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Malaysian Occupational Therapists' Perspective on Prayer Activity of Muslim Clients

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ABSTRACT

Introduction: Investigation on spiritual issue in healthcare practice received less attention. Muslims valued pray activity or known as salat as one of the important daily activity. However, negligible study is available on salat as the end goal of occupational therapy intervention. This study aims to investigate the awareness and the impact of Muslim-culture on occupational therapists in Malaysia. **Methods:** A cross-sectional survey study was conducted via internet-based and manual paper-and-pencil survey throughout occupational therapists in Malaysia. Descriptive and inferential statistics using percentage, Cronbach's alpha and Chi-square was implemented on the findings. **Results:** In total, 119 occupational therapists responded. The questionnaire has overall internal consistency of $\alpha = 0.74$. Occupational therapists have positive perceptions on spiritual activity but poorly translated into service implementation and faced challenges. Factors such as level of education, years of experience, religion, working location and work setting were significant on the awareness, perception, practice and challenges. Cultural-based practice is challenging for occupational therapy even in the majority-practice context. Occupational therapists should differentiate between belief and activity in spiritual issue to provide a better assistance for the clients. **Conclusion:** This study showed continuing education is desired to drive the occupational therapy profession for a better cultural-sensitivity service delivery.

Keywords: *Cultural awareness, Islam, Occupational therapy, Spiritual, Pray*

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INTRODUCTION

The history of occupational therapy began in the Western world and was spread to other countries including East Asia (e.g. Japan, Hong Kong, and Taiwan), South Asia (e.g. India), and among Muslim countries (e.g. Iran, Oman, United Arab Emirates, and Malaysia) (1–3). The spread has resulted in the clash of cultural values and understanding especially between the culture of the West and the culture of Islam. Islam is the second largest religion in the world with more than 1.6 billion followers (4). Meanwhile, Muslim population is the majority in Malaysia by 61.7% (5). Therefore, there is a probability for occupational therapists either international or local that deal with Muslim clients.

The purposefulness and meaningfulness of activity is closely related with cultural influences (1, 2, 6). The concern in occupational therapy arises on how an activity can be conducted following cultural norms. An example of this is how people eat. Each culture incorporates different ways and styles, i.e. the Malays and Indians use their right hand; Westerners use cutleries such as spoon, fork, and knife; and the Chinese use chopsticks. Once an individual suffers an illness, for instance stroke that impairs the individual's ability to eat independently, occupational therapists should provide an intervention that trains the clients to equip themselves with the skills that are meaningful according to their cultural values. Therefore, occupational therapists should train a Chinese client the skills in manipulating chopsticks for eating, as using the spoon and fork is less valued by the client. Similarly, occupational therapists need to help Muslim clients to maintain their practice of prayers (salat), as a goal in the occupational therapy intervention.

Salat is an activity obligatory for every Muslims and performed five times daily during sunrise, in the afternoon, in the evening, after sunset, and at night (7). Salat consist of specific patterns of physical movement, specific recitations of verses, and a devoted intention of praying only to God (Figure 1). To complete one salat, a person requires around 5 to 10 minutes including ablution. Ablution is compulsory to be done before performing a salat. Ablution is to purify oneself and become clean for the prayer to be accepted (7). Ablution requires washing some parts of the body in specific sequence and pattern such as washing the face; washing both hands, and forearms; swipe the head with water; and washing both feet.

However to date, most medical and health literatures focus on educational awareness of Muslim's characteristics; ethics of physical contact between males and females (i.e. limitations of direct touch between males and females except in emergencies); issues of dealing with minority or immigrant rights and challenges in communication; and culture value and moral ethics of health workers' interaction with clients (8–12). The practice of religion and culture can be confusing at times which resulted in the difficulty to differentiate between the practice of ethnic culture and practice of

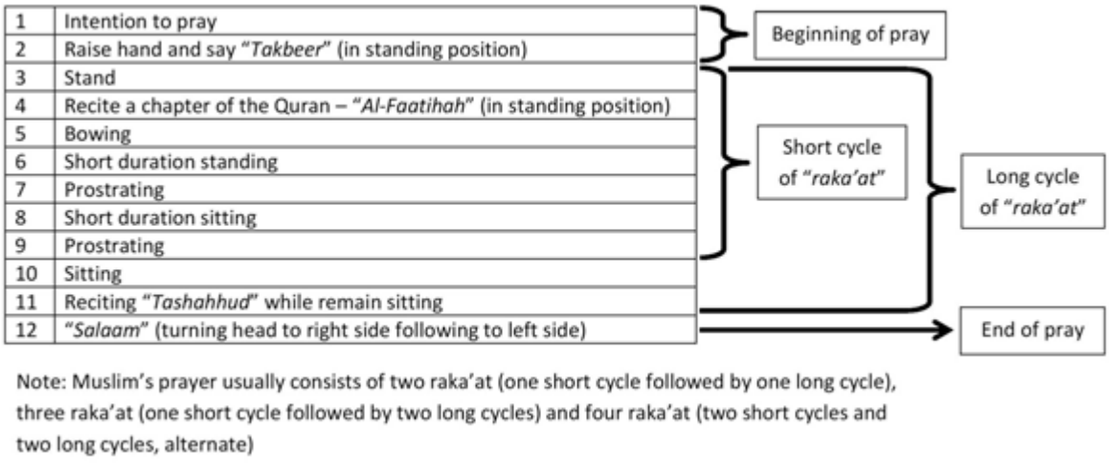

Figure 1: Flow cycle of salat activity.

religion (9, 13) as one of the challenges faced by occupational therapists.

Unclear distinctions between spiritual and religious activities in which those terminologies are used interchangeably is problematic. A qualitative study by Mthembu et al. (14) showed this complexity where spiritual and religious activities were interwoven together in the perception of occupational therapy students. This has resulted in the spiritual being viewed as a complex topic and a sensitive issue in which it is avoided from being discussed in the open, perceived negatively to be applied in professional practice, and received low interest by the health workers to improve their knowledge (11, 15, 16). Recently, spiritual aspects began to receive more attention in literature ever since the current definition of health began to include healthy psychological and social status as well as having good well-being and quality of life (17).

Added to the confusion is on the existence of pray terminology. The definition of pray brings several understanding from the most common which are conversational (unstructured discourse), meditative (focused awareness) and petitional (request), to least practice of ritual (structural) prayer (18). Thus, many literatures viewed prayer activity as a compensatory element in treatment and healing process (13, 18) rather than as a daily activity of the client. Therefore, little attention is given by practitioners and researchers to explore praying as the end goal of treatment.

Salat is considered as ritual prayer. Limited literature was found on the awareness of salat activity. A qualitative study by Mir and Sheikh (19) found that health workers lack awareness and are unwilling to discuss any spiritual related aspect from the client's perspective. Some practitioners were unaware of salat activity as a central role of the client's identity (19, 20). Further investigation from a qualitative study yielded the ability to perform salat is appreciated by the clients (7). In contrast, the role to assist clients in re-performing the salat was perceived with ambivalent response by twelve health workers in the qualitative study (7). Efforts have been made to provide awareness among health workers to include spiritual aspects in the practice. However, inclusion of spiritual aspect in practice remains controversial since spirituality is still viewed as an issue outside the professional context and remains unchallenged (19, 21).

Salat is one of the important daily activities for Muslims. Most literatures from the West are inadequate to provide answers for the needs of occupational therapists to assist Muslim clients in re-performing their salat activity. However, the acceptability of salat activity in occupational therapy service is also not well understood. A study by Berghammer et al. (22) overviewed existing scales on Islamic religiosity of Muslims across countries (Malaysia, Oman, United States, Austria). However, the scales were inappropriate to be used to investigate clinicians' and practitioners' perspective on due to the different focus of dimensions. The scales have multiple dimensions on belief, practice, ethical behaviour, experience and Islamic worldview and to capture the first-person's or client's perspectives. A study by Taylor et al. (15) is the closest resembles for this study. However, the attitude questionnaire developed by the researchers was vague to capture the perspective of occupational therapists specifically related to salat. Therefore, this study objectives are to:

1. Develop a specific questionnaire for the purpose of this study,
2. Explore the perception and perspective of Malaysian occupational therapists on salat, and
3. Determine factors contributed on better occupational therapy service delivery on salat activity for clients.

METHODS

A cross-sectional survey using a researcher-developed questionnaire was implemented for this study. Convenience sampling was recruited from an internet survey through Facebook pages and the manual survey of pencil and paper at a teaching hospital in Kuala Lumpur. Inclusion criteria included practicing occupational therapists having experiences in dealing with adult Muslim clients without mental health problems.

Procedure

Ethical approval was obtained from the Centre for Human Development and Applied Social Sciences, International Islamic University Malaysia (Ref No: IIUM/CERDAS/18). Invitations to participate in the survey were posted three times at different occasions in the occupational therapy group page on Facebook. All members in the groups who were interested to participate can click on the link provided which automatically diverts to the electronic survey page. Participants were required to go through the Participant Information Sheet first and click the "agree to participate" button as their consent to participate in the survey. Participation to complete the questionnaire was voluntary. Participants are free to withdraw from the study at any time before submitting the survey with no consequences. Conveying about this survey to other potential participants is allowed. Completion of the survey requires around 15 to 20 minutes.

Paper questionnaire was also provided as a manual survey which was passed to a representative for distribution at one teaching hospital. The teaching hospital was chosen due to its largest employment number of occupational therapists in Malaysia. Collection of the questionnaire was conducted one week after distribution by the representative and was thereafter passed to the researcher. The representative was used as a blinding purpose to reduce the risk of bias. The return of the questionnaire is considered as an act of consent. Participants who had completed the electronic survey were advised not to complete the manual survey.

Instrument

The questionnaire was developed by the researchers based on the literature review (7, 11, 12, 15, 16, 18, 19, 23, 24). Both authors independently read the included literature to understand the foundation of the topic. The first author was responsible for the development of the questionnaire and items available. The final development of the questionnaire was approved when a consensus agreement was achieved after a constructive discussion on each aspect of the questionnaire from both authors and one expert with an Islamic academic qualification background. At the beginning of the draft, only the framework of the questionnaire was agreed. The framework was developed as sections for the questionnaire. The sections available in the questionnaire were; (A) Demographic data, (B) Awareness, (C) Perception, (D) Practice, and (E) Challenges. Next, items were developed in each section. In the early draft, the awareness section consisted of four items, the perception section consisted of six items, practice section consisted of five items and challenges section consisted of five items. In the final draft, the awareness section maintained the four items, the perception section removed one item, and one item in the practice section was moved to perception section. One new item was included in each of the perception section and challenges section. Then every item was donated a specific five-point Likert scale. The questionnaire was then piloted to five individuals who were non-occupational therapists and acquaintance of the authors. The pilot was to ensure the clarity of the text and easy to be administered by lay individual. The questionnaire is presented in Appendix A.

Data Analysis

Statistical Package for Social Sciences (SPSS) for Windows software version 22.0 was used to analyse the data. Descriptive data using percentage and frequencies were mostly presented. The Chi-Square analysis was used to analyse for any existing association between the demographic factors with items in awareness, perceptions, practices, and challenges categories. The items in each category were inter-correlated using Spearman's rho and Cronbach's alpha was calculated to ensure the reliability of the questionnaire. A Cronbach's alpha between 0.70 and 0.95 is considered as good internal consistency (25).

RESULT

In total, 119 occupational therapists responded. The internet survey respondents were 65.3% (n = 78) and manual respondents were 34.7% (n = 41). The participants' mean age was 27.21 (SD = 4.783) years old. The majority were female (76.5%), Muslims (93.3%), having diploma degree as the highest qualifications (47.1%), years of experience between one to five year (61.3%), working in urban area (79.8%), in public institution (81.5%), and in clinical sector (63%). Details of the demographic data are shown in Table 1.

Reliability of the Questionnaire

Data from the participants in the actual survey (n = 119) was computed for the purpose to determine the reliability of the questionnaire. Spearman's rho analyses on the 20 items indicated significant relationship (at least $p < 0.05$) of each item with another item in the same section. Except items under "perception" section especially on Item 7 with Item 9 ($p = 0.099$), and Item 8 where it did not significantly correlated with any other items under the same category – with Item 5 ($p = 0.316$), with Item 6 ($p = 0.502$), with Item 7 ($p = 0.900$) and with Item 9 ($p = 0.409$). The Spearman's rho analysis on the 20 items found seven items with negative-correlations which indicated negative-structured items in concordance with the content-structure of the items. These were Item 8 (Do you find it challenging to deal with Muslim clients to fulfil their spiritual needs?), Item 15 (Never think about training the clients on performing prayer activity), Item 16 (Spiritual issue is a sensitive issue), Item 17 (Lack of literature and guidelines on spiritual activity is available to support practice), Item 18 (Lack of support from other healthcare practitioners on this issue), Item 19 (Lack of support from administrative staff on this issue), and Item 20 (Practice on spiritual activities is somewhat strange in health practices). For internal consistency, the overall Cronbach's alpha for the questionnaire was $\alpha = 0.74$, where each section value was $\alpha = 0.70$ for awareness, $\alpha = 0.64$ for perception, $\alpha = 0.87$ for practice, and $\alpha = 0.76$ for challenges. This indicates the internal consistency of the questionnaire is good and thereby strengthens the findings associated with the questionnaire.

Findings on Occupational Therapists' Perspectives on Salat

Responses of the questionnaire were collapsed from a five-point into a three-point Likert scale for ease of analysis. For negative-structured items, the response was reversed to make a concordance of the quality of response with positive-structured items. In brief, the awareness section showed undesired outcome where poor awareness on salat activity was perceived among clients and curriculum although deemed importance by the participants. Majority of the participants were having positive perception on all items from the findings in the perception section. In the practice section, all items showed undesired outcome. The challenges section managed to detect mixed outcome where desired outcome was found on personal perspective but the organisational perspective showed undesired outcome. Table 2 presents the frequency of respondents on each item.

Table 1: Summary of the participants' demographic (n = 119)

Demographic Information	n (%)	Mean (SD)
Age		27.21 (4.783)
Gender		
Male	28 (23.5%)	
Female	91 (76.5%)	
Religion		
Muslim	111 (93.3%)	
Non-Muslim	8 (6.7%)	
Years of experience		
Less than a year	16 (13.4%)	
One year to less than 5 years	73 (61.3%)	
Five years to less than 10 years	18 (15.1%)	
More than 10 years	12 (10.1%)	
Highest education level		
Diploma	56 (47.1%)	
Bachelor Degree	52 (43.7%)	
Master	9 (7.6%)	
Doctorate	2 (1.7%)	
Working location		
Urban	95 (79.8%)	
Rural	24 (20.2%)	
Type of working institution		
Public	97 (81.5%)	
Private	18 (15.1%)	
NGO	3 (2.5%)	
Self-employed	1 (0.8%)	
Working Scope		
Clinical (hospital)	75 (63%)	
Community-based	21 (17.6%)	
Mixed	18 (15.1%)	
Other	5 (4.2%)	

Table 2: Frequencies of response on each question (n = 119)

	Item	Negative response	Balance response	Positive response
Awareness				
1.	Do your clients ever ask/concern you about prayer activity?	55.5%	36.1%	8.4%
2.	Do the client's family members or caregiver ever ask/ concern you about prayer activity?	59.7%	30.2%	10.1%
3.	Are you aware on the importance of culturally awareness practice of prayer activity with your client?	3.4%	14.2%	82.4%
4.	Have you ever been exposed about cultural awareness issues such as prayer activity in your formal training?	34.5%	33.6%	31.9%
Perception				
5.	Do you discuss about prayer activity with your clients?	21%	32.8%	46.2%
6.	Do you feel comfortable to discuss about prayer activity with your client?	8.4%	24.4%	67.2%
7.	Do your clients feel comfortable to discuss about prayer activity with you?	16%	39.5%	44.5%
8.	Do you find it challenging to deal with Muslim clients to fulfil their spiritual needs?	42%	14.3%	43.7%
9.	Is it difficult to implement spiritual-based activity such as prayer activity in evaluation and intervention planning?	24.4%	52.9%	22.7%
Practice				
10.	Do you include prayer activity as one of a specific intervention aim?	35.3%	36.1%	28.6%
11.	Do you conduct any assessment/evaluation specifically related to prayer activity on your clients?	67.3%	21.8%	10.9%
12.	Do you conduct any intervention specifically related to train prayer activity on your clients?	56.3%	25.2%	18.5%
13.	Do you work with other professionals in evaluating or intervening your client on prayer activity?	63%	20.2%	16.8%
14.	Do you work with client's family members or caregivers in evaluating or intervening your client on prayer activity?	52.9%	32.8%	14.3%
Challenge				
15.	Never think about training the clients on performing prayer activity	8.4%	21.9%	69.7%
16.	Spiritual issue is a sensitive issue	48.7%	23.5%	27.7%
17.	Lack of literature and guidelines on spiritual activity is available to support practice	51.3%	33.6%	15.1%
18.	Lack of support from other healthcare practitioners on this issue	47.9%	31.9%	20.2%
19.	Lack of support from administrative staffs on this issue	41.2%	37.8%	21%
20.	Practice on spiritual activities is somewhat strange in health practices	27.8%	21.8%	50.4%

Table 3: Comparison of Likert score's mean on significant items associated with contributing factors

Factor		Item◊	Mean (SD) of the Likert score	X^2	*p*-value
Gender	Male	14	2.44 (1.002)	10.762	0.029
	Female		2.57 (1.069)		
Belief	Muslim	1	2.35 (0.881)	9.928	0.042
	Non-Muslim		2.88 (0.354)		
Years of experience	<1 year	6	3.81 (0.834)	31.856	0.045
	1 year – <5 years		3.82 (1.005)		
	5 years – <10 years		3.89 (1.231)		
	>10 years		4.33 (0.888)		
Education level	Diploma	4	3.02 (0.944)	21.825	0.040
	Bachelor		3.02 (1.129)		
	Master		2.11 (0.928)		
	Doctorate		3.00 (2.828)		
	Diploma	5	3.39 (0.867)	25.700	0.012
	Bachelor		3.23 (1.215)		
	Master		2.78 (1.302)		
	Doctorate		4.00 (1.414)		
	Diploma	11	2.11 (1.003)	21.763	0.040
	Bachelor		2.23 (0.877)		
	Master		2.11 (1.537)		
	Doctorate		1.50 (0.707)		
	Diploma	13	2.48 (1.191)	21.110	0.049
	Bachelor		1.90 (1.089)		
	Master		1.89 (0.782)		
	Doctorate		2.50 (0.707)		
	Diploma	19	3.27 (0.924) †	21.913	0.039
	Bachelor		3.17 (0.857) †		
	Master		3.56 (1.130) †		
	Doctorate		2.00 (1.414) †		
Working location	Urban	20	2.48 (1.157) †	13.492	0.009
	Sub-urban or rural		3.13 (0.850) †		
Working scope	Clinical	4	3.15 (0.954)	28.265	0.005
	Community-based		2.52 (0.981)		
	Mixed		2.72 (1.274)		
	Others		2.60 (1.817)		
Working scope	Clinical	5	3.51 (0.950)	22.809	0.029
	Community-based		3.00 (1.000)		
	Mixed		2.89 (1.278)		
	Others		2.60 (1.673)		
Working scope	Clinical	8	3.12 (1.208) †	27.151	0.007
	Community-based		3.05 (1.359) †		
	Mixed		2.50 (1.200) †		
	Others		1.20 (0.447) †		

◊ Item from the questionnaire
† Lower score indicates better outcome

Factors Contributed to Better Service Delivery

The Chi-square analysis found significant items were influenced by certain factors. The importance of cultural awareness was significantly influenced by the demographic factors of the therapists. The female gender influenced on the positive attitude in working with the client's family members or caregivers (Item 14) (X2 = 10.762, p = 0.029). Non-Muslim therapists influenced on the increase of clients asking on prayer activity (Item 1) (X2 = 9.928, p = 0.042). Years of experience influenced on the comfortableness of the therapist to discuss about prayer activity (Item 6) (X2 = 31.856, p = 0.045). In contrast, education level is the most influential factor. The factor is significantly associated with the following items: exposure on cultural awareness through formal training (Item 4) (X2 = 21.825, p = 0.04), discuss with clients on prayer issue (Item 5) (X2 = 25.7, p = 0.012), conduct evaluations related to prayer activity (Item 11) (X2 = 21.763, p = 0.04), work with other professionals (i.e. religious officers, doctors, nurses, social workers, etc.) in evaluating or intervening clients on prayer activity (Item 13) (X2 = 21.110, p = 0.049) and lack of support from administrative group (Item 19) (X2 = 21.913, p = 0.039). The working location in a sub-urban or rural area was significantly associated with challenges on viewing the spiritual practice as strange in the health sector (Item 20) (X2 = 13.492, p = 0.009). The working scope in clinical setting has better significance on exposure on cultural awareness through formal training (Item 4) (X2 = 28.265, p = 0.005), as well as discussion with clients on prayer issue (Item 5) (X2 = 22.809, p = 0.029). In contrast, clinical-based therapists faced significant challenges to face spiritual needs of the clients (Item 8) (X2 = 27.151, p = 0.007). Table 3 compare the means of significant association found on each item in detail according to the contributed factors.

DISCUSSION

Therapists' perception on the client's lack of involvement indicated poor awareness on the client's right to actively engage in determining the service they received was similar to previous studies (19, 20). Even though the clients' are aware of their rights, it is more on a passive one-way communication. Health practitioners are more dominant in giving information and making decisions on the treatment options. This superior-inferior concept is still predominant (26, 27) in Malaysian culture. Moreover, Malaysian culture makes the clients more receptive towards the services given with less inquiring over their rights (20, 28).

The perception of occupational therapists on salat activity is positive. This may be due to the majority of Muslim respondents which indirectly influence the high consciousness and perception on the importance of salat activity. This is supported by previous study where occupational therapists with spiritual beliefs were more empathic on spiritual care in practice compared to non-religious therapists (11, 15). The positive perception however is not translated into better practice and low limitations. The findings showed poor implementation of evaluation and intervention procedures targeting on the rehabilitation of salat activity. Poor multidisciplinary actions were also available among health professionals in actively dealing with salat activity issues. Multiple challenges faced by the occupational therapist (i.e. lack of literature; and support from the multidisciplinary team and administrations) have worsen the support to incorporate salat activity into practice. Although Islam is considered as the majority religion in Malaysia (5, 29), the education system in Malaysia including the health system is shaped by the Western system where secularism happens and Islam is considered a minority matter (2).

This resulted in lack of resources to be referred to and inadequate discussions among health professionals leading to poor protocol development in dealing with spiritual issues in the healthcare service. This issue indirectly penetrated the working system, affecting poor multidisciplinary collaboration.

The female gender influences the practice of working with caregivers in evaluating and intervening the clients. In Asian culture, the role of ensuring a cosy home and maintaining the hospitality of family members are carried out by women (2). This contributed to why female therapists appear to give more comfortableness and includes family members in training the clients. Years of experience are an asset when dealing with clients. Therapists become more prepared, think more critically, and are able to face any anxiety when discussing about spiritual aspect.

Our findings on the level of education as a contributing factor are complex and chaotic. Nevertheless, education is a powerful medium to influence occupational therapists perspective on salat activity and cultural competence. Occupational therapists with diploma qualification is expected to have responsibility in basic intervention focusing on the specific component of impairment for instance providing physical training and moulding a splint (30), meanwhile occupational therapists with bachelor qualification is expected to have bigger role in sophisticated intervention for instance preparing the client's integration within the community and work environment (31). Moreover, higher qualification gradually advances the ability on critical thinking, scientific application and argument and advances in understanding of knowledge (32). These aspects contributed to the therapist to become more empathised and ready to discuss on spiritual topic and provide relevant intervention.

The working location and scope of working are distinct features in providing rich and unique experiences for therapists. Exposure makes the concept learnt to be applied in practice, eliminate the confusion on cultural challenges, promotes respect to other culture and makes the therapists comfortable when dealing with other culture (33). This influences their empathy in practice as the demand and expectation is somewhat different. The majority of therapists working in the urban area and works in clinical settings which are heavily influenced by medical-model. The medical-model view clients on a specific problem of disease and disability; and treating the specificity into normal condition. The medical model also segregates the expertise of professionals to work solo, and having deductive and narrow view where the medical knowledge is considered as adequate (27). The social model in contrast is majorly practiced by therapists working in a community setting. Many sub-urban practices are on community clinics where the practice is keen on either a community-based or mixed on clinical-community practice. The social model view clients as a holistic being; encompassing the need to only treat their disability or disease, and empowered the clients to function in the society (27). Given the benefit of the social model, the medical model still continues to be practiced. First, the medical model has been established longer prior to the social model, and predominant in healthcare practice. Second, the medical model is effective, quick, and requires limited resources such as time, manpower, and objective development in solving a problem; making it favourable in clinical settings (26). The social model in contrast requires longer duration, a complex approach, and vague involvement of society; making it difficult to control and manage (27). High volume of clients in clinical setting provides more opportunity for the therapists to meet Muslims clients. This helps the therapists to be more open in discussing about salat activity. However, to include salat activity into practice is a complex decision which encompasses specific problem features and receives less attention in clinical settings.

Non-Muslim therapists received more attention from clients asking on prayer activity. This may occur as non-Muslim therapists' awareness on the importance of salat is less. Clients take the initiative to ask their therapist first rather than the other way round. This is supported by Mir and Sheikh (19) where non-Muslims practitioners were unaware of Muslims' culture and practice. Muslim therapists in contrast may already be aware of the salat activity and be the first to inform the clients on the related practice. This explains the findings on low active involvement of the clients and positive perception of the therapist. This outcome is expected as individuals have the tendency to be open on similar interests and beliefs due to shared experience and commonality (15).

Limitation of the study includes a low response from non-Muslim therapists in this study. This limits the exploration of minority culture population perceived on majority culture practice. A qualitative study by Beagan and Chacala (34) yielded that occupational therapists considered as a minority faced greater challenges in compensating the cultural clash. High tolerance is required by therapists through cultural humility and critical reflexivity on their own cultural value to negotiate with the needs of the majority.

Convenience sampling is another limitation of this study. Convenience sampling is considered bias since the participants may come from therapists having awareness and volunteered to participate in the study (35). However, the findings of this study are still valuable and can be used as a preliminary outcome in developing a hypothesis for future study.

The implication from the finding shows that even the majority culture practice faces challenges to be implemented in the occupational therapy service although the service is known to be cultural-sensitive (23). Occupational therapists should differentiate between spiritual ideology and spiritual activity. Spiritual activity is a functional activity that needs to be considered as part of daily living activities similar to bathing or dressing whereas spiritual ideology is the belief on the worldview of religion or meaning of life (15, 36). Therefore the spiritual activity is considered as a clients' right to be train by the occupational therapists. A clear distinction between the two helps occupational therapists to incorporate spiritual activity as part of the intervention goal. Cultural-relevant intervention makes the occupational therapy service to be more appreciated by the clients, more meaningful intervention for the clients and increases the clients' adherence towards the intervention (37, 38).

Malaysian occupational therapy service and education should follow the contemporary occupational therapy practice. The contemporary practice stressed on culture competence of the service when dealing with clients (37–39). Curriculum development that exposed the students to different cultural practice such as conducting fieldwork in different countries and professional training for the practitioners are warranted to produce a cultural competence service (39, 40). Our study is consistent with the previous study to promote local cultural practice such as the salat activity to be incorporated in the professional curriculum and training to ensure the service is relevant to Malaysia context.

CONCLUSION

Occupational therapists play an important role in assisting Muslim clients to perform salat activity. Occupational therapists in Malaysia have high awareness and a positive perception to include salat activity in their service. The awareness and perception is however poorly translated into practice. Continuous education, rich exposure, and vast experience are important to help therapists become better in providing service with cultural inclusivity; while facing the challenges and limitations available. These are possible over time, through involvement in variety of settings, and related-topical

curriculum development in professional education. This study findings not only benefits occupational therapists in Malaysia but also international when dealing with Muslim clients.

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APPENDIX A

Cultural Awareness on Prayer Activity among Occupational Therapists with Muslim-Majority Clients in Malaysia

SECTION A: Demographic data

Age											
Gender		Male				Female					
Religion		Islam		Christian		Hindu		Buddha		Atheist/No religion		Other
Email (*Optional*)											
Years of experience as an occupational therapist											
	Less than a year 1 to 2 years 11 months 3 years to 4 years 11 months 5 years to 6 years 11 months 7 years to 9 years 11 months More than 10 years										
Education level of OT qualification (Please mark where applicable)											
	Diploma		Degree		Other Postgraduate Course		Master		Doctorate		
Which best describes your working location?											
	Urban or city area Sub-urban or rural area Remote area										
What kind of institution do you work for? (Mark one only)											
	Public or Government Sector		Private		NGO		Self-employed				
What is the scope your OT job?											
	Clinical (hospital)		Community-based		Mixed		Other (*Please specify*)				

SECTION B: Awareness

		1	2	3	4	5
1	Do your clients ever ask/concern you about prayer activity?	Never	Rarely	Sometimes	Often	Always
2	Do the client's family members or caregiver ever ask/concern you about prayer activity?	Never	Rarely	Sometimes	Often	Always
3	Are you aware on the importance of culturally awareness practice of prayer activity with your client?	Not at all aware	Slightly aware	Somewhat aware	Moderately aware	Extremely aware
4	Have you ever been exposed about cultural awareness issues such as prayer activity in your formal training (example: undergraduate study, postgraduate study, continuous professional development [CPD])?	Not at all exposed	Slightly exposed	Somewhat exposed	Moderately exposed	Extremely exposed

SECTION C: Perception

		1	2	3	4	5
5	Do you discuss about prayer activity with your clients?	Not at all	Slightly	Somewhat	Moderately	Extremely
6	Do you feel comfortable to discuss about prayer activity with your client?	Not at all	Slightly	Somewhat	Moderately	Extremely
7	Do your clients feel comfortable to discuss about prayer activity with you?	Not at all	Slightly	Somewhat	Moderately	Extremely
8	Do you find it challenging to deal with Muslim clients to fulfil their spiritual needs?	Not at all	Slightly	Somewhat	Moderately	Extremely
9	Is it difficult to implement spiritual-based activity such as prayer activity in evaluation and intervention planning?	Very difficult	Difficult	Neutral	Easy	Very Easy

SECTION D: Practice

		1	2	3	4	5
10	Do you include prayer activity as one of a specific intervention aim?	Never	Rarely	Sometimes	Often	Always
11	Do you conduct any assessment/evaluation specifically related to prayer activity on your clients?	Never	Rarely	Sometimes	Often	Always
12	Do you conduct any intervention specifically related to train prayer activity on your clients?	Never	Rarely	Sometimes	Often	Always
13	Do you work with other professionals (i.e.: religious officer, doctors, nurses, social workers etc) in evaluating or intervening your client on prayer activity?	Never	Rarely	Sometimes	Often	Always
14	Do you work with client's family members or caregivers in evaluating or intervening your client on prayer activity?	Never	Rarely	Sometimes	Often	Always

SECTION E: Challenges

		1	2	3	4	5
15	Never think about training the clients on performing prayer activity	Mostly disagree	Disagree	Neutral	Agree	Mostly agree
16	Spiritual issue is a sensitive issue	Mostly disagree	Disagree	Neutral	Agree	Mostly agree
17	Lack of literature and guidelines on spiritual activity is available to support practice	Mostly disagree	Disagree	Neutral	Agree	Mostly agree
18	Lack of support from other healthcare practitioners on this issue	Mostly disagree	Disagree	Neutral	Agree	Mostly agree
19	Lack of support from administrative staffs on this issue	Mostly disagree	Disagree	Neutral	Agree	Mostly agree
20	Practice on spiritual activities is somewhat strange in health practices	Mostly disagree	Disagree	Neutral	Agree	Mostly agree

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