

Nurses' Competency in Caring for Muslim Patients

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Abstract

Problem or Purpose: This study aimed to assess the extent of cultural awareness of nurses on Muslim beliefs and practices and the degree of their cultural sensitivity towards caring for people having a different culture. *Methodology:* A quantitative descriptive-survey design was employed among the nurses employed in two urban hospitals in Region I, Philippines using convenience sampling. The Cultural Awareness and Sensitivity instrument and the self-constructed questionnaire on awareness on Islamic beliefs and practices were employed. *Results/Findings:* The nurses have moderate awareness and moderate sensitivity on the health beliefs and practices of Muslim patients. Specifically, they have moderate awareness on the subscales of dietary practices, family roles and organization and communication, and death rituals. In pregnancy and childbearing practices and religious practices they have poor awareness. *Conclusions/Implications to nursing practice:* Nurses should be encouraged to reflect on their clinical practice and to understand the impact of religious and cultural differences in their encounters with Muslim patients. In order to develop competency in caring for Muslim patients, nurses should first acquire knowledge about the Islamic beliefs and practices. *Index terms:* Muslim, nurses, Philippines, nursing competency

I. INTRODUCTION

Muslims are one of the fastest growing populations in the world. It is projected that by 2030 the global population of Muslims would be doubled from 1.1 billion in 1990 to 2.2 billion (Jones, 2011). The 2010 data shows that there are 1.6 billion Muslims worldwide with nearly two-thirds (*i.e.*, 985 million) living in the Asia-Pacific region ("The global religious", 2012). By 2030, nearly three-in-ten people (3:10) living in the Asia-Pacific region (27.3%) will be Muslims ("The future", 2011).

Moreover, Muslim population in the Philippines is steadily gaining. It comprises 5% to 9% of the Philippines' total population (Bureau of Democracy, Human Rights, & Labor, 2010; National Statistics Office, 2010). This means that there are about 4.6 to 8.3 million Muslims in the country. And while most of the Muslims live in the southern part of the country (*i.e.*, Mindanao) many are migrating to other islands, such as Luzon.

In the year 2000, the Office on Muslim Affairs reported that there were only 4,135 Muslim in Region I (Philippine Muslim Communities, 2011). However, by 2007 in one province alone (*i.e.*, Pangasinan), the number of Muslims has grown to more than 28,000 (Philippine Information Agency, 2007).

With this increasing number, together with the continuous migration of Muslims in Luzon, it is imperative that nurses should have the cultural competency in caring for Muslim patients.

Anchored on the concepts of cultural awareness and cultural sensitivity from the Cultural Competence Model this paper defines cultural competency as the healthcare providers' consideration and understanding on how social and cultural factors affect individuals' health and attitudes toward illness and disability (Purnell, 2002). Doorenbos, Schim, Benkert, & Borse (2005) point that "the cultural competence of healthcare providers is central to the healthcare system's ability to provide access to and delivery of high-quality, high-value healthcare" (p.1). In this paper, competency will be measured on the extent of the nurses' awareness and cultural sensitivity on the Muslim beliefs and practices. There exist numerous studies on assessing nurses' cultural competence. However, only a number of studies focus specifically on assessing the nurses' cultural awareness and sensitivity in caring for Muslim population (Halligan, 2006; Padela, Gunter & Killawi, 2011; Sidumo, Ehlers & Hattingh, 2010). Many of these studies report that one of the major barriers in providing quality care to Muslim patients is the lack of providers'

understanding of patients' religious and cultural beliefs and practices.

The lack of provider's awareness of the Muslim patients' cultural beliefs and practices may lead to negative consequences, such as patients' lack of trust and suspicion about the healthcare system, including providers (Hasnain, Connell, Menon, & Tranmer, 2011). Moreover, when lack of awareness is present, Muslim women experience discrimination and insensitivity about their religious and cultural practices. It leads to the limitation of health information or lack of cultural and religious specificity to meet their needs during pregnancy, labor and delivery, and postpartum phases (Reitmanova & Gustafson, 2008). A dearth of local empirical evidence that discusses the Filipino nurses' cultural competency in caring for Muslim patients also exists. This study therefore aimed to assess the extent of awareness of nurses on Muslim beliefs and practices. Moreover, it determined the degree of their cultural sensitivity towards caring for people having a different culture. Consequently, a health care provider brochure was developed to provide nurses an easy-to-use guide.

II. METHODS

A quantitative descriptive-survey design was adopted with a convenience sampling of 96 nurses in two urban hospitals in Region I. Hospital A is a 100-bed capacity while Hospital B is 300-bed capacity. The population comprise of 50 and 120 nurses but the accessible population consisted of 50 and 60 nurses during the data collection phase. However, only 96 nurses completed the survey.

I. Research instrument

The instrument had three sections. Section A, the Cultural Awareness and Sensitivity Scale, was adopted from Doorenbos, et al (2005) which previously had a Cronbach's alpha of 0.75. In this paper, it has a Cronbach's alpha of 0.420. This section comprises 11 items wherein one item was revised to be applicable in the local setting. Hence, from the original question "Language barriers are the only difficulties for recent immigrants to the United States" it was changed to "Language barriers are the only difficulties for recent Muslim immigrants to Luzon." It used 5-point Likert scale (*i.e.*, where SA = strongly agree to N = no opinion) in determining the level of sensitivity of the respondents. Four (4) items were reverse scored (*i.e.*, items 1, 2, 5, 8). The

higher the score, the higher is the cultural sensitivity of the nurse. The section B which assessed the awareness on Muslim beliefs and practices was selfconstructed. Concepts were derived from different sources, such as books for health care providers on Muslim, personal face-to-face interview of half a dozen Muslims, and online interview of almost 20 Filipino nurses who personally cared for Muslim patients. It was pilot tested and resulted to Cronbach's alpha of 0.824. It is composed of 40 dichotomous scale items (*i.e.*, True or False) which asked facts about the common health beliefs and practices of Muslim. It has five (5) subscales that include dietary practices, religious practices, pregnancy and childbearing practices, family roles and organization and communication, and death rituals. Thirteen items were false which include 4, 6, 7, 9, 12, 14, 17, 20, 21, 26, 28, 30, and 38. Higher score meant better awareness. And section C elicited the demographic data of the respondents.

II. Data Collection Procedure and Analysis

Once approval from the Chiefs of the Hospitals and Chief Nurses was granted, the survey was conducted during the nursing service meeting of the two hospitals. There were no existing ethics review boards of the hospitals at the time of the survey. Consent was implied as they answer the questionnaire. Nevertheless, anonymity and confidentiality were ensured prior to the distribution of the survey forms.

After the data collection, the figures were tabulated for analysis and interpretation. SPSS software and Microsoft excel were utilized. Frequency count, percentage, mean and weighted mean were used.

III. Participants

Out of the 96 respondents, 63.5% (n = 61) were female with the mean age of 31.09 years. Most were having only bachelor's degree (n = 77, 80.2%) and employed as permanent (n = 57, 59.4%). The median year of nursing practice is 5.5 which range from 4 months to 36 years. More than 60% have been practicing for 10 years or less (n = 62, 64.6%). More than half have never attended a seminar on Muslim beliefs and practices (n = 64, 66.7%), while the others have either attended such seminar at least once (see Table 1).

For the last 12 months, majority of the nurses have had a Muslim patient (n = 87, 90.6%).

Onethird cared for five (5) or more Muslims (n = 33, 34.4%) for the past year. Almost half have cared for a Muslim patient for 1-3 days (n = 40, 46.0%) while more than half cared for four (4) days or more. Finally, majority of the Muslim patients that were recently cared for were admitted at the OB ward (n = 30, 34.5%), followed by the Medical ward (n = 22, 25.3%) (see Table 2).

III. RESULTS AND DISCUSSION

I. Nurses' Overall Awareness of Muslim Health Beliefs and Practices

The results revealed that the respondents have a moderate overall awareness with regards to Muslim beliefs and practices (M = 3.00; Table 3).

the last 12 months (N=87)

Frequency of care	n	%
5 or more	33	34.4
3 -4 times	21	21.9
Twice	9	9.4
Once	24	25.0
Never	9	9.4
Duration of care		
1 - 3 days	40	46.0
4 - 6 days	24	27.6
7 days or more	23	26.4
Area of most recent Muslim patient care		
OB ward	30	34.5
Medical ward	22	25.3
Surgical Ward/ OR/ Orthopedic	10	11.5
ICU	8	9.2
Pediatric Ward/Neonatal Unit	7	8.0
ER	6	6.9
Pavilion/Private Room/Home care	3	4.6

Table 1. Demographic Data (N=96)

	n	%
Gender	61	
Female	35	63.5
Male		36.5
Age n = 88		
20-29 years old	51	53.1
30-39 years old	20	20.8
40-49 years old	14	14.6
50 and above	3	3.1
Mean	31.09	
Educational Attainment		
Bachelor's degree	77	80.2
with Masteral unit	9	9.38
with Master's degree	5	5.21
Others (not specified)	5	5.21
Employment status		
Permanent	57	59.4
Contractual	35	36.5
Others (not specified)	3	3.1
Probationary	1	1.0
Years of nursing practice		
≤ 1 year to 10 years	62	64.6
11 to 20 years	14	14.6
21 to 30 years	5	5.2
31 to 40 years	2	2.1
Missing	13	13.5
Number of times attended a seminar on Muslim beliefs and practices		
Never	64	66.7
Twice	21	21.9
Once	11	11.4

Table 2 Frequency, Duration and Area of Muslim Care for

Specifically, they have a moderate knowledge on the subscales of dietary practices, family roles and organization and communication, and death rituals. This shows that the nurses have already established a well-built foundation on the beliefs and practices of Muslim patients. This is probably due to the frequency of admission of Muslim patients in the hospital wherein more than half of the nurses had cared five Muslim patients and more for the last year.

Table 3 Extent of Awareness on Muslim Beliefs and Practices

	Sub-scales	Weighted
Mean (I)		
1. Dietary Practices	2.90 (M)	
2. Family Organization & Communication	2.69 (M)	
3. Death Rituals	2.59 (M)	
4. Pregnancy & Child-bearing Practices	2.38 (P)	
5. Religious Practices	1.91 (P)	
Total		3.00 (M)
Legend: 1= Interpretation; Very Poor 1.00-1.75; Poor 1.76-2.50; Moderate 2.51-3.25; High 3.26-4.00		

However, the result also shows that the nurses have poor awareness on the religious practices, and the pregnancy and childbearing practices of the Muslim patients. It is

interesting to note that even though majority of the Muslim patients cared by the nurses are admitted at the OB ward, the nurses had poor awareness on the practices related to pregnancy and childbearing. This implies that the nurses need to develop and acquire more knowledge on these areas of beliefs and practices of Muslim patients.

II. Awareness on Muslim Dietary Practices

Almost all of the nurses (n = 93, 96.9%) are aware of the Halal foods, such as, fish, eggs and vegetarian foods and the forbidden foods and drinks (*Haram*), such as pork and alcohol (n = 86, 89.6%) (see Table 4).

More than half of the respondents know that Muslims may prefer to eat meat that has been killed according to Islamic tradition (n = 53, 55.2%). The survey also revealed that almost 93% (n = 89) of the nurses surveyed know about the observance of fasting during the month of Ramadan. However, few of the respondents (n = 42, 43.8%) know who are the persons exempted from fasting and what treatment could break their fast (n = 54, 56.3%). Although many nurses showed adequate awareness regarding the Muslim patients' use of their right hand for eating and drinking (n = 66, 68.8%) there is lack of awareness on using the appropriate hand in feeding their Muslim patient (n = 19, 19.8%). Sidumo, Ehlers, and Hattingh (2010) yielded a similar result among non-Muslim nurses wherein nurses lacked awareness about Muslim practices concerning breastfeeding, medicine and food taboos.

Table 4
Frequency and Percentage of the Nurses' Correct Answers regarding Muslim's Dietary Practices

Dietary practices	n%
1. Muslims can eat fish, eggs, and vegetarian foods.	93 (96.9)
2. Muslims observe fasting from sunrise to sunset during the month of Ramadan.	89 (92.7)
3. Practicing Muslims eat pork and drink alcohol.*	86 (89.6)
4. Muslims are required to wash their hands before and after meals.	84(87.5)
5. Halal foods are foods that Muslims are allowed to eat.	80 (83.3)

6. Muslim patients who decide to fast while admitted in the hospital may take the following medications/treatments without breaking their fast: injections, blood tests, skin patches, or gargling.	78 (81.3)
7. Muslims choose to use their left hand for eating and drinking.*	66 (68.8)
8. The following will break the fast of a Muslim person: ear and nose drops, suppositories, inhaled medications.	54 (56.3)
9. Muslims may prefer to eat meat that has been killed according to Islamic tradition.	53 (55.2)
10. Pregnant, breastfeeding or menstruating women are required to fast during Ramadan.*	42 (43.8)
11. A nurse can feed a Muslim patient using either their right or left hand.*	19 (19.8)

*False answer

Halal and Haram Foods

Muslims are required to partake only *halal* diet. Halal means lawful and is used to designate food which is permitted in Islam (Queensland Health and Islamic Council of Queensland [ISQ], 2010). Pig meat and all its by-products are forbidden to Muslims, together with wild animals that use their claws or teeth to kill their prey (*e.g.*, birds of prey) (Queensland, 2010; Islamic Social Services of Oregon State [ISOS], 2009; Gulam, 2003). Pork by-products include ham, bacon, sausages, longganisa, and hotdog. Some ice cream, gelatin (*e.g.*, Jell-O) or products that contain gelatin (*e.g.*, gelatin capsule for medication) are also prohibited since their ingredient is commonly pork. Nevertheless, this gelatin should not be confused with the local "agar-agar" sold in the Philippine market which is usually marketed as "gelatin", since agar-agar is derived from a type of seaweed, hence, it is Halal (allowed) (People for the Ethical Treatment of Animals [PETA], n.d.). This has implication to the dietary service the hospital provides to its Muslim clients. It is imperative for the health care provider to ask the Muslim patient's adherence to their dietary regulation and dietary preferences. And nurses should also be aware that there are already available *halal* foods in the market or grocery that could be bought for the client.

The Muslim dietary guidelines also include the restriction of alcohol in any form. It is

significant for the health care provider to inform the client about the medication that may contain alcohol, such as mouthwash and medications (e.g., Benadryl, Dimetapp, Imodium, Lomotil, Phenergan, Tylenol) (Medical Society of State of New York, n.d.).

Fasting

Ramadan is the ninth month in the Islamic year, which follows a lunar calendar (Queensland Health & ISQ 2010). This year Ramadan is observed from June 17 to July 17. Fasting is compulsory for all healthy Muslims upon reaching puberty. Fasting begins an hour before sunrise and ends at sunset and includes a total fast or abstinence from any food, drink and sex (ISQ, 1996; ISOS, 2009). It is a practice for Muslims to consume a pre-dawn meal before fasting during the day (Queensland Health and ISQ, 2010).

Pregnant, breastfeeding or menstruating women, the ill and the ones travelling are exempted from fasting during Ramadan. However, some Muslim patients may still decide to fast while admitted in the hospital. Muslim patient could receive injections, blood tests, skin patches, or gargling as long as no fluid goes down the throat to break their fast (ISQ, 1996). Nevertheless, some therapy could break the fast such as ear and nose drops, suppositories, inhaled medications (Queensland Health & ISQ, 2010). Fasting may also be a source of concern for diabetic patients who choose to fast during Ramadan. Diabetes Australia has a comprehensive guide for health care workers on fasting and diabetes (The National Diabetes Services Scheme, 2015).

Use of Hand when Eating

It is important to note that Muslims consider their left hand as unclean since it is used to cleanse the genitals and anal areas after the

toilet. Therefore Muslims use their right hands when eating or drinking. In same manner, health care providers should use their right hands when giving or receiving something; similarly, when serving food or drinks they must let the client receive it with his or her right hand (ISQ, 1996). If health care providers are required to feed a Muslim patient, the use of the right hand is required to touch the food, but either hand is acceptable if utensils are used (Queensland Health & ISQ, 2010). Also, Muslims are required to wash their hands before and after meals, hence, it would be worthy to provide bed-bound patients portable hand washing facilities, such as *planggana* (basin) or *tabo* (dipper).

III. Awareness on Muslim Family Roles and Organization and Communication Practices

Majority of the nurses are aware that a male Muslim patient may prefer to have a male health care provider (n = 72, 75%) and that if a woman needs to be examined by a male physician, a female companion (i.e. nurse, family, relative) should be present in the room (n = 85, 88.5%). Moreover, also knows of the importance of visitation in Muslim culture (n = 73, 76.0%) and that the head or hair of Muslims should not be touched unless during a medical examination (n = 75, 78.1%). However, only a third of the nurses knows that permission is important when shaving the beard (balbas) of a Muslim patient and that female nurses could not just handshake or pat the male

Muslim patients (n = 38, 39.6%; n = 34, 35.4%, respectively). Finally, very few nurses (n = 36, 37.5%) are aware that the final decision for any consent should be from the father or husband (see Table 5).

Table 5

Frequency and Percentage of the Nurses' Correct Answers regarding Muslim's Family Roles and Organization and Communication

Family Roles and Organization and Communication	n %
1. If a woman needs to be examined by a male physician, a female companion (i.e. nurse, family, relative) should be present in the room.	85 (88.5)
2. Muslim would prefer to share a room with a person of the same gender.	79 (82.3)

3. For some Muslim women, it is important to ask for permission if <i>Hijab</i> , the head scarf, needs to be removed during procedure or physical examination.	79 (82.3)
4. The head or hair of Muslims should not be touched unless during a medical examination.	75 (78.1)
5. Muslim patients usually have a very few numbers of visitors.*	73 (76.0)
6. A male Muslim patient may prefer to have a male health care provider.	72 (75.0)
7. It is forbidden for the Muslim men to shave their beard.	59 (61.5)
8. It is not important to ask permission when shaving the beard (<i>balbas</i>) of a Muslim patient.*	38 (39.6)
9. If consent for a procedure is needed for Muslim women and children, the woman/mother makes the final decision.*	36 (37.5)
10. Female nurses could handshake or pat the male Muslim patients.*	34 (35.4)

*False answer

Gender issues and Privacy Muslim women are required to have a woman health care provider as is true for Muslim men. This also applies to housekeeping staff, lab technicians and other hospital employees who having direct contact with the patient (ISOS, 2009; Queensland Health and ISQ, 2010). But many Muslim patients are now open to have health care provider of different gender. Nevertheless, health care providers should still need to inform the patient when same-sex health care provider cannot be accommodated. Moreover, whenever a male healthcare provider cares for a female patient, he should always be joined by a female staff member or have the patient attended by one of her adult relatives. Exposure of the patient's body parts should be limited to the minimum and permission should be asked before gently uncovering any part of the body. Even more care should be taken when exposing private parts, and attempts should be made to avoid such exposures unless absolutely necessary (Al-Shahri & Al-Khenaizan, 2005). For added privacy of a Muslim woman, it is also worthy to post a sign at the door of the room, identifying the patient as Muslim and asking that visitors "Knock Before Entering" (ISOS, 2009; Al-Shahri & Al-Khenaizan).

Visiting the Sick

It is considered a communal obligation and a virtue to visit the sick (Queensland Health and ISQ, 2010). Wherever possible, arrangements should be made to accommodate large numbers of visitors in hospitals. Also, health care providers should discuss with the patient, or their family, the possibility of large numbers of visitors and the impact this may have on rest or care requirements of other patients (Queensland Health and ISQ, 2010 ISOS, 2009).

Touching

Filipinos are caring people and it is a common practice for nurses to touch patients for comfort regardless of their gender. Considering that majority of nurses employed in the hospital are female, it is imperative then to emphasize caution when touching and making eye contact with a Muslim patient of different gender. It was shown that few nurses are aware that female nurses could not just handshake or pat the male Muslim patients. On the other hand, majority knows that the head or hair of Muslims should not be touched unless during a medical examination (Charles & Daroszewski, 2012). This is because during prayers, they touch their foreheads to the ground and lift their hands to Allah (Muslim

Religious Practices as cited by Charles & Daroszewski, 2012).

Shaking hands and touching with the opposite sex when not related, is not permissible for Muslims according to the teachings of Islam. It is not allowed for a believing man to put his hand on the hand of a woman who is not related with him (mother, wife, sister, daughter, etc.). According to Muslim beliefs "It is better for you to be stabbed in the head with an iron needle than to touch the hand of a woman who is not permissible to you." (Estes, n.d., par 3).

Consent and Decision-maker

Consent of patients is an important consideration when procedures or even simple nursing care is needed to be accomplished. First, the Hijab is the traditional headscarf worn by most Muslim women which represents a woman's submission to her Creator and her connection with the faith (Muslims as cited by Charles & Daroszewski, 2012; "Why hijab", 2012).

One of the most important aspects of a man's appearance is his beard. It is compulsory upon a Muslim man to grow a beard and refrain from shaving or trimming it to less than the

length of a fist. It is *Haram* for a mature stable man to shave his beard without a valid medical reason ("Muslim Men", n.d.; "Status of the Beard", n.d.). Nurses should, therefore, ask for consent before removing the hijab or shaving beard. Finally, the family dynamics of the Muslim culture is patriarchal in nature. Very few nurses are aware that the final decision for any consent should be from the father or husband. This is one important factor to consider when asking for consent in any procedure that will be done to the Muslim patient, especially for Muslim women and children (ISOS, 2009).

IV. Nurses' Knowledge on Muslim Death Rituals

Majority of the nurses are aware that certain customary rites are needed for the client whose death appears to be imminent (n = 86, 89.6%) while few know that the deceased Muslim should be covered with a white cloth (n = 28, 29.2%). Most nurses are aware that Muslim burials are performed as soon as possible after death (n = 79, 82.3%) and that the body of a deceased Muslim person should only be handled by a person of the same sex, if possible death (n = 72, 77.1%) (see Table 6).

Table 6
Frequency and Percentage of the Nurses' Correct Answers Regarding Muslim's Death Rituals

Death Rituals	n %
1. If death appears imminent, a Muslim patient's family may wish to perform certain customary religious rites.	86 (89.6)
2. Decision regarding end-on-life issues (i.e., DNR code, use of mechanical ventilator) is usually made by the next-of-kin senior male (i.e., husband, father or older brother).	81 (84.4)
3. Muslim burials are performed as soon as possible after death, sometimes on the same day.	79 (82.3)
4. The body of a deceased Muslim person should only be handled by a person of the same sex, if possible.	72 (77.1)
5. The whole body of a deceased Muslim person should be covered by a black sheet.*	28 (29.2)

*False answer

If death appears imminent, a Muslim patient's family may wish to perform certain customary

religious rites. The simple practice which Muslims follow is to sit near the bed of the

patient and read some verses from the Qur'an and pray for the peaceful departure of the soul.

Postmortem Care

After death, the body of a Muslim must be handled with utmost respect only by a person of the same sex (ISOS, 2009). Moreover, the face of the deceased Muslim should preferably be turned towards Makkah while the face and whole body covered by a white sheet and a cross must never be placed on the body (ISOS, 2009). Also, it is important to note that the body must be handled as little as possible since Muslims believe that the body feels pressure and pain numerous times more than that applied. Muslims also believe that the soul remains close to the body until burial. Embalming is forbidden and Muslim burials are performed as soon as possible after death, sometimes on the same day (ISOS, 2009; ISQ as cited by Charles & Daroszewski, 2012).

V. Awareness on Muslim Pregnancy and Childbearing Practices

Majority of nurses are aware of the importance for a Muslim woman to have a companion uttering a special prayer on her behalf she is on labor (n = 80, 83.3%). The respondents are also aware that no other male should be at the delivery room except the husband (n = 79, 82.3%). However, only 25 (26.0%) of the nurses know about the prayer recited for the newborn baby and only 16 respondents (16.7%) are aware that the term

nasasaniban is used to describe by some Muslims to a Muslim woman who is having a difficult labor (see Table 7).

Labor and Postpartum care

Muslims believe in strict separation of the sexes outside of marriage. Unrelated men are not permitted to enter the room of a woman (ISOS, 2009). Further, Muslim men and women are not permitted to touch, or be touched, by members of the opposite sex unless they are married to them (ISOS).

With regards to modesty, it is important to note that health care provider should drape Muslim women for modesty during examinations.

This means care providers should ask a Muslim woman's permission prior to uncovering her body parts during sensitive exams (ISQ, 1996; Taheri, 2008).

Strict privacy should always be observed when examining a Muslim client. It is not acceptable to examine a Muslim person when the door of the examination or hospital room is open (Charles & Daroszewski, 2012). The practice of modesty and privacy creates unique problems in the delivery of health care services

In their study on the perspective of both provider and patients on caring for Muslim women, Hasnain and colleagues (2011) found that providers' lack of accommodation on the modesty needs exists. It was cited that providers perform intimate examinations without a female nurse present or making the patient sit in a revealing

Table 7
Frequency and Percentage of the Nurses' Correct Answers regarding Muslim's Pregnancy and Childbearing Practices

Pregnancy and Childbearing Practices	n %
1. A Muslim woman having a difficulty labor may asked for a companion to utter a special prayer for her.	80 (83.3)
2. It is preferable that no male should be in the delivery room except the husband.	79 (82.3)
3. Shortly after birth, a small amount of honey is placed on the abdomen of the infant.*	71 (74.0)
4. Islam requires mothers to breastfeed their children.	77 (80.2)
5. It is essential for most Muslims to bury placenta.	62 (64.6)

6. It is not important for a Muslim woman in labor to have a companion to utter a special prayer for her.*	52 (54.2)
7. If a miscarriage or stillbirth occurs, most Muslim parents do not bury the fetus.*	50 (52.6)
8. As soon as a child is born, a short prayer is recited into the baby's left ear.*	25 (26.0)
9. A Muslim woman who is having a difficult labor is called <i>nasasaniban</i> .	16 (16.7)

*False answer

hospital gown for x-ray examination in open waiting area with male patients.

Although majority of nurses are aware on the importance of having a companion while on labor very few know that the term *nasasaniban* is used to describe a difficult labor. This is an important factor to consider since majority of the admitted patients are OB cases and it was noticed that the policy in both hospitals prohibit the presence of significant others in the labor and delivery rooms. Moreover, clarification of the meaning of the word is necessary since, in Luzon *nasasaniban* connotes a different thing (*i.e.*, devil possession). After giving birth, it is important to give to the parents the placenta for burial because in accordance with Islamic tradition placenta is considered a part of the infant (ISOS, 2009).

Miscarriage, IUD and Abortion A fetus after the age of 120 days is regarded as a viable baby. A miscarriage or an intrauterine death occurring after 120 days of conception would require burial. Therefore, fetus from such events must be given to the parents for proper burial. The fetus is given a name after the burial (ISOS, 2009).

Moreover, abortion is not permitted in Islam unless there are very strong medical reasons. The first four months of pregnancy are recognized as a critical period for the development of the fetus. Nonetheless, abortion during this period for strong medical reasons is allowed. After the fourth month period has passed, the fetus is regarded as "alive". The termination of pregnancy after this stage is regarded as murder. However, if pregnancy constitutes a serious threat to the life of the mother, abortion is permissible irrespective of the period of gestation (ISOS).

Newborn care

As soon as a child is born, a Muslim father may wish to recite a prayer call into the baby's right ear followed by a second prayer call into the left ear. It does not take more than five minutes and unless the newborn requires immediate medical attention, health care providers should allow this to take place (Queensland Health & ISQ, 2010).

Another rite which is performed shortly after birth involves placing a chewed/softened date on the palate of the infant. If dates are not available, honey or something sweet is used as a substitute (Queensland Health & ISQ). Nevertheless, health care providers should advise parents about the risk of infant botulism when feeding honey (Queensland Health & ISQ).

VI. Awareness on Muslim Religious Practices

Majority (n = 79, 82.3%) are aware of the various positions during prayer, such as bowing, prostrating and standing. Yet, very few know about the cleansing ritual before prayers (n = 22, 22.9%) and the facing to Mecca while praying (n = 26, 27.1%) (see Table 8).

Muslims are required to pray five times a day facing Mecca. Prayers are usually performed on a prayer mat and include various movements, such as bowing, prostrating and sitting (Queensland Table 8 Frequency and Percentage of the Nurses' Correct

Answers Regarding Muslim's Religious Practices

Religious Practices	n %
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1. Muslim prayer involves standing, 79 (82.3) bowing, and prostrating.
2. If washing with water or having a 75 (87.1) bath is not possible for a Muslim patient, Tayammum is an alternative method of purification.
3. Muslim patients can pray while 62 (64.6) seated or in bed.
4. Muslims are required to pray five 26 (27.1) times a day while facing their back at Mecca*.
5. Right after prayer, Muslims are 22 (22.9) required to perform *wudhu* or ablution– a ritual washing or purification*.

*False answer

Health & ISQ, 2010). During prayers, they bowed down to touch their foreheads on the ground and then lift their hands to Allah (Muslim Religious Practices as cited by Charles & Daroszewski, 2012). Muslims prefer a quiet environment during prayers and are not allowed to talk or attend to any requests while praying, except in emergency situations (Al-Shahri & Al-Khenaizan, 2005). But those cognitively incapacitated women at the time of post-natal discharge and during menstruation are exempted (Queensland Health & ISQ, 2010). It is not necessary for ill patient to do all the usual prayer movements. These prayers can be performed in bed or while seated. Those who are able to get up and not physically or medically restricted to bed could be provided with a space to pray in a secluded, clean and quiet place. Further, a hospital chapel may also be used provided there are no religious icons present (Queensland Health and ISQ, 2010; ISOS, 2009). Some nurses may be concerned about the prayer time as this may affect the nursing care. But prayers are not lengthy (*i.e.*, about 5-10 minutes) and it would be worthy to delay usual care during prayer. Placing a “Do not disturb” or “Prayer on going” sign at the door is highly recommended.

Cleansing/Hygiene

Before a Muslim performs *Salaat* (prayer) or holds a copy of Qur’an, one needs to perform cleansing (ISOS, 2009). Cleanliness is part of the Islamic faith. There are various types of washing or ablution. (1) *Wudhu* is done before prayer and includes washing of the hands, mouth, nostrils, face, forearms, wiping the head, ears, and the neck and washing the feet with clean water; (2) *Tayammum*, or dry ablution, is a form of cleansing when water for

wudhu is not available or considered detrimental to health. It is performed by striking the palms of both hands on any unbaked earthly matter (e.g. stone or sand) and symbolically washes in two simple steps (ISOS). In the Philippines, some practice *Tayammum* by wiping the palms of the hands to any clean area, such as the hospital wall and lightly wiping the face and forearms..

With regards to these practices, washing facilities should be made available in the ward and in the toilets in the form of a simple plastic container for the individual to wash his or her private parts (ISOS, 2009). For patients who are bedridden, special care should be taken with cleanliness, especially with discharges, urine and stools and bleeding from any orifice, bearing in mind that the patient may wish to pray in bed. A dipper or basin of water should be made available to bedridden Muslim patients whenever they empty their bladder or move their bowel (ISOS). Finally, it is important to cognizant with the emphasis on modesty, hence, bed baths must be given by members of the same sex only (ISOS).

VII. Nurses’ Extent of Cultural Awareness and Sensitivity

The respondents have high cultural awareness and sensitivity as revealed with the mean 3.88 (Table 9). Specifically, most nurses have very high awareness that spirituality and religious beliefs are important aspects of many cultural groups (M = 4.28) and that many aspects of culture influence health and healthcare (M = 4.28). Moreover, many enjoy working with people who are culturally different from them (M = 4.10).

The Muslims in Luzon come from different parts of Mindanao which is divided into ten different Muslim subgroups. They have their own unique beliefs, practices and language. These groups comprise the Maranao which most of the Muslims in the Region come from, other subgroups include Maguindanao, Iranun, Tausug, Yakan, Sama, Molbog, Palawan, Kolibugan, and Kaagan (Bara, n.d.). With the various ethnicity and cultural groups of the Philippine islands together with the diverse religious beliefs, it is expected that nurses are well aware of the importance of spirituality whatever group a person may belong.

However, nurses may be prone to

stereotyping their Muslim patients by thinking that the guide-lines discussed above are true to “all” Muslim patients. As shown in the survey, the nurses have a low mean scores in the items “If I know about a person’s culture, I do not need to assess their personal preferences for health services and “People with a common cultural background think and act alike” and (*i.e.*, M =2.50; M = 2.10, respectively). The ISOS (2009) explains the careful consideration of the general Muslim beliefs and the individual patient’s diversity: Like members of all religions, Muslims practice their religion in different ways: some women cover, some do not; some men have beards, some do not; some women/men shake hands with opposite gender persons, some do not. The list goes on. However, in teaching the appropriate means of providing Medical Care to the Muslim population, we adhere to the strictest guidelines of Islam.

This affords you, the Medical Professional, with guidelines that will not offend any Muslim. If an individual Muslim makes a choice not to adhere to specific

Table 9
Mean Cultural Awareness and Sensitivity

Cultural Awareness and Sensitivity Scales	Mean	I
Spirituality and religious beliefs are important aspects of many cultural groups.	4.28	Very High
Many aspects of culture influence health and healthcare.	4.21	Very High
Aspects of cultural diversity need to be assessed for each individual, group, and organization.	4.19	High
I enjoy working with people who are culturally different from me.	4.10	High
Individuals may identify with more than one cultural group.	3.93	High
I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.	3.89	High
I understand that people from different cultures may define the concept of “healthcare” in different ways.	3.89	High
If I know about a person’s culture, I need to assess their personal preferences for health services.	2.50	Low

teachings of Islam in their treatment that is the exercise of the freewill given to them by God. However, we ask that, as the Medical Professional, you provide the therapy according to the strictest guidelines, unless the patient requests otherwise (p.13).

The respondents have the lowest mean in the area of communication. Many nurses believe that language barrier is the only difficulty for recent Muslim migrants in Luzon (M = 2.05). Since Muslim patients who are commonly admitted in the hospital speak the Maguindanaon language while the languages of people in the area of Region I are Pangasinense and Ilocano, basically language could be a main barrier for communication. In a study among critical care nurses, the nurses indicated the importance of the role of the family and religion in providing care. In the process of caring, the participants felt stressed and frustrated and they all experienced emotional labor. Communicating with patients and the families was a constant battle and this acted as a further stressor in meeting the needs of their patients (Halligan, 2006).

People with a common cultural background do not think and act alike.	2.10	Low
Language barriers are the not the only difficulties for recent Muslim migrants in Luzon.	2.05	Low
Race is the not the most important factor in determining a person's culture.	1.95	Low
Grand Mean	3.88	High

Legend: I= Interpretation; 1-1.80 -no opinion (very low sensitivity); 1.81-2.60 - strongly disagree (low sensitivity); 2.61-3.40- disagree (moderate sensitivity); 3.41-4.20 –agree (high sensitivity); 4.21-5.0 strongly agree (very high sensitivity)

Language barrier is not the only difficulty that nurses face. Non-verbal communication also plays essential role in the exchanging of information. The College of Nurses of Ontario (2009) points out that most of what we understand is conveyed by non-verbal cue. They add that it is not what we say but how we say it and that we should all learn how we convey information non-verbally to avoid expressing personal biases. Moreover, Seibert, Stridh-Igo, & Zimmerman (2002) recommend some ways on how to properly communicate to persons with different culture. First, they suggest that the nurse needs to double-check comprehension. They explain, “Remember, nodding and indicating some type of affirmative response does not necessarily guarantee understanding has been achieved. Re-explaining is useful and facilitates comprehension, particularly during times of stress. Effective communication launches effective care. One useful technique is to gently ask the patient or family member to convey the informations in his/her own words, before

concluding that he/she understands.”

Secondly, the nurse also needs to doublecheck for trust. The authors argue that “good communication leading to the establishment of trust” seemed to be more important to the participants than the expertise of the professional. They explicate that lack of trust can impede achieving the best possible outcomes because the patient and family might withhold essential health-related information. Another trust-related impediment occurs when patients and families fail to follow crucial instructions or do not believe recovery can be achieved.

Lastly, Seibert and colleagues emphasized about health care provider bias. They declare that health care providers do have biases and prejudices. So they recommend that we examine and recognise our own biases and

prejudices. They explained that it is a fact of life that prejudice and bias exist. Those who deny it are most afflicted. Identifying and recognizing this will help control its expression. To accomplish cultural awareness effectively “the health care professional must first understand his or her own cultural background and explore possible biases or prejudices toward other cultures” (p.146). Upon close examination of prejudice, bias, and their sources, it appears that fear is the foundation. Work to overcome these fears; education will facilitate the process.

VIII. Muslim Brochure

Based from the result of the study, an easy-touse brochure was developed by the author to assist nurses in developing their awareness in caring for Muslim patients. (See Appendix. Islamic Brochure for Nurses).

IV. CONCLUSION

The findings of this study highlight important insights into the cultural awareness and sensitivity of the nurses in caring for patients of Islamic denomination. The study revealed the moderate knowledge as well as moderate sensitivity of nurses on the health beliefs and practices of Muslim patients. Numerous areas that nurses need to be educated include the importance of a woman in labor to have a companion to utter a prayer for her; utterance of prayer for the newborn baby, determining the main decision-maker in the family when asking for consent, gender issues, and importance of modesty and privacy especially for Muslim women.

V. IMPLICATIONS TO NURSING PRACTICE

The poor awareness of nurses in Muslim patients' pregnancy and childbearing practices and religious practices should be addressed. Since majority of admitted patients are in the OB ward nurse should be encouraged to reflect on their clinical practice and to understand the impact of religious and cultural differences in their encounters with patients of Islam religion. In order to develop competency in caring for Muslim patients, nurses should first acquire knowledge on their beliefs and practices. Moreover, they should be prompted to evaluate their own cultural sensitivity and strive to develop respect and accommodation of the needs of patients.

VI. RECOMMENDATIONS

The findings of this study can provide guidance for future research studies that is aimed at ensuring culturally appropriate, patient-centered healthcare for Muslim patients in the Philippines.

For the hospital management, culture competent care can be enhanced by: (1) making necessary adjustments in the healthcare system; (2) developing an educational program, organizing seminars or providing training regarding the Muslim beliefs and practices; (3) using the brochure prepared by the author to enhance the awareness of nurse about the Muslim culture; and (4) encouraging the inclusion of culture-specific aspects in the nursing care plan for each patient. The small number of respondents included in this study may have an implication in the generalizability of the result hence, it is recommended that another research be conducted that involves a larger number of nurses. Furthermore, a research study using qualitative design is suggested, including both nurses and patients as the participants to enhance the understanding of the uniqueness of the Muslim culture (*i.e.*, Maguindanao) that immigrated in the area and identify possible barriers towards the provision of culturally appropriate care.

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