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Original Research Article

A Right or Privilege: Provision of Spiritual Care to Patients within Health Care Setting in Northern Ghana

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ABSTRACT

Spiritual care recognizes and responds to the needs of the human spirit in the face of ill health or sadness. These include but not limited to the need for a meaning of existence, self-worth, express oneself, faith, support and perhaps for rites, prayer, sacrament or simply for a sensitive listener. The study assesses the role of health care providers in providing the emotional and spiritual needs of the patients in adult wards. The study adopted the mix method approach. The study reveals a mean value of 4.04 meaning nurses regularly listen actively to patients talk about their religious/spiritual beliefs, strengths, and beliefs about God. Data from the study further reveal that nurses regularly give patients or caretakers the opportunity to talk about God and support coming from God. The study further revealed the following as the barrier to providing emotional/spiritual care to patients admitted to the adult ward of the hospital; Because of different beliefs of the staffs and the patients, most of the patients do not believe in superstition, lack of communication skills in giving this care, Lack of pastors and imams in the hospitals, multiple beliefs of the patients. Thus, it is recommended that policymakers like the government and the Ghana health service should be encouraged to capture the spiritual needs of patients in the management protocols. The Tamale central hospital should employ people who are well versed in spiritual health care in the hospital. The hospital should employ an Imam and a Pastor to complement the nurse's role in taking care of the spiritual needs of the patient.
Keywords: Spiritual Care, Patients, Religion, Emotions, Nurses,

BACKGROUND

Spiritual health and well-being are identified as an important part of a patient's life in the face of life-threatening illnesses. [(1,2)] There exist a historical relationship between spirituality and healthcare across populations. [(3)] Spirituality means different things to different groups making it difficult to have one all-encompassing definition. [(4,5)] In one breath, it has been, averred that spirituality denotes 'a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in any god'. [(6)] Others conceptualize spirituality as 'the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred'. [(7)] From the above conceptualizations, spirituality as a concept may not necessarily be restricted to people who are religious. Given consideration to the diverse conceptualization of the concept, issues regarding connectedness, meaning in

life and transcendence have been observed to run through spirituality. [8] Spiritual intervention in patients' care reflects two dimensions; the existential and the religious. [9,10] For others, patients' spirituality concerns entail their religious beliefs, prayers, and the relationship they have with God. According to the International Council of Nurses, spirituality is an important part of patient general care. [11] Some experts have argued to the effect that one may be acting unethically if health care providers fail to incorporate spirituality. [12] However, others contend that the lack of spirituality in healthcare practice is attributable to the lack of formal educational preparation on spirituality and spiritual care. [13-16] This gap in the educational preparation leaves health workers inadequately prepared to provide therapeutic spiritual care for patients. Experts in recent times have argued for the inclusion of spirituality and spiritual care activities in the nursing curricula. [14]

It is worth noting that spiritual care is part of holistic care and the neglect of the whole person in modern healthcare has resulted in wide-spread dissatisfaction both for patients receiving care and for healthcare professionals delivering the care. [17] According to DeLaune & Ladner, throughout history, people have dealt with pain, illness, and healing in spiritual ways. [17] It has observed that blending spirituality with other therapies provide patients with spiritual capital to understand how they contribute to the creation of their illness and to their healing. [18] Providing and sustaining the spiritual needs of patients requires the trust and sympathy of health care providers. Patients also need to be provided with the desirable environment, appropriate communication of the medical team, and respecting the patient's dignity and beliefs. Be that as it may, it is suggested that in addition to the general evaluation of patients, their spiritual needs in the health care setting be taken into consideration. [19] Existing literature suggests neglect of the provision of holistic spiritual and emotional care in their holistic healthcare approaches. [20,21]

MATERIALS AND METHODS

Study design

The research design adopted for this study was the mixed approach, involving both qualitative and quantitative methods. [22] The target population of this study was hospitalized adult patients (18years+) of the Tamale Central Hospital. Primarily, only adult patients on admission at the Tamale Central Hospital between February 2017 and February 2018 were selected for the study. Again, the study included the unit heads of the hospital, hospital management, faith-based healers, and prescribers as key informants.

Sampling Technique

The number of respondents sampled for the study was 221 (patients). A purposive sampling technique was used to select 15 hospital management and prescribers as well as unit heads whose considerable experience and knowledge required them to be interviewed. Using this technique, the researcher selected the respondents based on his/her knowledge of the population and the type of sample that best suits his/her goals. Management of the Tamale Central Hospital was made up of the medical superintendent, nurse managers, medical officers, unit heads and the physician assistants. All patients that were admitted to the adult wards and had spent seventy-two hours or more within the period of the study (2nd February 2017 to 16th February 2017) were interviewed. Only those who could talk and were willing to participate were interviewed.

Data collection techniques

Both survey and interview techniques were employed in the study. The data collection tools were both questionnaire and interview guide for the assurance of a reliable outcome. [23] The tool used was deemed satisfactory because the same tool was previously used by Mysoon and Musa in their studies. [24,25] The tool

used to collect the quantitative data from the adult patients admitted to the adult wards of the Tamale Central Hospital had two (2) sections; a demographic sheet and the Spiritual Care Rating Scale (SCRS)-domain frequency. The qualitative data were collected using interview guide to study the perception of unit heads (UH), nursing managers (NM), physician assistants (PA), medical officers (MO) and medical superintendent (MS) about the provision of spiritual care to the patients on admission.

Data analysis and presentation

Data analysis was both qualitative and quantitative. Qualitative data generated from interviews were analyzed using cross-case analysis. In this approach, responses to a common question from all interviewees in each category are analyzed together. Thus, each question was analyzed separately for patients and hospital management of the study area. Patton posits that it is easy to do a cross-case analysis for each question in the interview when a standardized open-ended approach is used. [(26)] In a cross-case analysis, participant's responses to a particular question are combined, identified a common theme across participants (cases) and analyzed and interpreted item by item.

Ethical Consideration

The choice of topic for this study was governed by the ethics of the target population and the general public. The privacy and confidentiality of respondents were considered in the design, choice of questions and administration of the questionnaire. Approval was also sought from the ethical review board of the University for Development Studies. The management of the study area and staff of Ghana Health Service were informed and permission sought before the commencement of the study.

RESULTS

Socio-Demographic Characteristics of Respondents

Table 1: Socio-Demographic Characteristics of Respondents

Categories of Respondent	Patients	Per cent (%)	Staff of Tamale Central Hospital	Per cent (%)
Sex Distribution of Respondents				
Male	61	27.6	5	33.3
Female	160	72.4	10	66.7
Total	**221**	**100**	**15**	**100**
Age of Respondents				
20 and below years	33	14.9	0	0.0
21-30 years	52	23.5	11	73.3
31-40 years	58	26.2	4	26.7
41-50 years	45	20.4	0	0.0
51-60 years	21	9.5	0	0.0
61+ years	12	5.4	0	0.0
Total	**221**	**100**	**15**	**100**
Level of Education of Respondents				
No formal education	66	29.9	0	0.0
Primary	52	23.5	0	0.0
JHS	47	21.3	0	0.0
SHS	42	19.0	1	6.7
Tertiary	14	6.3	14	93.3
Total	**221**	**100**	**15**	**100**
Marital Status				
Single	71	32.1	-	-
Married	113	51.1	-	-
Divorce	14	6.3	-	-
Widow	23	10.4	-	-
Total	**221**	**100**	-	-

Sources: Field Survey, 2017

Results from the study showed that 72.4% were female whereas 27.6% were male. With regard to the staff of the study facility, females were 66.7% while 33.3% were males (Table 1). Again, 14.9% of the patients were 20 years and below; 23.5% were between ages 21-30 years; 26.2% were between ages 31-40 years; 20.4% were between ages 41-50 years;

9.5% were between ages 51-60 years, and 5.4% were aged 61+ years. As regards the study facility's staff, those between ages 21-30 years were 73.3%; about 26.7% were between ages 31-40 years. As regards educational qualification, 29.9% had no formal education. Primary constitute 23.5%, Junior High School constitute 21.3%, Senior High School constitute 19.0%, and 6.3% had tertiary education. With the staff of the study facility, 6.7% of them were educated to Senior High School, and 93.3% had a tertiary level qualification. On the marital status of patients, results revealed that 32.1% of the patients were single, 51.1% were married, 6.3% were divorced, and 10.4% were widowed. The marital status of the staff was not sought for in the questionnaire.

Provision of spiritual care and asking questions about the patient's spirituality

The study again sought to establish the provision of spiritual care to patients and whether health care providers ask questions about their spirituality. The following values were used to do the analysis; 1 = Not at all; 2 = Not often; 3 = Occasionally; 4 = Regularly; 5 = At all times; and 6 = Do not know. The results are shown in tables 2 and 3.

Table 2: Hospitalization and Provision of spiritual healthcare

Hospitalization and Provision of spiritual healthcare	**N**	**Mean**	**SD**
Listen actively to you talk about your religious/spiritual beliefs, strengths, and your beliefs about God	221	1.36	1.345
Give you the opportunity to talk about God and support coming from God	221	1.08	1.015
Listen actively to stories from your spiritual life	221	1.16	1.196
Offer to read from the Qur'an/Bible on you or to share prayer and meditation with you	221	4.11	0.655
Help you to have a suitable place to pray, to read from Qur'an/Bible, or to meditate	221	3.96	0.563
Facilitate utilization of religious/spiritual resources available in the hospital that you can use (e.g., common prayer room, the Holy book- Qur'an/Bible, or other religious materials)	221	1.33	1.24
Help you listen to religious programs on radio or TV if available	221	1.27	1.543
Give you the opportunity to participate in religious or spiritual events arranged on the ward (e.g., praying with others or visit other patients in the hospital)	221	3.03	0.586
Offer to discuss with you the difficulties of practising prayer when sick	221	3.01	0.522
Arrange a visit by the hospital Imam/Pastor to comfort and support you if requested by you	221	3.71	0.602
Respect your privacy, dignity, religion, and religious and spiritual beliefs and rituals	221	2.94	1.177
Give your family the opportunity to visit you and to share prayer, reading from Qur'an, and mediation with you	221	3.06	0.783
Give your close friends the opportunity to visit you and to share prayer, reading from Qur'an/Bible, and meditation with you	221	1.32	1.570
Help you to become aware of the meaning and purpose of life in facing illness and suffering that have come with your condition	221	2.35	1.106
Spend time giving comfort, support, and reassurance when needed	221	5.23	0.768
Create a feeling of kindness, cheerfulness, and intimacy when giving care to you	221	1.17	1.264
Help you to feel hopeful and to keep a positive outlook	221	3.44	0.858
Help you to complete unfinished business or activities	221	2.63	1.056

Sources: Field Survey, 2017

Table 3: The frequency of health care providers' questions on patients' spirituality

How often did your care provider asked you ….	**N**	**Mean**	**SD**
About your spiritual/religious beliefs	221	1.07	0.717
About your relationship with God	221	1.33	0.655
About your relationship with yourself, and significant others	221	2.05	1.066
About the religious practices that you like to do	221	4.11	0.065
How your spiritual/religious practices (e.g., prayer, reading from Qur'an/Bible, and/or meditation) and beliefs help you to cope with the new situation after being diagnosed with cardiac disease	221	1.44	0.563
About religious books, articles, or symbols that you like to have	221	2.37	1.533
About your favourite places to practice your religious activities	221	3.72	0.572
About changes in your spiritual/ religious practices, and feelings about your condition	221	1.07	0.586
How they can help you to maintain your spiritual/religious strength after being admitted with this condition	221	1.25	0.522
What gives meaning and purpose to your life	221	3.41	0.602
About your life story and your future	221	1.42	1.177
About your sources of strengths and hope	221	3.06	0.783
About the most important relatives and/or friends to you	221	2.35	1.704
What brings joy, pleasure, and peace to your life	221	1.23	
About your forgiveness for others and how to show forgiveness for yourself	221	1.17	1.403
About the most loving things that you do for others or receive from them	221	3.44	0.786
The appropriate time to ask and discuss with your spiritual/religious issues	221	2.63	1.086

Sources: Field Survey, 2017

Listening to music or practising art

The study revealed that 37.5% of the patients had never been helped to listen to music or practise another art when requested for it, 26.2% did not know whether they received help to listen to music or practise another art on request, 20.3% of the respondents said not often do they had help in listening to music or practicing another art if requested by patients in the hospital, additionally, 8.4% of the patients indicated that it's not applicable for them to received help by listening to music or practising another art if requested by you, and 7.6% of the patients agreed that they always received help in listening to music or practising another art if requested by them.

Entertaining patients with humour

Further investigation indicates that 46.5% of the patients said nurses did not often make them laugh or introduce appropriate humour to them, 22.2% said they were never made to laugh, 15.3% indicated that they did not know whether nurses made them laugh, 10.7% said they were always made to laugh, and 5.3% of the patients indicated that it did not apply to them (Figure 2).

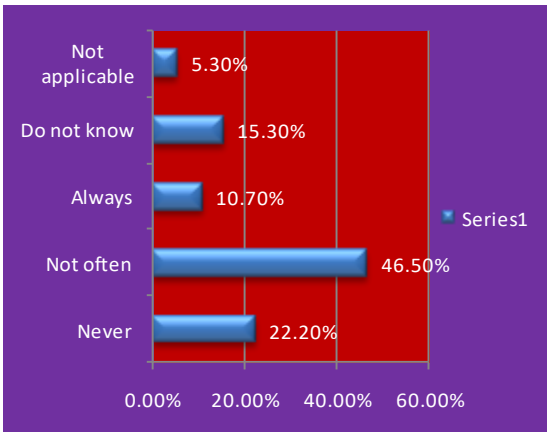

Figure 1: Make patients laugh with humour Sources: Field Survey, 2017

Support and reassurance

Again the study revealed that 58.5% of the patients indicated that nurses did not often hold their hands or put their hands over their shoulders to give them support and reassurance of recovery, 10.7% said that nurses held their hands or put their hands over their shoulders to give them support and reassurance of recovery, 10.3% said they did not know whether nurses held their hands or put their hands over their shoulders to give them support and reassurance of recovery, another 10.3% indicated that it was not applied to them, and 10.2% of the patients said nurses never held their hands or put their hands over their shoulders to give them support and reassurance of recovery (Figure 2).

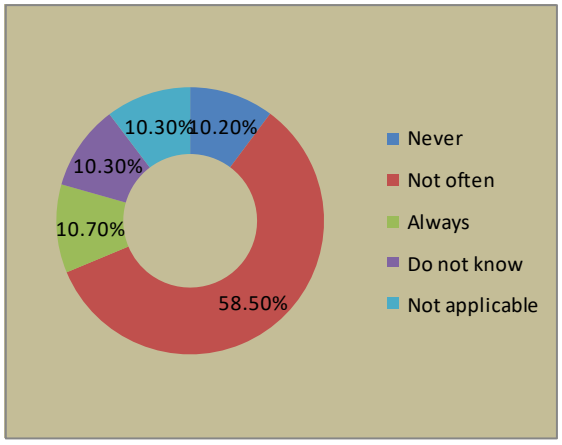

Figure 2: Provision of support and reassurance Sources: Field Survey, 2017

The right people to provide spiritual care

The study had 33.0% of the respondents who indicated that imams were the most appropriate persons to provide spiritual care during hospitalization, 22.6% again indicated nurses as the most appropriate persons to provide spiritual care during hospitalization, 18.6% were of the view that none of the various professionals including Imams and Pastors was the appropriate persons to provide spiritual care during hospitalization, 14.5% of the respondents argued that family members were the most appropriate persons to provide spiritual care during hospitalization, 4.1% mentioned Doctors as the most appropriate person to provide spiritual care during hospitalization, 3.6% indicated close friends as the most appropriate persons to provide spiritual care during hospitalization, and another 3.6% said pastors were the most appropriate person to provide spiritual care during their hospitalization.

Barriers in providing emotional/spiritual care to patients

On the issue of the meaning of spirituality, various responses were received from respondents concerning their understanding of the term spiritual care in health provision.

Spiritual care means how I believe in superstition as a nurse". There are some diseases that the patients will come with that cannot be treated medically unless through spiritual ways, for example "Jin" possession. (NM)

Spiritual care is about allowing the client to practice his religion and follows his beliefs: belief in God and the practice of one's religion. (UH)

The role of spirituality in the provision of health care was not left out by the respondents.

Spiritual care is very important because some of the patients come to the hospital and thinks that their conditions are due to God. For me, I am a Muslim. We believe that a Muslims illness is a period of test for him. If he should take the illness as coming from Allah and not from any worldly creation, he is rewarded and the pain he goes through is used to wipe his/her sins. (PA)

Spiritual care is very important because, some patient's conditions need spiritual intervention than just nursing intervention, for example when a client is possessed and is being brought to the health sector. There are several times that patients are brought to us here and later the relatives will ask for discharge against medical advice just because they think the patient is possessed. They normally take such patients to spiritual healers of their choice. (MO)

Respondent's again shared their views with regarding barriers to providing spiritual care to patients admitted to the adult wards:

Sometimes a patient will come and is a Muslim but the nurse is a Christian, the nurse may not know if the patient will even accept whatever the nurse will want to do for him/her. On the other hand, since there is the religious difference it is even the question of whether the nurse can even help the patients achieve her spiritual needs. (UH)

Most of the patients do not believe in superstition and lack of communication skills in giving this care. For some patients, they don't believe in spirituality. The lack of communication skills has to do with some of us health care workers. Some of us think one must belong to a religion but it is not by force. Some if they find someone who doesn't believe in superstition, the way they may talk to the person may not be good. Or even sometimes it is not about believing in superstition but some generally do not know how to talk.

DISCUSSION

As regards the extent to which nurses provide spiritual and emotional care, the results revealed that nurses at all times (mean value of 5.23) provided comfort and reassurance to patients on admission. This is fulfilling in view of the fact that what every patient on admission wants to hear is an assurance that they will be fine. Depending on the faith of the nurse at any point in time, the spiritual resources they have may help patients overcome their difficult situations. [27] Setting standards for spiritual care practices would help nurses to recognize the spiritual needs of their patients. [28,29]

On a regular basis, the study observed that nurses offer opportunities to patients to read the Holy books or share their content and prayer with others. Again, nurses assisted patients to identify suitable places to pray and meditate or read the Holy books. According to Carr et al., prayer offers a sense of strength and comfort for patients ambiguous or life-threatening illnesses. [30] This provision ties in well with the assumption that spiritual care is part of the professional function of nurses. [31] On a regular basis, they arranged for Imams and Pastors to visit and pray for the patients when the patients asked for it.

Occasionally, nurses allowed patients to take part in religious activities within the wards. As part of the care, nurses

provide, they have been entreated by their code of ethics to provide care to patients as far as possible according to the cultural and spiritual identity of the patient. [(31)] Patients are again given the opportunity to discuss with nurses the difficulties they encounter in observing prayers. Nurses again gave the opportunity to family members of the patients to share prayers with their relations. However, nurses did not listen to patients stories on their spiritual life. This is contrary to views expressed by Southall, that in storytelling, the narrator and the patient could potentially gain an understanding of the issues surrounding the storyteller thereby helping them their recovery. [(32)] Nurses also elicited from patients their source of strength and hope, what gives meaning and purpose to life including the memorable things in their life.

CONCLUSION

Based on the findings of the study it can be concluded that there is a relationship with patients and health care providers and significant others in providing spiritual care though not to the expectation of patients. Also, health care providers ask patients about their religious practices that they will like to do in the hospital but not often. Health care providers ask patients about their religious books, articles, or symbols that they will like to have with them in the hospital but not often and also health care providers ask patients occasionally about their favourite places to practise their religious activities in the hospital. Additionally, on occasional situations patients are asked about what gives meaning and purpose to their life after being admitted with their condition in the hospital, nurses asked patients about their sources of strengths and hope after they have been admitted with their condition in the hospital. The study further concludes that all the care providers are aware of the importance of and the need to provide spiritual care to the clients on admission into the adult wards of the hospital but admitted that the provision is infrequent.

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REFERENCES

1. Fisher, J.W. (2016) Assessing Adolescent Spiritual Health and Well-Being, *Social Science – Population Health* 2: 304-5
2. Koenig, H. (2009). Religion and medicine: Research findings and implications for clinical practice. *Southern Medical Journal*, 97(12):1194-1200.
3. Koenig, H. G. King, D. E. and Carson, V. B. (2012) A history of religion, medicine, and healthcare, in *Handbook of Religion and Health*, pp. 15–34, Oxford University Press, New York, NY, USA, 2nd edition,
4. Evangelista, C.B., Maria, E.L.L.S., Solange, F.G.C., de Souza, P.S.B., Jaqueline, V.B.V., & de Magalhaes, A. M.O. (2016) Palliative Care and Spirituality: *An Integrative Literature Review, Revista Brasileira de Enfermagem*, 69: 591-601
5. Tanyi, R.A. (2002) Towards clarification of the meaning of spirituality. *Journal of Advanced Nursing*, 39(5) 500-509
6. Murray, R.B. & Zentner, J.B. (1989) Nursing Concept for Health Promotion. *London: Prentice-Hall.*
7. Puchalski, C.M. (2010) Religion, medicine and spirituality: What we know and what we don't know and what we do, Asian Pacific *Journal of Cancer Prevention*, 11(MECC Supplement 1), 45-49
8. Weathers, E., Geraldine, M., & Alice C. (2016) Concept Analysis of Spirituality: An Evolutionary Approach, *Nursing Forum* 51: 79-96
9. Lovering, S. (2012) The Crescent of Care: A nursing model to guide the care of Arab Muslim patients, *Diversity and Equality in Health and Care*, 9: 171-178
10. Mamier, I., & Taylor, E.J. (2015) Psychometric Evaluation of the Nurse spiritual care therapeutic scale, *Western Journal of Nursing Research*, 37: 679-694
11. International Council of Nurses (2012). The ICN code of ethics for nurses, Geneva, Switzerland: *International Council of Nurses*.
12. Miner-Willams, D. (2006). Putting a puzzle together: making spirituality meaningful for nursing using an evolving theoretical

framework. *Journal of Clinical Nursing* (on line), 15: 811-821. Available: http://10.1111/j1365-2702.2006.01351.x (Accessed 13/4/ 2017).
13. Barlow, J. & Calam, R. (2011) A Public Health Approach to Safeguarding in the 21st Century, *Child Abuse Review*, 20(4): 238-255
14. Dunn, L. (2008). Spirituality and Nursing: Personal Responsibility. *Journal of Rural Nursing and Health Care* (online), 8(1): Available: http://rnojournal.binghamton.edu/index.php/RNO/article/view/119
15. Molzahn, A. E., & Sheilds, L. (2008). Why is it so hard to talk about spirituality? *Cancer Nurse*, 104(1), 25-2
16. O'Shea, Ng, T.P., Broekman, B.F., Niti, M., Gwee, X., & Kua, E.H. (2009). Determinants of successful aging using a multidimensional definition among Chinese elderly in Singapore. *American Journal of Geriatric Psychiatry*, 17(5), 407-416.
17. DeLaune, S.C. & Ladner, P.K. (2006) Fundamentals of Nursing: *Standards and Practice, 3rd edition.*
18. Micozzi, M. S. (2006). Spirituality, religion, and health. *American Psychologist*, 58(1), 24-35
19. Yousef, J. M. and Abedi, G., (2011). Pluralism, religion, and secularism. *Journal for the Scientific Study of Religion*, 6, 17–28.
20. Shepherd, F., (2012). The experience of spirituality in the lives of hospice patients. *Journal of Hospice and Palliative Nursing*, 5(1), 51-58.
21. Monareng, L.V. (2013). Spirituality as a universal concept: student experience of learning about spirituality through the medium of art. Nurse Education in Practice, 7, 275-284
22. Creswell, J.W. (2009). Designing and Conducting Mixed Methods Research. Thousand Oaks: Sage Publications.
23. Newman, L. (2006). *Social research methods: Qualitative and quantitative approach*. Boston: Pearson
24. Mysoon, K.A.E.N. (2012). Spiritual Care of the Hospitalized Patients Following Admission to the Cardiac Care Units: Policy Implications, *a PhD Dissertation Presented to the Graduate Faculty of the University of Akron*.
25. Musa, A.S. (2017) Spiritual Care Intervention and Spiritual Well-Being, *Jordanien Muslim Nurses' perpective*, 35(1)
26. Patton, M.Q. (1990). Qualitative Research and Evaluation Methods. *Sage Publications*: Thousand Oaks.
27. Kugle, K. (2013). Complementary health care practices: The Spiritual aspects of healing: an integral part of health and healing. *Gastroenterology Nursing*, 26(5): 212-214.
28. Glasper, A. (2011). Can nurses enhance spiritual care in end-of-life settings? British *Journal of Nursing* (online), 20(5): 316-317 Available: http://www.britisnjournalofnursing.com/
29. Taylor, E. J. (2007). Nurses caring for the spirit: Patients with cancer and family / caregivers expectations. *Oncology Nursing Forum (online)*, 30(4):585-590. Available: http://www.ncbi.nlm.nih.gov/m/pubmed/12861319/
30. Carr, T., Hicks-Moore, S., & Montgomery, P. (2011). What's so big about the "little things": A phenomenological inquiry into the meaning of spiritual care in dementia; Dementia: *The International Journal of Social Research and Practice*, 10(3), 399–414. DOI:10.1177/1471301211408122
31. Leistra, P. K. F., & Laube, R. (2008). The use of culturally congruent spiritual beliefs in the successful treatment of two cases of complicated bereavement for infant death. *Mental Health, Religion and Culture,* 11(3), 349-353.
32. Southall, D. J. (2011). Creating new worlds: The importance of narrative in palliative care. *Journal of Palliative Care*, 27(4), 310–314.

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