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UNDERSTANDING *SOLAH* COMPLIANCE AND ADHERENCE AMONG HOSPITALIZED MUSLIMS: A CRITICAL SURVEY ON THE BARRIERS, CHALLENGES, AND SYSTEMIC PERSPECTIVES

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ABSTRACT

Background and Purpose: Prayer (*Solah*) is a fundamental obligation for Muslims, essential for spiritual and mental well-being. However, hospitalized Muslim patients often neglect this practice due to various barriers, rarely explored from their perspective. This study investigates the barriers, disabilities, and systemic factors affecting *solah* compliance and adherence in orthopaedic wards, particularly within the Ibadah-Friendly Hospital (IFH) framework.

Methodology: A cross-sectional survey was conducted among 203 Muslim patients (aged 20–75 years) admitted to orthopaedic wards of a tertiary hospital. Self-reported questionnaires assessed prayer practices, disabilities, knowledge gaps, and exposure to IFH campaigns. Data were analysed using descriptive statistics and chi-square tests.

Findings: More than half (52.2%) of patients did not perform any prayers, while 36.1% performed some, citing Subuh and Asr as the most difficult. Barriers included mobility limitations (p=0.009), toileting challenges (p=0.009), knowledge gaps about *rukhsah* (p=0.031), insufficient assistance (p=0.006), and embarrassment (p=0.035). Lifestyle factors such as smoking and alcohol use (p=0.001 and p=0.034) further impacted adherence. Exposure to IFH campaigns improved compliance (p=0.019).

Contributions: This study highlights the need for education, tailored assistance, and improved hospital infrastructure. Strengthening IFH initiatives and integrating Muslim chaplainship can enhance *solah* adherence, fostering holistic care for Muslim patients.

Keywords: Muslim patients, ibadah-friendly hospital, barriers to religious practices, patient disabilities, hospitalization.

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1.0 INTRODUCTION

Solah (prayer) is a fundamental pillar of Islam, signifying devotion, discipline, and a spiritual connection with Allah. Performed five times daily, *solah* is an obligatory practice for all Muslims, irrespective of personal circumstances, including illness or hospitalization (Margolis et al., 2003; Mohamed et al., 2018). The Quran and Hadith emphasize its significance, offering religious concessions and leniencies (*rukhsah*) to accommodate those facing physical or situational challenges, such as illness or disability. These provisions allow modified prayer positions or symbolic gestures, underscoring Islam's principle of ease in fulfilling religious obligations (Adul, 2001; Che Mohamad et al., 2015; Sharifudin et al., 2018). Despite these allowances, adherence to *solah* among hospitalized Muslim patients remains low. Physical disabilities, such as immobility and pain, as well as limited access to ablution facilities, have been identified as significant barriers. Studies highlight that many patients are unaware of

rukhsah provisions, resulting in non-compliance with their spiritual obligations (Azhari et al., 2022; Che Mohamad et al., 2015; Sharifudin et al., 2018).

Although initiatives like Malaysia's *Ibadah*-Friendly Hospital (IFH) framework aim to integrate spiritual care into healthcare settings, adherence to *solah* among hospitalized Muslims remains inconsistent. Challenges such as overcrowded wards, limited staff training, and inadequate facilities hinder the effective implementation of these programs (Che Mohamad et al., 2015). Healthcare providers play a crucial role in guiding and assisting patients in fulfilling their religious duties, but resource limitations and competing responsibilities often constrain their ability to provide support. The gap between idealized frameworks and practical realities necessitates targeted research to identify and address the barriers Muslim patients face in adhering to *solah* during hospitalization.

This study focuses on hospitalized Muslim orthopaedic patients, whose conditions often involve injuries or impairments that directly impact mobility and cleansing—key components of *solah*. The primary objective is to identify the challenges these patients face, including physical limitations, lack of knowledge about *rukhsah*, and systemic barriers. By understanding these factors, the study aims to guide the development of tailored interventions that support *solah* adherence and enhance the implementation of IFH principles. Ultimately, this research seeks to promote holistic, patient-centred care that bridges the gap between spiritual obligations and clinical practices.

2.0 LITERATURE REVIEW

2.1 The Concept of *Ibadah* and *Solah* in Islam

The term *al-ibadah* in Arabic encompasses obedience, submission, and humility. In Islamic teachings, it signifies ultimate devotion, submission, and humility toward Allah, embodying the essence of worship and adherence to Islamic principles (Adul, 2001; Ariff et al., 2015; Che Mohamad et al., 2015; Mohd Yusoff et al., 2011; Sharifudin et al., 2005; Sharifudin et al., 2018). Muslims believe that the primary purpose of human existence is to worship Allah, making *al-ibadah* the foundation of their spiritual lives. This concept extends beyond formal rituals, reflecting sincerity and heartfelt devotion, which cannot be imposed upon others (Ariff et al., 2013; Che Mohamad et al., 2015; Goh et al., 2015;).

Solah is a key component of *al-ibadah* and involves specific physical postures combined with spiritual focus. Each sequence holds significance in promoting proper alignment and functionality. For instance, standing requires maintaining an upright posture to ensure stability. During the bowing position (*ruku'*), the body forms a right angle, keeping the spine straight

and aligned with the head and neck, which helps minimize strain on the lower back. The sitting position (*jalsah*) involves bending the knees while keeping the back straight, with the right foot dorsiflexed and toes pointed downward. The prostration position (*sujud*) is the most integral posture, reflecting ultimate humility and submission (Ariff et al., 2015).

2.2 Spiritual Significance of *Solah* During Hospitalization

Solah holds profound spiritual and therapeutic significance for Muslims, especially during illness. Beyond its religious obligations, *solah* provides psychological and emotional healing, fostering resilience, alleviating anxiety, and reducing depression (Azhari et al., 2022; Hariawan et al., 2019). The structured movements of *solah*, paired with Quranic recitations, create a meditative state that promotes mental well-being and enhances physical recovery (Ariff et al., 2013; Kow et al., 2019). Studies also link *solah* to improved physical health outcomes, such as better pain tolerance and enhanced immune responses (Ano & Vasconcelles, 2005; Kow et al., 2019). However, maintaining *solah* during hospitalization remains challenging, as physical disabilities, logistical barriers, and lack of awareness about *rukhsah* often hinder adherence (Aris et al., 2017; Azhari et al., 2022; Hafiz et al., 2015).

Hospitalized patients frequently face limitations in mobility and access to appropriate facilities, such as ablution spaces and clear kiblah directions. Knowledge gaps regarding *rukhsah* provisions further exacerbate these difficulties, with many patients unaware they can adapt their practices to their health conditions (Kow et al., 2019). Self-efficacy, the belief in one's ability to perform a task, is pivotal in *solah* adherence. Patients experiencing pain, physical dependence or emotional stress often doubt their ability to pray, leading to diminished engagement in self-care behaviours, including religious practices (D'Souza et al., 2017). Enhancing self-efficacy through education and motivational interventions is critical to empowering patients to maintain *solah* during hospitalization, contributing to their holistic recovery (Hariawan et al., 2019).

2.3 *Rukhsah* in Performing Religious Cleansing and *Solah* During Illness

Many Muslim patients are unaware of the *rukhsah* provided by Islam to facilitate prayer and religious obligations during illness and hardship, often leading to the neglect of *solah* (Al-Obaidi et al., 2012; Reza et al., 2002). Islamic teachings emphasize flexibility, allowing adaptations to religious practices based on individual circumstances, particularly for those with disabilities or illnesses. The concept of *rukhsah* has been extensively discussed in Islamic

literature to provide ease in diverse situations, but gaps in knowledge among patients and healthcare providers remain significant barriers to adherence (Che Mohamad et al., 2015).

Maintaining purity and cleanliness (*taharah*) is a common challenge for hospitalized patients. Issues such as limited mobility, surgical wounds, or casts often hinder proper ablution (*wudhu'*) or complete ritual washing (*ghusl*). Patients with severe disabilities, such as quadriplegia or wounds covered by specialized dressings, may find these acts impractical. In such cases, Islam permits alternative methods like *tayammum* (dry ablution) or modifications in *solah* postures, such as praying while seated or lying down. These allowances reduce the burden of maintaining cleanliness and enable patients to fulfil their obligations without compromising their health or recovery. However, limited awareness of these concessions exacerbates non-compliance, as approximately 35.6% of patients reported being unaware of *rukhsah* provisions, leading to prayer abandonment during hospitalization (Azhari et al., 2022).

Healthcare providers also face challenges in supporting patients' spiritual needs. A clear understanding of *rukhsah* principles, including the associated medical and religious considerations, is essential for providing accurate guidance (Che Mohamad et al., 2015). Despite initiatives like the IFH campaign, many healthcare institutions lack adequate resources or training to accommodate Muslim patients' spiritual requirements effectively. Tailored educational programs for healthcare providers, combined with patient-centred interventions, can bridge these gaps and foster a supportive environment that respects patients' spiritual obligations while addressing their medical needs.

2.4 *Ibadah*-Friendly Hospital (IFH) Campaigns and Initiatives

The IFH initiative, also known as the *Hospital Mesra Ibadah* campaign, was introduced in Malaysia to integrate spiritual care into healthcare services. Rooted in Islamic principles, the campaign aims to create an environment that supports Muslim patients' spiritual needs while promoting holistic care that addresses physical, mental, and spiritual well-being. Launched in the early 2000s (Sharifudin et al., 2005), the program gained traction under the Malaysian Ministry of Health, with collaboration from religious bodies such as JAKIM (Malaysian Department of Islamic Development). Core elements of the initiative include accessible prayer spaces, facilities for ablution, education on *rukhsah*, and training healthcare providers in culturally sensitive care (Azhari et al., 2022; Kow et al., 2019).

Despite its positive impact on *solah* adherence, patient satisfaction, and the integration of spiritual care into clinical practice, the implementation of IFH remains inconsistent across institutions. Many facilities face challenges such as limited resources, inadequate staff training,

and variability in program application. Studies reveal that up to 60% of healthcare providers lack comprehensive knowledge of *rukhsah*, limiting their ability to guide patients effectively (Hafiz et al., 2015). Structured workshops and training programs have been shown to significantly improve healthcare providers' understanding and confidence in supporting spiritual practices (Hariawan et al., 2019; Kow et al., 2019).

While the IFH campaign holds promise, systemic barriers hinder its widespread success. Overburdened healthcare providers, especially in wards with 40 to 50 patients, often struggle to balance spiritual support with core medical responsibilities (Che Mohamad et al., 2015). This underscores the need for categorizing patients based on their disabilities and needs, enabling caregivers to provide tailored assistance without compromising their primary roles. Tools like the *Ibadah* disability scale can systematically assess patients' needs and ensure personalized care (Sharifudin et al., 2022). Achieving IFH's full potential requires addressing four critical components: patient education, staff training, infrastructure and facilities, and hospital policies (Sharifudin et al., 2005). Without balanced attention to these areas, the campaign's effectiveness may remain limited. Research and innovation are crucial to bridging the gap between idealized principles and practical realities. Standardized protocols, resource allocation, and institutional commitment are essential for fostering an inclusive and supportive environment where patients can fulfil their religious obligations during hospitalization.

3.0 RESEARCH DESIGN

This study utilized a cross-sectional design to evaluate the barriers and challenges faced by Muslim patients in performing *solah* during hospitalization. The research was conducted in the general orthopaedic wards of a tertiary medical institution on the East Coast of Malaysia. The hospital was selected due to its diverse patient population and established participation in the *Ibadah*-Friendly Hospital (IFH) initiative. A quantitative approach was employed to understand the factors affecting *solah* performance and adherence comprehensively.

3.1 Study Population and Sampling

The study included 203 Muslim patients aged 20–75 years, admitted for various orthopaedic conditions, including trauma and post-surgical recovery that required prolonged hospital stays. Participants were eligible if they self-identified as Muslims and were physically capable of completing a structured survey independently or with minimal assistance. Patients with significant cognitive impairments or critical conditions (e.g., requiring intensive care), or those who declined to give consent were excluded to ensure data reliability. Purposive sampling was

employed to ensure the representation of patients with varying degrees of physical disabilities, capturing a broad range of insights.

3.2 Instruments and Measures

Data collection utilized a validated self-reported questionnaire designed to assess:

- Demographic details: Age, gender, diagnosis, and hospital stay duration.
- Prayer adherence and barriers: Frequency of *solah*, knowledge of *rukhsah*, and environmental or physical limitations affecting *solah* performance.
- Psychological and social factors: Embarrassment, perceived stigma, and fear of judgment in public settings.

In addition, the Hospitalized Muslim Trauma Ibadah Disability Scale (HM(T)-IDS) was employed to assess patients' ability to perform *solah* based on physical and environmental challenges (ARIFF JMK). The HM(T)-IDS categorizes assistance needs into four levels and demonstrated a high-reliability score (Cronbach's alpha = 0.79). Both the questionnaire and HM(T)-IDS were pilot-tested to ensure clarity and reliability (Sharifudin et al., 2005).

3.3 Data Collection Procedures

Participants were approached by trained research assistants who explained the study's purpose and ensured voluntary participation. Surveys were administered privately to encourage honest responses. Assistance was provided for patients with mobility challenges or visual impairments. Research assistants underwent standardized training to ensure consistency in administering questionnaires, recording responses, and applying the HM(T)-IDS scoring system.

3.4 Ethical Considerations

The study adhered to ethical principles and received approval from the institutional ethics review board (Ref.: UniSZA/UHREC/2022/413). Informed consent was obtained from all participants, who were fully briefed on the study's purpose, procedures, and their right to withdraw at any time. Patient confidentiality was maintained by anonymizing data and securely storing responses throughout the research process.

3.5 Data Analysis

Quantitative data were analyzed using statistical software. Descriptive statistics were used to summarize demographic characteristics and *solah* adherence rates. Inferential analyses, including chi-square tests, identified significant factors influencing *solah* adherence. The results were interpreted to provide actionable recommendations for improving support for hospitalized Muslim patients.

4.0 ANALYSIS AND DISCUSSION

4.1 Demographic Overview of Participants

The mean age of the participants was 34.2 years (SD=13.3), with the majority belonging to the 20–30 age group, reflecting a younger demographic typical of orthopaedic wards. Gender distribution was balanced, ensuring equitable representation. Over half (52.2%) of the participants did not perform obligatory *solah* during hospitalization, a finding consistent with previous local studies on *solah* adherence among hospitalized patients (Jailani et al., 2017; Yusof et al., 2018). However, contrasting results were reported by Azhari et al. (2022), where a higher adherence rate was observed. Notably, the study included participants from a broader range of wards, with most belonging to the 31–60 age group, highlighting heterogeneity in adherence rates across different institutions.

In the present study, neither age, gender, nor marital status significantly influenced *solah* adherence. However, the type of illness was a significant determinant (p=0.002). Participants with trauma, including fractures and spine conditions, were more likely to perform *solah* compared to other groups. Among the 203 participants, 75 reported that their injuries or illnesses caused significant difficulties in performing activities of daily living (ADL), ranging from problematic to complete inability. These were also found strongly associated with *solah* non-adherence (p=0.001). Interestingly, most participants did not perceive their general health as significantly impacted (p=0.373). Limb involvement did not show a statistically significant relationship with *solah* adherence (p=0.113). However, participants with upper or lower limb injuries were less likely to perform *solah*, due to challenges in performing ablution or tayammum. Paradoxically, participants with involvement of more than two limbs were more likely to perform *solah*, which may be attributed to the assistance provided by caregivers or relatives for their activities in the ward. Electively admitted patients demonstrated better *solah* adherence than those admitted post-surgery, where 62% did not perform their *solah*. The frequency of hospital admissions, however, did not significantly influence *solah* performance (p=0.117).

Table 1 summarizes the participants' demographic characteristics, while Table 2 details their distribution by occupation and academic qualifications. These findings scrutinize the role of specific health conditions, admission types, and challenges such as mobility and toileting difficulties in influencing *solah* adherence among hospitalized Muslim patients. They emphasize the need for tailored support and adequate caregiver assistance to address these barriers and improve *solah* performance in different patient groups.

Table 1: Demographic characteristics of participants (n=203)

Variables	*Solah* during hospitalization, n (%)		Mean (SD)	p value [a]
	Yes	No		
Overall participants	97 (47.8)	106 (52.2)		
Age of participants			34.2 (13.3)	0.618
18-30 years old	46 (48.9)	48 (51.1)		
31-40 years old	20 (55.6)	16 (44.4)		
41-50 years old	17 (41.5)	24 (58.5)		
> 50 years old	14 (43.8)	18 (56.3)		
Gender				0.303
Male	64 (45.4)	77 (54.6)		
Female	33 (53.2	29 (46.8)		
Status of marriage				0.646
Single	44 (49.4)	45 (50.6)		
Married with children	43 (48.9)	45 (51.1)		
Married with no children	6 (33.3)	12 (66.7)		
Types of Illness				0.002
Diabetic foot diseases (DFD)	10 (27.8)	26 (72.2)		
Trauma with fractures	48 (51.1)	46 (48.9)		
Infections other DFD	21 (42.9)	28 (57.1)		
Spine conditions	10 (62.5)	6 (37.5)		
Trauma without fractures	8 (100.0)	0 (0)		
Types of hospital admission				0.051
Emergency	52 (50.0)	52 (50.0)		
Elective	18 (64.3)	10 (35.7)		
Post-Surgery	27 (38.0)	44 (62.0)		
Frequency of admission				0.117
< 3 times	49 (45.4)	59 (54.6)		
3 to 5 times	22 (55.0)	18 (45.0)		
Very frequent	4 (100.0)	0 (0)		
No previous hospitalization	22 (43.1)	29 (56.9)		
General Health				0.373
Very good	4 (50.0)	4 (50.0)		
Good	46 (42.2)	63 (57.8)		
Fair	41 (55.4)	33 (44.6)		
Poor	6 (50.0)	6 (50.0)		
Limb Involvement				0.113
No limb involvement	2 (50.0)	2 (50.0)		
Unilateral lower limb	8 (44.4)	10 (55.6)		

Bilateral lower limbs	53 (43.1)	70 (56.9)	
Upper limb/ limbs	14 (46.7)	16 (53.3)	
More than two limbs	20 (71.4)	8 (28.6)	
Mobility in ward			0.009
Without aid	40 (62.5)	24 (37.5)	
With walking aid	22 (51.2)	21 (48.8)	
Need other's assistance	21 (42.0)	29 (58.0)	
Need to use wheelchair	0 (0)	4 (100.0)	
Confined to bed	14 (33.3)	28 (66.7)	
Toileting			0.009
No need assistance	50 (60.2)	33 (39.8)	
Require assistance	18 (75.0)	6 (25.0)	
Bed pan/ urine bottle	14 (25.0)	42 (75.0)	
Diapers	9 (37.7)	15 (62.5)	
Bladder catheterization	6 (37.5)	10 (62.5)	
Effects on ADL			0.001
Not at all	24 (50.0)	24 (50.0)	
Minimal difficulties	50 (62.5)	30 (37.5)	
Difficult	15 (26.3)	42 (73.7)	
Very difficult	6 (60.0)	4 (40.0)	
Unable to perform at all	2 (25.0)	6 (75.0)	
First time learn to perform *solah*			0.079
Before schooling	40 (47.1)	45 (52.9)	
Primary school	51 (45.5)	61 (54.5)	
Secondary school	2 (100.0)	0 (0)	
After completed schooling	4 (100.0)	0 (0)	
Daily *solah* performance prior to illness			0.001
Five times with additional prayers	38 (63.3)	22 (36.7)	
Five times only	13 (43.3)	17 (56.7)	
Four times only	8 (36.4)	14 (63.6)	
Three times only	12 (48.0)	13 (52.0)	
Two times only	10 (45.5)	12 (54.5)	
Sometimes	8 (23.5)	26 (76.5)	
Never prayed	0 (0)	2 (100.0)	
Frequency of performing *solah* at the mosque prior to illness			0.005
All the time	18 (69.2)	8 (30.8)	
3 to 4 times only	8 (50.0)	8 (50.0)	
1 to 2 times only	22 (71.0)	9 (29.0)	
Weekly (besides Friday prayers)	17 (50.0)	17 (50.0)	
Only for Friday prayers	10 (29.4)	24 (70.6)	

Once a month	16 (36.4)	28 (63.6)
Never	6 (33.3)	12 (66.7)

[a] *Chi-square test*

Table 2: Distribution of participants according to their occupations and academic qualifications (n=203)

Variables	*Solah* during hospitalization, n (%)	
	Yes	No
Occupation		
Housewife	12 (40.0)	18 (40.0)
Self-employed	12 (48.0)	13 (52.0)
Lorry driver	12 (50.0)	12 (50.0)
Student	8 (33.3)	16 (67.7)
Private sector	16 (80.0)	4 (20.0)
Labourer	10 (62.5)	6 (37.5)
Civil servant	4 (100.0)	0 (0)
Teacher	1 (50.0)	1 (50.0)
Not working	22 (40.7)	32 (59.3)
Others	0 (0)	4 (100.0)
Level of academic qualifications		
University	10 (100.0)	0 (0)
Higher secondary	31 (53.4)	27 (46.6)
Lower secondary	36 (40.4)	53 (59.6)
Primary school	16 (57.1)	12 (42.9)
Never went for formal education	0 (0)	6 (100.0)
Others	4 (50.0)	4 (50.0)
Refused to disclose	0 (0)	4 (100.0)

4.2 Factors Affecting ADL and *Solah* Performance

A total of 73 participants reported that their injuries or illnesses significantly impacted their ADL, with these difficulties strongly associated with *solah* non-adherence (p=0.001) (Table 1). Key limitations, including mobility (p=0.009) and toileting challenges (p=0.009), were particularly influential in preventing *solah* performance, while participants' general health perception did not show a significant association (p=0.373).

Although limb involvement did not exhibit a statistically significant association with *solah* adherence (p=0.113), practical challenges, such as performing ablution or *tayammum*, were identified as contributing factors to non-adherence, particularly among participants with

upper or lower limb involvement. Interestingly, participants with more than two affected limbs were more likely to perform *solah*, likely because they required and received assistance from caregivers for daily activities, including *solah*.

Common factors affecting ADL, such as comfort during hospitalization, fatigue, emotional disturbances, and laziness, were significantly associated with *solah* non-adherence (Table 3). Pain, while not statistically significant, was recognized as an important factor that contributed to participants' difficulties and should be considered in developing interventions to support *solah* adherence.

Table 3: Factors affecting ADL from the patients' perspective (n=203)

Variable and scale	***Solah* during hospitalization, n (%)**		p value [a]
	Yes	**No**	
Pain			0.053
0	0(0)	2 (100)	
1	8 (33.3)	16 (66.7)	
2	16 (53.3)	14 (46.7)	
3	26 (41.9)	36 (58.1)	
4	25 (67.6)	12 (32.4)	
5	22 (45.8)	26 (54.2)	
Not Comfortable			<0.001
0	6 (42.9)	8 (57.1)	
1	6 (75.0)	2 (25.0)	
2	26 (59.1)	18 (40.9)	
3	24 (32.4)	50 (67.6)	
4	27 (71.1)	11 (28.9)	
5	8 (32.0)	17 (68.0)	
Easily tired/ fatigue			0.047
0	14 (70.0)	16 (30.0)	
1	14 (46.7)	16 (53.3)	
2	27 (45.8)	32 (54.2)	
3	20 (34.5)	38 (65.5)	
4	18 (64.3)	10 (35.7)	
5	4 (50.0)	4 (50.0)	
Emotionally disturbed			0.010
0	47 (58.8)	33 (41.3)	
1	4 (23.5)	13 (76.5)	
2	18 (39.1)	28 (60.9)	
3	16 (38.1)	26 (61.9)	
4	8 (80.0)	2 (20.0)	
5	4 (50.0)	4 (50.0)	
Laziness			0.002
0	35 (64.8)	19 (35.2)	
1	8 (27.6)	21 (72.4)	
2	26 (40.6)	38 (59.4)	
3	20 (43.5)	26 (56.5)	
4	8 (80.0)	2 (20.0)	

[a] *Chi-square test*

4.3 *Solah* Practices Before Hospitalization

Most participants (n=112, 55.2%) first learned about their *solah* responsibilities during primary school, while 41.9% (n = 85) acquired this knowledge before starting school. However, prior knowledge of *solah* obligations did not significantly influence *solah* adherence during hospitalization (p=0.079). Interestingly, participants' *solah* performance during hospitalization was significantly associated with their pre-illness *solah* habits. Those who consistently prayed daily (p=0.001) and regularly attended *solah* at the mosque (p=0.005) before hospitalization were more likely to maintain *solah* adherence during their hospital stay. (Table 1)

Additionally, lifestyle factors such as smoking and alcohol consumption significantly influenced *solah* performance during hospitalization. Participants who reported smoking or consuming alcohol demonstrated lower adherence to *solah* (p=0.001 and p=0.034, respectively).

4.4 Performance of Solah and Challenges Hindering Its Adherence During Hospitalization

Among the 203 participants, only 97 (47.8%) performed *solah* during hospitalization, with most adhering to selective *solah* times rather than completing all five daily *solah*. *Subuh* (morning) and *Asr* (afternoon) were identified as the most challenging, with 42.3% of participants who prayed reporting difficulty in performing all five *solah*. Table 4 summarizes the frequency of *solah* performed daily by these participants.

Table 4: Performance of *solah* during hospitalization (n=97)

Variables	n (%)
Daily frequency	
Five obligatory *solah* with *nawafil* (additional *solah*)	8 (8.2)
Five times a day only	16 (16.5)
Four times a day only	4 (4.1)
Three times a day only	12 (12.4)
Two times a day only	10 (10.3)
Once daily	8 (8.2)
Once a week	4 (4.1)
Sometimes only	35 (36.1)
How did they perform their physical cleansing?	
Ablution as always	42 (43.3)
Ablution as complete as possible	40 (41.2)
Ablution combined with tayammum	6 (6.2)
Perform prayers without ablution or *tayammum*	9 (9.3)
How did they perform their *solah*?	
As normal	14 (14.4)
Sitting position	49 (50.5)
Lying position	20 (20.6)
Only with intention (without physical movement)	6 (6.2)
Perform *solah* only to respect the praying time	8 (8.2)
Duration of each *solah*	
< 5 minutes	22 (22.7)
5 to 10 minutes	49 (50.5)
10 to 15 minutes	18 (18.6)
15 to 20 minutes	2 (2.1)
> 20 minutes	6 (6.2)
Participants' feelings when able to perform their *solah*	
Very thankful	67 (69.1)
Felt a better person	8 (8.2)
Happier	8 (8.2)
No specific feeling prayer as prayer has been a routine	14 (14.4)
Most difficult *solah* to perform during hospitalization	
Fajar prayer (*Subuh*)	26 (26.8)
Zuhur	4 (4.1)
Asar	26 (26.8)
All five prayers	41 (42.3)

Participants who prayed predominantly preferred a sitting posture (50.5%) and generally took 5–10 minutes to complete each *solah*. While 43.3% continued using ablution as their cleansing method, others likely adapted due to physical limitations. Despite these challenges, 69.1% of participants expressed gratitude for being able to perform *solah* during their illness.

Beyond the factors affecting ADL discussed earlier, participants highlighted additional barriers to *solah* adherence during hospitalization (Table 5). The most significant obstacles included feelings of embarrassment and perceived stigma when praying in the presence of other patients (p=0.035) and the lack of assistance with *solah*-related tasks (p=0.006). These findings emphasize the psychological and logistical difficulties faced by hospitalized Muslim patients, highlighting the need for culturally sensitive care, tailored support systems, and improved hospital infrastructure to facilitate consistent *solah* practices (Hariawan et al., 2019; Sohkhlet et al., 2023).

Table 5: Reasons given by participants on why *solah* is neglected during hospitalization (n=203)

Reasons given	Solah during hospitalization, n (%)		p value [a]
	Yes	No	
Difficult environment and situation			0.785
Yes	73 (48.3)	78 (51.7)	
No	24 (46.2)	28 (53.8)	
Pain			0.955
Yes	18 (47.4)	20 (52.6)	
No	79 (47.9)	86 (52.1)	
Lack of knowledge			0.506
Yes	20 (43.5)	26 (56.5)	
No	77 (49.0)	80 (51.0)	
Embarrass with other patients			0.035
Yes	4 (100.0)	0 (0)	
No	93 (46.7)	106 (53.3)	
Believe that patients are allowed not to perform solah due to their illness			0.177
Yes	8 (66.7)	4 (33.3)	
No	89 (46.6)	102 (53.4)	
Lack of confidence			0.180
Yes	14 (37.8)	23 (62.2)	
No	83 (50.0)	83 (50.0)	
Lack of assistance			0.006
Yes	9 (90.0)	1 (10.0)	
No	88 (45.6)	105 (54.4)	
Prefer to perform the solah only after condition is cured			0.347
Yes	4 (66.7)	2 (33.3)	
No	93 (47.2)	104 (52.8)	
Feeling of "unclean/ impurity"			0.203
Yes	31 (41.9)	43 (58.1)	
No	66 (51.2)	63 (48.8)	
Never prayed before			0.147
Yes	18 (60.0)	12 (40.0)	
No	79 (45.7)	94 (54.3)	
Limited hospital facilities/ infrastructure			0.124
Yes	15 (62.5)	9 (37.5)	
No	82 (45.8)	97 (54.2)	

[a] *Chi-square test*

4.5 Exposure to the Ibadah-Friendly Hospital Campaign

Participants with exposure to the *Ibadah*-Friendly Hospital (IFH) campaign demonstrated significantly better *solah* adherence during hospitalization (p=0.019) (Table 6). Those who actively sought assistance from ward staff or were briefed by healthcare providers on *solah* practices during illness exhibited higher adherence rates.

Table 6: Influence of the *IFH* campaign and training in performing *solah* prior to hospitalization to their *solah* performance (n=203)

Variables	***Solah* during hospitalization, n (%)**		**p value [a]**
	Yes	**No**	
Knew about the IFH campaign			0.019
Yes	30 (62.5)	18 (37.5)	
No	67 (43.2)	88 (56.8)	
Were briefed by ward staff during ward admission			0.090
Yes	26 (59.1)	18 (40.9)	
No	71 (44.7)	88 (55.3)	
Had asked for assistance from ward staff			0.015
Yes	26 (65.0)	14 (35.0)	
No	71 (43.6)	92 (56.4)	
Attended training/ learned about performing *solah* during illness			0.031
Yes	55 (55.6)	44 (44.4)	
No	42 (40.4)	62 (59.6)	
Influenced by other patients performing *solah* in the ward			0.971
Yes	51 (47.7)	56 (52.3)	
No	46 (47.9)	50 (52.1)	

[a] *Chi-square test*

Among the types of training received before their illness, only lessons learned at local mosques were significantly associated with better *solah* performance during hospitalization (p=0.033) (Table 7). Participants with prior knowledge of *rukhsah* reported a greater likelihood of maintaining *solah* practices during hospitalization, a similar finding by Azhari et al. (2022).

Table 7: Types of training attended by participants (n=203)

Types of training/ lessons received	***Solah* during hospitalization, n (%)**		p value [a]
	Yes	**No**	
Workshops			0.480
Yes	9 (56.3)	7 (43.8)	
No	88 (47.1)	99 (52.9)	
Seminars			0.912
Yes	3 (50.0)	3 (50.0)	
No	94 (47.7)	103 (52.3)	
During schooling years			0.230
Yes	22 (56.4)	17 (43.6)	
No	75 (45.7)	89 (54.3)	
Classes/ summons at local mosque			0.033
Yes	23 (63.9)	13 (36.1)	
No	74 (44.3)	93 (55.7)	
Taught by family members			0.188
Yes	2 (25.0)	6 (75.0)	
No	95 (48.7)	100 (51.3)	
Taught by friends/ colleagues			0.950
Yes	1 (50.0)	1 (50.0)	
No	96 (47.8)	105 (52.2)	

[a] *Chi-square test*

These findings highlight the importance of structured educational programs, both within the community and hospital settings, to support hospitalized Muslim patients in fulfilling their religious obligations.

4.6 Feedback from Participants

Additionally, we gathered feedback from the participants on their responses to participating in the study (Table 8). The findings revealed that *solah* adherence during hospitalization did not significantly influence participants' feelings about the survey questions, with no reports of offense (p=0.216). Similarly, *solah* adherence did not affect their interest in participating in future related studies. Most participants expressed curiosity and a desire to know the outcomes of the survey, demonstrating engagement and positive reception to the research process. These results indicate that the survey methodology was culturally sensitive, ethically sound, and well-received by the participants, regardless of their level of *solah* adherence during hospitalization.

Table 8: Feedback received from participants on the survey (n=203)

Responses	***Solah* during hospitalization, n (%)**		**p value [a]**
	Yes	**No**	
Offended by the questions in the survey			0.216
Yes	21 (40.4)	31 (59.6)	
No	76 (50.3)	75 (49.7)	
Interested to participate future surveys			0.414
Yes	54 (45.4)	65 (54.6)	
No	43 (51.2)	41 (48.8)	

[a] *Chi-square test*

4.7 Disability Scores and Assistance Needs

The analysis using the HM(T)-IDS categorized patients into four levels of assistance needs (Sharifudin et al., 2022). Among the participants, 22.6% required minimal assistance (Category I), 33.9% relied solely on equipment assistance (Category II), 27.3% needed a combination of equipment and caregiver support (Category III), and 16.4% required full assistance for daily activities (Category IV). This stratification highlights the varying degrees of dependency among hospitalized patients and their potential challenges in adhering to *solah*. Patients in Categories I and II demonstrated higher *solah* adherence rates, indicating that less reliance on assistance may correlate with greater independence in maintaining religious practices.

Patients requiring full assistance (Category IV) exhibited the lowest adherence rates, with 89% reporting no *solah* activity during hospitalization ($p<0.001$). These findings highlight the significant barriers faced by fully dependent patients, including logistical challenges and reliance on caregivers. Tailored interventions, such as caregiver training and adaptive equipment for *solah*, are crucial to improving adherence (Hariawan et al., 2019; Sohkhlet et al., 2023). Integrating HM(T)-IDS into routine assessments can help healthcare providers systematically identify and address the specific needs of highly dependent patients, enhancing their spiritual and physical well-being.

4.8 Study Implications and Future Directions

This study identifies significant barriers that hinder hospitalized Muslim patients from performing *solah*, a fundamental aspect of Islamic worship. Physical limitations, lack of knowledge about *rukhsah*, psychological challenges, and systemic issues collectively contribute to poor adherence (Azhari et al., 2022). Addressing these challenges requires a

multifaceted approach that combines education, infrastructure improvements, and cultural sensitivity (Che Mohamad et al., 2015; Hariawan et al., 2019; Sohkhlet et al., 2023).

Physical barriers, such as pain, immobility, and difficulty in performing ablution or tayammum, remain substantial obstacles. These findings align with previous studies that emphasize the need for hospital facilities to accommodate these limitations (Al-Obaidi et al., 2012; Azhari et al., 2022; Kow et al., 2019; Sohkhlet et al., 2023), such as providing portable ablution kits and accessible *solah* spaces. Psychological challenges, including embarrassment and stigma, further complicate adherence, as patients often feel reluctant to pray publicly or request assistance. Similar trends have been observed in caregivers, where stress and emotional distress linked to caregiving roles impede their ability to address patients' spiritual needs (Sohkhlet et al., 2023). These challenges highlight the necessity for a supportive hospital culture that normalizes discussions about spiritual needs (Ariff et al., 2013; Aris et al., 2017; Sohkhlet et al., 2023).

To address these barriers, targeted educational interventions are critical. Many patients lack awareness of *rukhsah* provisions (Abdul Halim et al., 2024; Azhari et al., 2022; Che Mohamad et al., 2015; Kow et al., 2019), such as praying in a seated position or performing tayammum when water is unavailable. Incorporating these teachings into hospital admission protocols and training healthcare providers in culturally sensitive care can bridge the knowledge gap (Aris et al., 2017 Hariawan et al., 2019). Tools like the *Ibadah* disability scale offer structured assessments that enable tailored assistance and systematic spiritual care (Hariawan et al., 2019; Sharifudin et al., 2022). The use of such tools provided a structured assessment of patients' needs, enabling tailored assistance. Patients categorized as requiring full support (Category IV) were the most likely to neglect *solah*, emphasizing the importance of providing targeted resources for this group. The integration of these tools into routine patient assessments can enhance the delivery of culturally sensitive care (Hariawan et al., 2019; Sohkhlet et al., 2023).

Coaching has emerged as a transformative approach to improving *solah* adherence by addressing physical and psychological barriers through practical training, motivational support, and personalized guidance. Coaching programs enhance self-efficacy, a critical factor closely associated with engagement in self-care behaviours, including religious practices (D'Souza et al., 2017). Practical tools like wudu sprays and *tayammum* dust reinforce learning and application, while personalized coaching sessions, facilitated by healthcare providers and Muslim chaplains, effectively address knowledge gaps and psychological barriers such as embarrassment and fear of judgment. These collaborative efforts create a supportive

environment, enabling patients to overcome obstacles and align spiritual care with clinical practices (Hafiz et al., 2015; Hariawan et al., 2019).

Muslim chaplainship complements the coaching approach by addressing patients' spiritual, emotional, and ethical needs. Chaplains provide vital support, advocate for religious accommodations, and ensure hospital policies align with Islamic ethical standards (Mohamed et al., 2015). Despite challenges like limited recognition and insufficient training, integrating chaplaincy services into healthcare frameworks can enhance holistic care. Establishing accredited training programs and comprehensive policies are essential steps to maximize the impact of chaplainship, fostering an inclusive environment that empowers patients to maintain solah adherence during hospitalization (Hariawan et al., 2019).

Institutional initiatives like the IFH campaign show promise in improving *solah* adherence (Hafiz et al., 2015; Kow et al., 2019). However, inconsistent implementation and resource limitations hinder its full potential. Standardizing guidelines, ensuring staff training, and providing necessary resources can optimize its effectiveness (Hafiz et al., 2015). Coaching interventions also offer a structured approach to empowering patients by addressing cognitive and psychological barriers (Hariawan et al., 2019). These sessions, supported by tools like *tayammum* kits and personalized guidance, enhance self-efficacy and build confidence in maintaining *solah* practices.

Future studies should explore the scalability of these interventions across diverse healthcare settings and evaluate their long-term impacts. Collaborative efforts between healthcare institutions and religious organizations can further bridge the gap between clinical care and spiritual needs (Aris et al., 2017). Practical tools and infrastructure improvements, coupled with consistent training for healthcare providers and spiritual counsellors, will ensure holistic care that respects and supports patients' spiritual practices (Hariawan et al., 2019**)**.

By fostering an environment that integrates spiritual care into routine healthcare, institutions can contribute to the overall well-being of Muslim patients, aligning with the principles of holistic and patient-centred care.

5.0 CONCLUSION

This study identifies the multifaceted challenges hindering hospitalized Muslim patients from performing *solah*, including physical disabilities, knowledge gaps about *rukhsoh*, psychological challenges, and systemic barriers. Effectively addressing these issues necessitates comprehensive educational initiatives for both patients and healthcare providers, enhanced hospital facilities, and the integration of culturally sensitive care practices to help

patients maintain their religious obligations. The development and implementation of systematic assessment tools can offer actionable insights for tailoring support and optimize the effectiveness of IFH initiatives. By addressing these factors, healthcare institutions can foster a more inclusive environment that respects and accommodates patients' spiritual needs, ultimately contributing to their holistic well-being.

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