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Factors Influencing the Barriers to Performing Five Daily Prayers among Muslim Inpatients at RSUP Dr. Kariadi

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ABSTRACT

Background: Prayer is a fundamental obligation for Muslims, performed five times daily. For hospitalized Muslim patients, maintaining regular prayer routines can be challenging due to physical limitations, hospital infrastructure barriers, lack of religious knowledge, and insufficient support from healthcare providers. **Objective:** This study aims to identify the barriers Muslim inpatients face in performing prayers and to propose recommendations for improving spiritual accommodations in hospital settings. **Methods:** A qualitative study was conducted at RSUP Dr. Kariadi using in-depth interviews and participatory observation. Thirty Muslim inpatients, along with family members and medical personnel, were involved. Data were collected through semi-structured interviews and direct observations, then analyzed using thematic analysis to identify major influencing factors. **Results:** Physical limitations such as pain (40%), difficulty standing (50%), and movement restrictions from medical devices (33.3%) were key barriers. Facility-related issues, including inaccessible prayer rooms (70%) and lack of prayer aids (55%), significantly impacted patients' ability to pray. Religious knowledge gaps were notable, with 60% of patients unaware of permissible prayer adjustments (rukhsah). Furthermore, 80% reported no assistance from healthcare staff in facilitating prayer. Psychological factors such as stress (30%) and fatigue (25%) also affected patients' motivation, while encouragement from family and staff (50%) positively influenced prayer practices. **Conclusion:** Muslim inpatients encounter multiple barriers to performing prayers during hospitalization. Structured interventions, including improving hospital facilities, providing religious education, and training healthcare providers in spiritual care, are essential to support the spiritual well-being of Muslim patients.

Keywords : Prayer barriers, inpatients, hospital facilities, religious practices, medical support

INTRODUCTION

Prayer (ṣalāh) holds a central position in Islam, serving as a direct and obligatory act of worship that connects believers to God five times daily (1). The regular performance of prayer is not merely a ritual duty but is deeply intertwined with a Muslim's sense of spiritual identity, moral discipline, and psychological resilience (2). Recognizing the diverse circumstances of believers, Islamic law (sharīʿa) provides significant flexibility in the performance of prayer, allowing adjustments in posture, timing, and purification rituals for those who are ill, injured, or otherwise incapacitated (3).

Despite these religious allowances, hospitalized Muslim patients often face profound challenges in maintaining their prayer practices. Physical limitations resulting from illness or injury, the absence of appropriate facilities such as clean prayer spaces or accessible ablution areas, and a lack of institutional understanding of Islamic practices can severely disrupt patients' spiritual routines (4,5). Such disruptions are not trivial; growing evidence suggests that spiritual well-being is closely linked to psychological health, treatment adherence, and even physical recovery outcomes (5,6). When patients are unable to practice their faith as they deem necessary, it may exacerbate feelings of anxiety, helplessness, and alienation during hospitalization, potentially impeding the healing process.

Moreover, many healthcare institutions lack standardized protocols or training for staff regarding religious accommodations, leaving patients dependent on ad hoc measures or personal advocacy (7). Previous studies have reported that even when hospitals express a commitment to cultural competence, religious needs—particularly those involving daily ritual obligations like prayer—are often inadequately addressed (8). This gap underscores an urgent need for systematic efforts to understand and address the barriers Muslim inpatients face.

In light of these challenges, the present study seeks to explore the specific factors that hinder Muslim inpatients from fulfilling their prayer obligations at RSUP Dr. Kariadi. By identifying both institutional and patient-related barriers, the study aims to offer practical recommendations for improving spiritual accommodations in hospital settings. Enhancing such support not only honors patients' religious rights but may also contribute meaningfully to holistic, patient-centered care and improved health outcomes.

MATERIAL AND METHODS

Research Design

This study utilizes a qualitative research design to explore the barriers to prayer among Muslim inpatients at RSUP Dr. Kariadi. Qualitative methods are well-suited to understanding the lived experiences, perceptions, and meanings that participants attach to their religious practices during hospitalization (9). The design combines in-depth interviews and participatory observation to capture both individual perspectives and environmental factors influencing the ability to perform prayer.

Participants

The participants were 30 Muslim inpatients who met the following inclusion criteria: (1) conscious and communicative, (2) able to provide informed consent, and (3) willing to participate in the study. The sample was selected through purposive sampling to ensure diversity in terms of demographics (e.g., age, gender, illness type), which allows for a more comprehensive exploration of experiences across different patient groups.

Data Collection

Semi-structured interviews were conducted with three key participant groups: (1) Muslim inpatients, (2) their family members, and (3) medical personnel (e.g., doctors and nurses). The semi-structured format provided flexibility to explore individual experiences while ensuring consistency in the topics covered. The interview questions focused on understanding the challenges faced by patients in performing prayer, the role of family in facilitating religious practices, and the perspectives of medical

staff regarding religious accommodations. Each interview lasted between 30 and 45 minutes, and all interviews were audio-recorded with the consent of participants.

Observational data were collected to assess the physical environment of the hospital, including the availability and accessibility of prayer spaces, ablution facilities, and staff involvement in supporting religious practices. Observations were conducted in various hospital wards and prayer rooms to identify barriers related to the hospital's infrastructure. Field notes were recorded during each observation to document the context and specific challenges identified.

Data analysis followed the thematic analysis approach. The process involved the following steps:

1. Familiarization with the data: The audio-recorded interviews were transcribed verbatim, and the researcher listened to the recordings multiple times to ensure a deep understanding of the content.
2. Generating initial codes: Significant statements and phrases were identified and assigned codes.
3. Searching for themes: Codes were grouped into potential themes that captured recurring patterns related to barriers to prayer.
4. Reviewing themes: Themes were reviewed for coherence and relevance, and some were refined or combined.
5. Defining and naming themes: The final themes were defined, ensuring they comprehensively represented the key findings.

The use of triangulation (employing multiple data sources) and member checking (confirming findings with participants) was implemented to enhance the trustworthiness and validity of the results.

RESULTS

Barriers to Performing Prayers Among Muslim Inpatients: A Comprehensive Overview of Physical, Facility, Educational, and Psychological Challenges

The main challenges faced by Muslim inpatients in performing prayers during hospitalization has been shown in Table 1. Key barriers include physical limitations (pain, difficulty standing, and movement restrictions), hospital facility issues (inaccessible prayer rooms and lack of prayer aids), lack of knowledge about prayer adjustments, insufficient support from medical staff, and psychological factors (stress, fatigue, and lack of motivation).

Table 1. Barriers to Performing Prayers Among Muslim Inpatients

Barrier	Percentage of Patients Affected	Description
Physical Limitations		
Pain	40%	Patients reported pain hindering their ability to perform standing, bowing, or prostrating during prayer.
Difficulty Standing	50%	Due to illness, patients struggled to maintain standing positions during prayer.
Movement Restrictions (e.g., IV lines)	33.3%	Patients faced limitations due to medical devices such as IV lines or catheters.
Hospital Facility Constraints		

Barrier	Percentage of Patients Affected	Description
Inaccessible Prayer Room	70%	Patients found prayer rooms difficult to access due to distance from inpatient wards.
Lack of Prayer Aids (e.g., chairs)	55%	Inadequate prayer aids such as chairs or appropriate seating were reported.
Religious Knowledge and Awareness		
Lack of Knowledge of Prayer Modifications	60%	Patients were unaware of permissible adjustments to prayer due to illness.
Lack of Prior Religious Education	30%	Few patients received prior education from family or staff regarding prayer adjustments.
Healthcare Provider Involvement		
Lack of Assistance from Medical Staff	80%	Most patients received no support from healthcare providers regarding prayer practices.
Support in Finding Prayer Space or Position	10%	Only a small proportion of patients received help in finding a suitable place or position for prayer.
Psychological and Motivational Factors		
Stress and Anxiety	30%	Some patients experienced anxiety, affecting their motivation to pray.
Fatigue and Lack of Motivation	25%	Fatigue or a lack of motivation further hindered patients' ability to perform prayers.
Encouragement from Family and Hospital Staff	50%	Encouragement from family members and staff was helpful for patients to maintain their prayer routines.

DISCUSSION

The findings of this study reveal several significant barriers that Muslim inpatients face when attempting to perform their prayers in a hospital setting. Physical limitations were identified as the primary challenge, with a substantial number of patients reporting pain (40%) and difficulty standing (50%) due to illness, as well as movement restrictions (33.3%) caused by medical devices like IV lines. These results align with previous studies, which have highlighted how physical constraints in hospitals can impede religious observance (5,9). Given that prayer is a physically demanding act of worship, patients suffering from illness or injury may find it especially difficult to perform certain movements associated with prayer, such as standing, bowing, or prostrating.

Another major barrier identified was hospital facility constraints, particularly the inaccessibility of prayer rooms (70%) and the lack of prayer aids (55%), such as chairs or appropriate seating. The distant location of the prayer rooms from patient wards posed a logistical challenge, particularly for those with mobility issues or critical conditions requiring constant medical attention. These findings underscore the need for hospitals to improve infrastructure to ensure that prayer spaces are easily accessible to all patients, especially those with physical disabilities (7).

The study also revealed a knowledge gap regarding permissible prayer modifications (rukhsah), with 60% of patients unaware of the flexibility in prayer practices allowed for those in illness or physical distress. Additionally, 30% of patients had received no prior religious education or guidance from either

family or hospital staff on how to modify their prayers. This lack of knowledge likely contributes to the reluctance of patients to perform their prayers correctly, as they may fear they are not fulfilling their religious obligations appropriately. Previous research has indicated that religious education and communication about spiritual needs are vital in empowering patients to adapt their practices in accordance with their health conditions (10).

The role of healthcare providers was another critical factor, as 80% of patients reported that they did not receive any assistance from medical staff regarding prayer practices. Only a small portion (10%) received support from healthcare professionals in finding a suitable location or position for prayer. This lack of support highlights a significant gap in culturally competent care, where healthcare providers may not fully recognize the importance of spiritual well-being in patient recovery (8). Training healthcare providers on how to assist with religious accommodations can help foster a more inclusive and supportive care environment.

Lastly, psychological and motivational factors were found to affect patients' ability to maintain their prayer routines. 30% of patients reported experiencing stress or anxiety, which significantly impacted their motivation to pray. Additionally, 25% of patients cited fatigue or a lack of motivation as barriers to their spiritual practices. However, 50% of patients indicated that encouragement from family members and hospital staff helped them stay committed to their prayer routines. This highlights the importance of emotional and motivational support in enhancing patients' spiritual well-being during hospitalization. Providing emotional care alongside physical treatment is crucial for fostering a holistic approach to health that includes attention to mental, emotional, and spiritual needs (9,10).

CONCLUSIONS

In conclusion, these findings emphasize the need for structured interventions that address both practical and educational barriers to prayer for Muslim inpatients. Hospitals should consider implementing religious education programs for patients, improving prayer facilities, and ensuring that healthcare providers are trained to support religious practices. By addressing these challenges, hospitals can create a more spiritually accommodating environment that contributes to the overall well-being of their patients.

Competing Interests

The authors declare that there is no conflict of interest.

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