Toward Cultural Competence when Caring for Muslim Women and their Families: Application to Pregnancy Loss

By

Lynne Anne Thériault

A Practicum Project

Submitted to the Faculty of Graduate Studies in Partial Fulfillment of

the Requirements for the Degree of Master of Nursing

Faculty of Nursing

University of Manitoba

Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION

Toward Cultural Competence when Caring for Muslim Women and their Families: Application to Pregnancy Loss

BY

Lynne Anne Thériault

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree

Of

Master of Nursing

Abstract

Health care professionals require knowledge regarding Muslim culture and customs in order to provide culturally competent care to this population. This practicum project provides an overview of Muslim culture, including the role of Muslim women, men and the family in relation to common values with specific application to pregnancy loss in the hospital setting. Grief, death and the afterlife are discussed as well as burial customs and ceremonies relating to the loss of a pregnancy in the Muslim population. Some important values and their application to hospital care have been identified, such as, the significance of modesty to Muslims particularly for women and how it impacts the approach to care in the hospital, information on post-mortem religious rites in the loss of a pregnancy, and how the common practice of a memento program (e.g., lock of hair, pictures or foot prints) in North American societies is likely inappropriate since it may be considered to be desecration of the body.

These topics, developed into practice principles, should help enhance cultural competence among health care professionals when providing care to Muslim women and their families. In particular, the practice principles provide health care workers with an understanding of the practices in this faith in order to better provide culturally competent and holistic care to Muslim parents who have suffered a pregnancy loss. The final section of this practicum includes a summary of a variety of pertinent principles regarding Muslim faith and customs, which can be made available to clinical care areas within the hospital context.

Acknowledgements

I would like to say special thanks to Sr. Shahina Siddiqui from the Islamic Social Services Association (ISSA) for her time and input. She instilled confidence into my practicum project. She is a valuable member to the academic and Muslim community.

I would also like to express my gratitude to the members of my practicum project committee, Dr. Christine Ateah, Dr. David Gregory and Ms. Lisa Lloyd-Scott, for their insight, time, patience and commitment to producing a quality document.

Finally, special thanks to my friends, family (especially my dad Guy and dogs Beddy and Angelle) and to Louise Sabourin (graduate program assistant) for supporting and encouraging me through this journey of discovery and hard work. The completion of this practicum project would not have been possible with out the support of each member mentioned in this acknowledgement.

Table of Contents

List of Figures

List of Appendices

Chapter I: Introduction

With the ever-changing demographics of the Canadian population, including a diverse immigrant population, the need to transition from cultural sensitivity to cultural competency is essential for health care professionals. The issues surrounding death and grieving in pregnancy loss deserve specific attention. A lack of understanding of the appropriate cultural approach in caring for a family that has suffered a pregnancy loss can be detrimental to the current and future therapeutic relationships between the members of the family and health care team. The Muslim population has been identified as an important growing local population with very distinctive needs. This project clarifies and elaborates on current practices related to death, grieving and burial amongst Canadian Muslims and their views of the pregnancy loss. This cohort will be referred to as the Muslim population and Canadian Muslims interchangeably. This population is discussed in general in reference to Islam and focuses on common cultural norms. Practice principles and recommendations for health care professionals and possibly health care institutions are outcomes arising from this practicum project.

Cultural Competency

Increasing cultural competence among providers of care and within health care institutions is important for several reasons. This concept can help us respond to current and projected demographic changes in Manitoba and Canada regarding the Muslim population. This idea has gained interest as a potential strategy to improve the quality of care and enable cultural competency in our system (Betancourt, Green, Emilio Carrillo, & Park, 2005). The need for this transition to occur has been

established, yet the integration of a culturally competent approach has not been fully realized, because of lack of "awareness, knowledge, skills, and organization support to be effective as culturally competent providers of care" (Taylor, 2005, p. 136).

Cultural competence encompasses four factors: caring, cultural sensitivity, cultural knowledge, and cultural skills (Kim-Godwin, Clarke, & Barton, 2001). According to Betancourt et al. (2005), the goal of cultural competence is to "create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency," which will require action by various sectors in health (Cultural Competence, para. 1). To become a culturally competent provider requires a self-awareness and evaluation of one's own cultural roots, beliefs, and behaviours (Rorie, Paine, & Barge, 1996). These exercises support the development of health care professionals' awareness and sensitivity and preparation for future care situations.

> Cultural competence requires that we reject simplistic views of culture as monolithic and unchanging and the notion that people are fixed in cultural traditions, unable to modify their behavior, and learn new ways. In addition to making assumptions about cultural uniformity, we have failed to account for the shifting nature of cultures and the situations use of ethnic identities...Cultures are fluid and constantly changing *vis-à-vis* new environments and inconstant physical, social, economic, and political circumstances. People do not live their lives out in cultures; they live out their lives in communities, where circumstances generate conflict, where people do not always follow the rules...(Dreher & MacNaughton, 2002, p. 184).

This philosophy of care based on cultural competence must become a central focus for the development of effective intervention programs and policy-making initiatives (Rorie et al., 1996). The achievement of cultural competence is realized when we preserve a client's human rights to culturally congruent care (Pacquiao, 2003).

Definitions

There are multiple terms used to define various aspects of events in a pregnancy. Listed below are a number of important definitions to guide the reader. The definitions are critical as the diagnosis dictates care pathway. Following the pregnancy-related terms there will be a list of important religious definitions to orientate the reader to Islamic terminology. Islam is only beginning to become familiar to the Western cultures and there is still much confusion remaining even on common and simple religious terminology. Therefore, these terms and definitions have been included for the purpose of clarity.

Pregnancy-Related Terms and Definitions

Ectopic pregnancy. An ectopic pregnancy occurs when a fertilized egg implants itself outside of, or at the borders of, the uterus and starts to grow but will not be viable. This condition most commonly occurs in weeks 5-10 of the pregnancy. (EMedicine, 2005).

Fetal loss. Fetal loss includes stillbirths and cases of miscarriages, illegal abortions and unspecified abortions (Statistics Canada, 2005).

Miscarriage. Miscarriage is the spontaneous abortion of a fetus that occurs before 20 weeks of gestation (March of Dimes, 2004).

Molar pregnancy. A molar pregnancy results from the over-production of tissue into the placenta, which develops into a mass where no viable fetus is produced (National Library of Medicine, 2004).

Spontaneous abortion. A spontaneous abortion is the loss of a fetus due to natural causes (National Library of Medicine, 2004).

Pregnancy loss. Pregnancy loss is death of the fetus occurring at any gestational age (this includes miscarriages and stillbirths). The terms used for stillbirth is usually late pregnancy loss and for miscarriage is early pregnancy loss.

Premature labour. Premature labour is labour that occurs before 36 weeks of gestation but after the 20 weeks of gestation (Dambro, 2005; National Library of Medicine, 2004).

Spontaneous termination. The term "miscarriage" is the spontaneous termination of a pregnancy before the 20th week of pregnancy (National Library of Medicine, 2004).

Stillbirth. A Stillbirth occurs when the baby dies *in utero* after 20 weeks of gestation, occurring in approximately one in two hundred pregnancies (March of Dimes, 2002).

Common and Religious Terms and Definitions Used by the Muslim population

Abaya. The *abaya* is a sleeveless outer garment worn by Middle Eastern men (S. Siddiqui, personal communication, August 23, 2005).

Ablution. The process of *ablution* is performed by washing one's body or part of it as in a religious rite (Britannica Online Encyclopedia, 2005).

Allah. The word *Allah* means God.

Ahmadiyya. Ahmadiyya is a one of the schools of Islam (S. Siddiqui, personal communication, August 23, 2005).

Arab. An Arab is a member of an Arabic-speaking community or country (Britannica Online Encyclopedia, 2005).

Arabic. The word Arabic is a Semitic language originally of the Arabs of the Hejaz and Nejd (Britannica Online Encyclopedia, 2005).

Ensoul. The process of ensoulment is to be endowed with a soul (Barber, 2004).

Halal. Halal is a ritual sanctioned by Islamic law and usually refers to food and behaviour that is ritually fit for use (S. Siddiqui, personal communication, August 23, 2005).

Haram. Haram are foods and behaviours considered forbidden by religious law (S. Siddiqui, personal communication, August 23, 2005).

Hijab. The *hijab* is a veil worn by some Muslim women to cover the hair and forehead (Barber, 2004).

Igma. Igma is the general consensus of a law or belief or something that is agreed upon by most people (S. Siddiqui, personal communication, August 23, 2005).

Imam. An *imam* is the prayer leader of a *mosque* in Shiites. This Muslim leader is of the line of Ali held by Shiites to be the divinely appointed, sinless, infallible successor of Muhammad (Britannica Online Encyclopedia, 2005; S. Siddiqui, personal communication, August 23, 2005).

Islam. Islam is "the religious faith of Muslims including belief in *Allah* as the sole deity and in Muhammad as his prophet" (Britannica Online Encyclopedia, 2005). It is also interpreted as the civilization erected upon Islamic faith and the group of modern nations in which Islam is the dominant religion (Britannica Online Encyclopedia, 2005).

Islamic calendar. The Islamic calendar is a lunar calendar that is organized in cycles of 30 years (Britannica Online Encyclopedia, 2005).

Quran. The *Quran* is the book "composed of sacred writings accepted by Muslims as revelations made to Muhammad by *Allah* through the angel Gabriel" (Britannica Online Encyclopedia, 2005).

Mahram. Mahram is a blood relative (S. Siddiqui, personal communication, August 23, 2005).

Mosque. The mosque is a public building used for worship by Muslims (Britannica Online Encyclopedia, 2005).

Muhammad. Muhammad is the prophet and a founder of Islam (Britannica Online Encyclopedia, 2005)

Muslim. A Muslim has the literal significance of a person who submits to one God (*Allah).* He is also a believer in his faith and in the teachings of *Muhammad.* All Muslims must follow as well the 5 pillars of faith (Britannica Online Encyclopedia, 2005; Hawker, 2002; S. Siddiqui, personal communication, August 23, 2005).

Ramadan. The *Ramadan* occurs on the ninth month of the Islamic year where fasting is practiced daily from dawn to sunset (Britannica Online Encyclopedia, 2005).

Sabr. The word *sabr* symbolizes the display of patience (Britannica Online Encyclopedia, 2005).

Salat. Salat is the daily ritual prayer performed by Muslims (Britannica Online Encyclopedia, 2005).

Shariah. Shariah refers to the Islamic law based on the *Quran* (Britannica Online Encyclopedia, 2005).

Shedaya. The word *shedaya* signifies the Islamic laws that have been based upon religious teachings (S. Siddiqui, personal communication, August 23, 2005).

Sheik. A *Sheik* is a Muslim leader or a chief of an Arab tribe (Britannica Online Encyclopedia, 2005).

Shiite. Shiite is one of the schools of Islam (S. Siddiqui, personal communication, August 23, 2005).

Sunnah. Sunnah refers to the practical teaching of Prophet Muhammad (Arshad, Horsfall, & Yasin, 2004).

Sunni. Sunni is one of the schools of Islam (S. Siddiqui, personal communication, August 23, 2005).

Muslim Population in Canada and Manitoba

Population Growth Trends

To give the Canadian perspective of this population, there were 579,640 individuals in Canada and 5,095 in Manitoba who declared themselves to be Muslim according to the 2001 Canadian census (Statistics Canada, 2001). "Canada's Muslim population more than doubled over the past decade, increasing by 128.9% from 253,265 in 1991, to 579,640 in 2001. According to these statistics, Muslims represent 2% of this country's population, making Islam the fastest growing religion in Canada" (Wilner, Dimant, Scheinberg, & Klein, 2003, Distribution of the Jewish population in Canada, para. 7). Population growth trends for the Muslim community in Canada and Manitoba are depicted in figures 1.0 and 1.1.

The population expansion cannot be ignored; this trend will continue to change the population health needs in Canada and Manitoba. The significance of involving the family and community in many aspects of the Muslim's life may push the need to further expand the integration for holistic care. Another example is the essential need to preserve modesty in Muslim women, which might redesign the approach to care on the unit. This gives cause for health care professionals to educate themselves on the rather complex and distinct care needs of the Muslim population.

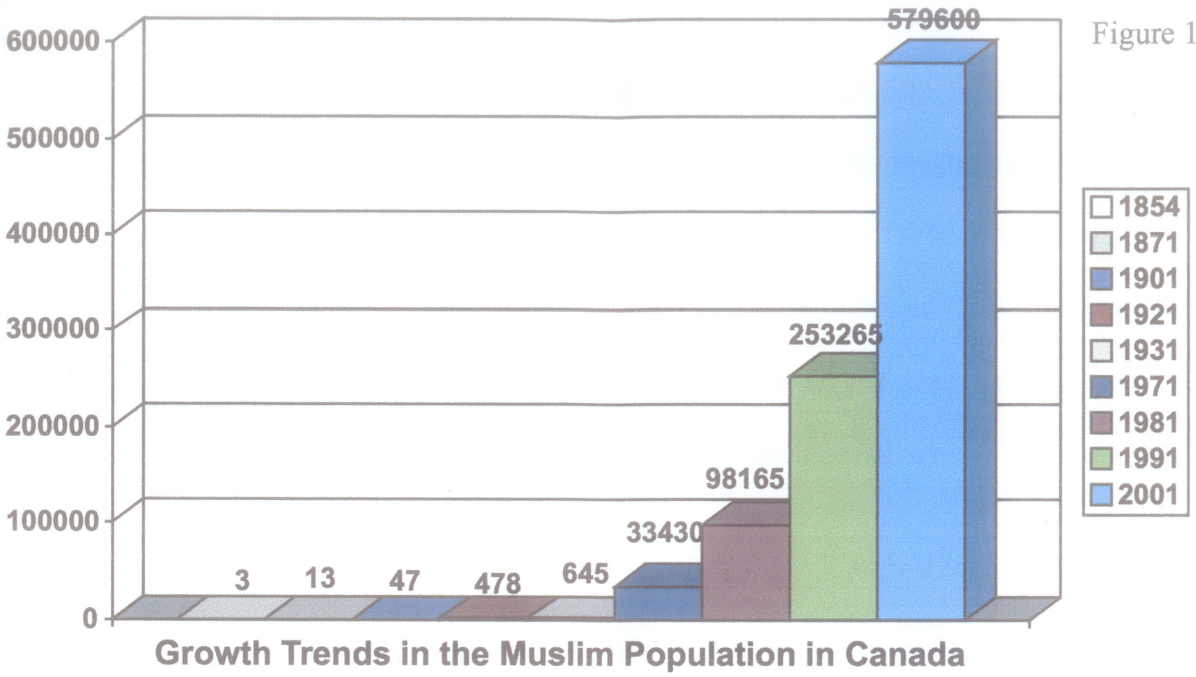


Figure 1.0

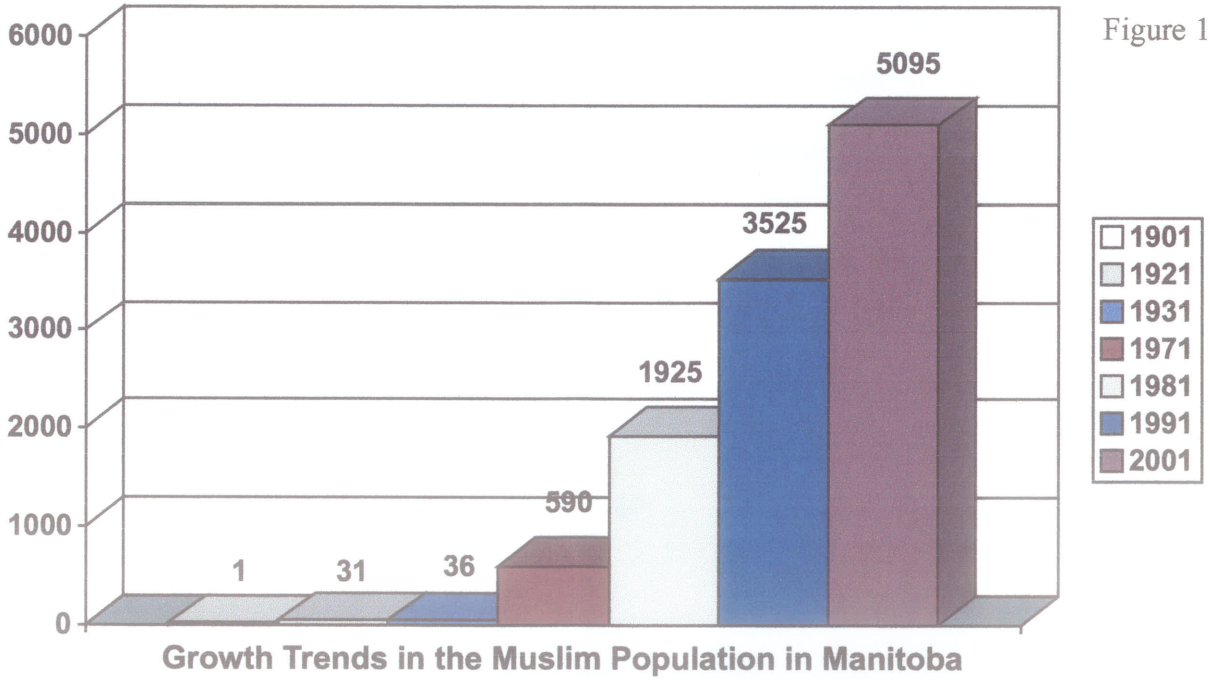
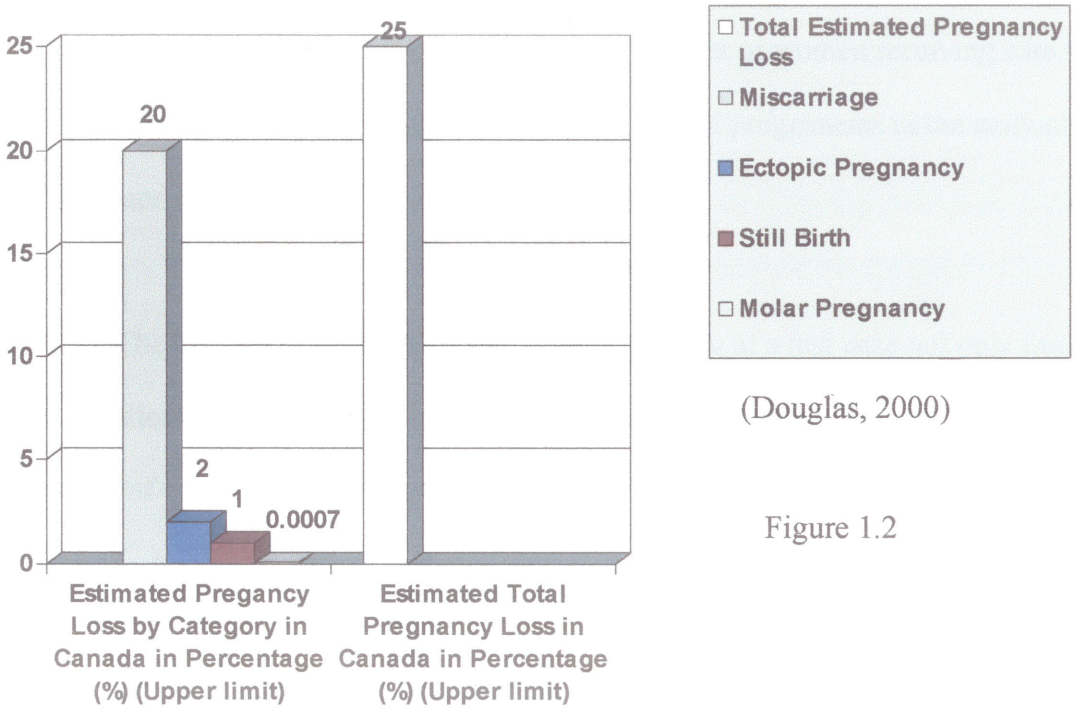


Figure 1.1

(Hamdani, 2001)

Prevalence of Pregnancy Loss

All expectant mothers carry risks of fetal loss in pregnancy. It is estimated that between 20 to 25 % of pregnancies end in miscarriage, ectopic pregnancy, molar pregnancy, or stillbirth. Miscarriage, the most common type of fetal loss, occurs in 15-20% of pregnancies. Ectopic pregnancy occurs in approximately 1-2% of pregnant women and 1% of fetuses considered to be viable (18 weeks of gestation) die in the womb. The rarest form of fetal loss is molar pregnancy and occurs in 1 out of 1500 to 2000 pregnancies.



(Douglas, 2000)

Figure 1.2

Statistics Canada keeps records of reported fetal loss events through the Hospital Morbidity Database where it accounted for 9,399 losses, or 1.2 losses per 1000 women in Canada and 831 losses, or 2.9 losses per 1000 women in Manitoba in 2002 (Statistics Canada, 2001). It was noted that there is no culturally specific data available to distinguish any variations existing in pregnancy loss with Muslim women in Manitoba or Canada. It is important to note that these numbers underestimate the real values; many miscarriages are not reported, particularly those that occur early in pregnancy and do not require hospitalization and those that are not recognized as a miscarriage (Harvard Medical School, 2004). However, since home pregnancy kits are able to detect pregnancy at very early stages miscarriages are able to be recognized as such and have the potential of increasing the number of women receiving care for this loss. New estimates calculate that closer to half of pregnancies in the early phase do not survive (Petrozza, 2004).

In Manitoba

The Muslim population in Manitoba is growing at a fast pace not only through immigration but also through local births. Most health care professionals working in the area of obstetrics and gynecology are likely to care for Muslim women and families who have experienced pregnancy loss. Given the delicate nature of this event, it would be beneficial for health care providers to have readily accessible resources or practice principles to provide culturally competent health care to Muslim women and their families.

Currently, there are no formal published guidelines in Manitoba or Canada on caring for Muslim families who have lost a pregnancy. The Winnipeg Regional Health Authority (WRHA) Women's Health Program would greatly benefit from such practice principles to improve cultural competency pertaining to the care of Muslim women (P. Gregory, Director, Women's Health Program, WRHA, personal communication, April 15, 2005). Such practice principles would be a valuable educational tool for health care providers and an important resource in institutions. The end result should be a better understanding of Muslim customs, which would facilitate the delivery of culturally competent care that attends to the distinctive needs of this population at a time of grief and vulnerability.

Purpose of Research Project

One perspective is that the tragic events of September 11, 2001 may have resulted in the stereotyping and marginalization of the Muslim population. There is a need for health care providers to be more informed to prevent inappropriate responses and reactions toward Muslim patients that may lead to a breakdown in the therapeutic relationship.

Gracey (2003) explains that culture, language, and religion play a vital role in patients' access and response to health services. She outlines that providing culturally sensitive care to the family requires health care providers to understand some of the fundamental principles of family dynamics and religious/cultural influences on life, birth, and death (Gracey, 2003). There is also a need to initiate motivation in institutions to enable an upstream thinking model to implement structures that assist and encourage providers to deliver competent care.

The purpose of this practicum project was to identify the critical issues surrounding the care of the Muslim family and their deceased infant (miscarried or stillborn) and to develop clear practice principles on how to manage this situation in keeping with Muslim customs and family intentions. This process entailed gathering information from current and classical literature through articles, guidelines and books. These practice principles will be recommended for use as an educational tool to provide health care workers with reasonable insights to deliver holistic and culturally competent care to the grieving Muslim family and community.

In addition to specific practice principles on the care of Muslim women and their families who experience a pregnancy loss, summaries on customs and rituals surrounding birth, death and grief were developed. The appendices include general information on the Islamic religion and culture, produced to present an overview of some basic Muslim customs and rituals.

Lastly, a representative from the Islamic Social Services Association (ISSA), who specializes in Muslim women's issues was consulted to ensure applicability of these principles with the local Muslim population and to discuss common relevant cultural and religious practices. These practice principles are not absolute and may not apply to all Muslim clients. Rather they are an overview of what may be encountered. It is important to discuss individual performances with Muslim woman and their partners to identify their true needs and wishes.

Chapter II: Methodology

This chapter explains the approach taken to develop the practice principles for health care professionals. The information was obtained primarily through a review of the literature describing the Muslim population's cultural and religious practices. In addition, further insight and feedback on the appropriateness of the information used for the development of the principles was obtained through discussions with the Executive Director of the Islamic Social Services Association.

Literature Review

The information gathering process entailed a review of the literature on Muslim customs and belief systems pertaining to pregnancy loss, death, and grieving. Some of the specific areas that were researched included the appropriate care, time frame, and procedures used for handling the remains of the pregnancy loss. This project involved looking at commonalities found in the Muslim culture. In addition, the role of Muslim women and men and the family was explored. The final areas researched were birthing and death customs, beliefs, and burial ceremonies.

A literature search of Medline, CINAHL and Bison catalogue (University of Manitoba Library) was conducted using the following search terms: abortion-spontaneous, fetal-death, miscarriage, stillborn, fetal loss, pregnancy, birth, abortion-spontaneous-psychosocial-factors; after life rituals, ceremonies, burial-practices, grief, death; Islamic religion, Islam, Muslim, culture; family, women; taboos, myths and facts; guidelines. Each of the terms was combined and mixed as considered appropriate. In addition, the World Wide Web was used for supplemental information or clarification.

Since it has already been determined that no clinical guidelines exist locally on caring for Muslim families who have experienced pregnancy loss, findings from the review of the literature were used to develop practice principles for health professionals working with the Muslim population. In addition to specific practice principles on the care of Muslim women and their families who experience a pregnancy loss, a summary of Muslim culture was developed for use in general health care situations.

Muslim Cultural and Religious Consultation

Finally, to ensure that the information being presented is relevant, appropriate and accurate, the Executive Director of the Islamic Social Services Association (ISSA) (United States and Canada), Sr. S. Siddiqui (Personal communication, August 23, 2005) was consulted. Sr. S. Siddiqui is also a member of Member of Manitoba Coalition of Human Equality and Member of the Cross-cultural coalition for the Prevention of Violence, Counselor and coordinator of community relations at the Manitoba Islamic Association and a Board Member of Manitoba Coalition of Peace.

Chapter III: Literature Review Findings

An Overview of the Muslim Culture to Increase Awareness and Provide Culturally Competent Care to Muslim Women and their Families

Basic Explanation of Islam

It is far beyond the scope of this practicum project to take on the monumental task of trying to explain the Islamic faith. The following excerpt, however, offers the reader a rudimentary explanation of the basic concepts of this religion.

Islam is a:

> Major world religion founded by Muhammad in Arabia in the early 7th century AD. The Arabic word *Islam* means "submission"—specifically, submission to the will of the one God, called *Allah* in Arabic. Islam is a strictly monotheistic religion, and its adherents, called Muslims, regard the Prophet Muhammad as the last and most perfect of God's messengers, who include Adam, Abraham, Moses, Jesus, and others. The sacred scripture of Islam is the *Quran*, which contains God's revelations to Muhammad...The religious obligations of all Muslims are summed up in the Five Pillars of Islam, which include belief in God and his Prophet and obligations of prayer, charity, pilgrimage, and fasting. The fundamental concept in Islam is the *Shari'ah*, or Law, which embraces the total way of life commanded by God (Britannica Online Encyclopedia, 2005, para. 1).

Islamic Religion, Views, and Population

Islam is a rich and diverse religion. "Although literature pertaining to perinatal bereavement care is scarce, there is abundant literature highlighting the considerable influences of Islam on daily living activities, on attitudes toward illness and death, and on familial and societal patterns of behavior" (Hébert, 1998, p. 65). This literature is open to interpretation when considering the variety of cultural differences of those who follow Islam. Having a basic awareness of the variations and commonalities of this faith can be beneficial to a successful health care practice with Muslim clients and their families.

While the majority of Muslims reside in India, Iran, and other parts of southeastern Asia and sub-Saharan Africa, large populations are also represented in Indonesia, Malaysia and Turkey. The Canadian Muslim community is growing at a rapid rate, as previously noted. Muslims also represent many different sub groups of Islam, linguistic backgrounds and may practice a variety of beliefs and customs.

Hodge (2005) summarized the proper mindset to take when approaching a member of Islamic faith. His recommendations are that you should be aware that no particular set of beliefs and values exists that is representative of all Muslims except for the five pillars of faith; individuals who self-identify as Muslims may or may not affirm a number of the beliefs and values (Hodge, 2005; S. Siddiqui, personal communication, August 23, 2005).

It is important, however, to be cognizant of the existing concepts that are widely held among Muslims. The 5 pillars of Islam derived from the *shari'a* are generally agreed upon practices and beliefs that comprise the common core of the

wider reality. "The degree to which individual Muslims practice the five pillars can be a good indication of the salience of faith in their lives" (Hodge, 2005, p. 164).

The 5 pillars of Islam are:

The profession of faith. The declaration of faith is to believe there is only one God (*Allah*) and that the Prophet Muhammad is his messenger (Lawrence & Rozmus, 2001).

Salat or prayer. Muslims are required to pray 5 times daily. The first prayer is before sunrise and the final is late night (S. Siddiqui, personal communication, August 23, 2005).

Sawm or fasting. Most Muslims fast during the month of the *Ramadan.* During the *Ramadan* there is abstinence from food, including drinking water, smoking and marital sexual intercourse from dawn to dusk (S. Siddiqui, personal communication, August 23, 2005) .

Zakat or almsgiving. Muslims are required to give 2.5 % of their wealth every year in charity or the community (Lawrence & Rozmus, 2001).

Hajj or pilgrimage to Mecca. Approximately 70 days after the *Ramadan* a pilgrimage is done during one's lifetime if he or she is able to do so both physically and financially (Lawrence & Rozmus, 2001).

As discussed earlier, there are diverse values within the Islamic religion. However, some would affirm that the foundation to the House of Islam would be community, family and the sovereignty of God. It is explained that "these principal values, along with the subsidiary values associated with them should not be conceptualized as discrete value structures. Rather, they are interrelated constructs

reflecting the unified, holistic Islamic cosmology" (Hodge, 2005, p.165). Another way to visualize Islam is not so much as a belief system but as a way of life that unifies metaphysical and materialistic dimensions (Izetbegovic, 1993).

The House of Islam views the community as a fundamental foundation rooted in the belief that all people are equal before God. They tend to emphasize benevolence, care for others, cooperation between individuals, empathy, equality and justice between people, the importance of social support and positive human relatedness (Kelly, Aridi, & Bakhtiar, 1996). Therefore, it is the individuals and the community's responsibility to protect and empower its members. The connection between family and community is closely interrelated and even sometimes considered to be integrated. The family model in an Islamic community is relatively broad, but the husband and wife, who have the responsibility of reproducing spiritual and social values, would define the core. As a result, both the nuclear and extended relatives that sometimes include members of the community are important to compliment social and spiritual health. The *Mosque*, in addition to being a holy Centre for the community can offer a variety of services to believers such as libraries, day cares, as well as social and sporting activities. As a result, these Centres can be an important resource for social support.

Family Roles and Social Conduct

In the Muslim religion, marriage is the celebration of the unions of two extended families, with the partner often selected by the respective families. Husbands and wives are held to be of equal worth but to have complementary roles (Corbett, 1994). The roles of the women are traditionally at home with the children

and the men to be providers for the family. It is not forbidden for women to work if it is to help provide for the family and this is changing with the evolution of modern times. Children are cherished and large families are encouraged. The responsibility of the mother is considered important in providing emotional support and guidance for her children, for their own well-being, and that of the community. An additional custom that most Muslims follow is to socialize only with members of the same sex unless it is with a family member.

Most Muslim societies are paternalistic but there are some that follow the matriarchy model (S. Siddiqui, personal communication, August 23, 2005). Decisions regarding patient care and the choice of treatment are often made with or by the family. A family might choose to reveal news to a patient slowly or initially give her a false story. This can cause an ethical dilemma when treatments need to be discussed. All these issues come in conflict with confidentiality and the power for a competent person to choose. It is important to be aware of these family dynamics, values and traditions to help guide and anticipate discussions with them.

Perspectives on Gender

An important Muslim value is modesty for both sexes, particularly for women who choose to adopt Islamic dress (*abaya*) that may include veiling (*hijab*). However, requirements for women and men are different. "Muslim women adhere, in varying degrees, to prescribed norms governing modesty, privacy, diet, and covering (*hijab*) that have important clinical implications for caregivers" (Roberts, 2002 , p. 224). What may seem like old-fashioned values to the newer Canadian generations are very

important to the Muslim woman, just as some common Canadian traditions may be viewed as vulgar to Muslims (Roberts, 2002).

The *hijab* may be a conscious choice of modesty for a woman and a way of not drawing attention to herself. She is also discouraged from wearing excessive jewelry, strong perfumes, or making unnecessary conversation in public, again, with the intention of not drawing unnecessary attention to herself. A woman who does not wear the *hijab* may still abide by a figurative *hijab* through her actions of modesty, which may be still very important to her. The behavioural demonstration of modesty might be displayed by maintaining a downward gaze and shy demeanor, especially in the presence of men. For example, "some patients may avoid prolonged eye contact out of respect and modesty" (Pennachio, 2005, Be sensitive to gender issues, para. 2).

To be aware of the modesty behavior pattern might help prevent a misinterpretation of the patient's body language significance. For example a Muslim woman may avoid eye contact particularly with a male health care professional out of preservation of modesty. This health professional may falsely interpret the reason behind her body language as evasiveness. This may also make one cognizant of how to interact and not offend their Muslim female client.

Dietary Concerns

Muslims practice abstinence from pork and its by-products, and alcohol including medicines containing these products (see Appendices A and B). There are exceptions made in the case of a life saving or health related intervention or if there are no substitutions.

Ramadan. Pennachio (2005) explains the technicalities of the *Ramadan* in the following excerpt:

> Fasting during the *Ramadan*, the ninth month of the lunar Muslim calendar (it begins in October this year), from approximately an hour before sunrise until sunset, is compulsory for all healthy adult Muslims. Potentially exempt from fasting are pregnant, lactating, or menstruating women, the sick, and travelers. If a person misses the fast, he makes up for it when he's able. Fasting encompasses total abstinence from food, drink (including water), smoking, and sexual relations. Although pharmaceuticals and IV drips technically aren't allowed, there's an exemption made for people who are ill. Still some patients may insist on fasting regardless, and in a life-threatening situation you should consult an *imam*, an Islamic religious leader, or an elder from the Muslim community to negotiate with the patient to accept the necessary treatment (Dietary issues may affect medical care, para. 4 & 5).

Birth Customs

Muslim women will often prefer a female health care provider. In addition, the support she will receive from her family during the delivery process will usually be from an older female such as her mother or mother-in-law instead of her husband. The absence of some fathers during this time is not for lack of concern but in accordance with upholding the value of cultural norms, although some fathers are now taking a more active role in the delivery process (S. Siddiqui, personal communication, August 23, 2005).

The importance of modesty for some Muslim women remains essential during the birthing process. A mother in labour may choose to stay fully gowned and may wear the *hijab* even if there are only women present. Finally, it is still a tradition in urban centres of some countries for the mother to stay in bed for a few days after the birthing process. Thus, the practice of getting women to ambulate shortly after delivering their child might be a strange concept to some patients.

Grief, Death and the After Life, and the Significance of Pregnancy Loss

The death of an infant at the final stage of gestation can be as difficult as the loss of any other loved one and will lead to a grief response. Grief can be displayed initially as shock, disbelief, and denial. If not dealt with properly, these feelings can turn into depression and anger. It is said that people who experience a perinatal loss never get over it; instead they learn to live with it (Hébert, 1998).

Muslims regard the loss of a term infant as equally significant to the loss of one who has lived this earthly life. Muslims treat the stillborn with utmost respect. Abu Huraina reported that *Allah's* Messenger said "The miscarried fetus that I send before me is dearer to me than the rider whom I leave behind" (Shabazz, n.d., Incompetent Cervix, para. 5). These beliefs stem from their strong view of life as a continuous cycle instead of a dead end point. The end of a life is seen as the will of *Allah* since He causes everything that happens to people and in nature. "The religious and behavioral focus is on acceptance of fate, the reality of the loss, and the primary of following Islamic practices in the relationship to God, even at one's moment of great pain and upheaval" (Rubin & Yasien-Esmael, 2004, p. 159). Even if some are not

full followers of their faith, when confronted with death, several will turn to their religion for answers and comfort.

When death occurs, it is considered God's will and it is viewed as inappropriate to display strong physical emotions such as wailing or tearing at clothes (Hébert, 1998; S. Siddiqui, personal communication, August 23, 2005). It is rare to see a strong outburst of emotions in public coming from a grieving mother who follows Islam, although crying is seen as an acceptable display of emotions (S. Siddiqui, personal communication, August 23, 2005). Nevertheless, families will respond with the death of a child in their own way. It is more common to see men suppress their emotions, where women might be more expressive. There is reassurance for the parents from the Muslim community and family to accept this peacefully and it is reiterated to them that this is God's will. The family, including extended members, and the community, will often surround the grieving couple and support and cater to them while encouraging them to return to their normal lives after the three-day mourning period. Some parents might turn to God and pray or recite verses with family or community members from the *Quran* for relief and support. They are also comforted with the reminder that their deceased child is pure and innocent and therefore guaranteed an entry into paradise. It is believed that the child these parents have lost will meet them at the gates of Paradise. It is explained that "Even the miscarried fetus will drag its mother towards *Jannat* (paradise) if she exercised patience in the hope of acquiring reward" (Bukhari, translated by Muhsin Kahn 1987, as cited in Arshad, et al., 2004, p. 484). Some cultures may mourn for 40 days during which time the gravesite is visited on Fridays (Hébert, 1998; S. Siddiqui,

personal communication, August 23, 2005). Some might then visit the gravesite each Friday for that time period after which they may call friends and relatives for a meal and prayers to signify the end of the mourning period (Hébert, 1998).

Ensoulment. The concept of the relationship that exists between body, spirit and soul is well defined by the *Quran.* The book speaks of:

> God's creation of Adam from the lump of clay, filled with Divine light, or the spirit of God. All people are thought to be a body, or shell, of clay, represented by darkness, with a Centre of divine spirit, or pure light. The space between body or shell, and spirit or light, is the soul – mixed darkness and light. The unique mixture of body and spirit in the soul is what differentiates individuals. At the time of death, the shell of clay is removed, exposing the soul of God (Ross, 2001, p. 84).

For the fetus, the process of ensoulment or full personhood occurs 120 days after conception in the womb (Pennachio, 2005). It is believed that the deceased lives on in the hearts of their loved ones, which could be strongly linked to the religious beliefs of the afterlife. "The significance of interpersonal relationships in life and after death should serve as a reminder of our common humanity even as we explore our similarities and differences" (Rubin & Yasien-Esmael, 2004, p. 159). At this point, the unborn infant is considered to have a soul like all other living human beings that hold this belief. This, if the stillborn child is preterm and is over 20 weeks of gestation, there is a need for full burial. All religious rituals apply in the case of a term stillbirth. This includes washing, shrouding and full burial ceremony. For miscarriages under 20 weeks gestation where ensoulment has not occurred, there are no set parameters, or

religious laws to follow, only the personal wishes of the parents (S. Siddiqui, personal communication, August 23, 2005). Islamic religious laws are flexible and vary across nations and people. It is important is to continuously confirm, with each grieving parents, their personal wishes and beliefs.

Death and Burial Customs and Ceremonies

Gatrad (1994) states that most of the customs have been laid down in the *Shari'ah* (Muslim laws), which are derived from the *Hadith* (practices and sayings of the prophet Mohammed) rather than the *Quran.* Some say that religious law does not require a preterm stillborn baby or fetus to be submitted to ritual washing nor shrouding (S. Siddiqui, personal communication, August 23, 2005). The majority of people (*Igma*) will have a full funeral service or burial for the stillborn after ensoulment has occurred (S. Siddiqui, personal communication, August 23, 2005). In addition, some would argue that both washing and shrouding rituals and a burial is required once ensoulment occurs after 20 weeks of gestation (120 days after conception, ensoulment) (Pennachio, 2005). Furthermore, a number of authors have written that some Muslims will perform the rituals of washing, shrouding and burial of a child who has died in the womb (e.g., Hébert, 1998; Pennachio, 2005).

To clarify, most will follow all post-mortem religious rites if a fetus has died at term but may exclude the washing and shrouding if the child was preterm. Most bereaved Muslim families will choose to follow these rituals with their full term deceased infants (S. Siddiqui, personal communication, August 23, 2005). However, as seen with other cultures when confronted with death, some may choose to proceed with all rituals.

Attending to the miscarried or stillborn infants body and remains. It is customary when handling the remains of the stillborn Muslim infant that at the time of death, the head should be facing a northeasterly direction (in Winnipeg) to face Mecca (the feet should be in the opposing direction) when named (S. Siddiqui, personal communication, August 23, 2005). Although it is viewed as ideal for the deceased to be turned towards Mecca when the child is named, it is believed that in the hospital it should be sufficient to turn the head toward the right (Gatrad, 1994; S. Siddiqui, personal communication, August 23, 2005). The baby's eyes and mouth should then be closed, the body and limbs straightened (the baby should not be left in the fetal position) with the feet or toes (depending of his or her size) tied together to prepare for rituals and burial (the nurse or other health allies can do this preparation before the rituals) (S. Siddiqui, personal communication, August 23, 2005). Also, the infant should be covered completely (so that no part is exposed) before being handed over to the family or community representative (Arshad et al., 2004). See Appendix C.

A washing ritual for the deceased is usually carried out shortly after death by the family or a community member (see Appendix D and E). Since the child is under 6 years of age the gender of the person performing this sacrament does not matter. This ceremony is usually performed in a designated area for Muslims in the funeral home or in a larger Mosque that has the facilities, "However, more and more hospitals are providing this facility for both sexes in a designated place in the mortuary" (Gatrad & Sheikh, 2002, p. 494). The larger hospitals (Health Science Centre and St Boniface Hospital) do not offer special areas designated to Muslims for these rituals. This ritual

can also be performed in the case of a full term pregnancy loss. This is also important if the fetus has attained ensoulment.

The washing ritual is then performed exactly as it would be done in preparation for the daily prayer, which entails washing the face, hands, arms, head and forehead, and feet up to the ankles (Sarhilll, Mahmoud, & Walsh, 2003; S. Siddiqui, personal communication, August 23, 2005).

> The body is turned onto its left side and warm water is splashed over the right side then reversed. This process takes place three times. Hot water should be used for washing after adding the leaves of the 'Lot tree' and it should then be filtered. Particular perfumes are usually applied over the body (Sarhill et al., 2003, p.36).

In addition, the *Quran* may not be recited near the corpse during the washing ritual; personal prayers repeating the declaration of faith may be offered and recited (Ross, 2001; S. Siddiqui, personal communication, August 23, 2005). The final step would be the shrouding with a white cloth, which is cut into three pieces for men and five for women (Sarhilll et al., 2003).

Burial. The body and all the other significant remains should be carried from the hospital in a casket, which is a simple wooden box; the use of a coffin is usually not allowed (Sarhill et al., 2003). The body is then transported by the funeral director or the family to the Mosque or funeral home (S. Siddiqui, personal communication, August 23, 2005). It is forbidden for the body to be embalmed or cremated since it is considered sacred and should not be cut or harmed in any way (Gatrad, 1994). In Manitoba, these religious rites are most commonly performed in funeral homes

facilities dedicated for Muslims (S. Siddiqui, personal communication, August 23, 2005). Once all other religious rites are performed, the body is then buried in the shroud with out the casket and positioned with the head facing Mecca (feet in the opposite direction).

Most Muslim cultures allow women to attend the funeral (S. Siddiqui, personal communication, August 23, 2005), although exceptions do exist where Muslim women are not allowed to attend, even if a female relative or a baby has died. "This is a result of the belief that women are of 'faint heart' and will easily break down." (Gatrad, 1994, Funerals, para. 2). Some believe that the reason for preventing the mother's attendance to her baby's funeral is to protect her and is rooted in the paternalistic family model. As a final note, out of respect for the deceased, the immediate relatives of the departed may not eat until after the funeral (Gatrad, 1994).

Mementoes

The implementation of a memento program, i.e., the gathering of "keepsakes" such as hand and foot prints, photographs and locks of hair, is often done with good intentions, but may be seen by most Muslims as a desecrations of the body (S. Siddiqui, personal communication, August 23, 2005). However, they should not be completely dismissed as an option for Muslim parents as some may still wish to benefit from these created memories. "Muslims believe that only God is able to recreate a living image, therefore photographs and hand and foot prints may be perceived as representation of the human form which is prohibited in Islam" (Gatrad, 1994 in Arshad et al., 2004, p. 483). According to Hébert (1998), these current practices are based on Euro-American theories of grief and loss and are aimed at

facilitating familial adaptation through the creation of memories. She adds that it is unfortunate that the influences of culture on bereavement patterns are often ignored and little attention is given to the applicability and suitability of these practices for the Muslim populations.

Chapter IV: Discussion and Practice Principles

There is an abundance of literature on Muslim culture and rituals, but there is no published consolidated information or guidelines applicable to pregnancy loss in Muslim women and families. The extensive literature search performed resulted in only one brief article from Britain specifically dedicated to pregnancy loss in Muslim women (Arshad et al., 2004). The need for a better understanding of the cultural complexity of this sensitive time is imperative to providing appropriate care to Muslim families.

It has become obvious that more research is required to gain a better understanding of culturally competent care for Muslim parents who have experienced a pregnancy loss. Nevertheless, there was a wealth of information on religious customs surrounding death and grief. There were scattered principles in regard to issues surrounding fetal death. Given the large number and growing population of the Muslim community in Canada and Manitoba, such practice principles would be a valuable resource for the health care worker. This practicum project represents the first attempt at developing such practice principles.

In addition, a summary of some basic beliefs, customs and rituals in Islam are included in the appendices. Also included is an overview of religious beliefs and background information, which extends beyond the basics in Appendices F and G. Finally, a list of common Islamic terms was added in Chapter I to guide health care providers when interacting with Muslim patients, families or community members.

The development of essential information summarized from the literature review and practice principles permits an overview of situations that may be encountered by a health care provider. One must keep in mind that these summarized practice principles are to be used as a basic reference rather that a specific guide given the variations existing in the Islamic religion and among individuals.

Practice Principles when Encountering Pregnancy Loss with Muslim Women and their Families

1. *Assess Adherence to Traditional Values.*

During the initial contact with the patient, it would be advisable to assess the client and family's level of adherence to traditional Muslim values to determine the need for special consideration for their care. This cannot be assumed by external appearance since some Muslims might have adopted the Western cultures dress style but still strongly hold the beliefs in Islam. To aide in this, the implementation of a tool to assess the level of spiritual and cultural influence would be suggested. The ethnicity framework of Fandetti and Goldmeir (cited in Hébert, 1998, p. 62) has been found to be a useful tool in perinatal bereavement management and was used in a case presentation of a Muslim woman experiencing pregnancy loss (Hébert, 1998). The goal of this model is to is to provide optimal bereavement care. This model is based on Jenskin's work (cited in Hébert, 1998) , and identifies three levels (micro, mezzo, and macro), which are used to assess the degree of religious and cultural influence. This information can then be used to determine the culturally appropriate intervention (Hébert, 1998). The micro level represents the person, the mezzo level is the family and macro level is the community. This approach helps capture the depth of

submergence of the client into a culture and religion including his or her family and community in the overview. This ethnicity framework gives suggestions and helps guide possible questions for each of these levels. It may also be used by the social or spiritual care department of institutions as a template consisting of a set of cross-cultural, pre-formulated questions or specific questions for each specific religious group, designed for the frontline admission staff. See Appendix H.

There are other approaches to tailor interactions with the patient to assess their cultural and religious heritage. One important question to ask on the intake form would be the school of Islam followed. This is particularly important if the patient is an *Ahmadiyya* Muslim who has distinct beliefs. It is also recommended to assess if the patient was born and raised in Canada and to evaluate the level of religious and cultural influences. If this individual is an immigrant or a refugee then the same can be assessed. Pennachio (2005) suggests getting a sense of how important Islam is to her or his daily life. However, it should not be presumed that her or his submergence into Western cultures negates the importance of some of their religious observances such as food and social relationships.

2. *Offer a Private Prayer Area.*

A proper praying area for clients with a prayer rug or *mussallah* could be provided so believers can continue with their prayer ritual and be respected for the values they hold (Pennachio, 2005). As well as having a *musallah* (a sheet or a towel will also do) for their obligatory prayer there should be facilities to perform the *ablution*, which includes the thorough washing of hands, mouth, nose, face, forearms, and feet.

The Health Science Centre of Winnipeg offers one sanctuary (2nd floor of the General) for all faiths it is presently under construction, there is another chapel in the rehab hospital that Muslims can also use. There is currently no special washing facilities other then the bathroom but they do have special prayer rugs available for Muslims. The St Boniface hospital in Winnipeg does offer a prayer room and rugs designated for their Muslims population but have no specially designated washing facilities. See Appendices F.

3. Consider Same-sex Healthcare Providers.

This issue would be important to address in the beginning of the therapeutic interactions to clarify the choices available and what could be done to accommodate the women's concerns and beliefs. For example, if there are no female physicians or nurses available, in the case of a Muslim female patient, the presence of another female health care attendant could be offered, or a person of her choice to be present during the exam. Patients typically prefer same-gender providers and may feel uncomfortable if left in seclusion with a physician of the opposite gender (Pennachio, 2005). If that is "unavoidable, leave the door or privacy curtain ajar (as long as your patient is dressed)" (Pennachio, 2005, Be sensitive to gender issues, para. 2). It is not unusual for a husband to ask to stay with his wife while she receives a physical exam. It is advised not to shake hands or hug patients, unless the patient initiates it (this is especially true for patients of the opposite sex) (Pennachio, 2005). The human resources department could arrange a list of easily accessible female physicians to assure their availability to treat female Muslim patients would also be advisable.

One more factor to be aware of is that Muslim women technically are not required to be completely covered in the presence of other women yet they might still choose to do so. To respect these women it would be recommended to have full covering gowns available. Pennachio (2005) recommends that ample time be given for the women to cover their hair, arms, and legs before entering the examination room, even if they are wearing a full-body gown. This author adds to even consider posting a sign stating, "Please knock before entering. This patient observes modest dress and requires the announcement of your presence" (Pennachio, 2005, Be sensitive to gender issues, para. 4).

The issue of consent and signing forms for underage females, particularly for a conservative Muslim, lies in the hands of her father, older brother, husband, or son. In the case of a therapeutic abortion strictly for medical reasons, both members of the couple must sign the consent form. It is important to note that an elective abortion is not supported by the Islamic faith. One solution suggested is to simply explain to both the patient and the relevant male figure the medical legal issues. If this does not resolve the conflict, an option is to have her sign first with a subsequent co-signature of the relative. Some of the issues mentioned above are a summarized in Appendix I.

4. Observe Dietary Practices.

Pay attention to specific `forbidden' food before offering to your patient. There are special considerations for the Muslim population when preparing the menu and food in the kitchen. Foods are divided into two groups, *haram* (forbidden foods) and *halal* (permitted foods). The forbidden food includes pork and its by-products, alcohol (including ingredients or recipes containing alcohol), blood (e.g., blood

pudding) and dead animals. Foods that are acceptable for consumption are cattle and fowl that have been slaughtered in the manner prescribed by Islamic scripture and all other foods not considered *haram.* Permitted is eating beef, lamb, fish and seafood (nothing that crawls or slithers on the ground e.g., snakes, and no carnivorous animals). Appendices A and B include descriptions of religiously allowed and forbidden foods to guide the patient's menu options.

There may also be some hidden byproducts of forbidden foods in a recipe. For example, forbidden foods for Muslims include pork and its by-products involving: pork gelatin products in yogurt, ice cream, marshmallows, some breakfast cereals and bacon bits (Robert, 2002). This might entail a review by the hospital of the ingredient list of some of the menu items offered. Some Muslims are not as particular with certain foods and some would argue that if there is only trace amounts of a forbidden product it becomes permitted. The sharing of a meal is both a social event and an act of worship. In accordance to the tradition of the prophet the right hand should be used to eat (S. Siddiqui, personal communication, August 23, 2005).

5. Observe the Need to Practice Modesty.

Muslim women will need support through the labour process. However, there might be added anxiety for two reasons. First, she is delivering a baby who has died. Second, depending on the patient's country of origin, some may hold the fear of maternal death since it is still very high in some parts of the world.

Modesty may remain important for Muslim women during the birthing process of a stillborn and the preference for a female health care practitioner remains essential during the event of birth. Exceptions will be made in an emergency to have an

attendant of the opposite sex care for the Muslim woman. These women may choose to wear the full gown and even the *hijab* during the birthing process. An older female figure such as a mother or mother-in-law may be present. It might be noted that the father is sometimes not present out of preservation of cultural norms but this is changing. These customs related to birth can also be found at the end of this document in Appendix I and J.

6. Provide Appropriate Grief Support.

The designated social work or spiritual care departments of an institution should establish a link with the local Mosques for support of Muslim patients. It is imperative for comprehensive care to have a social support Centre in a time of crisis when this family might feel misunderstood by the Canadian system. An essential asset to establish is a link with the local Mosques and Muslim Associations for support of Muslim patients if they wish to access this service. Usually, an institution's Spiritual Care department is contacted and they help make the link into the community. In Manitoba, two associations that may be contacted are the Manitoba Islamic Association or the Islamic Social Services to link with a community leader or an *imam*. It is important to clarify which school of Islam this patient follows before contacting a Mosque or association. This is important if he or she is part of *Ahmadiyya* school where, for example, the *Ahmadiyya* Muslim Centre-Mosque in Winnipeg would be provided as a contact point for support. In addition, if this person is part of the *Shiite* or a *Sunni* school of Islam (these are more closely related) either community from these two schools could be offered (but not an *Ahmadiyya* community leader) (S. Siddiqui, personal communication, August 23, 2005). It is important to note that this

service would not automatically be accessed on their behalf. As well, to preserve confidentially and privacy of the parents, the patient should initiate the contact.

> Traditionally, Muslims are very private about personal issues and are reluctant to share intimate details of their family life. If they are assured of the confidentiality on behalf of the provider, they may build trust and share some details to assist the service provider in understanding the situation (ISSA, 2002, p. 36).

It is important to note when offering support that group therapy or support groups might not always be the best choice to offer a Muslim family to help them cope with their loss since they usually prefer privacy in these matters. However, if there are local support groups intended specifically for Muslims and they are wanting therapy this might be offered.

There are also some common customs to be aware of, such as the display strong physical expression of grief such as wailing and tearing at clothing are usually restrained in public, although showing emotions such as crying is acceptable (S. Siddiqui, personal communication, August 23, 2005). In addition, condolences are usually offered within 3 days of the death. This time frame should be considered if any follow up (e.g., phone follow up) the hospital staff does for the Muslim woman or husband. Some of this information pertaining to rituals surrounding grief can be found in Appendices K.

7. Attend to the Miscarried or Stillborn Infant's Remains Appropriately.

Proper facilities could be provided to allow post-mortem religious rites if parents wish to do so in the hospital setting. Currently there are no designated post-mortem facilities for Muslims to perform these rituals in the two largest hospitals in Manitoba (Heath Sciences Centre and St. Boniface General Hospital). It is important to note that the family or a community member usually does all of these religious rites. These rituals are described in Appendix C for the purpose of assisting or enabling the Muslim parents to carry out these rites. It is imperative to note that the mother would not likely perform the post-mortem rituals in the postnatal period, since she may be experiencing lochial loss (Arshad et al., 2004). However, if no one else is available the mother may still perform these rituals according to, "the law of necessity" (S. Siddiqui, personal communication, August 23, 2005).

The stillborn baby is usually named with its head facing Mecca (in Winnipeg it is the north easterly direction), particularly if it is a term pregnancy or once ensoulment has occurred. Ideally, the face of the baby should be turned towards Mecca to receive his or her name, but in hospital turning the face towards the right should be sufficient (Gatrad, 1994). Following this, the infant will be prepared for the religious post-mortem rituals. A nurse or an affiliated health care provider can perform these following steps in preparation for the religious rites if requested or if needed (but the parents wishes should always be confirmed). First, the baby's eyes and mouth should be closed, then the body and limbs should be straightened and the feet or toes (depending on his or her size) tied together. This is done so the body stays straight for the post mortem rituals and burial once rigidity settles in (the baby should not be in

left the fetal position). The body is then covered before being handed to the family. Also, the deceased infant is thought to belong to God and should not be harmed in any way, including a post-mortem examination, unless required by law (Lawerence & Rozmus, 2001). A non-Muslim should avoid overhandling the deceased and gloves should be worn. Most families will likely wish to do the post-mortem care themselves. This process may be most significant if this was a full term pregnancy loss and may be important to some if ensoulment or full personhood has occurred (120 days after conception). Most of these post mortem rituals will be done at the funeral home in a specially designated area for Muslims. Alternatively, some larger Mosques may offer these facilities.

The following is a description of the washing ritual in case it is to be performed in the hospital setting. The ceremony of washing involves running lukewarm the water so it flows off the body. To facilitate this process in the hospital, a small slopping ramp with a baby-changing mat attached (see Appendix E) could be used. It is to be noted that if it is necessary to wash the body after death, a Muslim should do this (Lawrence & Rozmus, 2001).

A private room with warm running water available could be offered, if a parent or community member wishes to perform the washing ritual on the unit floor (this is usually done in the funeral home facilities). During this ritual the body is never left entirely uncovered particularly the perineum. The body is placed on a slopping ramp so everything flows downward. Gloves are usually worn to wash the body with their hands. Washing starts with the perineum to evacuate the impurities. A list of the essential materials needed for the washing ritual after death is outlined in Appendix E.

The list includes: liquid soap, cotton balls, a small towel, a pouring cup, disposable gloves, one or two small white sheets, blanket or cloth, some crushed camphor in water (lotus leaves are also used but their availability and cost makes them limited in use).

Finally, the Muslim baby and all the products of conception (e.g., placental tissue) are always buried, never cremated or embalmed. So then what needs to happen is a revision of procedures established by the institutions in regards to these fetal remains. Burial is usually performed within 24 hours although this period may be extended due to hospital procedures and the logistics of transferring the body to the funeral home. Usually the body will be transferred by casket (a simple wooden box) to the funeral home that same day and the rituals performed by the next day. Burial will be performed for the full term stillborn; it is mandatory by religious law. Most parents will choose also to bury the fetus if the process of ensoulment has occurred (120 days after conception). See Appendix L.

8. Consult with Families Regarding the Collection of Mementoes.

Mementoes are usually inappropriate for the miscarried or stillborn Muslim infant. To desecrate the body of the infant in any way would be offensive to most families who practice Islam. Even taking a picture or keeping items on file would be considered inappropriate to most Muslim parents. It would be wise to ask the parents what their wishes are even when considering filing these items for later.

9. Access and Provide Local Resources as Appropriate.

The social work or spiritual care service department of the hospital should seek out local Islamic religious leaders for guidance or assistance. See Appendix M for a list of contacts in Manitoba. When negotiating the best interests of the Muslim parents, there might come a time when local Islamic community leaders or an *imam* should be sought for guidance or assistance for a particular case. Those proceeding must consider issues of confidentiality in reference to local PHIA laws (Private Health Information Act).

Before contacting a community leader, a patient/family's School of Islam should be confirmed. For example, a Muslim who follows the *Ahmadiyya* School would only consult an *Ahmadiyya* community leader. In addition, if this person is part of the *Shiite* or a *Sunni* school of Islam (these are more closely related) either leader from these two schools could be consulted (but not an *Ahmadiyya* community leader) (S. Siddiqui, personal communication, August 23, 2005).

A proactive approach by the designated departments (social and or spiritual) of the institution would be to create a committed network of community leaders from the local Islamic community so patients and the health care team can readily access them as counselors and resources. This could be done by contacting local associations and assessing the communities' key contacts, existing supports, and cultural leaders. An added asset would be to seek out professionals who specialize in the field of Islam for consultation purposes. Again any discussion or disclosure of confidential patient information should be carefully considered and assessed prior to any consultation.

There is still a need for most the health care institutions to evolve and expand services to provide support for staff and patients in a time of need such as the pregnancy loss. Another step would be assessing the most common countries of origin with a list of the predominate languages spoken by the local Muslim population. Patients will come from various areas of the world and may speak Farsi, Urdu, Arabic, Pashtu or Malay (Pennachio, 2005). It should be ensured that there are adequate interpreter facilities in place and/or an arrangement with local physicians who speak the native language of the Muslim population. In addition, a list of bilingual staff and community members who are willing to interpret or translate should be regularly maintained. If there are no translating services available in an institution, there are telephone-translating services available 24 hours a day although they are usually costly. One option used in Winnipeg for emergency situations would be the Language Bank Company (204-943-9158) that offers a wide variety of translation services.

Chapter V: Recommendations for Education and Research, and Conclusion

The Muslim population is growing worldwide, in Canada, and in Manitoba. There is a visible transition occurring in the appearance of diversity in our local hospitals. There are great differences between Islamic customs and Muslim culture and Western cultures. This recent growth of the Muslim culture into the Canadian landscape has highlighted the need to expand the scope of the cultural competence of our institutions and health care professionals. Our health care system must now act to accommodate our local Muslim population, as times have changed and new needs have arisen.

There is an increasing importance for nursing education and research to identify and attend to emerging cultural disparities. Manitoba displays a culturally diverse population, which demonstrates the need to enhance nursing education. One recommendation would be to add a mandatory course on cultural diversity to be part of the nursing undergraduate curriculum to promote cultural competence.

To further enhance the body of literature, there needs to be further research undertaken by nurses in the area of cultural care and competency. There would be great benefit to having nurses pursue such research foci. This would enrich the literature on cultural aspects of care and could be used to further educate the current and future generations of health professionals. This practicum project is one example of related research. It will provide value not only in its role as a teaching tool and/or to raise awareness, but as an example of a project demonstrating the need for cultural competence in the diverse areas of health care delivery.

The focus of this project has been on the particular needs of a Muslim woman and family in the time of grief and loss of a child. This sensitive time period requires great attention to detail for complete mental and spiritual care of the grieving Muslim parents and reaffirms the need for cultural competency.

Cultural competence creates an environment for quality care and addresses disparities. Most Canadian institutions are providing excellent medically advanced care. However if a person/family is unable to navigate this system because of basic linguistic barriers this would be a simple yet crucial example of a shortcoming of these institutions. To uphold a quality standard of care, institutions need to initiate research and evaluate policy, and capacity (Bowen, 2004). To enable health professionals to deliver culturally competent care institutions need to implement support systems to offer personalized care to patients with distinctive needs (such as translation services).

In addition, the institutions and health care professionals can then both start progressing on the cultural competency continuum once they acknowledge and become aware of the evolving population needs. The cultural competence continuum model demonstrates transitions into various levels from cultural destructiveness to blindness to pre-competence that then may lead to cultural competency (see Appendix N). For this transition to occur, not only do these needs need to be acknowledged, but action plans must be created and institutions/health professionals should actively dedicate themselves to eliminate cultural disparities that exist. "Negative experiences in the health care setting may profoundly impact attitudes toward receiving care and influence the further utilization of health care services..." (Spruill & Davis, 2005, p. 2). It is a monumental task for a health care team and the

organization in which it works to attain cultural competence for every diverse need that exists. Instead of abandoning this overwhelming goal, the focus of energy for institutions and health professionals should be to attend to the common barriers encountered by the majority of their culturally and religiously diverse populations. In addition, they must acknowledge that responding respectfully and effectively to people of all cultures, languages, classes, races, sexes, cultural backgrounds and religions will be an ongoing process (Mak, 2002). Culture continuously evolves with life, which changes with time, communities, families, and individual beliefs.

The purpose of this practicum project was to attain a greater understanding of Islam with regards to pregnancy loss. The literature was reviewed and a series of principles for practice was compiled to provide a tool for health care providers to administer culturally competent care to female Muslim patients experiencing loss of pregnancy. In addition, the executive director of the Islamic Social Services Association (ISSA) has reviewed the practice principles and the summarized information.

In conclusion, delivering care that addresses culturally sensitive issues can help to minimize confusion and misunderstandings at a time of crisis for patients and leave the family with a sense of having been shown respect regarding their beliefs and values. The development of the principles for practice will be a valuable tool on the path to attaining the goal of cultural competency when delivering care to the grieving Muslim families.

References

American College of Obstetricians and Gynecologists (2002). *Medical library: early pregnancy loss: Miscarriage and molar pregnancy.* Retrieved July 25, 2005, from http://www.medem.com/medlb/article_detaillb.cfm?article_ID=ZZZJESDP97C&sub_cat=2005

Arshad, M., Horsfall, A., & Rubina, Y., (2004). Pregnancy loss – the Islamic perspective. *British Journal of Midwifery, 12*(8), 481-484.

Banawi, R., & Stockton, R. (1993). Islamic values relevant to group work, with practical applications for the group leader. *Journal for Specialist in Group Work, 18*(3), 151-160.

Barber, K. (Eds.). (2004). *Canadian Oxford Dictionary.* Don Mills, ON, Canada: Oxford University Press.

Betancourt, J. R., Green, A. R., Emilio Carrillo, J., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*(2), 499-506. Retrieved August 25, 2005, from http://content.healthaffairs.org/cgi/content/abstract/24/2/499

Bowen, S. J. (2004) Assessing the responsiveness of health care organizations to culturally diverse groups. (Thesis, University of Manitoba, 2004).

Britannica Online Encyclopedia (2005). *Major world religion founded by Muhammad in Arabia in the early 7th century AD.* Retrieved July 22, 2005, from http://www.britannica.com/ebc/article?tocId=9368246&query=Definition%20Islam&ct=gen1#cite

Britannica Online Encyclopedia. (2005). *Merriam-Webster's Collegiate Dictionary.* Retrieved July 22, 2005, from http://www.britannica.com/

Chen, P. (2004). *Medical Encyclopedia: Hydatidiform mole.* National Library of Medicine and the National Institutes of Health : Medline Plus. Retrieved July 25, 2005, from http://www.nlm.nih.gov/medlineplus/ency/article/000909.htm

Corbett, J. M (1994). *Religion in America* (2nd ed.). Englewood Cliffs, NJ, USA: Prentice Hall.

Dambro, M. R. (2005). *Abortion, spontaneous* (online ed.). Griffith's: 5 Minute Clinical Consult a Reference for Clinicians Description. Retrieved July 23, 2005, from http://www.5mcc.com/Assets/SUMMARY/TP0001.html

Dambro, M.R. (2005). *Premature labor* (online ed.). Griffith's: 5 Minute Clinical Consult a Reference for Clinicians Description. Retrieved July 23, 2005, from http://www.5mcc.com/content.html

Douglas, A. (2000). *The mother of all pregnancy books: An all-Canadian guide to conception, birth and everything in between.* Toronto, ON, Canada: Mcmillan Canada.

Dreher, M., & MacNaughton, N. (2002). Cultural competence in nursing: Foundation or fallacy? *Nursing Outlook, 50*(5), 181-186. Retrieved August 25, 2005, http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12386652&dopt=Abstract

EMedicine (2005). *Ectopic pregnancy overview.* Retrieved July 23, 2005, from http://www.emedicinehealth.com/articles/12435-1.asp

Fandetti, D. V., & Goldmeier, J. (1988). Social workers as culture mediators in health care settings. *Health and Social Work, 13*(3), 171-179.

Gatrad, A. R. (1994). Muslim customs surrounding death, bereavement, postmortem examinations, and organ transplants. *British Medical Journal, 309*(6953), Retrieved July 23, 2005 from http://bmj.bmjjournals.com.proxy2.lib.umanitoba.ca/cgi/content/abstract/309/6953/521

Gatrad, A. R. & Sheikh, A. (2002). Palliative care for Muslims and issues after death. *International Journal of Palliative Nursing, 8*(12), 594-597.

Gracey, K., (2003). Providing culturally sensitive care to the childbearing Islamic family: Part II. *Advances in Neonatal Care, 3*(5), 250-255.

Hamdani, D. H. (2001). *This chart was taken from "Muslims and Islam in Canada" Muslims and Islam in the American Continent,1*, Retrieved July 25, 2005, from http://www.anewlife.ca/teaching/online/demo.php

Harvard Medical School. (2004). Miscarriage. *Consumer Health Information.* Retrieved July 22, 2005, from http://www.intelihealth.com/IH/ihtIH/WSIHW000/9339/23832.html

Hawker, S. (Ed.). (2002). *Oxford: Mini dictionary thesaurus and wordpower guide.* (1st ed.). New York: Oxford.

Hébert, M. P. (1998). Perinatal bereavement in its cultural context. *Death Studies, 22*, 61-68.

Hodge, D. R. (2005). Social Work and the House of Islam: Orienting practitioners to the beliefs and values in the United States. *Social Work, 50*(2), 162-163.

Islamic Social Services Association (ISSA). (2002). *Muslim culture and faith: A guide for social service providers.* 1-40.

Izetbegovic, A. A. (1993). *Islam between east and west.* (3rd ed.). Plainfield, IN: American Trust Publications.

Kelly, E. W., Aridi, A., & Bakhtiar, L. (1996). Muslim in the United States: An exploratory study of universal and mental health values. *Counseling and Values, 40*, 206-218.

Kim-Godwin, Y. S., Clarke, P.N., & Barton, L. (2001). A model for the delivery of culturally competent community care. *Journal of Advanced Nursing, 35*(6), 918-925.

Lawrence, P., & Rozmus, C. (2001). Culturally sensitive care of the Muslim patient. *Journal of Transcultural Nursing, 12*(3), 228-233.

Mak, J. (2002). *Diversity and Human rights consortium: What is Cultural Competency?* Orogan, U.S.: Lane Community College, 1-3. Retrieved on August 25 2005, from http://www.dhrc.net/docs/cultural_comp.pdf

March of Dimes. (2004). *Miscarriage: Quick reference and fact sheets.* Retrieved July 22, 2005, from http://www.marchofdimes.com/professionals/681_1192.asp

March of Dimes. (2002). *Stillbirth: Quick reference and fact sheets.* Retrieved July 22, 2005, from http://www.marchofdimes.com/professionals/681_1198.asp

Nabeel, S., Mahmooud, F., & Walsh, D., (2003). Muslims beliefs regarding death and bereavement. *European Journal of Palliative Care, 10*(1), 34-37.

National Library of Medicine. (2004). *Medline Plus: Miscarriage.* Retrieved July 23, 2005, from http://www.nlm.nih.gov/medlineplus/ency/article/001488.htm

Nationmaster. (2005). *Encyclopedia: Islam in Canada.* Retrieved August 24, 2005, from http://www.nationmaster.com/encyclopedia/Islam-in-Canada

Pacquiao, D. F. (2003). *Cultural competence in ethical decision making. Transcultural concepts in nursing care* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Petrozza, J. C. (2004). *Early pregnancy loss.* Retrieved August 29, 2005, from http://www.emedicine.com/med/topic3241.htm

Pennachio, L. D. (2005). Caring for your Muslim patients: stereotypes and misunderstandings affect the care of patients from the Middle East and other parts of the Islamic world. *Medical Economics, 46*(5), Retrieved July 23, 2005, from http://infotrac.galegroup.com.proxy2.lib.umanitoba.ca/itw/infomark/621/314/96901675w3/purl=rc1_HRCA_0_A134167428&dyn=3!xrn_1_0_A134167428?sw_aep=univmanitoba

Roberts, K. S. (2002). Providing culturally sensitive care to the childbearing Islamic family. *Advances in Neonatal Care, 2*(4), 222-228.

Rorie, J. L., Paine, L. L & Barger, M.K. (1996). Cultural competence in primary care services. *Journal of Nurse-Midwifery, 41*(2), 92-100.

Ross, M. H. (2001). Islamic Tradition at the end of life. *Medsurg Nursing, 10*(2), 83-87.

Rubin, S. S. & Yasien-Esmael H. (2004). Loss and bereavement among Israel's Muslims: Acceptance of God's will, grief, and the relationship to the deceased. *Omega, 49*(2), 149-162.

Sarhilll, N., Mahmoud, F. & Walsh, D., (2003). Muslim beliefs regarding death and bereavement. *European Journal of Palliative Care, 10*(1), 34-37.

Shabazz, N. (n.d.). *An Islamic approach to miscarriage: Cause and trauma.* Retrieved July 22, 2005, from http://muslim-canada.org/miscarriage.htm

Spruill, I., & Davis, B. L. (2005). *Cultural competence: myth or mandate.* Virginia, U.S.: Hampton University School of Nursing, 1-13. Retrieved August 28, 2005, from http://64.233.187.104/search?q=cache:Bv6LSY9rqKYJ: ethicsjournal.umc.edu/ojs/include/getdoc.php%3Fid%3D116%26article%3D21 %26mode%3Dpdf+Spruill+Davis+Cultural+competence+myth+or+mandate& hl=en&client=safari

Statistics Canada. (2001). *Population by religion, by provinces and territories (2001 Census) (Quebec, Ontario, Manitoba, Saskatchewan)* Retrieved July 22, 2005, from http://www40.statcan.ca/l01/cst01/demo30b.htm

Statistics Canada. (2005). *Pregnancy outcomes by province or territory of residence (Fetal loss).* Statistics Canada, Canadian Vital Statistics, Birth Database and Stillbirth Database; Canadian Institute for Health Information, Hospital Morbidity Database and Therapeutic Abortion Database. The Statistics Canada publication Reproductive Health: Pregnancies and Rates, Canada, 1974-1993 Retrieved July 25, 2005, from http://www40.statcan.ca/l01/cst01/hlth64d.htm ?sdi=fetal%20loss

Taylor, R. (2005). Addressing barriers to cultural competence. *Journal for Nurses in Staff Development, (21)*4, 135-142.

Wilner, R., Dimant, F., Scheinberg, S. & Klein, R. (2003). *Audit of antisemitic incidents.* League for human rights of b'nai brith Canada. Retrieved July 25, 2005, from http://www.bnaibrith.ca/publications/audit2003/audit2003-00.html

Appendix A

Islamic Practices Regarding Food

1. In accordance to Islamic law, the right hand is to be used to eat food.
2. *Haram* (forbidden foods): pork and its byproducts, alcohol (including if it is an ingredient in a recipe or medication), blood (e.g., blood pudding) and dead animals (Appendix B) (S. Siddiqui, personal communication, August 23, 2005).
3. *Halal* (permitted foods): animals that have been slaughtered in the manner prescribed by Islamic scripture and all other foods not considered haram. This permits eating cattle, fowl, lamb, fish and seafood (Appendix B) (S. Siddiqui, personal communication, August 23, 2005).
4. Some Muslims may follow only partially some to these food restrictions due to various interpretations of the scriptures. Also, some believe if there are trace amount of a forbidden food it is found acceptable for consumption.
5. If there was only forbidden food available then the law of necessity will permit their consumption (S. Siddiqui, personal communication, August 23, 2005).
6. Sharing a meal is both a social event and an act of worship.
7. Overeating is discouraged.

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix B

Permitted and Forbidden Foods in Islam

Halal (Permitted Foods)	*Haram* (Forbidden Foods)
Muslims are allowed to eat all types of foods	Forbidden foods for Muslims include pork and its by-products. These foods are forbidden only if they contain in the ingredient list a pork by-product or other forbidden foods ▪ Gelatin pork products ▪ Yogurt ▪ Ice cream ▪ Marshmallows ▪ Some breakfast cereals
Religious Teaching: Permitted are the foods of "those who have received a Divine Scripture" (referring to the Christians and Jews).	*Religious Teaching:* Carrion blood that which has been dedicated unto any other than God… (*Quran*, 5:5)
Animal Products The slaughter and handling of animal products is dictated by religious teaching. ▪ Kosher products may be deemed acceptable. ▪ All fowl are permitted. ▪ Also permitted are eating cattle, lamb, fish and seafood	Alcohol and Other Intoxicants Alcoholic beverages are not allowed. Hidden ingredients in the preservation or preparation of foods may also be an issue. This includes ▪ Sauces that include alcohol, ▪ Sweets that include vanilla ▪ Medicines that contain alcohol as an active ingredient or preservative.
Religious Teaching: God's name should be mentioned over the animal while slaughtering it (*Quran*, 5:4). The animal should be slaughtered by slitting the front of the throat and allowing the blood to drain completely.	*Religious Teaching* … concerning wine and gambling. "In them is great sin, and some benefit, for men; the sin is greater" (*Quran*, 2:219).

NOTE: Mixing of *halal* and *haram* foods together will make the food *haram*.

(Some parts have been edited as per S. Siddiqui, personal communication, August 23, 2005)

(Robert, 2002, p. 226)

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix C

Muslim Religious Rites After a Pregnancy Loss

1. Wishes of the parents should always be confirmed first.
2. This process may be most significant if this was a full term pregnancy loss and may be traditionally practiced if ensoulment or full personhood has occurred (120 days after conception).
3. A non-Muslim should avoid overhandling the deceased and use gloves.
4. The religious rituals are usually done by a family or community member and not by a health care professional.
5. The health care provider may be asked to prepare the infant for the ritual (not do the rituals).

The stillborn baby is usually named with its head facing Mecca (in Winnipeg it is the northeasterly direction), particularly if it is a term pregnancy or once ensoulment has occurred. Ideally, the face of the baby who has died should be turned towards Mecca to receive his or her name, but in hospital turning the face towards the right should be sufficient (Gatrad, 1994; S. Siddiqui, personal communication, August 23, 2005).

To then follow will be to prepare the infant for the Islamic rituals. First, the baby's eyes and mouth should be closed, then the body and limbs should be straightened and the feet or toes (depending on his or her size) should be tied together and then covered (a nurse or affiliated health care provider can do these steps if needed). This is so the body stays straight for the post mortem rituals and burial when rigidity settles in (the baby should not be kept in the fetal position).

Also, the infant should be covered so that nothing is exposed before being handed over to the family or community representative (Arshad et al., 2004). It is necessary to wash the full term baby after death, but a Muslim should do this (Lawrence & Rozmus, 2001).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix D

Islamic Customs with Respect to Pregnancy Loss I:

Post Mortem Rituals Info

1. Most families will wish to do the post-mortem care; this process may be most significant if this was a full term pregnancy loss and may be traditionally practiced for some if ensoulment has occurred.
2. A family member or friend of the same gender of the deceased usually performs ritual washing soon after death. Since this child is under 6 years of age the gender of the person performing this sacrament does not matter.
3. It is also essential to be aware of the washing ritual if a family or community member wishes to perform this act in the hospital setting.
4. The shrouding and bathing ritual may be performed by the family or a community member for the term stillborn it is considered mandatory by religious law. Most Muslim bereaved families likely will choose to follow these rituals with their deceased term baby.
5. It is imperative to note that the mother would not likely perform this ritual in the postnatal period, since she maybe experiencing lochial loss (Arshad et al., 2004). Although, if she is the only one available she is permitted to do these under the "Law of necessity" (S. Siddiqui, personal communication, August 23, 2005).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

6. The deceased infant is thought to belong to God and should not be cut or harmed in any way, nor should a post-mortem examination be done unless required by law (Lawerence & Rozmus, 2001).
7. The fetus or stillborn should manipulated as little as possible.
8. Gloves should be worn if you need to care for the stillborn child.
9. The *Quran* may not be recited while washing the corpse; what may be recited is a repetition of declaration of faith prayers (S. Siddiqui, personal communication, August 23, 2005).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix E
Tools That May be Needed to Wash the Baby After Death

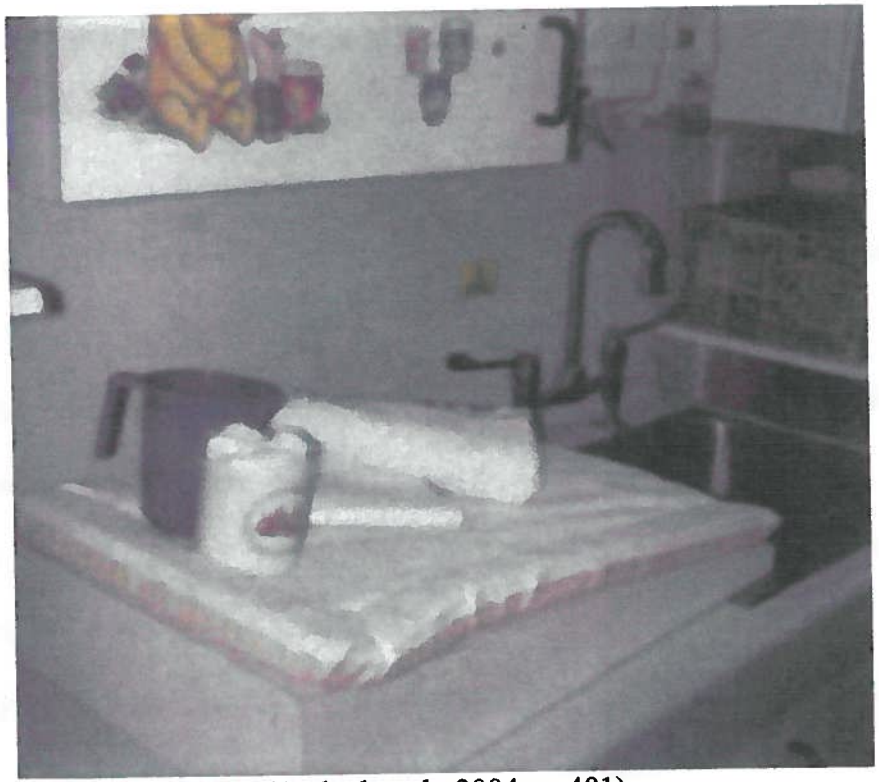
According to Religious Rites

It is necessary to wash the stillborn term baby after death, but a Muslim should do this

(Lawrence & Rozmus, 2001; S. Siddiqui, personal communication, August 23, 2005)

1. A private room with warm running water available.
2. Liquid soap
3. Cotton balls
4. A small towel.
5. A pouring cup.
6. Disposable gloves.
7. One or two small white sheet, blanket or cloth.
8. Camphor crushed in water (lotus leaves may also be used).
9. A small sloping ramp with a baby change mat attached (see figure below).

Bathing ramp in accordance to Islamic law



(Arshad et al., 2004, p. 481)

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix F

The Islamic Religion: General Information

1. The words Islam and Muslim are not interchangeable and do not carry the same meaning: this is a common mistake. A Muslim has the literal significance of a person who submits to one God. He is also a believer in his faith and in the teachings of *Muhammad.* All Muslims follow as well the 5 pillars of faith. Therefore, Islam is the religious faith of Muslims (Britannica Online Encyclopedia, 2005; Hawker, 2002).
2. You should not interrupt and you should give privacy to a person who is praying.
3. It is considered disrespectful to walk in front of a person who is praying (Pennachio, 2005). Provide a private area for prayer.
4. No eating or talking should be done during prayers (Pennachio, 2005).
5. The fast during the month of *Ramadan* involves complete abstinence from food or drink (including water) during the daylight hours.
6. The religion Islam is the second largest religion in the world, which is, estimated at1.3 billion followers (S. Siddiqui, personal communication, August 23, 2005).
7. The Mecca in Saudi Arabia is considered the birthplace of Islam (S. Siddiqui, personal communication, August 23, 2005).
8. "The geographic centre of Islam is on the Arabian Peninsula, with Muslims identifying Jerusalem as their holy city" (Ross, 2001, p.83).
9. Many Muslims recognize the Madinah and the Mecca in Saudi Arabia as a holy city (S. Siddiqui, personal communication, August 23, 2005).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

10. Cleanliness is very important to Muslims since a clean body signifies a pure soul (Lawrence & Rozmus, 2001).
11. Ritual purification before prayers is done with water but if unavailable sand or stone can be used.
12. The holy day for Muslims is Friday (from sunset on Thursday to sunset on Friday).
13. Twenty percent (20 %) of Muslims in the world are Arab (Lawrence & Rozmus, 2001).
14. Approximately 90 % of Arabs are Muslims (Lawrence & Rozmus, 2001).
15. The majority of Muslims live in 184 countries, including Saudi Arabia, Indonesia, Malaysia, Iran, Turkey and the countries of Asia and Su-Saharan Africa (Pennachio, 2005).
16. "Islam is the largest non-Christian religion in Canada" (Nationmaster, 2005, para.1).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix G

The 5 Pillars of Islam:

The profession of faith. The declaration of faith is to believe there is only one God (*Allah*) and that the Prophet Muhammad is his messenger (Lawrence & Rozmus, 2001).

Salat or prayer Muslims are required to pray 5 times daily. The first prayer is before sunrise and the final is late night (S. Siddiqui, personal communication, August 23, 2005).

Sawm or fasting. Most Muslims fast during the month of the *Ramadan.* During the *Ramadan* there is abstinence from food, including drinking water, smoking and marital sexual intercourse from dawn to dusk (S. Siddiqui, personal communication, August 23, 2005).

Zakat or almsgiving. Muslims are required to give 2.5 % of their wealth every year in charity or the community (Lawrence & Rozmus, 2001).

Hajj or pilgrimage to Mecca. Approximately 70 days after the *Ramadan* a pilgrimage is done during one's lifetime if he or she is able to do so both physically and financially (Lawrence & Rozmus, 2001).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix H

Ethnicity Framework
Micro: The person
Assess the person's cultural orientation: for example, languages spoken, religion professed, and generation of immigration of the primary client.
▼
Evaluate the importance of intraethnic group variations affecting the person's orientation.
▼
Consider the person's class membership as a mediating factor.
▼
Select ethnically compatible solutions to personal problems.
▼
Mezzo: The family, client group, and treatment team
Assess the ethnically based dynamics of the family, client group, or team.
▼
Assess the responsiveness of a group or team, whose members may themselves reflect different ethnic orientations.
▼
Evaluate the importance of intraethnic group variations in families, groups and treatment teams.
▼
Consider class membership as a mediating factor.
▼
Select ethnically compatible solutions at the family, group, or treatment team levels.
▼
Macro: The local and nonlocal community
Understand family boundaries with the larger community in intervention and planning.
▼
Facilitate community responsiveness to ethnic cultural needs.
▼
Be aware of the local-state-national policies affecting the integration of the ethnic groups.

(Fandetti & Goldmeier's model as cite in Hébert, 1998, p. 62)

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix I

Gender Issues, Family Roles and Socialization: General Information

1. A woman should not be in seclusion with a man unless he is a family member.
2. Modesty is important for both sexes but especially important for Muslim women. However, requirements are different.
3. "Muslim women adhere, in varying degrees, to prescribed norms governing modesty, privacy, diet and covering (*hijab*) that have important clinical implications for caregivers." (Roberts, 2002, p. 224).
4. Even in the presence of a female health care practitioner, the Muslim women may still choose to stay fully gowned with the *hijab* (veil).
5. A woman who does not wear the *hijab* may still abide by a figurative *hijab* through her actions of modesty, which may be still very important to her.
6. The behavioural demonstration of modesty might be displayed by maintaining a downward gaze and shy demeanor, especially in the presence of men.
7. A female health care provider should be assigned to care for the Muslim women.
8. Touching and shaking hands are not customary outside the family.
9. Some Muslim families are patriarchal and include the extended relatives as part of it.
10. Women are usually the primary caregivers.
11. Men are considered heads of the families.
12. The issue of consent and signing forms for underage females, particularly for a conservative Muslim, lies in the hands of her father, older brother or husband or son. In the case of a therapeutic abortion strictly for medical reasons, both members of the couple must sign the consent form (an elective abortion is not supported by the Islamic faith).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix J

Islamic Customs Related to Birth

1. The absence of some fathers during the birthing process is not for lack of concern but in accordance with upholding the value of cultural norms, although some fathers are now taking a more active role in the delivery process (S. Siddiqui, personal communication, August 23, 2005).
2. Exceptions will be made in an emergency to have an attendant of the opposite sex care for the Muslim woman.
3. An older female figure such as a mother or mother-in-law may be present especially for the first delivery.
4. The preference for a female health care practitioner remains during the event of birth.
5. Modesty remains important. The women may choose to wear the full gown and even the *hijab* during the birthing process.
6. It is important to consider when doing post-natal teaching that women abstain from marital sexual relations during lochial loss (S. Siddiqui, personal communication, August 23, 2005).
7. To prevent adverse outcomes from unneeded prolonged bed rest (rooted in practices of a few Muslim woman originally from urban centres of some countries), it is best to explain and discuss the medical reasons behind the Canadian philosophy.

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix K

Grief, Support and Related Customs and Beliefs: General Info

1. A small number of Muslim cultures do not allow women to attend the funeral.
2. Condolences are usually offered within 3 days of the death.
3. It is not customary for the parents to display strong physical expressions of grief such as wailing and tearing at clothes in public after the death of an infant, although crying is acceptable.
4. Group therapy or support groups might not always be the sensible choice to offer a Muslim family to help them cope with their loss since they usually prefer privacy in these matters, unless there is a local Muslim support group in place.
5. "Traditionally, Muslims are very private about personal issues and are reluctant to share intimate details of their family life. If they are assured of the confidentiality on behalf of the provider, they may build trust and share some details to assist the service provider in understanding the situation" (ISSA, 2002, p. 36).
6. Mementoes are usually not appropriate for Muslim parents and permission should always be sought even if these items are to be collected for later (e.g., taking a lock of hair or photograph).
7. Before offering community resources, the individual's School of Islam should be confirmed. For example, a Muslim who follows the *Ahmadiyya* School would only receive support from the *Ahmadiyya* community. In addition, if this person is part of the *Shiite* or a *Sunni* school of Islam (these are more closely related) either community from these two schools could be offered (but not an *Ahmadiyya* community leader) (S. Siddiqui, personal communication, August 23, 2005).

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix L

Islamic Customs with Respect to Pregnancy Loss II:

Burial Information

1. Burial is usually performed shortly after death, usually within 24 hours. However if this is not possible then the burial should occur by the following day.
2. The body and all the other significant remains should be carried from the hospital in a simple wooden box (casket) – the use of a coffin is not usually used (Sarhill et al., 2003). The casket is used for transportation purpose but the body is buried in the shroud only.
3. The Muslim baby and all the products of conception (e.g., placental tissue) are always buried, never cremated and not embalmed.
4. The body is usually brought to a funeral home where the rituals are performed in a designated area for Muslims.
5. Burial shall be performed for the term stillborn; it is mandatory by religious law. Most parents may also choose bury the premature stillborn if the process of ensoulment has occurred (120 days after conception).
6. For miscarriages under 20 weeks gestation where ensoulment has not occurred, there are no set parameters, or religious laws to follow, only the personnel wishes of the parents (S. Siddiqui, personal communication, August 23, 2005).
7. A small number of Muslim cultures do not allow women to attend the funeral.
8. Islamic religious laws are flexible and vary across nations and people (S. Siddiqui, personal communication, August 23, 2005) and therefore is important is to continuously confirm personal wishes and beliefs with all grieving parents.

Disclaimer: This information is only intended to give a broad and general description of Muslim culture. Some information may not be relevant to all of your Muslim clients.

Appendix M

List of Mosques and Associations in Manitoba and Canada

Ahmadiyya Muslim Centre-Mosque
525 Kylemore Avenue,
Winnipeg, MB R3L1B5
Contact: (204) 475-2642

Brandon Islamic Centre
Tenth Street
Brandon, MB
Prayers Held: Daily Prayers
Friday (*Jum'ah*) Prayers

Health Sciences Centre (Bannatyne Campus)
820 Sherbrook Street
Respiratory & Rehabilitation Centre Chapel
Second Floor, Room RR215
Winnipeg, MB
Contact: (204) 787-3884
Prayers Held: Friday (*Jum'ah*) Prayers

Islamic Educational Foundation Of Manitoba
731 Wellington Avenue,
Winnipeg, MB R3E0H9
Contact: (204) 774-8459
Prayers Held: Friday (*Jum'ah*) Prayers

Islamic Information Institute Of Manitoba
594 Ellice Ave.
Winnipeg, MB
R3G 0A3
Contact: (204) 779-4446
www.iiim.info

Islamic Social Services Association of Canada and the United States (ISSA)
PO BOX 21010
RPO Charleswood
Winnipeg, Manitoba
R3R 3R2
Contact: 1-866-239-ISSA (Toll Free - Canada)
info@issaservices.com
http://www.issaservices.com/

Muslim Association of Canada
1085 Grenon Ave.
Ottawa, ON
K2B 8L7
Mailing Address
332-1568 Merivale Road.
Ottawa, Ontario
K2G 5Y7
Contact: (613) 321-5000
Fax: (613) 321-5001
mac@macnet.ca
http://www.macnet.ca/national/index.php

Manitoba Islamic Centre (The Mosque)
247 Hazelwood Avenue,
Winnipeg, MB R2M4W1
Contact: (204) 256-1347
Prayers Held: Daily Prayers
Friday (*Jum'ah*) Prayers, *Tarawih*,
Prayers during *Ramadan*

Manitoba Islamic Association
247 Hazelwood Avenue,
Winnipeg, MB R2M4W1
Contact: (204) 256-1347
mia@miaonline.org
http://www.miaonline.org/contact/

Masjid-Manitoba Islamic Centre
247 Hazelwood Avenue,
Winnipeg,
MB R2M 4W1
Contact: (204) 256-1347

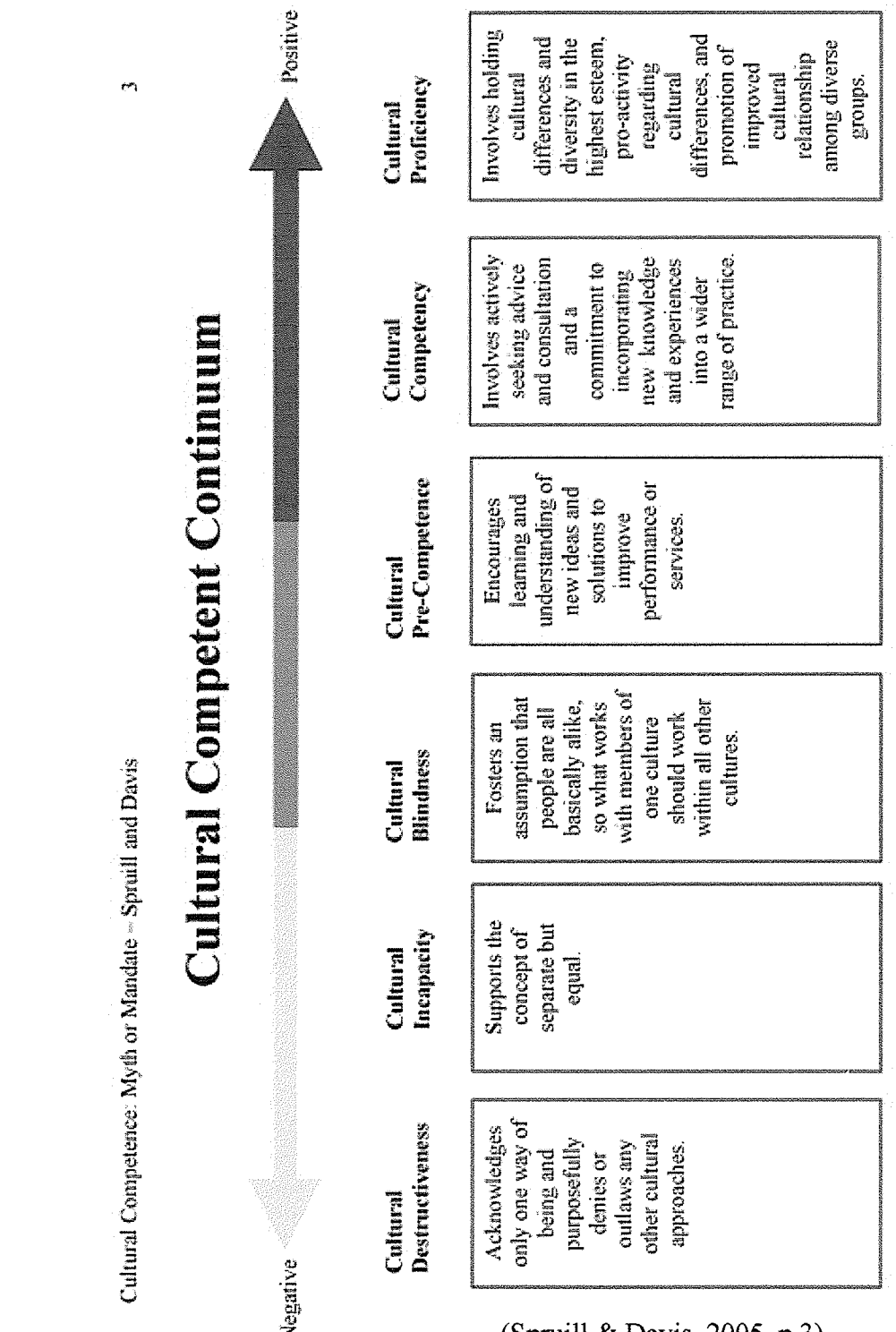
The Downtown Centre (Pakistani Association)
348 Ross Avenue
Winnipeg, MB
Contact: (204) 943-6928
Prayers Held: Daily Prayers
Friday (*Jum'ah*) Prayers,
Tarawih Prayers during *Ramadan*

University of Manitoba (Main Campus)
118C Engineering
University of Manitoba
Winnipeg, MB
Contact: www.um-msa.org
Prayers Held: Daily Prayers,
Friday (*Jum'ah*) Prayers
Tarawih Prayers during *Ramadan* (8 : 00 PM)

University of Winnipeg
515 Portage Avenue
Winnipeg, MB
R3B 2E9
Contact : (204) 786-9052
Prayers Held: Daily Prayers at 0RM03 Bulman Centre
Friday (*Jum'ah*) Prayers at 2C16 Centennial Hall
Tarawih Prayers during *Ramadan* (TBA)

Winnipeg Central Mosque (New Location)
715 Ellice Avenue
Winnipeg, MB
R3G 0B3
Contact: (204) 783-6797
Prayers Held: Maghrib & Isha,
Friday (*Jum'ah*) Prayers

Appendix N
Cultural Competent Continuum: Model



(Spruill & Davis, 2005, p.3)
Only part of the model is included