusal to provide service because of personal beliefs. The participants responded that although they opt for upholding their personal convictions, they stated that their decision will depend on the specifics of the case. Both participants have explained that they will consider the nature of the case, the condition of the clients and their significant others, their professional and personal judgment of the case, laws which are applicable to the case, and alternatives which do not compromise their beliefs. The participants have stated that if they decide not to provide the service, they will refer their clients to other professionals who might help them. In affirming his stance, Abdi has said that he will only practice and provide service so long as what he does is in line with his beliefs. He also mentioned that this is true even when the case involves a nationally or professionally accepted legal practice.

4.8.5 Religion and Spirituality in Education

The health professionals in this study were asked about the role of religion and spirituality in the education they have received, and the education they provide to their students (for those who teach). Most of the participants stated that such topics were not raised while they were students or even if the topic of religion was raised the discussions held were shallow. Few of the participants have indicated that their knowledge regarding the topic came from different seminars, personal discussions with their colleagues, and by learning from their seniors.

In explaining her experience as a teacher, Kidist said that religion and spirituality may have a place in health, but they do not practice it. She said that all her concern is related to the subject matter and covering the topics she needs to while giving lectures. She also stated that although there are no formal regulations, they are expected to focus on the subject only and avoid religious topics. She mentioned that one of the main reasons she avoids the topic is

because she is never certain where the conversation will go and that there is a possibility that she will be reported. Kidist also shared that even when she took a course on religion in medical school, the professor led discussions on various topics related to the philosophy of religion rather than religious doctrines or dogmas.

Ketema, who is also a professor and surgeon, said that he does not remember such discussions being held in class while he was a student. He explained that they were only taught how to treat a person and a client. Personally, Ketema prefers to teach practical ways in which his students can address the spiritual needs of their clients without directly raising the topic of religion. He has said the following regarding his stance on the matter.

> *We cannot deny the fact that all our patients need spiritual strengthening, no matter the religion they follow. I must make sure I support my patients on every level. We have come to understand that in our profession. I try to tell my students what to do when. We may not have it in our curriculum, but I must set an example for my students. And it helps shape the coming generation.* (Ketema, , August 26, 2020)

Regarding rules and regulations for clinical practice and education, Ketema also stated:

> *It is obvious that I cannot force you to follow my religion. That is when I try to convince you to follow something you do not believe in. But like I said before, telling my patients that God will save and protect them, giving all our attention to them using a "patient centered" approach would help improve the patient's state. No regulation refrains you from doing that or telling that to your students.* (Ketema, , August 28, 2020)

Ketema has also mentioned that he believes as much as this is an important part of the students' education; there is a big challenge in incorporating this into the curriculum.

4.9 Challenges for Integrating Religion and Spirituality into Clinical Practice

The participants of this study were asked to share if there are any issues which hinder the integration of religion and spirituality into clinical practice or education. The participants have indicated that there are three major issues which they believe hinders the integration namely fanaticism, sensitivity of the topic, and inclusivity. Belaynesh has stated that fanaticism among religious groups and health service providers leads to one rejecting the effectiveness of the other. She has that she personally believes there are enough evidence to show the effectiveness of both medical practices and religious practices. Accordingly, she believes that the decision to integrate the two will have good outcome.

Kidist expressed that she feels that the topic seems to be like one of those issues which are taboo. She stated that the reason she and other teachers are careful regarding this topic is because religion, like ethnicity, can be misinterpreted. Kidist has also shared a story in which a student accused her of intentionally failing the student because of the religion the student followed. She explained that the student used her request for the student to remove her gloves and roll up the sleeves of her hijab as an excuse for the low grades she scored on the exam Kidist gave. Kidist mentioned that students are required to dress appropriately for laboratory practices and that the same is true for practical examinations. She stated that she was still called-in to share her account of what happened even though her good reputation in working with students with different backgrounds is well-known.

The final issue the participants identified as one which hinders the integration of religion and spirituality into clinical practice is inclusivity. Ayelu and Berhane have stated that there are various religions and beliefs in our country and accordingly the needs of the clients differ. Berhane mentioned that although clients' receptivity towards the professionals' approach differs by the type of relationship they build; it is still difficult for the professionals to come up with specific services to address the needs of their clients. Ayelu stated that when

a service is based on religion, there might be individuals who do not agree with the professional or feel comfortable about it. Although she believes that it is unlikely that clients will feel uncomfortable about the integration of religion in clinical practice in our country (Ethiopia), she stated that providing an inclusive service which can satisfy everyone's needs will be exceedingly difficult.

Chapter Five: Discussion

5.1 Defining Religion and Spirituality

The health professionals in this study have stated religion and spirituality are concepts which are interlinked with one another. The participants have described religion as a system of beliefs which has its own practices and rituals like prayer. The participants have explained that religiosity or adherence can be expressed through the following of the religion's beliefs, doctrines, rules, and practices. These explanations, given by the participants, is consistent with the main components of religion encapsulated by the definition of religion given by Emile Durkheim, which are beliefs and practices which are relative to the sacred and are unified as a system (Thompson, 1982; p.125). Similarly, Koenig (2009), has asserted that the definition of religion most commonly involves these elements. On the other hand, it was found that the health professionals in this study have two different outlooks of spirituality.

The first outlook is that spirituality as a personal experience which involves living out one's religious beliefs. This group of participants also mentioned that they view religion and spirituality as being almost synonyms. Moberg (2010) has asserted that people who view every aspect of life as sacred often find it difficult differentiate between the two.

The second outlook, the participants in this study reflected, relates spirituality more with personal development, the way relationships are built, and as one of the participants stated, "the way we make sacrifices to get the things we want". In congruence with this finding is Zinnbauer (1997)'s observation that more and more things are becoming associated with spirituality although spirituality itself is described as something distinct religion or religiosity. Moreover, Lomas (2019) has found that religiosity, religious customs and/or religious institutions were not necessary for defining spirituality.

As the participants mentioned, their understanding of religion and spirituality is mainly attributed to familial and societal influences. A study, conducted by Howarth, Lees,

Sidebotham, Higgins, & Imtiaz (2008) in UK, has found that parents as well as their young children believe veneration towards religion is something which is passed downed from generation to generation. Likewise, Cornwall (1987), has found that personal social ties and demographics have a direct and indirect influence on religious beliefs and adherence. In consistency with the findings of this study, both studies have found that people believe religious stance is prone to change during adulthood. Nonetheless, the participants in this study have stated that they have upheld the religion they have now since childhood.

All participants in this study have asserted that spirituality is different from religion in that it refers something personal while religion refers to something communal. This distinction made between religion and spirituality was also noted by Zinnabauer, Pargament, & Scott (2001) who have explained that in recent times people polarize the two terms in various ways including the above. Even so, one participant has stated that both religion and spirituality, regardless of the way they are defined, help us achieve what we consider important. Although the statement does not clarify whether religion and spirituality can in themselves be goals in themselves, the statement can imply that the practice of extrinsic religiosity as defined by Masters (2013). Tanyi (2018) has also found that people approach spirituality to achieve an optimal state of functioning.

The participants in this study were also found to be highly devoted to their religion. They expressed their veneration through the upholding of various practices like prayer, attending religious programs, and fasting. Such high levels of devotion can be attributed for familial and societal influences. As seen in the literature section, people in our country Ethiopia, are highly spiritual and express their spirituality by upholding various religious rites like the ones mentioned above even to greater extent than adherents in other parts of the world (Diamant, 2017). However, the participants have indicated that their school and work environments were at times challenging because of the contradictory beliefs held by their

classmates and colleagues. But what made them withstand those challenges is the strong influence their parents had on them. Such influence of religious socialization even during children's adulthood was also noted by Cornwall (2008).

5.2 Relation of Religion and Spirituality with Health and Health Problems

The study has found that the health professionals in this study believe that spirituality is an essential part of a person's wellbeing. The participants have explained the importance of trying to heal people's psychological and spiritual needs for them to have fast and full recovery by gaining strength and resilience. Conversely, the health professionals have worked with clients who have negative religious or spiritual explanation for the health problems they face. The participants have stated that they encourage their clients to have a positive outlook of their health condition by providing them with a different perspective from the clients' own religion. This was noted to be one of the ways in which religion and spirituality are integrated into clinical practice. There were also participants who mentioned they will do nothing about it or just manage it as it comes.

During this study, it was observed that the participants often find it difficult to make any distinction between "the spiritual" and "the psychological" in talking about health. The major reason for this can be the fact that the participants had a developmental, emotional, and relational view of spirituality which greys out the boundary between the two concepts. This can also explain the fact that some professionals refer their clients who supposedly have religious or spiritual issues to psychologists or psychiatrists.

5.3 Integrating Religion and Spirituality into Clinical Practice

The study has found that the health professionals believe that the integration of religion and spirituality can have positive outcomes if it is the clients. The professionals stated that they encourage clients to uphold aspects of their religion and spirituality which promotes their health. The participants', however, were found to have different stance on

whether the professional should integrate his/her religion and spirituality into the service he/she provides. The professionals who integrate their religion and spirituality were found to do so if it does not do clients' any harm and the clients are willing to have such discussions. These findings reflect that the health professionals uphold the major principles of bioethics namely non-maleficence, beneficence, and autonomy (McCormik, 2018) in their clinical practice.

The specific ways the participants integrate religion and spirituality into clinical practice included just listening to clients, considering as one area of assessment, providing direct religious advises, reorienting client's beliefs to be more positive and functional, involving clergy in addressing client's needs, providing comfort and reassurance by using the clients' faith, providing services which consider clients' religious requirements, and by upholding professionality. These practices were found to be consistent with Puchalski (2001)'s means of providing spiritual care. She has stated that spiritual care involves compassionate presence, listening to patients' fears, hopes, pains, and dreams, obtaining spiritual history, incorporating spiritual practices, and involving chaplains (p.355). Nash & Yuen (2009) also stated that spiritual care involves various disciplines and includes chaplains or religious counselors.

Those who are not in favor of integrating religion and spirituality were found to view religion and clinical practice (medicine) as two things that cannot and should not be brought together. They have explained that religion is ideal while science, specifically medicine, is empirical. They have also mentioned that religion has its own place which should be separated from work. These assertions made by the participants reflects the independence model of describing the relationship between religion and science. De Cruz (2017), states that, in this model, religion is thought to specialize in "ethical values and spiritual meaning" while science is thought to specialize in "empirical questions about the constitutions of the

universe". According to an article by Understanding Science (2020), however, suggests that the assumption that religion and science address different matters should instigate an outlook that considers them as complimentary. Nonetheless, De Cruz (2017) has noted that much research is required to clarify the relationship between religion and science.

It was found that the participants are not aware of any guidelines to assess or address clients' religious and spiritual needs. The health professionals stated that religion and spiritual issues were not included in the education they have received or are giving currently. One participant, however, has mentioned that he includes practical demonstrations of how to address spiritual needs alongside physical ones though it is not part of the curriculum.

The participants have explained that this is because the topic of religion and spirituality is sensitive and the decision to include it or integrate it was often left for the professionals' decision. According to the participants in this study, the major reason for the overall neglect of religion and spirituality in health care relates to the socio-political changes that led to the liberalization and secularization of health care in the last 50 years. The findings are consistent with the study conducted by Farahani et.al. (2019) among nurses and physicians who provide health care for cancer patients in Iran. Their study has found that most of the professionals did not receive training on spiritual care even though they are interested in receiving one.

It was found that the health professionals in this study would not engage in clinical practices which conflict with their personal beliefs even if the practices are legal and acceptable. They have explained that there might be exceptions to this depending on the specifics of the case. One professional has stated that she believes that it is wrong to refuse professional duty based on one's beliefs.

As stated in the literature review section, whether health professionals can refuse to provide service on religious reasons is a controversial issue in our country and in other parts

of the world. In the US, although there is legal basis for refusing service on religious premise, the statutes have been rejected by Federal Court Judges because they are deemed to be biased towards the professional and do not keep the balance with service users (Curlin, Lawrence, Chin & Lantos, 2007). Lema (2012) states that though the rights to refuse service is safeguarded by various principles like religious freedom in Sub-Saharan Africa, the entity who refuses is expected to refer clients to health service provides who are able to provide those services. Consistently, the participants who opt for refusing service on religious basis do use referrals to direct clients to other professionals who may do so.

5.4 Hindrances for Integrating Religion and Spirituality into Clinical Practice

The findings of this study revealed that fanaticism, sensitivity, inclusivity, and neglect are identified as major factors which hinder health professionals from integrating religion and spirituality into clinical practice. In contrast to the axiological reasons presented by the participants, Brémault-Phillips et.al. (2015) findings show that there are fiscal issues which imped the integration of religion and spirituality in health care. The major challenges identified by their study were failure to develop and implement interventions after spiritual history, giving more attention to immediate physical needs, and care, and pressure to discharge without addressing spiritual needs with no follow-up afterwards. Brémault-Phillips et.al. (2015) have also suggested several practical measures to overcome these issues. However, the value conflicts which hurdle an integrative approach towards religion/spirituality and health care will require extensive research to come up with concrete solutions.

Chapter Six: Conclusion and Implications

This study must explore the beliefs and practices of health professionals in Addis Ababa on integrating religion and spirituality into clinical practice. The research had the objective of generating a summarized description of the participants definitions of religion and spirituality, ways of integrating religion and spirituality, and their experience in how religion and spirituality are addressed in various clinical settings. Accordingly, the following conclusions are drawn from the findings of these research along with recommendations and implications of the findings to policy, practice, research, and education.

6.1 Conclusion

The health professionals, who participated in this study, define religion as an organized system of beliefs which has its own doctrines, dogmas, institutions, practices, and rituals which are followed by groups of people. On the other hand, the professionals, define spirituality as either an individual's personal devotion to his or her religion or as something which encapsulates a person's life development by learning from experience, passion in pursuing his or her goals, and the way he or she builds relationship. Both outlooks of spirituality were found to be mixed with other concepts. Those who have the first outlook of spirituality synonymize spirituality with religion with the only distinction that the former is personal while the latter is communal, while those participants who have the second outlook of spirituality fail to differentiate 'the spiritual' from the 'psychological'. Overall, the health professionals express strong personal commitment to their religion and spirituality and encourage positive use of religion and spirituality among their patients.

As mentioned earlier, issues on whether to integrate religion and spirituality only arise when the religion and spirituality is that of the professionals and not the clients. This was found to be dependent on the participants' perception of the relationship between religion and science, and the relationship between religion and professional duty. It is important to note

that the intention of this study was not to imply that health professionals should integrate their religion into their practice. But rather it is to shed light on the role religion, spirituality, and spiritual care play in providing holistic health care which contributes to better health outcomes. The health professionals were found to recognize this important role and use it to provide better care for their clients. It was noted this does not, however, mean compromising professional practice, allowing religious and practices which jeopardize the health of the clients, or compromising one is deeply held beliefs.

The findings in this study demonstrate that health professionals play a role in assisting people to utilize both scientific knowledge as well as religious practices to attain, maintain, and retain an overall wellbeing. As discussed previously, these can at times be exceedingly challenging as upholding one may mean compromising the other. But the use of principles such as non-maleficence, beneficence, and clients' autonomy along with the professional practices of informed decision making, consent, and referral would greatly help the professionals maintaining balance in walking the thin line of integrating religion and spirituality with clinical practice. The fact that religion and spirituality are viewed to be an integral part of a person and his or her wellbeing, both by the health professionals and the public, is a substantial reason to explore ways to integrate religion and spirituality into health care services.

6.2 Implications for Social Work Practice

Social work is a profession and an academic discipline which seeks to enhance the wellbeing of individuals and the society holistically. It considers the biological, psychological, social, and spiritual as important aspects of an individuals' wellbeing. Each of these aspects of a person's health are interdependent and have significant contribution for the overall health of individuals. As the health professionals in this study indicated, religion and spirituality shape a person's perception of health and health problems. This does not only

determine a person's treatment decisions. Rather it can also impact their psychological and physical wellbeing. Social workers, thus, need to give considerable attention to their clients' religious and spiritual practices.

Stating the significance of religion and spirituality for social work practice is not sufficient. Professionals need to intentionally work to develop their competence to address religious and spiritual issues effectively. Social work schools must also equip their students with the necessary knowledge, skills, and values which will help them develop interventions to appropriately use religion and spirituality in the interest of those they serve. Such efforts can also benefit from extensive research and clear guidelines and policies.

6.3 Implications for Policy

The findings of these study show that health professionals have minimal awareness regarding policies, guidelines, or regulations which address religious or spiritual issues in health care. Although the common understanding that the topic is sensitive and should addressed by professional and ethical practice is commendable, the absence of such guidelines will lead to erratic practices among various health professionals. On the bright side, policies on the issue provides basis for evaluating the means and outcomes of the integration. Thus, specific guidelines should be put forth by the respective authorities to ensure that religious and spiritual issues in health care are addressed aptly. Moreover, they can also point out ways in which they can be used to improve the wellbeing of individuals and the society. The presence of policy in itself is not sufficient in itself. So, the policy must be backed up with awareness creation, strategic interventions, proper implementation, monitoring and evaluation to achieve successful integration of religion and spirituality into clinical practice.

6.4 Implications for Research

Most of the literature on the topic of religion, spirituality and health are situated with in the ideological and socio-political state of the western society. Thus, much research is required to develop the body of literature on the topic of religion, spirituality, health, and health care service. Accordingly, the researcher believes that conducting studies on the following areas would contribute to efforts to develop local knowledge on related issues. But more importantly, they will help determine effective ways of integrating religion and spirituality into clinical practice.

- Perceived relationship between religion and science, specifically to modern medicine.
- Health outcomes of religious practice like using holy water, faith healing, and dhikr. And comparison of these outcomes with biomedical and behavioral treatments.
- Clients' view of whether religion, spirituality, and spiritual care should be part of into health care services.
- The feasibility to integrating spiritual care as part of the overall health care.
- The role of personal religiosity and spirituality in service provision.

6.5 Implications for Education

The findings of this study show that minimal attention is given to religious/spiritual issues in clinical education. Even though health professionals intuitively understand that religion/spirituality is significant part of people and health, their education should thoroughly equip them to address the religion/spiritual issues in clinical practice. Accordingly, health professionals should be trained to:

- assess and identify religious/spiritual needs or resources of their clients
- determine the role of religion/spirituality in the health of clients
- device ways they can use the religious/spiritual resources of their clients to help them use those resource to improve their health

- effectively manage ethical or moral dilemmas related with religion/spirituality in their clinical practice
- provide health service in line with the religious/spiritual beliefs and practices of their clients and the boundaries of their professional expertise.

Reference

Abdul-Hamid, W. K. (2011). *The Need for a Category of Religious and Spiritual Problems in ICD-11.* Vol. 8 No.3: International Psychiatry.

Adamson, M. (2020). *Connecting with the Divine. 5 Major World Religions – See what these Different Religions believe about God:* EveryStudent.com. Retrieved March 3, 2020 from https://www.everystudent.com/features/connecting.html

Addisu Tsegaye. (2018). *Women's Fertility and Abortion Decision Amidst Religiosity, Normative and Moral Processes, Competing Discourses and Stigma in Addis Ababa:* Addis Ababa University Institutional Repository.

Albarracin, D. & Shavitt, S. (2018). *Attitudes and Attitude Change.* Annual Review of Psychology. DOI: 10.1146/annurev-psych-122216-011911

Alberta Health Services. (2015). *Health Care AND Religious Beliefs. (2nd ed.). Author.*

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: Author.

Araya. (2020). *Religious institutions expediting the fight against CORONA VIRUS.* Ethiopian Press Agency. Retrieved June 1, 2020 from https://m.facebook.com/ethiopianpressagency/?refsrc=http%3A%2F%2Fwww.press.et%2Fenglish%2F

Asare, M. & Danquah, S. A. (2017). *The African Belief System and the Patient's Choice of Treatment from Existing Health Models: The Case of Ghana.* Vol. 3 No.4:49; Acta Psychopathol. DOI: 10.4172/2469-6676.100121

Attum B., Wahdee A. & Shamoon Z. (2020). *Cultural Competence in the Care of Muslim Patients and Their Families.* StatPearls [Internet]. Treasure Island, FL; StatPearls Publishing.

Austin P., Macdonald J. & MacLeod R. (2018). *Measuring Spirituality and Religiosity in Clinical Settings: A Scoping Review of Available Instruments:* Religions MDPI DOI:10.3390/rel9030070

Baldacchino D. (2015). *Spiritual Care Education of Health Care Professionals.* Religions: MDPI. (p.594-613). DOI:10.3390/rel6020594

Bandura, A. (1994). Self-efficacy. In V. S. Ramachaudran (Ed.), Encyclopedia of human behavior (Vol. 4, pp. 71-81). New York: Academic Press. (Reprinted in H. Friedman [Ed.], Encyclopedia of mental health. San Diego: Academic Press, 1998).Bender C. &

McRoberts O. (2012). *Mapping A Field: Why and How to Study Spirituality:* SSRC Working Papers.

Black L. (2006). *Health Law: Limiting parents' rights in medical decision making.* Virtual Mentor. Vol.8, No.10. American Medical Association Journal of Ethics. (pp.676-680)

Bordens K. S. & Abbott B. B. (2011). *Research Design and Methods: A Process Approach.* (8th ed.). New York, NY. McGraw-Hill.

Boucher N. A., Siddiqui E. A. & Koenig H. G. (2017). *Supporting Muslim Patients During Advanced Illness.* Vol.21. Perm J. (pp.16-190). DOI: 10.7812/TPP/16-190

Bradshaw C., Atkinson S., & Doody O. (2017). *Employing a Qualitative Description Approach in Health Care Research.* Global Qualitative Nursing Research. Vol. 4. Sage Publication. (pp. 1-8). DOI:10.1177/2333393617742282

Brémault-Phillips S. et.al. (2015). *Integrating Spirituality as a Key Component of Patient Care.* Vol.6. Religions. (pp.476-498). DOI: 10.3390/rel6020476

British Broadcasting Corporation. (2014). *Religions and Circumcision*. Author. Retrieved April 17, 2020 from http://www.bbc.co.uk/ethics/malecircumcision/religions_1.shtml

Broeck J. V. den, Cunningham S. A., Eeckels R., & Herbst K. (2005). *Data Cleaning; Detecting, Diagnosis, and Editing Data Abnormalities.* Policy Forum. Vol. 2, No.10; PLoS Med. (pp.0966-0970). DOI: 10.1371/journal.pmed.0020267

Bryman A. (2006). *Integrating Quantitative and Qualitative Research: How is it done?* Qualitative Research. Vol. 6, No.1; Thousand Oaks, CA: Sage Publications. (pp.97-113). DOI: 10.1177/1468794106058877

Buehler D. A., Divita R. M. & Yium J. J. (1989). *Hospital Ethics Committees: The hospital attorney's role.* HEC Forum 1. (pp.183-193). DOI: 10.1007/BF00122363

Cambridge. (2020). *Feasibility.* Retrieved June 1, 2020 from https://dictionary.cambridge.org/dictionary/english/feasibility

Cambridge. (2020). *Frequency.* Retrieved June 1, 2020 from https://dictionary.cambridge.org/dictionary/english/frequency

Carter N., Bryant-Lukosius D., DiCenso A., Blythe J., & Nevile A. J. (2014). *The use of Triangulation in Qualitative Research.* Vol. 41., No.5.: Methods & Meainings. Oncology Nursing Forum. (p.545). DOI: 10.1188/14.ONF.545-547

Central Statistical Agency. (2007). *The National Population Census. Addis Ababa: Author.*

Chao C. C., Chen C. & Yen C. M. (2002). *The Essence of Spirituality of Terminally Ill Patients:* The Journal of Nursing Semantic Scholars. DOI: 10.1097/01.jnr.0000347604.89509.bf

Collins Dictionary. (2020). *Health Care.* Retrieved March 24, 2020 from https://www.collinsdictionary.com/dictionary/english/health-care

Cook C. C. H. (2015). *Religion and Spirituality in clinical practice*. Vol. 21. BJPsych Advances. (pp.42-50). DOI: 10.1192/apt.bp.114.013276

Cornwall, M. (1987). The Social Bases of Religion: A Study of Factors Influencing Religious Belief and Commitment. *Review of Religious Research, 29*(1), 44-56. DOI:10.2307/3511951

Creswell J. W & Plano-Clark V. L. (2011). *Designing and Conducting Mixed Methods Research.* (2nd ed.). Thousand Oaks, CA: Sage. (pp.53-106).

Creswell J.W. (2007). *Qualitative Inquiry & Research Design: Choosing Among Five Apporaches.* 2nd Edition. Thousand Oaks, California: Sage Publications.

Creswell J. W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* 3rd Edition. Thousand Oaks, California: Sage Publications.

Culliford L. (2002). *Spirituality and clinical care. Spiritual values and skills are increasingly recognized as necessary aspects of clinical care:* BMJ. (pp.1434-1435). DOI:10.1136/bmj.325.7378.1434

Curlin F. A., Lawrence R. E., Chin M. H. & Lantos J. D. (2007). *Religion, Conscience, and Controversial Clinical Practices.* Vol.356. No.6. N Engl J Med. DOI: 10.1056/NEJMsa065316.

Daniel Moges. (2019). *Facebook Usage Habit of the Youth: Challenges and Opportunities on Spiritual Activities.* Master's Thesis. Addis Ababa University. Addis Ababa University Institutional Repository.

De Cruz H. (2017). *Religion and Science.* Stanford Encyclopedia of Philosophy. Stanford University. Retrieved October 5, 2020 from https://plato.stanford.edu/entries/religion-science/

Delany, J. (1908). *Preparation for Death.* In The Catholic Encyclopedia. New York: Robert Appleton Company. Retrieved April 17, 2020 from New Advent: http://www.newadvent.org/cathen/04660c.htm

DeMartino E. S. et.al. (2017). *Who Decides When a Patient Can't? Statutes on Alternate Decision Makers.* Vol.376 No.15. N Engl J Med. (pp.1478-1482). DOI: 10.1056/NEJMms1611497.

Demir S. B. & Pismek N. (2018). *A Convergent Parallel Mixed-Methods Study of Controversial Issues in Social Studies Classes: A Clash of Ideologies.* Vol.18 No.1; EDAM. (pp.119-149). DOI: 10.12738/estp.2018.1.0298

Diamant J. (2017). *Ethiopia is an outlier in the Orthodox Christian world.* FACTANK. Pew Research Center. Retrieved April 17, 2020 https://www.pewresearch.org/fact-tank/2017/11/28/ethiopia-is-an-outlier-in-the-orthodox-christian-world/

D'Souza R. (2007). *The importance of spirituality in medicine and its application to clinical Practice.* Vol.186 No.10: MJA Publication. (pp.S57-S59).

Durkheim E. (1912). *The Elementary Forms of Religious Life.*

Elbarazi I. et.al. (2017). *The effect of religion on the perception of health states among adults in the United Arab Emirates: a qualitative study.* BMJ Open. DOI:10.1136/bmjopen-2017-016969

Eldh A. C. et.al. (2017). *Clinical interventions, implementation interventions, and the potential greyness in between – a discussion paper*: BMC Health Services Research. DOI: 10.1186/s12913-016-1958-5

Ellison C. G., Boardman J. D, Williams D. R. & Jackson J. S. (2001). *Religious Involvement, Stress, and Mental Health: Findings from the 1995 Detroit Area Study.* Social Forces. Vol. 80, No. 1. The University of North Carolina Press. (pp.215-249).

Embassy of the Federal Democratic Republic of Ethiopia UK. (2020). *Ethiopia declares State of Emergency to curb transmission of Coronavirus.* Retrieved May 17, 2020 https://www.ethioembassy.org.uk/ethiopia-declares-state-of-emergency-to-curb-transmission-of-coronavirus/

Ethiopia News Agency. (2020). *Attorney General Issues Directive for Execution of State of Emergency Proclamation.* Retrieved May 17, 2020 https://www.ena.et/en/?p=13819

Farahani A. S. et.al. (2019). *Evaluation of Health-Care Providers' Perception of Spiritual Care and the Obstacles to Its Implementation.* Vol 6., No.2. Asia-Pacific Journal of Oncology. (pp. 122-129). DOI: 10.4103/apjon.apjon_69_18

Federal Ministry of Health Ethiopia. (2018). *Directive on Continuing Professional Development for Health Professionals*: Author.

Federal Ministry of Health Ethiopia. (2020). *Health Management, Ethics and Research: Blended Learning Module for the Health Extension Programme.* Author.

Federal Ministry of Science and Technology. (2014). *National Research Ethics Review Guideline.* Author.

Frush B. W., Eberly Jr J. B. & Curlin F. A. (2018). *What Should Physicians and Chaplains Do When a Patient Believes God Wants Him to Suffer?* Vol.20, No.7; AMA Journal of Ethics. (pp.613-620). DOI: 10.1001/amajethics.2018.613

Gallagher S. & Tiemey J. R. (2013). *Religiousness/Religiosity, Encyclopedia of Behavioral Medicine.* Encyclopedia of Behavioral Medicine. New York, NY: Springer. DOI: 10.1007/978-1-4419-1005-9

Hacket C., Stonawski M., Skirbekk V., & Grim B. J. (2012). *The Global Religious Landscape.* The Pew Forum on Religion & Public Life: Pew Research Center.

Health & Human Services. (2019). *Conscience and Religious Freedom.* Author. Retrieved April 17, 2020 from https://www.hhs.gov/conscience/index.html

Hill P. C. et.al. (2000). *Conceptualizing Religion and Spirituality: Points of Commonality, Points of Departure.* Journal of Theory of Social Behavior. Oxford, OX4 Blackwell Publishers.

Howarth J., Lees J., Sidebotham P., Higgins J., & Imtiaz A. (2008). *Religion, beliefs, and partenting practices: A descriptive study.* Joseph Rowntree Foundation. University of Sheffield.

Hufford D. J. (2005). *An Analysis of the Field of Spirituality, Religion, and Health:* Metanexus Institute.

Hussein J. W. (2016). *The Social-psychological and Phenomenological Constructs of Spirituality in the Culture of Dhikr in Eastern Ethiopia.* Culture & Psychology: Sage. (pp.26-48). *DOI: 10.1177/1354067X16672415*

Jackson J. (2004). *The challenges of providing spiritual care.* Vol.20, No.3. Professional nurse. (pp.24-26).

Kahissay M. H., Fenta T. G., & Boon H. (2018). *Religion, Spirits, Human Agents, and Healing: A Conceptual Understanding from Sociocultural Study of Tehuludere Community, Northeastern Ethiopia:* Journal of Religion and Health. DOI Link: https://doi.org/10.1007/s10943-018-0728-6(0123456789().,-volV)(0123456789().,-volV)

Kaushik V. & Walsh C. A. (2019). *Pragmatism as a Research Paradigm and Its Implications for Social Work Research.* Vol. 8. Social Sciences. MDPI. DOI:10.3390/socsci8090255

Koenig H. G. (2009). *Research on Religion, Spirituality, and Mental Health: A Review.* In Review. Vol. 54, No.5: Canadian Journal of Psychiatry. (pp.283-291).

Koenig H. G., George L. K. & Peterson B. L. (1998). *Religiosity and Remission of Depression in Medically Ill Older Patients.* Vol.155, No.4*:* American Journal of Psychiatry. (pp.536-542).

Krejcie R. V. & Morgan D. W. (1970). *Determining Sample Size for Research Activities.* Educational and Psychological Measurement.

Lambert V. A. & Lambert C. E. (2012). *Qualitative Descriptive Research: An Acceptable Design.* Vol. 16, No. 4. Pacific Rim International Journal of Nursing Research. (pp.255-256).

LaRocca-Pitts M. (2012). *FACT, A Chaplain's Toll of Assessing Spiritual Needs in an Acute Setting.* Chaplaincy Today. Vol.28, No.1: e-Journal of the Association of Professional Chaplains. (pp.25-32).

Leuba J. H. (1904). *Professor William James' Interpretation of Religious Experience.* International Journal of Ethics, Vol. 14, No.3 (Apr. 1904): The University of Chicago Press. Retrieved November 20, 2019 https://www.jstor.org/stable/2375921

Lema V. M. (2012). *Conscientious Objection and Reproductive Health Service Delivery in Sub-Saharan Africa.* Vol. 16, No.1. African Journal of Reproductive. (pp.15-21). Retrieved October 6, 2020, from http://www.jstor.org/stable/23317028

Lomas T. (2019). *What is the essence of Spirituality?* Psychology Today. Retrieved January 30, 2020 from https://www.psychologytoday.com/us/blog/finding-light-in-the-darkness/201905/what-is-the-essence-spirituality

Markkula Center. (2017). *Health Care Decision for Incapacitated Patients Without Surrogates.* Author. Retrieved April 10, 2020 from https://www.scu.edu/ethics/focus-areas/bioethics/resources/healthcare-decisions-for-incapacitated-patients/

Masters K. S. (2013a). *Intrinsic Religiousness (Religiosity).* In: Gellman M.D., Turner J.R. (eds) Encyclopedia of Behavioral Medicine. New York, NY.: Springer. DOI: 10.1007/978-1-44-1005-9

Masters K. S. (2013b). *Extrinsic Religiousness (Religiosity).* In: Gellman M.D., Turner J.R. (eds) Encyclopedia of Behavioral Medicine. New York, NY.: Springer. DOI: 10.1007/978-1-44-1005-9

Maugans T. A. (1996). *The SPIRITual History.* Vol. 5. Arch Fam Med. (pp.11-16).

Mayhew M. J. (2004). *Exploring the Essence of Spirituality: A Phenomenological Study of Eight Students with Eight Different Worldviews.* Journal of Student Affairs Research and Practice: Routledge Taylor & Francis Group. (pp.1215-1242). DOI: 10.2202/1949-6605.1392

McCormick T. R. (2018). *Principles of Bioethics.* Health Science Library. UW Medicine. Retrieved October 5, 2020 from https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics

Meador K. G. (2009). *When Patients Say, "It's in God's Hands.".* In: Shinall Jr. M. C. (ed) Virtual Mentor. Vol. 11, No.10. American Medical Association Journal of Ethics. (pp.750-754).

Merriam-Websters Dictionary. (2020). *Integrate (Integrating).* Retrieved May 17, 2020 https://www.merriam-webster.com/dictionary/integrate#other-words

Miller W. R. & Thoresen C. E. (2003). *Spirituality, Religion, and Health.* Vol. 58, No. 1: American Psychologist. (pp. 24-35). DOI: 10.1037/0003-066X.58.1.24

Mulugeta Hussien. (2014). *Examining the role of Spirituality on students' Psychological well-being.* Addis Ababa University.

Moberg D. O. (2010). *Spirituality Research: Measuring the Immeasurable?* Vol. 62, No. 2. Perspectives on Science and Christian Faith.

Morgan D. *(2014). Pragmatism as a Paradigm for Social Research. Qualitative Inquiry:* Sage. *1045– 1053. 10.1177/1077800413513733.*

Nash D. B. & Yuen E. (2009). *The Role of Spirituality in Healthcare.* MedPage Today. Retrieved October 4, 2020 from https://www.medpagetoday.com/columns/focusonpolicy/14725

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). *How phenomenology can help us learn from the experiences of others.* Vol.8, No.2. Perspectives on medical education.

(pp. 90–97). DOI: 10.1007/s40037-019-0509-2

Neuman W. L. (2007). *Basics of Social Research: Qualitative and Quantitative Approaches.* (2nd ed.). Pearson Education, Inc.

NHS Scotland. (2009). *Spiritual Care Matters: An Introductory Resource for all NHSScotland Staff:* NHS Education for Scotland.

Nita M. (2019). *"Spirituality" in Health Studies: Competing Spiritualities and the Elevated Status of Mindfulness.* Journal of Religion and Health: Springer Publications. (pp. 1605–1618). DOI: https://doi.org/10.1007/s10943-019-00773-2

Oxhandler H. K. & Parrish D. E. (2016). *The Development and Validation of the Religious/Spiritually Integrated Practice Assessment Scale.* Research on Social Work Practice. Vol. 26(3): Sage Publication. (pp.295-307). DOI10.1177/1049731514550207

Oxhandler H. K. (2019). *Revalidating the Religious/Spirituality Integrated Practice Assessment Scale with Five Helping Professions.* Research on Social Work Practice. Vol. 29, No. 2. DOI:10.1177/1049731516669592

Palinkas L. A. et.al. (2016). *Purposeful sampling for qualitative data collection and analysis in mixed method implementation research.* Vol. 42, No. 5. Adm Policy Ment Health. PMC. (pp.533-544). DOI:10.1007/s10488-013-0528-y.

PBS. (2004). *Jewish Burial Practices.* Author. Retrieved April 16, 2020 from https://www.pbs.org/wnet/religionandethics/2004/02/06/february-6-2004-jewish-burial-practices/1794/

Popchavei P. (2018). *How many different religions are there in the world?* Quora. Retrieved April 17, 2020 from https://www.quora.com/How-many-different-religions-are-there-in-the-world

Powell L. H., Shahabi L. & Thoresen C. E. (2003). *Religion and Spirituality: Linkages to Physical Health.* Vol. 58, No. 1. American Psychologist. (pp.36-53).

DOI: 10.1037/0003-066X.58.1.36

Prusak J. (2016). *Differential Diagnosis of "Religious or Spiritual Problem" - Possibilities and limitations implied by the V-code 62.89 in DSM-5:* Psychiatr. Pol. (pp.175-186). DOI: 10.12740/PP/59115

Puchalski C. M. (2001). *The role of spirituality in health care.* Vol. 11., No. 4. Baylor University Medical Center Proceedings. (pp.352-357).

Rumun A. J. (2014). *Influence of Religious Beliefs on Healthcare Practice.* Vol. 2, No. 4. International Journal of Education and Research. (pp.37-48).

Saad M. & de Medeiros R. (2016). *Programs of religious/spiritual support in hospitals – five "Whies" and five "Hows".* Philosophy, Ethics, and Humanities in Medicine. DOI: 10.1186/s13010-016-0039-z

Schweilkart S. J. (2019). *Health Law: Who Makes Decisions for Incapacitated Patients Who Have No Advance Directive?* Vol.21, No.7; AMA Journal of Ethics. (pp.587-593). DOI: 0.1001/amajethics.2019.587.

Schwitzgebel. E. (2019). *Belief.* The Stanford Encyclopedia of Philosophy. Retrieved February 9, 2021 from https://plato.stanford.edu/archives/fall2019/entries/belief/

Segen's Medical Dictionary. (2011). *Clinical Practice.* Retrieved March 25, 2020 from https://medical-dictionary.thefreedictionary.com/clinical+practice

Selambizu Getachew. (2018). *The Role of Spirituality/Religiosity for Recovery from Substance Use Disorders Among Patients Who Received Treatment at Zeweditu Memorial Hospital Addiction Treatment Center: Qualitative Study:* Addis Ababa University Institutional Repository.

Seleshi Tessema. (2020). *Ethiopia: Muslims, Christians join to fight CORONA VIRUS: Ethiopian government relaxed broadcast rules to allow religious leaders to lead prayers on national TV.* ANADOLU AGENCY. Retrieved June 1, 2020 from

https://www.dailysabah.com/world/africa/muslims-christians-in-ethiopia-join-fight-against-covid19/amp#aoh=15910140366568&referrer=https%3A%2F%2Fwww.google.com&amp_tf=From%20%251%24s

Serkalem Tafesse. (2015). *The Use, Application, and Integration of Religion/Spirituality in Clinical Social Service: The Case of Clinical Social Service Providers:* Addis Ababa University Institutional Repository.

Shalowitz D. I., Garett-Mayer E. & Wendler D. (2007). *How Should Treatment Decisions Be Made for Incapacitated Patients, and Why?* Vol.3, No.3; PLoS Med. (p.35). DOI: 10.1371/journal.pmed.0040035

Sherwood H. (2018). *Religion: Why faith is becoming more and more popular*. The Guardian. Retrieved April 17, 2020 from https://www.theguardian.com/news/2018/aug/27/religion-why-is-faith-growing-and-what-happens-next

Shinall Jr. M. C. (2009). *The Separation of Church and Medicine.* Virtual Mentor. Vol. 11, No.10. American Medical Association Journal of Ethics. (pp.747-749).

Sim J., Saunders B., Waterfield J., & Kingstone T. (2018). *Can sample size in qualitative research be determined a priori?* International Journal of Social Research Methodology: Taylor & Francis Group. DOI: 10.1080/13645579.2018.1454643

SPHMMC (n.d.). *St. Paul's Hospital Millennium Medical College at a glance*. Author. Retrieved March 24, 2020 from: https://sphmmc.edu.et/about/

Straford D. (2015). *Elements of Outstanding Leadership: A Convergent Parallel Mixed Methods Study of the Development of Transformational Leadership.* Master's Thesis. Trinity Washington University.

Swihart D. L. & Martin R. L. (2020). *Cultural Religious Competence in Clinical Practice.* StatPearls [Internet]. Treasure Island, FL; StatPearls Publishing.

Tanyi R. A. (2002). *Towards Clarification of the Meaning of Spirituality, Journal of Advanced Nursing.* Journal of Advanced Nursing Vol. 39, No. 5: Blackwell. (pp.500-509).

Tarpley M. & Tarpley J. (2009). *Clinical Case: The Patient Who Says He Is Ready to Die.* Virtual Mentor. Vol.11, No.10. American Medical Association Journal of Ethics. (p.761-765).

Tebaber Workneh et.al. (2018). *Perceptions of health and illness among the Konso people of southwestern Ethiopia: persistence and change.* Vol.14, No.18; Journal of Ethnobiology and Ethnomedicine. DOI: 10.1186/s13002-018-0214-y

Teruwork Kebede & Jock Bol. (2016). *Ethiopian Man Puts Sons' Circumcisions before His Own.* jhpiego. Retrieved April 16, 2020 from https://www.jhpiego.org/story/now-thats-parenting-ethiopian-man-puts-sons-circumcisions-before-his-own/

Thompson K. (1982). *Emile Durkheim.* London. Tavistock Publications.

Tufford L. & Newman P. (2010). *Bracketing in Qualitative Research.* Qualitative Social Work. Vol. 11, No. 1. www.sagepublications.com (pp.80-96). DOI: 10.1177/1473325010368316

Understanding Science. (2020). *Science and religion: Reconcilable differences.* University of California Museum of Paleontology. Retrieved October 5, 2020 from https://undsci.berkeley.edu/article/science_religion

Visser P. S., Krosnick J. A. & Lavrakas P. J. (2000). *Handbook of research methods in social and personality psychology*. New York, NY, US: Cambridge University Press. (pp. 223-252).

Yawar A. (2001). *Spirituality in medicine: what is to be done?* Vol. 94, No. 10. Journal of The Royal Society of Medicine. (pp.529-533). DOI: 10.1177/014107680109401013

Zinnbauer B. J., Pargament K. I., Scott A. B. (2001). The Emerging Meanings of Religiousness and Spirituality: Problems and Prospects. Journal of Personality. Volume 67. (pp. 889–919). DOI:10.1111/1467-6494.00077.

Zinnbauer B. J. et.al. (1997). *Religion and Spirituality: Unfuzzying the Fuzzy.* Journal for the Scientific Study of Religion, Vol. 36, No. 4: Blackwell Publishing. (pp.549-564). URL: http://www.jstor.org/stable/1387689

Annex

Annex One: Informed Consent for Online Interviews

Purpose: The purpose of this study is to explore how health professionals integrate religion/spirituality in clinical practice. It aims to inform educators, health care institutions, practitioners, and policy makers on ways they can integrate religion/spirituality to better provide holistic care. The study is being conducted as a partial fulfillment of the requirement for the degree of master's in social work at Addis Ababa University of the researcher. This interview is intended to know and understand your views on integrating clients' religion and spirituality into clinical practice, which is also called religious/spiritually integrated practice.

Duration: 30 min

Beneficence: You will not receive any type of payment for participation in the study

Confidentiality: Your responses will be kept confidential and no identifying information will be shared with a third party without express consent from you. This does not account for any information collected, processed, or shared by the software used for the meeting. You will need to check on the software description and policy of use for information on this regard.

Consent: The researcher will only proceed with data collection when you indicate your willful participation by your signature on the bottom of this consent form. Therefore, you are free to not participate in the research or drop out at any given time.

Editing: You can communicate with the researcher any after the interview to review your response and make edits before the final report is submitted to the University and your institution.

Thank-you for your time and willingness to share your thoughts and opinions on this area in practice! We are grateful and hope you enjoy the survey! And feel free to contact the researcher if you would like more information on the research!

Researcher: *Natnael Alemayehu* **Addis Ababa University** **Participant's Initials: _____**

Contact Info. *+251 966 040 229* **School of Social Work** **Signature: _____**

Alemayehunathaniel@gmail.com *+251 111 225 950* **Date: _____**

Annex Two: Informed Consent for Face to Face Interviews

Purpose: The purpose of this study is to explore how health professionals integrate religion/spirituality in clinical practice. It aims to inform educators, health care institutions, practitioners, and policy makers on ways they can integrate religion/spirituality to better provide holistic care. The study is being conducted as a partial fulfillment of the requirement for the degree of master's in social work at Addis Ababa University of the researcher. This interview is intended to know and understand your views on integrating clients' religion and spirituality into clinical practice, which is also called religious/spiritually integrated practice.

Duration: 30 min

Safety Measures: The interview will be conducted in a well-ventilated area with a space which allows for physical distancing of 2 meters. This distance will be kept throughout the interview except for the signing of the informed consent. The researcher will make sure to wear a face mask and use sanitizers before the session and will only proceed with the interview if you do the same. You will be provided with a hand sanitizer before and after you receive and sign this informed consent. The research will also ensure that the consent paper you receive was/is properly handled.

Beneficence: You will not receive any type of payment for participation in the study

Confidentiality: Your responses will be kept confidential and no identifying information will be shared with a third party without express consent from you.

Consent: The researcher will only proceed with data collection when you indicate your willful participation by your signature on the bottom of this consent form. Therefore, you are free to not participate in the research or drop out at any given time.

Editing: You can communicate with the researcher any after the interview to review your response and edit before the final report is presented to the University and the institution.

Thank-you for your time and willingness to share your thoughts and opinions on this area in practice! We are grateful and hope you enjoy the survey! And feel free to contact the researcher if you would like more information on the research!

Researcher: *Natnael Alemayehu*
Contact Info. *+251 966 040 229*
Alemayehunathaniel@gmail.com

Addis Ababa University
School of Social Work
+251 111 225 950

Participant's Initials: _____

Signature: _____

Date: _____

Annex Three: Interview Guide for Integrating Religion/Spirituality into Clinical Practice

1. How would you define religion and spirituality?
    - Do they hold any meaning for you?
2. In what ways does your profession describe the terms?
    - How might the views in other professions relate or differ from this description?
3. How might religion and spirituality relate with clinical practice?
    - How do you see the significance of the relationship?
4. How are religion/spiritual needs and concerns assessed and/or addressed through clinical practice?
    - Are you aware of any standard tools used for this purpose? In general, or within the hospital
5. What matters can be considered spiritual/religious in health care? (e.g. a person believing a disease to be a curse from God or caused by evil spirits, or a patient refusing to take medicine because of such things are forbidden in their religion or s/he disregards medical treatment and seeks other religious/spiritual remedies)
    - In what ways are they addressed?
6. What factors may have shaped the definition of these issues and the ways they have been addressed?
    - What role do professional trainings in general and yours' play?
    - What resources are available/accessible to manage such issues?
    - Is there a standard procedure, hospital policy/norm and other legal/professional guidelines?
7. What do you feel about discussing such issues with clients and steps you can take to assist them in accessing resources which can help them in such conditions?

8. Was there an instance during practice where you came across religion/spiritual concerns? If yes, ask for description
    - If yes/how did you manage them?
    - If no/what issues may you encounter in the future?
    - How did you determine it was an issue?
    - What steps did/will you take in address them?
    - What do/will you consider in making decision?
    - What resources have/will you access and use?
    - What has inspired your approach?
    - How do you assess your actions?
9. What would it mean for you to integrate religion/spirituality into clinical practice?
10. What outcomes can this have for clients and health care in general?
    - What factors have positive contribution to these outcomes?
    - What are some of the things which may detract from the potential benefits?
11. What holds you back from engaging in such practice? What opportunities do you have to engage in such practice?
12. How does this fit in with the overall care/service you provide? (Health care principles, Professional duties, workload, resources including time and anticipated out come from the care)
13. How often do you engage yourself in religious/spiritually integrated practice? (In forms of training, consultation, interaction with clients, holistic assessment or use it as an intervention/ a basis for recommending interventions/referral to others like clergy)
14. What do you think of the topic in general and the discussion in the interview?
15. Who should I visit to learn more about my questions?

Thank You!