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Perceptions and Practices of Spiritual Care Among Nurses: A Qualitative Study in a Mission Hospital in Ghana

Gabriel Nanley Danyuo

nanleygabrielgabriel@gmail.com

Kwame Nkrumah University of Science and Technology (KNUST)

Joseph Issifu Shahadu

Kwame Nkrumah University of Science and Technology (KNUST)

Isaac Hayford Budu

Kwame Nkrumah University of Science and Technology (KNUST)

Gyamfi Jennifer

Kwame Nkrumah University of Science and Technology (KNUST)

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Abstract

Background

Spiritual care is a recognized dimension of holistic, patient-centered nursing. Despite a growing global consensus on its importance, nurses in many sub-Saharan African countries, including Ghana, face persistent barriers to integrating it into clinical practice. This study explored the perceptions and practices of spiritual care among nurses working in a mission hospital in Kumasi, Ghana.

Aim

To explore the perceptions and practices of spiritual care among nurses at a mission hospital, with the following specific objectives: (1) explore nurses' perceptions of spiritual care and its importance; (2) examine current practices and approaches to spiritual care integration; (3) identify factors influencing nurses' decision-making regarding spiritual care; (4) investigate the perceived impact of spiritual care on patient outcomes; (5) identify challenges and barriers to spiritual care provision; and (6) examine the role of nurses' personal beliefs and spirituality in spiritual care delivery.

Methods

A qualitative phenomenological design was employed. Fifteen purposively sampled registered nurses from the Church of Christ Mission Hospital (CCMH), Bomso, Oforikrom Municipality, Ashanti Region, Ghana, participated in individual, face-to-face, semi-structured, audio-recorded interviews between October and November 2023. Data were analyzed using Braun and Clarke's reflexive thematic analysis framework.

Results

Five overarching themes emerged: (1) Perceptions and Understanding of Spiritual Care, (2) Integration of Spiritual Care into Nursing Practice, (3) Barriers and Challenges to Spiritual Care Provision, (4) Personal Experiences, Reflections, and Faith Influence, and (5) Recommendations for Enhancing Spiritual Care Integration.

Conclusions

Spiritual care in CCMH remains aspirational rather than systematic. Dedicated curricular inclusion, workplace education, standardized assessment tools, interdisciplinary collaboration, and enabling institutional policies are essential to bridge the gap between nurses' recognition of spiritual care and its consistent, equitable delivery.

Ethical Compliance:

All procedures were performed in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or

comparable ethical standards.

Background

The World Health Organization (WHO) defines health as a state of complete physical, mental, social, and spiritual well-being, affirming that none of these dimensions can be neglected in the pursuit of genuine wellness (1). Nurses constitute the largest segment of the global health workforce, numbering over 20 million worldwide, and occupy a privileged position at the intersection of patients' physical, psychological, social, and spiritual needs (1). Holistic nursing care is mandated by international nursing codes, including the International Council of Nurses' (ICN) Code of Ethics (2), and is increasingly recognized as foundational to quality, patient-centered practice (3, 4).

Spiritual care is broadly defined as the practical expression of presence, guidance, and interventions aimed at enhancing individuals' spiritual well-being, including their connection to self, others, and a higher power or transcendent meaning. It is an essential component of holistic nursing (5). The evidence base for its benefits is substantial: patients who receive spiritual care report greater inner peace, improved coping, reduced anxiety, enhanced quality of life, and peaceful end-of-life experiences (6). Spiritual care is also associated with improved mental health outcomes among individuals experiencing depression, substance use disorders, and suicidal ideation (6).

Despite these well-documented benefits, the integration of spiritual care into clinical nursing practice remains inconsistent, particularly in Sub-Saharan Africa. Evidence on nurses' perceptions, practices, and competencies in spiritual care remains limited in Ghana, South Africa, and Nigeria (7–9). In Ghana, patients frequently attribute illness to supernatural causes, including curses, witchcraft, and divine punishment, sometimes delaying or forgoing orthodox medical care in favor of spiritual interventions (9–11). This cultural context renders spiritual care competence a practical necessity in effective healthcare.

Within Ghanaian nursing education and practice, spiritual care receives insufficient systematic attention in training curricula, institutional policies, and clinical governance frameworks. Nurses frequently report feeling inadequately prepared to assess and address patients' spiritual needs, citing limited formal training, high workloads, time constraints, and the absence of validated assessment tools and clear guidelines (12–16).

The Church of Christ Mission Hospital (CCMH), a Christian-affiliated facility in Kumasi serving a religiously diverse patient population, provides a significant setting for exploring how spiritual care is understood and practiced in Ghanaian nursing care. This study aimed to explore the perceptions and practices of spiritual care among nurses at this mission hospital, with the following specific objectives: (1) to explore nurses' perceptions of spiritual care and its importance; (2) to examine current practices and approaches to spiritual care integration; (3) to identify factors influencing nurses' decision-making regarding spiritual care; (4) to investigate the perceived impact of spiritual care on patient outcomes; (5) to identify challenges and barriers to spiritual care provision; and (6) to examine the role of nurses' personal beliefs and spirituality in spiritual care delivery.

Methods

Study design

A qualitative phenomenological research design was adopted to capture nurses' lived experiences and subjective perceptions of spiritual care (17). This approach is well-suited for an in-depth exploration of nurses' personal meanings, attitudes, and contextualized understanding of spiritual care within their professional practices. This study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (18) [see Additional file 1].

Study setting

The study was conducted at the Church of Christ Mission Hospital (CCMH) in Bomso, Oforikrom Municipality, Ashanti Region, Ghana. Established in 1983, CCMH is a Christian-affiliated facility that provides 24-hour services, including maternity, ENT, dental, public health, and emergency units. The hospital has a bed capacity of 34 and a staff complement of 115, including 62 nurses, six doctors, four physician assistants, and six pharmacists.

Participants and sampling

Purposive sampling was employed to recruit fifteen (15) registered nurses with a minimum of one year of clinical experience, ensuring diverse representation in terms of age, sex, rank, years of experience, religion, and marital status (17). The inclusion criteria were formal nursing registration and at least one year of clinical experience. Nurses in educational roles, student nurses, and those with less than one year of experience were excluded. Data collection continued until thematic saturation was achieved, defined as the point at which no new themes or codes emerged from the additional interviews (19).

Data collection

Data were collected between October and November 2023 through individual, face-to-face, semi-structured interviews guided by a 23-item interview guide [see Additional file 2] covering five domains: (1) background information, (2) perceptions of spiritual care, (3) integration of spiritual care into nursing practice, (4) personal experiences and reflections on spirituality, and (5) suggestions for improvement. Interviews were audio-recorded with participants' verbal and written consent and subsequently transcribed verbatim by the lead researcher (G.N.D.). A pilot interview was conducted with two nurses prior to the full data collection to refine the instruments. The interviews lasted 30–60 minutes.

Data analysis

Data were analyzed using Braun and Clarke's reflexive thematic analysis framework (20, 21), following six phases: (1) familiarization through repeated transcript reading and memo writing, (2) generation of initial codes, (3) searching for themes, (4) reviewing and refining themes, (5) defining and naming themes, and (6) producing the final analytic account. The transcripts were returned to the selected

participants for member checking purposes. All four research team members participated in the analytic process, and coding discrepancies were resolved through discussions and consensus. A complete theme development audit trail is provided [see Additional file 3].

Trustworthiness

Trustworthiness was ensured through four Lincoln and Guba criteria (22): credibility (prolonged engagement, member checking, and pilot testing), transferability (thick, contextualized description of the setting and participants), dependability (an audit trail of analytic decisions), and confirmability (reflexive journaling and peer debriefing). A full researcher reflexivity statement is provided [see Additional file 4].

Ethical considerations

Ethical approval was granted by the Kwame Nkrumah University of Science and Technology (KNUST) Committee on Human Research, Publication, and Ethics (Reference: CHRPE/AP/936/23) in accordance with the principles of the Declaration of Helsinki [see Additional file 5]. Written informed consent was obtained from all participants. Participants were assured of their right to withdraw at any time without consequence. Confidentiality was maintained through the use of coded identifiers (N1–N15), and all audio recordings and transcripts were securely stored.

Clinical trial number: not applicable

Results

Participant characteristics

Fifteen (15) registered nurses participated in this study. The participants' ages ranged from 28 to 42 years (mean age: 34.3 years). Eight were female and seven were male. Their clinical experience ranged from 1 to 15 years (mean: 7.0 years). The participants' ranks included Senior Nursing Officer (SNO, n = 7), Nursing Officer (NO, n = 6), Senior Community Health Officer (SCHO, n = 1), and Staff Nurse (SN, n = 1). Twelve (12) participants identified as Christians and two as Muslims. Eight (8) were married and seven (7) were single. The full participant characteristics are shown in Table 1. (insert here).

Most nurses described receiving only cursory, incidental exposure to spiritual care in their nursing training, without systematic instruction in assessment methods, intervention protocols, or ethical frameworks for interreligious practice. Thematic analysis yielded five major themes and 13 subthemes, as presented in Table 2. (insert here)

Theme 1: Perceptions and Understanding of Spiritual Care

Defining spiritual care as a component of holistic health

All 15 nurses conceptualized spiritual care as a dimension of holistic nursing that attends to patients' spiritual and religious needs alongside their physical, psychological, and social needs. Definitions are typically grounded in the WHO concept of complete well-being.

I am aware that when providing treatment, it is important to consider a client's beliefs. A complete state of physical, mental, social, psychological, and spiritual well-being is referred to as good health. Patients' spiritual health is crucial to their lives and the lives of all people. **(Nurse 1, SNO, 9 years' experience)**

I define spiritual care as a crucial facet of nursing care, where a nurse ensures that a client's or patient's spiritual requirements are satisfied while considering their religious beliefs. **(Nurse 5, SN, 2 years' experience)**

Several nurses extended their definitions beyond religion to encompass psychological and transcendent dimensions.

Spiritual care is the other type of care that is more psychological in nature. It is a facet of psychological care in which we rely on a higher power to support or contribute to a particular area of care. **(Nurse 11, NO, 1 year's experience)**

Nurse 7, who had received formal spiritual care training within their Muslim faith tradition, offered the most structured definition, emphasizing the importance of assessment before referral: "The nurse must first comprehend the patient's faith before assessing the problem and determining whether or not the nurse can meet their spiritual needs, in order for the spiritual leader to step in." (Nurse 7, SNO, 12 years' experience).

Spiritual care as a driver of patient healing

A strong and culturally anchored conviction shared by virtually all participants was that spiritual care actively facilitates healing.

There are cases where people are virtually at the end of their lives but entirely recover after a few prayers are offered. I presume that many patients who were denied spiritual treatment might have died because the only option left when the medications do not work and there is no hope is death. However, when prayers are offered, some of them completely recover. **(Nurse 4, SNO, 3 years' experience)**

Spiritual care has a favorable effect on advancing patient health. Some patients merely require prayer and counselling; they do not even require the medications we are giving them. **(Nurse 7, SNO, 12 years' experience)**

When a person is allowed to express his views and hopes, he will be freed from the fear he is experiencing, and in a short period of time, the illness he is experiencing will pass. **(Nurse 5, SN, 2 years' experience)**

Dual effects: spiritual care as beneficial and potentially harmful

Nurses demonstrated nuanced awareness that spiritual beliefs could occasionally work against biomedical care:

Some patients believe in the spiritual components of therapy and do not consider physiological and other factors. They do not pay attention to medical treatment because they think their illness is spiritual rather than physical. **(Nurse 2, SNO, 7 years' experience)**

Some pastors, like JW, forbid their followers from receiving medical treatment, and as a result, some patients in that situation pass away; this is a negative outcome of spiritual beliefs. **(Nurse 4, SNO, 3 years' experience)**

A patient went to Komfo Anokye to undergo orthopedic surgery, where metal plates were inserted into his legs. When he was discharged, he went to church and the pastor said 'jump and praise the Lord for you are healed.' He jumped and praised the Lord, and his condition deteriorated. Sometimes, because of spiritual beliefs, we lack common sense, thinking that faith alone can do the work. **(Nurse 11, NO, 1 year's experience)**

Theme 2: Integration of Spiritual Care into Nursing Practice

Informal and reactive approaches as the norm

All 15 nurses described the absence of standardized protocols, validated assessment tools, and documentation systems for spiritual care:

There is no particular trend in my workplace regarding the provision of spiritual care. There is no chaplain staff, and once a patient requests a spiritual advisor, there are no restrictions. We view this as providing spiritual care. **(Nurse 1, SNO, 9 years' experience)**

There are no established processes or procedures for you to follow at my place of employment. I know there is a chaplain at my workplace, but I have no idea how to contact him or what steps to take. **(Nurse 2, SNO, 7 years' experience)**

I do not believe that there are any current procedures for spiritual care in the ward. It depends on the nurse and the patient's willingness to communicate. **(Nurse 5, SN, 2 years' experience)**

We do not record that the pastor or the Imam was called to provide spiritual treatment because it is similar to the psychological care that we provide. **(Nurse 11, NO, 1 year's experience)**

Morning devotions as institutionalized spiritual care

The most consistent form of structured spiritual care was the daily morning devotions practiced by the hospital.

Every day, we conduct morning devotions for our patients, and that is how I know that we are providing spiritual care. It might take the shape of guidance, counselling, sometimes alone time with the patient, or joint prayer. **(Nurse 3, SCHO, 7 years' experience)**

At the hospital where I previously worked, we practiced morning devotions every Monday and Friday. Muslims observe Friday, whereas Christians observe Mondays. However, all of us will participate on both days. **(Nurse 7, SNO, 12 years' experience)**

Every Monday, we pray for the patients and visit them from ward to ward. This gives hope to patients and enhances the hospital's reputation. **(Nurse 10, SNO, 15 years' experience)**

Spiritual needs assessment: rare and unstructured

Formal, proactive assessment of patients' spiritual needs was reported as rare or absent by most participants.

Not frequently, but occasionally. We often leave that to the chaplains and do not do it ourselves. Although the spiritual side is equally important, we tend to concentrate on the physical and mental aspects instead, since we lack training on how to handle it. **(Nurse 1, SNO, 9 years' experience)**

I do not frequently evaluate the spiritual requirements of my patients because the nurse-to-patient ratio is approximately 1:10 or 1:20, and I have to attend to the needs of all these patients before my shift ends. **(Nurse 5, SN, 2 years' experience)**

It is rare to assess the spiritual needs of patients. However, it all depends on the condition of the patient, which will draw your attention. **(Nurse 7, SNO, 12 years' experience)**

I have never seen nurses assessing the spiritual needs of the patient and have never done that before. **(Nurse 14, NO, 9 years' experience)**

Decision-making triggers for spiritual care provision

Three consistent triggers shaped nurses' decisions to offer spiritual care: patient requests, failure of medical treatment, and observable clinical deterioration.

When you notice that the patient's condition is deteriorating despite all the care provided and there is no improvement, that is another factor that affects my decision. **(Nurse 1, SNO, 9 years' experience)**

When all care fails to work, when all medical and physical care fails after providing the recommended treatments, and there is no improvement. This is when we accept that spiritual treatment is needed. **(Nurse 5, SN, 2 years' experience)**

The type of patient you're dealing with and the severity of the condition, the presentation of signs, and the patient's request. When all medical treatments fail, this indicates that spiritual care is needed and must be considered. **(Nurse 7, SNO, 12 years' experience)**

Theme 3: Barriers and Challenges to Spiritual Care Provision

Inadequate formal education and training

This was the single most pervasive barrier, as articulated by all 15 nurses:

We were not expressly instructed on how to provide spiritual care to patients in the ward. We have not been adequately introduced to its concepts or methods. **(Nurse 1, SNO, 9 years' experience)**

Even in school, when they discuss it, they do not go into detail so that you understand how it should be done. We know that it is a part of nursing care, but most of the time we disregard it. **(Nurse 3, SCHO, 7 years' experience)**

Only the provision of psychological, mental, and spiritual care was taught in school; however, we did not receive any precise instructions on how to carry out spiritual care. **(Nurse 4, SNO, 3 years' experience)**

I have not received any training or formal education in spiritual care. **(Nurse 13, NO, 4 years' experience)**

These findings are consistent with global evidence. In a systematic review and meta-analysis of 35 studies involving 17,786 nurses, Wang et al. (13) established that nurses' perceptions and competencies in spirituality and spiritual care remain moderate globally, with lower competencies consistently observed among nurses without religious affiliation and those with lower levels of education than their counterparts. Rykkje et al. (23) confirmed in a scoping review that educational interventions for spiritual care must be integrated throughout nursing curricula, rather than delivered as isolated modules, to achieve meaningful and sustainable competence development.

Religious diversity as a practical and ethical barrier

Providing equitable spiritual care across the diverse religious landscape of their wards was described as a significant logistical and competence-related challenge.

A ward may have more than ten beds with a variety of patients with various religious beliefs. Confusion can arise from allowing a Christian leader to attend to a patient in a setting that would not be appropriate for a Muslim patient. **(Nurse 1, SNO, 9 years' experience)**

The difficulty is that we might not be able to invite religious leaders from other faiths, and if it is always pastors, people may feel excluded, whether they are Muslims or not. **(Nurse 2, SNO, 7 years' experience)**

I am a Pentecostal and have previously worked in an SDA hospital where you might want to pray in tongues, but the church leaders might show up and tell you to lower your voice. This will, in some ways, prevent you from cooperating with spiritual care as you would like. **(Nurse 5, SN, 2 years' experience)**

Faith-congruence bias

Nurses across faith traditions acknowledged greater comfort and confidence in providing spiritual care to patients who shared their religious beliefs.

It can be quite challenging because I am Christian and not Muslim. If a Muslim asks for an Imam, I do not know them and do not know how to perform their rites. **(Nurse 1, SNO, 9 years' experience)**

As a Christian, I believe that Christians require more care and attention from me. In theory, one cannot provide what one does not possess. We were trained as nurses, not pastors. **(Nurse 2, SNO, 7 years' experience)**

I am a Muslim and cannot provide spiritual care as Christians do. I can only do my best in things concerning my religion. **(Nurse 12, NO, 7 years' experience)**

A minority of nurses described more inclusive approaches.

As every person is different and has various traits, my beliefs have no bearing on how I provide spiritual care to my patients. I do not pressure people to act in a certain way. **(Nurse 6, SNO, 8 years' experience)**

We are all one people with different religious beliefs; some believe in God, others in Jesus, and others in Mohammed. Therefore, you should not condemn or judge an individual. **(Nurse 9, SNO, 8 years' experience)**

Institutional and systemic barriers

High nurse-to-patient ratios, the absence of documentation and referral pathways, and the hospital's Christian institutional culture were identified as obstacles.

If you are working with colleagues and you want to give a new way for the patients to practice what they believe, they see it as awkward, backward, and sometimes barbaric. **(Nurse 11, NO, 1 year's experience)**

The system itself restricts patients from performing certain tasks. This facility is perceived to be a Christian facility, so it will be very difficult to entertain fetish priests or someone who does not believe in Christianity. **(Nurse 11, NO, 1 year's experience)**

The Ministry of Health does not do a great job of educating people about spiritual care. If you go to provide care, someone may ask you if it is also part of your responsibilities. **(Nurse 12, NO, 7 years' experience)**

The nurse-to-patient ratio in Ghana could be 1 10, so taking care of these patients just before your shift ends will not allow you to provide them with the spiritual care we are expected to. **(Nurse 12, NO, 7 years' experience)**

Theme 4: Personal Experiences, Reflections, and Faith Influence

Transformative clinical encounters attributed to spiritual intervention

Nurses shared vivid, formative accounts of clinical encounters in which spiritual care interventions made a decisive difference in patient outcomes.

When an unconscious infant was brought to the ward, the mother asked to call her pastor for prayers. As soon as the pastor entered the room and prayed for the child, he awoke from his coma. It happened surprisingly and suddenly, healing the sick and their loved ones spiritually. **(Nurse 1, SNO, 9 years' experience)**

A 33-year-old woman was diagnosed with secondary hyperglycemia due to ketoacidosis. She did not improve significantly after a week of fluid and medication. A priest was called to pray for the patient's well-being. After approximately 24 hours, the woman, who was semi-conscious, suddenly became conscious. After three days, she was discharged after her blood sugar, plasma, and ketone levels returned to normal. **(Nurse 2, SNO, 7 years' experience)**

A patient admitted to the ward had been receiving oxygen for approximately one month. There was no possibility of recovery in this patient. I led her in prayer and guided her through Bible verses. I prayed and fasted with her. She was discharged after a quick recovery and later called to express her gratitude. **(Nurse 4, SNO, 3 years' experience)**

Peritonitis was diagnosed in a patient, which required surgical intervention. He invited spiritual leaders to pray for him. Combined with the medications he was already taking, the patient was able to heal and be discharged without the need for additional surgery. **(Nurse 13, NO, 4 years' experience)**

Personal spirituality as a professional resource

Most nurses described drawing on their personal faith as a daily, professional resource.

Before entering the ward to perform my duties as a nurse, I always pray, 'Oh God, I am starting my day's activities. May my presence be a source of healing for all patients I encounter in the ward. Guide my behavior so that whatever I do in the ward is very therapeutic for my patients.' **(Nurse 7, SNO, 12 years' experience)**

Every day before I leave for work, I pray to God for strength and assurance that He will protect me from harm while I perform my duties. **(Nurse 10, SNO, 15 years' experience)**

In the operating room, I never went to the theatre table without praying because I think there is something greater than the physical. **(Nurse 11, NO, 1 year's experience)**

Coping without structured institutional support

In the absence of formal debriefing or occupational well-being programs, nurses improvised personal coping strategies to manage stress.

By consoling them and requesting that they pray and have confidence in God, we do what we can to help. **(Nurse 1, SNO, 9 years' experience)**

If my beliefs coincide with those of the patient, we are fine to go, but if not, I ask my superiors for assistance, who help the clients. **(Nurse 2, SNO, 7 years' experience)**

If you pray all the time as a nurse, you will feel peaceful and satisfied. You will see that burdens are lifted from you. **(Nurse 10, SNO, 15 years' experience)**

Theme 5: Recommendations for Enhancing Spiritual Care Integration

Formal education and training as the primary solution

Almost every nurse spontaneously prioritized embedding spiritual care in nursing education as the most urgent reform.

The need for spiritual care should be emphasized in educational institutions as well. It should be considered as a whole so that students can gain more knowledge and understand how to use it before they graduate. It is challenging for nurses to provide spiritual care in the ward without formal training. **(Nurse 1, SNO, 9 years' experience)**

Training sessions, workshops, seminars, discussions, and open forums should be conducted for nurses to learn how to provide spiritual care. This will influence our healing processes, enhance nursing care, and improve prognosis. **(Nurse 5, SN, 2 years' experience)**

I believe it would be wise for authorities to ensure that the spiritual care component is always incorporated into the patient's plan of care or course of treatment. **(Nurse 7, SNO, 12 years' experience)**

The Ministry of Health and nursing students should receive additional training in spiritual care to ensure awareness of its importance in providing holistic care. **(Nurse 12, NO, 7 years' experience)**

Institutionalizing inclusive chaplaincy services and policy frameworks

Nurses proposed multi-faith chaplaincy, clear referral systems, and formal institutional policies as complementary structural reforms.

The hospital should offer accommodations for all religious beliefs that exist in our nation. It would be better if we also had an imam or a fetish priest, in addition to chaplains. Processes and personnel should be

established to help assess these needs. **(Nurse 2, SNO, 7 years' experience)**

Offices should be set aside in the facilities for spiritual leaders or representatives of various religions, such as a pastor or prophet for Christians, an Imam, or an African traditional representative. These spiritual leaders should be employed in various facilities. **(Nurse 12, NO, 7 years' experience)**

They should employ spiritual heads in various hospitals so that patients can seek help from them, and we should give room for patients to say a word or prayer as and when the need arises. **(Nurse 15, NO, 8 years' experience)**

Discussion

This study explored the perceptions and practices of spiritual care among 15 nurses at CCMH, a Christian mission hospital in Kumasi, Ghana, and generated five overarching themes illuminating a complex landscape in which nurses broadly value spiritual care and selectively draw upon it in clinical practice, yet lack the formal preparation, institutional structures, and standardized frameworks required for consistent and equitable delivery.

Perceptions and understanding of spiritual care

The nurses in this study demonstrated an intuitive and broadly holistic understanding of spiritual care, consistently anchored in the WHO definition of comprehensive, well-being. This resonates with Cooper et al.'s (24) critical synthesis and the systematic review and meta-analysis by Wang et al. (13), which collectively established that nurses across diverse global settings recognize the importance of spirituality and spiritual care but assign diverse and sometimes imprecise meanings to these terms, with perceptions and competencies remaining moderate globally. The tendency among participants to define spiritual care predominantly through the lens of religious practice risks narrowing spiritual care to its religious expression at the expense of its broader existential and humanistic dimensions (25).

The conviction that spiritual care drives patient healing is vividly illustrated through clinical narratives of seemingly miraculous recoveries, reflecting the deep cultural authority of spiritual and religious beliefs in Ghana’s health frameworks. Korsah et al. (9) documented similar patterns, in which Ghanaian patients with diabetes attributed their condition to witchcraft and sought spiritual rather than biomedical treatment. Gordon et al. (26) identified similar tensions in their review of spirituality in critical illness, noting that while spirituality generally correlates with positive health outcomes, religiously motivated health decisions can occasionally have adverse consequences.

Integration of spiritual care into nursing practice

Despite the broad recognition of the value of spiritual care, its integration into clinical nursing practice at CCMH has been predominantly informal, reactive, and unsystematic. This corroborates the consistent

global evidence that spiritual care is practiced inconsistently in the absence of standardized guidelines, validated assessment tools, and organizational support (12, 27, 28). The absence of documented spiritual care interventions is particularly significant; by remaining invisible in nursing records, spiritual care escapes clinical governance, accountability, and quality improvement.

Morning devotions at the CCMH represent the only institutionalized form of structured spiritual care. While collective devotional practices offer a meaningful form of communal spiritual care, they do not substitute individualized patient-level assessments and tailored care plans. Linda et al. (8) identified a similar pattern, in which institutional religious culture created a general spiritual environment without translating into systematic individual spiritual care competencies.

The reactive, 'last resort' trigger pattern of spiritual care is offered only after medical interventions have failed, at the patient's request, or when clinical deterioration is marked. This reflects the marginalization of spirituality within clinical decision-making frameworks. Kruizinga et al. (29) compellingly argued that spiritual care should be integrated into care planning from admission, rather than being reserved as a supplementary measure. Musa (30), in a randomized controlled trial, demonstrated that structured spiritual care interventions significantly improved patients' spiritual well-being when delivered systematically, reinforcing the case for proactive rather than reactive integration.

Barriers and challenges

Inadequate formal education and training emerged as the most universally expressed barriers to providing spiritual care. Kalkim et al. (14) established that nurses who lack dedicated spiritual care training report significantly lower confidence and competence in providing spiritual care. Cone and Giske (3) demonstrated that nurses in clinical practice have little professional preparation to facilitate spiritual care, and de Diego-Cordero et al. (12) confirmed that nurses express persistent feelings of inadequacy due to limited knowledge and skills. Adib-Hajbaghery et al. (31) similarly identified inadequate training, the absence of formal guidelines, and a lack of institutional instruction as the primary barriers, noting that healthcare providers consistently report uncertainty regarding the incorporation of spiritual care into practice (36). Wang et al. (13) confirmed that nurses' spiritual care competencies remain moderate globally, with those with lower educational attainment and no religious affiliation particularly likely to exhibit such deficits. In the West African setting, Bolarinwa et al. (7) found that over half of Nigerian nurses exhibited suboptimal spiritual care practices, with training being the most significantly associated factor.

The faith-congruence bias identified in this study–nurses' greater comfort and confidence with co-religionist patients and discomfort with patients of other faiths–represents a significant equity concern. Wang et al. (13) demonstrated, using a global sample, that nurses without religious affiliation had significantly lower spiritual care competencies. Guo et al. (28) found that personal belief systems and faith backgrounds were among the strongest predictors of nurses' spiritual care competence profiles.

Systemic barriers, particularly high nurse-to-patient ratios, the absence of institutional policy, and a Christian-dominant hospital culture that implicitly restricted non-Christian spiritual practices, compounded individual barriers. Guo et al. (28) corroborated that systemic factors, including time constraints and personnel limitations, are among the strongest institutional predictors of nurses' spiritual care engagement globally. Mascio et al. (32) found that nurses' models of spiritual care are significantly shaped by the availability of chaplaincy referral mechanisms and clear role definitions, highlighting that the absence of such structures actively undermines comprehensive spiritual care.

Personal experiences and faith influence

The richness and specificity of nurses' clinical narratives reflect the formative professional significance of experiential knowledge in a deeply religious cultural context. Özcan et al. (33) observed that nurses' perceptions and practices of spiritual care are shaped by their personal value systems and past experiences, and Moosavi et al. (25) noted that clinical encounters involving spiritual healing or distress create lasting professional memories. The near-universal absence of formal debriefing, peer support, or occupational well-being resources represents a significant gap in the literature. Ausar et al. (34) documented that nurses' personal spiritual practices function as significant coping resources but noted that informal resources are not a substitute for structured institutional support.

Recommendations

The strong consensus among nurses aligns closely with the recommendations of international scholars. Rykkje et al. (23) demonstrated that educational interventions are most effective when spiritual care content is included as mandatory content throughout nursing curricula rather than as elective content. Wang et al. (13) confirmed that formal education is the strongest modifiable predictor of nurses' spiritual care competence. Cone and Giske (3) proposed pedagogical frameworks for embedding spiritual care across curricula, while Cone et al. (35) documented the value of self-assessment tools, such as the EPICC Spiritual Care Competency Self-Assessment Tool, in raising student awareness and tracking professional growth, including among Ghanaian nursing students. The participants' calls for multi-faith chaplaincy, clear referral pathways, standardized assessment protocols, and enabling institutional policies align with the interdisciplinary model of spiritual care advocated by Balboni et al. (6) and Kruizinga et al. (29).

Limitations

This study has several limitations. The single-site design at a Christian mission hospital limits the transferability of the findings to public sector hospitals, faith-neutral facilities, or institutions in other regions or with different demographic compositions. The predominantly Christian sample means that Muslim and traditional African spiritual perspectives, while represented, were not explored with the same depth as Christian perspectives. Reliance on self-reported interview data introduces the possibility of social desirability bias, and the qualitative design precludes causal inferences from being made. Future research should employ multisite designs across diverse facility types, incorporate patients'

perspectives on spiritual care experiences, and utilize structured observations to examine actual spiritual care practices alongside self-reports of healthcare professionals.

Conclusion

This study provides rich, contextualized insights into how nurses in a Ghanaian mission hospital perceive and practice spiritual care. Nurses broadly recognize spiritual care as an integral component of holistic, patient-centered nursing and draw on vivid clinical experiences and personal faith as evidence of its value. However, spiritual care provision remains predominantly informal, reactive, and constrained by inadequate formal preparation, the absence of standardized frameworks and documentation, high workloads, challenges of religious diversity, faith-congruence bias, and an institutional culture that has not yet translated its religious mission into systematic, equitable individual spiritual care. Bridging this gap requires a dedicated nursing curriculum, continuing professional development, validated assessment tools integrated into routine care planning, multi-faith chaplaincy services, and the implementation of enabling institutional policies. These investments will equip Ghanaian nurses to meet the spiritual needs of their increasingly diverse patient populations with greater consistency, competence, and cultural sensitivity, thereby advancing genuinely holistic and person-centered health care.

Abbreviations

CCMH
Church of Christ Mission Hospital
CHRPE
Committee on Human Research, Publication and Ethics
COREQ
Consolidated Criteria for Reporting Qualitative Research
EPICC
Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care
ICN
International Council of Nurses
KNUST
Kwame Nkrumah University of Science and Technology
NO
Nursing Officer
SCHO
Senior Community Health Officer
SN
Staff Nurse
SNO
Senior Nursing Officer

WHO
World Health Organization

Declarations

Ethics approval and consent to participate

Ethical approval was granted by the KNUST Committee on Human Research, Publication, and Ethics (Reference: CHRPE/AP/936/23) in accordance with the principles of the Declaration of Helsinki [see Additional file 5]. Written informed consent was obtained from all participants prior to data collection.

Consent for publication

Not applicable.

Availability of data and materials

The datasets supporting the conclusions of this article are not publicly available due to participant confidentiality commitments but are available from the corresponding author upon reasonable request and with the permission of the KNUST Committee on Human Research, Publications, and Ethics. The interview guide supporting the conclusions of this study is included in the article's additional file [see Additional file 2].

Competing interests

The authors declare no conflicts of interest.

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Author contributions

GND conceptualized and designed the study, collected and analyzed the data, and drafted the manuscript. JIS supervised the entire study, provided critical intellectual input at all stages, and verified the manuscript for submission. IHB guided and refined the manuscript and supervised the data collection and analysis. GJ contributed to the data collection and reviewed the earlier drafts. All authors have read and approved the final version of the manuscript.

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Tables

Table 1: Demographic characteristics of participants

Participant	Age (years)	Sex	Rank	Experience (years)	Religion	Marital status
N1	37	F	SNO	9	Christian	Married
N2	32	F	SNO	7	Christian	Married
N3	37	M	SCHO	7	Christian	Single
N4	28	M	SNO	3	Christian	Single
N5	30	M	SN	2	Christian	Single
N6	37	M	SNO	8	Muslim	Married
N7	42	F	SNO	12	Christian	Married
N8	35	F	NO	5	Christian	Married
N9	34	F	SNO	8	Christian	Married
N10	40	M	SNO	15	Christian	Married
N11	30	M	NO	1	Muslim	Single
N12	35	M	NO	7	Christian	Married
N13	28	F	NO	4	Christian	Single
N14	35	F	NO	9	Christian	Single
N15	35	F	NO	8	Christian	Single

SNO-Senior Nursing Officer, NO-Nursing Officer, SCHO-Senior Community Health Officer, SN-Staff Nurse, F-Female, M-Male

Table 2: Major themes and subthemes from thematic analysis

Main theme	Subthemes
Theme 1 **Perceptions and Understanding of Spiritual Care**	1.1 Defining spiritual care as a component of holistic health 1.2 Spiritual care as a driver of patient healing 1.3 Dual effects: spiritual care as both beneficial and potentially harmful
Theme 2 **Integration of Spiritual Care into Nursing Practice**	2.1 Informal and reactive approaches as the norm 2.2 Morning devotions as institutionalized spiritual care 2.3 Spiritual needs assessment: rare and unstructured 2.4 Decision-making triggers for spiritual care provision
Theme 3 **Barriers and Challenges to Spiritual Care Provision**	3.1 Inadequate formal education and training 3.2 Religious diversity as a practical and ethical barrier 3.3 Faith-congruence bias 3.4 Institutional and systemic barriers
Theme 4 **Personal Experiences, Reflections, and Faith Influence**	4.1 Transformative clinical encounters attributed to spiritual intervention 4.2 Personal spirituality as a professional resource 4.3 Coping without structured institutional support
Theme 5 **Recommendations for Enhancing Spiritual Care Integration**	5.1 Formal education and training as the primary solution 5.2 Institutionalizing inclusive chaplaincy services and policy frameworks

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