

Gap Analysis of Spiritual Education Provision for Hospitalized Patients: Integrating Health Promotion in Hospital Settings

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ARTICLE INFO	ABSTRACT
<p>Manuscript Received: 30 Oct, 2025 Revised: 01 Jan, 2026 Accepted: 05 Jan, 2026 Date of Publication: 03 Mar, 2026 Volume: 9 Issue: 3 DOI: 10.56338/mppki.v9i3.9048</p>	<p>Introduction: Spiritual health is an important component of holistic healthcare that influences clinical outcomes and patient recovery processes. In the PRECEDE–PROCEED health promotion model, the fulfillment of spiritual needs is influenced by predisposing, facilitating, and reinforcing factors. There is still a significant gap between patients' spiritual needs and the services provided, especially in relation to worship guidance and strengthening relationships with God during treatment. To analyze the discrepancy between expected and provided spiritual education interventions for inpatients through the lens of health promotion.</p> <p>Methods: We conducted a quantitative descriptive study in a private hospital in Kendari City in June–July 2025. The participants were 76 inpatients (aged ≥ 18 years with a minimum stay of 2 days) and 15 nurses (clinical experience ≥ 6 months), who were recruited through purposive sampling. Data collection used a validated structured questionnaire with acceptable internal consistency (Cronbach's Alpha ≥ 0.70). Descriptive analysis was performed using jamovi software, while the gap between expected and provided education was analyzed through percentage comparisons and unmet need ratio calculations.</p> <p>Results: A significant discrepancy was found between patients' expectations of spiritual education and nursing practices. Only 9.2% of patients received education on strengthening spiritual connections, while 31.5% reported needing this support. Guidance on adjusting worship practices was provided to only 3.4% of patients, even though 12.7% expressed this need. Interestingly, 67.1% of patients continued their worship during illness, yet 88.2% of nurses did not offer guidance on worship adjustments. Conversely, over 85.5% of nurses provided education on patience, while only 29.8% of patients needed it. Major barriers included sensitivity to spiritual topics, limited time, and inadequate spiritual knowledge.</p> <p>Conclusion: The significant gap between expectations and services indicates systemic weaknesses in competency, support, and care orientation. Comprehensive and multilevel interventions are essential to ensure the accommodation of spiritual care in nursing services.</p>
<p>KEYWORDS</p> <p>Spiritual Care; Spiritual Education; Gap Analysis; Health Promotion</p>	

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INTRODUCTION

Spiritual health represents an integral dimension of holistic healthcare delivery that exerts profound influence on patient recovery trajectories (1). Empirical evidence demonstrates that adequate spiritual needs fulfillment enhances quality of life outcomes, expedites recovery processes, and attenuates patient anxiety levels. Nevertheless, the implementation of spiritual healthcare services in hospital settings continues to encounter multifaceted challenges that have yet to be comprehensively addressed (2–4).

On a global scale, merely 40% of hospitalized patients report satisfactory fulfillment of their spiritual needs (5,6). Numerous countries demonstrate inadequate formal integration between healthcare and spiritual services, notwithstanding the fact that the majority of patients maintain elevated expectations for spiritual support throughout their treatment trajectory (7,8). This incongruence between spiritual needs and their fulfillment signifies the existence of systemic barriers necessitating rigorous identification.

Principal impediments to spiritual care provision encompass insufficient competency among healthcare professionals in discerning spiritual needs, the paucity of standardized protocols, and substantial workload constraints (9,10). The inadequate fulfillment of spiritual care aspects in Indonesia, as documented in previous studies, is attributed to several factors: the perception of spirituality as a sensitive issue, nurses' time constraints, insufficient understanding of spiritual care provision, role ambiguity between nursing and chaplaincy functions, and the predominance of prayer practices as the sole spiritual intervention (11,12). Contemporary research investigating the educational requirements of healthcare professionals and barriers to spiritual fulfillment remains notably scarce and predominantly fragmented, characteristically concentrating on isolated aspects or singular respondent cohorts (13,14).

The novelty of this study resides in the development of a comprehensive framework that concurrently integrates educational needs assessment with systematic identification of implementation barriers, whilst accommodating Indonesia's considerable spiritual diversity. This approach is congruent with fundamental health promotion principles, particularly the Ottawa Charter's emphasis on personal skill development and the creation of health-supportive environments. The study endeavours to generate evidence-informed recommendations within the health promotion domain by empowering healthcare professionals to deliver culturally responsive, high-quality spiritual care. This multi-level intervention strategy represents a paradigmatic transition from fragmented, conventional spiritual care initiatives towards an integrated health promotion approach embedded within hospital healthcare delivery systems.

METHOD

Research Type

This study employed a quantitative descriptive design to examine the educational needs and barriers to spiritual fulfillment among hospitalized patients.

Population and Sample/Informants

The study sample comprised 76 respondents, including 76 hospitalized patients with the following inclusion criteria: age ≥ 18 years, minimum hospitalization duration of 2 days, alert and oriented mental status (*compos mentis*), ability to communicate effectively, and willingness to participate as respondents. Exclusion criteria included patients in critical condition and those with cognitive impairment. The study also involved 15 nurses assigned to the inpatient ward with a minimum work experience of 6 months and willingness to participate. The sampling technique utilized was purposive sampling, whereby samples were selected based on specific considerations or predetermined criteria established by the researcher in accordance with the research objectives (15). The sampling technique utilized was purposive sampling, whereby samples were selected based on specific criteria established by the researcher in accordance with the research objectives. While this approach allowed for targeted selection of information-rich participants, several limitations must be acknowledged. Purposive sampling inherently involves selection bias, as participant inclusion depends on the researcher's judgment, which may exclude relevant perspectives (16). Additionally, the sample's representativeness is limited, meaning findings may not be generalizable to the broader population. To address these limitations, the study employed transparent documentation of selection criteria and provided detailed participant characteristics. The findings should be interpreted within the context of the sampled

population, and future research with more diverse or probability-based sampling methods could enhance generalizability.

Research Location

The study was conducted in Kendari City during June-July 2025. The selection of the research site was based on considerations of accessibility and the hospital's willingness to participate in the study.

Instrumentation

The instruments utilized in this study consisted of structured questionnaires administered to nurses and patients, each comprising 10 items with Likert scale response options (scores range from 1 to 4). The instruments underwent rigorous validation through a two-stage process. First, content validity was assessed through expert judgment by three specialists in nursing and spiritual care. Each expert independently evaluated all items for relevance, clarity, and appropriateness using a 4-point scale (1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, 4 = highly relevant). The Content Validity Index (CVI) was calculated at both item level (I-CVI) and scale level (S-CVI). Items with I-CVI scores below 0.78 were revised or eliminated. The final instruments achieved S-CVI/Ave scores of 0.92 for the nurse questionnaire and 0.90 for the patient questionnaire, indicating excellent content validity. Second, reliability testing was conducted on 20 respondents outside the study sample, yielding Cronbach's Alpha values of 0.85 for the nurse questionnaire and 0.82 for the patient questionnaire (both ≥ 0.70), thereby confirming that the instruments possessed adequate internal consistency and were reliable for implementation.

Data Collection Procedures

Gap analysis was conducted using the following formula (17):

$$\text{Gap} = \text{Expected education (\%)} - \text{Provided education (\%)}$$

Interpretation: A positive gap value (+) indicates that educational needs have not been met, whereas a negative gap value (-) indicates that education has been fulfilled or exceeds expectations. The unmet need ratio was calculated using the following formulation (18): $(\text{Expectation} - \text{Provision}) / \text{Expectation} \times 100$

Data Analysis

The collected data were analyzed descriptively using the jamovi program (19,20).

Ethical Approval

This study has obtained ethical approval with number 116/KEPK-IAKMI/VI/2025 from the Health Research Ethics Committee of the Regional Management of the Indonesian Public Health Experts Association of Southeast Sulawesi Province.

RESULTS

Table 1. Characteristics of nurse respondents (n= 15) and patients (n= 76)

	Nurses	n	%	Patients	n	%
Sex						
	Male	2	13.3	Male	31	40.8
	Female	13	86.7	Female	45	59.2
Length of working				Age (year)		
	6-12 month	5	33.3	17-25	24	31.6
	>1-3 year	4	26.7	26-45	30	39.5
	>3 year	6	40.0	>45	22	23.7

The majority of nurses (86.7%) were female with diverse lengths of service, where nurses with >3 years of experience comprised the largest proportion (40.0%), followed by nurses with 6-12 months (33.3%) and >1-3 years

(26.7%) of service. Subsequently, among 76 hospitalized patients, the majority were female (59.2%), predominantly from the productive age group of 26-45 years (39.5%) and young adults aged 17-25 years (31.6%), with patients aged >45 years accounting for approximately 23.7%.

Table 2. Nurses' spiritual education practices

Spiritual education delivered by nurses	Never		Yes, ever		Yes, often	
	n	%	n	%	n	%
Remind to pray before doing something	39	51.3	27	35.5	10	13.2
Remind to be patient in undergoing treatment	11	14.5	34	44.7	31	40.8
Remind to read the holy book	53	69.7	18	23.7	5	6.6
Reminds us to bring our souls closer to God	36	47.4	33	43.4	7	9.2

The assessment of spiritual education delivery highlighted a significant deficiency in nurses' engagement with patients' spiritual needs, particularly in facilitating scripture reading practices (69.7% never provided reminders), and nearly half of the respondents (47.4%) reported that nurses never reminded them to draw closer to the Creator. Regarding the aspect of reminding patients to pray before undertaking activities, 51.3% of patients stated they never received reminders from nurses, 35.5% reported occasional reminders, and only 13.2% indicated they were frequently reminded. Nevertheless, education concerning patience during the course of treatment demonstrated more favorable outcomes, whereby 44.7% of patients reported receiving occasional reminders and 40.8% were frequently reminded by nurses, although 14.5% still never received such reminders.

Table 3. Worship Practices and Spiritual Education in the Care Process

Indicators	n	%
Worship/prayer practices during treatment		
No	25	32.9
Yes	27	35.5
Sometimes	24	31.6
Nurse explains how to worship when sick		
No	67	88.2
Yes	9	11.8
The expected spiritual education*		
Reminding about patience in facing illness	54	29.8
Remind about praying	36	19.9
Reminds us to bring our souls closer to God	57	31.5
Reminding about how to worship when sick	23	12.7
Remind about worship/prayer times	11	6.1

*) Respondents can choose more than one answer

Worship practices during hospitalization, 35.5% of patients reported continuing to perform worship/prayers, while 32.9% did not engage in worship practices, and 31.6% performed worship occasionally. Although some patients attempted to maintain their worship practices, the majority of nurses (88.2%) did not provide explanations on how to perform worship during illness. Only 11.8% offered such guidance.

Concerning patients' expectations for spiritual education provided by nurses, diverse needs were identified. The most prominent expectation was for nurses to provide reminders to draw closer to the Creator (31.5%), followed by expectations for reminders about patience in facing illness (29.8%) and reminders about prayer (19.9%). Additionally, there were expectations for nurses to provide reminders about worship methods during illness (12.7%) and worship/prayer times (6.1%).

Table 4. Practices and Barriers to Spiritual Education in Inpatient Services

Indicators*	n	%
Spiritual education practices that have been implemented		
Remind yourself to pray every time you do an activity	9	31.0
Message to patience in facing trials	6	20.7
Remind patients to get closer to God	13	44.8
Explaining how to worship when sick	1	3.4
Barriers to Providing Spiritual Services		
The spiritual aspect is a sensitive matter for clients.	10	55.6
Limited spiritually understanding	3	16.7
Time to providing spiritual services is limited	5	27.8

*) Respondents can choose more than one answer

Data from 15 nurse respondents revealed that the most frequently implemented spiritual education practices included providing reminders to pray before engaging in activities (31.0%), followed by conveying messages of patience in facing adversity (20.7%), and encouraging patients to strengthen their relationship with the Creator (44.8%). However, only a small proportion of nurses (3.4%) provided education on how to perform worship during illness, indicating limitations in offering practical guidance regarding worship adaptation. Regarding barriers encountered by nurses in delivering spiritual care, the majority of nurses (55.6%) perceived spiritual aspects as sensitive matters for clients, necessitating a cautious approach. Additional barriers identified included insufficient time to provide spiritual care (27.8%) and limited understanding of spirituality (16.7%)

Table 5. Analysis of spiritual education gaps

Educational Spiritual Content	Expected (%)	Provided (%)	Gaps (%)	Unmet Need (%)
Pray every time you do an activity	19.9	13.2	6.7	33.7
Patience in facing trials	29.8	40.8	-11	-36.9
worship when sick	12.7	3.4	9.3	73.2
Patients to get closer to God	31.5	9.2	22.3	70.8
Prayer times	6.1	0	6.1	100

The gap analysis revealed that education on "Drawing Closer to God" exhibited the largest gap (22.3%), with 70.8% of needs remaining unmet. Education on "Methods of Worship During Illness" demonstrated the second largest gap (12.7%), with an estimated 88.2% of patients not receiving this education and 73.2% of needs unaddressed. Education on "Patience" was adequately delivered (40.8%) of nurses frequently provided this education), though maintenance of this standard remains necessary.

DISCUSSION

The spiritual education gap analysis reveals critical disparities in spiritual care implementation within healthcare services. The most significant finding concerns the "drawing closer to the Creator" dimension, which shows a 22.3% gap. Although 31.5% of patients expected this education, only 9.2% received it, resulting in 71% unmet needs. This finding aligns with nursing practice data, where 44.8% of nurses claimed to provide such guidance, yet only 52.6% actually reminded patients to strengthen their relationship with the Creator. This discrepancy indicates a fundamental failure in fulfilling the connection dimension of comprehensive spiritual care framework, which should include maintaining divine relationships through worship practices. These gaps highlight the need for systematic improvements in spiritual care delivery to facilitate meaningful transcendent connections as essential components of holistic patient care (10,21). These findings suggest that healthcare delivery practices continue to be oriented toward the biomedical domain while neglecting the spiritual dimension that should serve as an integral element of holistic care. In populations characterized by elevated religiosity, spiritual connectedness has been shown to serve as a coping

mechanism and substantial source of psychological resilience that supports patient recovery processes. This condition demonstrates a discrepancy between the service practices being implemented and the fundamental tenets of client-centered care, which explicitly underscores the importance of healthcare service responsiveness to individual preferences, holistic requirements, and patients' value systems. The characteristics of the research sample also show that most of the patients were of productive age, a demographic group that also has similar spiritual needs when facing their disease conditions.

The most critical gap was observed in the content of "worship practices during illness," which exhibited a 9.3% discrepancy with the highest unmet need reaching 73%, where only 3.4% of patients received practical guidance despite 12.7% expressing this expectation. This finding is particularly concerning given that the data demonstrate 35.5% of patients continued to attempt worship practices and 31.6% did so occasionally, yet 88.2% of nurses failed to provide guidance on worship adaptation. This phenomenon creates a significant barrier that impedes patients from fulfilling their spiritual needs, contradicting the principles of health promotion that emphasize the importance of enabling factors—the provision of skills and resources that facilitate individuals in performing health-promoting behaviors (22,23).

In the spiritual context, nurses should function as enabling agents who facilitate patients in maintaining their spiritual practices despite illness. The absence of such practical education may generate additional psychological burden in the form of guilt or spiritual anxiety, which ironically can impede the recovery process (24,25). The research findings corroborate this by identifying that many nurses perceive themselves as lacking practical skills to facilitate patients' spiritual practices (10,26), while another study revealed that 85% of patients expect nurses to provide spiritual support and do not consider it overly personal to discuss (27).

The most intriguing paradox emerged in the "patience during treatment" content, which demonstrated a negative gap of -11%, indicating that the education provided (40.8%) exceeded patient expectations (29.8%), despite an unmet need of 37%. This "oversupply" phenomenon was substantiated by data showing that 85.5% of nurses had occasionally or frequently reminded patients about patience, substantially higher than other spiritual content such as reading sacred texts (30.3% occasionally/frequently) or drawing closer to the Creator (52.6% occasionally/frequently). This pattern suggests a fundamental misperception among nurses regarding patient priorities, whereby nurses overemphasize persuasive approaches to enhance compliance through patience rhetoric while neglecting substantive spiritual needs. Nurses tend to provide general and psychological spiritual support (such as patience) rather than practical worship guidance, reflecting limitations in spiritual care competency (28). Nurses focus solely on the meaning dimension (patience as the meaning of suffering) while overlooking the connection dimension that constitutes patients' primary need (21) thereby reflecting an approach oriented toward healthcare system interests in improving compliance rather than prioritizing patient-centered care principles that place patient values and preferences at the core of service delivery.

This disparity stems from three barriers identified in the study: nurses perceiving spiritual care as sensitive (55.6%), facing time constraints (27.8%), and lacking sufficient understanding (16.7%). From an ecological model perspective, the barrier of "insufficient understanding" at the individual level likely represents an underestimation, given that previous studies have found approximately 70% of nurses feel they lack adequate skills to conduct spiritual assessments, and 65% of physicians acknowledge discomfort in discussing spiritual issues with patients (29,30). The barrier of "spiritual aspects as sensitive matters" at the interpersonal level often serves as a rationalization for avoiding spiritual care because nurses feel uncomfortable or incompetent, despite research demonstrating that patients actually expect this support. The barrier of "time constraints" at the organizational level is essentially an excuse, old research demonstrates that simple interventions such as praying, reminding patients of prayer times, or facilitating worship positions require minimal time (31,32). The Theory of Planned Behavior explains the phenomenon observed in this study: although 86.7% of nurses possess awareness that additional spiritual aspects could be addressed with patients (positive attitude), low subjective norms and perceived behavioral control impede implementation due to the absence of standard operating procedures for spiritual care and lack of role models in clinical practice (10,33,34).

Overall, these findings highlight substantial deficiencies in three key areas within the study setting. First, in developing personal skills, nurses demonstrated limited competencies for spiritual care according to the Spiritual Care Competency Framework, which encompasses six core competencies. Second, in creating supportive environments, the hospital environment was not conducive to spiritual practice. Third, in reorienting health services,

healthcare delivery remained predominantly biomedically oriented with inadequate spiritual integration (35). The substantial unmet needs observed across spiritual aspects (ranging from 34-100%) suggest challenges in promoting "spiritual literacy" patients' understanding of how to adapt spiritual practices during illness—which constitutes an essential component of health literacy (21,36,37). The implications of these gaps warrant consideration: patients may seek spiritual needs fulfillment from unverified sources or sources potentially counterproductive to medical treatment. Moreover, opportunities to leverage spiritual care as a resource for enhancing patients' coping mechanisms, reducing anxiety, and supporting recovery may be missed (38,39).

To address these gaps, multi-level interventions aligned with the PRECEDE-PROCEED Model warrant consideration. At the predisposing level, interventions should focus on transforming nurses' perceptions of spiritual care as an integral professional responsibility, with early integration into educational curricula. Enabling factors include structured training programs encompassing spiritual communication techniques, needs assessment skills, and practical guidelines for facilitating patient worship across various clinical conditions, as research indicates that structured training can significantly enhance competencies (11,40,41). At the reinforcing level, institutional support mechanisms including standard operating procedures, recognition systems, and organizational culture development may provide concrete guidance for consistent spiritual care delivery as an integral component of comprehensive care (42,43).

CONCLUSION

This study identified a significant gap between patients' spiritual education needs and the services provided by nurses. The largest discrepancies were observed in education regarding "drawing closer to the Creator" (22.3%) and "methods of worship during illness" (9.3%), with unmet needs reaching 71% and 73%, respectively. Only 9.2% of patients received education on drawing closer to the Creator despite 31.5% expressing this need, and merely 3.4% received guidance on worship adaptation during illness although 12.7% required it. Paradoxically, 88.2% of nurses did not provide guidance on worship adaptation, whereas 67.1% of patients continued their worship practices despite their illness condition.

Conversely, there was an oversupply of "patience" education (negative gap of -11%), with 85.5% of nurses frequently emphasizing this aspect, although only 29.8% of patients expected it. Meanwhile, substantive spiritual education such as reading sacred texts (30.3%), drawing closer to the Creator (52.6%), and prayer (48.7%) remained largely neglected.

The primary barriers identified were the perception that spirituality is a sensitive matter (55.6%), time constraints (27.8%), and insufficient understanding (16.7%). Although 86.7% of nurses acknowledged their limitations, this awareness did not translate into concrete action due to inadequate competencies and inconsistent implementation in fulfilling spiritual care needs.

AUTHOR'S CONTRIBUTION STATEMENT

Muhammad Syahwal contributed to the conceptualization and design of the study, data acquisition, data analysis and interpretation, and drafting and finalization of the manuscript. Arfiyan Sukmadi contributed to the methodological framework, statistical analysis, data interpretation, and critical revision of the manuscript for important intellectual content.

CONFLICTS OF INTEREST

This research was conducted independently, and the authors affirm that there are no conflicts of interest that could influence the results or publication of this manuscript.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

In developing and revising this manuscript, the authors employed artificial intelligence (AI) tools, specifically DeepL and Claude.ai, to improve linguistic accuracy, refine sentence structure, and enhance overall readability. These technologies were used exclusively for language improvement and remained under the authors' direct supervision and critical evaluation. All intellectual contributions, including conceptual development,

interpretative analysis, and critical reasoning, represent the authors' original work. This statement reflects the authors' commitment to academic integrity, ethical publishing practices, and transparency in responsible scientific communication.

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