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ORIGINAL PAPER

The Development of Guidelines for the Inclusion of Spirituality and Spiritual Care in Unani Tibb Practice in South Africa: A Study Protocol

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Abstract

Unani Tibb is a holistic form of medicine, which highlights the interconnectedness of mind, body and soul. Despite this, there is very little evidence of spiritual care practices by Unani Tibb practitioners in South Africa. This protocol outlines a proposed process for developing guidelines to integrate spirituality and spiritual care in Unani Tibb practice. In phase one, a document review will be conducted on spirituality and spiritual care in complementary and alternative medicine and Unani Tibb. A series of quantitative and qualitative enquiries will follow to obtain the perspectives of various stakeholders in the Unani Tibb profession. Phase two will rely on the findings of phase I to develop guidelines according to the Delphi method. Experts in the relevant fields will be soliciting their opinions on the nature and content of the proposed guidelines. The data will be analysed using descriptive statistical analyses, thematic analysis and narrative synthesis. Ethics clearance has been obtained from the ethics committee of the university.

Keywords Unani Tibb · Spirituality · Spiritual care · Clinical practice · Delphi study

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Introduction

The World Health Organization (WHO 2013, 2020) highlights the importance of both complementary and alternative medicine (CAM) and spirituality in the health and well-being of populations around the world. It is estimated that up to 80% of Africans rely on CAM for their healthcare needs (Mahlangeni et al. 2014). Spirituality and CAM are interconnected in many ways. Spirituality is a foundational component of CAM, often discussed in the context of holistic care (Ben-Arye et al. 2011). Spirituality was found to be the strongest predictor for CAM use especially amongst patients affected with chronic conditions (Chang et al. 2007; Ben-Arye et al. 2011, 2012; Trinkaus et al. 2011; Ramakrishnan et al. 2014).

African traditional medicine, Unani Tibb and traditional Chinese medicine are some of the modalities of CAM practiced and utilized by millions globally (Mahlangeni et al. 2014). According to UNESCO, Unani Tibb is one of the oldest and most accepted forms of CAM (Asia/Pacific Cultural Centre for UNESCO 2000) practiced in 82 member states (WHO 2019). Unani Tibb is a modality of CAM practiced in South Africa (Peltzer 2009). It highlights the interconnectedness of mind, body and soul in the pursuit of health and well-being (Bhikha and Glynn 2017; www.ccrum.res.in). However, there is little evidence of spirituality and spiritual care in Unani Tibb practice.

Spirituality and spiritual care are topics firmly fixed within the healthcare agenda of most healthcare professions (McSherry et al. 2004). This is evident by the vast amount of research available on these topics (McSherry et al. 2004). Healthcare practitioners who provide spiritual care to their patients contribute significantly to improving their patients' physical and emotional well-being. Several studies agree that spirituality and spiritual care practices are closely linked to better health outcomes (Koenig 2012; McSherry et al. 2004; Melhem 2016). There is growing interest in most healthcare professions (McSherry et al. 2004). However, this is not the case for CAM professions (Grant 2007; Ramakrishnan et al. 2013).

In South Africa, many people regard CAM and spirituality as important components of their lives (Peltzer 2009). Mthembu et al. (2016) reported that in the South African context, spirituality and spiritual care were mainly examined in healthcare professions such as nursing, psychiatry and social work, and little is known in other health professions; it was also reported that practitioners felt ill-equipped to deal with the topic of spirituality with their patients (Mthembu et al. 2016). This seems to be the case for modalities of CAM like Unani Tibb.

Background

CAM plays a major role in the healthcare delivery of South Africa with an estimated 70–80% of the South African population seeking some form of CAM treatment (Peltzer 2009). Patients associate spirituality and spiritual care within the

CAM domain (Ellison et al. 2012). Unani Tibb is a modality of CAM, which is based on Greek medicine and has grown from a fusion of the traditional medical knowledge of various civilizations. Unani Tibb is defined as a comprehensive medical system, which provides preventative, promotive, curative and rehabilitative healthcare. This system is holistic in nature and takes into account the whole personality of the individual rather than taking a reductionist approach to disease (Bhikha and Glynn 2017). The fundamentals, diagnosis and treatment modalities of the system are based on scientific principles (Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy Government of India 2016). Unani Tibb remains the preferred form of CAM for millions of people around the world (Abdelhamid 2012). The philosophical principles of Unani Tibb highlight the importance of spirituality and spiritual care but these components are rarely seen in clinical practice. In a systematic review conducted on the utilization and practice of CAM in South Africa, Peltzer (2009) reports that many South Africans expect advice on spirituality and spiritual care from CAM practitioners. CAM practitioners claim to practice holistic medicine, which means that they should address the spiritual component of their patients (Peltzer 2009). However, the contribution to the area of spirituality and spiritual care within CAM remains minimal even though many patients choose CAM to support their spiritual care needs (Ellison et al. 2012). Studies conducted on Unani Tibb students and practitioners reported that both groups regarded the topic of spirituality and spiritual care as essential components to their education and profession (Ahmad 2015; Ramakrishnan et al. 2014). There is a definite need for further research on this topic given the paucity on the subject of spirituality and spiritual care within the Unani Tibb profession globally. Furthermore, Unani Tibb practitioners in South Africa are not formally trained within this area of practice.

Spirituality

Spirituality is a complex term, and its meaning and definition vary between individuals, philosophies and cultures (Melhem et al. 2016). There is no consensus on a definition of spirituality; however, it is agreed upon that it is a crucial concept to most people which encompass belief in a higher being, the search for meaning and a sense of purpose and connectedness (D'Souza 2007). Spirituality includes secular and philosophical, as well as religious and cultural, beliefs and practices (Puchalski et al. 2014). It highlights the relationship with the transcendent or sacred and has a strong influence on a person's beliefs, attitudes, emotions and behaviour (Phillips et al. 2015). All cultures have some form of spiritual practice, which focuses on a deeper interaction with a higher entity (Jantos and Kiat 2007). It is a fundamental component of quality of life, health and well-being in the general population and those affected by acute or chronic illnesses (Camody et al. 2008). Spirituality and healthcare are interrelated in all population groups since the beginning of recorded history (Koenig 2012). The inclusion of spirituality in the clinical setting is known as spiritual care (Melhem et al. 2016).

Spiritual Care

Today, spiritual care is considered an essential component of the overall care provided to improve the quality of life for patients (Melhem et al. 2016). Spiritual care is defined as the actions that are required to meet the spiritual needs of the patient (Melhem et al. 2016). It also refers to the care displayed by the health professional that fosters a professional relationship of dignity, respect, love, hope, unconditional acceptance and peace towards the patient (Mthembu et al. 2016). Spiritual care practices are seen as part of coping resources, which may improve pain management, enhance surgical outcomes, safeguard against depression and decrease the chance of patients engaging in substance misuse and suicidal behaviours. (Melhem et al. 2016). It is associated with feelings of spiritual support and connection as well as reduced depression, grief and anxiety, which provide a greater sense of peace and calm for patients (Phillips et al. 2015). Koenig reported that spiritual care-assisted patients to cope with many types of illnesses (Koenig 2012). Spiritual care supports the integration of body, mind and spirit. By addressing the spiritual aspects of patient care, clinicians can be truly holistic which focuses on the well-being of patients. The integration of spirituality and spiritual care guidelines allows clinicians deeper insight towards understanding their patients, thereby increasing their capacity to cure, relieve and comfort patients (D'Souza 2007). Despite the growing interest in spiritual care in health sciences education and clinical practice, there remain pervasive inconsistencies and uncertainties which inhibits the infusion of spirituality and spiritual care in health sciences education and practice (Mthembu et al. 2016). This seems to be the case in the field of CAM.

Spirituality and Spiritual Care in CAM

CAM is a broad field practiced worldwide and abundant as the people of the world. Most forms of CAM are tradition-based and result from centuries of observation, empirical practice and intuitive experience (Bhikha and Glynn 2017). Chang et al. (2007) reviewed 18 studies from nine countries and reported that spirituality was the most preferred form of CAM therapy chosen by populations living with diabetes (Chang et al. 2007). Similar findings were also reported in studies on other populations living with cancer (Trinkaus et al. 2011; Ben-Arye et al. 2012; Jazieh et al. 2012; Gillett et al. 2012). Spirituality was found to be the strongest predictor for CAM use amongst patients living with chronic disease. (Chang et al. 2007; Ben-Arye et al. 2011, 2012; Trinkaus et al. 2011; Ramakrishnan et al. 2014). Today, CAM has gained popularity amongst medical practitioners, researchers, government agencies and the public. Many patients associate spirituality and spiritual care within the CAM domain (Ellison et al. 2012). All CAM modalities recognize the concept of spirituality as key component to attaining wholeness for the mind, body and spirit. Spirituality within CAM has gained popularity since the 1980s (Keshet and Simchai 2014). However, there are inconsistencies with regard to CAM education and practice and the role of spiritual care that remains minimal amongst many

practitioners. There is a definite need to revive the holistic nature of CAM practice by reinforcing the concepts of spirituality and spiritual care (Grant 2007). The disconnection between CAM theory and practice seems to exist in CAM professions in South Africa as well.

Spirituality in Unani Tibb

Unani Tibb is a modality of CAM registered under the Allied Health Professions Council of South Africa (AHPCSA) and practiced in South Africa (Peltzer 2009). It remains the preferred form of CAM for millions of people around the world, especially in the Indian subcontinent, Pakistan, Afghanistan, Iran, China, Indonesia, Malaysia, Bangladesh, Sri Lanka, Middle East, Saudi Arabia, Kuwait, the United Arab Emirates and South Africa (Abdelhamid 2012).

Unani Tibb is a holistic form of natural medicine, which highlights the interconnectedness of mind, body and soul. The origin of any disease is viewed as multifactorial in nature, with genetic, physical, emotional, psychological and spiritual elements involved (Bhikha and Glynn 2017; www.ccrum.res.in). The basic philosophy of Unani Tibb is that the human body is composed of matter and spirit, these two entities are inseparable and a harmonious life is only possible when there is proper balance between the bodily (physical) and spiritual functions (Bhikha and Glynn 2017; Ahmad 2010). Therefore, it is expected that Unani Tibb practitioners place considerable emphasis on obtaining a detailed case history about the patient's spiritual and social life (Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy Government of India 2016; www.ccrum.res.in). Treatment goes beyond the individual's pathology and psychology; the practitioner should treat according to the familial, societal and the spiritual context (Bhikha and Glynn 2017; Ahmad 2010). Unani Tibb seeks the restoration of the body as a whole to its original state. It recognizes the important role of spirituality and spiritual care as the human spirit is considered to be the supreme regulator of man (Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy Government of India 2016, p. 32). Unani Tibb therapies may include application of mind–body practices (breathing exercises, visualization and meditation), herbal therapy, hands-on techniques (massage and cupping therapy) and counselling advise for the patient's spiritual life and social relationships (Bhikha and Glynn 2017; Ahmad 2010). Based on the importance of spirituality and spiritual care in Unani Tibb philosophy, it is expected to find these concepts present in clinical practice; however, this is not the case.

Spiritual care in Unani Tibb

In a survey by Ahmad (2015), it was reported that Unani Tibb students regarded spirituality as a relevant component to their education and profession. In addition, this study on the spiritual personality of Unani Tibb students reported significant correlation between student spiritual personality and their level of empathy expressed to patients; however, patients were not part of the sample group. This study had limitations about the generalization of findings, as it only

involved students from one setting. Ahmad (2015) reported that the sample size of only 100 participants was a limitation in providing sufficient information about the variables in this study. Furthermore, this study looked at student's perceptions on spiritual personality within a quantitative study design only; a mixed methods approach appeared to be more comprehensive to provide evidence with a complete and clearer picture of the phenomenon under investigation (Mthembu 2017). Disciplines in health sciences employ mixed methods to facilitate dialogue on the various methods of viewing, hearing and understanding the social world of research participants (Mthembu 2017).

A multisite exploratory study was conducted in five CAM tertiary care institutions in India on the role religion and spirituality in healthcare. Unani Tibb practitioners amongst other CAM professionals reported that they agreed that spirituality was a focus area for their patients during illness. They reported that they felt comfortable in addressing matters of spirituality but that they did not have the expertise to deal with this aspect appropriately. Some of the barriers to providing spiritual care included insufficient knowledge and training, insufficient time, general discomfort and a concern of offending patients. Unani Tibb practitioners and CAM professionals advocated for the inclusion of spirituality and spiritual care into the CAM curriculum and clinical practice (Ramakrishnan et al. 2014). Similar findings were previously reported in other healthcare professions (Mthembu et al. 2016).

Spirituality and spiritual care competence are regarded as essential values for all practitioners of care-giving professions such as the Unani Tibb profession (Bhikha and Glynn 2017; Ahmad 2010, 2015). Despite this, there is little or no evidence of spirituality and spiritual care competence in Unani Tibb training and practice. The WHO Benchmarks for training in Unani Medicine recognize three training programs all of which lack dedicated modules or topics within therapeutic modules for spirituality and spiritual care for Unani Tibb training and practice (WHO Benchmarks for training in Unani Medicine 2010). This refers to Unani Tibb education and practice throughout the South Asian continent (India, Bangladesh, Sri Lanka, etc.) as well as other regions like Iran and in South Africa. Unani Tibb practitioners seemed to be uninformed on spiritual care practices and, therefore, ill-equipped to attend to the spiritual health needs of their patients. There is a lack of research on the role of spirituality and spiritual care in Unani Tibb practise; there is a definite need for further research on this topic (Ahmad 2015; Ramakrishnan et al. 2014).

In summary, there are inconsistencies between Unani Tibb theory and practice concerning the role of spirituality and spiritual care. Unani Tibb practitioners may also experience uncertainties around the infusion of spirituality and spiritual care within the clinical setting as reported in other healthcare professions. There is a definite need to investigate this phenomenon and bridge the gap between theory and practice by developing clear guidelines to integrate spirituality and spiritual care for the Unani Tibb profession.

Research Objectives

To develop spirituality and spiritual care guidelines for Unani Tibb practice in South Africa, we aimed to achieve the following objectives:

- To conduct a scoping review on the role of spirituality and spiritual care in CAM.
- To conduct a scoping review on the role of spirituality and spiritual care in Unani Tibb
- To identify strategies used to integrate spirituality and spiritual care in clinical practice.
- To explore the perceptions and attitudes of Unani Tibb students, educators, practitioners and professional board members towards spirituality and spiritual care in Unani Tibb practice.
- To explore the perceptions and attitudes of patients towards spirituality and spiritual care in Unani Tibb practice.
- To develop guidelines for integrating spirituality and spiritual care in Unani Tibb practice according to the Delphi technique.

Theoretical Framework

This study is grounded in two theoretical frameworks, which are the existential humanistic framework and the Unani Tibb philosophical framework. The existential humanistic framework promotes a holistic view of human beings, specifically placing importance on using 'the whole person model' (Derobertis and Bühler 2006; Suri 2010). It recognizes the individual's potential to strive towards a higher level of personality integration and optimization of the person's conditions for future growth, health and fulfilment (Derobertis and Bühler 2006). This framework facilitates the development of a model of intervention that engage individuals at all levels: intellectually, spiritually and physically (Derobertis and Bühler 2006; Suri 2010).

The Unani Tibb philosophy highlights the interconnectedness of mind, body and soul. It directly informs Unani Tibb practice and guides practitioners towards the ideal approach to diagnosis and treatment, which defines the scope of practice of a Unani Tibb practitioner. A core principle of the Unani Tibb philosophy is the concept of temperament, which recognizes the uniqueness of every person. Temperament refers to the person's genetic profile, constitution or physique, spirituality, personality and behavioural tendencies (Bhikha and Glynn 2017; Hoosen 2017; www.ccrum.res.in). The Unani Tibb system of medicine recognizes the important role of spirituality and spiritual care in healthcare as the human spirit is considered the supreme regulator of man (Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy Government of India 2016, p. 32).

The existential humanistic framework and the Unani Tibb philosophical framework are related and similar in recognising that the optimizing of health and fulfilment is dependent on the 'whole person model'. The existential humanistic approach guides this study by recognizing the higher spiritual dimension and uniqueness of human beings, whilst the Unani Tibb philosophical framework allows this approach to fit within the Unani Tibb context.

Research Methodology

A mixed methodology will be used for this study because it will provide a deeper understanding of the problem as opposed to using one approach alone. The mixed methods approach combines qualitative and quantitative methods in the attempt to answer the research question in a satisfactory manner (Botma et al. 2010, p. 255). It provides comprehensive evidence with a complete and clear picture of the phenomenon under study (Mthembu 2017). The mixed methods approach is considered to be a better option towards understanding the complexities of the research problem (Botma et al. 2010, p. 255). Disciplines in health sciences employ mixed methods to facilitate dialogue on the various methods of viewing, hearing and understanding the social world of research participants (Mthembu 2017). Initially, quantitative numeric data will be collected with a self-administered questionnaire and analysed followed by the collection of qualitative text data through focus groups to explore participants' views in more depth so that the quantitative data may be better explained. Quantitative and qualitative methods are used in a complementary manner to allow for more elaboration, enhancement and clarification of the results (Botma et al. 2010, p. 256). Priority will be placed on the qualitative component of this study because qualitative methods focus on the qualitative aspects of the human experience of participants, which will inform and guide the necessary action that may be needed in this study (Brink 2009, p. 113). This study will employ a mixed methods design within distinct phases of the intervention mapping framework.

Research Design

Intervention mapping framework will be used in this study within an explanatory sequential design. The intervention mapping framework is commonly used in the development of health promotion programs (Bartholomew et al. 2006). It provides a framework or map with specific steps for effective decision-making at each step in the development of interventions (Bartholomew et al. 2006). The explanatory sequential design involves quantitative data collection and analysis, which has the priority of answering the research questions followed by qualitative data collection and analysis, which supports the initial quantitative results (Creswell and Clark 2011). This design will be further guided and informed by the intervention mapping framework.

Intervention mapping outlines phases from the recognition of a problem to the identification of a solution. This is accomplished by six steps: (1) logic model of

the problem, (2) intervention outcomes and objectives, (3) intervention design, (4) intervention production, (5) intervention implementation plan and (6) evaluation plan (Melnyk and Morrison 2012). This study will focus on identifying the needs and designing the intervention (guidelines). According to the WHO, guidelines refer to recommendations for clinical or public health interventions (WHO 2012). It is also described as evidence-based recommendations for preventing and treating certain conditions, improving health, managing medicines, planning of services for the community, development of an intervention for improving population health and delivering social care for communities (Adebiyi et al. 2018). The WHO's Handbook for guideline development was used to guide this study (WHO 2012).

World Health Organization Recommendations for Guideline Development

The following steps were followed towards the development of guidelines for spirituality and spiritual care in Unani Tibb practice.

1. The team agreed to design guidelines for spirituality and spiritual care in Unani Tibb practice based on informal, formal and scientific engagements with relevant stakeholders at a national and international level on the need for the proposed guidelines.
2. We planned on scoping relevant literature and conducting a needs assessment at a national and international level
3. Based on the preliminary information, the team then formulated the following key PICO questions:
    - *Population* Unani Tibb students, educators, regulators, practitioners and patients
    - *Intervention* a guideline to inform clinical practice.
    - *Comparison* (not applicable to this study).
    - *Outcomes* guidelines for spirituality and spiritual care in Unani Tibb practice.
4. Protocol design (mixed methods with a Delphi approach) was reported in this paper.
5. An application for ethics clearance for the study was obtained from the University of the Western Cape (Ethics number: BM20/2/7)
6. To conduct the quantitative and qualitative enquiry as outlined in this protocol.
7. To conduct a Delphi study based on previous quantitative and qualitative studies.
8. Disseminate the developed guidelines to various stakeholders in education, community organizations, professional associations, regulatory boards and the healthcare sector. The findings of this study will also be published in international peer-reviewed journals, presented at national and international conferences and submitted to WHO to be reviewed and included in the Benchmarks for the practice of Unani Tibb. See Fig. 1 (WHO 2012) and Fig. 2 (Adebiyi et al. 2018).

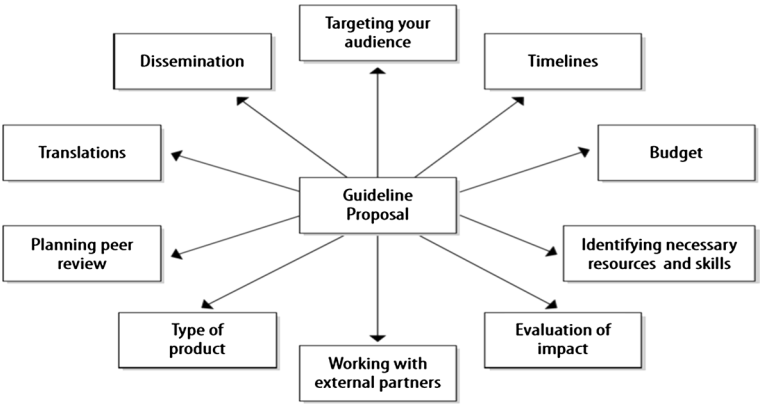

Fig. 1 WHO recommendations for the guideline proposal (WHO 2012)

Data Collection Procedure

This study will consist of two phases—Phase I will identify the problem, and Phase II will design the guidelines by means of a Delphi study. Each phase will be further be subdivided into stages or rounds, which fulfils the objectives of the study.

Phase I: Identifying the Problem

Phase I consists of three stages with the purpose of obtaining diverse information to develop the guidelines. Two scoping reviews and one literature review will be conducted in stage one followed by a series of quantitative enquires in stage two and qualitative enquires in stage three. Identifying the problem will be conducted in the following steps.

Stage One: Reviewing the Literature on the Role of Spirituality and Spiritual Care in CAM and Unani Tibb

Scoping reviews are considered ideal for identifying research gaps in the existing literature and drawing conclusions from existing literature regarding the overall state of the research activity (Arksey and O'Malley 2005). Scoping reviews are valuable in fields, which are complex or have not been reviewed comprehensively before. The Population Intervention Comparison and Outcome (PICO) framework will be used to conduct the reviews. The five steps involved in these scoping reviews will include identifying the research question, finding the relevant studies, selecting the studies that are relevant to the question, charting the data from the relevant studies and to collate, summarize and report the results (Arksey and O'Malley 2005). Electronic searches will be conducted using electronic databases and journals such as CINAHL, Ebscohost, BioMed Central, Scopus and Science Direct. The search

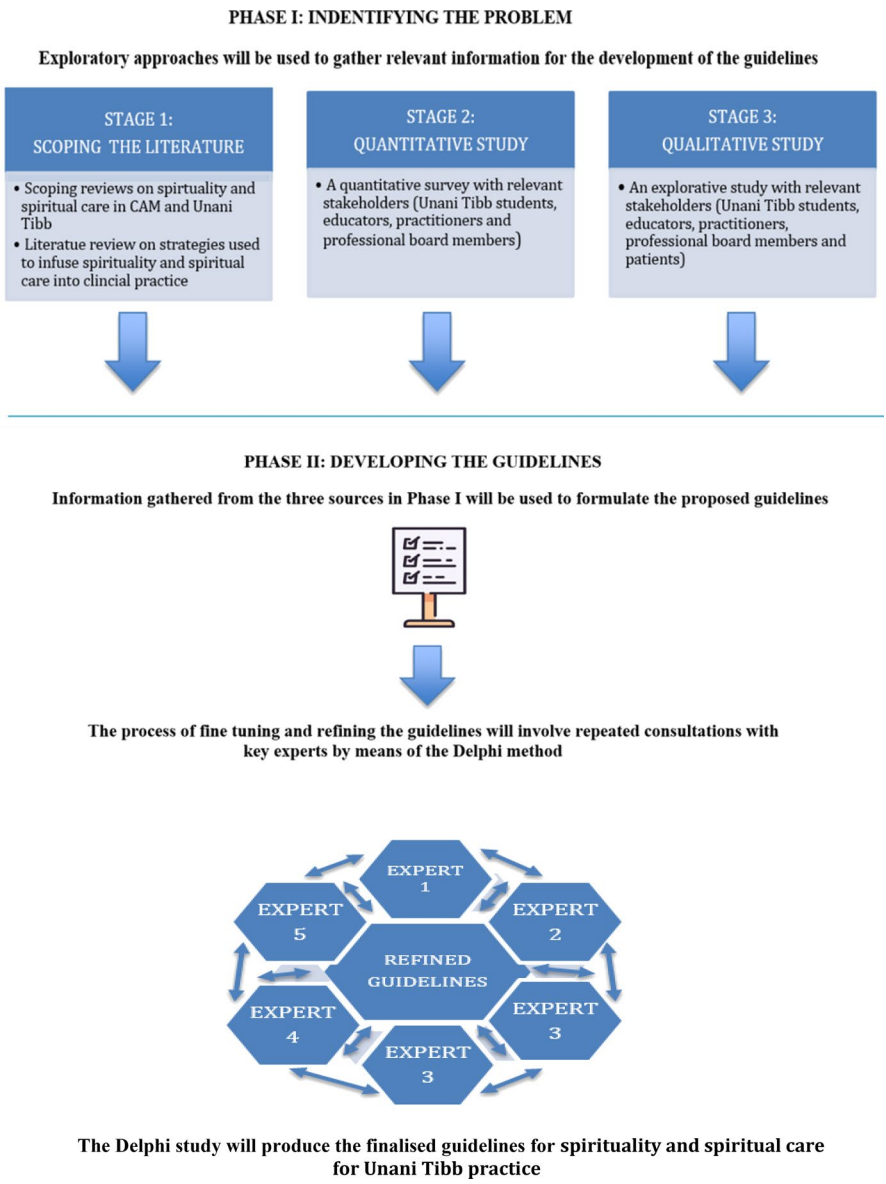

Fig. 2 The proposed methodological approach to the development of guidelines for spirituality and spiritual care for Unani Tibb practice

terms for the first scoping review will include spirituality *AND* complementary medicine, spirituality *AND* traditional medicine, spirituality *AND* alternative medicine, spiritual care *AND* complementary medicine, spiritual care *AND* traditional medicine, spiritual care *AND* alternative medicine from the records in these databases from January of 2000–December 2019. The search terms for

the second scoping review will include spirituality *AND* Unani Tibb and spiritual care *AND* Unani Tibb. The inclusion criteria will require studies to be relevant to CAM practitioners; scholarly, peer-reviewed; and full-text articles in the English language. The titles and abstracts of the relevant articles will be screened using inclusion criteria, and duplicates will be removed. Data analysis will be carried out by three reviewers, they will assess the articles, and any discrepancies will be addressed until agreement is reached. An adapted version of the data extraction tool as employed by Roman and Frantz (2013) will be used. Data will be categorized according to prevalent themes and shared in the results. Descriptive characteristics such as authors, year of publication, country where the study took place, study design, study population, sample size, modality of CAM, related CAM therapies, Unani Tibb, spirituality, spiritual care, clinical practice, patient perceptions, practitioner perceptions and key findings will be collected. A literature review will also be conducted to identify strategies used to integrate spirituality and spiritual care in clinical practice.

Stage Two: Quantitative Enquiry

A quantitative descriptive cross-sectional survey will be conducted to explore the perceptions and attitudes of Unani Tibb students, educators, practitioners and professional board members towards spirituality and spiritual care in Unani Tibb practice. Convenient non-probability sampling will be used to recruit all registered Unani Tibb students ($n=10$) in the Bachelor of Complementary Medicine (Unani Tibb) program and educators ($n=3$) who teach one or more Unani Tibb specific modules at the University of the Western Cape (UWC). Convenient non-probability sampling will also be used to recruit all registered Unani Tibb practitioners ($n=74$) and professional board members (3) on the AHPCSA registry. Data will be collected via an online (Google form) self-reported questionnaire which takes 20 min to complete. The questionnaire will consist of four sections which include information on demographics, a Spiritual Care-Giving Scale (SCGS), a Spirituality and Spiritual Care Rating Scale (SSCRS) and Spirituality Occupational Therapy (SOT) which was reported to be reliable in previous studies (Mthembu 2017). The instrument has been adapted to suit the context of this project. (The term 'Occupational Therapy' was replaced by 'Unani Tibb', and the term 'Occupational Therapist' was replaced by 'Unani Tibb practitioner'.) The instrument, information sheets and consent forms have been translated into Afrikaans and isiXhosa which are two of the eleven official languages in South Africa. Permission has been granted by the authors to adapt and utilize this instrument for this study.

A pilot study will be conducted on 10% of the sample as a trial run of the study (Clark-Carter 2010). This will be conducted in the same manner as the main study which will provide information on the reliability of the questionnaire. This process will provide insights into the data collection procedure (provide information on the time taken to administer the questionnaire as well as assist to assess the validity and internal consistency of the instrument). The pilot study will assist to assess the feasibility and approach to be used in the study.

Validity and reliability of this process will be observed. Reliability refers to the degree to which a measure would produce the same result from one occasion to another which is part of consistency (Clark-Carter 2010). The reliability of the SCGS and SSCRS has been established previously. The SCGS comprising five factors with 6-point Likert scale, which was developed and tested to be valid and reliable ($\alpha = 0.96$). The 17-item SSCRS demonstrated a reasonable level of internal consistency reliability, having a Cronbach's alpha coefficient of 0.64 (McSherry et al. 2004; Mthembu 2017). Reliability of the questionnaire will also be checked for stability and consistency by computing the reliability coefficient range from 0.00–1.00 with higher values greater than 0.8 and Cronbach's Alpha 0.00–1.00 greater than 0.07 acceptable. Validity refers to the degree to which what is being measured is what the researchers intended (Clark-Carter 2010). For the purpose of the study validity will be enhanced through use of previously validated questionnaires. Face and content validity of the instrument to will be used in the study. One international Unani Tibb practitioner and three South African Unani Tibb practitioners acknowledged as specialists in spirituality in Unani Tibb will be consulted to evaluate the questionnaire. The data analysis will be completed by two researchers. Quantitative data will be entered twice into SPSS version 2 by both researchers and reviewed for completeness. The data will then be coded, cleaned and checked for errors. Descriptive statistics will be used to describe the characteristics of the sample and responses to the survey. Data analysis will consist of frequencies, percentages, means and standard deviations. The descriptive statistical analyses will be summarized in the text and reported in tabular form. Frequencies will be performed in order to identify valid percent for responses to all questions in the instruments.

Stage Three: Qualitative Enquiry

An exploratory, descriptive and contextual qualitative approach will be used collect data about perceptions and attitudes of Unani Tibb patients and practitioners regarding spirituality and spiritual care at two community-based Unani Tibb clinics (Surrey Estate and Langa) in Cape Town, South Africa. Permission has been granted by the facility manager of these two sites to conduct this study. Purposive sampling will be used to recruit all Unani Tibb practitioners ($n = 8$) at the Tibb treatment centres in Surrey Estate and Langa. Participants will include both male and female registered (AHPCSA) Unani Tibb practitioners currently employed at these two sites. Purposive sampling will also be used to recruit patients ($n = 10$) at the Tibb treatment centres in Surrey Estate and Langa. Purposive sampling is commonly seen in qualitative research and it allows the researcher to select a sample based on the knowledge of the phenomena under study (Brink 2009, p. 135). Data will be collected via focus group discussions. The focus group discussion will be audio-recorded and transcribed verbatim. The focus group discussion will provide insight into the quantitative data previously obtained. It will explore the range of opinions of the participants (patients and practitioners) with regards to spirituality and spiritual care within Unani Tibb practice. The researchers and a qualified co-facilitator will facilitate the focus group discussion. This will take place in the boardrooms at both sites.

A pilot study will be conducted on 10% of the sample a trial run of the study (Clark-Carter 2010). This will be conducted in the same manner as the main study, which will provide information on the reliability of the interview process. This will provide insights into the data collection procedure. The pilot study will assist to assess the feasibility and approach to be used in the study.

Qualitative data will be analysed with thematic analysis into themes and categories according to Smith (2015). The first step begins with familiarization—in depth knowledge and engagement with the data set. The second step is coding—identifying and labelling relevant features of data. The third step involves searching for themes and refocusing the codes into an overarching theme. This is followed by reviewing the themes—this consists of two parts: (i) in relation to the collated, coded data for each theme and (ii) in relation to the data set, then naming and defining themes—identifying the essence of each theme, followed by the final analysis and writing up of findings. Prolonged engagement during data collection until data saturation is reached will ensure credibility of this study. Member checking will ensure that transcribed data are a truthful reflection of the participants' perceptions and attitudes. Peer debriefing will be conducted with all researchers involved.

Phase II: Developing the Guidelines

A modified Delphi method will be implemented in order to engage various stakeholders on spirituality and spiritual care in Unani Tibb practice with the aim to develop the appropriate guidelines for the profession. The WHO Handbook for guideline development (WHO 2012) recommends the use of the Delphi method. A modified Delphi method refers to the combination of a self-administered questionnaires and physical meetings of experts to discuss the results or to rate the indicators. The use of questionnaire-based rounds and the physical meeting constitutes one round. The benefit of using the modified Delphi technique is that previous work forms the foundation of the study (Mthembu et al. 2016). Each round builds on the results of the previous one. The results of each round are compiled and returned to the experts which allows them to revisit their responses in light of the compiled responses of all experts. This process generates the ideas of those who evoke consensus and those that do not. The ideas of all experts are considered and contribute to the guideline development (Hsu and Sandford 2007). The researcher provides an anonymous summary of the experts' decisions from the previous round and the reasons for their judgements. Experts are then encouraged to revise their earlier responses in the light of the replies of other members in the forum. This process summarizes the wide range of answers and converges the group answers towards consensus (Hsu and Sandford 2007). For this study, a Delphi study will be conducted consisting of three rounds. The first round will consist of a self-administered questionnaire, the second round will be a face-to-face workshop, and last round will serve to review the developed guidelines based on the consensus reached.

Five quality indicators will be incorporated in this study to improve the optimal use and reporting of the Delphi method. These quality indicators are questionnaire

for the first round, experts, sending questionnaire, next rounds and final round (Mthembu et al. 2016; WHO 2012).

Participation Selections

Experts will be chosen based on their proven research and/or clinical experience within the field of CAM, Unani Tibb, interdisciplinary education and practice and spirituality/spiritual care in other health professions. An invitation to participate in this study will be sent to 30 eligible experts by means of an email notification. This invitation to experts will enquire on their willingness to participate in this study which is an important quality indicator to the Delphi process (Boulkedid et al. 2011; Mthembu et al. 2016; WHO 2012). The intended amount of participants for the study will be between 10 and 15 experts who will be purposefully selected based on their expertise in the field, with a minimum of 5-year working experience. Experts from different disciplines such as religious leaders, nurses, psychologists, social workers, interdisciplinary educators and practitioners, Unani Tibb and other CAM clinicians/educators/researchers will be included in this study. The inclusion criteria for the selection of participants include: (a) with expertise in the field of health sciences education and practice, spirituality and spiritual care; (b) qualified with a bachelor's degree and holding a senior position in education or health or clinical practice; (c) conducted research and published about spirituality and spiritual care; and (d) employed as educators and clinicians in either universities, private practice, public health services or schools. Experts will be informed on the aims and objectives of this study, and they will be required to provide informed consent to enrol in this study. All participants will be informed about their right to withdraw from the study at any time during study without repercussion. The sending of the questionnaire to experts via email further fulfils a quality indicator to the Delphi process (Boulkedid et al. 2011; Mthembu et al. 2016; WHO 2012).

Data Collection

A self-administered questionnaire which is another quality indicator will be used for the data collection component in this study (Boulkedid et al. 2011; Mthembu et al. 2016; WHO 2012). The questionnaire will consist of parts A and B. Part A will require the participants' demographic information, country, education level, place of employment and nature of employment. Part B will contain the proposed guidelines which were developed from the preceding studies in Phase I. The proposed guidelines will be rated using a 4-point Likert scale (1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree) to test for consensus among participants of the study (Adebiyi et al. 2018; Mthembu et al. 2016; WHO 2012). The Google platform will be used for creating the self-administered questionnaire and used for dissemination to the participants. The Google platform automatically saves the participants' responses into an excel spreadsheet form. This will be completed within two rounds.

The first round of the Delphi study will focus on the results of Phase I (scoping reviews, quantitative and qualitative studies). This will provide information needed by the experts to generate ideas and themes, which will inform the development of

spirituality and spiritual care guidelines for Unani Tibb practice. The guidelines will be further guided by the existential and Unani Tibb theoretical frameworks. This information will be collated using a matrix framework. This will then be sent to the experts by email. The experts will then be asked to review the items summarized by the researchers, and they will be asked to rate or rank the order of items to establish priorities among items and to reach a consensus (Adebiyi et al. 2018; Mthembu et al. 2016; WHO 2012). In round two, experts will have the opportunity to discuss the reasons, clarifications and justifications regarding the items rated in round one by means of a face-to-face workshop. The information generated in the second round will then be analysed for further refinement of the document towards the final guidelines. The number of rounds will depend on the time available until data saturation has been reached. Round three will serve to validate the rated guidelines as true reflections of what the panel agreed upon in rounds one and two. A summative report will be generated and shared with all experts for comment. The panel experts will then be asked to check the correctness of the responses related to their agreement about the guidelines that should be used to integrate spirituality and spiritual care into Unani Tibb practice as part of the final round. The process of guideline development is expected to be evolving and time-consuming. The researchers intend to incorporate all the quality indicators recommended to fulfil the objectives of the Delphi method (Adebiyi et al. 2018; Mthembu et al. 2016; WHO 2012).

Data Analysis

Descriptive statistical analysis will be used for this study by using the Statistical Package for the Social Sciences (SPSS) software 23 (2016). The research team will check the completeness and correctness of the responses on the items of the questionnaire. The descriptive statistics will include participants' characteristics using numbers (n) and percentages (%). For the Delphi study, it is recommended that at least 70% of panel participants need to rate 3 or higher on a 4-point Likert-type scale, and the median score has to be greater than 3.25. (Boulkedid et al. 2011; Hsu and Sandford 2007; Mthembu et al. 2016).

Trustworthiness

Trustworthiness will be prioritized during this study. Rigor is a crucial aspect for qualitative research studies. This can be achieved by adhering to the following principles of trustworthiness: credibility, transferability, dependability, conformability and authenticity (Botma et al. 2010). Credibility will be guaranteed by means of prolonged engagement and persistent observation (investment of sufficient time) during the data collection phase. Member checking will be conducted by obtaining feedback from participants and confirmation on emerging interpretations of the study. This will be done to ensure that transcribed data are accurately and truthfully recorded. Peer review and debriefing will be conducted by the team throughout this study. Dependability and confirmability will be ensured through inquiry audits where the team will have access to the all data and relevant documents. Reflexivity

will be practiced throughout the study, which refers to regular self-reflection to clarify and eradicate any bias, preconceived ideas or assumptions.

Discussion

The essence of the proposed spirituality and spiritual care guidelines is to inform the practice of Unani Tibb in South Africa. The guidelines are intended to assist Unani Tibb practitioners to attend to the spiritual needs of their patients. Whilst having informal discussions with Unani Tibb students, educators, practitioners in both private and community settings, regulatory board members, association executive members and the head of a non-governmental organization, it was understood that the focused guidelines are non-existent in South Africa. Further engagements with international researchers, academics and practitioners from other regions like India, Sri Lanka, Bangladesh and Iran reported similar accounts. This was further confirmed by the WHO Benchmarks for training in Unani Medicine document (WHO 2010) which indicated the lack of dedicated modules or topics within therapeutic modules for spirituality and spiritual care for Unani Tibb training programs. This paved the way to a much needed deeper scientific enquiry at national and international level.

Towards exploring the field at a national level, a review paper entitled, 'The role of Spirituality in Unani Tibb' was presented at the South African Tibb Association's (SATA) 2019 annual general meeting (AGM) and colloquium. SATA was established in 1997 and is a national body representing the Unani Tibb profession in healthcare delivery and education in South Africa. SATA is the eleventh profession of the Allied Health Professions Council of South Africa for which the register was officially opened in September 2007. The AGM is a CPD (continuous professional development) accredited event which attracts Unani Tibb practitioners from various provinces all over South Africa (AHPCSA 2020). The colloquium featured several research topics which provided updates on education, research and practice for Unani Tibb practitioners. The deliberations at this event further supported the need for this study in the South African context. Towards seeking guidance from researchers in other regions, a further enquiry at an international level was needed.

To gain insights from the international community, a review paper entitled, 'The role of Spirituality and Spiritual Care in Unani medicine' was then presented at the International Conference on Unani Medicine hosted by the Department of Kulliyat (philosophy of Unani medicine), Faculty of Unani medicine at the Muslim Aligarh University in India (AMU 2020). The conference that took place from the 3–4 December 2019 was entitled 'Fundamentals of Unani Medicine: the basis for complete health'. This event was supported by AYUSH, a ministry under the Government of India dedicated to the development of education and research for Ayurveda, Yoga and Naturopathy, Unani Tibb, Siddha and Homoeopathy, which are the most prominent systems of CAM in India. Panel discussions highlighted the need for further research on the topic of spirituality and spiritual care in Unani Tibb education and practice. This event then led to the conceptualization of this protocol and the eventual adoption of this research approach.

The strength of using the approach outlined in this protocol lies in the fact that it has been successfully used to develop guidelines for the inclusion of spirituality and spiritual care in occupational therapy education in South Africa. This study reported that the research approach may be applicable to other healthcare professions as well (Mthembu 2017). This study proposes the use of multiple sources for data collection towards the development of the finalized guidelines; therefore, all stakeholders (students, educators, practitioners, regulators and patients) of Unani Tibb in South Africa are the key participants to the initial phase of the guideline development process. The finalized guidelines will be distributed to all the participants in the study and to the education sector (the School of Natural Medicine, Faculty of Community and Health Sciences at the University of the Western cape), the social sector like NGOs (the Ibn Sina Institute of Tibb), the professional association (SATA), the regulatory statuary body for CAM (AHPCSA) and Unani Tibb community clinics in the Western Cape, South Africa. The guidelines will be published in peer-reviewed journals to add to the literature on Unani Tibb practice. The findings will also be presented at national conferences such as those hosted by SATA and international conferences such as those hosted by AYUSH and CCRUM (the Central Council for Research in Unani Medicine under the Government of India). The guidelines will then be presented to the WHO working group committee for benchmarking the training and practice of Unani medicine so that it may be reviewed and considered for inclusion in future WHO publications. The WHO Benchmark document for the training and practice in Unani medicine serves to guide member states on the global standard for training and practice in the Unani Tibb profession.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval Ethics approval for this study has been granted by the Biomedical Research Ethics Committee at the University of the Western Cape in South Africa (Ethics number: BM20/2/7). Permission to conduct this study at the University of Western Cape has been granted by the Registrar's office (Reference number: UWCRP130420MH). Permission to conduct this study at the Tibb treatment centres has been granted by the facility manager for both community clinics. Participant's role in this study will be voluntary. All participants will be given an information sheet which clearly explains the purpose of this study and requests their participation. Participants will complete an informed consent form to participate in this study. Confidentiality will be observed as their names will not be disclosed throughout this study. A number system will be used instead of names. Participants will be informed that they have the right to withdraw from this study at any point. Participants will be informed that no benefit or harm is expected to occur during this study; however, the results may lead to better clinical practice in the future. Anonymity will be ensured when disseminating the results by using codes instead of names. In the event that any participant experiences any form of emotional harm, they will be referred for counselling.

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