PROJECT ABSTRACT

Master of Chaplaincy

Adventist University of Africa

Theological Seminary

TITLE: DEVELOPMENT OF A CHAPLAINCY MINISTRY THAT IMPACTS WHOLISTIC HEALTHCARE IN TAMALE ADVENTIST HOSPITAL, GHANA

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The Adventist Hospital in Tamale has an untrained chaplain; and Developing a plan could enhance wholistic healthcare. This study developed, implemented, tested and evaluated, a Spiritual Master Plan (SMP) and its impact on Wholistic Healthcare. The research design was quantitative research method; using simple random and clustered sampling procedures to study 70 patients and workers. Also, Nathan's Spiritual Model, and Health theories were used to develop the SMP. Fifteen workers were sampled using regression analysis and paired sampled t-test analysis for the post-implementation evaluation. The results showed a relationship between the SMP and Wholistic healthcare ($0.3< r <0.6.$) and ($F_{14}=4.8$, $p<0.05$). Wholistic Healthcare becomes stagnant when there was no SMP (95% CI [7.166, 20434]), B (0.5),

suggesting efficacy as compared to the SMP before the study. Thus, recommended as a resource for the Tamale Adventist Hospital and GAHS facilities.

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A Project

presented in partial fulfillment

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Master of Chaplaincy

by

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ACPE	Association of Clinical Pastoral Education
CARRE	Connecting Awareness Resources Available Referral and Evaluation
CPE	Clinical Pastoral Education
CPSP	College of Pastoral Supervision and Psychotherapy
GAHS	Ghana Adventist Health Service
NAD	North American Division
NSM	Nathan's Spiritual Model
SDA	Seventh-day Adventists
SMP	Spiritual Master Plan
VIPPAE	Visitation, Instrument, Presence, Prudence, Administrative-hospitality and Evaluation

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CHAPTER 1

INTRODUCTION

The establishment of a hospital is important to the growth of society.[1]The Seventh-day Adventist (SDA) Church shares in this quest and because of this operate healthcare institutions worldwide.[2] One of such institutions is the Adventist Hospital in Tamale, functioning under the Ghana Adventist Health Service (GAHS). These institutions are presumed to function employing the counsels and reforms of Ellen G. White; as it pertains to the wholistic or spiritual, physical, mental, and social response to healing and health services. [3]

On another hand, the chaplaincy ministry is exclusive, comprehensive, and professional in its scope: synchronizing religious and non-religious faculties to

[1] Phillipina M. Naude, "Hospital as a Social Institution," *Ministry, (*May 1942, 3-5.

[2] Jim E. Banta et al., "The Global Influence of the Seventh-Day Adventist Church on Diet," *Religions* 9, no. 9 (August 2018): 1, accessed April 30, 2021, https://www.researchgate.net/publication/327179700_The_Global_Influence_of_the_Seventh-Day_Adventist_Church_on_Diet.

[3] Edwin R. DuBose, "The Seventh-day Adventist Tradition," accessed April 30, 2021, https://www.advocatehealth.com/assets/documents/faith/adventist3.pdf.

influence society at all levels.[4] The Tamale Adventist Hospital as of 2018 had twelve major departments and a designated pastor from the North Ghana Mission as a chaplain (untrained).[5] Therefore, there was need for a full-time chaplain or develop a chaplaincy plan to aid spiritual care provision.

Statement of Problem

The Adventist Hospital in Tamale has an untrained chaplain, posted by the North Ghana Mission as chaplain of the Tamale Adventist Hospital. The pastor also serves as the District pastor of Tamale East. Developing a plan for assessing his current spiritual care practices could help enhance wholistic healthcare to patients and workers of the hospital. The challenge however that was anticipated was how to give a tweak to what is seen as professional and how the untrained pastor, once equipped with a Spiritual Master Plan, could guide him in healthcare chaplaincy roles to enhance spirituality.

Purpose of the Study

This study developed a Spiritual Master Plan (SMP) using Clinical Pastoral Education (CPE) residency outcomes; by reviewing the spiritual care practices of the Tamale Adventist Hospital concerning wholistic healthcare, professionalism, and the spiritual goals of the hospital. The study also implemented and evaluated the SMP to consider its impact on wholistic healthcare to the hospital's patients and stakeholders.

[4] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press Publishers, 2006), iv-v.

[5] Emmanuel Ansah, Director for Information Centre, Tamale SDA Hospital, interview by the author, Tamale, 15th November, 2018.

Research Questions

1. Are there disparities among the spiritual care practices (spiritual purpose statement, becoming like Jesus, growing character and identity, intentional connection, deliberate learning, sharing Jesus with others); and Christ-like communication approach to patients and staff?
2. Could the SMP inform wholistic healthcare practices in the Adventist Hospital?
3. Could there be a disparity between the SMP before the research work and the SMP after the research work?

Hypotheses

1. H_0: There is no difference between spiritual care practices across categories of Christ-like approach of communication to patients and staff.

   H_1: There is a difference between spiritual care practices across categories of Christ-like approach of communication to patients and staff.
2. H_0 There is no relationship between the Spiritual Master Plan and wholistic healthcare of Adventist Hospital.

   $H_{1:}$ There is a relationship between SMP and wholistic healthcare of Adventist Hospital.
3. $H_{0:}$ There is no difference between SMP before the research work and SMP after the research.

   $H_{1:}$ There is a difference between SMP before the research work and the SMP after the research work.

Justification

The study was designed to be relevant to the Tamale SDA Hospital, especially in developing an SMP that influenced and guided the spirituality of the hospital. It contributed to the resources of the chaplaincy department. Hence, it served as a guide to the untrained chaplain. The development and implementation of the SMP also informed chaplaincy on wholistic healthcare to the Tamale Adventist Hospital.

Delimitation

The geographical dynamics were determined based on issues related to time, effective implementation, and evaluation. The hospital is located in Tamale, the Northern Region of Ghana. Whereas GAHS has several hospitals in Ghana, the closest Adventist healthcare facility was the Wa Adventist Clinic in the Upper West Region. The Tamale Adventist Hospital was closer to the researcher and thus, ensured proximity and effective implementation. Cultural dynamics was also a reason the research was not extended to the whole of GAHS since every hospital operates in diverse cultural settings.

Limitations

The estimated sample size for the research work was reduced from 214 to 70 due to the sudden COVID-19 pandemic outbreak. The phobia and restrictions associated with the pandemic affected the patronage of the Adventists hospital in Tamale. For example, for management to control the spread of the disease, patients were not admitted in the hospital.

Research Methodology and Procedure

The research was conducted in the Tamale Adventist Hospital. This study gathered data from primary source (questionnaires). The study employed the quantitative research method to design and implement the program.

Chapter 1 of this project comprised the introduction, statement of the problem, the purpose of the study, justification, delimitation, limitation, methodology and procedure, expectations, and definition of terms. Chapter 2 expounded on the biblical and theological foundation: The paradigm and the generalized view of chaplaincy were explored. This section used an exegetical approach to study the text, "the Lord also hath put away thy sin" (2 Samuel 12: 13), and to derive extrapolations that underlined the chaplaincy ministry, wholistic healthcare, and the Spiritual Master Plan.

Chapter 3 reviewed extant literature, considering the conceptual, theoretical, and empirical aspects of the study. The reviewed documents also showed connections that could be evident in developing an SMP, and its impact on chaplaincy and wholistic healthcare.

Chapter 4 was the section for the data analysis and presentation. Permission was sought from the authorities of the hospital (see Appendix A for the Ethical Clearance Form).The study used exploratory analysis to review the spiritual care practices of the Tamale Adventist Hospital. A non-parametric independent test was used for further analysis to guide the designing of the SMP for the hospital. The variables were the patients, workers, and chaplaincy features that influenced wholistic healthcare.

The sampling population comprised of workers, who provide healthcare, and patients who accessed healthcare in the hospital; the simple random sampling method

was used to select the sample frame. The cluster sampling method was used to group the selected units after which proportionate sample size was drawn.

The sample size was determined out of the daily estimated target population of about 474 (94 in-patients, 158 out-patients, and 222 workers in the hospital).[6] The sample size determined out of the target population was 214 using criteria according to Krejcie and Morgan.[7]

$$s = \frac{\chi^2 NP(1-P)}{d^2(N-1)+\chi^2 P(1-P)}$$

Whereby

s = sample size required

χ^2 = the table value of Chi-square for one degree of freedom is 3.841

N = accessible population size

P = Population proportion assumed (0.5)

d = expressed a proportionate degree of accuracy

However, 70 respondents comprising of both workers and patients in the Adventist Hospital filled the questionnaires. This was due to the sudden spread of the COVID-19 pandemic. For workers, 10 groups made of 5 workers in each group were sampled. The in-patients were grouped at 3 different given times, and questionnaires were given to 12 of them. For out-patients, at 3 different given times, 8 individuals were given questionnaires. In these groupings, the researcher explained the purpose of

[6] Ibid.

[7] Kenya's Project Organization, "Sample Size Determination Using Krejcie and Morgan," accessed 24th February, 2021, http://www.kenpro.org/sample-size-determination-using-krejcie-and-morgan-table/.

the research to the participants. The participants were also given an opportunity to ask questions regarding the study and the questionnaire.

The main instrument used for collecting data for the study was questionnaires. The questionnaire was administered on a 1 to 5 Likert scale, whereas 1 is most obviously not aware and 5 is most obviously aware for section A, and sections B to F were scaled 1-never to 5-always. The ABIDE reflection questions and spiritual purpose statement questions were adapted to design the questionnaire for this study;[8] reflecting six areas (Section A, where are we; Section B, abundant discipling; Section C, bold godliness; Section D, intentional connecting; Section E, deliberate learning; and Section F, extravagant outreach).Thus, it was used to review the spiritual care practices of the Adventist Hospital before the implementation of the SMP. The adapted questionnaire generally follow the ABIDE questions exactly except for a few word changes and changing of overly long sentences. For example, the word "school" was replaced with hospital.

The ABIDE model is intended to draw and implement SMPs in Adventist Schools to become like Christ (wholistic education) in the North African Division (NAD). This SMP is drawn using staff, teachers, leadership, and stakeholders of the School. The ABIDE SMP has three sections: "who are we?" "Reflection questions" and the spiritual master plan. [9]

[8] Adventist Educators, "ABIDE: A Spiritual Master Plan Guide for Seventh-day," accessed 16th February 2021, https://nad-bigtincan.s3-us-west-2.amazonaws.com/leadership%20resources/administration/administrator's%20filing%20cabinet/other%20documents%2C%20forms%2C%20and%20letters/ABIDE%20master%20plan.pdf.

[9] Ibid.

The adapted questionnaire was self-administered to patients and workers because of the high illiteracy rate of most patients visiting the hospital. This ensured that the study achieved a high response rate. The research was also sensitive to gender, time, age, ethnicity, education, income level, and geographic location in the sampling process. The data collected was summarized and analyzed with Statistical Package for Social Sciences (SPSS)

Chapter 5, the program development section used the comparative study method to discuss the data analyzed in chapter four in connection with the Nathan's Spiritual Model (NSM) and the Health Theories, to draw the SMP template. This chapter implemented the SMP through chaplaincy intern outcomes to both patients and stakeholders of the hospital. The SMP developed was implemented at the female and male wards for two years.

Fifteen (15) workers were given questionnaires to respond to, which was based on the weekly schedule of the hospital. This formed the basis for the post-implementation evaluation.

Regression analysis and paired sampled t-test analysis were used for the post-implementation evaluation. There was also a seminar for relevant workers who provide healthcare and chaplaincy roles at the Adventist Hospital based on the SMP outcomes. Chapter 6 focused on the project summary, conclusions, and recommendations.

Expectations

Based on the outcome of this study, it is expected that the Tamale Adventist Hospital will be well informed of the important role of hospital chaplains. Chaplains nurture the spirituality of the hospital and enhance, wholistic healthcare in a

multidimensional way. This study is also expected to inform the practice of healthcare chaplaincy ministry using pastors, especially in Fields where there are few or no trained chaplains.

Definition of Terms

Healthcare

Understanding healthcare is quite complex. It seem however that separating the two words could suggest an easy understanding of the term. The understanding of health has gained recent insights by research. For example, the World Health Organization's definition of health as "complete wellbeing" has been challenged. Thus, some researches understand health to be the adaptability, adjustment, and self-management to social, physical, and emotional factors.[10]

The Health Care Systems is the avenue for attaining optimum health. Health Care could be defined as an "entirety of measures and activities conveyed by the community and especially its integral part – the health." .[11]

Wholistic

There are several arguments on holism and wholism. A survey conducted revealed that wholism is one important theology they Seventh-day Adventist church

[10] Machteld Huber et al., "How should we Define Health?" *British Medical Journal* 343, d4163 (July 2011): 1-3, https://doi.org/10.1136/bmj.d4163.

[11] Zvonko Sosic and Doncho Donev, **"**Contemporary Concept and Definition of Health Care," in *Health Promotion and Disease Prevention: A Handbook for Teachers, Researches, Health Professionals and Decision Makers*, eds., Doncho Donev, Gordana Pavlekovic, and Lijana Zaletel Kragelj (Lage, Germany: Hans Jacobs Publishing Company, 2007), 343, accessed April 27 2021, https://www.researchgate.net/publication/37683785_Contemporary_Concept_and_Definition_of_Health_Care

has taught that differs from anthropological dualism. The relationship of the physical, mental, and social faculties is understood as a single unit (total) not divided.[12]

Multi-dimensional Health

It is a complex adjective, involving or marked by several extents; wherein health refers to packages that address the components of health. Over the years, human classifications of health have led to several practices and studies that directly or indirectly suggest the emphasis now on multi-dimensional health care.[13]

For instance,integrated health, integrated wholeness, holistic, wholistic, etc. are used to describe the processes involved in attaining human wellness; which suggest emphasis on the spiritual, physical, mental, and social aspects in an endless change and adaptability in the human life cycle, health behavior, and systems.[14]

Spiritual Master Plan

This study refers to a Spiritual Master Plan as a developed output which could represent a tweak of what is known as professional in healthcare chaplaincy (Clinical Pastoral Education), to guide both the trained and untrained. Thus, the focus of such a

[12] Banta et al., *¨The Global Influence of the Seventh-Day Adventist Church on Diet,"* 251,

[13] Michael de Vibe et al., (*Ethics and Holistic Healthcare Practice* (Kentucky: Pediatrics Faculty Publications, 2009), Chapter II, accessed 28th April, 2021, https:/uknowledge.uky.edu/ pediatrics_facpub/138; Cross Reference the following sources for other Multi-dimentional healthcare studies. Christopher J. Armitage, Paul Norman, and Mark Conner, "Can the Theory of Planned Behavior Mediate the Effects of Age, Gender, and Multidimensional Health Locus of Control," abstract, *British Journal of Health Psychology* 7, no. 3 (September 2002): 299, https://bpspsychub.onlinelibrary.wiley.com/doi/epdf/10.1348/135910702760213698

[14]Daniel Ganu, *A Study Guide to Health Principles* (Accra, Ghana: Sylva Ventures, 2007), 1-5; Mark A. Finley and Peter N. Landless, *Health & Wellness: Secrets that Will Change Your Life* (Washington DC: Review and Herald, 2014), 9-10; M. H. Williams, *Lifetime Fitness and Wellness*, 4th ed. (Chicago, IL: Brown and Benchmark, 1996), 1-10.

plan is to help untrained chaplains to receive some form of knowledge and routines that shape and inform professionalism in the inter-disciplinary team

CHAPTER 2

BIBLICAL AND THEOLOGICAL FOUNDATION

Introduction

The study did an exegesis on, put "the Lord also hath הֶעֱבִיר חַטָּאתְךָ לֹא יהוָה[1] away thy sin*"* (2Sam 12:13, KJV)[2] to suggest a biblical basis for chaplaincy and wholistic healthcare.[3] Issues from the context after the word-study were used to suggest extrapolations and applications for the SMP, using Prophet Nathan's Spiritual Strategy. The study also explored the theological foundation of chaplaincy and wholistic healthcare. Again, Ellen G. White's perspectives on wholistic healthcare and spiritual care delivery were explored.

Exegesis on 2 Samuel 12:13

Traditionally, the Hebrew text combines the two books of Samuel namely, Book of Samuel and dates it to the "last half of the eleventh century and the early part

[1] WTT Leningrad Hebrew Old Testament. All subsequent Hebrew Scripture quotations, unless otherwise indicated, are taken from WTT.

[2] All Scripture quotations, unless otherwise indicated, are taken from King James Version (KJV).

[3] Bruce Corley, et al. *Biblical Hermeneutics: A Comprehensive Introduction to Interpreting Scripture*, 2nd ed. (Nashville, TN: Broadman & Holman Publishers, 2002), 21-38, 230-374. For the utilization of appropriate interpretation and contextualization, the grammatical-historical approach will form the basis for the hermeneutics. However, the allegorical and praxis approaches may be employed in the application section. Worldviews, cognitive processes (conceptual, psychological and concrete approaches), social structures, and forms and meaning may be considered in interpreting the context in 2 Samuel 11–12. (

of the tenth century B.C."[4] The background relates to the period when the Syro-Palestine nations wrangled for power. Thus, David at this period forms the United Kingdom. Nonetheless, his successes marked the dawn of his moral fall and family pandemonium.[5]

Issues that draw attention in 2 Samuel 13-13, include the nature of sin, the supremacy of the king, difficulty in subjects rejecting evil demands from kings, the subjects' inability to show displeasure for the king's evil act, why the baby should suffer for the sin of the parents.[6] This study however, explored the context in connections with David's clemency and transitions.

The context reveals David's remorsefulness about his folly and the assurance of God's forgiveness. However, words study on put away thy sin suggests important clarity that is worth noting. Put occurs about seven hundred and fifty-four times in the Old Testament and appears sixty-one times in different contexts. Away also appears about ninety-five times in different contexts; and seven hundred and five times in the Old Testament.[7]

Again, connections that exist between the two occurrences in the Old Testament seem apparent. In about fifteen occurrences, the Old Testament writers use put and away interchangeably, but with different original root renditions and contexts. For example, whereas גרשׁ, "to drive out*" (*Exod 2:17) and גָּנַב, "to deceive" (Gen

[4] Andrews E. Hill and John H. Walton, *A Survey of the Old Testament*, 2nd ed. (Grand Rapids, MI: Zondervan, 2000), 209.

[5] Ibid.

[6] John Goldingay, *An Introduction to the Old Testament* (Downers Grove, IL: Inter Varsity Press, 2015). 181.

[7] James Strong, *Strong's Exhaustive Concordance of the Bible,* s.v. *"Put" and "Away."*

31:20), refer to put away; the latter suggest stealing, while the former carries the idea of expulsion or divorce.[8]

These connections augment the deeper understanding of the verb עָבַר, "to cross over," which is used transitively in a broader sense; and stems from עבר, "to cause to pass," a primitive root and with the precise meaning to cover; otherwise: to deliver, to put away, to pass away, to alienate, and to pass over.[9]

David received forgiveness yet he was punished. Nathan states it precisely: "The LORD also hath put away thy sin thou shalt not die" (2 Sam 12:13). This suggests that David's crime will not warrant death or stoppage of the covenant, rather experience other penalties and effects: the death of the newly born baby; victory in the war (2 Sam 12: 26-28); family pandemonium; and Solomon's birth and enthronement are few examples of the cross over process.[10]

This, however, reveals correlations that suggest the past, present, and future of David. The point is that forgiveness in this context may widely and specifically be referred to as covered for David and his family.[11] To explain further, this transitional process as indicated by the Hebrew word עָבַר, "cross over," suggests a cross over period from when David's sin was forgiven upto the time the promises concerning the Messiah were fulfilled (Cf. 2 Sam 7:11-16).

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[8] Ibid.

[9] Ibid,

[10] Goldingay, *An Introduction to the Old Testament,* 174-181.

[11] Thus, Deliverance – Psalm 32: 1; 2 Samuel 12:13-14 or crossed over – transition – 2 Samuel 12:11-12; 13:1-36; 15-18; 1 Kings 1:5-53; Cf. Psalm 51; 32.

Context and Case for Biblical Basis of Chaplaincy

A study of the covenantal pattern between God and humanity relating to soteriology indicates a culminating basis entrenched in David's life purpose and lineage. More importantly, his encounter with Bathsheba and subsequent clemency by God form a hinge for the Davidic Covenant (2 Sam 7:1-17) and the ministry of Jesus:[12]

First, David's fall leads to his family chaos and Bathsheba's son: Solomon's enthronement: the one to build the Temple. This Temple is to be built where Abraham nearly sacrificed Isaac.[13] Secondly, Jesus Christ, whose death caused a stoppage of the Temple worship is predominantly projected to have come from David's root[14]

> Jewish sources from after the Exile show how the people eagerly awaited the coming of the promised Davidic descendent, the Messiah or Christ as an ideal king, he would reign on the throne of David and faithfullyinstruct the people in the Law of God. The Old Testament promise with regards to the ideal king of the Davidic lineage was fulfilled in the person of Jesus.[15]

From the above analyses, it could be deduced that David's predicament with Bathsheba (2 Sam 11-13) – relating to the transition and cross over process; its

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[12] Ranko Stefanovic, *Revelation of Jesus Christ: Commentary on the Book of Revelation* (Berrien Springs, MI: Adventist University Press, 2002), 173; Ivan T. Blazen, "Salvation," *Handbook of Seventh-day Adventist Theology*, ed., Raqual Dederen (Hagerstown, MD: Review and Herald, 2000), 271-312; John Murray, *The Covenant Grace* (London: The Tyndale Press, 1953), 1-5.

[13]Isaac Kalimi, "The Land of Moriah, Mount Moriah, and the Site of Solomon's Temple in Biblical Historiography," *Harvard Theological Review* 83, no. 4 (2011): 345-352, accessed 21st April, 2020, https://doi.org/10.1017/s001781600002383X; Cf. Ellen G. White, *Patriarchs and Prophets* (Washington, D.C.: Review and Heralds Publishing Association, 1890), 748-754.

[14] Lawrence M. Nelson, *The Sanctuary Made Simple* (Caldwell, ID: CHJ Publishing, 1996), 23-28; Stefanovic Zdravko, *Daniel: Wisdom to the Wise Commentary on the Book of Daniel* (Nampa, ID: Pacific Press, 2007), 361-366; Richard W. Schwarz and Floyd Greenleaf, *Light Bearers: A History of the Seventh-day Adventist Church* (Nampa, ID: Pacific Press Association, 1995), 40; Harry R. Boer, *A Short History of the Early Church* (Grand Rapids, MI: William B. Eedmans Publishing, 1976), 16; Cf. Matthew 27:50-51; 1:6,7, 20; 15:22; Luke 1:27; 3:23; Acts 7:45-7; Hebrews 7:14; Revelation 5:5; 3:21; Isaiah 53:12; 63:1-3.

[15] Stefanovic, *Revelation of Jesus Christ* , 173; Cf. Acts 2:29-36; 13:22-38; Hebrews 1:2-13

ensuing consequences in the past, present, and future and connections to the first advent and ministry of Jesus suggests the basis of redemption and also for the chaplaincy ministry.

Again, John Goldingay proposes that the phrase "a man after God's heart" (1 Sam 13:14); compared to 1 Sam 7:21), referring to David, should be understood as "a man God chose" (Ps 20:4). Goldingay argues against the popular interpretation that David is a man "whose heart matches God's heart."[16] By implication, David was chosen for a special purpose, and though not perfect it is not surprising that Jesus' root is traced to him.

Context and Spiritual Master Plan

David and Bathsheba's predicament show connections that underline the whole Scripture and the chaplaincy ministry: the themes and lessons on redemption, love, and compassion; calling and purpose of life; faithfulness and accountability to mission and task of life; ethics and roles; spiritual abuse and care; conflict management; the promise of God's presence; etc. are extrapolations that could serve as a foundation for chaplaincy (2 Sam 11-13).

More importantly, the texts under study suggests God's plan to redeem humanity through a process in David and his lineage, which began even before the foundation of this world (Gal 4:4).

A critical study of the context indicates that military, healthcare, and other areas of chaplaincy and institutions could be seen functioning.[17] The life and lineage of David also disclose the descent of Jesus, who from a personal perspective may be

[16] Goldingay, *An Introduction to the Old Testament,* 180; Cf. Acts 7:46; 13:22

[17] 2 Sam 11:1, 15; 12:1, and 13-28.

considered Master Chaplain; and Prophet Nathan as an agent just like all spiritual caregivers.

Nathan who provides spiritual care to David and his family had a strategy/plan, and important inferences could be deduced from his visit. Nathan is seen playing his prophetic roles: God acknowledged David's sin (2 Sam 11:27); sin is revealed to the prophet, and he had to do ministry (2 Sam 12:1). This kind of ministry provided by Nathan was through visitation. Thus, visitation could suggest basis in drawing a Spiritual Master Plan for the Tamale Adventist Hospital.

The prophet's message suggests his prudence: whereas, God gave him the message, how the message was to be delivered was not mentioned. Nathan had the right instrument, Parable. He was not anxious about his duty (2 Sam 12:7), did his assessment right, and was not judgmental. Yet, he spoke the truth. Nathan had the right tool and this was shown in his message.[18] Inference from Nathan's instrument of communication seems to have relevance in the SMP being drawn as proposed by this research.

God has dealt with people in different ways as far as salvation is concern. The quote, "I would moreover have given unto thee such and such things" (2 Sam 12:8)· seem to suggest the dynamic way God deals with humans. The issues here include, whether God is liberal or approve polygamy? Boubakar sanou in addressing the topic of prayer and mission suggested that God in the process of deliverance is patient and have several adapting approaches to dealing with humanity.[19]

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[18] Jonas Arrais, *Wanted: A Good Pastor: The Characteristics, Skills, and Attitudes Every Effective Church Leader Needs* (Silver Spring, MD: General Conference Ministerial Association, 2011), 34.

[19] Boubakar Sanou, "Prayer as a Strategic Weapon in Mission," *Journal of Adventist Mission Studies* 11, no. 1 (2015): 2-3, accessed on April 23, 2021, https://digitalcommons.andrews.edu/cgi/viewcontent.cgi?article=1264&context=jams

The underlining guidance that could suggest a basis for an SMP is the care giver's tact in blending his or her faith principles in the context of the hospital environment, where multi-faith prospects work and visit. Therefore, the question, is what roles will the Chaplain in the Adventist Hospital play to be non-proselyting. This seems to be a concern for scholars and the church leadership for the chaplaincy ministry and religious liberty.[20]

Without any plan guiding the activity of the chaplain, spiritual care provision becomes ad hoc; and this could lead to inexpert outcomes. Nathan could have given public declarations against David, but he chose to make it confidential.[21]

A prophet's work seems so encompassing and sometimes detailed, since God also appointed them to be his voice to the people in His theocratic administrative procedure.[22] Even after God chose kings for Israel, prophets were still involved in the administrative process in giving the mandate of God to direct the kings.[23] The point is that could Nathan's administrative role as prophet suggest a basis for the SMP being drawn for the Adventist Hospital in Tamale? Apparently, yes.

Context and Objections to Christian Proselytization

From the contextual study, it seems obvious that David's story fits adequately and could be considered a case for the biblical basis of chaplaincy. Nonetheless, there are perceived objections of the context to chaplaincy.

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[20] John Gray, "Proselytism and Religious Freedom," *Fides Et Libertas,* ed., Richard Lee Fenn (Hagerstown, MD: Review and Herald, 1999), 7-10; (Jonas Arrais, "Religious Liberty, Evangelism, and Proselytism" *Elders Digest,* July 2017, 14.

[21] David Janzen, "The Condemnation of David's Taking in 2 Samuel 12:1-14," abstract, *Journal of Biblical Literature* 131, no. 2 (2012): 209, accessed April 1, 2021, https://www.jstor.org/stable/23488221?seq=1

[22] William A. VanGemeren, *Interpreting the Prophetic Word: An Introduction to the Prophetic Literature of the Old Testament* (Grand Rapids, MI: Zondervan Academic, 2010), 19-30.

[23] Ibid.

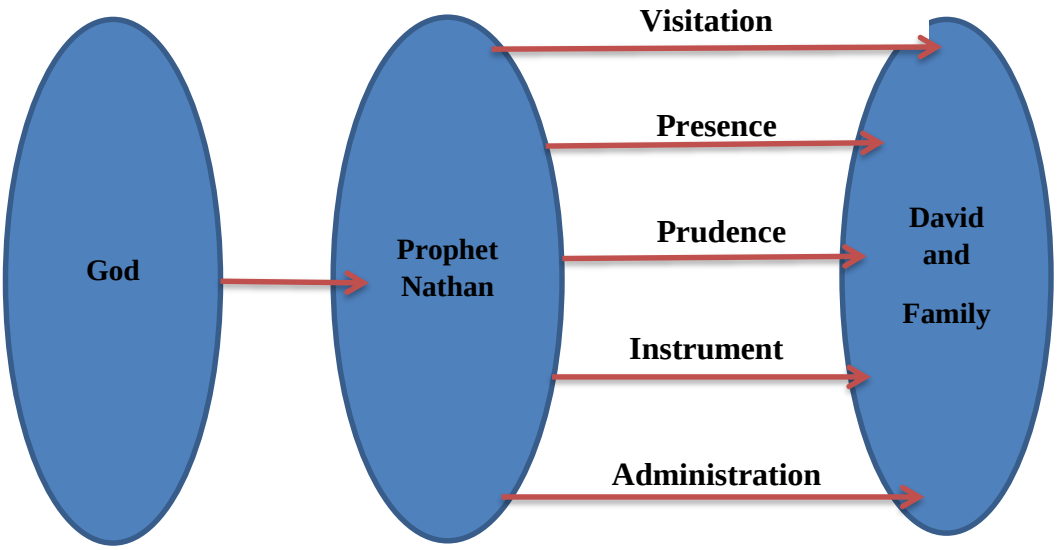

Figure 1. Nathan's Spiritual Model (NSM)

An example is the silence of the subjects to the king's atrocities, which was a practice of the time: A King among Syro-Palestine dwellers was considered above reproach.[24] God's intervention proved significant. This gives indications about the importance of being accountable in institution, just as God demanded from David.

Again, David's manipulations and marriage with Bathsheba is not a practice that should be encouraged, or better still the stigmatization that comes with it. A direct application of this may lead to misconceptions and a shift from the wholistic pattern of truth in the scripture.Thus, God does not endorse manipulative acts.[25]

[24] Ellen G. White, *Patriarchs and Prophets* (Washington DC: Review and Herald, 1890), 718.

[25] D. A. Carson, "Sin's Contemporary Significance," In: *Fallen: A Theology of Sin,* eds., Christopher W. Morgan and Robert A. Peterson (Wheaton, IL: Crossway, 2013), 24.

It should also be understood that the context does not suggest that God is contradicting Himself with regards to polygamy, rather it should be seen as one of the many ways God deals with humanity in the salvation process.[26]

Context and Impact of Wholistic Healthcare

Context and Wholistic Healthcare Indications. The context suggests the provision of health care issues as it relates to the outcome of God's judgment and death of the newly born. These healthcare issues could include midwifery issues (2 Sam 11:27); attending to the sick baby and palliative care issues (2 Sam 12:15-23); bereavement and morning losses (2 Sam 12:18-24); and Nathan's spiritual care services.

This further indicates the reality of the issues at stake in connection with the daily aggravations of life. Clearly, the context shows the interplay of the wholistic components, from the social, mental, emotional, physical, and spiritual perspective. Again, the roles God, David, Prophet Nathan, subjects, family, and newly born, relating to the beginning of the problem and God's intervention could suggest incidences of primitive health services.[27]

The Context and Spiritual Abuse. Prophet Nathan only developed his strategy/plan when there was a situation. In the context of hospital chaplaincy, where there is no plan, intentionality, and professionalism there could be space for spiritual abuse. This could result from a lack of expertise in dealing with boundaries, vulnerability, listening, and presence.

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[26] Sanou, "Prayer as a Strategic Weapon in Mission," 2.

[27] George B. Dintiman and Jerrold S. Greenberg, *Health Through Discovery*, 4th ed. (New York: Random House, 1989), 1-10.

There is evidence in the context to indicate the case of spiritual abuse. David and the Military ranks of Israel demonstrated this act to Bathsheba, Uriah, and even Joab. Lebacoqz and Driskill define Spiritual abuse as "the mistreatment of a person who requires help, support, or great spiritual empowerment, with the result of weakening, undermining, or decreasing that person's spiritual empowerment."[28]

While it is surprising to find leaders (for example, David) in such practices, it seems however that most cases of abuse are not even noticed. Where there is abuse, then the wholistic development of the human faculty could be thwarted.[29] Thus, as suggested by this study.

The Context and Spiritual Care. The context (2 Sam 11-13), also reveals a challenge and basis for the chaplaincy ministry. Highlighted is the reality of God's standards and expectations for his children. Thus, suggesting the ethical basis for the chaplaincy ministry. Like Prophet Nathan, the pastoral caregiver has the mandate to be efficient in the discharge of his or her duties, including a wholistic service to impact spiritual care seekers.

Theological Foundation

General Theological Basis

Paget and McCormack's study show that Jesus' assertion: minister to the smallest of these; thus, to the hungry, thirsty, stranger, unsheltered, sick, and captive

[28]Karen Lebacoqz and Joseph D. Driskill, *Ethics and Spiritual Care: A Guide for Pastors, Chaplains, and Spiritual Directors* (Nashville, TN: Abingdon Press, 2000), 131.

[29] Ibid, 127.

(Matt 25) forms a paradigm for the chaplaincy ministry.[30] These expectations appear to be re-echoed in the statement "love the Lord thy God with all thy soul, [mind, and forte] and love thy neighbor as thyself" (Mark 12:30-31).

The authors also made inferences to ministry of presence (Matt 26:36-45), and being sensitivity to all cultures (Acts 17:16-34) as the biblical bases for chaplaincy ministry.[31] Though the views of Paget and McCormack posit a biblical basis for the chaplaincy ministry; it appears rather that the whole life of Jesus depicts a deeper basis for chaplaincy than ordinarily focusing on his words or what preachers (for example, Apostle Paul) have said about him.

Thus, from a broader perspective, Scripture and its themes suggest a plan of deliverance entrenched in the wholistic ministry of the Trinity about the fallen world; which insinuates the general basis for the chaplaincy ministry and wholistic care.[32] The evidence of this is the apparent connections about salvation, which indicate that the ministry of Jesus is a fulfillment of the Old Testament.[33]

Generally, the theme of redemption: love, mercy, compassion, forgiveness, grace, care, justice, etc. could serve as the fulcrum of Scripture that show a considerable basis for chaplaincy. God's dealing with humanity is centred on love and

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[30] Paget and McCormack, *The Work of the Chaplain,* 5-7.

[31] Ibid, 9-11.

[32] Blazen, "Salvation," *Handbook of Seventh-day Adventist Theology*, 275.

[33] John H. Sailhamer, *The Meaning of the Pentateuch: Revelation, Composition and Interpretation* (Downers Grove, IL: InterVarsity Press, 2009), 462-463.

restoration.[34] Thus, the chaplain is called to be an epitome of such practices; and share in God's purpose of saving humans wholly.[35]

To achieve the plan of restoration God chose several people: prophets, kings, priests, servants, etc. this may be summed up to state principally that God called or chose a generation to serve as a means to reach and save humanity.[36] The chaplain should not be an exception to his or her mandate and calling in aiding in the final plan of restoration.[37]

This calling and mandate are propelled by understanding and meeting the mission of God in connection to the chaplain's purpose of life. In doing this in the context of the message to the entire world, pastoral caregivers play sensitive roles that directly or indirectly hasten the final restoration of God's people.[38]

This automatically establishes that the mission field is the world, which is unready to yield to God. The pastoral caregiver ministers at his or her place of work (hospitals, campuses, prisons, military, etc.); and the clients or targeted population are

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[34] Niels-Erik A. Andreasen, "Death: Origin, Nature, and Final Eradication," *Handbook of Seventh-day Adventist Theology*, ed., Raqual Dederen (Hagerstown, MD: Review and Herald, 2000), 331-334; Derek J. Morris, "Truth, Love, and Justice of God: An Interview with Jiri Moskala," *Ministry,* August 2016, 13-16.

[35] Ellen G. White, *Gospel Workers* (Washington DC: Review and Herald, 1915), 336.

[36]Hans K. Larondelle, "The Remnant and the Three Angels' Message;" *Handbook of Seventh-day Adventist Theology,* ed., Raqual Dederen (Hagerstown, MD: Review and Herald, 2000), 857.

[37] Ellen G. White, *Christian Service* (Hagerstown, MD: Review and Herald, 1925), 7-10.

[38] Reggie McNeal, *Practicing Greatness: 7 Disciplines of Extraordinary Spiritual Leaders* (San Francisco, CA: Jossey-Bass, 2006), 81-97

the people who need encounters to understand and appreciate the message of the Savior's love.[39] Thus, the chaplain could serve as such an agent.[40]

Integrated Whole Principle

Today, healthcare practices have become complex and dynamic. The focus seems to be on how to address health from the physical, mental, emotional, spiritual, etc. dimensions.[41] Health and wellness have also been understood as Integrated Wholeness where each component physical, mental, and spiritual aspects of the human being are considered as a single unit.[42]

The usage of Wholistic or Holistic posses biblical issues. Though the usage of holism or holistic have gained more popularity to wholism and wholistic; holism ideas have explanations that are carefully connected to Evolutionary, Religious, and Hellenistic (dualism) ideas.[43]

Theological discourses have proposed three views: the tripartite, bipartite, and integrated perspectives. In each case, the focus is on how to understand components of the human being (spirit, body, and soul), either as division or as a whole. The

[39] "The world is no more ready to credit the message for this time than were the Jews to receive the Saviour's warning concerning Jerusalem (. . ." Ellen G. White, *From Here to Forever* (Nampa, ID: Pacific Press Publishing Assiciation, 1982), 26.

[40] Ellen G. White, *Gospel Workers* (Battle Creek, MI: Review and Herald Publishing Co., 1892), 11.

[41] Daniel Ganu, *A Study Guide to Health Principles* (Accra, Ghana: Sylva Ventures, 2007), 2-3

[42] Mark A. Finley, Peter N. Landless, *Health Week Readings: Health and Wellness* (Accra, Ghana: Adventist Press, 2015), 9.

[43] Jim E Banta et al., "The Global Influence of the Seventh-Day Adventist Church on Diet," *Religions* 9, no. 9 (2018): 251, accessed 24th March 2021, https://www.researchgate.net/publication/327179700_The_Global_Influence_of_the_Seventh-Day_Adventist_Church_on_Diet.

complexity of the discourse lies in the modern understanding of wholism and spirituality. Thus, spirituality in the fourth sense; where the person has the spirit without any reference to God.[44]

That notwithstanding, wholism ideas views the world and human as complete and united. A deeper consensus is reached when the Greek root meaning of salvation is rendered, "health" or "wholeness"; which suggests how poised God is towards healing humanity in the process of salvation.[45]

Whereas, the terms wholistic and holistic may be dealing with the steps of attaining total health; however, the usage of holism could have implications for the Seventh-day Adventist doctrine. The terms have been used interchangeably by scholars; that notwithstanding,[46] this study settled for wholistic.

Ellen G. White's Writings and the Study

E. G. White's Health Reform

The writings of Ellen G. White are relevant and contribute greatly to the understanding of the current study. For example, she states that "Sanitariums shall be a means to rich high and low, rich and poor"[47] The lord also revealed to her concerning diet served in Sanitariums; and how health reform 'rescued' from

[44] Charles Sherlock, *The Doctrine of Humanity: Contours of Christian Theology*, ed. Gerald Bray (Downers Grove, IL: InterVarsity Press, 1996), 212-27.

[45] Ibid, 213.

[46] Rei Towet Kesis, "Wholistic or Holistic? Does It Matter?" accessed April 24, 2021, https://www.semanticscholar.org/paper/Wholistic-or-Holistic-Does-It-Matter Kesis/be96bfe569b765d14cf2860fc784e7ccb34c0d9a#paper-header

[47] Ellen G White, *Counsels on Health* (Mountain View, CA: Pacific Press, 1923), 203, 212.

physical, mental, and moral (social) degeneracy.[48] Most of the Spirit of Prophecy deliberations, point to preventive reforms that draw attention to the urgency of time for leadership and patients to seek for optimum health**.** [49] Thus, drawing a model for a chaplain's work in the hospital should seek to employ these reforms.

E. G. White and Health Dimensions

In her counsels to the church, she emphases on the mental, physical, and moral dimensions of health; and that these faculties have been given to humanity by God. The spiritual dimension as her writings suggest should not be over-looked. She seems to understand total health and health practices in a wholistic and multi-dimensional setting. [50]

During her time, chaplaincy was not at the fulcrum of health practices; but she well understood the role of spirituality to the recovery of the soul.[51] She counsels in her writings that Adventist Health Institutions are to provide services that address the spiritual and physical health of patients.[52]

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[48] Ellen G. White, *Counsel on Diet and Food* (Washington DC: Review and Herald, 1938), 282, 442, 447.

[49] Ellen G. White, *Counsel for the Church* (Nampa, ID: Pacific Press, 1991), 309.

[50]Ellen G. White, *Healthful Living* (Battle Creek, MI: Medical Missionary Board, 1897), 29.

[51] "The relationship that exists between the mind and the Body is very intimate. When one is affected the other, the other sympathizes. The condition of the mind affects the health to a far greater degree than many realize." Ellen G. White, *Ministry of Healing* (Mountain View, CA: Pacific Press, 1905), 241; Cf. Ellen G. White, *Mind, Character, and Personality* (Washington DC: Review and Herald, 1977), 764.

[52] White, *Counsel for the Church*, 309.

E. G. White and Spiritual Caregivers

She also suggests that dealing with the spirituality of patients should not just be listening for their pains, feelings, and uncertainties, but also finding moments of appreciation to God; acknowledging Jesus; yielding to the grace and courage of the words of God and the health reform. [53] See an opinion she holds for the person who must provide spiritual care:

> It is important that the one who is chosen to care for the spiritual interest of patients and helpers be a man of sound judgment and undeviating principle, a man who will have moral influence, who knows how to deal with minds, he should be a person of wisdom and culture, of affection as well as intelligence. He may not be thoroughly efficient in all respects at first; but he should, by earnest thought and exercise of his abilities, qualify himself for this important work. The greatest wisdom and gentleness are needed to serve in this position acceptable, yet with unbending integrity, for prejudice, bigotry, and error of every form and description must be met.[54]

This person (spiritual care-provider) should be able to control his temper; he should be a representation of docility, placidity, and love of the Adventist faith and Christ matchless love. She seems to suggest that all connected to the sanitarium should be embodiments of health reform and faith. This is to suggest that the Spirit of Prophecy guidance on wholistic health is related to reforms that were revealed to Ellen White.[55]

Summary

This chapter discussed the biblical and theological foundation of chaplaincy as it relates to the impact of wholistic healthcare in the context of developing a Spiritual

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[53] Ibid.

[54] Ellen G. White, *Testimonies for the Church* (Mountain View, CA: Pacific Press, 1876), 546.

[55] Ibid, 546-547.

Model from Prophet Nathan's encounter with King David. The theme of soteriology in scripture could suggest a basis for the healthcare chaplaincy ministry.

Subsequently, a study of the predicament of David and Bathsheba reveals a deeper understanding of salvation with considerable connections and extrapolations to the chaplaincy ministry; thus, underlining the importance of plan in the redemption story, Nathan's approach, and extrapolations for hospital ministry. Finally, a brief overview was made on the Spirit of Prophecy's views on the topic under study.

CHAPTER 3

LITERATURE REVIEW

Introduction

This section of the study looks at the contribution of extant literature relevant to the topic under study. The discussions were centred on the theoretical, conceptual, and empirical frameworks; and how this relates to developing an SMP for chaplaincy and wholistic healthcare.

Theoretical Framework

This aspect of the literature review considered the growing concern on what theories are available on wholistic health and how that could be understood within the context of chaplaincy roles, illness, and wellness.

Background of Chaplaincy

The background to the work of a chaplain “cappellani” is dated to the fourth century; deriving the name from where the remains of the half cloak of St. Martin was kept (“cappella diminutive of cappa”). Martin demonstrated a gesture of compassion

by sharing his cloak with a beggar who was in the rain. The remaining cloak was later kept in a tent, resulting into the name "chapel".[1]

During the period of King Charlemagne, he chose clergymen who lived in the palace to serve both civic and religious duties.[2] Recently, chaplaincy has grown to encompass services in religious and secular attachments (for example, hospitals, military, workplace, and prisons).[3]

It appears military and healthcare chaplaincies are well recognized.[4] Nonetheless, in Africa, especially for healthcare systems it seems there are limited deliberations and resources to enhance efficient and proficient pastoral care delivery.[5] That is for chaplaincy to evolve from its dwarfed stage in Africa, there is the need for flexibility and malleability to situations; to draw chaplaincy programs that fit the African system.[6]

This study suggests seven health theories that help understand illnesses, wellness and the roles health workers play to ensure optimum health; however, the Health Belief Model, Trans-theoretical models, and Social Cognitive theories will be used as major outcomes to understand and draw models for healthcare chaplaincy in the Adventist Hospital in Tamale.

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[1] Paget and McCormack, *The Work of the Chaplain*, 2-3.

[2] *Encyclopedia Britannica,* s.v. "Chauhan,Yamini," accessed 18 February, 2021, https://www.britannica.com/topic/chaplain.

[3] Paget and McCormack, *The Work of the Chaplain*, 35.

[4] Abraham K. Akih and Yolanda Dreyer, "Penal Reform in Africa: The Case of Prison Chaplaincy," *Herv. teol. Stud* 73, no. 3 (2017): a4525., accessed 25th February, 2020, (https://hts.org.za/index.php/hts/article/view/4525/10021

[5] Emem Agbiji and Obaji Mbeh Agbiji, "Pastoral Care as a Resource for Development in the Global Healthcare Context: Implications for Africa's Healthcare Delivery System," *HTS Theological Studies* 72, no. 4 (2016): 1-9, accessed 25th February, 2020, (http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0259-94222016000400104

[6] Akih and Dreyer, "Penal Reform in Africa: The Case of Prison Chaplaincy," a4525.

Health Belief Model

This model was developed in the 1950s to help comprehend why individuals did not use services proposed by health practitioners. It now addresses issues of prevention and detection and how that connects to lifestyle choices.[7]

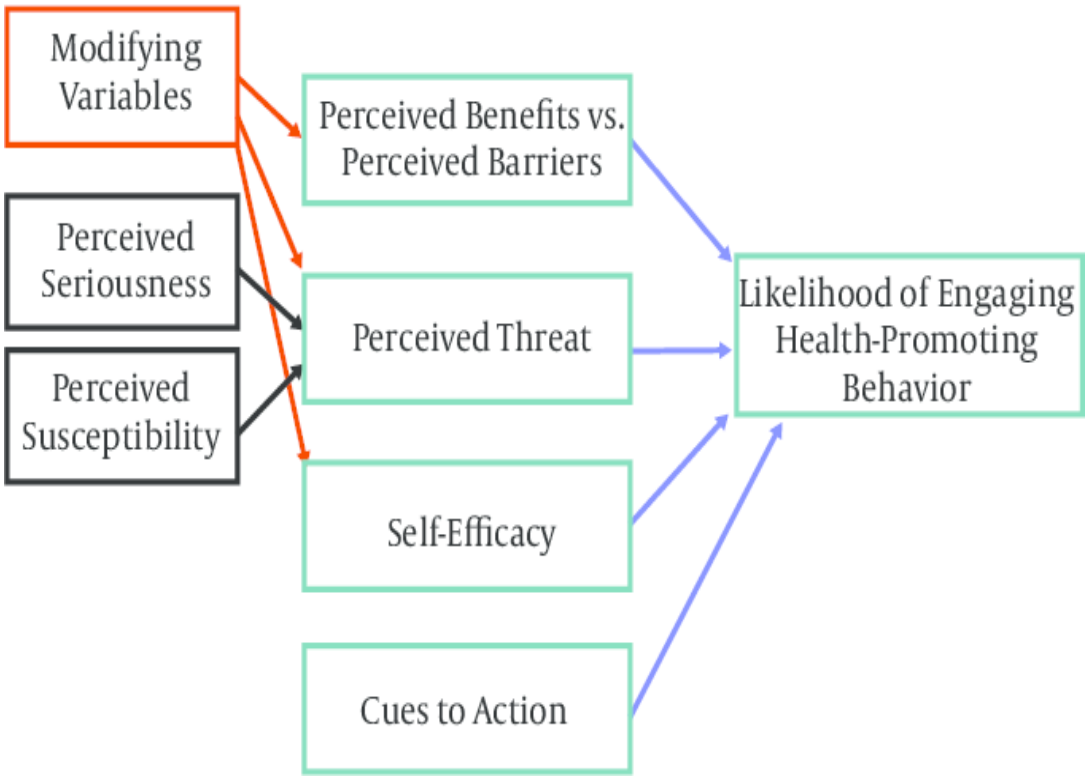

Figure 2. Health Belief Model[8]

[7] Charles Abraham and Paschal Sheeran, "The Health Belief Model," In: *Predicting and Changing Health Behavior*, eds. Mark Conner and Paul Norman (New York: McGraw-Hill, 2015), 31, accessed, April 27 2021, https://www.researchgate.net/publication/290193215_The_Health_Belief_Model.

[8] Mohammad Khajedaluee, "A Population-based Study into Knowledge, Attitudes and Beliefs (KAB) about HIV/AIDS - Scientific Figure on ResearchGate," (accessed 10 Jun, 2021, https://www.researchgate.net/figure/The-Health-Belief-Model_fig2_295839499.

Health Lifestyle Theory

This theory suggests that health lifestyle choices are not the unrelated random choices of individuals, but cluster in distinct patterns based on class, gender, and other structural variables." [9]

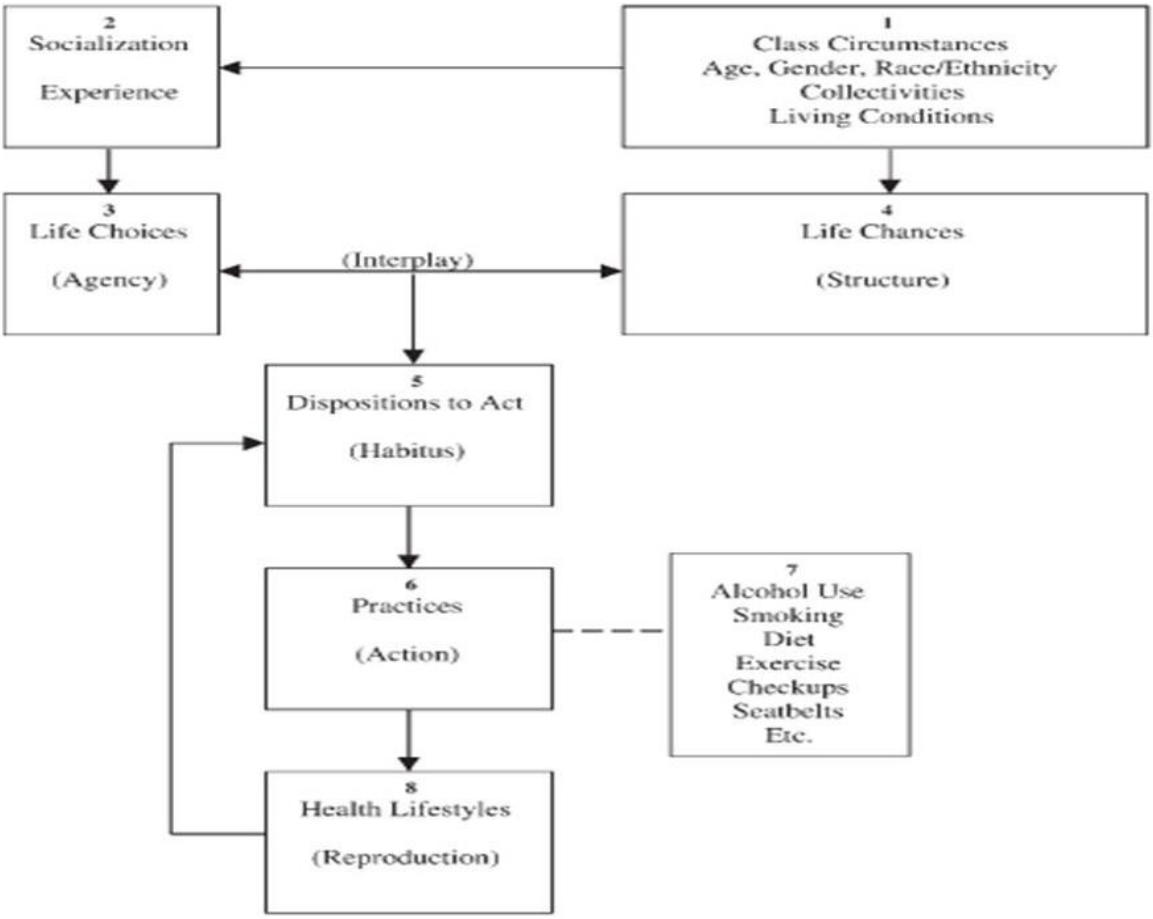

Figure 3. Health Lifestyle Theory[10]

[9] William C. Cockerham, "Health Lifestyle Theory and the Convergence of Agency and Structure," abstract, *Journal of Health and Social Behavior* 46, no. 1 (December 2017): 51, accessed 18th February, 2021, https://onlinelibrary.wiley.com/doi/abs/10.1002/9781118430873.est0160.

[10] Lisa Garnham, "Politics, place, health: an exploration of the relationship between socio-political change and public health in the town of Clydebank, framed by the problematic of the 'Scottish Effect' - Scientific Figure on ResearchGate," accessed 11 June, 2021, https://www.researchgate.net/figure/The-health-lifestyles-paradigm-Cockerham-2005-pp57-Fig1_fig4_279186495

Trans-Theoretical Models/Stages of Change

This model examines the health behaviors of an individual that changes over-time (actions and adaptations), and how that impacts wellness.[11] Thus, this model suggests that health is based on behaviour and the individual's reponses to change.

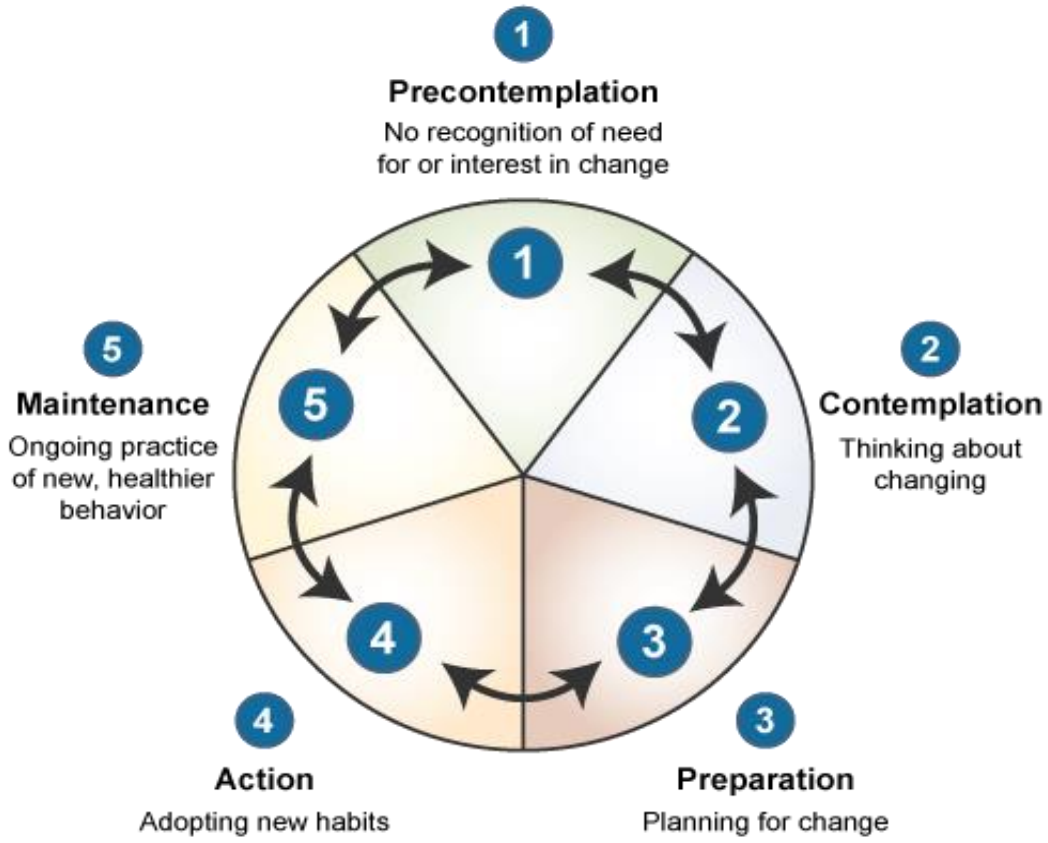

Figure 4. Trans-theoritical Model[12]

[11] James. O. Prochase and C. Di Clemente, "Transtheoritical Therapy: Towards a More Integrative Model of Change,"*Psychotherapy Theory, Research and Practice* 19, no. 3 (1982): 283, accessed 2nd March, 2020, http://doi.apa.org/getdoi.cfm?doi=10.1037/h0088437 (((

[12] Brittani Gray, "Change Management," accessed 11 June, 2021, https://www.pinterest.com/pin/88664686387884386/

Social Cognitive Theory

The underlining principle is that people learn not only from their involvements; but also, through the observation of others' actions and the effects of those actions. Proponents of this theory project three aspects: thus, personal, environmental, and behavior. Key indicators for health include "observational learning, reinforcement, self-control, and self-efficacy."[13]

Social Drift Theory

As people become ill, their ability to earn a living or attract an employed spouse decline and they fall to a lower social status than their parents. This theory suggests that illness causes poverty.[14]

Social Stress Theory

Poorer persons experience more stress, and they have less control over those stresses. Example of these stresses are unfavorable environmental condition, nutrition, and lack of access to health care. Thus, these stresses could inform types illnesses and recovery rates associated with certain groups of people.[15]

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[13]Albert Bandura, "Social Cognitive Theory," In: (*Annals of Child Development Six Theories of Children Development*, ed. R. Vasta, (Greenwich, CT: JAI Press, 1989) , 1-4, accessed 5th March 2021, https://www.uky.edu/~eushe2/Bandura/Bandura1989ACD.pdf

[14] Sze Chim Lee et al., "Area deprivation, urbanicity, severe mental illness and social drift — A population-based linkage study using routinely collected primary and secondary care data:" *Schizophrenia Research* 220 (June 2020): 130, accessed April 2 2021, https://www.sciencedirect.com/science/article/pii/S0920996420301547

[15] Cecil G. Helman, *Cultural, Health and Illness*, 5th ed. (Boca Raton: CRC Press, 2013), 134-138.

Health Literacy Theory

Andrews Pleasant suggests health literacy as a theory of behavior change that can produce positive gains in individual, community, and global health. This model can aid us avoid health problems and protect our health, as well as better manage those problems and unexpected situations that happen. This is due to the fact that there is access to health information. [16]

Conceptual Framework

This section of the literature review considers concepts that are associated with chaplaincy and wholistic or multi-dimensional healthcare. The focus was also to draw inference from the health theories, and build concepts that will guide the development of the SMP.

Wellness and Health Theories

Health is a concern for the world; and the centre of this is how to prevent and ensure wellness by practicing, researching, and drawing policies. That notwithstanding, optimum health is an individual responsibility.[17] A study by Lauren J. Roscoe, focused on understanding models on wellness for counselors, suggest that the complexity of wellness instruments seem insufficient.[18]

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[16] Andrews Pleasant, "Health Literacy: An Opportunity to Improve Individual, Community, and Global Health," abstract, *New Directions for Adult and Continuing Education* 20, no 130 (2011): 43, accessed 1st March, 2020, https://onlinelibrary.wiley.com/doi/abs/10.1002/ace.409

[17] Mark A. Finley, Peter N. Landless, (*Health Week Readings: Health and Wellness* (Accra, Ghana: Adventist Press, 2015), 9.

[18] Lauren J. Roscoe, "Wellness: A Review of Theory and Measurement for Counselors," abstract, *Journal of Counseling & development* 87, issue 2 (2011): 1556, accessed 1st March, 2020, https://onlinelibrary.wiley.com/doi/abs/10.1002/j.1556-6678.2009.tb00570.x

Wellness and Health are methods of attaining one's top state of mental and physical being. The individual characteristics, related to the role's stakeholders (chaplains inclusive) play to ensure well-being are intertwined and complex. For example, what encapsulate the dimensions of wellness (physical, mental, social, spiritual, environmental, and intellectual, etc.) has been understood in a multidimensional way.[19]

Wholistic and Holistic Health

The understanding of wholistic health should include "assessment diagnosis, treatment and preventive of wholistic illness in human beings to maintain wholistic health or enhance wholistic healing;" where human health is seen as made of parts that are integrated and attached.[20]

Thus, the wholistic elements could be made of the emotional, physical, social, mental, etc. devoid of hellenistic and evolutionary teachings suggested by Smut.[21] Holistic health is therefore, "Holistic healthcare is complete or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person, his or her response to illness and the effect of the illness on the ability to meet self-care needs." [22]

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[19] John R. Hjelm, *The Dimensions of health: Conceptual models* (Sudbury: Jones and Bartlett Publishers, 2010), 3-7.

[20] Deborah Jean Ziebarth, "Wholistic Healthcare: Evolutionary Conceptual Analysis," *Journal of Religion and Health* 55, no. 5 (2016): 3-4, accessed 14th January, 2020, https://link.springer.com/article/10.1007/s10943-016-0199-6

[21] Stanley J. Gross, "The Holistic Health Movement," abstract, *The Journal of Counseling & Development* 59, issue 2 (1980): 96, accessed on 3rd March, 2020, https://eric.ed.gov/?q=holistic+AND+health&pg=4&id=EJ236049; Hjelm, *The Dimensions of health: Conceptual models*, 3.

[22] Søren Ventegodt , Isack Kandel , David A. Ervin , and Joav Merrick, "Concepts of Holistic Care." In book: *Health Care for People with Intellectual and Developmental Disabilities across the*

At some point, these two words have been used interchangeably. For example, there are six models of health: biomedical, psychological, humanistic, existential, and transpersonal. The biological is reductionist; while the rest are holistic. Holistic in this context seems so encompassing; and thus, will need technical minds to understand the context and backgrounds of the authors?[23]

Inferences with the Health Belief Model suggest that an individual's lifestyle and choices based on beliefs could inform preventive and detective outcomes in receiving services or not-to, in a health system. Where choice of a patient, based on the understanding of wholistic and holistic could affect healthcare services and patronage.

Evaluation: Healthcare Chaplaincy and Theories

With the recent demand for support by patients and patient's family from health, social, and spiritual care providers at the hospitals, there is a need for emphasis on professionalism.[24] Health care is the improvement of health through the health system. That is a process which involves attending to patients to either prevent diseases, or provide treatment to ensure wellness. [25] Also, the outcome should be that

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Lifespan, ed., I.L. Rubin (Switzerland: Springer International Publishing, 2016), Chapter 148, accessed 14th June, 2021, https://www.researchgate.net/publication/301641481_Concepts_of_Holistic_Care

[23] Maare Tamm, "Models of Health and Disease," abstract, *British Journal of Medical Psychology* 66, no. 3 (September 1993): 213, accessed 2nd March, 2020, https://bpspsychub.onlinelibrary.wiley.com/doi/abs/10.1111/j.2044-8341.1993.tb01745.x; (Cf. Deborah Jean Ziebarth, P. Ann Solari-Twadell, "Faith Community Nursing: A Wholistic and Holistic Nursing Practice," In: *Faith Community Nursing*, ed. P. Solari-Twadell and D. Ziebarth (Switzeland: Springer, 2019), Chapter 3, accessed 3rd March, 2020, https://doi.org/10.1007/978-3-030-16126-2_3

[24] Ibid.

[25] World Health Organization, "Primary Health Care," accessed on 19th February, 2021, https://www.who.int/news-room/fact-sheets/detail/primary-health-care; Shelley E. Taylor, et al., *Social Psychology*, 10 ed. (Hoboken NJ: Prentice-Hall, Inc, 2000), 421

healthcare ensures the physical, mental, social, emotional, and spiritual well-being of people.[26]

In Africa or Europe the factors that determine health include improved living conditions, improved working conditions, later and less frequent childbirth, change in military strategies, improved nutrition, living condition, public sanitation, and improved health systems.[27] The African health system is weak due to infant mortality and maternal mortality rates, political and economic instability, environmental degradation, war, famine, and spread of diseases, bad leadership and structural violence.[28]

These conditions dwarf the health system of African compared to the relatively stable nature of the health system in Europe. Every health system is expected to meet the following characteristics at its best: privately governed: central agency; technology-focused; accessible to all; strong legal framework; wider coverage; and better benefits.[29]

Some nations in African are struggling to meet better standards for optimum health insurance for citizens due to Gross National Scarcity. This makes the health

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[26] Kathleen Galek, et al, "Referrals to Chaplains: The Role of Religion and Spirituality in Healthcare Settings," abstract, *Mental Health, Religion and Culture* 10, no. 4 (2007): 363, accessed 26th February, 2020, https://www.tandfonline.com/doi/abs/10.1080/13674670600757064

[27] Michael Marmot, "Social Determinants of Health Inequalities," *The Lancet* 365, no. 9464 (2005): 1099-1102, accessed 26th February, 2020, https://www.who.int/social_determinants/strategy/Marmot-Social%20determinants%20of%20health%20inqualities.pdf

[28] Juliet Nabyonga-Orem, et al., "Policy Dialogue to Improve Health Outcomes in Low Income Countries: What are the Issues and Way Forward?" *BioMed Central Health Services Research* 16, no. 217 (July 2016): 268-269, accessed 19th February, 2021, https://www.researchgate.net/publication/305424415_Policy_dialogue_to_improve_health_outcomes_in_low_income_countries_What_are_the_issues_and_way_forward

[29] David Axene, "What Makes U.S. Healthcare Different?" accessed on 19th February, 2021, https://www.insurancethoughtleadership.com/what-makes-us-healthcare-different/

insurance system inadequate, struggling to survive in the system; due to limited access, less technological equipment, fewer health practitioners, etc.[30] This indicators of the African health system could suggest existing challenges for any chaplaincy program at the hospital.

It is an undeniable fact that religion tends to influence social capital. This debate is fragmentary re the role spiritual healthcare givers provide as a resource that could affect global healthcare. Though this may be less a reality for Africa because its health and chaplaincy systems appear evolving, it is worth considering that there is potential for growth[31]

"The chaplain's role in the health care services has changed profoundly within the context of managerial and fiscal constraints, and increasingly pluralistic and secularized."[32] Thus, professional chaplaincy as a multidisciplinary team has significant roles to play in the health care system. Five largest health care chaplaincy institutions in North America representing over 10,000 members conducted research

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[30] Frank W. Drislane, Albert Akpalu, and Harry H. J. Wegdam, "The Medical System in Ghana,"*Yale Journal of Biology and Medicine* 87, no. 3 (2014): 321-326, accessed 9th June, 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144286/; Cf., Julia van Gemert-Pijnen et al., "A Holistic Framework to Improve the Uptake and Impact of Health Technologies," *Journal Medical Internet Research* 13 (2011): 111, accessed 15th February, 2020, https://www.researchgate.net/publication/51865938_A_Holistic_Framework_to_Improve_the_Uptake_and_Impact_of_eHealth_Technologies

[31] Emem Agbiji, Obaji Mbeh Agbiji, "Pastoral Care as a Resource for Development in the Global Healthcare Context: Implications for Africa's Healthcare Delivery System:" *HTS Theological Studies* 72, no. 4 (2016): 1-12, accessed on 25th February, 2020, (http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0259-94222016000400104

[32] Barbara Pesut, et al, "Hospitable Hospitals in a Diverse Society: From Chaplains to Spiritual Care Providers," abstract, *Journal of Religion and Health* 51 no. 3 (2012): 825, accessed 26th February, 2020, https://idp.springer.com/authorize?response_type=cookie&client_id=springerlink&redirect_uri=https%3A%2F%2Flink.springer.com%2Farticle%2F10.1007%2Fs10943-010-9392-1

which suggests the interchanging roles of chaplains as spiritual care and pastoral care providers.[33]

There seems to be the demand for valued outcomes by patients and patients' families from healthcare systems; where satisfaction is measured on reduced cost enhanced eminence of care cures rates, reduced interval of stay, and reduced use of health resources. Thus, the worth of chaplaincy is appraised on these standards;[34]which could be expectations patients set, and could measure patients' satisfaction.[35]

In connection with the diversity and evolution of healthcare chaplaincy, the Association of Clinical Pastoral Education (ACPE) suggests that chaplains are "full-fledged members of the health care team for example chaplains allowed to minute on patient medical records, which may not be the case in Africa).[36]

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[33] Larry VandeCreek and Laurel Burton, "Professional Chaplaincy: Its Roles and Importance in Health care," *Journal of Pastoral Care and Counseling* 55, no. 1 (2001): 81-97, accessed on 26th February, 2020, https://www.researchgate.net/publication/238600784_Need_for_ICTs_Assessment_in_the_Health_Sector_A_Multidimensional_Framework. https://www.researchgate.net/publication/252840751_Professional_Chaplaincy_Its_Role_and_Importance_in_Healthcare (Cf. Marieanne Ekedahi and Yvonne Wengstrom, "Coping Processes in a Multidisciplinary Healthcare Team – a Comparism of Nurses in Cancer and Hospital Chaplains," abstract, *European Journal of Cancer Care (*17, issue 1 (2007): 42, accessed 26th February, 2020, https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1365-2354.2007.00801.x; (Lauren C. Vanderwerker, et al, "What Do Chaplains Really Do? III. Referrals in the New York Chaplaincy Study," abstract, *Journal of Health care Chaplaincy (*14, no. 1 (2008): 57, accessed 26th February, 2020, https://www.tandfonline.com/doi/abs/10.1080/08854720802053861

[34] George F. Handzo, et al, "Outcomes for Professional Healthcare Chaplaincy: An International Call to Action," abstract, *Journal of Health Care Chaplaincy (*20, no. 2 (2014): 43, accessed on 26th February, 2020, https://www.tandfonline.com/doi/abs/10.1080/08854726.2014.902713. Cf. Katherine RB Jankowski, et al., "Testing the Efficacy of Chaplaincy Care," *Journal of Health Care Chaplaincy* 17, no. 3-7 (2011): 100-102, accessed 26th February, 2020, (https://www.researchgate.net/publication/51747405_Testing_the_Efficacy_of_Chaplaincy_Care

[35] Y. W. Choi, **"**Paradigm Shift in Adolescent Health Service Delivery," abstract, *Hong Kong Journal of Paediatr* 9, no. 4 (2004): 303, accessed 3rd September, 2020, http://www.hkjpaed.org/details.asp?id=31&show=1234, Medcom Ltd

[36] Roberta Springer Loewy, Erich H. Loewy, "Healthcare and the Hospital Chaplain," abstract, *Medscape General Medicine* 9, no. 1 (2007): 53, accessed 26th February, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924976/ (

After using a sample size of 3,300 on Chief Executive Officers of hospitals in America it was detected that some factors worked against chaplaincy. This even becomes worse when such assessments are conducted on healthcare chaplaincy in Africa.[37] It however appears that interdisciplinary healthcare authors neglect professional chaplaincy when discussing spirituality. There is the need for much emphasis from healthcare stakeholders to demand for professionalism for the chaplaincy ministry in hospitals.[38]

This calls for transformation not only in the developed countries but Africa where healthcare chaplaincy is evolving; to ensure that the demand for pastoral care and chaplaincy in the "wholistic" health care is achieved[39] The Trans-theoretical Model points to such evaluation on chaplaincy, to understand how the roles of healthcare chaplains in hospitals are changing; and how that could affect wellness and health behaviors.[40]

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[37] Kevin J. Flannelly, et al, "Factors Affecting Healthcare Chaplaincy and the Provision of Pastoral Care in the United States," *Journal of Pastoral Care and Counseling* 58, no. 1-2 (2004): 127-130, accessed 26th February, 2020, (https://www.researchgate.net/publication/8543091_Factors_Affecting_Healthcare_Chaplaincy_and_the_Provision_of_Pastoral_Care_in_the_United_States (

[38] Larry VandeCreek, "Professional Chaplaincy: An Absent Profession," abstract, *Journal of Pastoral Care and Counseling* 53, no. 4 (1999): 417, accessed 26th February, 2020, https://journals.sagepub.com/doi/abs/10.1177/002234099905300405; (Rudolf H. Moos and Jeanne A. Schaefer, "Evaluating Health Care Work Settings: A Holistic Conceptual Framework," abstract, *Journal Psychology and Health* 1, no. 2 (1986): 97, accessed 2nd February, 2020, https://www.tandfonline.com/doi/abs/10.1080/08870448708400318

[39] Margaret J. Orton, "Transforming Chaplaincy: The Emerging of a Healthcare Pastoral Care for a Post-modern World," abstract, *Journal of Healthcare Chaplaincy* 15, no. 2 (2008): 114, (accessed 26th February, 2020, https://www.tandfonline.com/doi/abs/10.1080/08854720903152513

[40] Prochase and Di Clemente, "Transtheoritical Therapy Towards a More Integrative Model of Change, 283.

Theories and Nature of Multi-Facet Healthcare

Multi-dimensional refers to the different parts of things; this could also suggest the complex nature of something.[41] When healthcare is defined as multi-facet it appears to be fragmentary and complex:[42] this could apply to the development of technologies and equipment;[43] the complexity involved in medicalization,[44] or adapting changes and models in health practices; etc.[45]

A multi-dimensional understanding of health is primarily related to how healthcare practices could address health and wellness from the physical, mental, social, environmental, and spiritual perspectives.[46] Health and wellness have also

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[41] *Merriam-Websters Dictionary,* s.v. "John Briggs and F. David Peat," accessed 14th June, 2021, https://www.merriam-webster.com/dictionary/multidimensional

[42] Daniel Ganu, *A Study Guide to Health Principles* (Accra, Ghana: Sylva Ventures, 2007), 2-4.

[43] Finn Borlum Kristensen et al., "The HTA Core Model - 10 years of Developing an International Framework to Share Multidimensional Value Assessment," abstract, *Value in Health* 20, no. 2 (2017): 244, accessed, 1st March 2020, (https://www.valueinhealthjournal.com/article/S1098-3015(16)34220-6/fulltext?_returnURL=https%3A%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS1098301516342206%3Fshowall%3Dtrue. Cf. Le Goff-Pronost, Robert Picard, "Need for ICTs: A Multidimensional Framework,"*Communication and Strategies* 83 (2011): 87-89, Michael P. Washburn, et al, "Large-scale Analysis of Yeast Proteome by Multidimensional Protein Identification Technology," *Nature Biotechnology* 19, no. 3 (2001): 87-88, accessed 1st March, 2020, https://www.researchgate.net/publication/238600784_Need_for_ICTs_Assessment_in_the_Health_Sector_A_Multidimensional_Framework

[44] Raffaele Federici, "Health, Medicalization and the Radical Media," *Biomedical Journal of Scientific and Technical Research* 23, no. 4 (2019): 3, accessed 1st March, 2020, https://biomedres.us/fulltexts/BJSTR.MS.ID.003931.php; Cf. Peter Conrad, *Medicalization: Changing Contours, Characteristics, and Context,* , In: Cockerham W. eds., *Medical Sociology on the Move* (Dordrecht, Netherlands: Springer, 2013), 195, accessed 1st March, 2020, http://ndl.ethernet.edu.et/bitstream/123456789/21710/1/William%20C.%20Cockerham.pdf#page=199

[45] Martha E. Banks, et al, "Integrative Healthcare and Marginalized Population," In Marie A Dicowden and Ilene Ava Serlin, eds*., Whole Person Healthcare 1: Humanizing Healthcare* (Westport, CT: Praeger Publishers, 2007), 147-149, accessed 1st March, 2020, https://psycnet.apa.org/record/2007-13039-008. Cf. Nazanin Sabooniha, et al, "An Evaluation of Hospital Information Systems Integration Approaches," abstract, *Proceedings of the International Conference on Advances in Computing, Communications and Informatics* 12 (August 2012): 498, https://dl.acm.org/doi/10.1145/2345396.2345479

[46] Ganu, *A Study Guide to Health Principles*, 2-3; M. H. Williams, *Lifetime Fitness and Wellness,* 4th ed. (Chicago, IL: Brown and Benchmark, 1996), 1-9.

been understood as Integrated Wholeness where each component physical, mental, and spiritual aspects of the human being are considered as a single unit.[47]

This could be associated with what Albert Bandura proposed regarding Social Cognitive Theory.[48] This reveals the outcomes health dimensions and how that impact personal and environmental experiences to affect health behavior; which suggests inherent and extrinsic values for healthcare systems and chaplaincy. This is how this applies:

Relationship between the Wholistic Elements

Wholeness in health encompasses physical, spiritual, mental, and social factors. And these interplays result in emotional, psychological, psychopathological, psycho-socio, biological, and spiritual factors that affect human well-being. The proper function or malfunction of these factors could affect wellness.[49]

A critical study of the wholistic factors suggests that the absence of a factor may affect wellbeing;[50] which means that healthcare practices should consider whole-person care. This should include both intrinsic and extrinsic factors that affect wellness.[51]

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[47] Finley and Landless, *Health Week Readings: Health and Wellness,* 9.

[48] Bandura, *Social Cognitive Theory,* 1-3

[49] George R. Bach, and Herb Goldberg, *Creative Aggression* (New York: Doubleday & Company, Inc, 1974), 109 – 116; Elizabeth Kubler-Ross, *Facing Up to Death: Measuring Behavior*, 2nd ed., ed. Paul Martin, and Patrick Bateson (Cambridge: Cambridge University Press, 1993), 266 – 268; Norman H. Wright, *The New Guide to Crisis and Trauma Counseling* (Ventura, CA: Regal Books, 2003), 127-129. Paul Hometowu, *Institutional Chaplaincy Work: Special Family Pastoral Ministry* (Accra, Ghana: Paul Hometowu, 2004), 9, 39, 40-44.

[50] World Health Organization, "Determinants of Health," accessed June 2, 2017, https://www.who.int/news-room/q-a-detail/determinants-of-health .

[51] Ganu, *A Study Guide to Health Principles,* 3

Empirical Framework

This section of the literature review considers possible outcomes for how the theories and the concepts could be practical and functional in the healthcare system or chaplaincy; considering the impact of wholistic healthcare, a spiritual master plan and its performance.

Chaplaincy Impact and Wholistic Healthcare

The activities of hospital chaplains have been properly written down since the early twentieth century. The work of a chaplain begins with a call and mandate to minister to all, help those in need, being available and tactical. Likewise, the primary role of a chaplain is providing spiritual care, which broadly encompasses helping clients with mental, physical, social, and emotional issues.[52]

Studies reveal that spirituality may play significant roles in healthcare. Chaplains also play a collaborative role with other health workers in showing compassion, listening, being attentive, available, etc.[53] The effective and professional roles of a chaplain serves, is based on his or her exposure to pastoral care, counseling, clinical psychology, communication, and theological background. These experties contribute significantly to the work of the chaplain in helping clients.[54]

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[52] Ibid. Cf. Paget and McCormack, *The Work of the Chaplain,* 3-10.

[53] Christina M. Puchalski, "The role of spirituality in health care," *Baylor University Medical Center Proceedings* 14, no. 4 (October 2001): 352, accessed 19th February, 2021, https://www.researchgate.net/publication/7400606_The_Role_of_Spirituality_in_Health_Care

[54] Collins R. Gari, *Christian Counseling: A Comprehensive Guide* (Nashville, TN: Thomas Nelson, 2007), 17 – 20 and 745-760. Cf. John Rhodes, *Success Secrets for Pastors* (Mountain View, CA: Pacific Press Publishing, 1965), 89-100; Carrie Doehring, *The Practice of Pastoral Care* (Louisville, KY: Westminster John Knox Press, 2015), xi-xxviii.

Spiritual Master Plan in Hospitals

A Spiritual Master Plan is a plan that could guide the activities of chaplains to enhance routines in the hospital environment. In America for example, where hospital chaplaincy is a phenomenon, a chaplain's expertise (in Clinical Pastoral Education) helps him fit in such environment with the other health workers. Thus, even though every worker has daily routines, the danger is for an untrained chaplain to attend to prospects with only a plan from his pastoral background.[55]

A search for a sample SMP for hospitals proved futile, that notwithstanding the question is that could there be a little shift from what is professional and adapting tested models that could make untrained chaplains efficient (especially in Africa)? Thus, the chaplain should be able to support practically the total patients' valuation and treatment; and use independent instruments to empower patient care. And also, to link spiritual dimensions; functioning more efficiently with other health experts; providing exceptional interventions that decrease the overall span of stay; use of hospital resources; and distress of patients meaningfully.[56]

A Pastor may have the expertise that could make him look like a chaplain in the hospital setting; but until he receives training as a professional, he may be handicapped in the discharge of duty. A Spiritual Master Plan could be a substitute model for pastors who have not been trained as healthcare chaplains. Though every trained chaplain in a hospital may have daily routines; it is a new thing to help a pastor who is playing some roles of chaplaincy in a hospital. For the untrained

[55] Loewy and Loewy, "Healthcare and the Hospital Chaplain," 53

[56] Elisabeth McSherry and William A. Nelson, "The Drg Era: A Major Opportunity for Increased Pastoral Care Impact or a Crisis for Survival?" *Journal of Pastoral Care* (41, no. 3 (1987): 201–203, accessed 3rd March, 2020, https://pubmed.ncbi.nlm.nih.gov/10285015/.

chaplain in healthcare to diagnose, ensure objective measures, possible prognosis, interventions, follow-up record keeping, and referral services, then some sort of training and developed program should serve as guide.[57]

The chaplain's roles in this kind of context seem so encompassing and dynamic. The General management theory, which here is used as a model theory to guide the work of the chaplain in the administering of the Spiritual Master Plan may seem involving. Figures 5 which has been adapted could help explain how effective the Chaplain's plan could work to impact the hospital.[58]

The Chaplain also becomes the agent of hospitality to patients and workers, with maximum support from the organization. This, however, suggests that the chaplain together with the administration have a collaborative role to achieve wholistic healthcare goal

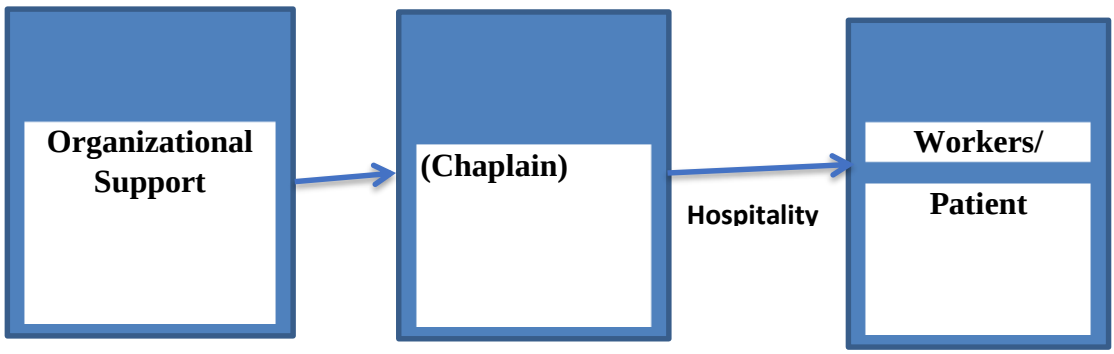

Figure 5. Adapted General Management Theory

[57] Ibid.

[58] Laurie J. Mullins, *Managing People in the Hospitality Industry*, 3rd ed. (England: Addison Wesley Longman Limited, 1998), 10-14.

It is expected that the outcomes of the chaplain's hospitality services with other workers should propel wholistic growth to the hospital. The chaplain who is at the hub of spiritual activities uses the developed plan in the structure (organization), of which the patients and workers will be the beneficiary of such hospitality. This should be such that he should be dynamic in using both non-human and human resources or tools to ensure performance. Figure 6 demonstrates this clearly.

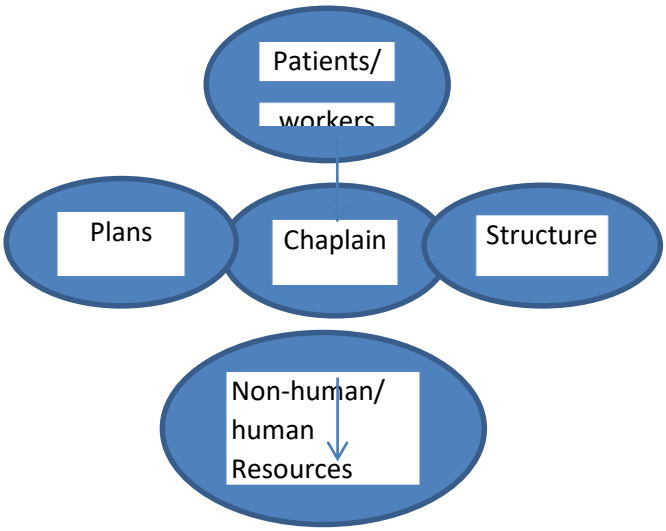

Figure 6. Performance of the Theory

Summary

The study reviewed related literature on the topic under study, by considering the theoretical, conceptual, and empirical frameworks. Out of seven theories, four were chosen to form the basis for the healthcare system and chaplaincy for this research. These include the General Management Theory, the Health Belief Model,

Trans-theoretical models, and Social Cognitive Theory. The focus of the chapter was how these related literature could guide the development of the Spiritual Master Plan.

Wellness was reviewed in the context of the background to chaplaincy and an evaluation on healthcare chaplaincy; wholistic and holistic; multidimensional healthcare and health theories as a conceptual framework. The empirical framework discusses the impact of chaplaincy on wholistic healthcare by considering the roles professional chaplains engage with other healthcare professionals and administration that could result in a good performance; using the General Management Theory as an assessment tool.

CHAPTER 4

FIELD RESEARCH

Introduction

This aspect of the research work analyzed data from the Adventist Hospital that served as the basis to create awareness on the spiritual care and spirituality of the hospital. The outline of the chapter includes the introduction, description of the population, research design, research rationale, appropriateness of the study, population, sample population, samplingprocedures and selection, instrumentation, data collection procedures, data analysis, and summary.

Description of Population

The Hospital started as a Clinic around 1996 in Jakarayili, a suburb of Tamale, Northern part of Ghana. The Tamale Adventist Hospital, is one of the 17 hospitals and clinics under the Ghana Adventist Health Services. The population in the urban area, per the population statistics from 2017-2020 is 648,211.[1]

The clinic moved to its present location on 2nd February 2004 under the charge of a retired Senior Medical Assistant and a visiting Medical Officer (Dr Bampoe). It was commissioned on 8th July 2004 by the then Regional Minister Hon. Ernest A. Debrah.

[1] Wikipedia, "Seventh-day Adventist Church in Ghana," accessed 19th February, 2021, https://en.wikipedia.org/wiki/Seventh-day_Adventist_Church_in_Ghana.

With the arrival of a permanent resident doctor, the clinic assumed the status of a Hospital in February 2005. It has since been granted accreditation as a Primary Hospital Level C by the government.[2] The Tamale Adventist Hospital as of 2018 had twelve major departments; and a daily estimated population of about 94 in-patients, 158 out-patients, and 222 workers in the hospital.[3]

Research Design

The study employed the quantitative research method. This was used to investigate the spiritual care practices of the hospital. Also, it serves as basis to develop the SMP.

Type of Research

Essentially, the quantitative approach was used to evaluate the spiritual care practices of the Adventist Hospital in Tamale with wholistic healthcare practices. This approach was used to draw and evaluate the SMP.

Research Rationale

The idea was to use this section of the study to review the spiritual care practices of the hospital before the development and testing of the SMP to inform important correlations. This could form a basis to assess the efficacy of the SMP before and after its implementation; and also to predict future outcomes when upgrading becomes necessary.

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[2] North Ghana Mission of Seventh-day Adventist, "Report Establishment of Hospital Archive Centre," (Tamale, Ghana: North Ghana Mission, 1995-2004), File No. 24

[3] Emmanuel Ansah, Director for Information Centre, Tamale SDA Hospital, interview by the author, Tamale, 15th November, 2018.

Appropriateness of Study

The study was relevant to the Tamale Adventist Hospital. It especially served as a resource for the chaplaincy unit or GAHS, and could serve as guide to the untrained chaplain. This study established the fact that giving a tweak to healthcare chaplaincy could serve as grounds for the development of chaplaincy in Ghana and Africa.

Population

Whereas GAHS has 17 clinics and hospitals in Ghana. There were two Adventist healthcare facilities in Upper West Region (Wa Adventist Clinic) and Northern Region (Tamale Adventist Hospital) respectively. The accessible population was Tamale Adventist Hospital. The hospital as at 2018 had a daily estimated population of about 474 (94 in-patients, 158 out-patients, and 222 workers in the hospital).[4]

Sample Population

The sample size determined out of the estimated population of 474 was 214. However, 70 workers and patients (in and out) responded to the questionnaires.This was due to the fear and restrictions associated with the sudden spread of the COVID-19 pandemic and strict protocols at the Adventist Hospital.

[4] Ibid.

Sampling Procedures and Selection

The simple random sampling method was used to select the sample from the hospital population of 474. The cluster sampling method was used to group the selected units after which a sample size of 214 was determined using criteria according to Krejcie and Morgan.[5]

$$s = \frac{\chi^2 NP(1-P)}{d^2(N-1)+\chi^2 P(1-P)}$$

Whereby

s = sample size required

χ^2 = the table value of Chi-square for one degree of freedom is 3.841

N = accessible population size

P = Population proportion assumed (0.5)

d = expressed a proportionate degree of accuracy

The 70 respondents chosen were as follows, for the workers, 10 groups made of 5 workers in each group were sampled. The in-patients were grouped at 3 different given times and questionnaires were given to 12 of them. For out-patients, at 3 different given times, 8 individuals were given questionnaires. In the sampling process, the research was sensitive to criteria such as gender, time, age, ethnicity, education, income level, and geographic location.

[5] Kenya's Project Organization, *Sample Size Determination Using Krejcie and Morgan,* August 25, 2012, accessed 24th February, 2021, http://www.kenpro.org/sample-size-determination-using-krejcie-and-morgan-table/

Research Instrumentation

The main instruments used for collecting data for the study was questionnaires. The questionnaire was administered on a 1 to 5 Likert scale, whereas 1 is most obviously not aware and 5 is most obviously aware for section A, and sections B to F were scaled 1-never to 5-always. The ABIDE reflection questions and spiritual purpose statement questions were adapted to design the questionnaire for this study;[6] reflecting six areas (Section A, where are we; Section B, abundant discipling; Section C, bold godliness; Section D, intentional connecting; Section E, deliberate learning; and Section F, extravagant outreach).Thus, it was used to review the spiritual care practices of the Adventist Hospital before the implementation of the SMP. The adapted questionnaire generally follow the ABIDE questions exactly, except for a few word changes and changing of overly long sentences. For example, the word "school" was replaced with hospital.

The ABIDE model is intended to draw and implement SMPs in Adventist Schools to become like Christ (wholistic education) in the North African Division (NAD). This SMP is drawn using staff, teachers, leadership, and stakeholders of the School. The ABIDE SMP has three sections: "who are we?" "Reflection questions" and the spiritual master plan. [7]

[6] Nina Atcheson, "ABIDE: A Spiritual Master Plan for Adventist Schools," *Adventist Educators*, December 3, 2020, accessed February 16, 2021, https://adventisteducators.org/2020/12/abide/

[7] Ibid.

Data Collection Procedure

The data collection captures the sources of data collected, the instrument of data collection, and the procedure used to collect the data. Data for this research were collected through primary sources (questionnaires); and analyzed using SPSS.

The questionnaire was self-administrated to patients and workers because of the high illiteracy rate of most patients that visit the hospital. This ensured that the study achieved a high response rate.

Prior to administering the questionnaires to the 70 respondents who were divided into groups, the researcher explained the nature and purpose of the study. Besides, participants were given opportunity to ask questions and seek clarifications**.**

Data Analysis

Exploratory Data Analysis

Exploratory data anysis also known as descriptive data analysis is an approach used to analyze sets of data by summarizing their main features, often through statistical illustrations and other data visualization methods.[8]

Table 1. Respondents Spiritual Awareness of the Hospital

	Frequency	Percent
Obviously not aware	14	20.0
Not aware	11	15.7
not sure	19	27.1
Aware	22	31.4
Obviously aware	4	5.7
Total	70	100.0

[8] Benony K. Gordor and Nathaniel K. Howard, *Introduction to Statistical Methods* (Cape Cost, Ghana: Ghana Mathematics Group, 2006), 12

Table 1 seemed to suggest that respondents who are obviously not aware (20.0%) of the spirituality of the hospital are 14.3% more than those who are obviously aware(5.7). Also, 27.1% are not sure of the spirituality of the hospital.

Table 2. Families Involvement in the Discipleship Process

	Frequency	Percent
Never	27	38.6
Sometimes	15	21.4
Occasionally	15	21.4
Regularly	7	10.0
Always	6	8.6
Total	70	100.0

As shown in the Table 2, 15 (21.4%) respondents believe that patients' families are occasionally involved in the discipleship process of the hospital. Table 2 depicted again that families that are never involved in the discipleship process of the hospital (38.6) are 30% than families that are always involved in the discipleship process (8.6).

Table 3. Hospital Models Christ's Character in Services Provided

	Frequency	Percent
Never	5	7.1
Sometimes	12	17.1
Occasionally	10	14.3
Regularly	18	25.7
Always	25	35.7
Total	70	100.0

In Table 3, the frequency of respondents who believe that patients and staff are always served in the model of the character of Christ is 28.6% more than those who believe patients and staff are never served in the model of the character of Christ in the hospital.

Table 4. Integration of Mission Statement in Hospital Services and Administration

	Frequency	Percent
Never	10	14.3
Sometimes	15	21.4
Occasionally	11	15.7
Regularly	18	25.7
Always	16	22.9
Total	70	100.0

As shown in Table 4, opinion seems to be divided with regards to the significance, and integration of the mission statement in the services and administrative processes of the hospital. 35 participatns, it means 48.6%, believe that an integration of mission statement in the hospital services and administrations are provided always or regularly. In the same time 26 participants, it means 37.2% expressed that the mission statement is sometimes or occasionally evident in the hospital services and administration. From the total of 70 participants, it means 100%, 10 (14,3%) believe that an integration of missionis not evident at all.

Table 5. Cross-tabulation of Church Promotion of Community in Hospital Context

Respondents	The local Adventist church promotes community within the hospital context					Total
	Never	Sometimes	Occasionally	Regularly	Always	
Out-Patient	1	5	3	2	1	12
In –Patient	1	1	3	1	0	6
Part-Time Worker	0	0	3	2	0	5
Full-Time Worker	6	8	12	8	9	43
Casual Worker	1	0	0	1	2	4
Total	9	14	21	14	12	70

Table 5 shows that 12 full-time workers indicated that the local Adventist church occasionally promotes community with the hospital, though 9 full-time workers believe community is promoted always in the hospital. In the same tiem 6 ful-time workers never used to hear about the church promption of community in the hospital. Meanwhile, in-patient and part-time workers seem to suggest almost similar responses from the never promoting community to always promoting community. A little bit different opinion was expressed by the Cousal warkers. Out of 4, three of them said that the local Adventis church promotes community within the hospital context. The out-patient group was also different from other presented groups. Out of 12 participants 5 said that the local Adventist church sometimes promotes community within the hospital context, 3 participants sais occasionally, 2 said, that it is a regular promotion, while for never and always there is one voice fro each.

Table 6. Cross-tabulation of Respondents' Spiritual Awareness of the Hospital

Respondent	Spirituality Awareness					Total
	Obviously not aware	Not aware	not sure	Aware	Obviously aware	
Out-Patient	4	2	3	3	0	12
In-Patient	1	2	1	1	1	6
PartTime Worker	0	1	2	2	0	5
Full Time Worker	9	6	12	14	2	43
Casual Worker	0	0	1	2	1	4
Total	14	11	19	22	4	70

As depicted in Table 6, out-patients and in-patients (N=4 and 2 respectively) expressed obviously not aware or obviously aware, but a roughly equal number (N=5 and 3 respectively) indicated that they were aware or not aware of the hospital's spirituality. Meanwhile, full-time workers were somewhat more likely aware of the spirituality of the hospital.

Quantitative Analysis

Kruskal-Wallis Test.[9]

H_0: There is no difference in spiritual care practices between distributions of treatments across categories of Christ-like approach of communication to patients and staff

[9] Richard M. Heiberger and Burt Holland, *Statistical Analysis and Data Display: An Intermediate Course with Examples in R*, 2nd ed. (New York: Springer, 2015), 590-591.

H_1: There is difference in spiritual care practices between distributions of treatments across categories of Christ-like approach of communication to patients and staff

Assumption. The Kruskal-Wallis non-parametric test is employed when the following assumptions are met as far as the data is concerned:

1. The data to be analyzed (dependent variable) should be ordinal or continues level (spiritual care practices)
2. The data should consist of two or more categories of independent groups (Christ-like approach of communication to patients and staff)
3. Observations are independent of each other

Table 7. Kruskal Wallis Test

	Spiritual purpose statement	Becoming like Jesus	Growing character and identity	Intentional connection	Deliberate learning	Sharing Jesus with others
Kruskal-Wallis H	8.128	12.763	20.698	37.619	15.841	8.470
Df	4	4	4	4	4	4
Asymptotic Sig.	.087	.012	.000	.000	.003	.076

Note. Grouping Variable: Christ-like approach of communications to patients and staff. Source: Fieldwork (2020), P<0.05 significance level

From Table 7, since p (0.087) is greater than the significance level (0.05) for the distribution of spiritual purpose statement and categories of Christ-like approach of communication, therefore, the null hypothesis cannot be rejected. The conclusion,

therefore, is that the distribution of spiritual purpose statement is the same across categories of Christ-like approach of communication to patients and staff.

Also, from the distribution of becoming like Jesus and the categorical groupings, the level of significance (0.05) is greater than the probability value (0.012). Therefore the null hypothesis is rejected with the conclusion that the distribution of becoming like Jesus is not the same across categories of Christ-like approach of communication to patients and staff.

Table 7 again shows that the distributions of growing, character and identity, intentional connection, and deliberate learning have p-values (0.000, 0.000 and 0.003 respectively) less than the significance level (0.05). Therefore, the hypotheses are rejected with a conclusion that there is a difference between treatment categories of Christ-like approach of communication to patients and staff across the three variables.

Moreover, the distribution of sharing Jesus with others and categories of Christ-like approach of communication has a p-value (0.076) greater than the significance level (0.05). Therefore, the null hypothesis cannot be rejected. The conclusion, therefore, is that the distribution of sharing Jesus with others, and treatment categories of Christ-like approach of communication to patients and staff are the same across.

Summary

The exploratory analyses showed that 35.7% respondents are not aware, 27.1 not sure, and 37.1 aware of the spirituality of the hospital. Again, 30% never involved and 21.4% occasionally show the involvement of family in the discipleship process. It was shown that 28.6% always served in the model of Christ's character more than

those who believe patients and staff are never served. Many respondents (N = 26, 37.2%) expressed that the mission statement is always evident or never evident.

The Cross-tabulation showed that most full-time workers, out-patients, in-patient, part-time workers and casual workers indicated that the local Adventist church occasionally promote community with the hospital. Again, Clients and some workers: representing (N=4 and 2 respectively) are not aware or obviously aware (N=5 and 3 respectively), or were aware or not aware of the hospital's spirituality

The qualitative analysis used Kruskal Wallis Test. It was shown from table 7 that the distribution of spiritual purpose statement is the same across categories of Christ-like approach of communication to patients and staff (p value – 0.08 and significance level – 0.05). Also, from the distribution of becoming like Jesus and the categorical groupings, the level of significance (0.05) is greater than the probability value (0.012).

The analysis also concluded that there was difference between treatment categories of Christ-like approach of communication to patients and staff across the three variables; and the distribution of sharing Jesus with others and categories of Christ-like approach of communication had a p-value (0.076) greater than the significance level (0.05).

CHAPTER 5

PROGRAM DEVELOPMENT

The study at this point developed the program in the form of designing an SMP. The chapter had three aspects: preparation, presentation, evaluation, and summary. And futher discussed in the context of the following sub-headings: discussion of chapter four findings, extrapolations from NSM and theories on wellness, developing the SMP template, implementation, and evaluation.

Preparation for Program Development

The preliminary stage of developing the program involved, discussing the findings in chapter four. It also included drawing inferences from health theories, and Nathan's Spiritual Model (NSM) discussed in chapters three and two respectively.

Discussion of Chapter Four Findings

The findings seemed to suggest that there is some awareness concerning spirituality in the Adventist Hospital; although a reasonable cross-section of patients and workers are not benefiting from chaplaincy programs, since they are not aware. It is however important to state that the level of awareness could inform the efficiency and outcomes of the spirituality plans to patients and workers.[1]

[1] Colleen Delaney, "The Spirituality Scale: Development and Psychometric Testing of a Holistic Instrument to Assessing the Human Spiritual Dimension," *Journal of Holistic Nursing* 23, no.

The study also established that there was a shared significance and integration of the mission statement in the services and administrative processes of the hospital. Thus, indicating that the chaplaincy unit and administration need to communicate and implement intentionally its visions and mission by fostering collaboration between all stakeholders, to minimize the level of unawareness.[2]

Again, the findings suggest that the local Adventist church promotes community in the hospital moderately. Whereas this may seem recommendable, it could be a source of concern, giving the number of patients and workers who are responding *always* to the influence of the local church on the hospital.

On another hand, the study shows that more stakeholders are indicating the hospital models Christ's character in the way patients and staff are treated. These extrapolations show that the hospital environment should be able to manage the church influence and Christ's character; and should be reflected in the daily operations of the hospital. Thus, should be done with prudence; to ensure professionalism, or be non-proselytizing.[3]

A non-parametric independent test conducted suggests that the spiritual purpose statement and sharing Jesus with others does not differ from the Christ-like approach of communication in the hospital. The implication could be that the hospital's general and spiritual goals hangs somehow on its purpose in sharing Christ.

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2 (2005): 145, accessed on 4th September, 2020, https://journals.sagepub.com/doi/10.1177/0898010105276180.

[2] Connie R. Curran and Mary K. Totten, "Mission, Strategy, and Stakeholders," *Nursing Economics* 28, no. 2 (April 2010): 116, accessed 19th February, 2021, https://go.gale.com/ps/anonymous?id=GALE%7CA236162696&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=07461739&p=AONE&sw=w nursingeconomics.net, (Gale Academic OneFile

[3] John Gray, "Proselytism and Religious Freedom," *Fides Et Libertas,* ed., Richard Lee Fenn (Hagerstown, MD: Review and Herald, 1999), 7-10

The relevant indicator should be addressing how professional of unprofessional this had been done. Nonetheless, these are the issues the SMP should be addressing.

Again, the non-parametric independent test reveals that Christ-like approach of communication to patients and staff does not reflect being like Jesus. The test also suggested that Christ-like approach of patients and staff does not relect growing character and identity. The same trend was shown for the deliberate learning and intentional connecting and Christ-like approach of communication. These differences suggest that the hospital has been doing enough to communicate or imitate the Christ-like approach; but the results show that this is not seen in the character and identity of the patients and staff.

The Christ-like approach of communications seems not to correspond with the outcomes to patients and workers becoming like Jesus. Thus, as a mission hospital, the chaplaincy unit's plan should focus on approaches that are non-proselytizing, yet reveals the compassionate and loving approach of Christ.[4]

Extrapolations from NSM

This approach by Prophet Nathan as discussed in the biblical foundation, chapter two suggested visitation, presence, prudence, instrument, and administrative outcomes of his ministry to King David and his family. It seems however that excerpts of the NSM could have adverse connections in the outcomes of the fieldwork done in the Adventist Hospital; and thus, inform extrapolations that could create an SMP template for operation at the Adventist Hospital.

[4] Ibid.

From the discussion of the analysis in chapter four, it was shown how the Adventist Hospital has been putting efforts as a missionary institution to administer wholistic health care. The plans of the hospital should be developing programs for the chaplaincy unit.

In the analysis it was established the interplay and dynamism between how to fulfill the mission and vision of the hospital in connection with the influence of the local Adventist church community, building Christ-like character; in the context of utilizing Christ's communication approach; without proselytizing. This enigma was shown in the respondents' intake on the rate of spiritual awareness and the chaplain's plan to ensure professional spiritual care.

However, it seems obvious that skilled visitation or chaplain's rounds, chaplain's presence, chaplain's tools or instruments, chaplain's prudence, and administrative hospitality inform professionalism. The outcome of such ministry was what brought a difference in King David's life; such processes is what this research is testing; hospitality that could ensure wholistic outcomes in the Adventist Hospital in Tamale.

The performance of such processes or Spiritual plans is that the chaplain in the delivery of wholistic health care becomes the fulcrum, functioning to improve patients and workers care, human resource, and sound administration as shown in Laurie J. Mullins' book, *Managing People in the Hospitality Industry*.[5]

[5] Laurie J. Mullins, *Managing People in the Hospitality Industry*, 3rd ed. (England: Addison Wesley Longman Limited, 1998), 10-14.

Extrapolations with Health Theories

Professionally, the chaplain does not work in a vacuum. He is a member of the interdisciplinary team; who work in collaboration to ensure that patients experience wholistic health care delivery.[6] As already discussed in the literature review of this research, some health theories were chosen to form a hinge around this study. The theories drew attention to what the outcome of health delivery should be. Thus, wellness.

Inferences from chapter four established a relationship between patients' families support, hospital environment, and the local Adventist church influence on the wholistic wellness.[7] This is what these theories are indicating: Health belief model pointing to questions of preclusion and detection and how that connects to lifestyle choices.[8] Health lifestyle theory revealing lifestyle choices and its interplay on class, gender, etc. (Cf. social drift theory and social stress theory). [9] Trans-theoretical models address actions, adaptations, and wellness;[10] Social Cognitive theory, learning through personal involvement, observations and effects of learning others' actions; etc.[11]

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[6] Larry VandeCreek, "Professional Chaplaincy: An absent Profession," *Journal of Pastoral Care and Counseling* 53, no. 4 (1999): 417-420, accessed 26th February, 2020, https://journals.sagepub.com/doi/abs/10.1177/002234099905300405

[7] Source: Fieldwork (2020).

[8]Karen Glanz, "Behavioral & Social Sciences Research," accessed 18th February, 2021, https://obssr.od.nih.gov/wp-content/uploads/2016/05/Social-and-Behavioral-Theories.pdf

[9] Cockerham, Health Lifestyle Theory and the Convergence of Agency and Structure, 51.

[10] J. O. Prochase and C. C. Di Clemente, "Transtheoritical Therapy Towards a More Integrative Model of Change," *Psychotherapy Theory, Research and Practice* 19, no. 3 (1982): 276, accessed 2nd March, 2020, http://www.esourceresearch.org/Default.aspx?TabId=734

[11] Albert Bandura, "Social Cognitive Theory," In: *Annals of Child Development, Theories of Child Development, ed.* Rose Vasta (Greenwich, CT: JAI Press ,1989), 1-3

Therefore, to draw an effective health model that will inform wholistic health care, it is essential to consider the behavior of the stakeholders involved, how that affects wellness, and the expected outcomes for the research.

Presentation of Developed Program

Developing the SMP Template

From the above comparisons, theVisitation, Instrument, Presence, Prudence, Administrative-hospitality, and Evaluation (VIPPAE) Model seems to fit as the chaplain's plan for effective ministry. This is represented as follows:

V – Visitation of Chaplain. This visitation should be skilled. It should not be like the usual way of a pastoral visit, since the setting demands professionalism. The chaplain will be trained on how to do visits at the hospital: from how to get into the ward, how to behave with the inter-disciplinary team, what to do during visitation to patients and workers, what times are appropriate for visits, and what are the time tables for routine visits, what are the ways of responding to emergency routines? The anatomy of visitation designed by Masih Basharat, CPSP Diplomat formed the basis for visitation (see Appendix B).

I – Instruments or tools of Chaplain. for effective ministry, then the chaplain must have some knowledge and skills. CARRE adapted from Moses Taiwo, an ACPE Educator could be a basis of the chaplain’s outcomes at the hospital (see Appendix B).[12]

[12] C – Connecting; A – Awareness; R – Resources and support system; R – Referral System; and E – Evaluations

Here, the chaplain is expected to combine active listening, observing boundaries, and referral system to help stakeholders of the hospital. Referral should be highlighted; since the pastor to be trained may not have all that it takes to be a professional in all aspects. That notwithstanding, referral could sometimes communicate professionalism and acknowledgment of vulnerability.[13]

P – Presence of Chaplain. The ministry of presence is a special ministry where chaplains being available to their prospects representing Christ. Just being there, being non-anxious and non-judgmental. Even silence could be a price[14]

P – Prudence of Chaplain. The chaplain should be able to demonstrate wisdom and practicable knowledge in dealing with stakeholders of the hospital. Thus, the hospital environment is a delicate environment, which needs the chaplain to be prudent and professional.

For example, to be sensitive to religion and culture, handling information of patients and workers, respecting boundary and confidentiality, etc. To be prudent also calls for continual learning and reading by the untrained chaplain. In this case, the expectation should be for the pastor or chaplain to receive some training in Clinical Pastoral Education. Conversely the VIPPAE model or upgrading it could serve as substitute [15]

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[13] Giancarlo Lucchetti, Rodrigo M. Bassi, and Alessandra L Granero Luccetti, "Taking Spiritual History in Clinical Practice: A systematic Review of Instruments," *Explore* 9, no. 3 (2013): 159, accessed 4th September, 2020, (https://pubmed.ncbi.nlm.nih.gov/23643371/; Cf. Elisabeth McSherry, "The Need and Appropriateness of Measurement and Research in Chaplaincy: Criticalness for Patient Care and Chaplain Department Survival Post 1987," *Journal of Health Care Chaplaincy* 1, no. 1 (1987): 3-42, accessed 4th September, 2020, https://pubmed.ncbi.nlm.nih.gov/10285015/

[14] Paget and McCormack, *The Work of the Chaplain,* 2-12.

[15] Fenn, Fides Et Libertas, 7-9.

A – Administrative Hospitality. as a representative of God, the untrained chaplain should be able to fit into the administrative model of the hospital, coordinating the spirituality of the hospital as it involves the management, workers, patients, and patients' family to inform wholistic healthcare practices. Thus, the untrained chaplain should have some skills that will enable him to adjust to the interdisciplinary team.[16]

E – Evaluation. The evaluation of self and ministry is relevant for efficacy in the work of the Chaplain in the Adventist Hospital. Here, the use of Verbatim and weekly clinical Assessment should be incorporated in the practices of the chaplain (see Appendix B). The chaplain should have a connection to other resources that could help him evaluate his work and sometimes debrief him to avoid burnouts.

Program Implementation

The SMP template was implemented at the female ward for two years; where the chaplain scheduled weekly routines to the Adventist Hospital. During these times the chaplain worked with a few of the units of the hospital: female ward, male ward, children ward, maternity ward, pharmacy department, accounts department, and psychiatric unit.

Twice a week and occasionally throughout the week, the chaplain had scheduled visitations to the hospital. Most interactions were with patients, workers, untrained chaplain, and management. There were times emergency calls were made to attend to patients needs. There was a weekly clinical report form used and reported to a Supervisor (Basharat Masih, PhD, CPSP Diplomat); and monthly verbatim presentation with intern chaplains who were under training via online (Zoom) from

[16] VandeCreek and Burton, "Professional Chaplaincy: Its Roles and Importance in Health Care," 81

2018 to 2019 as evaluation of intern chaplain's ministry to the Adventist Hospital in Tamale.

Program Evaluation

The study at this section considered the post-implementation data description and evaluation; where there was a final evaluation. The post-implementation questionnaires were given to fifteen workers whose responses were analyzed and discussed reference to wholistic healthcare using regression and paired sampled t-test analyses.

Analysis of SMP: Post-Implementation

Regression Analysis.

H_0: There is no relationship between the Spiritual Master Plan and Wholistic Healthcare

H_1: There is a relationship between the Spiritual Master Plan and Wholistic Healthcare

Table 8. *Regression Analysis of SMP and Wholistic Healthcare*

		Wholistic Healthcare	Spiritual Master Plan
Pearson Correlation	Wholistic Healthcare	1.000	.519
	Spiritual Master Plan	.519	1.000
Sig. (1-tailed)	Wholistic Healthcare	.	.024
	Spiritual Master Plan	.024	.
N	Wholistic Healthcare	15	15
	Spiritual Master Plan	15	15

$p<0.05$

The direction of the relationship is moderately, positively correlated. Meaning that SMP and wholistic healthcare tend to increase together. Thus, wholistic healthcare is associated with SMP. The magnitude of the relationship is approximately moderate between $0.3< r <0.6$.

Table 9. Analysis of Variance for SMP and Wholistic Healthcare

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	12.333	1	12.333	4.800	.047[b]
	Residual	33.400	13	2.569		
	Total	45.733	14			

Source: Fieldwork (2020), $p<0.05$

SMP and wholistic healthcare have a statistically significant linear relationship ($F_{14}=4.8$, $p<0.05$). Therefore, the null hypothesis could be rejected with the conclusion that SMP is significantly associated with Wholistic Healthcare.

The essence of the Health Belief Theory becomes relevant in guiding healthcare chaplaincy in operating with the SMP and Wholistic Healthcare to provide services that could assist the system and patients in choices, detections, and preventions.[17]

Table 10. Model Summary for SMP and Wholistic Healthcare

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.519[a]	.270	.214	1.60288

$p<0.05$

[17] Karen Glanz, "e-Source: (Behavioral & Social Sciences Research," (accessed 18th February, 2021, https://obssr.od.nih.gov/wp-content/uploads/2016/05/Social-and-Behavioral-Theories.pdf

The adjusted R-squared (21.4%) of the variability in Wholistic Healthcare could be counted for by SMP.

Table 11. Coefficient of Variation

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	13.800	3.071		4.494	.001	7.166	20.434
Spiritual Master Plan	.500	.228	.519	2.191	.047	.007	.993

$p<0.05$

The model is statistically significant ($p<0.05$) with the least square regression line given by: $\hat{y} = \alpha + \beta x = 13.8 + 0.5x$, where α (13.8) is the estimated Wholistic Healthcare constant value when there is no SMP (x=0) implementation. Therefore, Wholistic Healthcare becomes stagnant when there is no Spiritual Master Plan (95% CI [7.166, 20434]). B (0.5) is the slope of, and a change in Wholistic Healthcare for a unit change in SMP (95% CI [0.007, 0.993]). As SMP is increased by a unit change, Wholistic Healthcare also increases. The correlation between Wholistic Healthcare and SMP is positive, therefore as SMP is being developed and upgraded over time, the impact on Wholistic Healthcare and Chaplaincy professionalism also increases:

This in practice has inference for the health theories reviewed under the theoretical framework. The Trans-theoretical Model points to the fact that people's behavior that change over time could affect wellness. Consequently, this is what the analysis above is indicating. As the behavior of the stakeholders in the Adventist Hospital adapts to informed and researched practices, the tendency for efficiency

could be detected. This could move from the personal to the environmental level and proposed by Bandura to affect behavior that encourages wellness.[18]

Paired Sampled t-Test Analysis.

H_0: There is no significant difference in SPM 1 mean and SMP 2 mean, $U_1 = U_2$

H_1: There is a significant difference in SPM 1 mean and SMP 2 mean, $U_1 \neq U_2$,

Assumption.

4. The data should be normally distributed
5. The variables must be dependent and continuous

Normality Assumption.

Table 12. Normal Distribution of Mean Difference in SMP1 and SMP2

		Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	Df	Sig.	Statistic	Df	Sig.
SMP Difference	Mean	.136	15	.200*	.942	15	.404

p<0.05

As shown in Table 12, the two p-values are greater than the significance level 0.05 representing that the spreading of the data is not significantly different from the normal distribution. Thus, it could be assumed that the normality assumption model fit the data.

[18] Karen Glanz, "e-Source: (Behavioral & Social Sciences Research," (accessed 18th February, 2021, https://obssr.od.nih.gov/wp-content/uploads/2016/05/Social-and-Behavioral-Theories.pdf. *Cf.* Bandura, *Social Cognitive Theory*, 1-4.

Dependency assumption.

Table 13. Sampled Correlations of SMP1 and SMP2

		N	Correlation	Sig.
Pair	SMP 1 and SMP 2	15	0.446	0.006

$p<0.05$

Table 13 depicted that there is a moderately and positively correlation between SMP 1 and SMP 2 ($r = 0.446$, $p<0.05$). However, the model is fitted. As observed in Table 15, there was a significant average difference between SMP 1 and SMP 2 ($t_{14} = -6.3$, $p<0.05$). On average, SMP 1 (-1.08 mean) was less effective than SMP 2 (95% CI [-1.45, -0.71]). This shows that the Spiritual Master

Table 14. Paired Sampled Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair	SMP 1	3.36667	15	.632926	.163421
	SMP 2	4.4444	15	.62573	.16156

$p<0.05$

Plan after the study was more effective as compared to the Spiritual Master plan before the study; especially when inferring from the General Management Theory, where the chaplain in the management system of the hospital becomes the agent of hospitality to patients and stakeholders of the hospital.[19]

[19] Mullins, *Managing People in the Hospitality Industry*, 10-14.

Table 15. Paired Sampled Test

Pair 1	Paired Differences					T	Df	Sig. (2-tailed)
	Mean	Std. D	Std. Error Mean	95% CI				
				Lower	Upper			
SMP 1 SMP 2	-1.077778	.662537	.171066	-1.444678	-.710877	-6.300	14	.000

Source: Fieldwork (2020), $p<0.05$

Evaluation Outcomes

1. The post-implementation analyses and findings suggest that both Wholistic Healthcare and SMP are greatly and significantly associated.
2. It also suggests that the correlation between Wholistic Healthcare and SMP is positive; thus, as SMP is being developed and upgraded over time, the impact on Wholistic Healthcare and Chaplaincy professionalism also upsurges.
3. The study also revealed that the Spiritual Master Plan after the study was more effective as compared to the Spiritual Master Plan before the study.

Indicators for the Training

The Appendix B shows this outline.

1. Training to be done using the material the Anatomy of Visitation by Basharat Masih, PhD.
2. Training on the Ministry of Presence will be done using the Material by Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain.*
3. The instrument to be used for the Training will be CARRE – Connecting, Awareness, Resources, Referral System, and Evaluation. The Chaplain of the Adventist Hospital will be trained on how to use this tool.

4. The knowledge base of the chaplain about the work environment of the hospital and patients will be explored. For example, lessons on cultural studies, confidentiality and boundary, inter-disciplinary team, patient care, and mental health will be taught.
5. The chaplain will also be given training on his roles and how that helps the management.
6. The chaplain will also be taught how to do self and patient evaluation using Verbatim and weekly clinical reporting forms.

Summary

The study reviewed and discussed the analysis done in chapter four, corresponded that to the NSM in the biblical foundation, and the health theories on wellness in chapter three, Literature Review, to design an SMP Template. This became a basis for the implementation of the template, questionnaires analyzed and re-adapted, which became the basis for the training of the pastor who provides spiritual care to the Adventist Hospital in Tamale.

CHAPTER 6

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Project Summary

The research used the quantitative approach using exploratory research to review the spiritual care practices; non-parametric independent test together with the NSM and the health theories on wellness were used to design the SMP for the Tamale Adventist Hospital. The first set of Questionnaires were given to 70 respondents comprising of both workers and patients.

The study shows 14.3% less than those who were aware of the spirituality programs of the hospital. 30 per cent of the responses indicate that families are never involved more than families are always involved in the discipleship process of the hospital (median=2, IQR=2). Many respondents (N = 26, 37.2%) expressed that the mission statement is always evident or never evident (median = 3, IQR = 3). The distribution of sharing Jesus with others and treatment categories of Christ-like approach of communication to patients and staff is the same across. The null hypothesis is rejected with the conclusion that the distribution of becoming like Jesus is not the same across categories of Christ-like approach of communication to patients and staff.

The NSM from the Biblical and Theological foundation and the Health Theories on wellness was inferred to develop an SMP to be implemented by the intern chaplain. After which there were a post-implementation analysis and evaluation using

regression analysis and paired sampled t-test analysis as tools. Thus, the magnitude of the relationship ($0.3< r <0.6.$) and significant relationship ($F_{14}=4.8$, $p<0.05$) between wholistic healthcare and the SMP was evident. Wholistic Healthcare becomes stagnant when there is no Spiritual Master Plan (95% CI [7.166, 20434]). B (0.5) is the slope of, and a change in Wholistic Healthcare for a unit change in SMP (95% CI [0.007, 0.993]).

After analyzing data gathered from the 15 workers, as shown above, it was revealed that the Spiritual Master Plan after the study was more effective as compared to the Spiritual Master Plan before the study; indicating good performance based on the General Management Theory.

Conclusion

The study was focused on assessing the SMP of the Adventist Hospital and to develop, implement a new SMP from NSM and some Health theories on wellness. This was to be a basis to train the pastor who has been designated as chaplain from North Ghana Mission. Post-implementation evaluation of the SMP developed suggested that the SMP was more effective compared to the previous health care provision. Thus, the implemented SMP could be a resource to guide this chaplain in his duties in the Adventist Hospital in Tamale. That notwithstanding the study also emphasized the importance of upgrading this developed SMP.

Recommendations

The study, therefore, wants to make these recommendations to improve healthcare practices in the Adventist Hospital in Tamale.

1. That the Adventist Hospital seeks to improve the professionalism of the untrained chaplain to ensure efficiency in the provision of spiritual care by the

chaplaincy unit adapting the outcomes of this research as a basis for transformation in healthcare chaplaincy.

2. Again, as a basis, the Ghana Adventist Health Service should seek to ensure professional healthcare chaplaincy (perhaps a full-time where practical), by either training its chaplains in CPE, which is rare in Africa. Conversely, outcomes of this research and other related studies could be adapted to restructure healthcare chaplaincy; and used as training tools to guide chaplains in GAHS.
3. Finally, in the case of adapting outcomes such as this study, there should be the constant effort by stakeholders to ensure further studies that inform trends and growth in chaplaincy in GAHS; especially as it reflects initiations that give a tweak to CPE as an urgent demand to cause a revolution in healthcare chaplaincy in Ghana.

APPENDIXES

APPENDIX A

ETHICAL CLEARANCE FORM

ETHICAL CLEARANCE FORM

I, YAKUBU ISHMAEL HAKIM, a student of the AUA Master of Chaplaincy Program, do hereby ask permission to go ahead with my research, with the full intention of collecting data in an ethical manner, without harm of any kind to those who will give me information.

Title of the project: THE IMPACT OF CHAPLAINCY ON HOLISTIC HEALTHCARE IN TAMALE SEVENTH-DAY ADVENTIST HOSPITAL

Place where the project will be carried out: SDA HOSPITAL, TAMALE

I agree to obtain the informed consent of the persons whom I will interview or survey. I will avoid causing any harm to these subjects. I also agree to maintain the confidentiality of those interviewed/surveyed. Finally, the information gathered will be used exclusively for my project.

Signature of the student — Date: 15/10/18

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Permission has been _____ granted _____ denied.

Signature — Date: 15TH OCTOBER 2018

PR K. E. AMOUZOU
HEAD OF FACILITY
SDA HOSPITAL
BOX 250 TAMALE

Position

APPENDIX B

PROGRAM IMPLEMENTATION INSTRUMENT

Anatomy of Visitation

Basharat Masih proposes Six-level Strategy of visitation as follows: Introductory level, Connecting level, Conversational level, Assessment level, Therapeutic level, Conclusion level.

Introductory level: the first contact is at the door, knock the door; followed by presenting oneself into person's clear view; introduction of yourself; your name and who do you represent; seek permission for the visit; and watch out the clues of welcoming or not welcoming dynamics, gently moving inside the room.

Connecting Level: It is a "make-it or break-it junction"; It is the body language as well as the words of welcome; a welcoming indication is the first connecting point; your second introduction/ you are a partner of healing team; make known the religious service available; beware that the patient is still checking you out; next move/ may I sit down and speak to you?

Conversational Stage: This level is where the essence of the visit takes place; respect patient's privacy; allow the patient to set the agenda and help the person to trust you; be flexible; watch the clues about what is important to the person; gently guide the person into those areas to open up to your ministry; let the person tell the story of his/her crisis. Allow the person to maneuver the topic

Assessment Level: Assessment level and Conversation level go together; clarify the issues and relevant factors; discover patient's core concerns (primary concerns); that significant changes have occurred in person's mental, physical,

spiritual, and social life? How a person's intentions, resources of vitality, support and faith are employed? Listen to the person's story of crisis (active listening).

Therapeutic Level: Not every visit requires therapy. The therapeutic level begins when a patient does or says something significant offering himself or herself for your ministry. Cautions and boundaries must be closely watched. The chaplain must ensure the patient is not manipulated emotionally, spiritually, or relationally. Chaplains own agenda must be kept aside. Patient's energy level must be watched. Your limitation needs to be watched (and refer). The chaplain has several direct therapeutic interventions: logotherapy/conversation medicine, Scripture reading, prayer, Holy Communion, anointing, touch ministry.

Conclusion of Termination of Visit: Stay connected. Conclusion of your visit is as important as the beginning. Watch out for a natural conclusion (parking pause). Do not cut the patient off. The guiding words here are to close the visit cleanly and clearly. Indicate your intention to depart/ ask permission to depart. A word of prayer as a benediction is appropriate. Keep the chair back to its place and quietly walk out, leaving the door as you found it (or asking how the patient wants it left). Inform family as well as his/her nurse that you are leaving. Do not promise a follow-up visit but if you do, keep your promise. A referral is appropriate if a follow-up visit is needed.

CARRE Assessment Model

Adapted from Moses Taiwo, PhD, ACPE Educator

C - Connect

A – Awareness

R – Resources Available

R – Referral system

E – Evaluations

Verbatim/ CRE Face Sheet Format

AUA/BU CHAP 669, CPE UNIT #1

YOUR ENCOUNTER WITH THE PERSON YOU MEET

CLINICAL SITE: *SADA Hospital*	**Age:** *unknown*
PERSON'S NAME I INTERVIEWED: *Kalf*	**Sex:** *Male*
CHAPLAIN: *Yakubu Ishmael Hakim*	**Marital Status:** *Single*
Date of Visit: 29th August 2018.	**Children:** *One*
Place Visited: *MDS*	

RELIGIOUS PREFERENCE: Christian

OBSERVATION: the patient looks lean; with bandages on the left leg. He had rapped the hospital bed sheet on his body; he was gazing intently at me as I stepped closer to him. The environment around his bed was disorganized and a little discomforting smell. This patient never had absolute privacy since there were about six beds with sick persons, and four nurses at the end of the ward.

ADDITIONAL FACTUAL INFORMATION: no additional factual information.

PERSON'S PRIMARY CONCERN(s): the patient's primary concern was money to pay bills to be discharged after a skin graft (treating him for an un-healing sore); also anticipating total healing this time.

CHAPLAIN'S RESPONSE: through a ministry of presence, non-anxious, and non-judgmental, I responded to his nostalgic desire to be discharged; issues related to his inability to afford such expenses; and also, his health concerns.

SUPERVISOR: Basharat Masih, PhD

The Visit/ Verbatim.

DATE OF VISIT: 29/08/2018 TIME OF VISIT: 10:30am DURATION OF VISIT: 43minutes

C – Chaplain S – Patient B – Brother

Verbatim	Chaplain's Thoughts & Feelings
C 1: Hello, Good afternoon Sir (I was moving the other sick person towards him)	When I saw that he had lost so much weight I was imaging that his condition would be critical
S 1: Good afternoon (he responded with an open smile while looking intently at me)	I felt welcomed and was hoping to have a good visit.
C 2: I am Chaplain Ishmael and part of the healing team. Just like the doctors and nurses take care of you, I also have a role to play to help you in the healing process	I was explaining myself so that he will know exactly who I am and what roles I played.
S 2: Ok, you are welcomed	I felt that was the time to initiate a talking relationship.
C 3: can I seat down? (there was a chair closer to me; at this point, I could sense a strange smell, not from the sore but his body and clothes)	I felt discomfort at the smell, I thought that I had committed myself and needed to be professional
S 3: yes (he said that joyfully)	I was determined not to let my non-verbal communication disrupt my visit with regards to the scent.
C 4: How are you today?	I thought of knowing how his health was.
S 4: As for today I am fine, I thank God. (his facial expressions seem to suggest	I felt good to know that the patient sounded hopeful

that he was happy about the progress of his health)	
C 5: ok, thank God, so what was the problem that brought you to the hospital?	I wanted to know what his medical condition was
S 5: the doctor did skin grafting for me, I have this sore on my leg and for a long time I have treated it but it doesn't heal. I went to the Tamale Teaching Hospital (TTH), but the doctor brought me here to do the operation for me.	I was wondering what skin grafting was, but I thank God his actions gave me an idea of what he meant
C 6: wow, ok (while listening)	Was thinking of the next question to ask
S 6: anytime I went the TTH they will just treat me small and I go back home because there was no money. But this time the doctor decided that there he will not discharge me so that it will force my relatives to look for money to cure me. The amount of the surgical operation was GHC 2,500.00. we got GHC 2,000.00 for him so he was bought the items for the surgery when state doctors went on strike, so he decided to bring me to the Tamale SDA Hospital which is private	I was confused as to whether to address his surgical operation or to gear the conversation towards his financial problem. I was thinking that the way he had grown lean, he would have been more concern first about how bad his health was. That got me confused. But eventually, I settled on addressing his surgical operation.
C 7: Wow, so how do you feel after the surgical operation?	
S 7: I am fine. The only place paining me is my thigh where the doctor cut to mend the sore	At this point, I now knew exactly what his primary concern was
C 8: Oh ok, so the sore does not pain any longer except where the doctor cut?	I now realized that he was responding well to treatment except that he had to pay his balance before his discharge
S 8: Yes. (a young man comes in and seats at the other side)	I was wondering who that person was, but I could guess from the way he sat down conveniently that he should be related to the patient

C 9: oh ok, that God your health is improving, so how do you intend to raise the balance of GHC 500.00.	I wish I had money to donate. I also felt like if am not able to do something to help this man then my ministry will not be effective. I was also asking myself if I could do that for every patient who needed financial assistance.
S 9:Hmm! there is no money, my brothers in Accra are those who struggle to raise the GHC 2000. 00; my mother and father are helpless. Sometimes I am even ashamed when I ask them for money because for six years I have been struggling with this sore and I stopped working.	I could sense his helplessness
C 10: I am sorry about that, apart from the family are there any other places you feel you could get help; like your church?	Felt like exploring all avenues to help them look for the help he needed
S 10: yes, the church has been helpful, for all these six years they have been making contributions to help me when I came to the hospital. My pastor is always encouraging me. I told the pastor and he said they will be looking at what to do.	I could feel his helplessness
C 11: ok, while you are looking for all these avenues, I will check whether the hospital has social work services.	Was just hoping such services may be available to help the patient
S11: thank God (Hopeful and laughing). I knew God will answer my prayers (then he pulls prayer paper full of quotations written by him, then he read some – Matth. 11:28; James 5:)	I felt like he sensing that the social work services mentioned suggest that he was going to get help and that I have been a savior.
B 1: what is the social work service?	
C 12: they address situations like you are going through and to look at all avenues to help do away with stress that may even cause the sickness to be worse (so I asked to confirm the	I know confirmed that he was a relative I also thought of using his prayer list to encourage him

identity of that man and I was told they were related, then I shift to the Sick again)	
C 13: my brother God is still in control; he carries our burdens and he cares so much about us. I am happy that you have not given up.	I now wanted to know how his health had affected his life
S 12: thank you	
C 14: how has your health for these six years affected your life in general?	I was going to round up when this came into mind.
S 13: I impregnated a woman and saw a family marry her, so I saved GHC 300.00 when the sore started so I used the money to treat myself. The woman could not wait for me and has married another man. I also lost my job and since then I have not been working. I sometimes feel ashamed when asking for money from my parents.	I feel sad for him
C 15: (was silent for some seconds) I am sorry about all that you have gone through (I did encourage him)	I felt this man needed hope ones again and God should grant him one
C16: are there any other concerns you may want to share?	Wanted to close the visit
S 14: Pray for me	
C 17: what would you want me to pray about? (He asks me to pray for his health and what we discussed)	
Prayer: our father in heaven, want to thank you for the life of my brother, and his family, I pray that you will specially visit him to grant him healing. I also want to pray that if it is your will you will provide funds for him to pay his balance for the operation in Jesus name Amen!	
C 18: may I have the permission to leave? (then I left after permission was given, I also promised to visit again.)	

ANALYSIS OF VISIT

THEOLOGICAL CONCERNS:

The patient seems connected to God and his faith community. He still trusts that God was in control and will provide money for him; though the situation seemed helpless. It appears the sickness has caused burnout in him; that notwithstanding he appears joyful and hopeful about life. On a different basis, there are times he feels ashamed of his predicament. That he has become a burden to others. He was also hopeful that his interaction with me was God sent. That is giving him hope that God had not just sent me to encourage him but to lead away for his financial problems.

PSYCHOLOGICAL CONCERNS:

The patient generally seemed stable emotionally. He feels the desire to resume a sense of purposefulness and responsibility rather than being dependent. He has also experienced some losses due to the six years crisis. The results of this are the occasional feeling of worthlessness and ashamed of himself and life. That notwithstanding, he seems to have a deeper trust that God is controlling his life situation

SOCIOLOGICAL CONCERNS:

He has lost touch with society on one level: in terms of friends, employment, would-be wife, family, etc. However, on another end, he seems strong and connected to the church social group and God. He connected well with me. Maybe his major challenge will be the issue of how sometimes he feels ashamed his over-dependence on others.

INTERN CHAPLAIN'S ANALYSIS

The first phenomenon that struck me was the nostalgic desire to have an encounter with this patient; yet on a different end I had to balance between the reality and being professional: As soon as I sensed the smelling environment of my client, my challenge was how to offer a non-judgmental, non-anxious, empathic listening. Up to now, I am torn between the fact that I was pretending under the veil of being professional. Why did I have to spend all those minutes there instead of visiting a short one? I think that Jesus would have done what I did. The patient needed my presence and I think that God gave me the strength to be professional.

I chose this visit because it reminds me of being professional in my line of duty. It also reminds me of the duty to be there for the helpless. I also think that it reminds me of the need to be sensitive to draw the boundaries where necessary.

THEOLOGICAL REFLECTION:

I think that this person's sense of courage and trust for God spoke loudly to me. Such a condition and no money to pay bills yet were still strong. This reminds me of the Great Controversy and how God expects us to trust him even amid trials and afflictions. I wonder what I would have done if I were in the situation of this man. How will I feel if at a stage of my life I have to be dependent on others?

I choose this conversation because it teaches me the reality of sin and how we need to trust and serve God no matter the circumstance. I find solace in 1 Corinthians 15:51-54. That Jesus should come soon so that all these troubles will pass by. Where there will no more pain or segregations.

PASTORAL OPPORTUNITIES:

I was hoping to meet with this patient again so that I could see the possible avenues to explore to help him get out of the hospital; more importantly, to encourage and be with him in all these troubles he is facing. I also hope to meet with the hospital leadership to consider what the hospital could do in such cases

Sample Clinical Weekly Report

AUA/BU CHAP 699 CPE PROGRAM
WEEKLY CLINICAL EXPERIENCE REPORT (Due on every Friday)

(1) Your Name: YAKUBU ISHMAEL HAKIM

(2) Reporting on Friday: Date: 4/10/2019

(3) Name and address of your Clinical Sites: SDA HOSPITAL, TAMALE

(4) Phone number of your Clinical Site: +23350

(5) Name of the person/administrator of your clinical site who has authorized you to do clinical work: GEORGE AMOUZOU

Date	Clinical hrs/ From __to __	Total hours	Comments if any
	9:00 – 12:00pm	3	
	9:00 – 11:00/1:00 – 4:00	5	
	10:00 – 12:00/2:00 – 5:00	5	
	12:00 – 4:00pm	4 hours	
	11:00 – 12:00pm	1	
	1:00 – 3:00pm	3	

Total Clinical hours of the week are: 21 For the Month: SEPT Grand Total 80+10=90+1=

Your Signature [signature] Date: 07/10/19

Name of your Clinical site supervisor Tinya Elizabeth Signature [signature] Date 07/10/19

Seminar Outline

1. General understanding of Healthcare Chaplaincy

    History of Chaplaincy

    Understanding the Healthcare Environment

    The Roles of the Healthcare Chaplain

2. Primary Routines of a Chaplain

    V – Visitation

    I – Instruments

    P – Presence

    P – Prudence

    A – Administrative Hospitality

    E – Evaluations

3. Understanding Active Listening

4. Boundary and confidentiality

5. Understanding the patients

    Patient psychology

    Mental Health

6. Doing and Creating a Referral System

APPENDIX C

QUESTIONNAIRES

Questionnaire 1

QUESTIONNAIRE TO REVIEW WHOLISTIC HEALTHCARE

AND SPIRITUAL CARE PLAN OF THE

TAMALE SEVENTH-DAY ADVENTIST HOSPITAL

The objective of this questionnaire is to review wholistic healthcare and spiritual care plan in the context of drawing a Spiritual Master Plan for the Tamale Adventist Hospital. It will be highly appreciated if you could take some time to complete it. Your answers will be treated as confidential.

Thank you.

We invite you to consider where the hospital is and where it should be in the context of the following questions; by ticking [√] your preferred option in the scale of 1-5

Section A: Where Are We? Spiritual Purpose Statement [√]

	1	**2**	**3**	**4**	**5**
1.Your awareness of the hospital's spiritual goals when it comes to the staff, patients, and their families					
2. Knowledge of what strengthens the aspirations of the hospital					

3. Any Bible Verse that helps direct the hospital's spirituality					

Section B: Abundant Discipling: Becoming Like Jesus [√]

	1	**2**	**3**	**4**	**5**
4. Faith talk happens in the hospital community					
5. Faith talks happen through Staff sharing with staff					
6. Faith talks happen through Staff sharing with patients					
7. Faith talks happen through Patients sharing with patients					
8. Faith talks happen through Patients sharing with staff					
9. Faith talks happen through chaplain/pastor sharing with all					
10. Faith talks happen through guest pastors/chaplains					
11. The hospital collaborates with the church to disciple the hospital environment?					
12. Worship periods are more relevant for patients and staff					
13. Families are involved in the discipleship process					
14. Patients and staff are intentionally invited to be disciples of Jesus?					
15. Your walk with Jesus at the moment is okay					
16. You spirituality could grow to help you disciple others					
17. You Value Love, Selflessness, Kindness, Joy, Integrity					

Section C: Bold Godliness: Growing Character and Identity [√]

	1	**2**	**3**	**4**	**5**
18. Patients, staff and non-staff are given opportunities to make the right choices in the hospital.					

19. Patients, staff, and non-staff are given opportunities to fail —and learn from their failures.					
20. Opportunities should be given to patients, staff, and their families to form and shape their identities as children of God and to develop their unique spiritual needs?					
21. It is necessary to demonstrate a redemptive approach to Discipline.					
22. Intrinsic values form the foundation for motivation.					
23. Extrinsic values form the foundation for motivation.					
24. Model Christ's character in the way we treat patients and staff is important					
25. Cherished values: Love, Wisdom, Kindness, Justice, Respect, Discernment, Responsibility, Tenacity					

Section D: Intentional Connecting: Building Community [√]

	1	2	3	4	5
26. Your contribution to community amongst the staff and patient is relevant.					
27. Building community among the patients and staff is important.					
28. Reaching out to the patients and staff in meaningful ways that involve them in hospital life should communicate a Christ-like approach.					
29. Patients and staff are encouraged to lead out in building community in the hospital.					
30. Patients and staff families are involved in building community in the hospital.					
31. It is important to encourage patient and staff to take ownership of the community the supports the hospital's vision.					
32. The local Adventist church promotes community within the hospital context.					
33. Values: Respect, Teamwork, Caring, Patience, Forgiveness					

Section E: Deliberate Learning: Seeking Wisdom through a Biblical Lens [√]

	1	2	3	4	5
34. Skills of workers reflect Christ.					
35. The hospital is mindful of the great controversy.					
36. This is evident in the services and interactions with patients, staff, and their families.					
37. Patients are pointed to search the Bible for answers in the Services of the hospital.					
38. If not is there a need to involve the Chaplain?					
39. There is physical evidence of the hospital being distinctively Adventist.					
40. The mission statement is evident and integrated into the services, administration, and assessment of the hospital					
41. Thinking, Quality, Innovation, Creativity, Commitment, Resolve, Courage, Responsibility, Focus, Teamwork					

Section F: Extravagant Outreach: Sharing Jesus with Others

	1	2	3	4	5
42. The hospital community reflects Christ?					
43. The hospital's reputation in the local community is okay.					
44. The hospital fulfills its mission in the services and activities it provides the global community.					
45. The hospital should share the distinctive Seventh-day Adventist message with the global community?					
46. Service, Responsibility, Teamwork, Boldness, Respect					

Section G: Respondent Information [√]

47. Gender: Male [] Female []

48. Age: Under 18 [] 18-30 [] 31-40 [] 41-60[] Over 60 []

49. Identity: Patient [] Part-time worker [] Full-Time worker [] Casual worker []

50. If worker Rank: Junior Staff [] Senior Staff [] Administration []

51. Resident: In-Tamale [] Out-of-Tamale [] Out-of-Northern Region []

52. Faith Community: SDA [] None SDA [] Muslim [] Asian Religion []

QUESTIONNAIRE EVALUATING THE WORK OF THE CHAPLAIN TO INFORM THE INFLUENCE OF WHOLISTIC HEALTHCARE IN THE ADVENTIST HOSPITAL IN TAMALE

The objective of this questionnaire is to evaluate the work and spiritual plan of the chaplain in the female/male wards of the hospital and how that influence wholistic healthcare. Kindly take some time to complete this form. Your answers will be treated as confidential. Thank you

Kindly respond to the questions by ticking [√] your preferred option in the scale of 1-5

VISITATION MINISTRY	
1.The chaplain during his duties served to represent God during visits in the ward.	1 2 3 4 5
2. The visit of the chaplain was relevant to the spirituality of patients and workers.	1 2 3 4 5
IMPACT ON WHOLISTIC HEALTH CARE	
3. Chaplain was involved in the general purpose of the hospital	1 2 3 4 5

4. The visit of the chaplain to the wards was helpful to the administration.	1 2 3 4 5
5.The chaplain was sensitive to patient primary needs	1 2 3 4 5
6. Rate the support of the chaplain to the organization in the female ward?	1 2 3 4 5
7. Generally the chaplain was an agent of hospitality to workers and patients	1 2 3 4 5
8. The chaplain served as a liaison between workers and patients	1 2 3 4 5
9. The importance of spirituality to wholistic healthcare was evident.	1 2 3 4 5
PRUDENCE DURING VISITATIONS	
10. The chaplain was practical in dealing with workers and patients in the ward	1 2 3 4 5
11. The Chaplain did not hesitate to introduce his faith to patients and workers.	1 2 3 4 5
12. The chaplain was hesitant to share his faith with workers and patients.	1 2 3 4 5
13. The chaplain's duties sought to represent learning outcomes from biblical lens	1 2 3 4 5
14. The chaplain respected the patients' autonomy.	1 2 3 4 5
ASSESSING INSTRUMENTS DURING VISITS	
15. The listening skills of the chaplain was relevant during rounds to patients	1 2 3 4 5
16. The referral skills of the chaplain was relevant during rounds to patients	1 2 3 4 5
17. The presence to patients and workers was relevant during rounds.	1 2 3 4 5
SPIRITUAL MASTER PLAN	
18. The chaplain's routines to the hospital were a vital component to patients and workers.	1 2 3 4 5
19. The Chaplain's plans and duties to the ward and to provide spiritual care was helpful	1 2 3 4 5
20. Chaplain's plans indicate collaboration in the inter-disciplinary team during visits	1 2 3 4 5

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