KATHOLIEKE UNIVERSITEIT LEUVEN
FACULTY OF THEOLOGY AND RELIGIOUS STUDIES

"SURELY WE BELONG TO GOD AND TO HIM SHALL WE RETURN"
ATTITUDES, BELIEFS AND PRACTICES REGARDING DEATH AND DYING AMONG MIDDLE-AGED AND ELDERLY MOROCCAN MUSLIM WOMEN IN ANTWERP (BELGIUM)

A dissertation presented in partial fulfilment
of the requirements for the
Doctor's Degree in Religious Studies

Supervisor

Prof. Dr. Bert Broeckaert

by

Chaïma Ahaddour

2018

Acknowledgements/Dankwoord

"Nothing that's worthwhile is ever easy."

— Nicholas Sparks, *Message in a Bottle*

Een doctoraat schrijven is net zoals het beklimmen van een hevige berg. Het bereiken van de top bleek een lang traject te zijn, met heel wat hobbelende wegen vol hindernissen. Vooral het schrijven van de artikelen vormde de zwaarste en meeste woelige bergrit. Desalniettemin was dit een traject vol hoogtepunten waarnaar ik met veel voldoening, vreugde, en levenswijsheid terugkijk. Het was een grote uitdaging die mij gevormd heeft tot wie ik vandaag de dag ben. Het schrijven van mijn doctoraal proefschrift had ik echter nooit tot een goed einde gebracht zonder de hulp en steun van heel wat mensen. Deze personen wil ik dan ook uitdrukkelijk en hartelijk in dit dankwoord vermelden. Ik ben vooral God dankbaar voor deze uitdaging. Dankzij Hem sta ik nu waar ik sta. Zonder God en het geloof in Hem, zou ik het nooit zover hebben geschopt.

Van de grote pot inkt die nodig was voor dit werk, wil ik de sierlijkste druppels gebruiken om een aantal mensen rondom mij te bedanken. Eerst en vooral gaat een bijzondere dank naar prof.dr. Bert Broeckaert voor de begeleiding, het nalezen en bijsturen van mijn teksten, en vooral voor zijn grote steun bij de laatste spurt van dit traject. Maar nog belangrijker, ik ben hem vooral dankbaar om mij de thema's van dit doctoraal onderzoek te introduceren die mij nu zeer nauw aan het hart liggen en voor de kansen die ik kreeg om mij hierin te verdiepen. Mijn dank gaat ook naar dr. Stef Van den Branden voor het delen van zijn expertise, de kritische kijk op de resultaten, de oprechte steun, *tout court* voor de fijne samenwerking.

Ook ben ik wijlen prof.dr. Gino Schallenbergh, prof.dr. Helge Daniëls en prof.dr. Nadia Fadil zeer dankbaar. Zonder hen was ik überhaupt nooit op dit pad terecht gekomen, want zij waren degene die in mij geloofden en mij na mijn masterthesis mij aanmoedigden om een doctoraal onderzoek te verrichten en zo ging het balletje rollen. Ik ben hen zeer erkentelijk voor het herkennen van het onderzoekersvermogen in mij en om in mij *tout court* te geloven.

Dank aan collega's en vrienden waaronder Dries, Liesbeth, Elisabeth, Liesbet John, Frederiek, Anton, Aäron, Josien, Lieve, Kristien, Els, Judith, Machteld, Saloua, Sarah, Kim, Alenka en Stephanie om elke keer een hart onder de riem te steken en voor de fijne babbel. Onze koffiemomenten zal ik niet gauw vergeten!

Dank aan de Faculteit en met name prof.dr. Johan Verstraeten, prof.dr. Anthony Dupont, prof.dr. Yves de Maeseneer, prof.dr. Mehdi Azaiez, prof.dr. Pierre van Hecke en prof.dr. Annemie Dillen voor de zoveel fijne gesprekken van over koetjes en kalfjes tot over de zin van het leven en

vooral om mij te waarderen voor wie ik ben. Ik bedank jullie dat ik altijd mezelf mocht zijn. Binnen het secretariaat liepen er ook nog een tal van mensen rond die meer dan hun steentje bijdroegen aan mijn werk, soms in hoge nood bijvoorbeeld wanneer ik problemen ondervond met mijn laptop (denk maar aan *NVivo* of *Endnote*!) of bij het maken van een bestelbon of soms gewoon met een deugddoend babbeltje. Grote dank aan Evelien, Filip, Jacqueline, Martine en Caroline.

Dit doctoraatsonderzoek werd financieel mogelijk gemaakt door het Bijzonder Onderzoeksfonds van de KU Leuven, via zijn ondersteuning van het onderzoeksproject *European Muslims and the End of Life. Turkish and Moroccan Attitudes towards Suffering, Dying and Mourning in Antwerp, Belgium*, (OT/12/003, promotor Bert Broeckaert), waarvoor dank.

Een *bijzonder bijzonder bijzonder* grote dank aan mijn ouders, broers en zussen. Mijn jarenlang werk zou nooit geworden zijn wat het nu is, zou ik hierbij de steun niet hebben gehad van al mijn dierbare naasten. In de eerste plaats wil ik mijn geliefde ouders bedanken voor de onvergetelijke steun, bemoedigende woorden en geduld doorheen mijn doctoraatstraject. Dit zal eeuwig gegrift blijven in mijn geheugen. Ik bedank mijn ouders, broers, zussen, nichten, vriendinnen en mijn schoonzus om steeds in mij te geloven, voor het duwtje in de rug wanneer de berg te steil werd, maar ook om gewoon 'er te zijn'. De vele discussies over mijn onderzoeksresultaten tot midden in de nacht zal ik niet gauw vergeten. Een expliciet grote dank aan mijn vader, Ismael, Elias, Farah, Sana en Myriam voor jullie enthousiasme voor mijn doctoraal onderzoek, het nauwkeurig nalezen van de artikels en het delen van jullie reflecties over de onderzoeksresultaten die vaak leidden tot urenlange gesprekken. Ik ben ook mijn broertje Abdel Mounaïm dankbaar die altijd erin slaagde om mij te overtuigen dat uiteindelijk alles goed zou komen. En dat is waar nog ook! Mijn dank gaat ook naar mijn neefje Taysir die er keer op keer in slaagde om mij even al mijn zorgen te doen vergeten en om een glimlach op mijn gezicht te laten verschijnen in tijden van moeilijkheden. Daarnaast wil ik ook mijn grootouders, tantes en nonkels bedanken die keer op keer smeekbedes verrichten voor mij opdat ik het doctoraat tot een goed einde zou brengen.

Dit doctoraat draag ik op aan mijn grootvader Ahmed Ahaddour en mijn tante Fatima El Asri. Van mijn opa hebben wij tien jaar geleden afscheid moeten nemen. Hij was een sterke en autodidacte man, die over onschatbare wijsheid beschikte. Zonder zijn harde werk, inspanningen en opofferingen –waaronder zijn dierbaar land te verlaten om zijn kinderen een betere toekomst te bieden, zou ik hier de dag van vandaag allicht niet hebben gestaan. Ten tweede draag ik dit werk op aan mijn jonge tante, Fatima El Asri, die we zeven maanden geleden op een pijnlijke en verdrietige manier hebben verloren. Deze ervaring heeft mij geleerd om te genieten van elk moment, want het leven is zo kostbaar. Daarnaast heeft dit ook nog meer kracht bij gezet waarom dit onderzoek –meer dan ooit– zo belangrijk is. Haar verlies heeft mij geleerd om mijn onderzoeksthema's in een ander, maar ook genuanceerd, daglicht te plaatsen. Moge zij in vrede rusten.

And *last but not least*, wil ik alle participanten bedanken voor hun medewerking en de bereidwilligheid om hun deur te openen en hun diepste gevoelens en verhalen te delen, want zonder hen zou dit proefschrift werkelijk niet tot stand zijn gekomen.

Table of Contents

Arabic Transcription System

For transliteration of Arabic terms, the transliteration system of *al-Masāq*[1] was used. This system does not take into account sun and moon letters.

ʿ	ء	ḍ	ض
b	ب	ṭ	ط
t	ت	ẓ	ظ
th	ث	ʿ	ع
j	ج	gh	غ
ḥ	ح	f	ف
kh	خ	q	ق
d	د	k	ك
dh	ذ	m	م
r	ر	n	ن
z	ز	h	ه
s	س	w	و
sh	ش	y	ي
ṣ	ص		

Short vowels	Long vowels
a – u – i	ā – ū – ī

[1] *Al-Masāq* is an international peer-reviewed journal covering all aspects of (Islamic) Mediterranean culture from Late Antiquity to Early Modernity (7th-16th centuries) which has its own transliteration system/spelling convention of the Arabic language. http://www.tandf.co.uk/journals/authors/calm-style.pdf

Bibliography

ABDEL-KHALEK, A. M., "The Arabic Scale of Death Anxiety (ASDA): Its Development, Validation, and Results in Three Arab Countries." *Death Studies* 28, 5 (2004) 435-457.

ABDEL-KHALEK, A. M., "Islam and Mental Health: A few speculations." *Mental Health, Religion & Culture* 14, 2 (2011) 87-92.

ABDEL-KHALEK, A. M., "Why Do We Fear Death? The Construction and Validation of the Reasons for Death Fear Scale." *Death Studies* 26 (2002) 669-680.

ABDULLAH, S., "Kinship Care and Older Persons: An Islamic perspective." *International Social Work* 59, 3 (2016) 381-392.

ABU-RAS, W. & L. LAIRD., "How Muslim and Non-Muslim Chaplains Serve Muslim Patients? Does the Interfaith Chaplaincy Model have Room for Muslims' Experiences?" *Journal of Religion & Health* 50, 1 (2011) 46-61.

ADIB, S. M. & G. N. HAMADEH., "Attitudes of the Lebanese Public Regarding Disclosure of Serious Illness." *Journal of Medical Ethics* 25, 5 (1999) 399-403.

AFARIDI, N., *et al*., "Elderly in Abbottabad: Health Problems and Loneliness." *The Professional Medical Journal* 21, 1 (2014) 185-190.

AGGOUN, A., Les Musulmans face à la mort en France. Paris: Vuibert, 2006.

AGGOUN, A., "Les Carrés Musulmanes: Enjeu de l'Integration des Musulmans de France." (2009); http://www.lemonde.fr/idees/article/2009/11/30/les-carres-musulmans-enjeu-de-l-integration-des-musulmans-de-france-par-atmane-aggoun_1273919_3232.html (Accessed 14 December 2014).

AGHABABAEI, N., "The Euthanasia-Religion Nexus: Exploring Religious Orientation and Euthanasia Attitude Measures in a Muslim Context." *OMEGA — Journal of Death and Dying* 66, 4 (2013) 333-341.

AHADDOUR, C. & B. BROECKAERT., "Muslim Burial Practices and Belgian Legislation and Regulations: a Comparative Literature Review." *Mortality* 22, 4 (2016) 356-373.

AHADDOUR, C. & B. BROECKAERT., "“For Every Illness There is a Cure”: Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine." *Journal of Religion & Health* (2017); http://dx.doi.org/10.1007/s10943-017-0466-1(Accessed 4th August 2017).

AHADDOUR, C., B. BROECKAERT, & S. VAN DEN BRANDEN., *Belgian Muslim Women and Treatment Decisions at the End of Life*. 31st European Conference on Philosophy of Medicine and Healthcare: "Emerging Technologies in Healthcare". Belgrade (Serbia), 2017a.

AHADDOUR, C., B. BROECKAERT, & S. VAN DEN BRANDEN., *"Our Body is a Trust from God". Views of Belgian Muslim Women on Active Termination of Life*. 4th International Conference on Ageing in a Foreign Land. Adelaide (Australia), 2017b.

AHADDOUR, C., S. VAN DEN BRANDEN, & B. BROECKAERT., "Institutional Elderly Care Services and Moroccan and Turkish Migrants in Belgium: A Literature Review." *Journal of Immigrant and Minority Health* 18, 5 (2015) 1216-1227.

AHADDOUR C., S. VAN DEN BRANDEN, & B. BROECKAERT., "Purification of Body and Soul for the Next Journey. Practices surrounding Death and Dying among Muslim Women." *Omega Journal of Death and Dying* (2017a); https://doi.org/10.1177/0030222817729617 (Accessed 10th September 2017).

AHADDOUR C., S. VAN DEN BRANDEN, & B. BROECKAERT., "Between Quality of Life and Hope. Attitudes and Beliefs of Muslim Women toward Withholding and Withdrawing Life-Sustaining Treatments." *Medicine, Health Care and Philosophy* (2017b); https://doi.org/10.1007/s11019-017-9808-8 (Accessed 18th October 2017).

AHADDOUR C., S. VAN DEN BRANDEN, & B. BROECKAERT., "God is the Giver and Taker of Life”. Muslim Beliefs and Attitudes regarding Assisted Suicide and Euthanasia. *AJOB Primary Research* (2017c); https://doi.org/10.1080/23294515.2017.1420708 (Accessed 29th December 2017)

AHADDOUR C., S. VAN DEN BRANDEN, & B. BROECKAERT., “God’s Land is Vast”. Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased. *Mortality* (2017d); https://doi.org/10.1080/13576275.2017.1413543 (Accessed 20th December 2017)

AHADDOUR C., S. VAN DEN BRANDEN, & B. BROECKAERT., "Every Soul Shall Taste Death". Attitudes and Beliefs of Moroccan Muslim Women living in Antwerp (Belgium) toward Dying, Death and the Afterlife. *Death Studies* (forthcoming).

AHMED, F., M. MUHAMMED, & A. ABDULLAH., "Religion and Spirituality in Coping with Advanced Breast Cancer: Perspectives from Malaysian Muslim Women." *Journal of Religion and Health* 50, 1 (2011) 36-45.

AHMED, A., "Death and Celebration among Muslim Women: A Case Study from Pakistan." *Modern Asian Studies* 39, 4 (2005) 929-980.

AHMED, A. A., "Health and Disease. An Islamic framework.", in SHEIKH & A. R. GATRAD (eds.), *Caring for Muslim patients*,Oxford: Radcliffe Publishing, 2008, 35-45.

AHMED, M. & S. KHAN., "A Model of Spirituality for Ageing Muslims." *Journal of Religion & Health* 55, 3 (2015) 830-43

AHMED, R. A., P. C. SORUM, & E. MULLET., "Young Kuwaitis' Views of the Acceptability of Physician-Assisted Suicide." *Journal of Medical Ethics* 36, 11 (2010) 671-676.

AHSAN, A., M. KHAN, & R. SIDDIQUI., "The Healing Power of Prayer in Islam." *Indian Journal of Positive Psychology* 3, 2 (2012) 168-172.

AJROUCH, K. J., "Caring for Aging Muslim Families: A Needs Asessment." (2016); http://www.ispu.org/wp-content/uploads/2016/12/Caring-for-Aging-Muslim-Families-full-report.pdf (Accessed 20th May 2017).

AL-AZRI, M. H., *et al*., "Coping with a diagnosis of breast cancer among Omani women." *Journal of Health Psychology* 19, 7 (2014) 836-846.

AL-BAR, M. & H. CHAMSI-PASHA., *Contemporary Bioethics Islamic Perspective*. New York: Springer International Publishing, 2015; https://link.springer.com/book/10.1007%2F978-3-319-18428-9 (Accessed 20th December 2016).

AL-HEETI, R., "Why Nursing Homes Will Not Work: Caring for the Needs of the Ageing Muslim American Population." *The Elder Law Journal* 15, 1 (2007) 205-231.

AL-JAHDALI, H., *et al*., "Advance medical directives: a proposed new approach and terminology from an Islamic perspective." *Medicine, Health Care, and Philosophy* 16, 2 (2013) 163-169.

AL-JAZīRīʾ, A., *Islamic Jurisprudence According to the Four Sunni Schools - Al Fiqh 'ala Al Madhahib Al Arba'ah*. Vol. 1 *Modes of Islamic Worship*. 2009; https://archive.org/details/IslamicJurisprudenceAccordingToTheFourSunniSchoolsAlFiqhalaAlMadhahibAlArbaah. (Accessed 15th March 2017).

AL-SHAHRI, M., "Islamic theology and the principles of palliative care." *Palliative and Supportive Care* 14, 6 (2016) 635-640.

AL-SHAHRI, M., N. FADUL, & A. ELSAYEM., "Death, dying and burial rites in Islam." *European Journal of Palliative Care* 13, 4 (2007) 164-167.

ALBAR, M., "Organ Transplantation: A Sunni Islamic Perspective." *Saudi Journal of Kidney Diseases and Transplantation* 23, 4 (2012) 817-822.

ALLADIN, W., "The Islamic Way of Death and Dying: Homeward Bound.", in C. M. PARKES, P. LAUNGANI, & B. YOUNG (eds.), *Death and bereavement across cultures*. London: Routledge, 2015.

ALWANI, Z., "The Qur'anic Model on Social Change: Family Structure as a Method of Social Reform." *Islam and Civilisational Renewal* 3, 1 (2011) 53-74.

ANSARI, H., "'Burying the dead': making Muslim space in Britain." *Historical Research* 80, 210 (2007) 545-566.

ARABIAT, D. H., *et al*., "Jordanian Mothers' Beliefs About the Causes of Cancer in Their Children and Their Impact on their Maternal Role." *Journal of Transcultural Nursing* 24, 3 (2013) 246-253.

ARAMESH, K., "The ownership of the human body: an islamic perspective." *Journal of Medical Ethics and History of Medicine* 2, 4 (2009) 1-12.

ARAMESH, K. & H. SHADI., "An Islamic Perpective on Euthanasia." *American Journal of Bioethics* 7, 4 (2007) 65-66.

ARDA, B. & V. RISPLER-CHAIM., *Islam and Bioethics*. Ankara: Ankara Üniversitesi Basımevi, 2012; http://kitaplar.ankara.edu.tr/dosyalar/pdf/846.pdf (Accessed 20th December 2016).

ASSOUS, A. B., "Cultural and Islamic Values in Relation with Death." *European Scientific Journal* 9, 5 (2013) 1857-1881.

ATHAR, S., "Islamic Perspective in Medical Ethics.", in A. SHAHID (ed.), *Islamic Perspectives in Medicine. A Survey of Islamic Medicine* (Achievements & Contemporary Issues), Indianapolis: American Trust Publications, 1993, 187-194.

ATHAR, S., "Islam and Abortion." *Islamic Horizons* 45, 4 (2016) 40-41.

ATIGHETCHI, D., *Islamic Bioethics: Problems and Perspectives*. New York: Springer, 2007.

ATIGHETCHI, D., "Islamic Perspectives on Vulnerable groups.", in J. THAM, A. GARCIA, & G. MIRANDA (eds.), *Religious Perspectives on Human Vulnerability in Bioethics* (Advancing Global Bioethics 2), Netherlands: Springer, 2014, 175-191.

AYUBA, M. A., "Euthanasia: A Muslim's Perspective." *Scriptura* 115 (2016) 1-13.

AZAIZA, F., *et al.*, "Death and Dying Anxiety among Elderly Arab Muslims in Israel." *Death Studies* 34, 4 (2010) 351-364.

BAARDA, B., M. DE GOEDE & T. TEUNISSEN., *Basisboek kwalitatief onderzoek : handleiding voor het opzetten en uitvoeren van kwalitatief onderzoek*. Houten : Stenfert Kroese, 2009.

BABGI, A., "Legal Issues in End-of-life Care: Perspectives from Saudi Arabia and United States." *American Journal of Hospice & Palliative Medicine* 26, 2 (2009) 119-127.

BADAWI, G., "Muslim Attitudes towards End-of-Life Decisions." *Journal of the Islamic Medical Association of North America* 43, 3 (2011) 134–139.

BADDARNI, K., "Ethical Dilemmas and the Dying Muslim Patient." *Asian Pacific journal of cancer prevention* 11, 1 (2010) 107.

BAEKE, G., *Religion and Ethics at the End of Life. A Qualitative Empirical Study among Elderly Jewish and Muslim Women in Antwerp (Belgium)* (Unpublished doctoral dissertation Theology, KU Leuven), Leuven, 2012.

BAEKE, G., J. P. WILS, & B. BROECKAERT., "Be Patient and Grateful: Elderly Muslim Women's Responses to Illness and Suffering." *The Journal of Pastoral Care & Counseling* 66, 3 (2012) 5:1-9.

BAEKE, G., J. P. WILS, & B. BROECKAERT., "It's in God's Hands: The Attitudes of Elderly Muslim Women in Antwerp (Belgium) toward Active Termination of Life." *AJOB Primary Research* 3, 2 (2012) 36-47.

BAIDER, L., "Cultural Diversity: Family Path Through Terminal Illness." *Annals of Oncology* 23, 3 (2012) 62-65.

BALKAN, O., "Burial and Belonging." *Studies in Ethnicity and Nationalism* 15, 1 (2015) 120-134.

BALKAN, O., "Between Civil Society and the State: Bureaucratic Competence and Cultural Mediation among Muslim Undertakers in Berlin." *Journal of Intercultural Studies* 37, 2 (2016) 147-161.

BECK, C. T., "Qualitative research: the evaluation of its credibility, fittingness, and auditability." *Western Journal of Nursing Research* 15, 2 (1993) 263-266.

BEDIR, A. & S. AKSOY., "Brain Death Revisited: It Is Not 'Complete Death' According to Islamic Sources." *Journal of Medical Ethics* 37, 5 (2011) 290-294.

BEGUM, S. & M. SEPPÂNEN., "Islamic Values in Elderly Care in Finland: The Perspective of Muslim Women Caregivers." *Journal of International Women's Studies* 18, 2 (2017) 59-73.

BENORE, E. R. & C. L. PARK., "Death-Specific Religious Beliefs and Bereavement: Belief in an Afterlife and Continued Attachment." *International Journal for the Psychology of Religion* 14, 1 (2004) 1-22.

BENSAID, B. & F. GRINE., "Old Age and Elderly Care: An Islamic Perspective." *International Journal of Philosophy of Culture and Axiology* 11, 1 (2014) 7-30.

BERGER, J. T., "Redefining the Domains of Decision Making by Physician and Patient." *International Journal of Clinical Practice* 65, 8 (2011) 828-830.

BHOPAL, K., "Researching South Asian women: Issues of Sameness and Difference in the Research Process." *Journal of Gender Studies* 10, 3 (2001) 279-286.

BLOOMER, M. J. & A. AL-MUTAIR., "Ensuring Cultural Sensitivity for Muslim Patients in the Australian ICU: Considerations for Care." *Australian Critical Care* 26, 4 (2013) 193-196.

BLUMER, H., "What Is Wrong With Social Theory? American Sociological Review." *Official Journal of the American Sociological Society* 19, 1 (1954) 3-10.

BOUSETTA, H. & B. MARÉCHAL., *Islam en moslims in België: Lokale uitdagingen en algemeen denkkader*. Brussel: Koning Boudewijnstichting, 2004.

BOWKER, J., *The Meanings of Death.* Cambridge: Cambridge University Press, 1991.

BOWLING, B., "Ethnic minority elderly people: Helping the community to care." *Journal of Ethnic and Migration Studies* 17, 4 (2003) 645-652.

BROCKOPP, J. E., "Islam and Bioethics: Beyond Abortion and Euthanasia." *Journal of Religious Ethics* 36, 1 (2008) 3-12.

BROCKOPP, J. E., *Islamic Ethics of Life. Abortion, War and Euthanasia* (Studies in Comparative Religion), Columbia: University of South Carolina Press, 2004.

BROCKOPP, J. E. & T. EICH., *Muslim Medical Ethics: From Theory to Practice* (Studies in Comparative Religion), Columbia: University of South Carolina Press, 2008.

BROECKAERT, B., "Belgium: Towards a Legal Recognition of Euthanasia." *European Journal of Health Law* 8 (2001) 95-107.

BROECKAERT, B., "Medisch Begeleid Sterven: Een Begrippenkader." *Ethische perspectieven* 16, 4 (2006) 380-391.

BROECKAERT, B., "Treatment Decisions at the End of Life. A Conceptual Framework.", in S. PAYNE, J. SEYMOUR, & C. INGLETON (eds.), *Palliative Care Nursing Principles and Evidence for Practice.* Berkshire: Open University Press, 2008, 402-421.

BROECKAERT, B., "Euthanasia and Physician Assisted Suicide.", in T. WALSH *et al.* (eds.), *Palliative Medicine*. Amsterdam: Elsevier, 2009a, 110-115.

BROECKAERT, B., "Euthanasia and Palliative Care in Belgium: The Attitudes of Flemish Palliative Care Nurses and Physicians toward Euthanasia." *AJOB Primary Research* 1, 3 (2009b) 31-44.

BROECKAERT, B., "The Attitude of Flemish Palliative Care Physicians to Euthanasia and Assisted Suicide: An Empirical Study." *Ethical Perspectives* 16, 3 (2009c) 311-335.

BROECKAERT, B., "Treatment Decisions in Advanced Disease – A Conceptual Framework." *Indian Journal of Palliative Care* 15, 1 (2009d) 30-36.

BROECKAERT, B., "Palliative Care Physicians' Religious/World View and Attitude Toward Euthanasia: A Quantitative Study among Flemish Palliative Care Physicians." *Indian Journal of Palliative Care* 15, 1 (2009e) 41-50.

BROECKAERT, B., "The Diverse Influence of Religion and World View on Palliative-Care Nurses Attitudes towards Euthanasia." *Journal of Empirical Theology* 24, 1 (2011) 36-56.

BROECKAERT, B. & FLEMISH PALLIATIVE CARE FEDERATION., *End of Life Decisions – A Conceptual Framework*. Brussels: FPZV, 2006.

BROWN, E., "Ethnic and Cultural Challenges at the End of Life: Setting the Scene." *Journal of Renal Care* 40, 1 (2014) 2-5.

BUGAY, A., P. C. SORUM, & E. MULLET., "The Acceptability of Physician-Assisted Suicide As A Function of Circumstances: A Preliminary Study of Turkish Students' Views." *Psicologica* 35, 3 (2014) 715-728.

BURGER, I., "Zijn de Care-Voorzieningen Klaar Voor De Groeiende Groep Turkse en Marokkaanse Ouderen In Den Haag?" *Epidemiologisch Bulletin* 43, 2/3 (2008) 13-29.

CALLENS, M. & L. VANDERLEYDEN., *Generaties En Solidariteit In Woord En Daad*. Brussel: SVR (Studiedienst van de Vlaamse Regering), 2012.

CAMPO, J. E., "Muslim Ways of Death: Between the Prescribed and the Performed.", in K. GARCES-FOLEY (ed.), *Death and Religion in a Changing World*. New York - London: Sharpe, 2006, 147-177.

CHAVEZ, C., "Conceptualizing from the Inside: Advantages, Complications, and Demands on Insider Positionality." *The Qualitative Report* 13, 3 (2008) 474-494.

CHITTICK, W. C., ""Your Sight Today is Piercing": The Muslim Understanding of Death and Afterlife.", in H. Obayashi (ed.), *Death and Afterlife. Perspectives of World Religions* (Contributions to the Study of Religion), Westport: Greenwood Press, 1992, 125-139

CHITTICK, W. C., "Muslim Eschatology.", in J. L. WALLS (ed.), *Oxford Handbook of Eschatology*. New York: Oxford University Press, 2008, 132-150.

CHOONG, K. A., "Islam and Palliative Care." *Global Bioethics* 26, 1 (2015) 28-42.

CHOTÉ, A., *et al*., "De Toekomst Van De Thuiszorg Voor Hulpbehoevende Allochtone Ouderen."; http://www.stoom.org/downloads/Essay%20Foets%20Thuiszorg.allochtonen.defintief.doc (Accessed 27th January 2014).

CHOWDHURY, N., "Integration Between Mental Health-Care Providers and Traditional Spiritual Healers: Contextualising Islam in the Twenty-First Century." *Journal of Religion and Health* 55, 5 (2016) 1665-1671.

COHEN, J., *et al*., "Differents Trends in Euthanasia Acceptance Across Europe. A Study of 12 Western and 10 Central and Eastern European Countries, 1981-2008." *European Journal of Public Health* 23, 3 (2012) 378-380.

COHEN, J., *et al*., "Public Acceptance of Euthanasia in Europe: A Survey Study in 47 Countries." *International Journal of Public Health* 59, 143 (2014) 143-156.

CORBIN, J., & A. STRAUSS., *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory* (Fourth Edition), California: SAGE Publications, 2015.

CRESSWELL, J. W., & V. L. PLANO CLARK., *Designing and conducting mixed method research*. Second edition. Thousand Oaks, CA: SAGE Publications, 2011.

CYRIACO, A. F. F., *et al*., "Qualitative Research : Key Concepts and a Brief Overview of Its Application in Geriatrics/Gerontology." *Geriatrics, Gerontology and Ageing* 11, 1 (2017) 4-9.

DAMGHI, N., *et al*., "Withholding And Withdrawing Life-Sustaining Therapy In A Moroccan Emergency Department. An Observational Study." *BMC Emergency Medicine* 11, 12 (2011) 1-8.

DAUVRIN, M., *et al*., "Towards Fair Health Policies For Migrants And Ethnic Minorities: The Case Study Of ETHEALTH In Belgium." *BioMed Central Public Health* 12, 726 (2012) 1-11.

DHAMI, S. & A. SHEIKH., "The Muslim Family. Predicament And Promise." *Western Journal of Medicine* 173, 5 (2000) 352-356.

DE GRAAFF, F. M., "Partners in Oalliative Care? Perspectives of Turkish and Moroccan Immigrants And Dutch Professionals." (Unpublished doctoral disseration UvA), Amsterdam, 2012; http://www.pigmentzorg.be/sites/default/files/files/partners.pdf (Accessed 24th January 2014).

DE GRAAFF, F. M. & A. L. FRANCKE., "Barriers to Home Care for Terminally Ill Turkish and Moroccan Migrants, Perceived by GPs and Nurses: A Survey." *BMC Palliative Care* 8, 3 (2009).

DE GRAAFF, F. M., A. L. FRANCKE, & M. E. T. C. VAN DEN MUIJSENBERGH., *Communicatie en Besluitvorming in de Palliatieve Zorg voor Turkse en Marokkaanse Patiënten met Kanker*. Amsterdam: UvA Spinhuis, 2010.

DE GRAAFF, F. M., *et al*., "Understanding and Improving Communication and Decision-Making in Palliative Care for Turkish and Moroccan Ommigrants: A Multiperspective Study." *Ethnicity & Health* 17, 4 (2012) 363-384.

DE GRAAFF, F. M., *et al*., "Perspectives on Care and Communication Involving Incurably Ill Turkish and Moroccan Patients, Relatives and Professionals: A Systematic Literature Review." *BMC Palliative Care* 11, 17 (2012) 1-37.

DE GRAAFF, F. M., *et al*., "'Palliative Care': A Contradiction In Terms? A Qualitative Study of Cancer Patients with A Turkish or Moroccan Background, Their Relatives and Care Providers." *BMC Palliative Care* 9 (2010) 19-19.

DE KOCK, C., *et al*., *Ouder Worden in een Veranderende Damenleving*. Antwerpen: Garant, 2014.

DENKTAS, S., "Health and Health Care Use of Elderly Immigrants in the Netherlands. A Comparative Study." (Unpublished doctoral dissertation Erasmus University), Rotterdam, 2012.

DENKTAS, S. & M. FOETS, "Differences in Health Care Use Between Elderly Immigrants And Indigenous Elderly." *Ethnicity & Health* 9, 1 (2004) 9.

DENKTAS, S., *et al*., "Ethnic Background And Differences In Health Care Use: A National Cross-Sectional Study of Native Dutch and Immigrant Elderly In the Netherlands." *International Journal for Equity in Health* 8 (2009).

DENZIN, N. K., & Y. S. Lincoln, *The Sage Handbook of Qualitative Research*. 4th ed. Thousand Oaks: Sage, 2011.

DERLUYN, I., *et al*., *Naar een Interculturele Gezondheidszorg: Aanbevelingen van de ETHEALTH-Groep voor een Gelijkwaardige Gezondheid en Gezondheidszorg voor Migranten en Etnische Minderheden*. Brussel: Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu, 2011.

DESSING, N. M., *Rituals of Birth, Circumcision, Marriage, and Death Among Muslims In The Netherlands*. Leuven: Peeters, 2001.

DIESTE, J. L., *Health and Ritual in Morocco: Conceptions of the Body and Healing Practices*. Brill, 2013.

DIJKSTRA, I., "Etnische Matching tussen Cliënt en Hulpverlener is Niet Noodzakelijk." *GZ Psychologue* 7 (2011) 6-9.

DWYER, S. C, & J. L. BUCKLE., "The Space Between: On Being An Insider-Outsider In Qualitative Research." *International Journal of Qualitative Methods* 8, 1 (2009) 54–63.

ELSAMAN, R. S & M. A. 'ARAFA., "The Rights of the Elderly in the Arab Practice." *Marquette Elder's Advisor* 14, 1 (2012) 1-53.

ERDEK, M., "Pain Medicine And Palliative Care As Alternative To Euthanasia In End-of-Life Cancer Care." *The Linacre Quarterly* 82, 2 (2015) 128-134.

FADIL, N., "Not-/Unveiling as an Ethical Praxis." *Feminist Review* 98, 1 (2011) 83-109.

FADIL, N., "Recalling the 'Islam of the Parents' Liberal And Secular Muslims Redefining the Contours of Religious Authenticity." *Identities: Global Studies in Culture and Power* 22, 6 (2015) 82-99.

FITZPATRICK, S., *et al*., "Religious Perspectives on Human Suffering: Implications for Medicine and Bioethics." *Journal of Religion and Health* 55, 1 (2016) 159-173.

GAILLY, A., "Cultuurgevoelige Hulpverlening." *Cultuur Migratie Gezondheid* 5, 3 (2008) 152-163.

GANGA, D. & S. SCOTT., "Cultural "Insiders" and the Issue of Positionality in Qualitative Migration Research: Moving "Across" and Moving "Along" Researcher-Participant Divides." (2006); http://dx.doi.org/10.17169/fqs-7.3.134 (Accessed 27th July 2017).

GARDNER, K., "Death, Burial And Bereavement Amongst Bengali Muslims In Tower Hamlets, East London." *Journal of Ethnic and Migration Studies* 24, 3 (1998) 507-521.

GARDNER, K., "Death Of A Migrant: Transnational Death Rituals And Gender Among British Sylhetis." *Global Networks* 3, 2 (2002) 191-204.

GATRAD, A. R., "Muslim Customs Surrounding Death, Bereavement, Postmortem Examinations, And Organ Transplants." *BMJ* 309 (1994) 521-523.

GATRAD, A. R., B. J. MUHAMMAD, & A. SHEIKH., "Reorientation of Care in the NICU: A Muslim Perspective." *Seminars in Fetal and Neonatal Medicine* 13, 5 (2008) 312-314.

GATRAD, A. R. & A. SHEIKH., "Palliative Care for Muslims and Issues Before Death." *International Journal of Palliative Nursing* 8, 11 (2002) 526-531.

GATRAD, A. R. & A. SHEIKH., "Palliative Care for Muslims and Issues After Death." *International Journal of Palliative Nursing* 8, 12 (2002) 594-597.

GHALY, M., "Islam en Handicap: Praktijkthema's en Islamitische Ethische Opvattingen." *Tijdschrift voor Gezondheidszorg en Ethiek* 2, 17 (2007) 40-45.

GHALY, M., *Islam And Disability: Perspectives in Theology and Jurisprudence*. New York: Routledge, 2010.

GHALY, M., "Religio-Ethical Discussions On Organ Donation Among Muslims In Europe: An Example Of Transnational Islamic Bioethics." *Medicine, Health Care and Philosophy* 15, 2 (2012) 207-220.

GHALY, M., "Euthanasia.", in K. FLEET *et al.* (eds.), *Encyclopedia of Islam*, London: Brill Online, (2015), http://dx.doi.org/10.1163/1573-3912_ei3_COM_26254 (Accessed 27th July 2017).

GHALY, M., *Islamic Perspectives on the Principles of Biomedical Ethics* (Vol. 1, Intercultural Dialogue in Bioethics), UK: World Scientific Publishing, 2016.

GIELEN, J., "Ethical Attitudes and Religious Beliefs at the End of Life. A Study of the Views of Palliative-Care Nurses and Physicians in Flanders (Belgium) and New Delhi (India)." (Unpublished doctoral dissertation Theology, KU Leuven), Leuven, 2010.

GIELEN, J., *et al.*, "Can curative or life-sustaining treatment be withheld or withdrawn? The opinions and views of Indian palliative-care nurses and physicians." *Medicine, Health Care, and Philosophy* 14, 1 (2011) 5-18.

GIELEN, J., S. VAN DEN BRANDEN, & B. BROECKAERT., "The Operationalisation of Religion and World View in Surveys of Nurses' Attitudes toward Euthanasia and Assisted Suicide." *Med Health Care Philos* 12, 4 (21 July 2009 2009) 423-431.

GIELEN, J., S. VAN DEN BRANDEN, & B. BROECKAERT., "Religion and Nurses' Atittudes to Euthanasia and Physician Assisted Suicide." *Nursing Ethics* 16, 3 (2009) 303-318.

GILLIAT-RAY, S. & M. ALI., & S. PATTINSON., *Understanding Muslim Chaplaincy* (Religion and Society Series), Oxford: Ashgate 2013.

GLASER, B. G. & A. L. STRAUSS., *The Discovery of Grounded Theory. Strategies for Qualitative Research*, New York: Aldine Publishing Company, 1967.

GUBA, E., & Y. LINCOLN,. *Fourth Generation Evaluation*. California: SAGE Publications, 1989.

HADI, M. A., & J. CLOSS., "Ensuring Rigour and Trustworthiness of Qualitative Research in Clinical Pharmacy." *International Journal of Clinical Pharmacy* 38, 3 (2016) 641-46..

HALEVI, L., *Muhammad's Grave: Death Rites and the Making of Islamic Society*. New York: Columbia University Press, 2007.

HAQUE, A. & H. KESHAVARZI., "Integrating Indigenous Healing Methods in Therapy: Muslim Beliefs and Practices." *International Journal of Culture and Mental Health* 7, 3 (2014) 297-314.

HARANDY, T. F., *et al.*, "Muslim Breast Cancer Survivor Spirituality: Coping Strategy or Health Seeking Behavior Hindrance?" *Health Care for Women International* 31, 1 (2010) 88-98.

HARFORD, J. B. & D. M. ALJAWI., "The Need for More and Better Palliative Care for Muslim Patients." *Palliative & Supportive* Care 11, 1 (2013) 1-4.

HASNAIN, R. & S. RANA., "Unveiling Muslim Voices: Aging Parents with Disabilities and Their Adult Children and Family Caregivers in the United States." *Topics in Gerriatric Rehabilitation* 26 (2010) 46-61.

HEDAYAT, K. M., "When the Spirit Leaves: Childhood Death, Grieving, and Bereavement in Islam." *Journal of Palliative Medicine* 9, 6 (2006) 1282-1291.

HEDAYAT, K. M. & R. PIRZADEH., "Issues in Islamic Biomedical Ethics: A Primer for the Pediatrician." *Pediatrics* 108, 4 (2001) 965-971.

HERTOGEN, J., "Moslims in België per gewest, provincie en gemeente: Evolutie 2011, 2013 en 2015." (2015); http://www.npdata.be/ (Accessed 27 December 2015).

HERTOGEN, J., "Marokkaanse-, Turkse- en islamachtergrond per gemeente." (2016); http://www.npdata.be/ (Accessed 20 July 2017).

HOOPMAN, R. *et al.*, "Methodological Challenges in Quality of Life Research among Turkish and Moroccan Ethnic Minority Cancer Patients: Translation, Recruitment and Ethical Issues." *Ethnicity & Health* 14, 3 (2009) 237-253.

HOSSAIN, F., "The Destite Elderly of Bangladesh: Socio-Economic Perspective." *Middle East Journal of Business* 8, 3 (2013) 23-34.

HUNTER, A., "Deathscapes in Diaspora: Contesting Space and Negiotiating Home in Contexts of Post-Migration Diversity." *Social & Cultural Geography* 17, 2 (2015) 247-261.

HUNTER, A., "Staking a Claim to Land, Faith and Family: Burial Location Preferences of Middle Eastern Christian Migrants." *Journal of Intercultural Studies* 37, 2 (2016) 179-194.

HUSSEIN, H. & J. R. Oyebode. "Influences of Religion and Culture on Continuing Bonds in a Sample of British Muslims of Pakistani Origin." *Death Studies* 33, 10 (2009) 890-912.

ILKILIC, I. "End-of-Life Decisions at the Beginning of Life.", in I. ILKILIC *et al.* (eds.), *Health, Culture and the Human Body. Epidemiology, Ethics, and History of Medicine, Perspectives from Turkey and Central Europe*, Istanbul: Betim Center Press, 2014, 433-444.

INGHELBRECHT, E., *et al.*, "Attitudes of Nurses Towards Euthanasia and Towards Their Role in Euthanasia: A Nationwide Study in Flanders, Belgium." *International Journal of Nursing Studies* 46, 9 (2009) 1209-1218.

ISGANDAROVA, N., "Effectiveness of Islamic Spiritual Care: Foundations and Practices of Muslim Spiritual Care Givers." *Journal of Pastoral Care & Counseling* 66, 3 (2012) 1-16.

ISGANDAROVA, N. & T. O'CONNOR., "A Redefinition and Model of Canadian Islamic Spiritual Care." *Journal of Pastoral Care & Counseling* 66, 2 (2012) 7.

ISLAM, M. N. & D. C. NATH., "A Future Journey to the Elderly Support in Bangladesh." *Journal of Anthopology* (2012); http://dx.doi.org/http://dx.doi.org/10.1155/2012/752521 (Accessed 4th May 2017).

ISLAMIC CODE FOR MEDICAL AND HEALTH ETHICS. (2004); http://islamset.net/ioms/code2004/index.html.https://link.springer.com/book/10.1007%2F978-3-319-18428-9 (Accessed 20th December 2016).

IYILIKCI, L., *et al.*, "Practices of Anaesthesiologists with regard to Withholding and Withdrawal of Life Support from the Critically Ill in Turkey." *Acta Anaesthesiologica Scandinavica* 48, 4 (2004) 457-462.

JAFARI, N., *et al.*, "Spiritual Well-Being and Quality of Life in Iranian Women with Breast Cancer Undergoing Radiation Therapy." *Supportive Care in Cancer* 21, 5 (2013) 1219-1225.

JONKER, G., "The Knife's Edge: Muslim Burial in the Diaspora." *Mortality* 1, 1 (1996) 27-43.

JONKER, G., "The Many Facets of Islam: Death, Dying and Disposal between Orthodox Rule and Historical Convention.", in M. PARKES, P. LAUNGANI, & B. YOUNG (eds.), *Death and Bereavement Across Cultures*, London-New York: Routledge, 1997, 147-165.

JOOTUN, D., *et al.*, "Reflexitivity: promoting rigour in qualitative research." *Nursing Standard* 23, 23 (2009) 42-44.

KADROUCH-OUTMANY, K., "Islamic burials in the Netherlands and Belgium. Legal, religious and social aspects." (Unpublished doctoral dissertation Leiden University), Leiden, 2014.

KADROUCH-OUTMANY, K., "Religion at the Cemetery. Islamic Burials in the Netherlands and Belgium." *Contemporary Islam* 10, 1 (2016) 87-105.

KHALID, I., *et al.*, "End-of-Life Care in Muslim Brain-Dead Patients: A 10-Year Experience." *American Journal of Hospice and Palliative Medicine* 30, 5 (2012) 413-418.

KHALIFA, N., *et al.*,"Beliefs about Jinn, Black Magic and the Evil Eye among Muslims: Age, Gender and First Language Influences." *International Journal of Culture and Mental Health* 4, 1 (2011) 68-77.

KHALIL, M. H., "Is Hell Truly Everlasting? An Introduction to Medieval Islamic Universalism.", in C. LANGE (ed.), *Hell in Islamic Traditions*, New York: Cambridge University Press, 2015, 166-174.

KHAN, S. & M. AHMAD., "The Case for Muslims Aged Care in the West." *Journal of Religion, Spirituality & Ageing* 26, 4 (2014) 281-299.

KIRPITCHENKO, L. & L. VOLODER., "Insider Research Method: The Significance of Identities in the Field.", in *SAGE Research Methods Cases*, London: Sage Publications, 2014, 1-20.

KLASS, D. & R. GOSS., "The Politics of the Grief and Continuing Bonds with the Dead. The Cases of Maoist China and Wahhabi Islam." *Death Studies* 27, 9 (2002) 787-811.

KMI., *Islamitisch Begraven in Vlaanderen: Inspiratie voor Lokaal Overleg*. Brussel: Kruispunt Migratie-Integratie vzw, 2013.

KMI., *Islamitisch Begraven: Gemeenten met Aangepaste Perken*. Brussel: Kruispunt Migratie-Integratie, 2014.

KOC, A., "Nursing Students' Attitudes Towards Euthanasia: A Study In Yozgat, Turkey." *International Journal of Caring Sciences*, 5, 1 (2012) 66-73.

KOCH, T., "Establishing Rigour in Qualitative Research: The Decision Trail." *Journal of Advanced Nursing* 53, 1 (2006) 91-100

KOENIG, H. & S. AL SHOHAIB., *Health and Well-Being in Islamic Societies: Background, Research, and Applications*, Switzerland: Springer International Publishing, 2014.

KOSHEN, H., "A Somali Perspective On Death, Grief and Culture. Culture Perspectives on Death in Families.", in J. CACCIATORE & J. DEFRAIN (eds.), *The World of Bereavement*, Switzerland: Springer International Publishing, 2015, 25-39.

KRAWIETS, B., "Brain Death and Islamic Traditions. Shifting Borders of Life?", in J. BROCKOPP (ed.), *Islamic Ethics of Life. Abortion, War and Euthanasia*, Columbia: University of South-Carolina Press, 2003, 194-213.

KRISTIANSEN, M., *et al.*, "The practice of Hope: A Longitudinal, Multi-Perspective Qualitative Study among South Asian Sikhs and Muslims with Life-Limiting Illness in Scotland." *Ethnicity & Health* 19, 1 (2014) 1-19.

KRISTIANSEN, M. & A. SHEIKH., "Understanding faith considerations when caring for bereaved Muslims." *Journal of Royal Society of Medicine* 105, 12 (2012) 513-517.

KRISTIANSEN, M., *et al.*, "Experiencing Loss: A Muslim Widow's Bereavement Narrative." *Journal of Religion and Health* 55, (2016) 226-240.

LANGE, C., *Paradise and Hell in Islamic Traditions*. New York: Cambridge University Press, 2016.

LAPIDUS, I. M., "The Meaning of Death in Islam.", in H. M. SPIRO, *et al.* (eds.), *Facing Death. When Culture, Religion and Medicine Meet*, New Haven-London: Yale University Press, 1996, 148-159.

LEUNG, L., "Validity, Reliability, and Generalizability in Qualitative Research." *Journal of Family Medicine and Primary Care* 4, 3 (2015) 324-327.

LODEWIJCKX, E., *Ouderen van Vreemde Herkomst in het Vlaamse Gewest. Origine, Sociaal-Demografische Kenmerken en Samenstelling van hun Huishouden*. Brussel: Studiedienst van de Vlaamse Regering, 2007.

LODEWIJCKX, E. & E. PELFRENE., "Huishoudensstructuur en Solidariteit tussen de Generaties bij Personen van Vreemde Afkomst.", in L. VANDERLEYDEN & M. CALLENS (eds.), *Generaties en Solidariteit in Woord en Daad*, Brussel: Studiedienst van de Vlaamse Regering, 2012, 51-76.

MALTERUD, K., "Qualitative Research: Standards, Challenges, and Guidelines." *The Lancet* 358, 9280 (2001) 483-88.

MATTHEY, L., R. FELLI, & C. MAGER., "We Do Have Space in Lausanne. We Have a Large Cemetery': The Non-Controversy of A Non-Existent Muslim Burial Ground." *Social & Cultural Geography* 30 (2013) 245-265.

MCLAUGHLIN, M. H., *et al.*, "Attitudes of Muslims Living in the United States Toward Long-Term Care Descisions and Diagnosis Disclosure for Elderly Family Members." *The American Geriatrics Society* 64, 10 (2016) 2132-2137.

MERTON, R. K., "Insiders and Outsiders: a Chapter in the Sociology of Knowledge." *American Journal of Sociology* 78, 1 (1972) 9-47.

MEULENKAMP, T. M., A. P. VAN BEEL, & D. L. GERRITSEN., *Kwaliteit van Leven bij Migranten in de Ouderenzorg. Een onderzoek onder Turkse, Marokkaanse, Surinaamse, Antilliaanse/Arubaanse en Chinese Ouderen*. Utrecht: Nivel, 2010.

MILEWSKI, N. & D. OTTO., "The Importance of a Religious Funeral Ceremony Among Turkish Migrants and Their Descendants in Germany: What Role do Socio-demographic Characteristics Play?" *Journal of Intercultural Studies* 37, 2 (2016) 162-178.

MILLER, A., "Opinions on the Legitimacy of Brain Death among Sunni and Shi'a Scholars." *Journal of Religion and Health* 55, 2 (2015) 394-402.

MOOSA, E., "Brain Death and Organ Transplantation - An Islamic Opinion." *South African Medical Journal* 83, 6 (1993) 385-386.

MORELLI, A., "L'Espace du Cimetière et les Cortèges d'Enterrements Comme Enjeux de Pouvoir entre Laïques et Catholiques (Belgique, xix-xx siècle).", in A. DIERKENS & A. MORELLI (eds.), *Topographie du Sacré. L'Emprise Religieuse sur L'Espace* (Volume 18, Problèmes d'histoire des religion), Bruxelles: Université de Bruxelles, 2008.

MORERAS, J. & S. TARRÉS., "Les Cimetieres Musulmanes en Espagne: Des Lieux de L'Altérité." *Revue Européenne de Migrations Internationales* 28, 3 (2012) 13-26.

MORGAN, J. D., "Islam.", in J. D. MORGAN & P. LAUNGANI (eds.), *Death and Bereavement Around the World* (Volume 1 Major Religious Traditions), Amityville: Baywood Publishing, 2002, 153-157.

MORTELMANS, D., *Handboek kwalitatieve onderzoeksmethoden*. Leuven: Acco, 2008.

MORTELMANS, D., *Kwalitatieve analyse met Nvivo*. Leuven: Acco, 2011.

MORTELMANS, D., *Handboek kwalitatieve onderzoeksmethoden*. Leuven: Acco, 2013.

MURSHIDAH, H. & M. KALYANI., "Grief Experience of Bereaved Malay/Muslim Youths in Singapore: the Spiritual Dimension." *International Journal of Children's Spirituality*, 15, 1 (2010) 45-57.

NABOLSI, M. M. & A. M. CARSON., "Spirituality, Illness and Personal Responsibility: The Experience of Jordanian Muslim Men with Coronary Artery Disease." *Scandinavian Journal of Caring Sciences* 25, 4 (2011) 716-724.

NOWICKA, M. & L. RYAN., "Beyond Insiders and Outsiders in Migration Research: Rejecting A Priori Commonalities. Introduction to the FQS Thematic Section on "Researcher, Migrant, Woman: Methodological Implications of Multiple Positionalities in Migration Studies"." *Forum Qualitative Social Forum* 16, 2 (2015) 1-15.

O'SHAUGHNESSY, T. S. J., *Muhammad's Thoughts on Death: A Thematic Study of the Qur'anic Data*. Leiden: Brill, 1969.

PADELA, A. I., A. AROZULLAH, & E. MOOSA., "Brain Death in Islamic Ethico-Legal Deliberation: Challenges for Applied Islamic Bioethics." *Bioethics* 27, 3 (2013) 132-139.

PADELA, A. I. & O. QURESHI. "Islamic Perspectives on Clinical Intervention Near the End-of-Life: We Can But Must We?" *Medicine, Health Care and Philosophy* (2016). http://dx.doi.org/10.1007/s11019-016-9729-y (Accessed 20th November 2016).

PADELA, A. I., H. SHANAWANI, & A. AROZULLAH., "Medical Experts & Islamic Scholars Deliberating over Brain Death: Gaps in the Applied Islamic Bioethics Discourse." *Muslim World* 101, 1 (2011) 53-72.

PADELA, A. I. & A. MOHIUDDIN., "Ethical Obligations and Clinical Goals in End-of-Life Care: Deriving a Quality-of-Life Construct Based on the Islamic Concept of Accountability Before God (Taklīf)." *The American Journal of Bioethics* 15, 1 (2015) 3-13.

PADELA, A. I., "Islamic Medical Ethics: a Primer." *Bioethics* 21, 3 (2007) 169-178.

PADELA, A. I., *et al.*, "The Role of Imams in American Muslim Health:Perspectives of Muslim Community Leaders in Southeast Michigan." *Journal of Religion & Health* 50, 2 (2010) 359-73.

PADELA, A. I., *et al.*, "The Perceived Role of Islam in Immigrant Muslim Medical Practice within the USA: an Exploratory Qualitative Study." *Journal of Medical Ethics* 34 (2008) 365-369.

PADELA, A. I., *et al.*, "Religious Beliefs and Mammography Intention: Findings from a Qualitative Study of a Diverse Group of American Muslim Women." *Psycho-Oncology* 25, 10 (2016) 1175-1182.

PADELA, A. I. & T. A. BASSER., "Brain death: the challenges of translating medical science into Islamic bioethical discourse." *Medicine and Law* 31, 3 (2012) 433.

PARKES, C. M., *Death and Bereavement Across Cultures*. London: Routledge, 2000.

PEETERS, R., "Health and Illness of Moroccan Immigrants in the City of Antwerp, Belgium." *Social Science & Medicine* 22 (1986) 679-684.

PEW RESEARCH CENTER., "The Future of World Religions: Population Growth Projections, 2010-2050." (2015); http://www.pewforum.org/2015/04/02/religious-projections-2010-2050/ (Accessed 27th October 2016).

QAZI, F., *et al.*, "The Degree of Certainty in Brain Death: Probability in Clinical and Islamic Legal Discourse." *Theoretical Medicine and Bioethics* 34, 2 (2013) 117-131.

QURESHI, O. & A. I. PADELA., "When Must A Patient Seek Healthcare? The Perspectives of Islamic Jurists and Clinicians into Dialogue." *Zygon* 15, 3 (2016) 592-625.

RADY, M. Y., J. VERHEIJDE, & M. ALI., "Islam and End-of-Life Practices in Organ Donation for Transplantation: New Questions and Serious Sociocultural Consequences." *HEC Forum* 21, 2 (2009) 175-205.

RADY, M. Y. & J. L. VERHEIJDE., "Brain-Dead Patients Are Not Cadavers: The Need to Revise the Definition of Death in Muslim Communities." *HEC Forum* 25, 1 (2012) 25-45.

RADY, M. Y. & J. L. VERHEIJDE., "Islam and Physician-Assisted Death." *Critical Care Medicine* 37, 8 (2012) 2493-2494.

RAHMAN, F., *Health and medicine in the Islamic tradition*. Chicago: Kazi Publications, 1998.

RISPLER-CHAIM, V. *Islamic Medical Ethics in the Twentieth Century* Vol. 46. Social, economic and political studies of the Middle East Leiden: Brill, 1993.

ROELANDS, M., *et al.*, "Attitudes of Belgian Students of Medicine, Philosophy and Law Toward Euthanasia and the Conditions for Its Acceptance." *Death Studies* 39, 3 (2015) 139-150.

ROLFE, G., "Validity, Trustworthiness and Rigour: Quality and the Idea of Qualitative Research." *Journal of Advanced Nursing* 53,3 (2006) 304-10.

ROZARIO, S., "Allah is the Scientist of the Scientists: Modern Medicine and Religious Healing among British Bangladeshis." *Culture and Religion* 10, 2 (2009) 177-199.

ROZARIO, S., "Islamic Piety Against the Family: From 'Traditional' to 'Pure' Islam." *Contemporary Islam* 5, 3 (2011) 285-308.

SAAF, A., B. S. HIDA, & A. AGHBAL., *Belgische Marokkanen. Een Dubbele Identiteit in Ontwikkeling*. Brussel: Koning Boudewijn Stichting, 2009.

SACHEDINA, A., "End-of-Life: the Islamic View." *Lancet* 366, 9487 (2005) 774-779.

SACHEDINA, A., *Islamic Biomedical Ethics: Principles and Application*. Oxford: Oxford University Press, 2009.

SACHEDINA, A., "Islam.", in M. COBB, C. M. PUCHALSKI, & B. RUMBOLD (eds.), *Oxford Textbook of Spirituality in Healthcare*, Oxford: Oxford University Press, 2012, 55-62.

SAEED, F., *et al.*, "End-of-Life Care Beliefs among Muslim Physicians." *American Journal of Hospice and Palliative Medicine* 32, 4 (2015) 388-392.

SAIYAD, S., "Do Not Resuscitate: A Case Study from the Islamic Viewpoint." *Journal of the Islamic Medical Association* 41, 3 (2009) 109-113.

SALMAN, K. F., "Health Beliefs and Practices Related to Cancer Screening among Arab Muslim Women in an Urban Community." *Health Care for Women International* 33, 1 (2012) 45-74.

SAMAOLI, O., "Vieillesse de l'autre et de l'immigré." *Le Sociographe* 35, 2 (2011) 94-98.

SAMAOLI, O., "Vieillesse des Immigrés: Quelques Interrogations d'Actualité." *Gérontologie et Société* 139, 4 (2011) 67-75.

SARHILL, N., *et al.*, "The Terminally Ill Muslim: Death and Dying from the Muslim Perspective." *The American Journal of Hospice & Palliative Care* 18, 4 (2001) 251-255.

SCHULTZ, M., K. BADDARNI, & G. BAR-SELA., "Reflections on Palliative Care from the Jewish and Islamic Tradition." *Evidence-Based Complementary and Alternative Medicine* (2012). http://dx.doi.org/http://dx.doi.org/10.1155/2012/693092 (Accessed 15th October 2016).

SERROKH, R., "Les Immigrées au Crépuscule de Leur Vie. Parcours et Vecus de Femmes Agées Immigrées Marocaines." *Lettre de l'IRFAM* 25, 1 (2011) 1-21.

SEUNTJENS, M., "A-Way of the Dead Body: Een Topografie van Rouw-en Grafrituelen bij de Turkse Gemeenschap in Gent." (Unpublished Master's thesis, University of Ghent), Ghent, 2012.

SHADID, W. A. R. & P. S. VAN KONINGSVELD., *Islam in Nederland en België*. Leuven: Peeters, 2008.

SHAH, N. M., *et al.*, "Decline in Co-residence of Parents and Children among Older Kuwaiti Men and Women: What Are the Significant Correlates?" *Journal of Cross-Cultural Gerontology* 26, 2 (2011) 157-174.

SHAH, S. M., *et al.*, "Arab American Immigrants in New York: Health Care and Cancer Knowledge, Attitudes and Beliefs." *Journal of Immigrant Minority Health* 10, 5 (2007) 429-436.

SHAHZAD, Q., "Playing God and the Ethics of Divine Names: an Islamic Paradigm for Biomedical Ethics." *Bioethics* 21, 8 (2007) 413-418.

SHANAWANI, H. & M. H. KHALIL., "Reporting on "Islamic Bioethics in the Medical Literature: Where Are the Experts?", in J. BROCKOPP & T. EICH (eds.), *Muslim Medical Ethics. From Theory to Practice*, Columbia: University of South Carolina Press, 2008, 213-228.

SHAW, A., "Rituals of Infant Death: Defining Life and Islamic Personhood." *Bioethics* 28, 2 (2014) 84-95.

SHEIKH, A. & A. R. GATRAD., *Caring for Muslim patients*. Oxford: Radcliffe, 2008.

SHIRAZI M., A. SHIRAZI & J. BLOOM., "Developing a Culturally Competent Faith-Based Framework to Promote Breast Cancer Screening Among Afghan Immigrant Women." *Journal of Religion and Health* 54, 1 (2015) 153-159.

SHIRAZI, M., *et al.*, "Afghan Immigrant Women's Knowledge and Behaviors Around Breast Cancer Screening." *Psycho-Oncology* 22, 8 (2013) 1705-1717.

SIM, J., "Collecting and Analysing Qualitative Data: Issues Raised by the Focus Group." *Journal of Advanced Nursing* 28, 2 (1998) 345-52.

SINUNU, M., K. M. YOUNT, & N. A. EL AFIFY., "Informal and Formal Long-Term Care for Frail Older Adults in Cairo, Egypt: Family Caregiving Decisions in a Context of Social Change." *Journal of Cross-Cultural Gerontology* 24, 1 (2009) 63-76.

SMETS, T., *et al.*, "Attitudes and Experiences of Belgian Physicians Regarding Euthanasia Practice and the Euthanasia Law." *Journal of Pain and Symptom Management* 41, 3 (2011) 580-593.

SMITH, J. I., "Eschatology", in J. D. MCAULLIFE (ed.), *Encyclopaedia of the Qur'ān* (2001) 44-54; http://dx.doi.org.kuleuven.ezproxy.kuleuven.be/10.1163/1875-3922_q3_EQCOM_00055 (Accessed 15th February 2017).

SMITH, J. I. & Y. Y. HADDAD., *The Islamic Understanding of Death and Resurrection*. Oxford: Oxford University Press, 2002.

SMITS, F., F. VAN TUBERGEN, & S. RUITER., "Religious practices among Islamic immigrants: Moroccan and Turkish Men in Belgium." *Journal for Scientific Study of Religion* 49, 2 (2010) 247-263.

STEUNENBERG, B. & N. DE WIT., "Diversiteit in Vergrijzing: Cultuursensitieve Ouderenzorg voor de Eerste Generatie Turkse en Marokkaanse Migranten." *Bijblijven* 29, 4 (2013) 39-44.

STRAUSS, A. & J. CORBIN., *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks (Calif.): Sage, 1998.

SUHAIL, K., N. JAMIL, J. OYEBODE, & M. A. AJMAL., "Continuing Bonds in Bereaved Pakistani Muslims: Effects of Culture and Religion." *Death Studies* 35, 1 (2011) 22-41.

SUURMOND, J., *et al.*, "Barriers in Access to Home Care Services among Ethnic Minority and Dutch Elderly - A Qualitive Study." *International Journal of Nursing Studies* 54 (2016) 23-35.

TALLOEN, D., *Zorg voor allochtone ouderen*. Mechelen: Kluwer, 2007.

TALLOEN, D., J. VERSTRAETE, & J. CHECH., *Allochtone Ouderen, Senioren van bij Ons. Lessen uit dePpraktijk*. Brussel: Koning Boudewijnstichting, 2012.

TAYEB, M., E. *et al.*, "A "Good Death": Perspectives of Muslim Patients and Health Care Providers." *Annals of Saudi Medicine* 30, 3 (2010) 215-221.

TEPEHAN, S., E. ÖZKARA, & M. F. YAVUZ., "Attitudes to Euthanasia in Icus and Other Hospital Departments." *Nursing Ethics* 16, 3 (2009) 319-327.

TESEI, T., "The Barzakh and the Intermediate State of the Dead in the Quran.", in C. LANGE (ed.), *Hell in Islamic Traditions*, New York: Cambridge University Press, 2015, 31-55.

THOMAS, E., & MAGILVY, J. K., "Qualitative Rigor or Research Validity in Qualitative Research." J*ournal for Specialists in Pediatric Nursing* 16, 2 (2011) 151-155.

TILKIN, G., "Le Linceul Reconnu pour les Funérailles." *Droit Belges & Cultes* (2014). http://belgianlawreligion.unblog.fr/2014/02/03/le-linceul-reconnu-pour-les-funerailles/ (Accessed 27th December 2015)

TIMMERMAN, C., E. VANDERWAEREN, & M. CRUL., "The Second Generation in Belgium." *The International Migration Review* 37, 4 (2003) 1065-1090.

UR-RAHMAN, M., S. ABUHASNA, & F. M. ABU-ZIDAN., "Care of Terminally-Ill Patients: An Opinion Survey among Critical Care Healthcare Providers in the Middle-East." *African Health Sciences* 13, 4 (2013) 893-898.

VAN DEN BRANDEN, S. *Islamitische Ethiek aan het Levenseinde. Een Theoretisch Omkaderde Inhoudsanalyse van Engelstalig Soennitisch Bronnenmateriaal en een Kwalitatief Empirisch Onderzoek naar de Houding van Praktiserende Marokkaanse Oudere Mannen in Antwerpen* (Unpublished doctoral dissertation Theology, KU Leuven), Leuven, 2006.

VAN DEN BRANDEN, S. & B. BROECKAERT., "Medication and God at Interplay: End of Life Decision Making in Male Moroccan Migrants Living in Antwerp, Flanders, Belgium.", in J. BOCKOPP & T. EICH (eds.), *Muslim Medical Ethics: from Theory to Practice*, Columbia: University of South Carolina Press, 2008, 194-208.

VAN DEN BRANDEN, S. & B. BROECKAERT., "The Ongoing Charity of Organ Donation. Contemporary English Sunni Fatwas on Organ Donation and Blood Transfusion." *Bioethics* 25, 3 (2009) 167-175.

VAN DEN BRANDEN, S. & B. BROECKAERT., "Living in the Hands of God. English Sunni E-Fatwas on (non-)Voluntary Euthanasia and Assisted Suicide." *Medicine, Health Care and Philosophy* 14, 1 (2010) 29-41.

VAN DEN BRANDEN, S. & B. BROECKAERT., "Necessary Interventions. Muslim Views on Pain and Symptom Control in English Sunni e-Fatwas." *Ethical Perspectives* 17, 4 (2010) 626-651.

VAN DEN BREEMER, R. & M. MAUSSEN., "On the viability of State-Church Models: Muslim burial and Mosque Building in France and the Netherlands." *Journal of Immigrant & Refugee Studies* 10, 3 (2012) 279-298.

VAN WEZEL, N., *et al.*, "Family Care for Immigrants with Dementia: The Perspectives of Female Carers living in the Netherlands." *Dementia* 2016, 15, 1 (2016) 69-84.

VANDERLEYDEN, L. & D. MOONS., *Zorgverwachtingen en Zorgpatronen in Vlaanderen naar Herkomst*. Brussel: Studiedienst van de Vlaamse Regering, 2013.

VASSART, C., *Migration et Vieillissement: La Situation Particulaire des Personnes Agées D'Origine Etrangère en Belgique*. Brussel: Koning Boudewijnstichting, 2007.

VENHORST, C., *Muslims Ritualising Death in the Netherlands. Death Rites in a Small Town Context* (Death Studies), E. VENBRUX & T. QUARTIER (eds.), Zurich: Litt, 2013.

VENHORST, C., *et al.*, "Islamic Ritual Experts in a Migration Context: Motivation and Authority in the Ritual Cleansing of the Deceased." *Mortality* 18, 3 (2013) 235-250.

VERHAGEN, I., *et al.*, "Culturally Sensitive Care for Elderly Immigrants Through Ethnic Community Health Workers: Design and Development of a Community Based InterventionPprogramme in the Netherlands." *BMC Public Health* 13, 227 (2013) 1-8.

VOAS, D. & F. FLEISHMANN., "Islam Moves West: Religious Change in the First and Second Generations." *Annual Review of Sociology* 38 (2012) 525-545.

WAARDENBURG, J., "Death and the Dead" in J. D. MCAULLIFE (ed.), *Encyclopaedia of the Qur'ān* (2001); http://dx.doi.org/10.1163/1875-3922_q3_EQCOM_00049 (Accessed 15th February 2017).

WAHEED, W., *et al.*, "Overcoming Barriers to Recruiting Ethnic Minorities to Mental Health Research: A Typology of Recruitment Strategies." 15, 101 (2015). https://doi.org/10.1186/s12888-015-0484-z (Accessed 20th July 2017).

WASSERMAN, J. A., N. AGHABABAEI, & D. NANNINI., "Culture, Personality, and Attitudes Toward Euthanasia: A Comparative Study of University Students in Iran and the United States." *Omega - Journal of Death and Dying* 72, 3 (2016) 247-270.

WELCH, A. T., F. E. REYNOLDS, & E. H. WAUGH., "Death and Dying In the Qur'an." in F. E. REYNOLDS & E. H. WAUGH (eds.), *Religious Encounters With Death. Insights From the History and Anthropology of Religions*, Pennysylvania: University Park Pennsylvania State University Press:, 1977, 183 -199.

WESTERMARCK, E., *Ritual and Belief in Morocco: Vol. II (Routledge Revivals)*, Oxford: Routledge, 2013.

WOLFE, M., "Muslim Death in England and the Constraints Encountered." The Third Postgraduate Conference of the Association of University of Theology and Religious Studies, Derby, 2000.

WRAY, S. & M. BARTHOLOMEW., "Some Reflections on Outsider and Insider Identities in Ethnic and Migrant Qualitative Research." 7, 1 (2010). 7-16.

YASIEN-ESMAEL, H. & S. S. RUBIN., "The Meaning Structures of Muslim Bereavements in Israel: Religious Traditions, Mourning Practices, and Human Experiences." *Death Studies* 29, 6 (2005) 495-518.

YERDEN, I., "Tradities in de Knel. Zorgverwachtingen en Zorgpraktijk bij Turkse Ouderen en hun Kinderen in Nederland." (Unpublished doctoral dissertation, UvA), Amsterdam, 2013.

YONG, V. T. F., "Interviewing Men on Sensitive Issues." *Contemporary Nurse* 11, 1 (2001) 18-27

YOSEF, A. R. O., "Health Beliefs, Practice, and Priorities for Health care of Arab Muslims in the United States: Implications for Nursing Care." *Journal of Transcultural Nursing* 19, 3 (2008) 284-291.

YOUSUF, R. M. & M. FAUZI., "Euthanasia and Physician-Assisted Suicide: A Review from Islamic Point of View." *International Medical Journal of Malaysia* 11, 1 (2012) 63-68.

YPINAZAR, V. A. & S. A. MARGOLIS., "Delivering Culturally Sensitive Care: The Perceptions of Older Arabian Gulf Arabs Concerning Religion, Health, and Disease." *Qualitative Health Research* 16, 6 (2006) 773-787.

ZAMAN, M. Q., "Death, Funeral Processions, and the Articulation of Religious Authority in Early Islam." *Studia Islamica* 93 (2001) 27-58.

ZEILANI, R. & J. E. SEYMOUR., "Muslim Women's Experiences of Suffering in Jordanian Intensive Care Units: A Narrative Study." *Intensive and Critical Care Nursing* 26, 3 (2010) 175-184.

ZEILANI, R. & J. E. SEYMOUR., "Muslim Women's Narratives about Bodily Change and Care During Critical Illness: A Qualitative Study. " *Journal of Nursing Scholarship* 44, 1 (2012) 99-107.

“There is no way to reach the end without mastering the beginning.”

—al-Ghazālī

Introduction: Giving Voice to the Unheard

The presence of Muslims in Belgium and Europe is a fact. Islam has become the second largest religion in many European countries including Belgium. Today, Belgium and several other European countries are confronted with the ageing of its Muslim population. In Belgium, Muslim mass-migration began in the 1960s, with large-scale settlement of guest workers, mainly from Morocco and Turkey (Bousetta & Maréchal, 2004; Shadid & van Koningsveld, 2008; Pew Research Center, 2015). The migration history of the Moroccan workers to Belgium, mostly from northern Morocco, fits in a broader economic migration wave, steered by a shortage of workers in the coalmine, steel and car industry across European countries. The Moroccan labour migration to Belgium is to be mainly situated in the period between 1964 –year when a bilateral agreement was signed between Belgium and Morocco, and 1974– date when a labour migration stop was installed (Bousetta & Maréchal, 2004; Timmermans, 2006). In 2016, sociologist Jan Hertogen estimated that Muslims counted for 7.2 % of the Belgian population. Nearly half of the Muslim population in Belgium is from Moroccan descent (Hertogen, 2016).[1] This presence entails many challenges in the context of health, end-of-life and bereavement care as well as in the burial landscape.

To date, in European debates on death and dying, hardly any attention is paid to the views and attitudes of (Moroccan) Muslims, one of the largest ethnic and religious minorities. To this day, discussions on biomedicine, elderly and end-of-life care are still deeply influenced by contemporary secular-Western and/or Christian approaches, overshadowing other traditions. In this respect, voices of Muslims –who form the largest religious minority in Belgium– are absent. Given the fact that Europe, and more specifically Belgium, are becoming more multicultural and –religious and thus society underwent radical demographical, cultural and religious changes, care can no longer be provided solely from a Christian or Western secular framework. The number of empirical studies that deal with the views of the rapidly growing number of Muslims living in the West on death and dying is very limited (Baeke 2012b; Van den Branden 2006). Several studies have shown that religious and philosophical affiliation have a great impact on the attitudes towards end-of-life decisions (Baeke, 2012; Gielen et al. 2006; Kristiansen et al., 2012; Van den Branden, 2006). However, a detailed account of Muslims' lines of reasoning and practices regarding death and dying is missing to a large extent.

In order to provide dignified elderly, end-of-life and bereavement care in contemporary Belgium and Europe, attention has to be given to all dimensions of the human being including one's cultural and

[1] However, no number of the exact amount of Muslims in Belgium exists, as estimations are mainly based on nationality, which does not take into account the naturalisation of a large number of Moroccans (Cuyvers & Kavs, 2001; Dasetto, 1997).

religious background. Therefore, we considered it important to take a closer look into the views and practices of Muslims on these topics.

A descriptive, encompassing and comprehensive account of Muslims' attitudes and beliefs on illness, bioethical issues at the end of life, death, dying, the afterlife, burial, mourning and remembrance in a European setting, and more specifically in the Belgian context, is lacking to a great extent. More specifically, hardly any research has systematically examined how religion shapes the attitudes and practices regarding death and dying among Muslims. The role of religion is often only briefly mentioned as an explaining factor in a fragmented way and studies often lack an encompassing descriptive account of the (religious) line of reasoning behind certain attitudes or practices. This non-normative, descriptive exploratory study focuses on seven research questions: (1) what are the attitudes, beliefs and practices of middle-aged and elderly Moroccan Muslim women regarding death, dying and the afterlife; (2) what are the attitudes and beliefs of middle-aged and elderly Moroccan Muslim women towards health, illness, medicine and end-of-life issues; (3) what is the reality of elderly care for Muslims in Belgium and in Europe with regard to organization and policy and what are the attitudes and practices of Muslims in Belgium regarding care for the elderly; (4) what are the burial practices of Muslims in Belgium and Europe and how are the practices influenced by the burial regulations of each country; (5) what are the attitudes, beliefs and practices of Moroccan Muslim women regarding mourning and remembrance; (6) does religion play a role in our participants' way of thinking regarding death and dying and can we observe a shift in the views and practices of first and second generation Moroccan Muslim women and (7) how do practices and rituals of Muslims take shape in the particular context of migration to Belgium?

This study is part of a larger research programme initiated in 2002 under the supervision of prof. Bert Broeckaert. In the context of this research project, three large empirical studies had already been undertaken. Dr. Stef Van den Branden (2006) conducted a qualitative empirical research on religion and end-of-life ethics among first generation elderly Moroccan Muslim men (n=10) in Antwerp (Belgium), as well as among experts (n=5) (cf. imams and physicians). Dr. Joris Gielen studied the views on this topic of palliative care nurses and physicians in Flanders (Belgium) and New Delhi (India). Dr. Goedele Baeke examined the attitudes of Jewish and Muslim women in Antwerp (Belgium) towards religion and end-of-life ethics. More specifically, Baeke conducted an empirical research in 2012 among first generation elderly Moroccan (n=15) and Turkish (n=15) Muslim women living in Antwerp (Belgium). Within the framework of the large research programme of prof. dr. Bert Broeckaert, the present doctoral dissertation provides a broader perspective on death and dying among both middle-aged (40+) and elderly (60+) Moroccan Muslim women. Not only do we focus on ethical themes, but also on topics such as care for the elderly, burial practices, mourning and remembrance.

Structure of the dissertation

This doctoral project consists of two parts: a literature study and an empirical study. The literature study consisted in exploring and reviewing the available theoretical and empirical studies on Muslims and death and dying. More specifically and given the fact that other systematic reviews had already been done in the dissertations of Van den Branden and Baeke, considerable attention has been given to the topic of Muslims in Belgium/Europe and elderly care (P1§1) and burial practices from a policy/judicial perspective (P1§2), which resulted in two published literature review articles. In chapter one, we provide insight into the accessibility and use of elderly facilities by Moroccan and Turkish migrants in Flanders and Brussels and identify their specific needs and wishes regarding care for the elderly. In addition to this, we give an overview of the way in which Belgian policy has dealt with the issue of migration/migrants and elderly care. In chapter two, we discuss Muslim burial practices and more specifically the choice of burial location. This chapter provides a legal and policy perspective on Islamic burial and describes how the topic of Islamic burial has been addressed in Belgium. In addition, we compare Belgian burial regulations and their impact on Islamic burial with those of the neighbouring countries.

The second part of our dissertation deals with the core of our doctoral work, namely our empirical study. This part of the dissertation explores and describes the attitudes, beliefs and practices of Moroccan Muslim women regarding care for the elderly (P2§1); health, illness and medicine (P2§2); bioethical issues at the end of life including active termination of life (P2§3) and withholding and withdrawing life-sustaining treatment (P2§4); dying, death and the afterlife (P2§5); practices surrounding death and dying (P2§6); burial and repatriation (P2§7) and mourning and remembrance (P2§8 + P2§9). In these empirical chapters, we discuss whether in these areas differences exist between middle-aged and elderly participants. In contrast to the first generation elderly Moroccan Muslim women, who are mainly uneducated and illiterate, middle-aged women show much more socio-economic diversity. Moreover, they were not raised in a homogenous, rural, traditional Islamic environment but brought up in a Western context and live less isolated from the broader Belgian society. What has been the effect of this assumed stronger Western influence on their attitudes, beliefs and practices? In addition to this type of questions, we discuss in these chapters how the real-world attitudes and practices of our participants relate to normative Islamic views. Are these attitudes mirroring normative Islamic views or do we find important differences?

Given the research questions and topics to be explored and the fact that this doctorate is the result of a research project (OT/12/003: *European Muslims and the End of Life. Turkish and Moroccan Attitudes towards Suffering, Dying and Mourning in Antwerp, Belgium*), we decided to write a PhD consisting of (published) articles. The research topics and the number of articles were decided when the research project was submitted and therefore determined before starting the doctoral study. All chapters were conceived as articles suitable for individual publication in peer-reviewed international scientific

journals. As such, each chapter focuses on the central research questions and simultaneously has its own specific aim. As a result, the dissertation contains substantive repetitions in the empirical chapters – for instance in the method section and regarding the background information of the participants. With permission of the doctoral committee of the faculty of Theology and Religious Studies, the chapters in this dissertation maintained the original form of the article, also with regard to layout and reference style.

In the empirical articles, considerable attention has been given to normative Islamic perspectives on the topic studied to explore in this way any similarities and differences with the participants' line of reasoning and practices. We did not consider it useful, though, to give a broad overview of Islamic end-of-life ethics, as Stef Van den Branden extensively elaborated on this matter. We understand normative Islamic literature as works that write on death and dying and argue what from an Islamic viewpoint or Islamic frame of reference based on Islamic tradition and scripture should be done. In our research, we make a distinction between the study of normative Islamic views and that of the views of Muslims. The former is concerned with the study of texts, doctrines, and those who produce texts and doctrines (e.g. prescriptions regarding mourning and remembrance), while the latter involves the human actors engaged in various ways with these texts and doctrines. The latter includes the sociological and anthropological study of Muslims –in our case– with regard to death and dying. In the discussion section, we have cited authors who are presenting and describing normative Islamic works and viewpoints. We focused only on *Sunnī*-perspectives on the topic studied. Nearly 85% of Muslims consider themselves to be *Sunnī* (Pew Research Center, 2011). While *Sunnī* and *Shiʿī* theology share much in common, *Sunnī* and *Shīʿa* denominations have their own legal theory (*ʾusūl al-fiqh*).

All articles have been submitted to international peer-reviewed journals. The following articles have already been published or have been accepted for publication. In part one, chapter one was published in *Journal of Migrant and Minority Health* (Ahaddour, Van den Branden & Broeckaert, 2015) and chapter two appeared in *Mortality* (Ahaddour & Broeckaert, 2016). In part two, chapter two was published in *Journal of Religion and Health* (Ahaddour & Broeckaert, 2017) and chapter three in *AJOB Empirical Bioethics* (Ahaddour, Van den Branden & Broeckaert, 2017a). Chapter four appeared in *Medicine, Health Care and Philosophy* (Ahaddour, Van den Branden & Broeckaert, 2017b) and chapter six in *Journal of Death and Dying* (Ahaddour, Van den Branden & Broeckaert, 2017c). Chapter seven was published in Mortaility (Ahaddour, Van den Branden & Broeckaert, 2017d). Chapter six has currently been accepted in *Death Studies* (Ahaddour, Van den Branden & Broeckaert, forthcoming). Parts of some chapters were presented at international conferences (Ahaddour, Broeckaert, Van den Branden 2017a, b). The status of our articles (January 9th 2018) can be found in the table below.

Article	**Journal**	**Status**
1. *Institutional elderly care services and Moroccan and Turkish migrants in Belgium: a literature review*	Journal of Immigrant and Minority Health (IF: 1,314)	Published
2. *Muslim Burial Practices and Belgian Legislation and Regulations: a comparative literature review*	Mortality (IF: 0, 245)	Published
3. *"What Goes Around Comes Around". Attitudes and Practices regarding Ageing Care for the Elderly among Moroccan Muslim Women*	Journal of Religion & Health (IF: 0,873)	Revise & Resubmit – 6/12/2017 Resubmitted – 6/01/2018
4. *"For Every Illness There Is a Cure". Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine*	Journal of Religion & Health (IF: 0,873)	Published
5. *"God is the Giver and Taker of Life". Muslim Beliefs and Attitudes of Moroccan Muslim Women toward Assisted Suicide and Euthanasia*	AJOB Empirical Bioethics (IF: 0,45)	Published
6. *Between Quality of Life and Hope. Attitudes and Beliefs of Muslim Women toward Withholding and Withdrawing Curative and Life-Sustaining Treatment*	Medicine, Healthcare & Philosophy (IF: 1,067)	Published
7. *"Every Soul Shall Taste Death". Attitudes and Beliefs of Moroccan Muslim Women living in Belgium toward Dying, Death and the Afterlife*	Death Studies (IF: 1,17)	Accepted for publication 15/12/2017
8. *Purification of Body and Soul for the Next Journey. Practices surrounding Death and Dying among Muslim Women*	Journal of Death and Dying (IF: 0,676)	Published
9. *"God's Land is Vast". Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased*	Mortality (IF: 0, 245)	Published
10. *Submitting to God's Will. Attitudes and Beliefs of Muslim Women regarding Mourning and Remembrance*	Death Studies (IF: 1,17)	Accepted with major revisions – 6/11/2017 Resubmitted – 14/12/2017
11. *A Temporary Farewell. Practices of Muslim Women regarding Mourning and Remembrance*	Journal of Death and Dying (IF: 0,676)	Under review

Methods

Literature Study

In the first year of research, a comprehensive and extensive literature study was conducted of theoretical and empirical studies on the impact of Islam on dying and death, with a particular focus on care for the elderly and burial practices from a policy and legal perspective. This literature study resulted into two published review articles and was also briefly mentioned in all empirical articles in the introduction and discussion part. The literature study was also used for the preparation of the interview guide as well as for the comparison with our empirical data. Different sources were used to gather and collect academic, grey and policy literature, including databases (*PubMed, LIMO, JSTOR, Google Scholar, The Islamic Medical and Scientific Ethics Database*), hand searching and reference list searching. By grey literature we mean documents or materials outside formal academic publication channels, including reports, news articles and information guides. Literature dealing with Islam/Muslims and death and dying from different perspectives such as medical sciences, religious sciences, theology, anthropology, sociology and policy literature were included. We also significantly expanded the database in *EndNote*, a reference programme, of our research group, which contains all bibliographic references relevant for the present and (for) future research. All references are organised thematically according to our research topics.

Qualitative Empirical Study

For our study on the attitudes, beliefs and practices regarding death and dying, we chose qualitative empirical research as our methodology. Qualitative research is a suitable method for exploring opinions, meaning and experience as well as for areas which have not been researched yet (Corbin & Strauss, 2015, p.5; De Baarda, De Goedele, Teunissen, 2006; Denzin & Lincoln, 2011; Mortelmans, 2008). 'Qualitative' refers to properties of research units and processes and meanings that arise or are attributed, and not to measuring and representing in terms of quantities or frequencies. In qualitative empirical research, much freedom is given to participants to determine the direction and outcome of the research process within the confines of the research object. Through this inductive way, rich data are produced that might result in hypothesising and theorising in the analyses process, but that are not expressed numerically (Glaser & Strauss, 1967; De Baarda et al., 2006; Denzin & Lincoln, 2011).

We chose a qualitative research method that involves an inductive process as we were particularly interested in *the way* middle-aged and elderly Moroccan Muslim women view and deal with death and dying and the *meanings* they assign to it. By using this inductive method, we sought to draw a broad and in-depth picture of the attitudes, beliefs and practices of Moroccan Muslim women regarding death and dying, and more specifically to explore the role of religion in this matter. In contrast to a deductive strategy where hypotheses, which are often deduced from existing theories, are drawn up and

tested, this (more) inductive method is suitable as it involves a 'theory' that emerges from the data (Corbin & Strauss, 2015; Mortelmans 2008, 2011).

Given the sensitivity of the issues we discussed, the limited or non-existing literacy of our participants and their withdrawn way of life (first generation), quantitative methods were simply not an option.

This research is descriptive and exploratory: it concerns descriptive research in the sense that we seek to provide a detailed descriptive account of the attitudes, beliefs and practices of middle-aged and elderly Moroccan Muslim women living in Antwerp regarding death and dying. In a descriptive study, it is not only about identifying and describing, but also categorising our participants' perspectives and interpretations and reconstructing their way of thinking. Our empirical research is also exploratory and fills an important gap: there are very few studies about death and dying among European Muslims. Our study offers a comprehensive perspective on death and dying as perceived and experienced by middle-aged and elderly Moroccan Muslim women and explores the role of religion.

In our study, we opted for a non-normative, descriptive and exploratory approach. This dissertation has no explanatory ambitions and does not aim to formulate normative judgments on the issue at hand. Our main goal is to reconstruct middle-aged and elderly Moroccan Muslims' ways of thinking and practices and compare these with normative Islamic views while highlighting any similarities and differences between both.

Design: Sample and Setting

In this research, semi-structured interviews were chosen because of the possibility to enquire about meaning, opinions and motives for action in a differentiated and open way. This method is adequate to map the experience and way of thinking of people, but also –because of its interactive character– to capture non-verbal language. Our choice for semi-structured interviews was based on its promise to provide the richest material necessary to answer our research questions. We chose face-to-face interviews due to the specificity of the research group, in particular the elder Moroccan population in Belgium, and due to the sensitivity of our research topics (Yong, 2001). As the majority of first generation Moroccan women are poorly educated and illiterate, face-to-face interviews enabled the participants to ask more information and were free to add something else they might feel relevant to the discussion. This also enabled the interviewer to repeat the questions and to ask additional questions to clarify certain points or to delve further into a topic (Corbin & Strauss, 2015, p.37). The choice for a focus group would not be suitable for this research given the sensitive nature of the topics, the less guaranteed anonymity and the existing social pressure within the Moroccan community, which would likely result in a decline of participation and/or reinforcement of social desirable answers. A

disadvantage of focus groups is indeed that the process can be undermined if some participants are reluctant to contradict others or when the topic under discussion may cause embarassement (Sim, 1998)

In qualitative studies, the data collection method often consists of interviews with a relatively small sample of individuals from a particular population. In contrast to quantitative research, qualitative research does not aim to provide answers on research questions that are statistically representative and which can be generalised to a population. The trustworthiness of a qualitative research involves the discovery of recurring structures and patterns in empirical data and on abstracting these structures and patterns resulting into theoretical substantive notions that can answer research questions (Beck, 1993; Mortelmans, 2008; Leung, 2015; Noble & Smith, 2015; Rolfe, 2006).

In our empirical research we made use of purposive sampling which is a non-random selection of participants. This involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Cresswell & Plano Clark, 2011). The variables, according to which the sample is drawn up, are linked to the research question. Purposive sampling aims to acquire profound insights into the topics studied and to find answers to the research questions (Corbin & Strauss, 2015; Mortelmans, 2008). Purposive sampling starts from a series of criteria set by the researcher to select units (Mortelmans, 2008). The sample selection must also be done in such a way that maximum variation remains within the criteria set to enable the research theme to be effectively explored in depth and breadth. This means that in our quest for potential participants, we tried to achieve a maximum diversity and heterogeneity in the socio-demographic background (e.g. education, socio-economic situation, marital situation, native language).

We have chosen to conduct our study on the attitudes, beliefs and practices regarding death among middle-aged and elderly Moroccan Muslim women living in Antwerp (Belgium). Because of the cultural characteristics of the research population –more specifically the common gender segregation in traditional Muslim societies, in particular among first and second generation Moroccan Muslim communities (Hoopman, 2009; Timmerman, 2001)– and the female gender of the interviewer, purposive sampling for qualitative interviewing was limited to Moroccan Muslim *women*. We were, however, (also) able to interview experts in the field, who were mainly second generation Moroccan Muslim male professionals. Access to and interviewing 'ordinary' first and second generation Moroccan men would probably have been more difficult. We chose women of Moroccan descent, as this population is one of the largest Muslim communities in Belgium (Hertogen, 2016). Our choice for Antwerp is based on two important reasons. First of all, this city has the largest Muslim population in Flanders. More specifically, 19.2 % of Antwerp's population is Muslim (Hertogen, 2016). Second, Antwerp as a port city is considered to be one of the most multicultural cities in the world.

The key participants in this research were Moroccan women, who have spent their life in Antwerp, and were 40+ and 60+. We chose *elderly* women as they are, given the increasing ageing of this population, more confronted with end of life and health care needs. We have also included *middle-aged* women as they have been mainly brought up or born in a Western context, in contrast to the first generation who grew up in a traditional Islamic context, but also because they often function as 'informal carer' providing family care for older persons/parents. We found it particularly interesting to focus on these two groups as there is hardly any research that deals with both first and second generation (Moroccan) Muslims, and in particular women, in Europe. This criterion is very closely linked with the general framework of the study, which seeks to ascertain whether possible differences can be found between first and second generation Moroccan Muslim women's views and practices regarding death and dying. We have chosen middle-aged women between 40 and 60 years and elderly participants above 60 years, as we wanted to interview both the existing first and second generation Moroccan Muslim women in Belgium. The inclusion of people from the age of 60 – as elderly/older participants- was based on research (Berdai, 2005; Cuyvers & Kavs, 2001; Schellingerhout, 2004; Yerden, 2013) conducted among first generation Moroccan migrants, which suggest that they define a relatively young age as old age and thus have a sense of 'early' ageing. 'First generation' is defined as persons who migrated to Belgium at an adult age (over 18 years) in the context of labour migration (from the late sixties) or marriage. 'Second generation' is defined as persons born in Belgium from first generation parents or emigrated to Belgium before the age of 7 (Timmermans 2006). However, it is important to take into account the continued influx of first generation persons among the Moroccan population as a result of family reunification or marriage migration (Cuyvers & Kavs, 2001). The snowball method is an appropriate method for collecting groups that are difficult to access or 'hiding' groups and for a quick and targeted finding of people who can provide accurate and reliable information. This is a type of purpose sampling where existing participants recruit future subjects from among their acquaintances who fit the selection criteria or might know people who fit these criteria. The sample group appears to grow like a rolling snowball (Mortelmans, 2008). Later, we will further explain our own specific snowball process.

Apart from interviews with women, we also conducted interviews with experts in the field in order to place the key material more accurately within the wider spectrum of Muslims. We interrogated experts to find out more about the way Moroccan Muslim women view and deal with death and dying. The views of Moroccan Muslim women formed the main focus of this study, and not the personal views of the experts in the field which by no means were seen as normative. We were only interested in their observations and experience regarding Moroccan Muslim women. This method was useful, as it provided rich background information, which enhanced sensitivity to subtle nuance in data and made us more sensitive to what appeared in the data ('theoretical sensitivity', Corbin & Strauss 2015). In this context, the method of 'bracketing' (Corbin & Strauss, 2015) was applied, i.e. a process of holding

assumptions and presuppositions in suspension to improve the rigour of the research. Second, the data of the interviews with experts were used as a comparative method to check the consistency and trustworthiness and to limit biases of our findings of the interviews with Moroccan Muslim women. In other words, the inclusion of experts enabled us to evaluate our data on the adequacy of the information and its credibility. The selection of experts in the field was based on the technical knowledge that the experts had on our research topics and their familiarity with the research population in their professional capacity. In particular, we recruited experts in the field for each topic studied including Muslim physicians, Muslim nurses, imams, burial undertakers, a palliative care consultant, a psychosocial consultant, a specialised corpse washer, a *ḥijāma* practitioner and elderly care consultants.

Name	Gender	Level of Education*	Profession	Ethnicity
Nora	Female	High	Nurse	Moroccan
Laila	Female	High	Nurse	Moroccan
Soumiya	Female	High	Elderly care consultant	Moroccan
Khawla	Female	Low	Specialized corpse washer	Moroccan
Farida	Female	High	Physician	Afghan
Myriam	Female	Low	Palliative care consultant	Moroccan
Fadila	Female	High	Psychosocial care consultant	Moroccan
Imane	Female	High	*Ḥijāma* practitioner	Moroccan
Salima	Female	High	Elderly care consultant	Moroccan
Nourdin	Male	Low	Imam	Moroccan
Faysal	Male	Low	Imam/Islamic teacher	Moroccan
Kamal	Male	High	Physician	Moroccan
Zakaria	Male	Low	Burial undertaker	Moroccan
Rachid	Male	High	Burial undertaker	Moroccan
Daniel	Male	High	Expertise in burial and policy	Dutch

***** With regard to level of education, we define low level as having a maximum degree of secondary education. High level is understood as having attained the degree of higher education.

Recruitment Process

The recruitment of experts and Moroccan Muslim women started in August 2014 and ended in July 2015. Different routes of recruitment were adopted to incorporate a diversity of profiles within the

female Moroccan Muslim community through snowball sampling. To start, we wrote an invitation letter to the experts in the field and to Muslim women which was sent via mail. This letter laid out the purpose of our study, explained what participation in the research entailed and guaranteed the anonymous and confidential processing of the data. This method was mainly fruitful for the recruitment of experts, nevertheless this approach also resulted in a few responses of middle-aged Muslim women. A second procedure was recruiting potential participants through our personal network. Third, several women were also recruited via mosques, women's associations and socio-cultural organisations and events of religious or cultural organisations. Face-to-face contact was an important impetus for interlocutors to gain their trust and to accept the invitation for an interview. A fourth method was through phone contact with potential respondents. This method was mostly used in the snowball sampling phase, as I received telephone numbers from key persons. A fifth fruitful method was the use of social media including *Facebook* to recruit second-generation/middle-aged participants.

Overall, Moroccan Muslim women showed a great willingness to participate in this study. Only two people I asked for an interview, refused. Although I am familiar with the Moroccan Muslim community, I found that the recruitment of first generation elderly Moroccan women was more difficult than that of second generation middle-aged women. Potential reasons not to participate were the sensitivity of the research topics and the underestimation of their own knowledge and opinions. The latter was often tackled by explaining why and how their involvement and voice was important to be heard. A second reason was the lack of familiarity with the concept of interviewing and research and fear of a lack of anonymity (e.g. assumption of 'video-recording'). Lack of knowledge about research processes also leads to a distrust of research (Gill et al., 2012). This was quite in contrast with our experience in recruiting middle-aged women who were more familiar with the concept of an interview and research. A third reason –also indicated by Waheed et al. (2015)– was the possible stigma for the family, and the influence of the spouse could encourage the decision for non-participation in research. Once participants agreed upon participating in the research, they were contacted again before the interview to confirm the interview appointment, to ensure that they were still willing to be interviewed, and to provide information (once again) about the aim and design of the study.

Interview guide

Face-to-face interviews were based on a semi-structured interview protocol covering the following topics: demographic background (e.g. year of birth, residence, marital status); religion; care for the elderly; health, illness and medicine; end-of-life ethics (e.g. active termination of life, palliative treatment and symptom control, withholding and withdrawing treatment); death, dying and the afterlife; burial; mourning and remembrance. We therefore made use of an interview protocol that comprised a more elaborate and structured questionnaire, with the main topics already formulated in question form (Mortelmans, 2008). The advantage of semi-structured interviews is that each participant is provided

with similar topics and questions, as it is flexible and iterative and provides sufficient space and opportunity for the participant to tell his/her story. This allows the research topic to be explored both in depth and in breadth. As the interview guide does not have to be strictly adhered to, enough room remains to go deeper into certain answers given by the persons concerned and to bring the researcher new insights and perspectives. At the same time, the interviewer can follow a particular direction during the interview on the basis of the interview guide and thus limit the possibility of straying (Mortelmans, 2008). A written questionnaire or protocol provides the guarantee that all participants, in a certain sense, give a 'pre-coded' response to the same pre-arranged topics or questions, making the answers comparable (Corbin & Strauss, 2015; De Baarda et al., 2006).

The interview guide was drawn up based on a literature study of normative/theoretical and empirical studies on death and dying and the previous studies done by Van den Branden and Baeke. Based on the literature study, we deduced sensitising concepts which functioned as the basis for our questionnaire to be able to ask detailed and broad questions on the topics studied. It is important to mention that we only reviewed literature before and after the datacollection and data analysis (in the context of writing the review articles and comparing the research findings after analysis). During datacollection and analysis, we made use of the bracketing method which was strengthened by a time break between reviewing literature (first and fourth year) and datacollection and analysis (second and third year). Our questionnaire for the interviews with Moroccan Muslim women consisted of general questions and a few specific questions for elderly and for middle-aged participants. The questionnaire was drawn up in Dutch, *dārija* (Moroccan-Arabic dialect) and *tarifit* (a Berber dialect). An interview questionnaire was made for the interviews with experts which consisted of general questions for all experts, complemented with specific questions related to their expertise. It is important to mention that the experts were not asked about their own personal views, but about their observations and experience with Moroccan Muslim women in the context of death and dying. The interview guide was discussed with and approved by the committee that guided this study and consisted of Prof. Bert Broeckaert & Dr. Van den Branden.

The draft interview guide was pilot-tested on family members including my mother and grandmother (not participating in the study) as they represented the group studied. This was done to verify whether the questions were understandable – both in the Moroccan Arabic and in the Berber language.

Conceptual Framework of Treatment Decisions in Advanced Disease

When addressing bio-ethical issues at the end of life, we made use of the conceptual framework of treatment decisions in advanced disease. Attitudes towards treatment decisions at the end of life were explored by making use of hypothetical cases that were formulated on the basis of the typology of

Broeckaert (Broeckaert 2008, 2009a, b; Broeckaert and Flemish Palliative Care Federation 2006). Broeckaert developed a typology of treatment decisions at the end of life in order to provide clarity regarding ethical dilemmas in end-of-life care, which can be found in the box below. In this dissertation, findings are presented according to the choices concerning (forgoing) curative and/or life-sustaining treatment (1) and euthanasia and assisted suicide (3).

(1) (Forgoing) curative and/or life-sustaining treatment

- Initiating or continuing a curative or life-sustaining treatment
- Non-treatment decision: *"withdrawing or withholding a curative or life-sustaining treatment, because in the given situation this treatment is deemed to be no longer meaningful or effective".*
- Refusal of treatment: *"withdrawing or withholding a curative or life-sustaining treatment, because the patient refuses this treatment".*

(2) Pain and symptom control

- Pain control: *"the intentional administration of analgesics and/or other drugs in dosages and combinations required to adequately relieve pain."*
- Palliative sedation: *"the intentional administration of sedative drugs in dosages and combinations required to reduce the consciousness of a terminal patient as much as necessary to adequately relieve one or more refractory symptoms".*

(3) Euthanasia and assisted suicide

- Voluntary euthanasia: *"The administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable by the patient, at this patient's request".*
- Assisted suicide: "intentionally assisting a person, at this person's request, to terminate his or her life".
- Non-voluntary euthanasia: *"The administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable, not at this patient's request".*

Interview procedure

The interviews with fifteen experts in the field took place between September 2014 and October 2015. The interviews with Moroccan Muslim women took place between October 2014 and September 2015. On average, each interview took 120 minutes, making up a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. This was the case after 13 interviews with middle-aged participants and after 12 interviews with elderly participants. These were followed by five more interviews where no new themes emerged (resulting in fifteen interviews with middle-aged and fifteen interviews with elderly Moroccan Muslim women).

The interviews were mostly conducted in the language chosen by the participant. With elderly participants, mainly *tarifit* (a Berber language) or *dārija* (Moroccan Arabic language) was spoken, whereas with middle-aged participants mainly Dutch was spoken with occasional interruptions in *dārija* or *tarifit*. As the interviewer masters these languages, there was no need for the involvement of an interpreter. To put the participants more at ease, they were given the choice where and when the interview could take place, which gave them a certain amount of control. This required flexibility of the interviewer in order to gain trust. The setting of the interviews varied and was dependent of the participant's preferences. This was an important condition, especially given that sensitive themes would be addressed. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organisation or in a quiet tea house). Although the researcher always explicitly mentioned that the interview had to take place in private so that it was ensured that the participant could not be distracted or influenced by a third person's presence, in two interviews the participant's daughter joined the conversation for a while after which I politely requested and explained the importance of a private conversation. In three interviews, interruption occurred by family visits or an emergency call and therefore a second part for the interview had to be scheduled.

Overall, I felt that a fair basis of trust grounded most interviews and that most participants spoke openly. Often, when elderly participants were shy/insecure or not quite talkative at the beginning of the interview, I would talk about myself or family (e.g. background, migration history) to make the participant feel comfortable and to gain trust. Nevertheless, when some participants (e.g. Khadija) did not want to talk about a certain topic, after repeating the question for a second time, I did not insist. Throughout my interviews, however, I tried to remain as open as possible to the rhythm and answers of my participants. After each interview, I immediately wrote notes, including information about the physical context of each interview, its ambience, significant non-verbal communication and the impressions.

The interviews were audio-recorded on an *iPhone*. The benefit of this recording device was its user-friendliness in the interviewing process as it was quick and easy to operate. Given its small and compact nature, it took an unobtrusive place during the interview. More specifically, participants were

less or not aware of its presence and therefore it made the conversation much less artificial. This choice avoided 'observer's paradox', in which participants are aware that everything they said was recorded. Another reason for the choice of the *iPhone* was the excellent recording quality. After each interview, the recording was transmitted to the computer. The only drawback was that the transition required a special programme (CopyTrans from WindSolution) on my Windows PC, which made *iPhone* less user-friendly. To ensure the sound storage, I also made backups of every original digital recording, which were deleted after having transcribed all interviews – to ensure the anonymity of the participants.

The interviews were transcribed verbatim, which means literally typing out everything, word by word, in order to achieve reliability and avoid bias (Silverman, 2005; Mortelmans 2008; De Baarda et al., 2006). This process of transcribing took place between March 2015 and March 2016. This process is the first step in the preparation of the data analysis (Mortelmans, 2008, 2011). The transcriptions were made using the free *Express Scribe software*. This programme made it possible to control the digital playback device using the soft keys on the computer keyboard from Microsoft Word. The software offers extensive features such as playback, stop, forward, rewind the sound recording. The ability to slow down sound recordings has proven its service in the transcription of pieces that were hard to understand and to translate interviews accurately. To enhance accuracy of the transcript process, the transcripts were also checked against field notes taken at the time of data collection. We have chosen to translate the interviews in *dārija* and *tarifit* into Dutch so that the guiding committee could check the rigour and credibility of the coding and the analysis of the data (Malterud, 2001). Transcribing the interviews varied between 12 and 18 hours depending on the length of the interview and the translation required. Each interview consist of 35 to 50 pages, making a total of approximately 1900 pages. It is also in this context that I sometimes relied upon family members for accurate translations and understanding of certain proverbs in the different local dialects of *dārija* or *tarifit.*

Participants' (Socio-)Demographic Information & Health Situation

The group of middle-aged Moroccan Muslim women (n=15) were aged between 41 and 55 years old, the group of elderly women (n=15) were aged between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labour migration, family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Among our middle-aged participants, twelve were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (with up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of three to five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. In contrast to the middle-aged participants, they had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber Muslim women spoke Arabic, and only two Moroccan Arabic Muslim women had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants has become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes.

Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them are highly educated. In contrast to elderly participants, ten of the fifteen middle-aged participants are economically active (from labourers to officials).

Nearly all elderly participants are diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. The health issues of our middle-aged participants are limited to knee problems and geriatric migraine. Three elderly participants and one middle-aged respondent reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a poor health condition. In general, our middle-aged participants reported a better health condition than the elderly participants did. Five middle-aged and four elderly participants reported that they have been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson’s disease, dementia, several types of cancer and severe chronic disease.

A) Description of characteristics of middle-aged participants

Name	Year of Birth	Place of Birth	Place of Residence	Marital Status	Arrival in Belgium	Nationality	Level of Education	Proficiency of Languages	Number of Children	Number of Grandchildren
Ikram	1971	Nador	Hoboken	Married	1971	MA + BE	High	BR, NL, FR, AR	4	0
Sabiha	1966	Temsamane	Deurne	Married	1968	MA + BE	Low	BR, NL, FR, AR	6	1
Louiza	1967	Imzouren	Hoboken	Married	1973	MA + BE	Low	BR, Nl, AR, FR, EN	6	0
Loubna	1965	Fes	Kiel	Widow	1967	MA + BE	Low	AR, NL, FR, EN	4	1
Kaltoum	1961	Nador	Borgerhout	Married	1972	MA + BE	Low	BR, AR, NL, FR, EN	5	2
Sarah	1972	Rabat	Hoboken	Married	1986	MA + BE	High	AR, FR, NL, ENG, TR	2	0
Fawzia	1969	Turnhout	Borgerhout	Married	/	MA + BE	High	BR, AR, NL, FR, ENG	3	0
Lamya	1973	Borgerhout	Borgerhout	Married	/	MA + BE	High	BR, NL, FR	2	0
Badria	1972	Nador	Borgerhout	Married	/	MA + BE	High	BR, AR, FR, EN	4	0
Hannan	1973	Berchem	Berchem	Married	/	MA + BE	High	BR, NL, FR, EN	4	0
Nihad	1973	Borgerhout	Zemst	Married	/	MA + BE	High	AR, NL, FR, EN	3	0
Halima	1969	Borgerhout	Borgerhout	Married	/	MA + BE	High	AR, NL, FR, ES, DE	1	0
Radia	1972	Deurne	Deurne	Married	/	MA + BE	Low	NL, AR, EN	4	0
Warda	1975	Hoboken	Hoboken	Married	/	MA + BE	Low	AR, NL, BR, FR, EN	5	0
Narima	1970	Hoboken	Hoboken	Divorced	/	MA + BE	Low	AR, NL, BR	5	2

B) Description of characteristics of elderly participants

Name	Year of Birth	Place of Birth	Place of Residence	Marital Status	Arrival in Belgium	Nationality	Level of Education	Proficiency of Languages	Number of Children	Number of Grandchildren
Zoulikha	1955	Ouarzazate	Kiel	Married	1971	MA + BE	Low	AR/BR, NL, FR	4	4
Naziha	1930	Nador	Deurne	Widow	1966	MA + BE	/	BR	5	'many'
Zohra	1955	Tetouan	Kiel	Married	1975	MA + BE	Low	AR/BR, NL	4	4
Laziza	1951	Temsamane	Hoboken	Married	1978	MA + BE	/	BR	9	10
Charifa	1956	Berkane	Antwerp central	Divorced	1988	MA + BE	Low	AR/FR	1	0
Malika	1955	Oujda	Deurne	Widow	1980	MA + BE	Low	AR/FR, NL	4	2
Rahma	1935	Imzouren	Antwerp central	Widow	1999	MA + BE	/	BR	5	15
Huda	1953	Tanger	Hoboken	Married	1978	MA + BE	Low	AR/NL	7	16
Fatma	1951	Al-Hoceima	Berchem	Widow	1972	MA	/	BR/AR	10	11
Aicha	1943	Oujda	Borgerhout	Married	1965	MA	/	AR/BR	7	13
Khadija	1950	Nador	Hoboken	Widow	1974	MA + BE	/	BR/AR, FR, NL	6	8
Yamina	1949	Al-Hoceima	Antwerp central	Widow	2005	MA	/	BR/AR	0	0
Alia	1953	Nador	Berchem	Married	1972	MA + BE	/	BR/AR	9	11
Nuria	1957	Casablanca	Antwerp central	Married	1974	MA + BE	Low	AR/BR, FR, NL, EN	5	0
Haddad	1947	Tanger	Hoboken	Widow	1972	MA + BE	/	AR	8	9

Participant observation

Another methodological tool that was used in order to obtain the information necessary for analysis and to evaluate the accuracy and trustworthiness of the information gathered during the interviews was participant observation. In other words, participant observation served as a supplement to the interview data or as a broad background against which the interview data gained their meaning. This approach emphasises how people give meaning to different aspects of their life, which has enabled us to gain a better understanding of how Muslims view and deal with death and dying. The key idea behind this method is that a researcher should participate in the daily life of the population studied, observing things that happen, listening to what is said and questioning people over time and thus exploring the social reality of the research population (Mortelmans, 2008). Participant observation was conducted between October 2014 and April 2017.

For this study, I adopted a participant role, given that I am a member of the Moroccan Muslim community and thus embedded in the context studied. This facilitated me to participate and observe the 'natural setting' of Moroccan Muslim women. I could engage in the setting as a total participant which enabled me to gain information and access into difficultly accessible settings (Mortelmans 2008, p. 287). An example is that I could easily join death prayers or attend mourning visits in the personal and direct environment without the entourage being aware, which enhanced the rigour and credibility of my observations and thus avoided bias.

Four sick visits were attended, among which two Moroccan Muslims who were diagnosed with an incurable disease. Second, a *ḥijāma* ('cupping')-consultation was attended. Third, I visited two dying palliative Muslim patients in the hospital. The first palliative patient had lung cancer and was given pain control. The second palliative patient was in a brain-dead state attached to a mechanical life-supporting device. This enabled me to gain a deeper understanding of the farewell process among Moroccan Muslims which includes asking forgiveness, reciting the *Qur'ān*, pronouncing the Islamic creed and prayers.

Fourth, six death prayers (*ṣalāt al-janāza*) were attended in Antwerp, Sint-Niklaas, Brussels and in Trougout (Morocco). This participation was fruitful as it enabled us to gain insight into the way in which Moroccan Muslims deal with a dead body. Fifth, I visited the Islamic Mortuary in Antwerp where I received a private tour. I was informed and demonstrated how (a) the washing of the deceased is performed (*ghusl al-mayyit*), (b) the body is wrapped in shrouds (*kafan*) and (c) the deceased is bid farewell. I attended and participated in a personal farewell of a deceased relative after washing and shrouding the deceased and before putting the body in a coffin. Sixth, I participated in a repatriation of a dead body from Belgium to Morocco. Seventh, I attended a burial of a deceased relative in Trougout (Morocco). Eighth, I visited a Muslim plot in Ghent (Scheldeakker-Zwijnaarde) and Antwerp

(Schoonselhof-Hoboken) and a cemetery in Trougout (Morocco). This has led to a deeper understanding of these cemeteries with regard to organisation and structure. Eighth, seven mourning visits (*taʿziyya/rehzeyyith*) and four memorial ceremonies (*ṣadaqa/sedqeth* or *ṭolba/tarba*) were attended, which led to a deeper understanding of the way in which a deceased is treated within the Moroccan Muslim community. The participant observation provided us with rich and valuable data on the way Moroccan Muslims deal with illness, death and dying and enabled me to assess the accuracy of the data collected, to foster insights by other means and to include some elements in the study that initially were not taken into account.

Besides participant observation, I also had several informal conversations related to the study with members of the Moroccan Muslim communities. Many casual conversations were fruitful to the research which enhanced a deeper understanding of the participants' perspectives and practices and a deeper analysis of the data. This method of participant observation also taught me to be sensitive and well aware/conscious of what I saw and heard. Field notes were taken of the activities observed and participated, capturing key verbal and nonverbal communication.

Ethical considerations

There is a broad agreement that ethical considerations must be taken into account when conducting research. Researchers need to protect the interest of their participants in their study by ensuring confidentiality of the information that is given to them (Mortelmans, 2008; Corbin & Strauss, 2015). Before we started with our empirical research, we had submitted an application at The Social and Societal Ethical Committee (KU Leuven, Belgium), which was positively evaluated. We obtained an ethical review certificate confirming that our research was in accordance with the stipulated ethical standards for scientific research (e.g. anonymity and informed consent).

We informed each of the participants before the interview that all the information would be kept confidential. In order to guarantee the anonymity of our participants, we made use of pseudonyms. In most cases, the explanation of the general goal of the research was sufficient to ensure the participants of our credibility and the truthfulness of our intentions. In the context of the issue of illiteracy, obtaining consent in a traditional manner was difficult especially among (first generation) elderly Moroccan women. Nevertheless, audio-recorded methods of obtaining informed consent have been proven as an acceptable alternative to written consent in study populations where literacy skills are variable (Lloyd et al., 2008). For our participant observations, we have also asked the consent of the participants.

Data Analysis

The data analysis process is the ultimate phase of every scientific inquiry in which the research is expected to combine theory and data to generate new knowledge (Mortelmans, 2008). The objective of

the analysis of the different types of empirical material (interviews, participant observation) was to answer the research questions central in this study and thus to explore and describe the attitudes, beliefs and practices of Moroccan Muslim women regarding death and dying. In addition, the data analysis aimed to explore the role of religion and to sketch the similarities and differences in attitudes, beliefs and practices one may find between first and second generation Moroccan Muslim women.

In order to facilitate data analysis, a qualitative data analysis software package (*NVivo, version 10*) was used. The use of the software does not lead to automatic data analysis, but the data can be organised so that the researcher's interpretative analysis and classification of data can occur faster and more efficiently. *NVivo* offers the possibility to store interview transcripts and coded data and to consult them easily (Mortelmans, 2011). During coding and analysis, I kept notes of decisions made and analytical linking, by using *NVivo*'s memo tool or a notebook. Memos helped to analytically interpret the data, such as emerging concepts and relationships. The data of the interviews with Muslim women and with experts were analysed separately in an *NVivo*-project. Moreover, the findings of our interviews with Muslim women were compared with those of the interviews with experts per concept and category and subsequently compared with empirical studies (cf. see discussion part in empirical articles).

Grounded theory methodology (Corbin and Strauss, 2015; Glaser and Strauss, 1967; Strauss and Corbin, 1998) was used to code and analyse the interview data. The specificity of the Grounded theory methodology can be explained in that it aims at thoroughly capturing the worldview of the individual respondent as a basis for constructing the worldview of the social group to which the respondent belongs. The Grounded theory was a good fit for this study as it enabled us to explore areas that have not yet been investigated through induction. Therefore, the methodology stresses the use of 'taking the role of the other' and the 'constant comparative method' as basic research techniques (Glaser and Strauss, 1967). This comparative method should be evaluated based on the transparency of the methodological process and the resulting conceptual framework. By adding codes to the data and through constant comparisons, key concepts –generated inductively– were identified in the interviews and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants. An a priori coding framework or themes were not employed, as these might assume the importance of particular factors before the analysis (Corbin & Strauss, 2015; Mortelmans, 2008, 2011; Strauss and Corbin, 1998). In other words, no themes and codes were appointed a priori, nor did we fix our views by taking existing theories as starting points for the analyses (Mortelmans, 2011), but themes and concepts were derived from the data during analysis (Corbin & Strauss, 2015). In other words, our themes were not part of any a priori hypothesis. Our point of departure of Grounded theory is that the analysis must happen inductively. Grounded theory emphasises that the primary purpose of research is to generate theory and that the process of contemporaneously collecting, coding and analysing data is controlled by the emerging theory (Corbin & Strauss, 2015). Our study does not aim

to develop a theory, though, but seeks to provide a detailed reconstruction of our participants' way of thinking.

Process of Coding

Analysis was done concurrently with data collection, using an iterative analysis technique, so that future interviews were shaped by the themes identified in prior interviews (Corbin & Strauss, 2015). This process involves constant comparison, which means that data are broken down into manageable pieces and each piece is compared for similarities and differences with the data already present (Corbin & Strauss, 2015, p.47; Mortelmans, 2008). Theoretical sampling suggests that the gathering of data is based on the analysis of previous data (Glaser & Straus, 1967; Corbin & Strauss, 2015, p.68). The core of this technique is that data collection and sampling are interwoven; it thus decides which data are essential to construct an in-depth and broad theory (Mortelmans, 2008; Corbin & Strauss, 2015). Corbin & Strauss (2015) argue that if a main idea (concept) is repeated in subsequent data, we have some validation of the original concept (Corbin & Strauss, 2015). Concepts are grouped together to form categories and each category is developed in terms of its dimensions and properties (Corbin & Strauss, 2015). In practice, this means that we started the analysis with a limited selection of the research material by selecting and coding a number of interviews, thus bringing it to a higher conceptual level. Although we continuously compared our data after each interview, there were two main waves of data collection and analysis to further develop and update the previous codes/findings. The first wave of coding and analysis of the interviews with Moroccan Muslim women took place between July 2015 and August 2015. A second wave took place between May 2016 and September 2016. The stage of coding is critically important to the whole analysis, since these codes form the building blocks of the further analysis (Mortelmans, 2008). It is also exactly in this phase that the questionnaire protocol was adjusted and further specified, for example by asking more specified questions about their views on dying and death and the difference between the two. We repeated this until all the interviews were coded and no new codes emerged or were detected.

We started our empirical study with the interviews with experts (from September 2014 until April 2015 + September 2015), followed by the interviews with women (from October 2014 until September 2015). The interviews with experts in the field, as well as the literature study, were used as background information to enhance sensitivity to subtle nuance in data and to what appeared in the data ('sensitising concepts') (Blumer, 1954; Corbin & Strauss, 2015, p. 50 & 339). Such sensitising concepts alerted us to what is present in the empirical material and as a result often also emerged as codes during (open) coding (Mortelmans, 2008), such as "vice-regency", "lifespan", "life as a test". Before beginning the project, we turned to the literature to formulate questions for initial interviews. After the analysis of the empirical data, we also turned to literature to check the reliability of our data and to show how our data support, add to or amend other theories dealing with the same topic (Mortelmans, 2011; Corbin &

Strauss, 2015 p.371). In other words, a literature review was conducted prior to commencing this empirical study and updated following our analysis. This way we compared our insights and conclusions to established theories and were able to locate our interpretations within the larger body of professional theoretical knowledge (see 'Discussion' section in every empirical chapter) (Corbin & Strauss, 2015, p. 60). In this context, the method of 'bracketing' (Corbin & Strauss, 2015) was applied, which is a process of holding assumptions and presuppositions in suspension to improve the rigour of the research. Pre-existing knowledge about the topic was deliberately withheld until initial data collection and analysis are complete, in order to prevent it from influencing the research findings (Elliot & Jordan, 2010; Mortelmans, 2008; Corbin & Strauss, 2015).

The data were coded using Grounded theory's three major steps of coding: open, axial and selective coding. The purpose of the open coding is attaching labels to transcription and identify properties and dimensions in the form of a code/concept that may be relevant for answering the research question (Corbin & Strauss, 2015; De Baarda et al, 2006; Strauss & Corbin, 1990). During open coding, the data were broken down, examined and compared in order to identify similarities and differences while categorising the data. An example of open coding is that participants mention viewing illness as a test of God ("test of God") and being predestined ("predestination") and for which they should be "patient" and "grateful". In addition, also codes emerged from our own theoretical thinking which is called theoretical sensitivity, which entails the researcher's ability to have theoretical insight or theoretical prior knowledge (sensitising concepts) (Corbin & Strauss, 2015). Examples are the codes/concepts "euthanasia", "autonomy", "self-determination". The result of open coding is an extensive list with free codes (Strauss & Corbin, 1998). This process of open coding, which took about 450 hours, was performed in July 2015; from October 2015 until December 2015 and from April 2016 until August 2016. For each interview, a summary of the crucial codes/concepts was written down on paper as well.

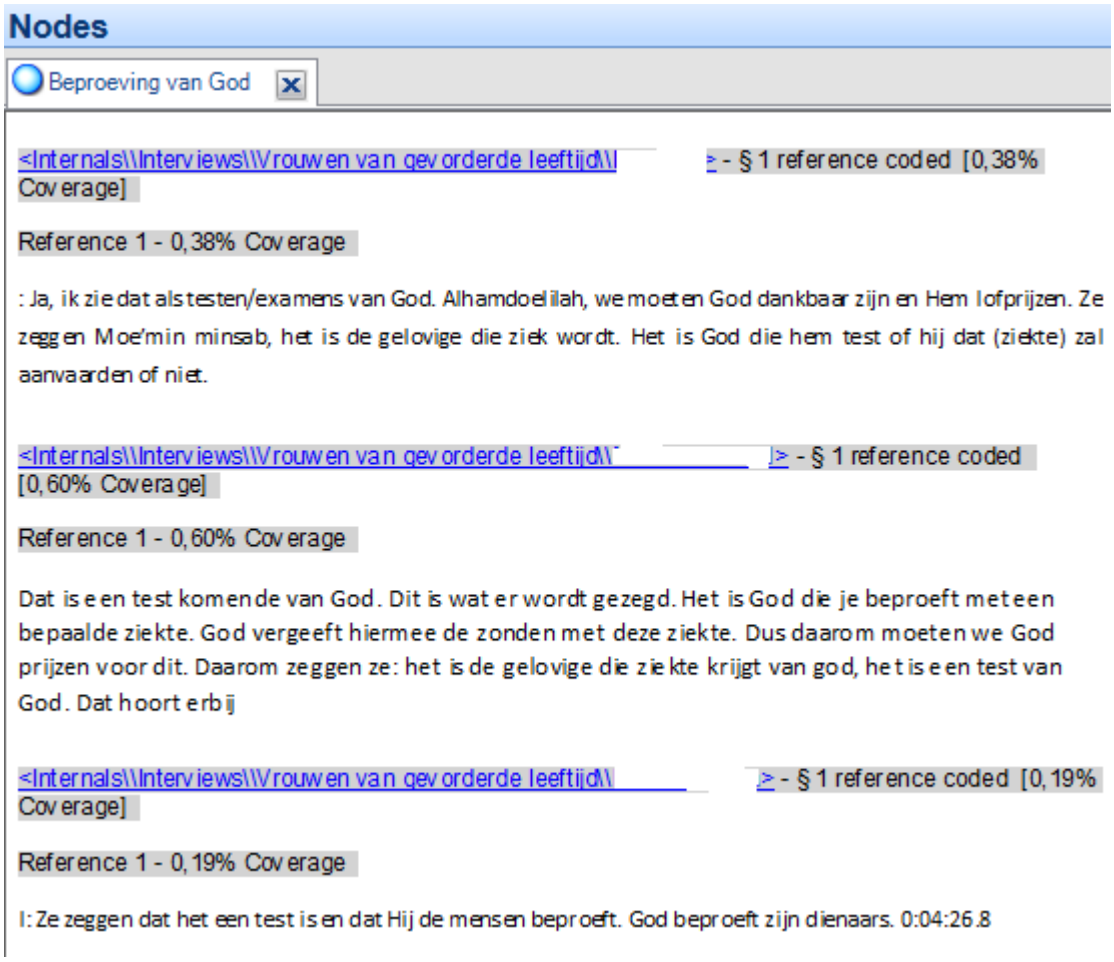
Axial coding, the second step in the coding process consists of going through the list of open codes in which we bring a hierarchical structure by reducing codes on the one hand, and integrating them on the other hand. This systematic and abstraction process involves exploring the relationship between developed categories, constructing a code tree, building it up and re-arranging the codes that are part of it. Placing the codes logically in the tree helped to clarify concepts and recognise their place in the wider emerging framework and to see relations between the categories and subcategories. These categories form the structure or are the building blocks of a 'theory' or theoretical insight (Corbin & Strauss, 2015; De Baarda et al., 2006; Mortelmans 2008, 2011; Strauss & Corbin, 1990). In a concept or category, open codes ("illness as a test from God", "patient", "grateful") that refer to the same underlying theme or the same aspect are put together, such as "understanding of illness", "response to illness" (see table 1 and 2 below). At the end of this phase, all codes are integrated into concepts or

worked out in properties and dimensions. It is not only necessary to further refine the axial coding work, but also to verify it. This was done by returning to the data and testing the coding paradigm to empirical material. In this phase, concepts were reduced, merged and compared (Mortelmans, 2011). This process of axial coding, which took about 450 hours, was conducted in August 2015 and from July 2016 until September 2016.

Table 1: Coding frame – views on illness: understanding and reaction

Houding	0	0
Antwoord	0	0
Aanvaarden	16	23
Doodwens = haram	1	2
Fisabillah [de weg nr God)	2	3
Geduld	13	16
Hamada - alhamdoelilah zegg	18	33
Kritiek op fatalisme	3	3
Niet klagen	7	10
Ongeduld = djahl	1	1
Plicht op zoek gaan naar beha	15	19
Richten tot God	22	42
Vertrouwen leggen in God	26	34
Zelf reflecteren over oorzaak (	1	2
Betekenis	1	1
Aftakeling lichaam	5	8
Beproeving van God	18	31
Bezoek van God	6	7
Boze oog	3	6
Geen straf	4	4
God geeft ziekte	22	33
Hasanaat	6	6
Herinnering om dankbaar te zij	5	5
Pijn lijden is zwaar	8	8

Table 2: Interview excerpts – understanding of illness as a test of God

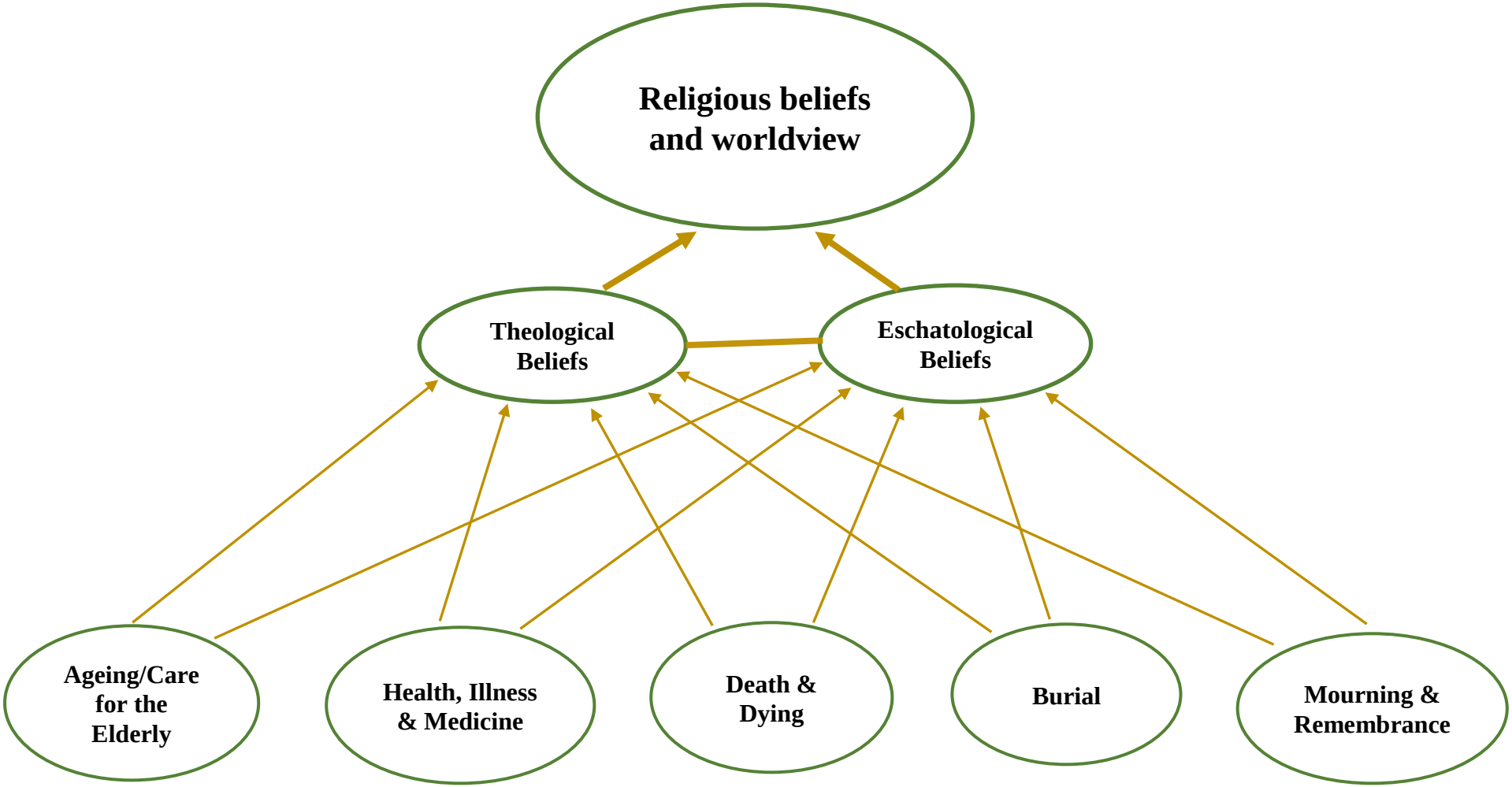


The final result of a codification process which relies on Grounded Theory is supposed to be the creation of a theory, which is reached through selective coding. This third step in the coding process, which often intertwined with the process of axial coding, is a process in which relationships between the core category and other categories are systematically identified. In other words, it is a process of integrating and refining a theory as an answer to the research question (Corbin and Strauss, 2015; Mortelmans, 2011; Strauss and Corbin, 1990). As we did not aim to develop a substantial theory, we sought to find theoretical insights into the way of thinking of Moroccan Muslim women towards death and dying. A useful method in this process was the recorded memos in the previous phase on detected crosslinks between concepts and categories. Analysing entails interpreting while seeking to understand the perspective of the participant. It is clear that the coding process does start from the collected data, but there is also a lot of reflection and interpretation on the part of the researcher (Mortelmans, 2008). Reflection on the personal role happened in the form of note writing. This final process, which took about 250 hours, took place in August 2015 and from August 2016 until October 2016, together with the drafting of the report of our research findings.

When key categories were well developed and the relation between categories were clear and no new relevant data emerged, theoretical saturation ('theorising') was reached. This means that the key categories are fully developed and that relations between different categories are clear and consistent (Corbin & Strauss, 2015; Mortelmans, 2011). However, it is important to mention that stopping the sampling involves judgment and is always tentative. Therefore, the theoretical sensitive judgment about saturation is never precise (Glaser & Strauss, 1967, p.64).

At the heart of theorising lies the interplay between researcher and the data out of which concepts are identified, developed in terms of their properties and dimensions and integrated around a core category through statements denoting the relationships between them all (Corbin & Strauss, 2015; p.63). In other words, the core of a theory is about abstracting theoretical concepts and relations (Strauss & Glaser, 1998). However, our small-scale exploratory study did not aim to develop a substantial theory or theoretical/conceptual model: via the codification process, we primarily aimed at entering into and reconstructing the way of thinking of Moroccan Muslim women and thus to achieve theoretical insights.

In our exploration of the attitudes, beliefs and practices of Moroccan Muslim women regarding death and dying, a tentative theorising/theoretical conclusion or insight was the clear relation between religious beliefs and the attitudes and practices regarding ageing, illness, treatment decisions at the end of life, death, burial and mourning (see table below). Religious beliefs and worldview seem to play a crucial role in our participants' attitudes and practices. The way one views the afterlife, whether having a traditional/classical representation or not, has an impact on how one looks at treatment decisions at the end of life and burial. Another tentative core concept was that personal confrontation with a palliative situation or severe illness or high care needs might have an impact on how one views ethical dilemmas (palliative sedation) and professional elderly care services. Throughout this study, we added interview excerpts to exemplify the participants' way of thinking. We do not intend to use our data as an illustration of normative Islamic views, but we do confront our reconstruction of Muslims' ways of thinking with normative views and other empirical studies and highlight any similarities and differences between both.


Religious beliefs and worldview
Theological Beliefs
Eschatological Beliefs
Ageing/Care for the Elderly
Health, Illness & Medicine
Death & Dying
Burial
Mourning & Remembrance

Personal and Research Experience of the Researcher

No one starts a research as a blank page. We do not separate who we are from the research and analysis we do and we must be self-reflective about how we influence the research process and vice versa. We always occupy a certain position (e.g. academic, female, Muslim) and this position colours our vision. The 'issue' of researcher membership or insiderness is relevant to mention here as the researcher plays a direct and intimate role in both data collection and analysis (Corbin & Strauss, 2015, p.14). Insider research or insiderness refers to when researchers conduct research with populations of which they are also a member and share the knowledge of the studied group because of their cultural linguistic, ethnic, national or religious association with it (Dwyer & Buckle, 2009; Kanuha, 2000; Merton 1972). Postmodernism emphasizes the importance of understanding the researcher's context (e.g. gender, ethnicity etc.) as part of narrative interpretation (Dwyer & Buckle, 2009) and encourages the cultivation of self-reflexivity (Jootun et al. 2009; Nowicka & Ryan, 2015).

Being an insider is more complex and multifaceted than usually recognised (Ganga & Scot, 2006). According to Merton (1972), the outsider-insider distinction is a false dichotomy since outsiders and insiders have to deal with similar methodological issues on positionality and (since) the knowledge produced by researchers varies according to their position in the field. He suggests that neither insiders nor outsiders have privileged or more valid knowledge about a group and that neither of the positions occupies a higher status in terms of objectivity, subjectivity or authenticity. The idea is that there is no neutrality, but only greater or less awareness of one's biases. Insiderness or outsiderness are not fixed or static positions (Wray & Bartholomew, 2010; Kirpitchenko & Volder, 2014).

However, being a member of the Moroccan Muslim community resulted in several advantages. First, the insider position allowed me to gain easier access to the research population and to be easily accepted by the participants. This again contributed to levels of trust and resulted in a stronger rapport (Bhopal 2001, Kirpitchenko, 2014). By conducting fieldwork in familiar settings and communities, I had easier access to informants and the opportunity to recruit informants in my existing social networks (Bhopal, 2001; Kipitchenko & Volder, 2014; Mortelmans, 2008, p.256). This closeness and familiarity to the group also provided a nuanced and unique insight about this underrepresented group and into sensitive topics, resulting in a greater depth of the data gathered (Chavez, 2008). Their openness and willingness to share their experience might be explained by the assumption of understanding and of shared distinctiveness, which might have increased the authenticity and trustworthiness of the study (Bhopal, 2001). Several participants explicitly mentioned that they were happy to see a female Moroccan Muslim conducting the research, which facilitated their willingness to participate.

Second, being an insider also bridged the language and communication barrier by understanding the spoken and unspoken language of the interview (Ganga & Scott, 2006; Kirpitchenko, 2014; Nowicka & Ryan 2015). This means being familiar with the native language(s) and sensitivities and having insight into the linguistic emotional principles of participants, but also stimulating natural interaction and behavior, detecting nonverbal gestures of embarrassment and discomfort (Chavez, 2008) or avoiding topics by saying ("God knows best"). Another example of 'bonding' through language among elderly participants was the respectful way of addressing them as 'aunt' in Moroccan Arabic or Berber language.

Third, being an insider made it easier for me to immerse myself in the living world of Moroccan Muslim women but without losing control over the interview or answering questions which might entail loss of nuances the participants might have wished to add. As mentioned before, when (elderly) participants were shy/insecure or not quite talkative at the beginning of an interview, I would talk about myself or family (e.g. background, migration history) to make the participant feel comfortable, but also by being emphatic (e.g. nodding and humming) and thus encouraging them to continue narrating. I believe that sharing my own personal history helped me to gain the trust of the research participants and that it enabled them to share in greater detail their views, experiences and practices and thus was a potential opening-up for some elder participants. For example, when participants found out that my roots lie in Morocco (Temsamane), this led to geographical connections. This sharing of information worked surprisingly well to start the conversation and gain trust. However, I acknowledge at the same time that this might have constructed a particular picture of me as a person/researcher and might have influenced the interview process.

Fourth, being female might also have facilitated the willingness of women to participate. According to Hoopman et al. (2009), gender of the researcher is important. They argue that women are generally more acceptable because in many cultures, including the Moroccan culture, it is more acceptable for a woman to interview a man than the other way around. No problems were found in interviewing male Moroccan experts in the field, though, which might be explained by the fact that I contacted them in their professional capacity.

Fifth, being female and of the third generation might also explain the often-given position of 'daughter' or 'granddaughter' among elderly participants during the interview. The openness and the participation of participants might also be understood from within that perspective. My young age and the fact that many of the participants interviewed had (grand)children of my age seem to have been a benefit. This position of 'daughter' or 'granddaughter' sometimes made it difficult to request the elderly participant to respond to the question as they often narrated a story or experience in detail and thus strayed off topic. It is exactly here that I explicitly positioned myself as a researcher by requesting in a friendly and respectful way to return to the question. Another example is that some

elderly participants would made this 'familiarised' position clear by inviting me for a meal after the interview or inviting me to come back for a coffee.

Despite the important benefit of being a member of the group studied, there were also drawbacks that should be acknowledged (Dwyer & Bucke, 2009). First, my participants often took my knowledge about their views and practices for granted and assumed that I knew what they meant without delving into the topic. Often participants made assumptions of similarity and therefore insufficiently explained their individual views or experiences by for example saying: "You know what I mean", "You know how this goes among us Muslims/Moroccans". I often felt it was difficult not to succumb to the impression of being knowledgeable about my participants' lives, views and practices. To overcome this, I repeatedly asked them for elaboration ("I know what you mean, but please tell me more" or "what do you mean" or "could your further explain") also known as 'waving the red flag' (Corbin & Strauss, 2015 p.98). It is exactly in this respect that I had to position myself as an 'outsider' by requesting them to explain. This insider/outsider status changed at different points in my research. In addition to this, my 'insider' status also constituted surprised reactions when asking elderly participants whether they perform the prayer (*ṣalāt*). As they considered this an 'evidence' – certainly at their age –, they felt offended, as I seemed to give them the impression of putting that 'evidence' into question. As a result, posing this question often made me feel uncomfortable.

A second confrontation was that often I was being 'interviewed' by (mainly elderly) participants, which I refer to as 'double interview'. Here I made the distinction between answers to questions that might influence the interview and harmless information. For example, elderly participants would frequently ask me from where I originally am, or my (grand)parents, and whether I am married or not. I considered this harmless information, but also a way of gaining trust by sharing this information, as these questions were often posed at the beginning of an interview. When the questions contained content related to the study, I directly suggested that I would answer the question after the interview. An example was a question of a middle-aged participant about my personal view on palliative sedation.

Third, a risk of sharing the same background is the '(counter-effect in) reciprocity' requests from participants for support or services (Chavez, 2008), which result in struggle with this dual role of insider/outsider. This familiarity also created certain unexpected expectations such as when an elderly participant asked, before starting the interview, to quickly go shopping with her. Another example is the request of an elderly participant to help her with administration or assist her linguistically when contacting a lawyer.

Fourth, belonging to the same community also raised issues about anonymity and confidentiality. In the context of an elderly participant's non-response, there was a concern that information from the interview would not remain confidential and she was afraid that her participation would be exposed in fear of reaction of the social environment. While on the one hand being a member of the same community (e.g. female Moroccan Muslim) allowed the participants to speak to me confidently in deep and detailed conversations, on the other hand this might also have restrained the participants from giving views that might not seem in accordance with normative Islamic views or hampered in providing 'deviated' answers out of fear of being judged.

Disciplined bracketing of the assumptions and detailed reflection on the subjective research process, with a close awareness of one's own personal biases and perspectives, is important to reduce potential concerns/bias associated with insider membership (Jootun et al., 2009). My insider/outsider status was not a fixed category, but was rather negotiated throughout the research process.

Not only have I influenced this study, but the study has also influenced me and assisted me personally in understanding and dealing with death and dying. This study personally helped me in dealing with the loss of my aunt in February 2017, as I was already well acquainted with the perceptions, views, difficulties and practices of (Moroccan) Muslims with regard to death and dying. I compared my experience and views on dealing with care for an elderly person with high needs, withdrawing a life-sustaining treatment and loss of a loved one with the empirical data. This also helped me to view the data from another perspective. In addition, this research also made me as a person more sensitive to the topic studied in my personal life by being more aware of what ageing, death and dying means.

Nevertheless, I was confronted with a difficulty during the writing process of the articles (from withholding life-sustaining treatment until mourning), as at that moment I was simultaneously experiencing the subject of the article in my personal life. I acknowledge that this might have influenced the writing process of this dissertation. Another confrontation was the emotion and pain expressed by my participants when dealing with the topics care for the elderly, dying, death, mourning and remembrance. It was difficult to remain detached and unaffected when dealing with human experiences, particularly those related to pain and loss. Rather than attending to ethical concerns through arbitrary distance, in this context, I found it more important to empathise with them and give them the space to express their emotions upon which I reacted by giving them a hug or by saying "I'm sorry for your loss" or "May God have mercy upon him/her" when talking about a deceased loved one.

Control Strategies: Rigour and Credibility

The aim of rigour is to show the consistency of the study methods over time and provides an accurate and faithful representation of the population studied (Beck, 1993; Guba & Lincoln, 1989; Rolfe 2006; Thomas & Magilvy, 2011). To ensure the rigour and credibility of the study, several strategies/techniques were adopted (Cyriaco et al 2017; Noble & Smith, 2015; Leung, 2015). First, preoccupied ideas and assumptions, theoretical notions gained through the literature study and interviews with experts were bracketed as much as possible (Jootun et. al. 2009; Mortelmans, 2008). An effective strategy was to literally ignore as much as possible the literature of the area under study during the analysis process, in order to assure that the emergence of categories will not be contaminated by preconceived concepts (Glaser & Strauss, 1967). After the analysis of our empirical data, the literature study and the data of the interviews with experts were compared with the data of our interviews with Moroccan Muslim women to check their consistency and credibility.

A second technique was keeping a journal and taking notes during all phases of the study. Memos are personal notes by the researcher, which he/she usually uses to keep track of and develop his/her own thinking (Beck 1993; Koch, 2006). The writing of memos comes down to the notation of ideas when they arise. My ideas arose while interviewing, after interviewing, while talking to my (grand)mother, while transcribing and analysing interviews, while writing an article and especially before sleeping. Memos were written down on my phone, in my notebook and in *NVivo*. This technique is considered by qualitative research as a supportive tool for the researcher to guide the analysis (Mortelmans, 2011). Memo writing is designed to ensure that we thoroughly familiarise ourselves with our data. These memos often are reflections about data which have an interpretative or analytical character (Mortelmans, 2008). I distinguish different memos or notes including analytical/theoretical notes, reflexive notes, methodological notes and field notes. Analytical notes were implicit links between pieces of the data which often give a start or building block of a theory such as the relationship between body/life and the viceregency of the human being. They helped to develop theoretical insights on the topics studied, certainly while coding and analysing the data (Beck 1993; Corbin & Strauss, 2015; Lincoln & Guba 1989; Mortelmans 2008; Strauss & Corbin, 1998). In methodological notes, concerns about the method of data collection and analysis were kept. In this way, they assisted in writing out the methodological accountability of the study, such as the choice of audiotaped consent, choices with regard to the development of certain categories (e.g. making a difference between normative ideas on certain practices and actual practices) and choice of journals. During data collection, detailed notes were taken after each interview on the interview course, impressions, setting and interruptions as well as during participant observation. Self-awareness by writing frequent memos about my reactions and feelings during data collection and analysis can helped me to recognise the influence that I had on the research and, just as importantly, that the

research had on me (Corbin & Strauss, 2015, p. 348). Researchers are part of the social world under study. It is thus vital to be aware of any pre-conceived ideas about the topic, and to bracket them as much as possible and remain open to the data (Jootun et al. 2009). By writing everything down, I was well aware of the personal views, perspectives, difficulties when collecting and analysing data. At the same time, they were also used for comparative purposes against the views and perspectives of the participants. An example is the story of a middle-aged participant who lost her two young children, which had a great impact and occupied my thoughts for days. Another example is the story of Khadija who lost her parents and husband and feels abandoned by her children. By keeping notes, this fostered self-awareness such as the response to the data (e.g. difficult experience of advanced illness, loss of a loved one). At the same time, this promotes credibility and conformability of the research findings (Koch 2006)

Third, through the usage of the *triangulation* of different data gathering procedures, this research aspired to add breadth, complexity, richness, depth and comprehensiveness to the studied phenomenon. Different methods were used to gather material for analysis to ensure that the theoretical insights derived represent a comprehensive and accurate picture of the data based on the combination of interviews with women and interviews with experts, participant observation (field notes) and the literature study. The research topics and objects are thus investigated from different perspectives by using different data sources (Mortelmans, 2008, p.435). This is important to assess the validity of the data, but sometimes also to provide new insights. Triangulation is not a tool to check the validity of data and labeling data as 'true' or 'false' but to ascertain validity of the inferences derived from different sources (Hadi & Closs, 2016).

Fourth, the findings have been submitted to *peer debriefing* by the guiding committee, consisting of the promotor and a post-doctoral researcher, to control and ensure the consistency and credibility of the data collection and analysis (Corbin & Strauss, 2015; Mortelmans, 2008; Koch, 2006; Guba & Lincoln 1989). The guiding committee reviewed all phases of the study including data collection, data analysis and dissemination. In order to increase the rigour and reliability of the developed concepts and analysis, double coding was performed. A post-doctoral researcher independently coded a few interview transcripts and subsequently compared these with my coded transcripts. This way, ambiguities or blind spots in the analysis could be noticed and tackled.

A fifth strategy applied was *data checking with members of Moroccan Muslim community* (also known as 'member checking') to verify whether the analysis by the researcher was considered credible and recognisable (Baarda et al., 2006; Cyriaco et al 2017; Guba & Lincoln 1988; Mortelmans, 2008; Long 2000; Koch 2006; Rolfe 2006). More specifically, findings were regularly discussed with people in this setting to receive feedback of people who are in the setting. To check the accuracy and interpretation of the data, I shared a draft of my articles with several members of

the Moroccan Muslim community. I asked them to read my interpretations and conclusions and to indicate whether they were consistent with their experience and their reflections.

Our final strategy was the detailed comparison of our data with the existing findings of the larger research programme (cf. Van den Branden 2006; Baeke 2012) in which our doctorate is embedded. This enabled us to check the rigour and credibility of our data.

PART 1: REVIEWS ON MUSLIMS, ELDERLY CARE, BURIAL & POLICY

1. Institutional Elderly Care Services and Moroccan and Turkish Migrants in Belgium

Introduction

In Belgium, Muslim migration began in the early sixties of the twentieth century. At that time, guest workers from Muslim countries, more specifically from Turkey and Morocco, were recruited in large numbers. Whereas there was hardly any Muslim presence in Belgium before the sixties, in a few decades Islam has become the second largest religion in the country [1]. Today, Belgian Flemish society is confronted with the ageing of this Muslim population [2-5]. Whereas the situation of elderly migrants in the Netherlands is well documented, little information is available on this part of the Belgian population. Until recently, migration and ageing were considered as separate and different phenomena, each covered by a different policy. Only recently have Belgian policy makers begun to realise that migrants too are part of a collective ageing that is taking place in this country [6].

The aim of this literature review is threefold. Firstly, this article seeks to provide a review of the available studies on accessibility and use of institutional care services among Moroccan and Turkish migrants in Flanders and Brussels. Given the central role played by the regional authorities in elderly care, we focus on the Flemish, Dutch-speaking part of the country. Secondly, this paper aims to identify, using the available data, the specific needs of Moroccan and Turkish migrants regarding elderly care services. Finally, it provides an overview of the way in which Belgian policies have provided a response to these challenges.

Methods

For this review, we included primary and secondary studies from academic, grey and policy literature relevant to the Belgian context and published between 1965 and 2014 in Dutch, English and French. To locate academic, grey and policy literature, we searched PubMed, LIMO, JSTOR and Google Scholar. Hand searching and reference list searching were also used to locate additional academic, grey and policy literature. As academic studies on this topic are scarce, this literature review is predominantly based upon grey and policy literature. By grey literature we mean documents or materials outside formal academic publication channels, including reports, news articles, and information guides. The main keywords guiding our search were: migrant, Muslim, Moroccan, Turk*, ethnic* minority, cultural*, Islam*, religion. These terms were crossed with: ageing, Belg*, elder*, older, senior, care, health, institutional services, residential, nursing home, access*, use/utilisation, formal care, migration, policy, Federal*, province* and Flemish. In order to meet the aims of the review, literature had to deal with the accessibility and the use of institutional elderly care services by Moroccan and Turkish migrants and/or the subject of their needs regarding elderly

care. Our search yielded 21 references which predominantly contain small scale qualitative empirical studies. Eight empirical studies (2 quantitative and 6 qualitative studies), 5 policy documents, 3 theoretical studies, 3 news articles and 2 popularized reports have been included (Table 1 and 2). It is worth mentioning that, firstly, no peer-reviewed articles have been found and, secondly, large scale empirical studies on these topics are lacking to a great extent. The majority of the literature focused on a description of ageing among elderly migrants; needs and wishes regarding their old age, and subsequent initiatives undertaken. In the discussion section, we have compared the Belgian data with the large available empirical studies in the Netherlands.

1. Empirical and theoretical studies

Author (s), Year of Publication, Title	Purpose	Type + methodology	Results
Cuyvers G, Kavs J. (2001), De huidige en toekomstige behoeften van allochtone ouderen aan welzijns- en gezondheidsvoorzieningen.	1. To determine needs of elderly migrants (Italian, Spanish, Greek, Portuguese, Moroccan, Turkish and African elderly). 2. To identify solutions for quality improvement.	Qualitative research: 1. 4 focus groups with Elderly (>50 years) Italian, Moroccan and Turkish people from Flanders (n=5-12). 2. 3 focus groups and in depth-interviews with privileged witnesses (n=10).	Mutual ignorance between elderly migrants and Flemish care services. Care need of elderly migrants will increase and family care will decrease. Several barriers: language barrier, financial constraint and cultural barriers.
Janssens A, Timmerman C. (2003), Hoe elkaar de hand reiken? De zoekende interactie tussen de allochtone ouderen en het zorgaanbod in de stad Antwerpen.	To explore the needs, wishes and expectations of elderly migrants and the extent to which demand is made upon professional care provision.	Qualitative research: 1. In depth-interviews with elderly (>50) Moroccan (n=16) and Turkish migrants (n=13) from Antwerp. 2. 2 focus groups and in depth-interview with privileged witnesses (n=9).	Little or no care need that cannot be taken by the children; very limited appeal to care services; count upon family care; care and return dilemmas, cultural and religious barriers (experience of religion, gender relation).
Berdai S. (2005), Vergrijzing...een kleurrijk gegeven!	1. To map health and social welfare needs of elderly migrants. 2. To obtain an insight into the issues that elderly migrants encounter when appealing to health and social welfare services.	Qualitative research: 1. In depth-interviews with 30 elderly (>55 years; 19 women, 11 men) Moroccan, Turkish, Italian, Spanish, and Black-African people from Brussels. 2. In depth-interviews with privileged witnesses (n=24) and family caregivers (n=6).	Situation of elderly migrants is comparable with that of autochthonous elderly (80+) in a disadvantaged position. Little knowledge of provision of care services and a number of thresholds are observed, such as financial situation, language, culture and food.
Declercq A, Wellens N, Demaerschalk M, De Coster I. (2006), De ontwikkeling van een vormingsprogramma over de zorg voor allochtone ouderen in rusthuizen en rust- en verzorgingstehuizen.	1. To develop a training program on the demands and needs of elderly migrants in residential care. 2. To map the perspective of provision (elderly care services) and perspective of demand (elderly migrants).	Qualitative research: 1. Focus groups with elderly (>60) African people (n=8) and intermediaries (n=8). 2. 28 survey of privileged witnesses in elderly care services; staff (n=28) and directors (n= 10).	Training program is best embedded in existing training packages. Elderly migrants are unknown in the sector of elderly care. An increase of appeal upon care services is expected.
Levecque K, Lodewyckx I, Van den Eede S. (2006), Gezondheid en gezondheidszorg bij allochtonen in Vlaanderen.	1. To provide an overview of the health situation of autochthonous and allochthonous population in Flanders. 2. To map the accessibility and utilisation of different health care provisions among the two populations.	1. Literature study 2. Quantitative analyse of Health Interview Survey of 1997, 2001 and 2004.	Perception of subjective health differs significantly depending upon the region of origin. Moroccan and Turkish people make less use of preventive health care, curative care and medical consumption, but rely more frequently upon traditional healers (cf. psychic, somatic complaints).
Lodewijckx E. (2007), Ouderen van vreemde herkomst in het Vlaamse Gewest: origine, sociaal-demografische kenmerken en samenstelling van hun huishouden.	1. Quantitative description of a few socio-demographic characteristics of elderly people of foreign origin. 2. A thorough analysis of household types of elderly people of foreign origin. 3. To explore expectancy pattern of elderly people of foreign origin towards family care and formal care reflected in the composition of their household.	Quantitative and qualitative research: 1. Population data of National register 2. Socio – Economic Survey 2001 3. Qualitative analyse of a focus group with elderly migrants (>55) of West –Europe, South-Europe, North-Africa, Turkey and Poland.	Moroccan and Turkish elderly people live much less on their own and thus more with other people, compared with autochthonous elderly population. The household structure is comparable with the household structure in the country of origin. Moreover, children and family take care of the elderly. Elderly Moroccan and Turkish people can count upon family care. This population lives more in a multi-generational household; compared with autochthonous Belgians.
Talloen D. (2007), Zorg voor allochtone ouderen.	1.To explore the theme care for elderly migrants. 2. To provide possible solutions for quality care provision for every person and in particular elderly migrants.	Literature study: 1. Results of project 'Aging in Flanders' (inventory of needs and wishes of 1500 Italian, Spanish, Portuguese, and Greek elderly people). 2. Theoretical case study of Moroccan and Turkish elderly migrants.	There are specific points of interest among Moroccan and Turkish elderly regarding care. The differences between the care need of autochthonous and elderly migrants is the way in which it is interpreted. Several barriers are mentioned: financial constraint, lack of knowledge of health care system, cultural and religious barriers, care and return dilemmas and low level of education.

Vassart C. (2007), Migration et vieillissement: la situation particulaire des personnes âgées d'origine étrangère en Belgique.	To describe the impact of the evolution of elderly migrants in Belgium.	Qualitative research: Focus group on the topic immigration and ageing of the population with researchers from different disciplines of social sciences and with fieldworkers.	Changing economic situation; there is no certitude that family care can be assured with the same continuity. Immigration is a reinforcing factor for issues that are inherent to old age (isolation, poverty, dependence).
Derluyn I, Lorant V, Dauvrin M, Coune I, Verrept H. (2011), Naar een interculturele gezondheidszorg: aanbevelingen van de ETHEALTH-groep voor een gelijkwaardige gezondheid en gezondheidszorg voor migranten en etnische minderheden.	To carry out recommendations that can promote a greater equality in health care situation of migrants and ethnic minorities by an expert panel.	Literature study	Developed 46 recommendations for the Belgian government which can be summarised as following: (1) developing strategies to dispose of adequate information regarding ethnicity and health differences and realisation of culturally competent services and health care providers; (2) Providing same health opportunities to MEM (migrants and ethnic minorities); (3) Particular attention to certain vulnerable groups; (4) Making health care accessible for MEM.
Lodewijckx E, Pelfrene E. (2012), Huishoudensstructuur en solidariteit tussen de generaties bij personen van vreemde afkomst: in: Generaties en solidariteit in woord en daad.	1. Comparison of household structure of Moroccan, Turkish, Italian and Spanish population, with that of Belgian population. 2. To compare care patterns that are common among elderly migrants of Morocco and Turkey.	Quantitative research: 1. Population data of National register 2. Socio – Economic Survey 2001	The elderly population of foreign origin shows a younger age structure than the Belgian population. Moroccan and Turkish migrants have a more traditional view on elderly care. Their attitude towards collective housing is rather negative.
Talloen D, Verstraete J, Chech J. (2012), Allochtone ouderen, senioren van bij ons: lessen uit de praktijk.	To provide an overview of the initiatives taken in order to narrow the gap between elderly migrants and the existing provision of services and social, cultural and other activities.	Qualitative research: Three intervision meetings in which project supervisors exchange information on (a) the methods applied, (b) the difficulties encountered and (c) the responses to it.	Many efforts are needed to let elderly migrants participate fully in society, such as, a further interculturalisation of provision, sensitisation of target groups, more cooperation between care and diversity sectors and strengthen competencies of providers working with elderly migrants.

2. Other types of literature

Author (s), Year of Publication, Title	**Type & description**
Van der Sypt. (2015), Het belang van interculturaliseren van de ouderenzorg.	A popularized report on the importance of interculturalization of elderly care.
Bhutani S, Charkaoui B. (2005), Bouwsteen VIII: ouderenzorg voor iedereen.	A short popularized report of Minority Forum on the state of the art of the situation of elderly care among ethnic minority and migrants in Belgium from a policy perspective.
Flemish Government. (2009), Residential decree of 13 March 2009.	Decree of Flemish department of Welfare, Public Health and Family.
Interdepartementale Commissie Etnisch-Culturele Minderheden. (2001), Het Vlaams beleid naar etnisch-culturele minderheden: jaarrapport 2001.	Policy document: Annual report on ethnic- cultural minorities and different fields including education, welfare, leisure.
Vandeurzen J. (2010), Vlaams ouderenbeleidsplan 2010-2014.	Policy plan towards elderly people of Flemish department of Welfare, Public Health and Family on residential care.
Vandeurzen J. (2012), Nota van de Vlaamse regering. Vlaams ouderenbeleidsplan 2010-2014: Voortgangsrapport 2010-2011	Policy plan towards elderly people of Flemish department of Welfare, Public Health and Family.
Vervotte I. (2007), Vlaams Ouderenbeleidsplan 2006-2009.	Policy plan towards elderly people.
Binst JM. (2011), Gebrek aan ouderen-woonzorg voor allochtonen wordt nijpend " Steek ons alsjeblieft niet in een rusthuis".	News article on the lack of elderly residential care for migrants in Brussels.
Hubo B. (2014), “Moslimkamers in rusthuis De Overbron”.	News article on Muslim chambers in nursing home De Overbron in Brussels.
Patrick Martens (2011). “Allochtone ouderen vinden weg naar zorg niet”.	News article on elderly migrants not finding their way to professional care.

Research population

In this review, the research population consisted of elderly Moroccan and Turkish migrants. Although, the Flemish residential care decree considers a person of 65 years and older as an elderly person, in this review we have broadened the scope of those considered elderly to 50 years old, as studies were found on this particular age group too. According to study of Cuyvers & Kavs [7], Belgian elderly migrants consider old age from the age of 50.

In 2013, almost 1,2 million people of foreign origin lived in Flanders. This corresponds to approximately 18% of the total population. In 2013, Jan Hertogen estimated that Muslims were 6,5% of the Belgian population (22,6% in Brussels and 4,7% in Flanders), 46,4% were from Moroccan and 25,8% from Turkish descent [8]. Statistics of the Federal Government (FOD) have shown that in 2010 the Belgian population counted nearly 10 million people, of which 1.745.740 were 65 and older (women: 1.015.151; men: 730.589). According to these statistics, there were 8.472 elderly Moroccans (women: 4928; men: 3550) and 4.227 elderly Turks (women: 2549; men: 1678) of 65 years and older [9]. The share of elderly people of Moroccan and Turkish origin comprised 6%, against 27% of the elderly Belgian population [11].

More specific details on this elderly migrant population were found in a study carried out by Lodewijckx [5]. In 2004, almost 5% (62000) of all elderly people over 55 years old in Flanders were from foreign origin, 1% (18000) were of non-western origin. Moroccans formed 9% and Turks 7% of the share of elderly people of foreign origin. Moroccan and Turkish elderly people formed only a small share of the total population, among which the number of elderly people of 80+ was extremely limited. An important note in this regard is that this population showed a young age structure. As such, the majority of this group was younger than 65 years old. The size of this population, as well as the average age, was increasing at the same time [5].

There are two important limitations regarding figures on this population in Belgium. Firstly, the figures on Moroccan and Turkish migrants are not entirely reliable or representative for the totality of elderly Moroccan and Turkish migrants, due to the fact that a part of this population have naturalised. Since the 1990's, the Belgian legislation on naturalisation has changed dramatically which has led to a large number of immigrants obtaining Belgian nationality. Thus, figures on migrants are based upon the criterion of nationality, as a result of which the naturalized population are not taken into account. In reality, the number of Moroccan and Turkish elderly population is higher [7, 12]. It is important to note that figures on elderly Moroccan and Turkish population include Moroccan and Turkish migrants who came in the late 1960s and 1970s, and the continue influx of elderly Moroccan and Turkish migrants as a result of family reunification [7, 12]. Secondly, no official prognosis of the number of elderly migrant people exists at national or regional level. However, a calculation has been found in a study of Cuyver & Kavs in 2001. According to this study,

an increase is expected of the number of people over 60+ from Morocco and Turkey between 2001 and 2020. More specifically, whereas in 2001 Flanders' elderly population (60+) consisted of 22,7% autochthonous, 6% Moroccans and Turks, and in Brussels 25,5% autochthonous compared with 8% of Moroccan and Turkish elderly people, in 2020 the elderly Moroccan and Turkish population in Flanders and Brussels will vary between 25% and 30% [7]. This calculation is in keeping with the abovementioned figures of 2004 and 2010.

Results

Accessibility and Utilisation of Institutional Elderly Care Services by Elderly Moroccan and Turkish Migrants in Flanders and Brussels.

According to Talloen [4], the first generation Moroccan and Turkish migrants fulfil a pioneering role regarding ageing in the Belgian context. Indeed, they lack the experience of ageing in a foreign country, as a result of which they do not find their way in the Flemish landscape of care services [7]. Though care services and providers themselves believe that migrants are familiar with the provision of institutional elderly care services [4, 7, 10], this is not the case. As a result of the limited use of care services by this migrant population, institutions are not stimulated to offer services tailored to their needs [4, 7, 10]. Presently, no detailed figures exist on the number of elderly migrants in elderly care facilities at national, Flemish or regional level. According to Declercq et al. [12], this lack of data might be explained by the fact that very few Moroccan and Turkish migrants reside in residential care facilities.

To this day, the demand for institutional elderly care by Moroccan and Turkish migrants is very low [11]. Many studies have confirmed this observation based upon small scale qualitative research [4, 5, 7, 11, 12]. However, according to these studies in Flanders, a high demand of institutional care services by elderly Moroccan and Turkish people is to be expected in the near future. This assumption is based upon the expected increase of this population as aforementioned, as a result of which an increase of demand for care is simultaneously expected [2, 4, 5, 7, 11, 12]. Given the expected increase of high age (80+) Moroccan and Turkish people, an increase of demand for care on the one hand, and the decrease of willingness of the younger generation to take care responsibility towards their parents, especially those in high need of care, on the other hand, is expected. Consequently, there is a certainty that in the near future more appeal will be made upon formal care [5, 7, 11, 12, 14]. Depending on the intensity of the care required, family caregiving might come under pressure and might not be able to fully take responsibility for the care [5].

A study by Cuyvers & Kavs [7] pointed out that migrants in Flanders are more likely to make a higher use of general practitioners services and a much lower use of physiotherapy and elderly care. The explanation given for this difference is, firstly, that unlike the latter type of care, medical care is

a well-known territory for them and secondly, that Moroccan and Turkish migrants assume that they can rely upon the traditional family safety net and thus count upon family caregiving. According to Berdai's research, 76.6% of elderly migrants in Brussels prefer to be taken care of by their children and nearly 90% refuse to reside in a retirement home [15]. Vera Jans, a member of Flemish Parliament, carried out a survey among 740 recognised elderly care services in Flanders of which 133 were filled out. Only 19 elderly migrants, who were of German, Italian and Polish origin (no Moroccan or Turkish migrants), were detected in 133 elderly care services [16].

Many studies in Belgium [4, 7, 8, 12-14] report a positive correlation between the extent of integration and the accessibility and utilisation of elderly care services by migrants. Thus, the better the socio-cultural integration, the more migrants make use of medical and care facilities. Moroccan and Turkish migrants' access to the available mainstream elderly care services in Flanders and Brussels is hindered by a number of specific factors: the language barrier, a low level of education, a lack of knowledge of the healthcare system, financial, cultural and religious barriers and the so-called return and care dilemmas. In what follows, we briefly discuss each of these factors.

Language Barrier

Most of the elderly Moroccan and Turkish migrant population in Flanders have little knowledge of the Dutch language, which hampers their access to and utilisation of elderly care services [4, 7, 10, 12, 13]. Concerning this, it is worth mentioning that Dutch language courses for migrants have only been organized by the Belgian government since the late nineties. Additionally, studies [4, 12, 13] have shown that classical information material such as folders and campaigns in Dutch hardly reach this group. According to Cuyvers & Kavs [7], communication among autochthonous Belgians is also more direct than among migrants, particularly when it concerns sensitive topics such as ageing.

Low Level of Education

According to research carried out by Levecque et al. [14], education determines not only health condition, but also access to institutional care services. Many Belgian studies [2, 4, 7, 10, 12, 13] report that the provision of information and administrative procedures including filling out forms are hindered by a high illiteracy rate among elderly Moroccan and Turkish migrants in Flanders. Berdai's study pointed out that approximately 63% of elderly migrants in Brussels demand simplified procedures and more coherence in administrative management. Lodewijckx observed in his study in Flanders that nearly 70% of the elderly Moroccan male population (between 65 and 74 years old) and 40% of Turkish male migrants have not enjoyed education compared with approximately 5% of their autochthonous counterparts. The situation among women is much worse; respectively 82% of Moroccan women and 70 % Turkish women are uneducated, compared with 6% of the autochthonous elderly population [5]. According to Levecque et al. [14], a higher level of education leads to a better assimilation in the host country and to a higher use of care services.

Financial Barrier

The poor financial situation and low socio-economic position of many elderly migrants in Belgium is a key barrier to the accessibility and utilisation of institutional care services. Several studies have also reported that a low socio-economic position often seems to explain poorer health [4, 12, 15]. In 2006, approximately 57 % of the Moroccan and Turkish population versus 12,66 % of the totality of the Belgian population lived in poverty [6].

Levecque et al.'s research [14] points out that people with insufficient income save on health care. Moreover, six out of ten Moroccan and Turkish households report a low expenditure on health care in comparison with one out of four households among the autochthonous population. The explanation given is that these expenses are high and difficult in relation to their household budget. In other words, one out of four households of Moroccan and Turkish origin postpone medical care due to their financial situation. According to Berdai's research, 83,3 % of elderly migrants mentioned the financial aspect as a threshold for the utilisation of health care [15]. In sum, these economic factors have an immense impact on the utilisation of care services by migrants in general, but also specifically on the admission to nursing homes due to the huge costs involved [6].

Lack of Knowledge of Health Care System

There is a broad agreement in the literature that elderly migrants are not aware of elderly care facilities due to a lack of familiarity with the existing care structures in Belgium [4, 10, 12, 13]. According to research of Janssens & Timmermans [2] and Talloen [4], the major obstacles for elderly migrants are the complex administrative system, the bureaucracy and the lack of knowledge of care services. The reason given for this lack of familiarity, is the fact that when care is needed, Moroccan and Turkish migrants tend to rely upon oral information and upon informal family care [4, 12]. According to Lodewijckx's research, 21% of all care-dependent elderly people are migrants. Over 10% of the elderly autochthonous population (75+) lives together with their children (in law) and/or grandchildren, whereas seven out of ten Moroccan and Turkish 75+ persons live in a multi-generational household [9].

With regard to formal care, this population cannot refer to a similar concept in their culture or home country, which also explains their perceived negative image of this type of care [4, 12]. Formal care is a type of care that is typical for a modern individualistic western society, whereas in traditional collective societies such as Morocco and Turkey, care responsibility lies in the hands of the family and/or social network [5]. Whereas in their home country a wide social network exists upon which they can rely, in Belgium this network is fragmented or missing to a large extent.

Cultural and Religious Barriers

The access and use of institutional care services are also limited by a number of factors which have a cultural and religious basis. According to several studies [4, 7, 15], care services have little knowledge of the cultural and religious beliefs and practices of Moroccan and Turkish migrants regarding ageing, health, illness and gender relations. Traditional explanatory models of illness and illness behaviour coming from Morocco and Turkey keep existing in Belgium [14]. According to Declercq et al., elderly Moroccan and Turkish people experience a different illness perception which seems to be a bottleneck for access to residential and nursing homes [12]. Elderly migrants' health complaints have often a psychosomatic origin and are often connected to psychosocial issues. Illness is often seen as a test by God; the 'evil eye' is another explanatory factor for both illness and misfortune, which is powered by jealousy [4]. This population attaches a great importance to customs from the popular belief of their country of origin which are connected with religious therapy, and thus for these issues, they often seem to rely upon traditional healers [12]. Formal elderly care does not take into account the attitudes towards health and illness experience and treatments of this migrant population and consequently, might be one of the reasons why they avoid these services based upon the assumption that they would not be understood [4, 10]. This is also one of the reasons why deployment of care providers with intercultural competences, particularly of the same background, seems to be crucial to provide an environment that is familiar within their social world [4, 7, 12, 14]. Besides, in traditional collective societies the use of formal care generates a loss of face within a community that equates this with children not fulfilling the care responsibilities that they hold towards their parents [4, 7, 12].

Return and Care Dilemmas

With regard to the utilisation of services, Cuyvers & Kavs, Janssens and Talloen [2, 4, 7] argued that the so-called return dilemma plays a major role among Moroccan and Turkish migrants. This dilemma implies that these migrants hold the assumption of getting old in their home country. In this respect, Declercq et al. [12] refers to conflicting desires among this population. On the one hand, the family, the climate and nostalgia make Moroccan and Turkish migrants want to return to their home country. According to Berdai's research, less than 40% of the Brussels elderly migrant population definitely wants to return to their country of origin. On the other hand, this migrant population wishes to reside in Belgium because of practical and emotional reasons including the presence of their (grand)children and social and financial security. As a result, these elderly migrants feel disoriented and alienated [15].

Cuyvers & Kavs, Talloen, and Janssens [2, 4, 7] also observed an important care dilemma among Moroccan elderly people and less among their Turkish counterparts. Elderly Muslims rely upon their children when care is needed. This care is seen as having a religious foundation; it is a religious duty based upon the *Qur'ān*. Despite the fact that children acknowledge this duty, they

seem, however, not always able to fulfil this wish. The assumption of parents and of care services and providers that informal care through the family will remain a substantive part of care for migrants coming from collectivistic societies has to be revised [4]. As a result of globalisation and individualisation, the traditional structure of the extended family has changed into a more western nuclear family model. This means that the focus is now on a family group consisting of a pair of adults and their children [9]. The family solidarity that was central in Moroccan and Turkish culture is less present among the second and third generation. Numerous factors have explained this change, including adapting western norms and values, living less multi-generational, but also the changing socio-economic context in which both men and women work outside the home. As a result, it is no longer guaranteed that children will take care of their parents, which implies a fragmentation of the traditional ideal of integral care provided by the family [7, 11].

Needs and Wishes of Moroccan and Turkish Muslim Migrants in Belgium

According to a study by Talloen et al. [10], there is essentially little difference between the needs of autochthonous elderly people and migrants. In line with this statement, Vassart [6] stresses that the literature tends to single out the differences rather than the similarities regarding their needs. However, the needs arising from symptoms of ageing are little or no different from those of autochthonous people, including help with housekeeping, personal hygiene and administration [7]. Nevertheless, Moroccan, Turkish and Italian migrants also have typical characteristics which have to be taken into account including poorer conditions of health due to their lower socio-economic status, a lower level of education, a particular lifestyle, their working conditions and the migration context [2, 4, 7, 12, 15], which have led to premature ageing also known as the ‘Exhausted Migrant Effect’ [6].

Several Flemish and Brussels studies [2, 4, 7, 15] indicated a number of specific needs among Moroccan and Turkish migrants regarding institutional elderly care services, though till today no detailed studies are available. First, this population prefers to be cared in their own language and by care providers of the same cultural background. The native language of a person plays an important role in realising a certain continuity in life, and it becomes a symbol for the idea of feeling at home in one’s (new) environment [15]. Second, given that the elderly attach great importance to their food culture, Moroccan and Turkish migrant elderly also wish to preserve their own cultural eating habits and religious dietary requirements [4, 7, 12, 15]. Third**,** with regard to nursing homes, these migrants stressed the importance of having their own room for privacy as well as for receiving their family [15]. Fourth, religion plays a central role in every aspect of elderly Moroccan and Turkish migrants’ lives, including in the provision of care. In this regard, elderly Muslims have the need to experience and practice their religion by praying, fasting and reading the *Qur’ān* [12, 15]. Berdai [15] stated that religion plays a major role in their lives as they mainly reflect on their present life and at the same

time prepare themselves for the hereafter. Besides, religion also plays an important role for these elderly migrants as it enables them to cope with difficult circumstances [15]. In this regard, elderly Muslims want their cultural and religious background to be respected. In Belgium, however, more detailed information regarding the specific views, needs and attitudes of elderly Muslims is lacking.

Belgian Policy Perspectives on Institutional Elderly Care and Migrants

Belgium is a federal state consisting of three communities and three regions [17]. The Communities have the responsibility over the policy on the elderly and the recognition and programming of elderly care facilities. Until recently, little attention had been devoted to the issue of ageing of Moroccan and Turkish migrants and their access to institutional elderly care in Belgium's policies. However, a few initiatives have been taken at different policy levels that begin to address this issue.

As regards to the way in which Belgian policy approach Turkish and Moroccan Muslims in their documents, three crucial points are worth mentioning here. First, Belgian policy conceives of elderly Turkish and Moroccan Muslims simply as *allochthonous* (migrant) elderly. Belgian policy prefers to use this more general, neutral term. However, and this is our second point, when the word *allochthonous* is used, it is not used in a general way (including also the many other migrant groups such as Spanish, Italian, Polish, French and Dutch), it is in fact most of the time used to refer to Turkish and Moroccan people only. Third, although the totality of the Moroccan elderly population as well as the vast majority of the Turkish population are Muslim, this element is remarkably not specifically and directly addressed in these policy documents.

At the Federal Level

No explicit Federal policy is directed to the issue of migration and ageing. However, a number of initiatives have been taken to address the issue of migrants' access to healthcare. First, in the context of the language barrier in health care, the Federal Public Service Health has financed the presence of intercultural mediators since 1999. Second, at the order of the Federal Minister of Social Affairs and Health, Laurette Onkelinx (1992-1993 and 2007-2014), and the Director-General of the Federal Public Service Health, Food Chain Safety and Environment, Christiaan Decoster, research has been carried out by a group of experts to assess health inequalities regarding the accessibility of health care among ethnic minorities, but also seeking to develop recommendations for tailoring the Belgian health care to the presence of migrants and ethnic minorities [18]. According to this study, an improvement in this matter can only be achieved if all policy levels are involved.

At the Flemish level

The focus of Flemish policymakers and their policies has remained limited to improving access to health care for "vulnerable groups" including poor people, lesbian and gay people, people with

disabilities and elderly migrants. Particularly, the Flemish and Provincial policies on the elderly shows a minimum of interest by stressing (1) the improvement of care access for elderly migrants, (2) the interculturalisation of care and care providers by stimulating intercultural competences and (3) informing and sensitising elderly migrants [2, 10, 18, 19].

At the Flemish level various initiatives have been taken to address the issue of the ageing of migrants and ethnic minorities. In 2001, Flemish policy paid attention to the elderly members of ethnic minorities for the first time. The Minister of Public Health, Welfare and Equal Opportunities, Mieke Vogels (1999-2003), set up a study group of experts aiming to formulate recommendations to the Belgian government [20, 21]. This project aimed to integrate the recommendations on migrants and the subject of elderly care into a legal decree on the elderly, but unfortunately this has not been realized [21]. Second, the Flemish Government supported projects in several regions of Flanders under the umbrella of 'Ageing in Flanders' which also aimed to an interculturalisation of elderly care and the sensitisation of elderly migrants at the local and regional level. Third, the Minister of Public Health, Welfare and Equal Opportunities, Mieke Vogels, aimed to adapt and re-orientate the current policy on the elderly towards the new future needs of elderly people in Flanders by initiating a study conducted by psychologists Cuyvers and Kavs in 2001, aiming to assess the needs of elderly migrants in Flanders. This study pointed out that care services have to be tailored to every elderly person and suggested abandoning the idea of assimilation which assumes that all elderly persons should adapt themselves to the standard care provided. Besides this, these researchers argued that interculturalisation should be a standard of quality and recognition that has to be implied in every institutional care service in Belgium [7]. Fourth, in 2004 the Minister of Welfare, Health and Family, Inge Vervotte (2004-2007), pointed out in her policy document, in which she opted for an inclusive policy on the elderly, that an interculturalisation process of elderly care and welfare had to be achieved [22, 23]. Unfortunately, this plan has not been operationalised [21]. Fifth, commissioned by Minister Inge Vervotte, Declercq (LUCAS, KU Leuven) has conducted a study on elderly migrants in nursing homes, seeking to develop an education programme regarding the demands and needs of elderly migrants in residential care [12]. Sixth, following the Flemish residential care decree of 13 March 2009[1], the focus on migrants has been indirectly limited to the following points: (a) "the accessibility to residential care has to be guaranteed without discrimination on the basis of ideological, religious and philosophical beliefs or membership or on any other basis" (Art. 4, 1°); (b) "particular attention has to be paid to diversity" (Art. 4, 11°); (c) "particular attention has to be paid to specific target groups" (Art. 4, 12°); and (d) "a recognised local service centre has to pay attention to the accessibility of care provision to ethnic minorities and newcomers" (Art. 19, 3°). "All recognised elderly care services and associations have to take these operating principles into account" (Art. 4, 1°) [24]. Seventh, in 2010 the Minister of Welfare, Health and Family, Jo Vandeurzen (2010-

[1] Flemish Residential Care decree, 13 Mars 2009: http://www.juriwel.be/ws/Export/1017896.html.

2014), acknowledged in his policy on the elderly that elderly migrants have specific needs that have to be met, though these were not specified or discussed in this policy document. Hence, he calls out for person-centred care which will benefit every elderly individual [19].

At the Level of the Brussels Capital Region

In 2004, Ovallo (Consultation Platform for Elderly Migrants) conducted a study commissioned by the Flemish Community Commission to gain insight into the gap between elderly migrants and healthcare and welfare services in Brussels. This platform is a collaborative initiative of organisations in Brussels that functions as a bridge between target groups and government institutions, seeking to realise an inclusive policy that is based upon a model of society in which every culture is respected. The purpose of this study was twofold. First, it sought to assess the needs of elderly migrants in Brussels regarding health, welfare and wellbeing. Second, it sought to sensitise local policy and health care institutions on the specific needs and problems of this population [15]. In 2014, with grants by the Flemish and French Communities, a new multicultural senior housing project called 'Maison Biloba' has been set up in Brussels in collaboration with private organisations [23]. Recently, Senator Bert Anciaux proposed to provide a couple of rooms within the existing Flemish nursing home 'De Overbron' in Brussels specifically for elderly Muslims. Within this nursing home, Muslim residents will receive care with specific attention paid to their own culture and religion such as appropriate food, care and entertainment. His main goal is to provide a pluralistic nursing home that takes into account the needs of Muslims [26].

Discussion

In Belgium, a small number of initiatives aimed to increase awareness of the needs of elderly migrants regarding care. Unfortunately, a lack of continuity, durability, coherence and structural embedding has been noticed with regard to these initiatives [8]. Moreover, Van der Sypt [13] argued that as a result of a lack of sense of urgency most short-term initiatives, often experimental projects, reach an end when project funds are exhausted. Despite the fact that the Flemish policy on the elderly acknowledged the specific needs of migrants, it did not yet succeed in tackling this issue at a structural and institutional level [13]. According to Berdai [15], the government does not sufficiently stimulate institutional care services to interculturalise.

The Flemish policy on the elderly emphasizes the inclusive character of care provision based upon the idea that services should represent a faithful reflection of a society in which the idea of living together with respect for cultural and religious diversity is stressed [6, 19]. As such, every measure is supposed to embrace this inclusive policy, meaning that elderly care services have to be accessible by and tailored to the needs of the totality of the population [18]. A categorical provision can be created for a specific population when it is necessary, but should be limited in time. The

ultimate goal is to eventually lead every elderly person to the regular care provisions [18, 25]. According to the Flemish policy plan for the elderly, categorical care services are not needed if tailored care is provided [19].

As mentioned earlier, the Belgian policy documents use the general term *allochthonous* elderly when actually referring to Moroccan and Turkish Muslims. It is not a coincidence that in this way their religious and ethnic identity is sidestepped. The Belgian government seeks to maintain the principle of neutrality by which every person is treated equally [27]. Belgium is also characterised by a separation of Church and State. The assumption is held among many health professionals that religion belongs to the private sphere. Therefore a categorical policy based upon nationality, ethnicity and/or religion is avoided [4, 6, 19, 25, 28].

Similar to the Belgian studies, Dutch studies [29-33] report a positive correlation between the extent of integration and access to and use of care services by Moroccan and Turkish migrants. In other words, due to their lacking knowledge of the health care system, little use is made of care services. Moreover, according to large scale research of Schellingerhout in 2004 on health and wellbeing among elderly migrants at national level, 13 % of Moroccan and 18 % of Turkish elderly people know people residing in a nursing home or have visited one once, in comparison with 81 % of the autochthonous Dutch population. In reality, hardly 1% of Turkish and 0% of Moroccan elderly population resides in a residential nursing home, compared with 5% of the autochthonous Dutch population [33]. Regarding the utilisation of home care services, elderly Moroccan and Turkish migrants use it rarely, respectively 7% and 1%, when compared with the autochthonous older persons (16%). A study of 2012 confirms these data. The Turkish (3,6%) and particularly Moroccan (11,7%) elderly population use home care services significantly less frequently, when compared with the autochthonous elderly population (21,7%) [31].

Common barriers to accessibility and utilisation of elderly care services have been noted, such as the preference for informal family care, the poorer socio-economic situation, the language, return dilemma, financial and cultural and religious barriers [30, 33-38]. Concerning the preference for informal care, Schellingerhout observed that 76% of Moroccan, 56% of Turkish and only 18% of the elderly population in the Netherlands, agree that children should take care of their parents when they have reached old age. In reality, 54% of Moroccan, 30% of Turkish and 10% of Dutch people receive informal care. Regarding the level of education, 76% of Turks, 69% of Moroccans and 24 % of the autochthonous Dutch population encounter difficulties with filling out forms. With regard to their financial situation, the number of elderly with a low income is remarkably high among the Moroccan (86%) and Turkish population (67%) in comparison with autochthonous people (11%) [33]. Concerning the return dilemma, nearly 78% of Moroccan and approximately 72% of Turkish elderly migrants wish to reside in the Netherlands because of their family [31]. Most importantly,

studies show that issues relating to cultural and religious beliefs and practices (cf. gender relations, *ḥalāl* food etc.) are the most fundamental reasons for the low use of institutional elderly care among Muslim migrants [34, 36, 38]. Additionally, Meulenkamp et al. [36] observes a discrepancy between what Muslim migrants find important and what care services deliver or can deliver, certainly in intramural facilities, in the Netherlands. This discrepancy seems to increase when the need of care becomes intensive and the elder has to be admitted into a care facility.

In contrast with Belgium, the Netherlands has taken more measures to address the specific needs of elderly Muslim migrants of Moroccan and Turkish descent [18]. Remarkable, the institutional care that is provided reflects the integration policy of the country involved. The Netherlands seems to adopt the philosophy of multiculturalism in which the care provision takes into account multicultural and individual differences in order to provide care that suits the social environment of every person. In that way, people of other cultures can feel at home in the Dutch society, but can also keep in touch with their own culture. Since the early 1990s, the Netherlands started the interculturalisation of care services [37]. Moreover, the Netherlands has various faith-based, multi- and mono-cultural care services tailored to the needs of Muslim migrants, which are based upon the philosophy that the best care is given by taking background and culture into account [39]. As such, the first department of nursing for Muslims, 'De Rustenburg' in Rotterdam, was created in 2001 by the Council of Public Health and Care. Nowadays, in the Netherlands, cultural and faith-based care organisations are common and present in large numbers [40]. In 2011 a nursing home (Sefkat) funded by the Ministry of Public Health, Welfare and Sport and the Province of Noord-Brabant was built especially for Turkish and Moroccan Muslim elderly people and provides a level of care which is sensitive to culture and religion [41]. Another example is the organisation AAZorg which takes a multicultural approach by matching the ethnic origin of the client with the origin of the healthcare provider. By providing care in the own language this organisation hopes to offer better care [42].

The United Kingdom too allows mono-cultural and faith-based care services. The policies of the United Kingdom are characterised by significant allowance for cultural and religious diversity. The State as a neutral body provides space for different forms of cultural and religious experiences. Examples of categorical elderly care services are the Muslim day care centres 'Care2Care' in Sheffield and 'Muslim Elderly Day Care Centre' in Glasgow. Providing categorical care in the Netherlands and the United Kingdom is based upon the respect for the wish of every elderly person to grow older in an environment that remains familiar (e.g. language, culture and religion) [43, 44]. Germany takes the same route as Belgium. Germany has espoused the idea of 'open neutrality' [45]. As such, the German State sees itself as neutral in matters of religious belief. However, the German government does not prevent private initiatives such as the first nursing home 'Turk Bakim Evi' for Turkish Muslims created in 2006 and a day care service 'Kamil Day Care' for Turkish and Moroccan

elderly Muslims that provides religion-sensitive care [46]. By contrast, in France, where a stronger assimilation model is emphasized, no specific measures are taken at policy level regarding the ageing of migrants. Furthermore, this Republican model, which embraces *laïcité* as the classic answer to religious and cultural differences, assumes that every citizen can participate in society on the condition that the language and culture of the host country is adopted [45].

5. Conclusion

An important limitation of this study is that the available data on elderly care and migrants which was located during research covers only data on the situation of the Flemish Community in Flanders and Brussels. This means that this data is not applicable to the French community in Brussels and Wallonia.

The effective use of and access to the available care services among elderly Moroccan and Turkish migrants in Belgium is hindered by a number of factors such as the language barrier, a low level of education, financial barrier, a series of cultural and religious barriers, lack of knowledge of health care system and the so-called return and care dilemmas. As a result, care facilities are not easily accessible and they correspond insufficiently to their specific needs, which are mainly religiously and culturally rooted (e.g. gender relations, *ḥalāl* food etc.). As a result, Muslim migrants from Turkey and Morocco seem to fall into the gap between the inaccessible provision of elderly care services by the State and the fragmentation of traditional family caregiving.

The inclusive and neutral Belgian policy on the elderly seems to give insufficient attention to the aforementioned issues. By using the general word *allochthonous* when in fact specifically referring to Moroccan and Turkish people, ethnicity and nationality are given less emphasis and religious beliefs and needs are ignored. Indeed, an important lacuna is observed in the literature concerning the specific religious and cultural needs of this population. For this reason and in order to provide and guarantee adequate and respectful elderly care, more research is needed that covers a.o. the beliefs and attitudes of Moroccan and Turkish Muslims regarding illness and health; the role of religious practice/contemplation when reaching old age; the impact of their eschatological beliefs on their daily lives; the role of religion and worldview in palliative care and end of life decision making.

References

1. Barrett DB, Kurian GT, Johnson TM. World Christian encyclopedia: a comparative survey of churches and religions AD 30-AD 2200. New York: Oxford University Press; 2000.
2. Janssens A, Timmerman C. Hoe elkaar de hand reiken? De zoekende interactie tussen de allochtone ouderen en het zorgaanbod in de stad Antwerpen. Antwerpen: Steunpunt

Gelijkekansenbeleid, Consortium Universiteit Antwerpen & Limburg Universitair Centrum; 2003.

3. White P. Migrant populations approaching old age: prospects in Europe. J Ethn Migr Stud. 2006;32(8):1283-1300.
4. Talloen D. Zorg voor allochtone ouderen. Mechelen: Kluwer; 2007.
5. Lodewijckx E. Ouderen van vreemde herkomst in het Vlaamse Gewest: origine, sociaal-demografische kenmerken en samenstelling van hun huishouden. Brussel: Studiedienst van de Vlaamse Regering; 2007.
6. Vassart C. Migration et vieillissement: la situation particulaire des personnes âgées d'origine étrangère en Belgique. Brussel: Koning Boudewijnstichting; 2007.
7. Cuyvers G, Kavs J. De huidige en toekomstige behoeften van allochtone ouderen aan welzijns- en gezondheidsvoorzieningen. Kempen: Katholieke Hogeschool Kempen: Departement Sociaal Werk; 2001.
8. Hertogen J. Aantal moslims in België in 2013. http://www.npdata.be/BuG/239-Moslims-2013/. Accessed 6 June 2015.
9. Statistics Belgium (NSI). Population by nationality, gender, age on 1/1/2010 http://statbel.fgov.be/nl/modules/publications/statistiques/bevolking/population_natio_sexe_groupe_classe_d_ges_au_1er_janvier_2010.jsp. Accessed 4 June 2015.
10. Talloen D, Verstraete J, Chech J. Allochtone ouderen, senioren van bij ons: lessen uit de praktijk. Brussel: Koning Boudewijnstichting; 2012.
11. Lodewijckx E, Pelfrene E. Huishoudensstructuur en solidariteit tussen de generaties bij personen van vreemde afkomst: in: Generaties en solidariteit in woord en daad, Vanderleyden L and Callens M. Brussel: Studiedienst van de Vlaamse Regering; 2012:51-76.
12. Declercq A, Wellens N, Demaerschalk M, De Coster I. De ontwikkeling van een vormingsprogramma over de zorg voor allochtone ouderen in rusthuizen en rust- en verzorgingstehuizen. Leuven: Lucas; 2006.
13. Van der Sypt E. Het belang van interculturaliseren van de ouderenzorg: in: Ouder worden in een veranderende samenleving. Antwerpen; De Kock C, Vens E, Beljoudi Y, Van Kerkckhove C.: Garant; 2014:95-112.
14. Levecque K, Lodewyckx I, Van den Eede S. Gezondheid en gezondheidszorg bij allochtonen in Vlaanderen. Antwerpen: Steunpunt Gelijkekansenbeleid, Consortium Universiteit Antwerpen & Universiteit Hasselt; 2006.
15. Berdai S. Vergrijzing...een kleurrijk gegeven! Brussel: Brusselse Welzijns- en gezondheidsraad vzw; 2005.

16. Patrick Martens. “Allochtone ouderen vinden weg naar zorg niet”. De Knack (2011). http://www.knack.be/nieuws/belgie/allochtone-ouderen-vinden-weg-naar-zorg-niet/article-normal-26881.html. Accessed 5 June 2015.
17. Vande Lanotte J, Bracke S, Goedertier G. België voor beginners: wegwijs in het Belgisch labyrint. Brugge: Die Keure; 2010.
18. Derluyn I, Lorant V, Dauvrin M, Coune I, Verrept H. Naar een interculturele gezondheidszorg: aanbevelingen van de ETHEALTH-groep voor een gelijkwaardige gezondheid en gezondheidszorg voor migranten en etnische minderheden. Brussel: Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu; 2011.
19. Vandeurzen J. Vlaams ouderenbeleidsplan 2010-2014. Brussel: Vlaamse overheid: Department Welzijn, Volksgezondheid en Gezin; 2010.
20. ICM. Het Vlaams beleid naar etnisch-culturele minderheden: jaarrapport 2001. Brussel: Vlaamse overheid: Interdepartementale Commissie Etnisch-Culturele Minderheden, 2001.
21. Bhutani S, Charkaoui B. Bouwsteen VIII: ouderenzorg voor iedereen. Open Forum dag. Brussel: Minderhedenforum; 2005.
22. Vervotte I. Beleidsnota 2004-2009. Brussel: Vlaamse Overheid: Department Welzijn, Volksgezondheid en Gezin; 2004: 46-80.
23. Vervotte I. Vlaams Ouderenbeleidsplan 2006-2009. Brussel: Vlaamse Overheid: Department Welzijn, Volksgezondheid en Gezin; 2007.
24. Flemish Government. Residential decree of 13 March 2009. Brussel: Department of Welfare, Public Health and Family. (2009) http://www.juriwel.be/ws/Export/1017896.html.
25. Vandeurzen J. Nota van de Vlaamse regering. Vlaams ouderenbeleidsplan 2010-2014: Voortgangsrapport 2010-2011 Brussel: Vlaamse Overheid: Department Welzijn, Volksgezondheid en Gezin; 2012: 1-94.
26. Hubo B. Moslimkamers in rusthuis De Overbron. Brussels News: Brussels This Week (2014) http://www.brusselnieuws.be/nl/nieuws/moslimkamers-rusthuis-de-overbron. Accessed 24 October 2014.
27. Coppenolle W. Het recht op godsdienstvrijheid en de neutraliteit van de staat: het recht op godsdienstvrijheid in de multiculturele rechtsstaat. Leuven: Katholieke Universiteit Leuven: Rechten; 2007.
28. Binst JM. Gebrek aan ouderen-woonzorg voor allochtonen wordt nijpend "Steek ons alsjeblieft niet in een rusthuis". Brussels News: Brussel This Week (2011) http://issuu.com/brusselnieuws.be/docs/binder_bdw1305. Accessed 1 December 2011.
29. Liefbroer AC, Mulder C. Op je familie kun je rekenen: opvattingen over familiesolidariteit onder autochtonen en allochtonen. Demos. 2004;20(10):87-88.

30. Choté A, Foets M, Hoefman R, Hofmeester E, Koopmans G, Lötters F. De toekomst van de thuiszorg voor hupbehoevende allochtone ouderen. Rotterdam: Erasmus Universiteit; 2009.
31. Denktas S. Health and health care use of elderly immigrants in the Netherlands. A comparative study. Rotterdam: Erasmus University: University Medical Center; 2012.
32. Yerden I. Tradities in de knel: zorgverwachtingen en zorgpraktijk bij Turkse ouderen en hun kinderen in Nederland. Amsterdam: University of Amsterdam: Faculty of Social and Behavioural Sciences; 2013.
33. Schellingerhout R. Gezondheid en welzijn van allochtone ouderen. Den Haag: Sociaal Cultureel Planbureau; 2004.
34. de Graaff FM, Francke AL. Barriers to home care for terminally ill Turkish and Moroccan migrants, perceived by GPs and nurses: a survey. BMC Palliative Care 2009;8(3):1-9.
35. Celik A, Groenestein P. Het is niet alles (g)oud wat er blinkt: diversiteit in het ouderenbeleid. Utrecht: Forum Instituut voor Multiculturele Vraagstukken; 2010.
36. Meulenkamp TM, van Beek AP, Gerritsen DL. Kwaliteit van leven bij migranten in de ouderenzorg: een onderzoek onder Turkse, Marokkaanse, Surinaamse, Antilliaanse/Arubaanse en Chinese ouderen. Utrecht: Nivel; 2010.
37. den Draak M,de Klerk M. Oudere migranten: kennis en kennislacunes. Den Haag: Sociaal en Cultureel Planbureau; 2011.
38. Verhagen I, Ros WJG, Steunenberg B, de Wit NJ. Culturally sensitive care for elderly immigrants through ethnic community health workers: design and development of a community based intervention programme in the Netherlands. BMC Public Health. 2013; 13(227): 1-8.
39. Serrokh R. Les immigrées au crépuscule de leur vie: parcours et vecus de femmes âgées immigrées marocaines. Lettre de l'IRFAM. 2011;25(1):1-21.
40. Facilitair Netwerk Allochtone Ouderen. Allochtone ouderen en wonen. Utrecht: FORUM Instituut voor multiculturele vraagstukken; 2004.
41. Zorggroep Elde. Verpleeghuis Sefkat. s.d. Available from: http://www.zge.nl/ZGE_C01/ShowDocument.asp?OriginCode=H&OriginComID=1&OriginModID=605&OriginItemID=0&CustID=694&ComID=1&DocID=251&SessionID=&Ext=.pdf. (Dutch version) Accessed September 15 2014. For the Arabic version, see: http://www.zge.nl/ZGE_C01/ShowDocument.asp?OriginCode=H&OriginComID=1&OriginModID=606&OriginItemID=0&CustID=694&ComID=1&DocID=106&SessionID=&Ext=.pdf. For the Turkish version, see: http://www.zge.nl/ZGE_C01/ShowDocument.asp?OriginCode=H&OriginComID=1&OriginModID=607&OriginItemID=0&CustID=694&ComID=1&DocID=50&SessionID=&Ext=.pdf.

42. Bäckes MA, van Barschot M, van Dooren E, van Duijneveldt I, Eigenraam A, van der Kruis A, ter Kuile S, van Lipzig M, Rutgers W, Staal R, Schalk M, Tossaint R, van Veen R, Verschuren J, van Wijck F. Organisaties in de langdurige zorg: vernieuwing en onderscheid 2012. Utrecht: Drukkerij Crezee; 2012.
43. Ingleby D. Getting multicultural health care off the ground: Britain and the Netherlands compared. Int J Migr Hlth Soc Care. 2006;2(3/4):4-15.
44. Sheikh A. Should Muslims have faith based health services? BMJ. 2007;334:74.
45. Joppke C. State Neutrality and Islamic Headscarf Laws in France and German. J Theory and Society. 2007; 36: 313-342.
46. Gülcan K. A cheval entre la Turquie et la Belgique. Témoignages de migrants âgés d'origine Turque de Bruxelles. La lettre d'IRFAM. 2010;22(2):15-21.

2. Muslim Burial Practices and Belgian Legislation and Regulations

1. Introduction

European countries are increasingly challenged by the integration and ageing of their Muslim population. In Belgium Muslim migration began in the 1960s, with large scale settlement of guest workers mainly from Morocco and Turkey. In a few decades, Islam has become the second largest religion in Belgium and even the fastest growing religion in Europe (Shadid & van Koningsveld, 2008; Pew Center, 2015). In 2013, sociologist Jan Hertogen estimated that Muslims counted for 6,5% of the Belgian population (Hertogen, 2013). Today, Belgian society is confronted with the ageing and dying of its first generation of Muslim citizens. Given that Muslims as well as policymakers held the assumption that their settlement in Belgium would only be temporary, policies consisted mainly in providing suitable housing and payment. The establishment of Islamic cemeteries did not fall within the scope of this policy (Kadrouch-Outmany, 2014). It's only up till the 90's, that discussion on burial legislation and Muslim burial rituals emerged on the political agenda. This is a vast contrast compared with neighbouring countries, including the Netherlands, Germany and France where as a result of this early attention a significant amount of literature is available on Muslim burial practices, which is not the case in Belgium.

The aim of this literature review is threefold. First, it seeks to provide an overview of Muslim burial practices in Belgium. As this is a crucial issue and the (only) topic dealt with in the available literature, our focus is primarily on Belgian Muslims' choice of burial location and the underlying reasons for this choice. Second, it aims to identify the way in which Belgian public policies have dealt with the topic of Islamic burial. Third, it seeks to compare Belgian burial regulations and their impact on Islamic burial with those of the neighbouring countries.

2. Methods

For this review, literature relevant to the Belgian context published between 1997 and 2016 in Dutch, French and English has been included. Several databases including PubMed, LIMO, JSTOR and Google scholar were consulted, though the majority of literature has been located through hand searching and reference list searching. The main keywords guiding our search were: Muslim, migrant, Islam*, religion, religious. This terms were crossed with: funeral, burial practices/rituals, policy, legislation, law, regulation, Belgium, Flanders, Wallonia, Netherlands, France, United Kingdom, Germany. Our search yielded 47 references of which 24 theoretical studies, 9 legal/policy documents, 6 empirical studies, 5 reports/essays and 3 news articles. Large scale empirical or legal studies are lacking to a great extent. Grey literature (reports etc.) proved to be an important source of information.

3. Results

3.1. Muslim burial practices in Belgium

Today only a very small minority of the Muslims in Belgium choose to be buried in Belgium. Indeed, approximately 90% of Muslims prefer to be repatriated and buried in the country of origin – for the vast majority this is Turkey or Morocco (Jonker, 2004; Kadrouch-Outmany, 2014; Seuntjens, 2012). No detailed figures exist on the preferences of Muslims regarding choice for burial locations nor on the effective number of Muslim burials in Belgium or repatriations at national, regional or local level. According to the study of Kadrouch-Outmany (2014), the assumption of being repatriated at death to the country of origin, is also shared by younger generation Muslims (75%). In the literature, the following four aspects have been identified as the underlying reasons for repatriation: religious barriers, financial constraints, a lack of knowledge of burial facilities and a sense of belonging. In what follows, we briefly discuss each of these factors.

3.1.1. Religious barriers

Religious aspects of burial seem to be the key reason for the choice of being buried in the country of origin where an Islamic burial is guaranteed. First, Muslims are traditionally buried in a separate Islamic cemetery with each body in a separate grave facing Mecca. The construction of the grave consists of a niche dug out at a side of the grave into which the body is placed (*lahd*) or of a deep vertical grave in which a trench is dug out in the middle. According to Kadrouch-Outmany's research (2014, 2016), the use of *lahd* is not common in Belgium as the soil is not always stable enough. Second, Muslims are buried in shrouds whereas in Belgium this is not allowed everywhere. Kadrouch-Outmany (2014, 2016) observed that in Flanders, where burial in shrouds is permitted, Muslims are often buried in a coffin given that the soil is often not stable enough. Third, deceased Muslims are expected to lie undisturbed in the grave till the end of time. Precisely for this reason many Muslims wish to be buried in the country of origin or ancestors (de Ley, 2004; Jonker, 2004; Kadrouch-Outmany, 2014, 2016; Renaerts, 1997; Seuntjens, 2012). However, this idea of perpetuity in the country of origin has to be nuanced, as graves are also cleared out in big cities after a long amount of time (Kadrouch-Outmany, 2014, 2016). Nevertheless, graves in perpetuity seem to be more assured in country of origin than in Belgium, where often graves are cleared out after a certain amount of time. Consequently, many Muslims seek to be buried in their country of origin. Fourth, burial takes place as soon as possible, preferably within 24 hours as recommended by the Islamic tradition. However, this prescription seems also to be an issue with regard to repatriation, as a burial within that amount of time cannot be met by legal and administrative formalities. Fifth, Muslims themselves traditionally lower the deceased in the grave whereas in Belgium this is not possible everywhere (Kadrouch-Outmany, 2014; Seuntjens, 2012). As a result of the aforementioned issues, the Muslim ritual of burial had to adapt itself to the Belgian juridical rules (de Ley, 2004; Renaerts, 1997). For a large majority of Muslims repatriation is still the best answer.

3.1.2. Financial constraints

Financial aspects too seem to have a deciding impact on burial practices of Muslims in Belgium. Burial in Belgium involves high costs and a large majority of Muslims is already insured to be repatriated (Jonker, 2004; Kadrouch-Outmany, 2014; Kanmaz & Zemni, 2005; Seuntjens, 2012). Kadrouch-Outmany's study (2014, 2016) highlighted that the majority of Muslims opt for repatriation since they have been paying a small annual fee for decades, which assures them that all burial costs are covered but also because of the idea that graves are practically free of cost.

3.1.3. Social aspects

According to Jonker (2004), Kadrouch-Outmany (2014, 2016) and Seuntjens (2012), Muslims have a stronger sense of belonging to their country of origin in matter of burial, contrasting to a sense of belonging to Belgium in everyday matters. Returning to one's roots was frequently mentioned in Kadrouch-Outmany's study (2014, 2016), as an important element in Muslims' choice of where they wanted to be buried, even if they themselves were not born in the country of their ancestors. According to this author, this choice seems also to be fuelled by the growing discussion about dual nationality, the alleged lack of loyalty of Muslims and the failed integration of Muslims into Belgian society (Kadrouch-Outmany, 2014, 2016). With regard to the latter, Kadrouch-Outmany (2014, 2016) and Kanmaz & Zemni (2005) argue that Belgian policy and policymakers have not given sufficiently attention to enhancing the integration of Muslims as full Belgian citizens as they assumed their settlement would only be temporary.

3.1.4. Lack of knowledge of burial facilities

The low rate of burial in Belgium among Muslims might be explained by the insufficient knowledge Muslims have of existing burial facilities in Belgium. Studies (Kadrouch-Outmany, 2014; Seuntjens, 2012) pointed out that a majority of Muslims is not aware of the existence of Islamic or Mecca-oriented plots. Furthermore, Kanmaz and Zemni (2005) argued that this lack of knowledge might be explained by a lack of involvement and active efforts of the Muslim community itself, as well as of the Muslim Executive of Belgium, the official Muslim interlocutor with the Belgian Federal government. In line with this statement, Seuntjens study (2012) stated that mosques do not provide information on existing burial facilities.

The fact that a majority of Muslims expect to be repatriated to the country of origin at death, does not imply that this practice is not accompanied by a number of issues. First, dealing with grief becomes more difficult for the bereaved due to the distance between the deceased and the bereaved (de Ley, 2004; Kanmaz & Zemni, 2005; Seuntjens, 2012). Second, in any case the burial cannot take place in a fast pace as recommended by the Islamic tradition (Kadrouch-Outmany, 2014). Third, high costs are involved, though to a lesser extent when compared with the cost of concessions in Belgium,

certainly when the deceased is not insured (Kanmaz & Zemni, 2005; Seuntjens, 2012). Fourth, this option encompasses complex administrative formalities which seem to be time consuming (Jonker, 2004; Seuntjens, 2012).

The practice of repatriation is certainly not a static fact. The scarce available literature suggests that a shift is taking place in the burial landscape of Belgian Muslims. A minority of Muslims is buried in Belgium including children, political refugees and Belgian converts (Kadrouch-Outmany, 2014, 2016; Kanmaz & Zemni, 2005). Additionally, in the future generations of Muslims, an increase is expected in the number of burials (de Ley, 2004; Jonker, 2004; Kadrouch-Outmany, 2014; KMI, 2013; Renaerts, 1997; Seuntjens, 2012). Though no hard data are available on the effective burials in Belgium as well as on the preferences of burial location among older and younger Muslim generations. This assumption is based upon the expected increase of this population, alongside the assumed weakening bond with the country of origin. Given the fact that later generations were born and raised in Belgium, an increase in demand for burial in Belgium is expected (de Ley, 2004; Jonker, 2004; Kadrouch-Outmany, 2014; KMI, 2013; Renaerts, 1997; Seuntjens, 2012). According to Jonker (2004), Kadrouch-Outmany (2014) and Seuntjens (2012) younger Muslim generations think about burial in Belgium, but at the same time this idea generates a quandary of loneliness and not sharing the same ground of ancestors.

3.2. Belgian regulations regarding cemeteries and corpse disposal

Actual Muslim burial practices cannot be seen separately from the existing legal and organisational framework. Until recently, Belgian authorities devoted little attention to the issue of Islamic burial in this country. It was the disappearance of the young Loubna Benaïssa, or rather the subsequent discovery of her remains in 1997 which brought the issue of Islamic burial under attention and led to several legal proposals in this regard (de Ley, 2004; Kadrouch-Outmany, 2014, 2016; Kanmaz & Zemni, 2005; Seuntjens, 2012). As a result, regulations have been revised at several policy levels in order to meet Islamic burial requirements. In order to understand these revisions, some background information regarding the history of cemeteries in Belgium is necessary.

3.2.1. At federal level

The strong emphasis on neutrality of Belgian law and policy and its reticence regarding the creation of separate religious cemeteries and plots cannot be seen separately from the history of cemeteries in Belgium (Kadrouch-Outmany, 2014). In the nineteenth century, the code of Napoleon was still in force and more specifically, article 15 of the decree of Napoleon in 1804 (23 Prairal an xii) permitted the establishment of separate cemeteries and plots for religious communities (Catholics, Protestants, Jews) with different entrees (Christians, De Pooter, & Tilkin, 2011; Kadrouch-Outmany, 2014, 2016; Lamberts, 1986; Morelli, 2008). However, this seemingly pluralistic approach did not cover or include those who were not adhering to a specific church and those who were denied a Christian

burial for canonical reasons (Kadrouch-Outmany, 2014; Lamberts, 1986; Morelli, 2008). At that time, most of the cemeteries where Catholic, but fell under the authority and supervision of the municipalities. Catholic cemeteries established many separate plots where those deemed 'unworthy' were buried. These were situated on the outskirts of the cemetery (Lamberts, 1986). In 1873 tensions between Catholics and liberals led to 'the cemetery war' (Christians et al., 2011; Kadrouch-Outmany, 2014, 2016). Liberals advocated for a secularisation of cemeteries arguing that everyone should be buried next to each other (Kadrouch-Outmany, 2014; Lamberts, 1986; Morelli, 2008). In 1879, the decree of 1804 was revised. The further establishment of separate plots for the 'unworthy' was prohibited; the property of cemeteries had to be reverted to the municipalities (Lamberts, 1984). From then onwards people were buried on cemeteries without distinction upon the basis of religion or faith (Christians et al., 2011; Kadrouch-Outmany, 2014, 2016; Morelli, 2008).

In 1971, the burial law was revised (Burial Law, 1971). This revised law stipulated the general conditions for the organisation of burials and abolished three elements. First, the controversial article 15 was abolished meaning that cemeteries could no longer be submitted to confessional rules, but had to be subject to the principle of neutrality (Christians et al., 2011). Second, the establishment of new private cemeteries was no longer possible (de Ley, 2004; Kadrouch-Outmany, 2016). Burial is only possible in municipal and intermunicipal cemeteries administered by local authorities (art. 16§1). Therefore, cemeteries fall under the authority and supervision of the local municipality and police (art. 4). Nonetheless, private cemeteries that already existed before this law was promulgated, for instance monasteries, could be still maintained (Christians et al., 2011). Third, the eternal concession was abolished. Concessions are only granted for a maximum term of fifty years (art. 7). This decision was based upon the fact that less people were demanding an eternal concession, but also the result of an increased shortage of space in the cemeteries (Kadrouch-Outmany, 2014, 2016; Seuntjens, 2012).

The topic of Islamic burial emerged with the discovery, in the wake of the Dutroux affair, of the remains of Loubna Benaïssa in 1997. Loubna, a nine-year-old Moroccan Muslim girl from Brussels, was kidnapped in 1992 and it was only after five years that her body was found in the basement of a gas station, near her parental home. The bereaved family found out that it was not possible for Loubna in Brussels to be buried according to Islamic burial rituals. Thus Loubna had to be repatriated to the country of origin (de Ley, 2004; Kadrouch-Outmany, 2014; Kanmaz & Zemni, 2005; Seuntjens, 2012).

As a result of this public attention, in May 1997 the topic of Islamic burial was raised during debates in the Belgian Senate. More specifically, issues related to Islamic burial facilities were addressed including the question of separate cemeteries with graves facing towards Mecca, burial without coffin and graves in perpetuity (Christians et al., 2011; Kadrouch-Outmany 2014, 2016;

Kanmaz & Zemni, 2005; Renaerts, 1997). During this debate, the Minister of Interior, Vande Lanotte (1994-1998), made it clear that the realisation of plots for Muslims, defined as graves elevated towards Mecca, could be possible under certain conditions, however, no exception were to be made to the legal articles of Burial law of 1971 regarding the obligation of burial in a coffin (art. 12) and the abolition of graves in perpetuity (art. 7). The Minister went on to state that 'an exception for private cemetery only exists for monasteries. Some have thought mistakenly that a separate cemetery for the Islamic community could be established based upon this exception'. (Senate, 1997). In other words, the Islamic community was not allowed to set up private cemeteries; this right was reserved to monasteries only. The discussion led to a circular issued by the Council of Ministers in 2000 dealing also with the setting up of Islamic plots in public cemeteries (Christians et al., 2011; Kadrouch-Outmany, 2014, 2016). First of all, this circular strongly stressed that burials are only possible on municipal and intermunicipal cemeteries. However, it was mentioned in the circular that based upon article 16§3 'an exception to the obligation of a burial in a municipal cemetery (art. 16§1) could me made upon religious and philosophical reasons. […]. This possibility was created with the aim to avoid extensive exhumations as burials in private places were once common among the monastic orders. The establishment of private cemeteries can only be authorized by the Minister of Public Health under certain conditions'. (Federal Ministerial Circular, 2000). An exception for the Muslim community was thus not provided (Christians et al., 2011). Second, this circular also emphasized three fundamental principles that should characterize cemeteries; (a) a municipal character meaning that burial is only possible in public cemeteries (viii, 1); (b) a neutral character meaning that no distinction is made based upon religion or philosophical belief (viii, 2); and (c) the municipal authority should not decide who is and who is not to be buried in the cemetery (viii 3)(Federal Ministerial Circular, 2000). The circular stated that the earlier burial law (1971) did not exclude the arrangement of separate plots for adherents of a specific religion or philosophical conviction, by which graves with similar external characters can be grouped together. Nevertheless, three conditions were linked to this provision. First, the plot must not be physically isolated from the rest of the cemetery but may be separated by a hedgerow. Second, a separate access to the plot is possible under the condition that it remains within the confines of the cemetery. Third, burials must be in compliance with the regulations with regard to hygiene and public health (viii, 3) (Federal Ministerial Circular, 2000). Despite the possibility of creating this space, it is mentioned explicitly that municipalities are not obliged to provide this arrangement (Christians et al., 2011).

Another important development related to Islamic burial, was the revision of the burial law of 1971 in 2001 in what has become known as the Lambermont-agreement, i.e. the collective name for three political agreements made in 2000-2001 on the further adjustment of the federal constitution. Regarding our topic, this agreement stipulated that the authority responsible for cemeteries and corpse disposal is not anymore the federal but the regional government (Christians et al., 2011; de

Ley, 2004; Janssens, 2016). Therefore, the regional governments are authorized to develop their own regulations.

3.2.2. At regional level

A consequence of the fact that the regions now have the final authority over cemeteries and corpse disposal is the fact that there are important differences between the regions (Flanders, Wallonia, Brussels Capital) in the way they accommodate the burial needs of Muslims (Christians et al., 2011; Kadrouch-Outmany, 2014).

In 2004, the Flemish region was the first to create its own rules regarding cemeteries and corpse disposal that replaced the federal burial law (Christians et al., 2011; de Ley, 2004; Hudson, 2016; Jonker, 2004; Kadrouch-Outmany, 2014; KMI, 2013). The Flemish decree of 2004 made two important adjustments that had a direct impact on Muslim burials, i.e. the possibility of burial in shrouds and the adjustment of the concession. This decree created the possibility to renew a concession for a period of maximum 50 years (art. 7§1). Nevertheless, a renewal can be refused when it is proved that the grave has been neglected (art. 7§2). The second adjustment is related to the corpse disposal: it is no longer legal obliged to be buried in a coffin (art. 11) (Flemish Decree, 2004). For the latter decision ecological and not religious reasons were given (Kanmaz & Zemni, 2005).

The Flemish ministerial circular (Flemish, Ministerial Circular, 2006) regarding the application of the decree of 2004, which dealt with the corpse disposal of a deceased that followed a certain religion or belief adopted the same three fundamental characters of cemeteries regarding Islamic plots that were included in the federal circular of 2000.

In 2009, Wallonia issued a decree (L-1232-2&4) that replaced the federal law and went in force in 2010 (Wallonian Decree, 2009). The content of the federal law as well as the three fundamental characteristics of cemeteries that were included in the federal circular remained the same in the decree of Wallonia. With regard to the use of shrouds, Wallonia still prescribes a coffin and does not mention shrouds in her decree (art. L-1232- 17 & 18) nor in the circular of 23 November 2009 of the Minister of Wallonia. Nor was any adjustment made regarding the duration of the concession (Christians et al., 2011; Wallonian Ministerial Circular, 2009).

In contrast with Flanders and Wallonia, the region of Brussel-Capital has not issued yet an ordinance that replaces the federal law nor did it decide upon the theme of confessional plots (Christians et al., 2011; Kadrouch-Outmany, 2014). In an ordinance of 26 July 2013, this region has accepted burial without a coffin (Brussels-Capital Ordinance, 2013), though this possibility has not been operative yet (Hudson, 2016; Le Soir, 2015).

3.2.3. At local level

At local level, municipalities enjoy great freedom in the organisation and management of cemeteries as no legal obligation exists (Hudson, 2016; Janssens, 2015; KMI, 2014). Nevertheless, policies must be in accordance with Belgian law and constitution and with regional regulations. Due to the neutral character of the government, municipalities are urged to treat everyone equally and to guarantee the freedom of worship (Federal Ministerial Circular, 2000). Despite the existing legal apparatus, Kanmaz & Zemni (2005) argue that Muslim communities feel dependent on the goodwill of the local authorities. The terms of concession depend from municipality to municipality. Municipalities are free to decide in their municipal acts the length of the period graves may be granted. According to Kadrouch-Outmany's research (2014, 2016), more than half of Belgian municipalities' cemeteries offer an extension period of 30 or 50 years for graves with concession. Another example is that in Belgium permission of burial by the municipality can be granted only 24 hours after death, but since no federal law is regulating this matter, several municipal acts offer an exemption to this rule, allowing a speedy burial (Kadrouch-Outmany, 2014, 2016). Concerning Islamic mourning and grave rituals, these can be implemented in all freedom in several municipalities. For example in Ghent, Muslims can seal the grave themselves under the supervision of a municipal officer (Seuntjens, 2012).

From the literature a clear diversity can be identified among municipalities in the way they arrange cemeteries to meet the needs of Muslims. This diversity can be divided in three groups.

The first group are municipalities who explicitly reject the establishment of an Islamic plot. A few municipalities and politicians resisted vehemently against this provision emphasising its contradiction to the principle of neutrality of cemeteries, while referring to ghettoising and desecularisation of cemeteries (de Ley, 2004; Kadrouch-Outmany, 2014, 2016; Kanmaz & Zemni, 2005). Arguments of lack of space and the financial cost too have been brought up as counterarguments to the establishment of Islamic plots (Kadrouch-Outmany, 2014).

The second group are municipalities who are not willing to create a plot for Muslims solely, based upon the conviction that every person, regardless of nationality, race, and religious or philosophical belief should be buried fraternally next to the other (KMI, 2007). Hence, they found a solution in creating Mecca-oriented plots i.e. graves facing towards Mecca which are not reserved for Muslims exclusively, but are individual graves for Muslims and non-Muslims. This is the case in Mechelen and Ghent (Jonker, 2004; Kadrouch-Outmany, 2014; Seuntjens, 2012). In this respect, it must be noted that although the discussion on a Mecca-oriented plot in Mechelen has been ongoing since 2004, the effective implementation of this establishment has only been accepted in September 2016 by the council meeting of Mechelen (De Morgen, 2016; De Standaard, 2016). According to Jonker (2004), these municipalities adopt the secular (*laicistic*) principle of neutrality. They want to

meet the expectations of Muslims on the one hand and not take a step back in the liberalisation of death in which equality and inclusion is guaranteed on the other hand.

The third group are municipalities that established Islamic plots to accommodate the needs of Muslims. According to Kadrouch-Outmany's research (2014), about 17% of the Belgian municipalities included in the research (*n*=267) realised an Islamic plot in their cemetery in the conviction that this establishment is in accordance with the neutrality and equity principle. Today, there are 33 Islamic plots of which the majority are located in Flemish municipalities (Christians et al., 2011; Hudson, 2016; KMI, 2014).

3.3. Islam and Burial legislation in Neighbouring Countries

Not only Belgium, but several European countries, including the Netherlands, the United Kingdom, Germany and France are challenged by the issue of Islamic burial. In what follows, we briefly discuss burial regulations and burial organisation and their impact on Muslim burial practices in the neighbouring countries.

3.3.1. The Netherlands

The first law on burial and cremation of 1869 secured religious communities the right to denominational cemeteries (art. 14), with own rules and regulations (art. 37), and to parts in public cemeteries (art. 19) which made the creation of Islamic cemeteries and plots possible (Van den Breemer & Maussen, 2012; Kadrouch-Outmany, 2016). In the beginning of twenty-first century the representative body of Dutch Muslims (CMO) was created. It plays an advisory role in representing the interests of Islamic communities in relation with the Dutch government (Szumigalska, 2015). Several commissions were established to advise the Dutch government in matters related to the integration of Muslims, including the facilitation of Islamic burial in the Netherlands such as Platform Islamic Burial Amsterdam (2004) and the study group Islamic Cemeteries Brabant (2005) (de Jong, 2012). In 1991, the law of 1869 was revised. The new Burial and Cremation Act of 1991 removed a number of obstacles for Muslims and adherents of other religions (Dessing, 2001; Shadid & van Koningsveld, 2008; Szumigalska 2015). This act no longer requires the deceased to be buried in a coffin and makes shrouds legally possible in all Dutch municipalities. In addition, burial within 36 h became possible as well as burial on Sundays and holidays (De Jong, 2012; Kadrouch-Outmany, 2014, 2016). In this respect, however, Szumigalska (2015) points out that a burial within 36h is not automatically guaranteed, but can be made if permission is granted by both mayor and public prosecutor. Despite the fact that the Netherlands accommodated several prescriptions of Islamic burial, public cemeteries do not offer graves in perpetuity. Thus, public graves are only granted for a maximum of 10 years contrary to a private grave which can be granted for a minimum of ten years to an unlimited period (de Jong, 2012; Dessing, 2001; Kadrouch-Outmany, 2014, 2016). Two kinds of cemeteries are distinguished in the burial law – the municipal and special cemeteries. Special

cemeteries refer to cemeteries held by for example religious communities. The law does not explicitly regulate the conditions of the establishment of Islamic cemeteries or delimited areas of municipal cemeteries (Szumigalska, 2015).

Today there are 70 Islamic plots within public cemeteries – the first was established in The Hague (1932) – and one private Islamic cemetery in Almere (2007). Some Dutch municipalities also even take into account the existing diversity within the Islamic community and thus provide Islamic plots for different religious denominations. For example, the Islamic plot of the municipal graveyard of Westduin in The Hague, established in 1994, is internally divided into seven subplots separated by hedgerows. It is divided among seven different Islamic organizations belonging to three different Islamic denominations i.e. Sunni, Shia and Ahmadiyya Muslims (Dessing, 2001; Kadrouch-Outmany, 2014, 2016).

3.3.2. The United Kingdom

The authorities respond more inclusively and more positively to the burial needs and demands of Muslims (Ansari, 2007). Furthermore, Muslims have successfully negotiated accommodation of religious practices in a range of public spheres and arenas of policy including burial arrangements (Gilliat-Ray, 2015). The provision of Islamic plots and the allowing of Islamic cemeteries are based upon the equity principle, which implies that Muslims are entitled to the same rights as others in creating denominational structures based upon religious freedom. Additionally, burial with shrouds has been made possible since the Burial in Wool Act of 1667 (Jonker, 2004). Moreover, additional measures have been taken to accommodate the needs of Muslims by making weekend burials possible (Wolfe, 2000). With regard to concession in public cemeteries, two general types of graves are offered, on the one hand an unpurchased grave which is granted generally for maximum 14 years and on the other hand, a purchased grave which can be rented for a maximum of 100 years. Nevertheless, non-municipal burial grounds can make up their own rules and provide graves in perpetuity (Home Office, 2004). A growth of British Muslim funeral services and burial grounds is observed (Gilliat-Ray, 2015). Several Islamic plots in public cemeteries as well as private Islamic cemeteries exist today in the UK, including in cemetery of Brookwood, the Muslim cemetery in Glasgow, and Gardens of Peace in London (Hunter, 2015; Hussain, 2014; McLoughlin, 2012; Mustapha, 2016). Also, a range of Islamic organisations has been established to facilitate an Islamic way of dealing with life and death including the national Muslim Council of Britain and the Muslim Burial Council of Leicester (Hussain, 2014).

3.3.3. Germany

In Germany, only churches and religious communities have the legal status of public law corporation (*Körperschaften des öffentlichen rechts*) and can establish denominational cemeteries. However, this

is difficult to obtain (Rohe, 2014). Germany is a federal state that consists of 16 states that are responsible for their burial legislation. Laws thus vary from state to state. The role of religion in the public sphere is slightly different between the states too. The German constitution provides that State and religion are separate, even though this separation does not prevent cooperation between religious communities and the State (Spielhaus, 2015). In Germany, several umbrella organisation have been founded that control and support Muslim communities including the *Koordinationsrat der Muslims in Deutschland* (Council of Muslims in Germany) and *German Islam Konferenze* (German Islam Conference) (Ferrari & Bottoni, 2015; Rohe, 2012; Spielhaus, 2015). A few Islamic public and private cemeteries exist; there are also more than 70 Islamic plots in cemeteries run by the state or by Christian churches (Rohe, 2012). Till today, Islam is still not recognised as a corporation of public law and thus cannot own any cemeteries. Muslim burial sites are in nearly all cases parts of municipal cemeteries (Rohe, 2016). The state of North-Rhine Westphalia modified its funeral law code in 2014, now allowing funerals without coffins – also permitted in Hesse since 2013 – burial 24 h after death and facilitating the establishment of cemeteries by religious communities which no longer requires the particular status of a corporation under public law (Jonker, 2004; Rohe 2014, 2016). The possibility of a grave for more than the usually permitted period of 10-20 years are broadened but are not assured in perpetuity (Rohe, 2014).

3.3.4. France

Today France embodies a system of strict separation between public authorities and religious groups that would entail very limited if any relation between state and religion. The state does not recognise any religious groups but they are submitted to a regime of private law. The French Council of Muslim Faith (CFCM) – which is the representative body of Islam – has been established in order to address and discuss aspects of Muslim religious practices (Fornerod, 2016). Cemeteries in France are regarded as a neutral public space where French citizens are united and where individual freedom, equality and neutral treatment for every person is guaranteed. Since 1804, the Napoleon Decree has abandoned confessional cemeteries with the exception of some Jewish and Protestant cemeteries and only in 1881 were separate confessional parcels legally prohibited (Van den Breemer & Maussen, 2012). Article 28 of the 1905 law on the separation of Church and State prohibits religious symbols on the public parts of the cemetery, though symbols are permitted on individual graves (Fornerod, 2016; Van den Breemer & Maussen, 2012). Given the French principle of *laïcité*, there is theoretically no legal possibility of religious burial places in public cemeteries (Zwilling, 2016). The laws of 1881 and 1884 prohibited the establishment of confessional divisions in municipal cemeteries and stated that cemeteries, are public, mandatory and *laïc* (Selby, 2015). In other words, managing cemeteries and burials is a public service and falls under the authority and supervision of the municipality. Although the courts have recognised the ability to maintain existing denominational cemeteries, no new religious privately run cemetery can be created (Fornerod, 2016). Fornerod

(2016) states that the regulation of denominational burial places is marked by uncertainty from a legal point of view. Although it is constrained by *laïcité*, France does have two Islamic cemeteries (l'ile de Reunion in 1857 and Bobigny in 1937) as a result of historical circumstances as well as 75 Islamic plots (*carré*) on public cemeteries with the permission of the Ministry of Interior (Aggoun, 2006; Fregosi, 2012; Zwilling 2016). In 1975, 1991 and 2008 the Ministry of Interior Affairs published a circular in which mayors were encouraged to create Islamic plots, but it did not oblige it as it would be regarded as a rupture with the constitutional principle of *laïcité* (Aggoun, 2006; Fornerod, 2016; Van den Breemer & Maussen, 2012). The result is a plot without legal and formal status described as a grouping of graves according to confessional lines as the sum outcome of individual choices (Van den Breemer & Maussen, 2012). Burial without a coffin is still forbidden. Inhumation within 24h is not possible nor are unlimited leases of graves provided. An exception is this regard, is the region of Alsace – where the law on recognised religion is still applicable – that inaugurated its first municipal Muslim cemetery in Strasbourg in 2012 (Fornerod, 2016; Frégosi, 2012; Zwilling, 2016). Although a strong *laïcité* is emphasized, it does however not mean that no cooperation exist. Indeed, the French State does subsidise for instance chaplaincy and does permit private initiatives including Islamic schools (Fornerod, 2016; Zwilling, 2016).

In the following table, we offer an overview of the possibilities of Islamic burial according to the regulations in Belgium and its neighbouring countries (Table 1).

Table 1. An overview of the possibilities of Islamic burial according to the regulations in Belgium and its neighbouring countries

Burial Regulations	Islamic plots in public cemeteries	Public Islamic cemeteries	Private Islamic cemeteries	Burial with shrouds	Graves in perpetuity	Renewal of concession
Belgium	✓	-	-	✓*	-	✓*
The Netherlands	✓	✓	✓	✓	-	-
The United Kingdom	✓	✓	✓	✓	-	-
France	✓*	-	-	-	-	-
Germany	✓	✓*	✓*	✓*	-	✓*

*Variety within country (from region/state to region/state]

4. Discussion

In Belgium burial regulations have been revised several times in order to accommodate Islamic burial. Importantly, this sensitive discussion seems to be inherently linked to the conception of the relation between State and Church and the interpretations of neutrality but also of the principles of equality and of religious freedom.

The notions of neutrality and equality are, however, ambiguous and can and are interpreted in different ways. Differences are observed between municipalities upon the basis of their interpretation of neutrality. Basing itself on the equity principle the Belgian burial regulation stipulates that every person has a right to a similar piece of ground in Belgian public cemeteries (Federal Ministerial Circular, 2000). But this can be interpreted in two ways. On the one hand, every person has the right to be buried in a municipal cemetery and is equal in death; no distinction is to be made upon the basis of religion or faith, in order to counteract discrimination and ghettoisation in cemetery and burial (de Ley, 2004; Seuntjens, 2012). Therefore, allowing Islamic burials and plots is considered a regrettable backward step as far as the secular neutrality of public institutions is concerned (Kanmaz & Zemni, 2005). According to this interpretation of neutrality, separation between Church and State means that any religious concept must be relegated to the private sphere and thus no adjustment can be made upon the basis of religion. According to de Ley (2004), this interpretation of laicity harms the fundamental right of religious freedom.

On the other hand, neutrality in the cemetery can be interpreted as citizens buried in the same burial area, but each with it owns characteristics in which religious freedom is respected. This more 'open' interpretation of neutrality implies a certain guarantee of religious freedom. In this respect, Kanmaz & Zemni (2005) argue that the request for a separate burial ground is not a question of apartheid but a question of religious sensitivity and equality. The integration of Muslims into Belgian society as full citizens requires also the possibility of being buried according to their own rites in the country where they have been living. If not, Muslims are expelled or obliged to send their deceased loved ones to the country of origin or country that they have barely known, and thus are deprived of the possibility to visit regularly the graves of their deceased loved ones (de Ley, 2004; Kanmaz & Zemni, 2005). In conclusion, these different interpretations of neutrality were clearly remarkable among municipalities in their decision (not) to establish Islamic or Mecca-oriented plots.

Burial regulations also seem to differ from region to region. Hence, it is remarkable that Wallonia and Brussels-Capital have made less efforts to meet the burial needs of Muslims (e.g. shrouds, graves in perpetuity) when compared to Flanders (Flemish Decree 2004). In contrast with Flanders, Brussels-Capital has not yet issued its own burial regulation nor has this region and Wallonia dealt extensively with the issue of Islamic burial. In Wallonia and Brussels burial in shrouds and graves in perpetuity are still not possible. It is a striking observance that the region of Brussels-Capital, though it has the largest Muslim population in Belgium, still has not succeeded in accommodating the burial needs of Muslims. Nonetheless, the changes that were made in Flanders, were only applied when they were beneficial for everyone. In other words, no adjustment were made upon a religious or cultural basis. According to Kanmaz and Zemni (2005), the use of shrouds for example has been permitted upon an ecological basis. The possibility of providing specific plots has to be seen within a larger picture in which this option is not new but had already been provided for

war veterans, children and the monastic community and subsequently for urn fields and columbaria too. So it could be argued that no exception was made for Muslims. It is also worth mentioning, with regard to this possibility of reserving plots for certain groups that unlike the federal document the Flemish document did not mention the Islamic faith specifically but referred in general to 'religious and ideological groups' (Christians et al., 2011). In other words, Flanders seems to avoid any specific ideological or religious note in their regulations, which gives a glimpse of their rather strict interpretation of neutrality.

Closely related to the Church and State relation, the integration and institutionalisation of Islam seem also to affect the discussion on Islamic burial. Belgium adopts the system of 'recognised religions' by which ecclesiastical administrations are responsible for the temporal needs of the religious communities (Fadil, 2012). Islam was recognised in 1974 and only in 1999 the representative organ of Islam (Muslim Executive of Belgium) was established (Janssens, 2016). The representation issue and the lack of a hierarchically structured religious ecclesiastical administration seems also to have dominated and impeded the discussion on Islamic burials (Kadrouch-Outmany, 2014).

Belgium and its neighbours all have established plots for Muslims in its public cemeteries, though differences exist in status and form of these plots (*cf.* Islamic/Mecca-oriented plot, *carré*). An Islamic plot is defined as a separate plot with graves into the direction of Mecca, exclusively for Muslims, whereas in a Mecca-oriented plot, e.g. in Belgium, graves are faced towards Mecca, but are considered individual graves meaning that Muslims and non-Muslims are buried next to each other. In contrast, a *carré*, which exists in France, is not considered officially a Muslim section nor as an official part of the cemetery. With regard to the establishment of Islamic public cemeteries, the Netherlands, the United Kingdom and a few states in Germany –unlike Belgium and France– do recognise and allow the establishment of confessional public cemeteries.

In contrast with Germany, the United Kingdom and the Netherlands, Belgium and France seem not be in favour of the establishment of private Islamic cemeteries as this seems to intervene with their interpretation of neutrality. In this regard, it seems that Belgium prefers an inclusive policy in which every person is buried in public cemeteries without the creation of categorical structures. However, it must be noted that this establishment is only possible in some states in Germany. Also, a few exceptions exist in Belgium and France which are solely related to historical cemeteries and which leave thus no room for private Islamic cemeteries. A few historical private (confessional) cemeteries are still maintained after the amendment of the law stating that cemeteries are a municipal matter. With regard to the use of shrouds, France is the only country who does not allow this practice at all. However, it is important to mention that variety exist in the allowing of this practice among regions or states within one country, including Belgium and Germany. Regarding graves in

perpetuity, in none of these countries Muslims can find eternal peace. In contrast with France and Belgium, Germany, the Netherlands and the United Kingdom do allow private Islamic cemeteries to create their own regulations and thus enable them to provide graves in perpetuity. Belgium and Germany sought to find a solution for this issue by providing the possibility of concession renewal.

Legal possibilities for Islamic burial thus differ considerably from country to country. In an important way these differences reflect different approaches regarding State/Church relations. Of course Belgium and it neighbours share the principle of religious freedom and of equality. However, the precise way in which these principles are interpreted and applied to Islam depends largely on historical traditions concerning the relation between State and religion.

In the Netherlands, the separation of Church and State was introduced in 1848 (Kadrouch-Outmany, 2014). The Netherlands aims to achieve governmental neutrality by a principled pluralism that welcomes and supports all religious and secular structures of belief (Berger, 2015; Van den Breemer & Maussen, 2012). For the Dutch government, freedom of religion includes adapting laws of burial in order to accommodate specific religious practices (Berger, 2015). Similar to the Netherlands, the United Kingdom is shaped by an established Church and at the same time adopts multiculturalism as the appropriate model regarding public sphere. There is no written constitution governing the status of religion. The English legal tradition and Human Rights Act (1998) guarantee religious freedom and religious practice within the limits of public order (McLoughlin, 2012). In opposite, in France, under the separation regime established by the 1905 law, no religion is officially recognised nor funded, as such all religious communities are to be treated equally. The Republican citizenship model and *laïc* separation of religion and politics significantly shape the lives of French Muslims. Burial grounds have been a point of discussion given that *laïc* laws dictate that there should be no separate or specially marked plots areas. In contrast, the establishment of private Islamic schools and institutes is, however, possible based upon the freedom of education (Fornerod, 2016; Selby, 2015). Though, a notable exception exist in department of Alsace and Moselle, where the law on secularism is applicable and thus where religions can be officially recognised and receive public funding (Selby, 2015; Van den Breemer & Maussen, 2012). The French regime exemplifies a more strict separation model with the constitution stipulating that France is a secular Republic (Van den Breemer & Maussen, 2012). In contrast with the Netherlands and the United Kingdom and similar to Belgium, Germany sees itself as neutral in religious belief (Rohe, 2012).

According to Fadil (2012) and Kanmaz & Zemni (2005), the Belgian Constitution of 1831 emphasizes equality, religious freedom and neutrality. Neutrality is often defined as religion that is put into the private sphere and does not interfere with the public domain. The Belgian government seeks to maintain the neutrality principle by which every person is treated equally without making distinctions between people upon the basis of religious or ideological affiliation (de Ley, 2004;

Kanmaz & Zemni, 2005). Yet, Belgian law does allow public authorities to recognise and finance various religions (Fadil, 2014).

However, it is worth noting that though in Belgium this strict, exclusive and rather French interpretation of neutrality may be present in the laws and regulations regarding cemeteries, this is certainly not the case for many other domains. Not only in the Netherlands, but in Belgium too (especially Flanders), the so-called pillarisation system has been known for creating powerful denominational structures in many fields including health care, education, labour unions, finance etc. This pillar system is defined as an establishment of (state-subsided) functions or structures based upon philosophical or religious beliefs (Dobbelaere & Laermans, 1998). This comprehensive system – in Flanders the Catholic 'pillar' was (and to a lesser degree still is) very powerful – does however not cover cemeteries and inhumation.

How then to explain the rather exclusive neutrality regarding cemeteries if it was a more inclusive understanding of neutrality, based upon the constitution, which has made the pillarisation in most other domains possible? For an answer we have to look to the specific historical context of the nineteenth century regarding cemeteries in which the power over cemeteries fell completely in due course from the hands of the church into those of the municipalities which led to their secularization as we discussed earlier. Lamberts (1986) argues that in that period Catholics did succeed in establishing a net of Catholic schools, though a pillarisation of cemeteries was not realised. Lamberts (1986) explains this development by stating that Catholics gave the priority to education rather than cemeteries as it was from a legal point of view easier to establish schools based upon the Constitution than to maintain cemeteries as article 17 of the Constitution (1831) explicitly defined the freedom of education ("Education is free").

We can thus basically distinguish three different interpretations of neutrality and religious freedom in the public sphere. The first type are countries like the Netherlands and the United Kingdom, which appears to be characterized by an active pluralism regarding the expression of religion in the public sphere. Religious freedom and equity are guaranteed by meeting the needs of the diverse groups and individuals in society and thus also by providing a burial that is in line with the characteristics and identity of the deceased. In these countries, public and private Islamic cemeteries are allowed. It seems that in these countries the institutionalisation of Islamic burial places is the strongest in contrast with other countries. However, it must be noted that a stronger institutionalisation of other domains (cf. media, education, chaplaincy) has been observed in Belgium, France and Germany, whereas the domain of burial has received little attention till today (Fornerod, 2016; Hudson, 2016; Rohe, 2014; Zwilling 2016). The second type is characterized by a strict secular attitude towards any religious expression. The secular neutrality relegates religion out of the public sphere as a way to guarantee equity. To this type belongs France, which guarantees

religious freedom, but not at the expense of its *laïcistic* principle. As such, France seeks to accommodate the burial needs of Muslims without compromising or hazarding its strict secular neutrality. Therefore, the establishment of private Islamic cemeteries nor burials in shroud seem to be possible. The third type, to which Germany and Belgium seem to belong, takes up a middle position between religious pluralism – embracing religious freedom – and strict secular neutrality. According to De Pooter (2010), Belgium indeed fluctuates between the two dominant interpretations of neutrality (inclusive vs exclusive). Nonetheless it is important to note that this typology cannot be regarded as black-and-white, given also the fact that an important variety exists between states or regions within these countries for example regarding to renewal of concession.

In sum, significant differences, linked to different interpretations of neutrality and religious freedom in the public sphere, can be perceived between on the one hand the Netherlands and the United Kingdom which have accommodated their regulations to meet the burial requirements of Muslims in a larger extent and on the other hand France that only made minor adjustments for Muslim burial practices, whilst Germany and Belgium take a position in between.

5. Conclusion

The studies found and discussed in this review focus mainly on repatriation to the country of origin as a result of a number of factors including religious barriers (e.g. burial in shrouds, grave in perpetuity etc.), financial constraints, lack of knowledge of the existing burial facilities and a sense of belonging. Till today no Islamic burial is guaranteed in the Belgian context that is completely in accordance with their religious and cultural beliefs. Only recently, several measures have been taken at different policy levels to accommodate the Islamic burial practices such as the establishment of Islamic plots, the permission of burial in shrouds and the renewal of concession. Nevertheless, the current status differs from region to region and from municipality to municipality. The extent of adapting regulation and arranging cemeteries is dependent of the adopted interpretation of neutrality and religious freedom. Different interpretations have led to different options provided by Belgian municipalities. This also true when we compare Belgium to its neighbours: differences in the way countries deal with Islamic burial are closely related to different conceptions of Church/State relations.

In our review, we observed a great lacuna in the literature regarding the specific burial practices of Muslims in Belgium. For this reason and in order to provide and guarantee a dignified burial, more research is needed. Research that covers a.o. the beliefs, attitudes of Muslims regarding death, dying and the afterlife is needed in order to understand its impact on the attitudes and practices of Muslims regarding burial, but also exploring actively the needs and wishes of Muslims regarding the existing funeral infrastructure in the Belgian context.

6. References

Aggoun, A. (2006). *Les Musulmans face à la mort en France*. Paris: Vuibert.

Ansari, H. (2007). 'Burying the dead': Making Muslim space in Britain. *Historical Research*, *80*(210), 545-566. doi: 10.1111/j.1468-2281.2007.00432.

Berger, M. S. (2015). The Netherlands. In J. Cesari (Ed.), *The Oxford Handbook of European Islam* (pp. 23-63). Oxford: Oxford University Press.

Brussels Capital Ordinance (2013). Voorstel van ordonnantie tot wijziging van de wet van 20 juli 1971 op de begraafplaatsen en de lijkbezorging om de plaatsing van het stoffelijk overschot in een ander lijkomhulsel dan een doodskist toe te staan [Proposal of ordinance to amend the law of 1971 regarding cemeteries and corpse disposal, allowing the placement of the remains of a body in a different body wrapping than in a coffin]. Retrieved from http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&table_name=wet&cn=2013072603.

Burial Law. (1971, August 13). Retrieved from http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&cn=1971072030&table_name=wet.

Christians, L. L., De Pooter, P., & Tilkin, G. (2011). Islam et parcelles confessionnelles dans les cimetieres en Belgique [Islam and confessional plots in cemeteries in Belgium]. *Revue de droit communal*, *2*, 2-12.

de Jong, F. (2012). *Islamitisch begraven in West-Brabant* [Islamic burial in West-Brabant] (Unpublished master's thesis). Tilburg University, Tilburg.

de Ley, H. (2004). *Het recht op een menswaardige begrafenis* [The right to a dignified burial] (Essay). Retrieved December, 10, 2015 from http://www.cie.ugent.be/CIE2/deley32.html.

De Morgen. (2016, September 7). Na 10 jaar eindelijk een beslissing: Mechelen krijgt moslimbegraafplaatsen [Finally a decision after 10 years: Mechelen gets Muslim cemeteries]. *De Morgen.* Retrieved October 9, 2016, from http://www.demorgen.be/binnenland/na-10-jaar-eindelijk-een-beslissing-mechelen-krijgt-moslimbegraafplaatsen-bdd35c51/

De Pooter, P. (2010). De Kerk-Staatverhouding in België [The Church-State relation in Belgium] . In K. Martens, F. Judo (Eds.), *Handboek Erediensten: bestuur en organisatie* [Guide of Cults: Management and organisation] (pp. 1-53). Brussel: Larcier.

De Standaard. (2016, September 7). Begraafplaats krijgt oostelijk gericht perceel op vraag van moslimgemeenschap [Cemetery gets an East-oriented plot at the request of the Muslim

community]. *De Standaard.* Retrieved October 9, 2016, from http://www.standaard.be/cnt/dmf20160907_02457391

Dessing, N. M. (2001). *Rituals of birth, circumcision, marriage, and death among Muslims in the Netherlands*. Leuven: Peeters.

Dobbelaere, K., Laermans, R. (1998). *Godsdienst en kerk in een geseculariseerde samenleving: een keuze uit het werk van Karel Dobbelaere* [Religion and church in a secularised society: A selection of the works of Karel Dobbelaere]. Leuven : Universitaire pers Leuven.

Fadil, N. (2012). Belgium. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 4, pp. 69-93). Leiden: Brill.

Fadil, N. (2014). Belgium. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 6, pp. 83-107). L.eiden: Brill.

Federal Ministerial Circular (2000, January 27). *Omzendbrief betreffende de toepassing van de wet van 20 juli 1971 op de begraafplaatsen en de lijkbezorging, gewijzigd bij de wet van 20 september 1988* [Circular regarding the application of the law of 20 July 1971 concerning cemeteries and corpse disposal, amended by the law of 20 September 1988]. Retrieved from http://www.etaamb.be/nl/omzendbrief-van-27-januari-2000_n2000000063.html.

Ferrari, S., Bottoni, R. (2015). The Institutionalization of Islam in Europe. In J. Cesari (Ed.), *The Oxford Handbook of European Islam* (pp. 619-655). Oxford: Oxford University Press.

Flemish Decree. (2004, January 16). *Decreet op de Begraafplaatsen en de Lijkbezorging* [Decree concerning Cemeteries and Corpse Disposal]. Retrieved from http://binnenland.vlaanderen.be/decreet/begraafplaatsen-en-lijkbezorgingsdecreet.

Flemish Ministerial Circular. (2006, March 10). *Omzendbrief betreffende de toepassing van het decreet van 16 januari 2004 op de begraafplaatsen en de lijkbezorging en de uitvoeringsbesluit* [Circular regarding the application of the decree of 16 January 2004 concerning cemeteries and corpse disposal and implementing order]. Retrieved from http://codex.vlaanderen.be/Portals/Codex/documenten/1016897.html.

Fornerod, A. (2016). *Annotated Legal Documents on Islam in Europe: France*. Leiden: Brill.

Fregosi, F. (2012). France. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook Of Muslims* (Vol. 4, pp. 211-227). Leiden: Brill.

Gilliat-Ray, S. (2015). The United Kingdom. In J. Cesari (Ed.), *The Oxford Handbook of European Islam* (pp. 64-103). Oxford: Oxford University Press.

Hertogen, J. (2013). *Aantal moslims in België* [Number of Muslims in Belgium]. Retrieved November 2, 2016, from www.npdata.be

Home Office. (2004). *Burial law and policy in the 21st century: the need for a sensitive and sustainable approach*. Home Office. Retrieved April 13, 2016, from http://webarchive.nationalarchives.gov.uk/+/http:/www.dca.gov.uk/consult/buriallaw/burialaw_cp.pdf.

Hudson, J. F. (2016). Belgium. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 7, pp. 87-113). Leiden: Brill.

Hunter, A. (2015). Deathscapes in diaspora: contesting space and negiotiating home in contexts of post-migration diversity. *Social & Cultural Geography, 17*(2), 247-261. doi: 10.1080/14649365.2015.1059472

Hussain, D. (2014). The United Kingdom. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 6, pp. 625-648). Leiden: Brill.

Janssens, Y. (2015). *Annotated Legal Documents on Islam in Europe: Belgium*. Leiden: Brill.

Jonker, G. (2004, April 3). *De groei van moslimpercelen op openbare begraafplaatsen in Europa* [The increase of Muslim plots in public cemeteries in Europe]. Paper presented at the meeting on Islamic cemeteries in East Flanders organized by the Flemish Government in Ghent, Belgium. Retrieved December 10, 2015, from http://www.cie.ugent.be/CIE2/jonker1.html.

Kadrouch-Outmany, K. (2014). *Islamic burials in the Netherlands and Belgium. Legal, religious and social aspects* (Unpublished doctoral thesis). Leiden University, Leiden. Kadrouch-Outmany, K. (2016). Religion at the cemetery Islamic Burials in the Netherlands and Belgium. *Contemporary Islam, 10*(1), 87-105. doi: 10.1007/s11562-015-0341-3.

Kanmaz, M., & Zemni, S. (2005). Religious discriminations and public policies: "Muslim burial areas" in Ghent. *Migration Letters*, *2*(3), 265-279.

KMI. (2007). *Moslimbegraafplaatsen in Vlaanderen: een stand van zaken* [Muslim cemeteries in Flanders: The state of affairs] (Report). Brussel: Kruispunt Migratie-Integratie.

KMI. (2013). *Islamitisch begraven in Vlaanderen: inspiratie voor lokaal overleg* [Islamic burial in Flanders: Inspiration for local consultation] (Report). Brussel: Kruispunt Migratie-Integratie.

KMI. (2014). *Islamitisch begraven: gemeenten met aangepaste perken* [Islamic burial: Municipalities with adapted plots] *(Report).* (Report). Brussel: Kruispunt Migratie-Integratie.

Lamberts, E. (1986). De kerkhovenkwestie [The issue of graveyards]. In *Het openbaar initiatief van*

de gemeenten in België 1795–1940 [The public initiative of municipalities in Belgium 1795-1940]. *Handelingen*. (Vol. 2, pp. 785–792). Brussel: Gemeentekrediet van Belgie.

Le Soir. (2015, July 7). Bruxelles: l'usage d'un linceul pour les musulmans toujours impossible [Brussels: The use of shrouds is still impossible for Muslims]. *Le Soir*. Retrieved December 17, 2015, from http://www.lesoir.be/929528/article/actualite/fil-info/fil-info-belgique/2015-07-07/bruxelles-l-usage-d-un-linceul-pour-musulmans-toujours-impossible.

McLoughlin, S. (2012). United Kingdom. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (pp. 619-641). Leiden: Brill.

Morelli, A. (2008). L'espace du cimetiere et les corteges d'enterrements comme enjeux de pouvoir entre laiques et catholiques (Belgique, xix–xx siecle) [The space of cemetery and burial processions as challenges of power between secularists and Catholics (Belgium, xix–xx century)]. In A. Dierkens & A. Morelli (Eds.), *Topographie du sacré: L'emprise religieuse sur l'espace* [Topography of the sacred: Religious hold on space] (Vol. 18, pp. 141–152). Bruxelles: Universite de Bruxelles.

Mustapha. A. (2016). The United Kingdom. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 7, pp. 607-620). Leiden: Brill.

Pew Research Center. (2015). The Future of World Religions: Population Growth Projections, 2010-2050. Retrieved October 27, 2016, from http://www.pewforum.org/2015/04/02/religious-projections-2010-2050/

Renaerts, M. (1997). La mort: de l'exclusion à l'intégration [Death: From exclusion to integration]. In F. Dassetto (Ed.), *Facettes de l'Islam Belge* [Facets of Belgian Islam] (pp. 213-223). Louvain-la-Neuve: Académia-Bruylant.

Rohe, M. (2012). Germany. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 4, pp. 245-268). Leiden: Brill.

Rohe, M. (2014). Germany. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 6, pp. 262-287). Leiden: Brill.

Rohe, M. (2016). Germany. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 7, pp. 272-288). Leiden: Brill.

Senate (1997). Vande Lanotte in Belgian Senate, Parliamentary proceedings – Meetings of 25 June 1997. Retrieved from http://www.senaat.be/www/?MIval=/Registers/ViewReg&COLL=H&PUID=16777225&TID=16782066&POS=1&LANG=fr.

Selby. J. A. (2015). France. In J. Cesari (Ed.), *The Oxford Handbook of European Islam* (pp. 23-63). Oxford: Oxford University Press.

Seuntjens, M. (2012). *A-way of the dead body: een topografie van rouw-en grafrituelen bij de Turkse gemeenschap in Gent* [A topography of mourning and grave rituals among the Turkish community in Ghent] (Unpublished master's thesis). University of Ghent, Ghent.

Shadid, W. A. R., & van Koningsveld, P. S. (2008). *Islam in Nederland en België* [Islam in the Netherlands and Belgium]. Leuven: Peeters.

Spielhaus, R. (2015). Germany. In J. Cesari (Ed.), *The Oxford Handbook of European Islam* (pp. 104-157). Oxford: Oxford University Press.

Szumigalska, A. (2015). *Annotated Legal Documents on Islam in Europe: The Netherlands.* Leiden: Brill.

Van den Breemer, R., & Maussen, M. (2012). On the viability of State-Church models: Muslim burial and mosque building in France and the Netherlands. *Journal of Immigrant & Refugee Studies*, *10*(3), 279-298. doi: 10.1080/15562948.2012.693037.

Wallonian Decree. (2009, March 6). *Décret modifiant le Chapitre II du Titre III du Livre II de la première partie du Code de la démocratie locale et de la décentralisation relatif aux funérailles et sépulture* [Decree amending Chapter II of Title III of Book II of first part of the Code of local democracy and decentralisation regarding burials and graves]. Retrieved from https://wallex.wallonie.be/PdfLoader.php?type=doc&linkpdf=13737-14232-7746.

Wallonian Ministerial Circular. (2009, October 29). *Arrêté du Gouvernement wallon portant exécution du décret du 6 mars 2009 modifiant le Chapitre II du Titre III du Livre II de la première partie du Code de la démocratie locale et de la décentralisation* [Circular of Wallonian Government implementation of Decree of 6 March 2009 amending Chapter II of Title III of Book II of first part of the Code of local democracy and decentralisation]. Retrieved from https://wallex.wallonie.be/index.php?doc=15799&rev=16536-9624.

Wolfe, M. (2000, June). *Muslim death in England and the constraints encountered*. Paper presented at the third postgraduate conference of the Association of University of Theology and Religious Studies, Derby, England.

Zwilling, A. L. (2016). France. In N. Nielsen, S. Akgönül, A. Alibašić & E. Raciu (Eds.), *Yearbook of Muslims* (Vol. 7, pp. 226-246). Leiden: Brill.

PART 2: EMPIRICAL STUDY ON DEATH AND DYING

"Seek ye counsel of the aged for their eyes have looked on the faces of the years and their ears have hardened to the voices of life. Even if their counsel is displeasing to you, pay heed to them."

—Khalīl Jibrān

1. "What Goes Around Comes Around". Attitudes and Practices regarding Ageing and Care for the Elderly among Moroccan Muslim Women

Introduction

Today, Belgium and several other European countries are confronted with the ageing of its Muslim population. In Belgium, Muslim mass-migration began in the 1960s, with large-scale settlement of guest workers mainly from Morocco and Turkey. Subsequent generations have been born and grew up in Belgium. In a few decades, Islam has become the second largest religion in Belgium and even the fastest growing religion in Europe (Shadid & van Koningsveld, 2008; Pew Research Center, 2015). The Moroccan community is considered one of the largest Muslim communities in Belgium. In 2016, sociologist Jan Hertogen estimated that Muslims counted for 7,2% of the Belgian population. Nearly half of the Muslim population in Belgium is of Moroccan descent (Hertogen, 2016). The Muslim migrant population is still younger on average than the non-migrant population (Lodewijckx & Pelfrene, 2012). In 2011, the share of elderly people of Moroccan and Turkish origin comprised 6%, against 27% of the elder native population (Lodewijckx & Pelfrene, 2012). The importance of adequate and dignified professional elderly care gains it importance because of demographic population developments and the assumed fragmentation of traditional family care giving among this population (Ahaddour, Van den Branden, & Broeckaert, 2015).

To date, little empirical data exist on the attitudes and practices of Muslims living in Belgium regarding care for the elderly as most studies focus on migrants of different ethnicities (Berdai, 2005; Cuyvers & Kavs, 2001; Declercq, Wellens, Demaerschalk, & De Coster, 2006) and only a few concentrate on Muslims (Khan & Ahmad, 2014; McLaughlin, Elahi, Ciesielski, & Pomerantz, 2016; Zokaei & Philips, 2000). The studies of Ajrouch (2005) among Arab-American migrants and of Yerden (2013) among Turkish migrants in the Netherlands show that care for the elderly is viewed as a religious duty of the children and that Muslims have care-expectations towards their children. Several studies also report barriers to access and utilisation of professional elderly care including language, culture and religion such as the study of Cuyvers & Kavs (2001) among elderly migrants in Belgium and the study of Mclaughlin et al. (2016) among Muslims in the United States. Ahaddour et al. (2015) conducted a review of the available literature on Moroccan and Turkish migrants in Belgium and care for the elderly, in which they compared the Belgian situation with a number of other European countries. This review shows that till far little attention has been given to this topic and more specifically to Muslims in Belgium. The effective use of and access to the available care services among elderly Moroccan and Turkish migrants in Belgium is hindered by a number of factors such as the language barrier, a low level of education, a financial barrier, a series of cultural and religious barriers, lack of knowledge of the health care system and the so-called return and care dilemmas. Elderly care facilities are not easily accessible and they correspond insufficiently to their

specific needs, which are mainly religiously and culturally rooted. Despite the existence of both theory and data that support the influence of religion on care-expectations and on care needs, hardly any study has systematically examined how religion shapes the attitudes, behaviour and wishes regarding ageing and care for the elderly. The existing body of research often lacks an encompassing account of the (religious) way of thinking of Muslims as well as a comparative perspective highlighting similarities and differences between first and second generation (Moroccan) Muslims in an European context.

The aim of this article is threefold. First, we seek to elicit the attitudes and practices of middle-aged and elderly Moroccan Muslim women toward ageing and care for the elderly. Second, we aim to identify possible differences between middle-aged and elderly women's attitudes and practices. In contrast to the first generation elderly Moroccan Muslim women in Belgium, who are mainly illiterate and lack formal education, the group of middle-aged women shows much more educational and socio-economic diversityThey often function as 'informal carer' providing family care for older persons/parents. Moreover, they have not been raised in a homogenous, rural, traditional Islamic environment and live less isolated from the broader Belgian society than the previous generation. Our main point of focus is whether a shift towards a more secular approach may be observed in their views and practices when compared to elderly Moroccan Muslim women. Third, we seek to explore which role religion plays in the attitudes and practices of these two generations of Muslim women.

Methods

Design

Between October 2014 and September 2015, thirty semi-structured interviews were conducted with a sampling of middle-aged and elderly women in the Moroccan community in Antwerp (Belgium) who self-identify as Muslim. This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. Because of the cultural characteristics of the research population –more specifically the common gender segregation in traditional Muslim societies, in particular among first and second generation Moroccan Muslim communities (Hoopman, 2009; Timmerman, 2001)– and the female gender of the interviewer, purposive sampling for qualitative interviewing was limited to Moroccan Muslim women. We have chosen middle-aged women between 40 and 60 years and elderly participants above 60 years, as we wanted to interview both the existing first and second generation Moroccan Muslim women in Belgium. Whereas the first generation has passed the age of 60 years old, the second generation today consist of persons between the age of 40 and 58 years. 'First generation' is defined as persons who migrated to Belgium at an adult age (over 18 years) in the context of labour migration (from the late sixties) or marriage. 'Second generation' is defined as persons born in our country from first generation parents or

emigrated to our country before the age of 7 (Timmermans, 2006). We have chosen Antwerp for two important reasons. First, this city has the largest Muslim population in Flanders: 19,2 % of Antwerp's population is Muslim (Hertogen, 2016). Second, Antwerp as an international port city is considered to be among the most multicultural cities in the world.

Different routes of recruitment (e.g. mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured topic list covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) and Dutch. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organization or in a quiet tea house). To help us with the interpretation of our data, the interviewer (first author) also interviewed 15 experts in the field (e.g. elderly care consultants, Muslim physicians, Muslim nurses, imams etc.) about particular topics of our study between September 2014 and September 2015. This method was, firstly, helpful as it provided rich background information. Secondly, it helped us to be more sensitive towards the data from our interviews with Moroccan Muslim women. Thirdly, the data of the interviews with experts were used in a comparative method to limit biases and ascertain the reliability of our interpretation of the findings from the interviews with the Moroccan Muslim women.

Apart from interviewing, the first author also conducted participant observation between December 2014 and April 2017. Several visits of the sick, a *ḥijāma*-consultation, death prayers, ritual washings of the dead body, repatriation of a deceased, burial, mourning gatherings were attended and several Islamic cemetery plots were visited.

This study is part of a research programme initiated in 2002. Van den Branden (2006) carried out a study on end-of-life ethics among first generation Moroccan Muslim men from Antwerp (Belgium) in which he addressed the topic ageing, though in a limited extent. The present study is part of a larger research on the attitudes, beliefs and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp). In this research, themes such as health, illness, medicine, end-of-life issues (e.g. active termination of life; palliative treatment and symptom control; withholding and withdrawing treatment), death and dying, the afterlife, mourning and remembrance and burial practices were also addressed. (Ahaddour & Broeckaert, 2016, 2017; Ahaddour et al. 2015, 2017a, 2017b, 2017c; Ahaddour et al., forthcoming-a, forthcoming-b). Based on our review on Muslims/Moroccan and Turkish migrants in Belgium (Ahaddour et al. 2015), we observed an important lacuna in the literature concerning the specific religious and cultural needs of this population. The present study aimed to fill this gap by describing

the actual attitudes, beliefs and practices of Moroccan Muslim women and identifying the relationship between the religious beliefs and the perception of ageing and care of the elderly.

In this study, we opted for a non-normative, descriptive, exploratory approach. This study was approved by the Social and Societal Ethics Committee (KU Leuven, Belgium). In order to guarantee the anonymity of our participants, we made use of pseudonyms.

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology (Corbin & Strauss, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used to code and analyse the interview data. By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants. In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. Findings of the interviews with Muslim women were compared with those of the interviews with experts and subsequently compared with normative and empirical studies (cf. discussion). Our research findings were regularly discussed with our guiding committee and with several members of the Moroccan Muslim community.

Results

Participants' (Socio-)Demographic Information & Health Situation

Our group of middle-aged Moroccan Muslim women (n=15) was between 41 and 55 years old; our group of elderly women (n=15) was aged between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labor migration, family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of between three to five languages. Noteworthy is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women

spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber participants spoke Arabic and only two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were illiterate and lacked formal education, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes. Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

With regard to living arrangements, more than half of our participants lived in an apartment, while others lived in a house. None of our participants lived in a multigenerational household.

The health issues of our middle-aged participants were limited to knee problems and migraine. Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a bad health condition. Five middle-aged and four elderly participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer and severe chronic disease. In general, our middle-aged participants reported a better health condition compared to elderly participants.

Attitudes and Practices Regarding Ageing and Care for the Elderly

i. Understanding of Ageing

Our participants immediately and spontaneously interpret ageing from a religious framework. All participants argue that ageing is a normal process in one's lifecycle (*sunnat al-ḥayāt*), created by God, the ultimate author of life and death. They explain that ageing and death are inevitable; for either of them no medicine exists.

> "I live my time, we can't change anything. I see this with my parents, with my mother. It's part of life. We are also ageing and our kids will also become grandparents. We can't choose." Loubna – middle-aged – poor health condition

> "It's God who gave us old age. You get old after being young. It's obvious. Age follows us and so is death. It's part of life." Rahima – elderly – poor health condition

All participants unconditionally believe in an omnipotent God, who is the ultimate author of illness and cure, of life and death. Based upon their firm belief in predestination (*al-qadr*), mainly elderly participants emphasize that ageing is predestined (*maktab* or *maktūb*) by God and is thus part of God's plan. In this respect, a few participants explicitly add that they accept everything that comes from God. Several participants underline the importance to accept and show gratitude for their age given by God. All this is confirmed by our experts.

> "And if God has written it, then it's welcome. We have nothing to say about it. We are not like the unbelievers who complain like 'Oh my birthday, I hate that day'. They just want to stay young. We know that old age comes from God. It's destined." Malika – elderly – good health condition

> "All age has its beauty. When you're young, then you always feel good and strong, you have your health and for this you're grateful to God. That's nature. People need to be grateful to God in all circumstances and at all times. People need to be satisfied with what God has given them. You can't be scared or have fear to become old. People can't run away from ageing. It's predestined." Nuria – elderly – good health condition

> "I think they just accept their fate, they don't actually think about it too much. Sometimes they do say like 'I get tired too fast', but they still accept that aging comes from God. They're actually grateful and know that it's a part of life." Laila – Muslim nurse

Reaching old age is also understood by our participants from within an eschatological perspective. Indeed, they mention the importance of preparing for the afterlife by practicing more intensely their faith as death is more imminent. Life, given by God as a test, is understood as a preparation for the afterlife. This is also shared by our experts

> "Yes, when you're getting older, you think more of death. You think about it and I think that it's important that you're prepared. Of course, when it's time, it's time." Nihad – middle-aged – good health condition

> "The older you're getting, the closer you're to death. You know you're going down that road, so you must be prepared by turning to God, focusing on your prayers." Naziha – elderly – fair health condition

> "Especially the older generation, as they grow older, you see that they become more pious. You also see that they practice more deeply into their religion, because they become more aware of death that's approaching and of life in the hereafter." Nourdin – *ʾimām*

Many participants also define old age from a biological and psychological perspective. First, half of our participants associates ageing with reaching a certain age. Indeed, they mention that old age starts from the age of 60, whereas a few participants ascribe this to the age of 80. Moroccan people often consider themselves as 'elderly' once they become a grandparent. Interestingly, two elderly participants refer in this respect to the age of the prophet Muḥammad as the standard for old age and for expecting death.

> "You have a person of 40 years old, who says 'Yes, I'm old, I'm tired.' And you have people who are 60 years old but so alive. That's really surprising. I don't know, but in my eyes, being old is if you are 80 years old I think." Warda – middle-aged – good health condition

> "If you are 50 or 60 years old then your health weakens. It's no longer the same as when you were 20 or 30 or 40 years old. Then you have a strong health, but above 50 not anymore. The prophet said: "My community will live between the age of 60 and 70 years. Those who exceeds it, we call it '*arḍ al 'umur*' (old age)." Haddad – elderly – poor health condition

Second, half of our participants considers being care-dependent or having a weak physical or mental health condition (e.g. physical detoriation, forgetfullness) as a sign of reaching old age. Noteworthy, several participants also equate reaching old age with experiencing loneliness and having high care needs.

> "I associate being old with being sick and not being able to help yourself, if he/she can't walk anymore. So if his/her health is bad. If a person can walk and can talk, than he's not old. Being old is like being sick or bedridden. Somebody who needs help." Halima – middle-aged – good health condition

> "Someone is old, if his/her mind is declining, or if he/she's alone and has no children. Someone who has nobody around him/her to take care of him/her or if he/she doesn't find food, no clothes, nobody who can take care of her/him." Laziza – elderly – poor health condition

Noteworthy, one third of our participants –mainly elderly women– experiences a dilemma with regard to the idea of a permanent return to the country of origin. On the one hand they would like to return to Morocco due to the presence of family, property and the climate and on the other hand they prefer Belgium due to the presence of (grand)children and well-organised health care. For most of these participants, the solution is to commute between these two countries. In addition, several participants also refer to the political tension, racism and discrimination they experience in Belgium nourishing the wish to return to the country of origin. On the other hand, a few participants mention that their wish to return is also inhibited by still having unmarried children at home and therefore feeling the responsibility to take care of them.

> "No I was born here, but however, I have those moments when I think of going back to Morocco, yes. When everything is going normal then I don't think about it, no. But when there's, racism, something like that, then you think 'Look, I'm going back'. But you know fully well that it's actually not real, but you keep pretending like 'I can'. When I'm tired of it, then I think 'I can do this', but when I'm there I think 'I can't do it. I really can't live here'." Halima – middle-aged – good health condition

> "I wish to return to Morocco, but the problem is that I still have children at home and we can't leave them behind. You can't split yourself in two. Now, when all my children are married, they all have their home, then it's easy. I will commute. But if all my children are still at home, then I can't do it." Fatma – elderly – poor health condition

> "Most of them still think of heading back. They've built a house over there, but they find it difficult to leave their children here. It's a dilemma." Fadila – Psychosocial consultant

Only one sixth of our participants still cherishes the wish to return back to their country of origin *permanently* due to the presence of their family and the strong bonds they feel with their country of birth, but also because of the wish to die there. They strongly experience a feeling of nostalgia toward the country where they were born and have spent their youth. Nevertheless, a few

participants have indicated that it is in the hands of God whether they will return or not. They explain that if God has predestined this for them, than they shall return.

> "If my kids leave the house, then I would like to return to my country. It's better. I have my family there, my sisters. First of all, when you die there, you get buried immediately. Here you have to stay for I don't know how long, in a cold storage. Each person wishes to die in his/her country." Malika – elderly – good health condition

> "Yes, I was born in Morocco. I've spent my entire youth in Morocco, my first love [laughs]. You see?[…] I've seen beautiful things and I've had my youth there. I've a nostalgic feeling towards Morocco. Ah it's really my biggest dream." Charifa – elderly – poor health condition

Half of our participants –mainly middle-aged women– does *not* express the wish to return to their country of origin when reaching old age. They mention they felt more connected to Belgium as they were born or mainly brought up there or because that they have spent more than half of their life in this country. Other reasons are the presence of their children and grandchildren in Belgium and the absence of living family in the country of origin. This is also confirmed by our experts.

> "No, because I don't feel connected to Morocco. I want to see my children and my grandchildren, and so forth. I want to go for a while to Morocco, but mostly I want to live here. Since I was born here, I think it's more logical." Radia – middle-aged – poor health condition

> "I've almost no one in Morocco. My parents died and the rest of my family is spread throughout Morocco and in the Netherlands. I'd rather stay here than return to Morocco. I do have family in Morocco, but here I have my kids. I built my life here. I was young when I came to Belgium, so I spent my entire life in Belgium." Zohra – elderly – poor health condition

> "The second and third generation won't return because of the weakening bond with the country of origin." Fadila – Psychosocial consultant

ii. Attitudes and Practices Regarding Care for the Elderly

a. Informal Family Care-Giving

The majority of our participants have strong traditional care-expectations towards their children. First of all, this preference of care is clearly religiously framed: care for the parents is a religious duty of the children based upon the *Qur'ān*. This too is confirmed by our experts.

> "Yes, that's true. Care for the parents is a duty of the children. That's just how it is. I have this opinion and God also said it. It doesn't come from a human that you need to take care of your parents, it comes from God." Hannan – middle-aged – good health condition

> "Yes, It's written down in the *Qur'ān*. You have to take care of your parents, You're obliged to that. I expect care of my child." Charifa – elderly – poor health condition

> "Yes, it's really in our culture and actually in our religion too. You're actually obliged to take care of your parents and everyone knows it." Nora – Muslim nurse

The majority of our participants explicitly refers to the high position assigned in Islam to parents, and in particular the mother. They are of the opinion that children are religiously obliged to

show mercy and respect towards their parents (*birr al-wālidīn/arḍat al-wālidīn*). They also emphasize that as long children satisfy their parents, they will be blessed in their life and receive eschatological good marks (*ḥasanāt*). Thus, pleasing parents is equated with pleasing God. They are of opinion that people who are pious and have a good heart spontaneously take care of their parents.

> "Parents, they are important and you can't even say 'ugh' to them.[…] That's why God tells us that we need to respect our parents.[…] Those who want *arḍat al-wālidīn*, they'll take care of us. They say that paradise lies under your mother's feet." Kaltoum – middle-aged – poor health condition

> "Yes, in our religion it is mandatory for the children to take care. In our religion the son has to take care of his mother. Children with good faith take care of their parents. And if you abandon them, and you hurt your parents or you made your parents mad, God will be mad at you. That's how it is in our religion.[…] They need to show respect towards their parents. Paradise lies under their parents' feet. If you do injustice to your parents, God will judge you for that." Haddad – elderly – poor health condition

Interestingly, several participants strongly emphasize the implications of one's action. Indeed if children do (not) take care of their parents, their children will do the same articulating it as *kamā tudīn tudān* ('what goes around comes around'). This idea of repercussion is strongly framed in a religious context: God will give you what you have given to others. This is also strongly related to the idea of reciprocity in the care-relation. This is also confirmed by our experts.

> "They say *kamā tudīn tudān*. If you put your parents in an elderly home, then your kids will do the same to you. God said what you do, they [children] will do to you too." Kaltoum – middle-aged – poor health condition

> "A woman who has good children, expects that her kids will take care of her as she took care of them. What you did to your parents, that's what your children will do to you. *Kamā tudīn tudān*. I hope that children will show mercy and kindness towards their parents." Yamina – elderly – fair health condition

> "They're like 'if you've not been able to realize it yourself, what example have you given to your child concerning treatment of parents? *Kamā tudīn tudān*. Well, you reap what you sow'." Soumiya – Elderly care consultant

A second perspective is that mainly elderly participants are of the opinion that taking care of the parents is traditionally done and should be done by the children and more specifically by the son and daughter in law. They emphasize that this is a tradition (*'āda*) that must be kept alive and continued. Interestingly, several participants –mainly elderly– mention to have followed the tradition of giving birth to many children as a safety net to ensure care in their old days.

> "Normally it's the daughter in law who takes care of the parents, because the son is the closest to his mother. It's kind of the son's duty to take care of the parents. But also you have brought many children into the world based on the idea that the day I need my children, they will be there for me. That's one of the reasons why we and our parents have given birth to many children." Sabiha – middle-aged – fair health condition

> "We have this custom of children taking care of their parents. They can't throw out their parents. Your children need to be by your side. They should help you. They understand you best. But if they don't take care of you, then why did I bring so many to the world? I want for them to come, so I won't get bored. So I don't feel neglected." Aïcha – elderly – fair health condition

Third, our participants strongly emphasize the importance of reciprocity in care-relations. They state that they would like to be taken care of by people who are closest to them. Here, a strong link is made between the education of children and care for the elderly. As such, they explain that they expect care of their children when they are care-dependent as they also gave care to their children when they were dependent. In contrast to the majority of elderly participants who assigns this care duty to a son, middle-aged participants have much less expectations towards their sons and daughter in law, but count more on their daughters. Indeed, they explain that as they have not given care to the daughter in law, they do not assign a care-duty to her. This too is confirmed by our experts. We observed that as daughters nowadays tend to live closer to their parents (when compared to sons), especially when parents in law live abroad, they often take up this care-responsibility.

> "I want to be cared for by my daughter and not by my son. First of all, he's a man, and his wife must do it then and I really don't want that, because she's not my child. I didn't take care of her and therefore she does not have to take care of me. Do you see?[…] She's a daughter of an outsider. I wouldn't feel at ease. I'd love to get it from my daughter. She would take care of me as I did with her." Hannan – middle-aged – good health condition

> "I want to be taken care of by my children. I also took care of them and took care of everything, so when I'm old, my kids will have to take care of me." Zohra – elderly – poor health condition

> "I think they rather think like 'If I become care-dependent, then I hope my kids will take care of me. After all, I raised my children, so I hope they'll help me, take care of me till death." Nora – Muslim nurse

Interestingly, a few participants state that they do not have care-expectations towards their children, but expect their partner to take up this care-responsibility as they have promised to take care of one another.

> "It's his duty. You married each other to be together and to take care of each other. It's in a two direction." Nihad – middle-aged – good health condition

> "My kids have their own life, they work, they have their kids. I hope my kids are happy in their home. If I would stay with them, I would be a burden to them. They would neglect their husband. That's why I'm counting on my husband. I'm there for him and he's there for me." Huda – elderly – fair health condition

In reality, the majority of our participants (eleven elderly participants and nine middle-aged participants) took care of or are still taking care of their parents (in law). Often care is distributed among the children. None of my elderly participants lives with their children, except for two elderly participants who living with their unmarried daughter. Interestingly, nearly half of our elderly

participants states that due to the geographical distance they could only help their parents (in law) in the country of origin on a financial level.

b. Care Uncertainties and Tensions

In relation to the fragmentation of the traditional ideal of integral care provided by the family, one third of our participants' attitudes and care-expectations are strongly marked by uncertainties with regard to care in their old days. This was strongly present among participants who are childless, widowed or do not have daughters. Although the majority of our participants expects to receive care of their children, mainly middle-aged participants indicate that they have less expectations toward their children because their children are more independent when compared to previous generations. The most important explanation given for the care uncertainty by many participants is the socioeconomic change which resulted in both men and women leaving home for work. As a result, the younger generation lacks the time to take care of their parents. This is also confirmed by our experts.

> "I think everyone expects and hopes that children will take care of them. But we've come to a time where we think, 'I don't want to burden them'. You love your parents, but you can't. So I think today parents now think realistic like 'everyone works'." Halima – middle-aged – good health condition

> "Yes, if you're no longer care-independent, then it's more than normal that you count on your children. Who else is going to take care of you? But in reality, we don't find our children. They all work. They all have their own family. They're too busy." Fatma – elderly – poor health condition

> "In the Moroccan community, well, the elderly assume that the children will be there for them. What do we see in reality? They're not there, because they all have their own family, they all work." Fadila – Psychosocial consultant

Second, several participants explain this decline of family caregiving by the adoption of western norms and values among younger Muslim generations. They are of the opinion that Muslims today have a more western mentality in which individualism takes the lead and the collectivistic way of thinking, including the traditional idea of care giving, declines.

> "Yes. We are really adapting to the western lifestyle.[…] I suppose we are a bit western I think. I think even I do not want to burden my kids, because they need to move on, on their own. We've taken over this individualism." Badria – middle-aged – good health condition

> "I have this feeling that we became more western and the children also took over this Belgian mentality.[…] Uhm, we became more distant for a part and western on all levels. We don't see much Belgians taking care of their parents and yes, we adopt this too." Radia – middle-aged – poor health condition

Third, two participants explain this development by referring to the changing family structure. They explain that as young Muslims opt to have less children they have a smaller safety net to rely on, in contrast to the older generation. This is also shared by our experts.

> "She [her mother] actually counts on us to give care. She has many children and if you distribute the tasks, it's doable. If everyone takes one day in the week. But if you have fewer kids, then it's heavier and practically more difficult." Nihad – middle-aged – good health condition

> "Now it's difficult. Back in the days, we didn't go outside to work. We beared many children and we did the household, but now the daughters in law work, they have their job. Nowadays, they don't bear a lot of children. Only two or three and they already say they're tired (laughs)." Aïcha – elderly – good health condition

> "They can't keep expecting. The first generation had six to seven kids. They think there'll be someone who'll take care of them'. But now among the current generation, large families do not exist. Three to four children max so the chance of being cared for is really small." Imane – *ḥijāma* practitioner

Fourth, mainly elderly participants indicate that the daughter in law often acts as a barrier and thus stands in the way of the son as family caregiver. Because people live less in a multigenerational or extended house and more in nuclear family houses, taking care of the older generation has become more difficult. According to our participants this is also the case in Morocco. Participants mention that the son and daughter in law do not take up the care responsibility anymore, but that daughters nowadays take care of their parents. This entails that mainly middle-aged women provide care to older people.

> "It's very good if you find one of your children who wants to do that. My own mother had beared three sons, of which one is still alive, well my mother couldn't even find him. Why? The wives of my brothers don't want to take care of her nor take her into their home." Laziza – elderly– poor health condition

> "The daughters in law accept their own family but not their husbands'. Once the in-laws are old, they'll no longer accept them. They do not take in their in-laws. They only take care of themselves and their kids[…]. It's no longer as it used to be, all living in one house, they ate together with daughters in law, sons and parents. It changed everywhere, in Morocco as well. It no longer exist, everyone has their own place." Rahima – elderly – poor health condition

Fifth, several participants mention that providing family care often brings a lot of tension and pressure, mainly when taking care of elderly with high care needs (cf. dementia, Parkinson). When children are not able to fully take responsibility for this care, this seems to generate feelings of guilt and of failure as a result of not meeting the expectations of their parents and/or community. This was mainly brought forward by participants who are confronted themselves or in their immediate environment with advanced illness and/or high care needs.

> "It's difficult, because yes, sometimes it can be difficult. I tell you, it's not that easy to take care of an older person, because sometimes it's physically not feasible, because it's heavy. And sometimes it's mentally not feasible. And often you would feel guilty if you don't provide care." Sabiha – middle-aged – fair health condition

> "It's really not that easy. I see this with my dad. It's all easier said, but if you have one at home than you know what that is. Yes, taking care of a demented is difficult.[…] My mom took care of him for 15 years. Now she can't anymore. She deteriorates. She's tired." Loubna – middle-aged – poor health condition

Noteworthy, a few elderly participants put their trust in God as response to their future care needs, as God is *al-Rāziq* (the Provider). They explicitly mention to count on God when care is needed. This way they avoid the discussion about this sensitive topic which reflects the uncertainties they face with regard to care in their old days.

> "No but God is there [laughs]. There's God, one should not count on someone, but on God. No, you count on God. Why would you say like 'When I'm old, how am I going to do it?' Why would you say such a thing? Put your trust in God." Alia – elderly – poor health condition

> "Yes, I count on God [avoids topic]." Naziha – elderly – fair health condition

Given that many are not sure whether their children will take care of them, they hope it will eventually not be needed. Noteworthy, mainly elderly participants explicitely mention to request God to end their life before becoming care-dependent or having a bad health ('*qad saḥa qad la'mar'*). In other words they hope to live as long as they have a good health and thus are (care) independent so that they would not become a burden for their children/family. This is also confirmed by our experts.

> "I ask God to not abandon us or fall into someone's hands. I ask God that we die with good health. I hope to leave to God when I'm not care-dependent, without burdening our children nor ourselves or daughters in law, no one." Malika – elderly – good health condition

> "I have no one and that's why I ask God 'Oh Lord of the worlds, I hope you'll take my soul before I deteriorate'. Because who'll take care of me? My parents are dead, my sisters have their hands full with their children. Who will take me? Who will carry me? I hope God will take my soul sooner, before I become care-dependent." Yamina – elderly – fair health condition

> "They want to be cared for preferably by their own children, although a few don't want to burden them, they'll explicitly say like 'I want to be able to handle myself for so long before I burden my children.' Actually, they ask God to let them die before they are dependent of their children. I heard that a lot." Salima – Elderly care consultant

c. Professional Care

- Barriers

The majority of our participants is thankful for the existence of professional health care including elderly care. In this respect, they refer to the well-organised and equal access to health care in contrast to the situation in their country of origin. However, the overwhelming majority does not make use of elderly care services and this because of several barriers. First, our participants –mainly elderly– have little knowledge of the existing elderly facilities. The foremost known facilities are elderly homes, home care and service flats. The last two types were mainly mentioned by middle-aged participants. Only two middle-aged participants mention the existence of day care centers and health services.

> "No, only health service. I don't think other services exist. Yes, of course you have service flats to live as independently as possible and that's also the main point of care. And an elderly home of course." Nihad – middle-aged – good health condition

> "I can't really say honestly. I only know elderly home." Haddad – elderly – poor health condition

On the other hand, from a religious perspective, several participants have a rather negative picture of elderly care facilities and particularly elderly homes based on an assumed lack of respect for the patient's religious background. They state that elderly homes devote insufficient attention to religious observances (e.g. *ḥalāl* food, prayer, gender segregation) and thus is not tailored to Muslim's needs. Several participants state that often abuse is made of the weak position of elderly Muslims with high need of care (e.g. dementia) by not respecting his/her religious needs or wishes including *ḥalāl* food and intimacy norms.

> "Care provision is not tailored to Muslims. Once, I checked with an elderly home who had a Muslim woman. I had said 'What about her prayer and food?'. They said 'Yes, she can pray in her room and the food is adjusted'. But it's not true, it's not adjusted, because I checked with the care services. They say 'on the day pork is being served, they give her vegetarian food, a dish without meat'. And it costs as much as others.[…] But imagine if you're demented, then it's another story of old age. So even if they give you pork, you'll eat it without knowing it." Sarah – middle-aged – good health condition

> "They don't take Muslims into account. I know a Moroccan demented woman in a nursing home who's being washed by men as well as women and that's bad for her. She has worn a veil for so long and always covered herself. And if you see her, she's just a typical Moroccan traditional woman with a *jallaba* [Moroccan dress] and now suddenly they cut her hair and left her like that without her veil. I really feel sorry for her." Hannan – middle-aged – good health condition

Third, cultural barriers also play a role. Several respondents show a strong dismissive attitude towards residential care as they equate admitting into an elderly home with abandonment by the children and abuse by health care providers as they take the situation in their country of origin as frame of reference. For our participants, this generates a loss of face within a community that equates it with children not fulfilling the care responsibilities that they hold towards their parents and therefore often express this as *ʿīb* (e.g. shame/disgrace). This is also shared by our experts.

> "I wouldn't bear the thought of sending my parents to an institution, while I'm still in good health. Even if I would be falling down, I think I would still take care of them. How difficult it may be.[…] It's shameful to bring them to an institution. It's a shame." Narima – middle-aged – good health condition

> "An elderly home? No no no [tears falling], *Allāh yistar* (may God protect us). Children should not neglect their parents. It's a shame and a great injustice. I hope I'll never end up there. I'd rather die before they put me there." Rahima – elderly – poor health condition

> "It's taboo. A retirement home or a nursing home, they see it as a place where you drop your parents and that's it. That you'll also be forgotten, so they compare it to what is happening in Morocco. So the retirement homes, these are places where you abandon people where people are abused." Fadila – Psychosocial consultant

Many participants also equate an elderly home with having a lack of freedom and experiencing loneliness. In this respect, they mention the great importance of spending their old days

in a familiar environment with their family. Several elderly participants even mentioned that they would rather die by asking God to not to reach a very old age than to be placed in a nursing home, as they do not want to fall into the hands outsiders (e.g. health care providers).

> "Everything needs to be adjusted, because you're not free. You're not allowed to drink as much coffee as you like. You may drink one or two cups a day. That's no life. You've worked your entire life, you've taken care of your kids your entire life and in the end your children put you in an elderly home? No, No." Zoulikha – elderly – good health condition

> "Elderly home is really tough. You have no freedom and also when you die you'll die alone. They only get one room. Nothing else. It's like putting you in jail. They're neglected." Laziza – elderly – poor health condition

The fourth barrier mentioned by the majority of our participants is that the use of and access to elderly care services is hampered by the fact that elderly Muslims have a limited knowledge of the Dutch language. They say that elderly Muslims prefer to be cared for in their own language and preferable by care providers of the same cultural and religious background for a better communication. All this would help them to feel more at ease/at home. This too is confirmed by our experts.

> "They want to experience their religion, it's part of their identity. It's important that they feel good of course, that they can speak the language. Feeling at home as much as possible, that makes a difference." Nihad – middle-aged – good health condition

> "The problem is that they don't speak the language. My mother can't speak Dutch. If there are care providers who speak the language, then they'll [elderly Muslims] take the step faster. If it were Muslims, than yes. They will understand you better." Lamya – middle-aged – good health condition

> "They don't know the language and this fosters a huge stress. If they're taken care of, then they'd want it by someone who speaks the same language, so if they want a nurse, then it must be someone who speaks Arabic or Berber language, because they would feel at ease." Laila – Muslim Nurse

Finally, several participants also indicate the high financial costs involved when relying upon professional elderly care as a barrier. They mention that they receive a low salary and therefore are not able to pay for it. Several elderly participants mention that they need to be more financially supported and request lowering the costs of medication. This was mainly mentioned by participants whose relative is in high need of care (e.g. dementia, Parkinson).

> "I hope the care becomes more affordable, that they'll give more subsidies, for example, to nursing homes. Because for instance, a couple, if a person goes to a nursing home, the spouse will have to pay 1500 or 1600 euro per month.[…] And now he [her father] has Alzheimer. So we pay, with my brothers and sisters. We all help to pay, because my father doesn't have enough. [Professional] care is expensive." Loubna – middle-aged – poor health condition

> "When I had surgery, I needed someone to come and help me, but for free. For example, I earn 1000 euro, how much would be left of it? Do you understand? If I've to pay for external care, how much will remain? I find [professional] care expensive." Charifa – elderly – poor health condition

- Open Attitude

Taking into account the abovementioned barriers, several participants argue that they would only rely on professional elderly care such as an elderly home as a last resort. They believe this is, nevertheless, a good option for Muslims who are childless or for elderly with high care needs.

> "It's good and important for those who have nothing and don't have children, it's needed. It's mandatory, there's nothing to do about it. If there were no options, then I would do it. It's normal." Nuria – elderly – good health condition

> "For those who have no children it's important that they receive help, that they can maintain themselves.[…] Then it's not a bad thing if he calls on it. Poor thing, he has no one." Haddad – elderly – poor health condition

Our participants show a more open attitude towards home care than towards an elderly home based upon the idea that with the first type of care they remain within their own familiar environment. This is also confirmed by our experts. Noteworthy, mainly middle-aged and elderly participants who are personally or in their direct environment confronted with severe illness/palliative situation and/or high care needs show much more openness towards professional elderly care services in general. Participants who do not have a daughter indicate that they would rely upon professional elderly care not to burden their children: they refer to home care, service flats or even an elderly home if the latter takes into account their cultural and religious needs. Nearly one third of our participants states that they or a relative (e.g. husband) relied upon elderly care services including home care or cleaning service. Only one middle-aged participant, Loubna, mentions that her demented father has been admitted into a nursing home.

> "I will do as much of my household chores as possible. So as much as I can and if I can't I'll let someone help me. So to start with home care and if that doesn't work, then a service flat." Lamya – middle-aged – good health condition

> "I would rely on home care,. because they come and wash you, by the evening your children and grandchildren are present, but not admitting in an elderly home. That life, the warmth of my children. Seeing my grandchildren grow and staying at home, that's actually my wish." Kaltoum – middle-aged – poor health condition

> "But eventually I think that, for example, that they would rather choose home care than residential services, and the second generation I certainly see them going to a service flat, because it would still be their own house and you have a certain freedom. You don't have that with an elderly home." Laila – Muslim Nurse

Our participants find it of utmost importance to preserve their own cultural eating habits and religious dietary requirements, religious practices including praying and fasting, reading the *Qur'ān*

and their physical integrity being respected. This entails that women are washed by female health care providers and men by male health care providers. Many participants firmly emphasize the importance of ageing in a familiar context and of elderly care services respecting Muslims' cultural and religious background in realizing a certain continuity in life. This is related to the feeling of being welcome and feeling at home. Some participants show openness towards pluralistic elderly care services, whereas other prefer Muslim/Islamic professional elderly care services. They believe that the latter type would be more appealing and beneficial for Muslims as all their needs would be met and thus are more reassured of a dignified ageing and care.

> "We want the rituals, obligations, food, the prayer to be taken into account. Basically like how they've lived at home. Men and women in separate rooms. It's important that they can be who they are, just to be who you are. How they can practice their religion as they do at home. If I go to an elderly home, than I've to live there as I did before, in a trusted environment where you can be yourself. Getting older in a trusted environment. That's what I want to strive to. And that at the end of their life, they lived on the path to God." Louiza – middle-aged – good health condition

> "My wish is that in the future, there will be a place where Muslims could go. These people need to feel good in their last years, not lonely, *ḥalāl* food, care by same gender, being able to pray, leisure activities adjusted to Muslims, providing *Qur'ān* lessons and Muslim caregivers. They'd have to feel at home. That's my wish. To be free as if you're at home." Kaltoum – middle-aged – poor health condition

Interestingly, all participants are of opinion that future Muslim generations will rely even more upon professional elderly care due to a stronger expected fragmentation of family caregiving. Another explanation given is that due to the stronger integration of younger generations, a higher demand of professional elderly care is expected as younger Muslims generations will demand professional care that meets their needs as they are also part of Belgium's population and thus are entitled to it. A few participants associate the fragmentation of informal care with a 'decline of religiosity' among young Muslims generations among whom respect and mercy towards parents is lacking.

> "I don't know if the future generations will take care of their parents. I don't know, but there are many children of this generation who don't give the same amount of respect as we did. Their softness is gone. The next generation won't have a choice but to call for professional care. We're having a hard time, let alone the next generations." Narima – middle-aged – good health condition

> "Yes, I think they [younger generation] will rely more in the future. They have also paid for their rights.Yes, if you have rights, you can demand things. Young people will demand things they are entitled to." Khadija – elderly – poor health condition

Discussion

Our study shows that ageing and care for the elderly are strongly perceived within a religious framework by both middle-aged and elderly Moroccan Muslim women. The findings of our

interviews with middle-aged and elderly Moroccan Muslim women are (nearly) identical to those of the interviews with our experts in the field. Moreover, no differences were observed between the religious views and attitudes of our elderly and middle-aged participants. Both groups understood ageing as evidently and essentially linked to God. Both strongly emphasized theological and eschatological notions in their answers (e.g. old age given by God; family caregiving as a religious duty; heavenly reward for taking care of parents). Our participants also attach a great importance to practicing their religion at the end of life (e.g. turning to God, prayers). Our findings show that despite being embedded in the western context, the Islamic frame of reference remains vividly among Moroccan Muslim women living in Antwerp (Belgium).

In contrast to elderly participants, the idea of a permanent return to the country of origin or a return dilemma was lacking to a great extent among middle-aged participants. This might be explained by their stronger attachment to Belgium as they were mainly brought up or born there, but also by the simple fact that their family and especially their children and grandchildren are living there.

Nearly all our participants holds traditional views on care for the elderly, based on religious and cultural arguments (e.g. duty of children to take care of their parents). Whereas mainly elderly participants give this care responsibility to the son, middle-aged participants prefer to be cared for by their daughters instead of their daughters in law with whom they have no reciprocity-relation. Interestingly is that we observed a clear shift in the traditional care-expectations of the son to the daughter. This might be explained as daughters live more nearby their parents, but also that multigenerational housing is less common. In other words, the daughter in law tend to take less a carer role in the husband's family, and take instead (more) care of their own parents. This preference is also based on the idea that women wish to be cared for by people for which they cared for. At the same time middle-aged participants have less traditional care-expectations towards their children. This shift in attitude and expectations can be explained by the fact that middle-aged participants themselves experience the pressure of combining work with taking care of their children as well as their parents in the Belgian context. In contrast to middle-aged participants, elderly participants strongly underline the idea of repercussion when children do not fulfil the care responsibilities that they hold towards their parents.

Among both middle-aged and elderly participants we observed a strong discrepancy between expectations and reality as a result of socio-economic developments (both men and women work outside the home; changing family structure). Care uncertainties were mainly found among participants who are widow and/or childless and tensions among participants who take care of relatives with high needs of care. When asking our participants about their care-expectations in their old days, we noticed that this still remains a sensitive topic. On the one hand, mainly elderly

participants indicated that only God has knowledge over the future, whereas middle-aged participants often stated they had not thought about it yet. On the other hand, both elderly and middle-age participants do not wish to become a burden for their children and hope to maintain their independence as long as possible. Elderly participants firmly emphasize the wish to live as long as they are independent and hope that God takes away their life before becoming care-dependant. This was not explicitly mentioned by our middle-aged participants. By contrast, their response lies in their willingness to rely upon professional elderly care services. In contrast to middle-aged participants, elderly participants hold a strong negative image toward professional elderly care and in particular residential homes. This might be explained by their reference to elderly homes in the country of origin which are often viewed as places of abandonment. Therefore this type of care is viewed as a last option only for people who are childless or have high care needs.

We found a more western understanding of care of the elderly among middle-aged participants resulting in a tolerant attitude towards professional elderly care. The more positive attitude towards professional elderly care services that was found among middle-aged participants could be linked to the decline of the traditional extended family care giving. This openness might be also explained by a better knowledge of health care facilities (linked to their higher literacy and education, resulting in a better access to information), but also as aforementioned because of their difficult experience (of pressure) of the combination of work and taking care of the family. We also observed that middle-aged participants are more adapting to western norms and values with regard to care for the elderly as well as a Western lifestyle including the shift from an extended to a nuclear family. A similar tolerant attitude towards professional care was found among participants who have been confronted with a palliative situation or severe illness themselves or in their direct environment. Indeed, they showed more openness towards the use of professional elderly care as they have experienced that taking care of a person with incurable/advanced illness and high care needs is difficult.

Both elderly and middle-aged participants show a greater acceptance of home care services than residential care. The main barriers found had a linguistic –mainly for elderly participants– cultural and religious basis. All participants recognize the importance of providing dignified and tailor-made professional elderly care for vulnerable groups including elderly who are widow, childless and/or in need of high care (e.g. dementia, Parkinson). They underline the importance of maintaining one's lifestyle in residential care facilities. In this respect, many of our participants prefers Islamic elderly care services which would meet all the religious and cultural wishes of Muslims.

Comparison with Normative Islamic Views

Considerable attention has been given to old age and the position of elderly/parents in *Qur'ānic, ḥadīth* and *exegesis* literature (Bensaid & Grine, 2014). Our participants' line of reasoning was strongly similar to the line of thought in normative Islamic literature on ageing and care for the elderly. In both our interviewees and normative Islamic literature, we find an unconditional belief in God's omnipotence and omniscience concerning life and death and in predestination (Al-Jeilani, 1987; Atighetchi, 2007; Bensaid & Grine, 2014; Rahman, 1998).

In line with our findings, Bensaid and Grine (2014) found that in the Islamic tradition old age (*shaykhūkha*) is defined as a stage of weakness, forgetfulness and physical feebleness. On the other hand, like our findings, scholars (Atighetchi, 2014; Bensaid & Grine, 2014) mention that Islam describes ageing as growing wisdom and more specifically defining the age of forty as a time of maturity and wisdom. Scholars (Bensaid & Grine, 2014; Rahman, 1998) confirm our finding that old age is rather viewed as an undesirable episode of human life based on the *ḥadīth* in which the prophet Muḥammad sought refuge in God from geriatric old age. However, even when one is sick of one's life, one should ask God to keep him/her alive as long as life is good for him/her and if not to end his/her life. This line of thought was also found among our participants. Both normative Islamic literature and interviewees support the idea that old age provides the individual with purification and reform through spiritual and moral refinement increasing performance of good deeds as people move closer to the end of life.

Both our interviewees and scholars argue that the Islamic faith emphasizes the importance of kindness, compassion and gentleness towards parents as a fundamental religious duty based upon the *Qur'ān* (Q17:23-24) and *ḥadīth* (Abdullah, 2016; Atighetchi, 2014; Bensaid & Grine, 2014; Dhami & Sheikh, 2000; Elsaman & 'Arafa, 2012; Khan & Ahmad, 2014). Al-Heeti (2007) also mentions that parents and in particular the mother receives a high position in Islam. This filial piety is a religious edict that requires children to love and respect their parents; speaking with grace and respect, especially parents in old age. Similar to our findings, several scholars (Al-Heeti, 2007; Bensaid & Grine, 2014) state that the *Qur'ān* strongly encourages children to grant high esteem to their parents and not show unrest, anger or discomfort. They mention that causing sadness or unrest to parents causes God's anger. This line of reasoning was also found among our participants.

Like our findings, Bensaid and Grine (2014) argue that the Islamic faith advances a reciprocal relationship of spirituality and mutual benefit between honouring the elderly and one's future wellbeing. Both our interviewees and scholars (Al-Heeti, 2007; Atighetchi, 2014; Elsaman & 'Arafa, 2012) state that the Islamic tradition views parental satisfaction as a genuine indicator for divine satisfaction: gratitude to parents is equated with obedience and respecting God and blessing of parents equivalent to being blessed by God.

In keeping with our findings, Bensaid and Grine (2014) state that care for parents is also understood as *birr al-wālidīn* ('righteousness to parents'). Similarly, scholars (Al-Heeti, 2007; Begum & Seppänen, 2017; Bensaid & Grine, 2014; Dhami & Sheikh, 2000; Khan & Ahmad, 2014) argue that Islam strongly requires Muslims to take care of their ageing parents based on the *Qur'ān*, more specifically verses 17:23-25. These verses express the relationship of mutual kinship care through various injunctions that command children to take care of their parents in an acknowledgement of the reciprocal care between them. The Islamic faith prescribes Muslims to care of their parents as their parents cared for them when they were younger (Abdullah, 2016; Al-Heeti, 2007; Elsaman & 'Arafa, 2012). This line of thought was also present among our participants. Like our findings, Al-Heeti (2007) indicates that the strain of caring for one's parents in this most difficult time of their lives is considered in Islam a honourous duty and blessing and an opportunity for great spiritual growth as it is viewed as a means of receiving great reward in paradise.

Comparison with the Empirical Literature

To date, only a few empirical studies exist on the attitudes and practices of migrants/Muslims living in Belgium regarding ageing and care for the elderly. Most studies found focus on different migrant populations in Europe (Berdai, 2005; Cuyvers & Kavs, 2001; Meulenkamp, van Beek, & Gerritsen, 2010; Talloen, 2007; Zokaei & Philips, 2000) or focus on Muslims in Australia, United States, Asia and Middle-East (Aytaç, 1998; Hasnain & Rana, 2010; Islam & Nath, 2012; Khan & Ahmad, 2014; McLaughlin et al., 2016; Shah, Hanan, Yount, & Shah, 2011; Sinunu, Yount, & El Afify, 2009). There is almost no documentation on the actual attitudes and practices of (Moroccan) Muslims regarding old age and care for the elderly; no studies are comparing first and second generation women in a European context in this regard. In contrast to the abovementioned studies that deal with perspectives on ageing and care for the elderly in a fragmented way, our study offers an encompassing, comprehensive and detailed perspective on attitudes and practices of Moroccan Muslim women living in Belgium.

The findings of our study show, nevertheless, several similarities with the results found in abovementioned empirical studies including: defining ageing as a decline of health, high position of the elderly, care for the elderly as a religious duty for the children, fragmentation of family care, barriers to access and utilisation of professional elderly care services, specific needs and wishes of Muslim populations. In contrast to these studies, our study yielded innovative and more detailed information on the views of both first and second generation Muslims towards ageing; the religious perspectives on ageing and care for the elderly (theological and eschatological considerations); lack of return dilemma among middle-aged Moroccan Muslim women due to the weakening bond with the country of origin; the specific problems of vulnerable groups (strong care uncertainties among older people who are widow, childless, in high need of care or have no daughters);the changing care-

expectations among second generation Muslims (less care-expectations towards their son; no reciprocity care relation with daughter in law; openness towards professional elderly care) and the strong approval of Islamic professional elderly care.

In keeping with our findings, several studies (Berdai, 2005; Cuyvers & Kavs, 2001; Schellingerhout, 2004; Yerden, 2013) conducted among (Moroccan) migrants in Belgium and the Netherlands report that elderly Moroccan migrants define a relatively young age as old age (from the age of 50). As in our study, Van den Branden (2006) found that Moroccan Muslim men strongly link ageing with a weakening health and/or physical detoriation.

In line with our findings, Khan and Ahmad (2014) and Van den Branden (2006) support our finding that with ageing Muslims think (more) about the inevitable death and therefore turn to God by performing good deeds, but also to find solace. The ageing process often leads to a search for meaning in life which in turn leads people to seek comfort in religion and spirituality. In contrast to other studies, our participants provided more religious considerations with regard to their attitude towards ageing (e.g. ageing given by God who is omnipotent; ageing as part of God's plan). Several studies (Berdai, 2005; Cuyvers & Kavs, 2001; Declercq et al., 2006; Van den Branden, 2006) confirm that a return dilemma exists among elderly Moroccan migrants between the desire to return permanently to the country of origin and the wish to stay in the adopted homecountry and therefore many opt to commute. In our study we found that this return dilemma is completely lacking among middle-aged Moroccan Muslims.

Several studies conducted among (Moroccan) migrants and Muslims in the Netherlands and Belgium (McLaughlin et al., 2016; Schellingerhout, 2004; Suurmond, Rosenmöller, El Mesbahi, Lamkaddem, & Essink-Bot, 2016; van Wezel et al., 2016; Yerden, 2013) show that older persons from Moroccan descent prefer and use family caregiving more often and more intensively than native elderly people. Moreover, they view this task primarily as a task for women. McLaughlin et al. (2016) found –as in our study– that 62% of American Muslims aged 40 and older would prefer care at home by family and friends. Similar to our findings, many studies among (Moroccan) migrants and Muslims (Ajrouch, 2005, 2016; Cuyvers & Kavs, 2001; Sinunu et al., 2009; van Wezel et al., 2016; Yerden, 2013; Zokaei & Philips, 2000) found that caring of older persons is considered a moral and religious obligation and that care and respect towards parents are viewed as an important part of Muslim's expression of faith. In keeping with our finding, research of van Wezel et al. (2016) and of Sinunu et al. (2009) shows that Muslims understand providing care for the elderly as a test from God and an important way to earn heavenly reward. Nevertheless, eschatological considerations in Muslims' perspective on ageing and care for the elderly –as found te be of central importance in our study- are not mentioned by any other research.

Several studies (Ajrouch, 2005; Cuyvers & Kavs, 2001; Sinunu et al., 2009; van Wezel et

al., 2016; Yerden, 2013) confirm that caring for parents is viewed in terms of reciprocity: children are repaying the elderly parent for the care that they received as a child. In contrast to our findings, van Wezel et al. (2016) found that this reciprocity was also present for the care of elderly parents by the daughter in law for the care the spouse received as a child. This was, however, not mentioned by our participants. Like our findings, several studies (Ajrouch, 2005; Cuyvers & Kavs, 2001; Yerden, 2013) also indicated a difficulty among older adults in talking openly about their desires and needs regarding care in their old days and a lack of communication on care expectations between first and second generation. As in our study, Yerden (2013) found that first generation Turkish people in the Netherlands assign the care responsibility to sons and that women also have care-expectations of their daughters as they tend to live more nearby.

Similar to our findings, many studies (Cuyvers & Kavs, 2001; Hossain, 2013; Khan & Ahmad, 2014; Lodewijckx & Pelfrene, 2012; Schellingerhout, 2004; Talloen, 2007) observed care uncertainties among (Moroccan) migrant and Muslim communities in the West and noticed a shift among younger generation Muslims/migrants regarding the traditional landscape of family care. Indeed they also found that it is no longer guaranteed that children will take care of their parents. Providing family care comes under pressure as a result of the changing lifestyle, socio-economic situation and values of the younger generations in the West. As in our study, research (Hasnain & Rana, 2010; Islam & Nath, 2012; Khan & Ahmad, 2014; Lodewijckx & Pelfrene, 2012; Sinunu et al., 2009; Yerden, 2013) found that this shift regarding the provision of family care can be explained by the changing socio-economic context as women enjoy (a higher) education and both men and women work outside the home. This shift contributed to the fragmentation of the traditional extended family household structures and to changing gender roles. Similar to our findings, a study by Yerden (2013) indicates that Turkish people, particularly in the migrant context, live in a smaller housing and therefore family caregiving became less evident.

Research (Ajrouch, 2016; Aytaç, 1998; Khan & Ahmad, 2014; Shah et al., 2011; Talloen, 2007; Yerden, 2013; Zokaei & Philips, 2000) confirms that changing values and adapting to western norms and values are driving forces in the decline of family caregiving among younger generation Muslims. Younger generations have less traditional views on care for the elderly and are putting emphasis on individuality and freedom. Ajrouch (2016) confirms our findings that first generation Muslims fear to become a burden on their children should they need care in later life, but also that second generation Muslims have less care-expectations towards their children. Similarly, her second generation participants had no preference to live with their children when they reached old age and were not averse to living in a nursing home based on the desire to shield their children from the challenges of providing care for their parents. Yerden (2013) found that these concerns were most present among elderly people who are childless or have no sons. This was not entirely the case in our study as we found that especially (middle-aged) participants who have no daughters were more

confronted with this problem. Though Hossain (2013) does confirm our finding that that women who are childless or widowed and older persons with illness requiring intensive care are at greater risk.

In line with our findings, many studies (Cuyvers & Kavs, 2001; Declercq et al., 2006; Denktas, 2012; Schellingerhout, 2004; Suurmond et al., 2016; Talloen, 2007; van Wezel et al., 2016) indicate a low frequency and intensity of professional elderly care services use among Moroccan migrants in Belgium and the Netherlands. A study by McLaughlin et al. (2016) among elder Arab-American Muslims shows that 65,7% would want their loved one cared for at home by elderly care services and only 12,7% would wish to be taken care of in a nursing home.

Research confirms that (Moroccan) migrants/Muslims have a limited knowledge of existing professional elderly care services (Cuyvers & Kavs, 2001; Declercq et al., 2006; Khan & Ahmad, 2014; Schellingerhout, 2004; Suurmond et al., 2016; Talloen, 2007). Several studies confirm the correlation between the extent of integration and the accessibility and willingness to utilize elderly care services (Cuyvers & Kavs, 2001; Declercq et al., 2006; Levecque, Lodewyckx, & Van den Eede, 2006; Talloen, 2007). This was also observed in our study as middle-aged participants show more willingness to rely upon professional elderly care services. Yerden (2013) found that both first and second generation have little or no knowledge of care facilities in the Netherlands. This was, however, not entirely the case in our study as we observed that middle-aged participants were clearly better informed.

Similar to our findings, several scholars (Al-Heeti, 2007; Berdai, 2005; Cuyvers & Kavs, 2001; Denktas, 2012; Schellingerhout, 2004; Talloen, 2007) also indicate that the low socio-economic position and the poor financial situation are a barrier referring to the high costs involved of professional (elderly) care services care for (Moroccan) migrants/Muslims. Studies (Cuyvers & Kavs, 2001; Declercq et al., 2006; Schellingerhout, 2004; Talloen, 2007) support our finding that elderly (Moroccan) migrants' low utilization of elderly care services is due to a language and communication barrier. Ajrouch (2016) and Khan and Ahmad (2014) also found that formal care in which caregivers relate and have cultural commonalities make it more desirable for the older adults to be taken care of by other Muslims. A study of Suurmond et al. (2016) shows that for elderly Moroccan migrants in the Netherlands the language barrier is the main cause of impeded access to professional home care services. This is also found in our study, however, cultural and religious barriers seem also to have a great impact.

Like our findings, many studies (Ajrouch, 2016; Al-Heeti, 2007; Berdai, 2005; Cuyvers & Kavs, 2001; Declercq et al., 2006; Hasnain & Rana, 2010; Khan & Ahmad, 2014; McLaughlin et al., 2016; Schellingerhout, 2004) found an averse towards professional care services and in particular residential care as people fear that their religious and cultural needs will not be met (e.g. *ḥalāl* food, number and frequency of family visit, a prayer room, care by the same gender). In line with our

findings, Khan and Ahmad (2014) found in their study that the critical aspect of faith or religion is not taken into account in the existing professional elderly care services and therefore deprives Muslims of a viable choice amidst the array of services to mainstream receivers. They also found – as in our study– that residential care becomes a complex issue for those who try to observe their faith which is very important to them and to be able to continue a lifestyle that follows the tenets of Islam.

In keeping with our findings, many studies (Berdai, 2005; Cuyvers & Kavs, 2001; Declercq et al., 2006; Khan & Ahmad, 2014; Talloen, 2007) found a negative image of professional care and mainly residential care associating it negatively with abandonment and neglecting one's care duties. Scholars (Ajrouch, 2005; Al-Heeti, 2007; Berdai, 2005; Hasnain & Rana, 2010; Khan & Ahmad, 2014; McLaughlin et al., 2016; van Wezel et al., 2016; Yerden, 2013) confirm our finding that there is a stigma and a sense of shame or failure and fear for negative response by the community associated with utilising aged care services such as a nursing home and therefore is seen as taboo. As in our study, several scholars (Berdai, 2005; Cuyvers & Kavs, 2001; Yerden, 2013) found that residential care service is only perceived as a last resort. Several studies (Ajrouch, 2016; Berdai, 2005; Sinunu et al., 2009; van Wezel et al., 2016) show that admission to residential care is understandable or inevitable if care becomes too burdened, for example with demented people creating unsafe situations and requiring continuous care. In line with our findings, several studies (Berdai, 2005; Cuyvers & Kavs, 2001; Elsaman & 'Arafa, 2012; Sinunu et al., 2009) indicated to have found a certain open attitude among migrants/Muslims towards professional care services, more specifically for older persons in need such as a person who has no children (or whose children live far away). Furthermore, similar to our findings, van Wezel et al. (2016) also observed a more tolerant attitude towards professional care among the younger Muslim generation in the Netherlands.

Many studies (Berdai, 2005; Khan & Ahmad, 2014; Yerden, 2013) support our finding that a more tolerant attitude and greater willingness to use home care services can be found as the older person thus remains in his/her safe and familiar environment. This entails a degree of freedom in continuing with one's life patterns. In keeping with our findings, Yerden (2013) also found a positive attitude among second generations toward professional care, mainly home care and to a lesser extent elderly home, when they become care-dependant as they do not want to become completely dependent from children nor care services.

Khan and Ahmad (2014) confirm our participants' line of thinking that accommodating the provision to the needs of Muslims would be essential, e.g. providing appropriate facilities to engage in religious activities and considering dietary needs, separation of sexes and care by the same gender. Al-Heeti (2007) confirms our participants' preference of creating a Muslim nursing home as it would avoid the issues Muslims face such as language barriers, isolation from other Muslims, dietary restrictions and modesty concerns. Like our findings, a study of McLaughlin et al. (2016) shows that 78,3% of Arab-American Muslims would consider using a nursing home designed for Muslims. In

keeping with our findings, studies (Cuyvers & Kavs, 2001; Declercq et al., 2006; Khan & Ahmad, 2014; McLaughlin et al., 2016; Talloen, 2007) predict that future generations (Moroccan) migrants/Muslims will demand and rely more upon professional elderly care services and that the need to establish a Muslim nursing home would become stronger as the Muslim population ages and their families become more integrated with the Western culture and society.

Our exploratory findings should be interpreted with several limitations in mind. First, given the nature of our data (specific group; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. The specificity of Moroccan Muslims in Belgium have to be taken into account including the quite problematic socio-economic position. Mainly elderly or first generation Moroccan women are illiterate and lack formal education, and are living quite isolated from Belgian society. Second, given the fact that we only interviewed (mainly) a healthy population –although we found great similarities between our participants who nevertheless were confronted with ageing symptoms or with severe illness (e.g. cancer, dementia) themselves or in their immediate environment– it would still be interesting to do an in-depth investigation of Muslim patients personally confronted with high care needs on their views and practices regarding ageing and caring for the elderly. Further studies could explore whether the impact of religion on views and practices regarding ageing and care for the elderly differs among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

The organisation of adequate care for the elderly is of the utmost importance. Providing dignified elderly care entails meeting the cultural and religious needs of patients. Considerable attention should be given to the provision of holistic care where physical, mental, social and spiritual dimensions in care practices are taking into account. By offering insights into the actual attitudes and practices regarding ageing and care for the elderly, this study aims to offer tangible leads to health care professionals for a more adequate tailor-made care for Muslim patients both in home care and residential elderly care services. An effective approach must incorporate the diversity of Muslims to avoid a homogenizing framework. Providing training in cultural competences is of utmost importance. The future inevitable aging problem needs proper attention to the policy makers for taking sustainable aging policies. Sensitization of elderly care services among Muslims through different channels (e.g. word of mouth, mosques etc.) is of great importance.

Conclusion

Our study reveals that religious beliefs play a crucial role in how Moroccan Muslim women perceive and deal with ageing and care for the elderly. Religious beliefs seem to be an important framework through which Muslims understand life, ageing and death. We observed strong care uncertainties and

tensions among our participants and a shift in traditional care expectations of the son towards the daughter. Access and utilisation of professional elderly care is impeded by religious, cultural, financial and language barriers and by a lack of knowledge of professional elderly care facilities. We found a more open attitude towards professional elderly care among middle-aged Moroccan women than among elderly women.

References

Abdullah, S. (2016). Kinship care and older persons: an Islamic perspective. *International Social Work, 59*(3), 381-392.

Ahaddour C., & Broeckaert B. (2016). Muslim Burial Practices and Belgian Legislation and Regulations: a comparative literature review. *Mortality, 22* (4), 356-373.

Ahaddour C., & Broeckaert B. (2017). "For Every Illness There Is A Cure". Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-017-0466-1,

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (2015). Institutional Elderly Care Services and Moroccan and Turkish Migrants in Belgium: A Literature Review. *Journal of Immigrant and Minority Health, 18*(5), 1216-1227.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (2017a). Between Hope and Quality of Life: Beliefs and Attitudes of Moroccan Muslim Women toward Withholding and Withdrawing Curative and Life-Sustaining Treatment. *Medicine, Health Care and Philosophy*, art.nr. https://doi.org/10.1007/s11019-017-9808-8.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (2017b). Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women. *Journal of Death and Dying*. https://doi.org/10.1177/0030222817729617 .

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (2017c). "God's Land is Vast". Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased. *Mortality.* https://doi.org/10.1080/13576275.2017.1413543

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-a). "God is the Giver and Taker of Life". Beliefs and Attitudes of Moroccan Muslim Women toward Assisted Suicide and Euthanasia. Accepted for publication in *AJOB Empirical Bioethics.*

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-b). "Every Soul Shall Taste Death". Beliefs and attitudes of Muslim Women toward Dying, Death and the Afterlife. Accepted for publication in *Death Studies*.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-c). A Temporary Farewell. Attitudes, Beliefs and Practices of Muslim Women regarding Mourning and Remembrance. Manuscript submitted for publication.

Ajrouch, K. J. (2005). Arab-American immigrants elder's view about social support. *Ageing Society, 25*, 655-673.

Ajrouch, K. J. (2016). Caring for Aging Muslim Families: A Needs Asessment. Retrieved 17 May 2017 from http://www.ispu.org/wp-content/uploads/2016/12/Caring-for-Aging-Muslim-Families-full-report.pdf

Al-Heeti, R. (2007). Why Nursing Homes Will Not Work: Caring for the Needs of the Ageing Muslim American Population. *The Elder Law Journal, 15*(1), 205-231.

Al-Jeilani, M. (1987). Pain: Points of View of Islamic Theology *Acta Neurochirurgica.Supplementum, 38*, 132-135.

Atighetchi, D. (2007). *Islamic Bioethics: Problems and Perspectives* (Vol. 31). New York: Springer.

Atighetchi, D. (2014). Islamic Perspectives on Vulnerable groups. In J. Tham, A. Garcia & G. Miranda (Eds.), *Religious Perspectives on Human Vulnerability in Bioethics* (pp. 175-191): Springer.

Aytaç, I. A. (1998). Intergenerational Living Arrangements in Turkey. *Journal of Cross-Cultural Gerontology, 13*(3), 241-264.

Begum, S., & Seppänen, M. (2017). Islamic Values in Elderly Care in Finland: The Perspective of Muslim Women Caregivers. *Journal of International Women's Studies, 18*(2), 59-73.

Bensaid, B., & Grine, F. (2014). Old Age and Elderly Care: An Islamic Perspective. *International Journal of Philosophy of Culture and Axiology, 11*(1), 7-30.

Berdai, S. (2005). Vergrijzing...een kleurrijk gegeven! Brussel: Brusselse Welzijns- en gezondheidsraad vzw.

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory*. Fourth Edition Aufl. California: SAGE Publications

Cuyvers, G., & Kavs, J. (2001). De huidige en toekomstige behoeften van allochtone ouderen aan welzijns- en gezondheidsvoorzieningen *Departement Sociaal Werk*. Kempen: Katholieke Hogeschool Kempen.

Declercq, A., Wellens, N., Demaerschalk, M., & De Coster, I. (2006). *De ontwikkeling van een vormingsprogramma over de zorg voor allochtone ouderen in rusthuizen en rust- en verzorgingstehuizen*. Leuven: Lucas.

Denktas, S. (2012). *Health and health care use of elderly immigrants in the Netherlands. A comparative study*. (PhD), Erasmus, Rotterdam.

Dhami, S., & Sheikh, A. (2000). The Muslim family. Predicament and promise. *Western Journal of Medicine, 173*(5), 352-356.

Elsaman, R. S., & 'Arafa, M. A. (2012). The Rights of the Elderly in the Arab Practice. *Marquette Elder's Advisor, 14*(1), 1-53.

Glaser, B. G., and A. L. Strauss. (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research.* New York: Aldine Publishing Company.

Hasnain, R., & Rana, S. (2010). Unveiling Muslim Voices: Aging Parents with Disabilities and Their Adult Children and Family Caregivers in the United States. *Top Gerriatr Rehabil, 26*, 46-61.

Hertogen, J. (2016). Marokkaanse-, Turkse- en islamachtergrond per gemeente. Retrieved 20 July 2017, from http://www.npdata.be/

Hoopman, R. et al., "Methodological Challenges in Quality of Life Research among Turkish and Moroccan Ethnic Minority Cancer Patients: Translation, Recruitment and Ethical Issues." *Ethnicity & Health* 14, 3 (2009) 237-253.

Hossain, F. (2013). The Destite Elderly of Bangladesh: Socio-Economic Perspective. *Middle East Journal of Business, 8*(3), 23-34.

Islam, M. N., & Nath, D. C. (2012). A Future Journey to the Elderly Support in Bangladesh. *Journal of Anthopology*, 1-6. doi: http://dx.doi.org/10.1155/2012/752521

Khan, S., & Ahmad, M. (2014). The Case for Muslim Aged Care in the West. *Journal of Religion, Spirituality & Ageing, 26*(4), 281-299. doi: http://dx.doi.org/10.1080/15528030.2013.867424

Levecque, K., Lodewyckx, I., & Van den Eede, S. (2006). Gezondheid en gezondheidszorg bij allochtonen in Vlaanderen. Antwerpen: Steunpunt Gelijkekansenbeleid, Consortium Universiteit Antwerpen en Universiteit Hasselt.

Lodewijckx, E., & Pelfrene, E. (2012). Huishoudensstructuur en solidariteit tussen de generaties bij personen van vreemde afkomst. In L. Vanderleyden & M. Callens (Eds.), *Generaties en solidariteit in woord en daad* (pp. 51-76). Brussel: Studiedienst van de Vlaamse Regering.

McLaughlin, M. H., Elahi, A., Ciesielski, J., & Pomerantz, S. (2016). Attitudes of Muslims Living in the United States Toward Long-Term Care Descisions and Diagnosis Disclosure for Elderly Family Members. *The American Geriatrics Society*. doi: 10.1111/jgs.14352

Meulenkamp, T. M., van Beek, A. P., & Gerritsen, D. L. (2010). Kwaliteit van leven bij migranten in de ouderenzorg. Een onderzoek onder Turkse, Marokkaanse, Surinaamse, Antilliaanse/Arubaanse en Chinese ouderen. Utrecht: Nivel.

Pew Research Center. (2015). The Future of World Religions: Population Growth Projections, 2010-2050. Retrieved 27 August 2017 from http://www.pewforum.org/2015/04/02/religious-projections-2010-2050/

Rahman, F. (1998). *Health and medicine in the Islamic tradition*. Chicago: Kazi Publications.

Schellingerhout, R. (2004). Gezondheid en welzijn van allochtone ouderen. Den Haag: Sociaal Cultureel Planbureau.

Shadid, W. A. R., & van Koningsveld, P. S. (2008). *Islam in Nederland en België*. Leuven: Peeters.

Shah, N. M., Hanan, E. B., Yount, K., & Shah, M. A. (2011). Decline in Co-residence of Parents and Children among Older Kuwaiti Men and Women: What Are the Significant Correlates? *Journal of Cross-Cultural Gerontology, 26*(2), 157-174.

Sinunu, M., Yount, K., & El Afify, N. (2009). Informal and formal long-term care for frail older adults in Cairo, Egypt: family caregiving decisions in a context of social change. *Journal of Cross-Cultural Gerontology, 24*(1), 63-76.

Suurmond, J., Rosenmöller, D. L., El Mesbahi, H., Lamkaddem, M., & Essink-Bot, M. (2016). Barriers in acces to home care services among ethnic minority and Dtch elderly - a qualitive study. *Internation Journal of Nursing Studies, 54*, 23-35.

Talloen, D. (2007). *Zorg voor allochtone ouderen*. Mechelen: Kluwer.

Timmerman, C. 2001. Groeiende diversiteit op vele fronten. Het onderzoek naar de socio-culturele en religieuze praxis bij allochtonen in Vlaanderen. In *Komende generaties. Wat weten we (niet) over allochtonen in Vlaanderen*, ed. by J. Vranken, C. Timmerman and K. Van der Heyden, 297-312. Leuven-Leusden: Acco.

Van den Branden, S. (2006). *Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen.* (Unpublished doctoral disseration), Katholieke Universiteit Leuven, Leuven.

van Wezel, N., Francke, A., Kayan-Acun, E., Devillé, W. L., van Grondelle, N. J., & Blom, M. M. (2016). Family Care for Immigrants with Dementia: The Perspectives of Female Carers living in the Netherlands. *Dementia, 15*(1), 69-84.

Yerden, I. (2013). *Tradities in de knel. Zorgverwachtingen en zorgpraktijk bij Turkse ouderen en hun kinderen in Nederland.* (Unpublished doctoral disseration), University of Amsterdam, Amsterdam. Retrieved 15 May 2017 from http://dare.uva.nl/record/1/392857

Zokaei, S., & Philips, D. (2000). Altruism and Intergeneratonal Relations among Muslims in Britain. *Current Sociology, 48*(4), 45-58.

"*We must accept finite disappointment, but never lose infinite hope*."

— Martin Luther King Jr.

2. "For Every Illness There Is A Cure". Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine

Introduction

In European debates on elderly care and end-of-life care, hardly any attention is paid to the views and attitudes of ethnic and religious minorities, including Moroccan Muslims. To this day, these discussions are still deeply influenced by contemporary secular-Western and/or Christian approaches, overshadowing other traditions (Gielen et al. 2009). As they grow older, Muslims in Belgium and other European countries increasingly seek Western health care, as the need for more health care routinely rises. Belgium is becoming more multicultural and multireligious. Therefore, providing adequate and dignified care is crucial. Today, Belgium and several other European countries are confronted with the ageing of its Muslim population. In Belgium, Muslim mass-migration began in the 1960s, with large-scale settlement of guest workers, mainly from Morocco and Turkey. In a few decades, Islam has become the second largest religion in Belgium and even the fastest growing religion in Europe (Shadid & van Koningsveld 2008; Pew Research Center 2015). In 2015, sociologist Jan Hertogen estimated that Muslims counted for 7% of the Belgian population. Nearly half of the Muslim population in Belgium is from Moroccan descent (Hertogen, 2015).

The way people view and deal with health and illness may relate to and be influenced by their religion (Ahmad et al. 2011; Baeke et al. 2012; Salman 2012; Van den Branden & Broeckaert 2008; Ypinazar & Margolis 2006; Zeilani & Seymour 2010). Muslim patients might have distinctive health needs that are related to their religious and cultural beliefs. Western understanding of illness and health is strongly based upon a biomedical model in which a separation of body and mind is the main feature, while Islam adopts a holistic view where body, mind and spirit are considered as a whole (Levecque et al. 2006). Several empirical studies report that religious beliefs and the perception of health and illness were closely interwoven and brought forward theological elements, such as the study of Ypinazar and Margolis (2006) among older Arabian Gulf Muslims and the study of Van den Branden and Broeckaert (2008), who interviewed elderly Moroccan Muslim men living in Belgium (Antwerp). The studies of Padela et al. (2016) among American Muslim women (40+), and of Salman (2012) among young Arab Muslim women, both focusing on health behaviour, found that religion-related beliefs, including ideas about duty to God and about vice-regency, might influence decisions in seeking treatment.

Despite the existence of both theory and data that support the influence of religion on the perception of health and illness, little research has systematically examined how religion shapes the attitudes and behaviour towards health, illness and medicine. The role of religion is often briefly mentioned as an explaining factor in a fragmented way and often lacks an encompassing descriptive

account of the (religious) line of reasoning among Muslims. As such, a descriptive, encompassing and comprehensive account of Muslim's attitudes and beliefs on health, illness and medicine in a European setting, and more specifically in the Belgian context, is lacking to a great extent. We also seek to verify whether a shift can be observed between first and second generation Moroccan Muslim women.

This study is part of a larger research programme initiated in 2002. Van den Branden (2006) conducted a qualitative empirical research on religion and end of life ethics among first generation elderly Moroccan Muslim men (n=10) in Antwerp (Belgium), as well as among experts (*n*=5) (cf. imams and physicians). Baeke (2012) conducted a similar empirical research among first generation elderly Moroccan (*n*=15) and Turkish (*n*=15) Muslim women living in Antwerp (Belgium). This study provides a broader perspective on health, illness and medicine among both middle-aged (40+) and elderly (60+) Moroccan Muslim women. To help us with the interpretation of our data, we also interrogated 15 experts in the field (e.g. Muslim physicians, Muslim nurses, imams, palliative care consultant etc.) about particular topics of the study, including the views of Moroccan Muslim women on health, illness and medicine. These interviews functioned as background information that the empirical data of our interviews with Moroccan Muslim women were projected upon and compared with. This study is part of a larger research on the attitudes, beliefs and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp). In this research, themes such as care for the elderly, end-of-life issues (e.g. active termination of life; palliative treatment and syptom control), death and dying, the afterlife, mourning and remembrance and burial practices were also addressed. Based on the wider study, seven empirical articles have currently been submitted to a journal and are under review (Ahaddour, Van den Branden, & Broeckaert, Forthcoming-a, Forthcoming-b, Forthcoming-c, Forthcoming-d, Forthcoming-e, Forthcoming-f, Forthcoming-g). Two literature reviews have already been published (Ahaddour & Broeckaert 2016; Ahaddour et al. 2015). The present study was performed in order to discover and describe the relation between the perception of health, illness and medicine and medical decisions at the end of life.

The aim of this article is twofold. First, we seek to bring forward the attitudes and beliefs of middle-aged and elderly Moroccan Muslim women living in Antwerp (Belgium) towards health, illness and medicine. We also included the middle-aged population, mainly from the second generation, as this group shows much more socio-economic diversity, in contrast to first generation elderly Moroccan Muslim women, who are mainly uneducated and illiterate, but also because of the assumed stronger influence of the West they have experienced, as they have been brought up in the West. This second generation is no longer raised in a homogenous, rural, traditional Islamic environment and lives much less isolated from the broader Belgian society. We are mainly interested whether a shift may be observed in their beliefs and attitudes compared to those of the first generation

elderly Moroccan Muslim women. Second, we seek to explore the role of religion in the attitudes of these two groups of Muslim women.

Methods

Design

Sample and Setting

From October 2014 until September 2015, 30 semi-structured interviews were conducted with a snowball sample of middle-aged and elderly self-perceived Muslim women in the Moroccan community in Antwerp (Belgium). This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. We have chosen the city of Antwerp for two important reasons. First of all, this city has the largest Muslim population in Flanders. Nearly 19 % of Antwerp's population is Muslim (Hertogen 2015). Second, Antwerp as a port city is considered to be one of the most multicultural cities in the world.

Different routes of recruitment (e.g. mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured topic list covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) and Dutch. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organization or in a quiet tea house). To help us with the interpretation of our data, the interviewer (first author) also interviewed 15 experts in the field (e.g. Muslim physicians, Muslim nurses, imams, palliative care consultant etc.) about particular topics of our study between September 2014 and September 2015. These interviews functioned as background information that the empirical data of our interviews with Moroccan Muslim women -as they are the main focus in our study- were projected upon and compared with. In the present study, experts were interrogated to find out more about the views of Moroccan Muslims on health, illness and medicine. This also functioned as a way to ensure the reliability and validity of our data. Apart from the interviews, the first author also conducted participant observations between December 2014 and February 2017. Several visits of the sick, a *ḥijāma* consultation, death prayers, ritual washings of the dead body, repatriation of a deceased, burial and mourning gatherings were attended and several Islamic cemetery plots were visited.

Data Analysis

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio

recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology (Corbin & Strauss 2015; Glaser and Strauss 1967; Strauss and Corbin 1998) was used to code and analyse the interview data. By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants. In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. The data of the interviews with Muslim women and with experts were analysed separately in a *NVivo*-project. Moreover, the findings of our interviews with Muslim women were compared with those of the interviews with experts per code and categories and subsequently compared with empirical studies (cf. discussion). Our research findings were regularly discussed with our guiding committee and with several members of the Moroccan Muslim community.

Ethical Considerations

In our study we opted for a non-normative, descriptive, exploratory approach. The design and conduct of our study were approved by the Social and Societal Ethics Committee (KU Leuven, Belgium). Given the existing illiteracy among elderly Moroccan Muslim women, on some occasions the informed consent was recorded orally in the sound-recording; other Muslim women gave a written consent. In order to guarantee the anonymity of our participants, we made use of pseudonyms.

Results

Participants' (Socio-)Demographic Information & Health Situation

The group of middle-aged Moroccan Muslim women (n=15) were aged between 41 and 55, the group of elderly women (n=15) were aged between 61 and 86. When the ages are split into 10-year age groups, nine women were in their forties, six in their fifties, ten in their sixties, three in their seventies and two in their eighties. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labour migration, family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of three to five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke

tarifit as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber participants spoke Arabic and only two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes.

Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. The health issues of our middle-aged participants were limited to knee problems and migraine. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a poor health condition. Nine participants reported that they have been confronted with incurable and terminal illnesses within their immediate environment, including dementia, Parkinson, several types of cancer and severe chronic disease. In general, our middle-aged participants reported a better health condition (three: poor; one: fair and eleven: good) than our elderly participants did (eight: poor; three: fair; four: good). This self-reported health condition is provided throughout this article for every interviewee.

Attitudes towards Health and Illness

Health

Our participants immediately and spontaneously interpret health from a religious framework: health is a trust (*ʾamāna*) and blessing *(niʿma)* from God. God is seen as the ultimate steward/manager of life and body, but also as the creator of health. Several participants underline the importance of gratitude for this health given by God.

> "A blessing, a huge blessing. And something you can immediately lose, if you lose time and health, you can hope to get your money back and win it back, but losing your health weakens you. It's a huge blessing, a responsibility." Halima – middle-aged – good health condition

> "Yes *al-ḥamdulillāh* (all praise to God), you keep on thanking Allāh for what you have. So you keep on thanking Allāh, every time you get up you say; '*al-ḥamdulillāh* today is a bit better [a better day]'. Even if your day is

> worse, you keep on thanking God with the idea of: '*al-ḥamdulillāh*, I'm better'. I always think that there's always much worse. So my motivation is: although I have what I have, it could always be worse." Haddad – elderly – poor health condition

Cause of illness

Not only health, but illness too is seen by all participants, whether middle-aged or elderly, from a religious perspective. All participants are convinced that God is the creator of all illnesses. This perception has to be viewed against the background of their unconditional belief in God's omnipotence, who governs life, death, and both illness and cure.

> "Illness comes from God, God is the One that gave this to us. […]. This illness is from God. Only God knows who will be affected by an illness. […]. It's an illness from God and He's the One who heals us. It is God who gives it [illness] and takes it way." Kaltoum – middle-aged – poor health condition

> "Everything is in God's hands. Everything is in the hands of God. It is God who gives illness and it is God who heals. […]. If God wants to, He takes away your soul. If God wants to, He will heal you and you will still live. He is All-Seeing (*al-Shāfī*), He is the Guardian (*al-Wālī*), He is capable of anything (*al-Qādir*). Everything is in His hands. We have no control over anything." Fatma – elderly – poor health condition

Illness is predestined (*maktab* or *maktūb*) by God and is to be ascribed to God's will *(al-qadr)*. A few participants emphasize that God is the only One who possesses knowledge (*Allāhu aʿlam*) of the cause of illness, pointing to God's inscrutable plans for humankind. Yet our participants firmly believe that God only gives things that have benefits for the human being.

> "Being ill happens with a reason, because otherwise people wouldn't get sick, I think. It is destined, but only God knows why we get ill." Narima – middle-aged – good health condition

> "It is God who gives it. Everything happens with *qadr* of God, for instance someone who is in a wheelchair and suffers. Everything comes from God, but it happens for a reason." Zohra – elderly – fair health condition

A few, mainly elderly, participants mentioned other metaphysical explanations for illness, referring to the evil eye (*al-ʿayn*) – generated by human jealousy (*al-ḥasad*) and sorcery (*siḥr*). These findings are in keeping with our interviews with experts, who state that especially elderly Moroccan Muslim women often tend to give such a cultural-religious explanation for illness, which our experts refer to as folk belief and superstition. Most of the time, these explanations are offered for mental illnesses, which are still perceived as taboo.

> "What I do feel is the evil eye. […]. I feel it like 'That woman has educated children etc.' You know? Our Moroccan people doesn't say *ṣalāt ʿalā al-nabī* or something [pray for blessing]. They don't know it. My oldest daughter also suffers from it, she also has a very big house. It's all jealousy. You see? Then they say 'Gosh, you have two children and your daughter this and your daughter that.' So she has two children, of which the eldest is autistic. […] And where do you think this comes from? This is due to the [evil] eye of the human being." Malika – elderly – good health condition

> "The folk belief plays a huge role in illness and you see that especially when people get sick. Especially the elderly, and the elderly people who then say '[…] he or she is possessed, or that is not cancer, that is possession.' So they look for an explanation beyond the illness." Fadila – Psychosocial consultant

Only four middle-aged participants also express a natural explanation for illness, referring to human responsibility as a cause of illness, although they believe that only with God's consent (*bi-ʾidhni Allāh*) illness is created: a person's will and ability do not operate outside the will of God.

> "So, I know it's from God. […] But it can also be explained by, for example, yeah, if you have a cold, then it was because you went outside and you've caught a cold. Right? That's not it… you won't say 'It's God who gave me this.' No, sometimes we've, […] we've done it ourselves." Sabiha – middle-aged – fair health condition

> "To me it… it happens, *al-ḥamdulillāh*. It happens to you, but Allāh tells us that a lot comes from your own hands. There is a lot that comes from ourselves, a lot. Sometimes people cause the illness themselves, but it does happen solely with the permission of God (*bi-ʾidhni Allāh*)." Halima – middle-aged – good health condition

Understanding of Illness

Different understandings of illness are offered by our participants. First of all, all participants firmly share the belief that illness is a test (*ʾibtilāʾ*) from God. For example, participants believe that God gives an illness to put the person to the test, in order to verify to which extent the ill person will show acceptance (or patience or gratitude). Participants who were confronted with severe illness or who had a difficult life believe that God puts those whom He loves to the test the most. In our participants' answers, however, we noticed a difference between the justification of the majority of the elderly participants who enjoyed no or little religious education and other middle-aged and elderly participants who show a higher religious literacy (cf. following religious classes; mosque). The latter group tends to provide a more elaborated and stronger theological justification in their answers, though in essence their answer remains the same.

> "It's from God. With illness, God is testing you. It's a test from God." Huda – elderly – religious illiterate – fair health condition

> "Illness is a test, an exam in this world. God sees if you have patience for what He has given you. And if you don't have patience, He will give you even more. If God is pleased with you, then He gives you an illness. […] God loves his servants/people and gives illness to those He loves. Think of the prophet ʾAyyūb, peace be upon him." Zoulikha – elderly – religious literate – good health condition

Second, all participants unanimously state that illness is a means of purifying one's sins (*maghfirat al-dhunūb*), which is perceived as a mercy of God (*raḥma*). This expiation of sins or cleansing effect is frequently linked to the eschatological belief that life and illness are part of God's test for entering the eternal life in paradise. Therefore, several participants mention the preference of being tested or afflicted in this worldly life rather than in the grave or afterlife. Several participants believe that people who are suffering from a severe illness die as a martyr and thus enter directly into paradise as a pure and sinless human being. Again, as far as the strength of their argumentation is

concerned (but not the essence of their answer), we noticed a difference between participants who are religious illiterate and participants who show a higher religious literacy.

> "The human being is purified from his sins." Naziha – elderly – religious illiterate – fair health condition

> "That is the earthly world. With illness your sins will be forgiven. God is *al-Raḥīm* (Merciful). The *ʾimām* says that if you die with cancer, you are a *shahīd* (martyr). If you die of it, then you are a *shahīd*, you immediately enter paradise." Yamina – elderly – religious literate – fair health condition

> "They think 'It's a test, and it is in the afterlife we get our reward.' So they know that it's a purification. Therefore, they prefer to suffer here than in the hereafter." Laila – Muslim nurse

Third, one third of our participants share the notion of illness as a visit from God. These participants express this visit as God thinking of them, but also reminding them of being grateful, since health is an evidence of God's blessing (*niʿma*).

> To me, illness means that Allāh thinks of me. I always say that. […] If I haven't been sick for a while, then I think that Allāh has forgotten me. (laughs). Seriously, and whenever I'm sick I always say: *al-ḥamdulillāh*, He thought about me. Really." Radia – middle-aged – poor health condition

> "Illness is a visit from God. God gives illness so that people realize the blessings (*niʿmāt*) they have received from God. We only realize that when we are ill." Naziha – elderly – fair health condition

Fourth, only a small minority formulate illness as a reflection on one's life, behaviour and conduct towards oneself, others and God. Illness reminds them of the purpose and temporality of life, of the importance of being modest, and thus helps them to restore their relationship with God. In cases of severe/incurable illness, participants highlight that reflection is not only intended for the ill person, but also for other healthy people. Here, we noticed a difference between the justification of the elderly participants who are illiterate and other middle-aged and elderly participants who show a higher educational level. The latter group tends to provide a more extensive theological justification in their answers, though again in essence their answer remains the same.

> "And I think that it is also necessary that a person becomes ill, just as a reminder. […]. It reminds you that you need each other, you need other people. That you have to help each other. […]. And also, then you think of God more. If all is well, then you don't really think about it. And if you need help, then you turn to God more." Louiza – middle-aged – low educated – good health condition

> "Illness is a visit from God, the Exalted. It is a moment to reflect upon our lives." Huda – elderly – illiterate – fair health condition

Though all aforementioned understandings of illness are also shared by the experts, only one explanation seems not to correspond with our interviews. According to a few experts, a small minority of – mainly elderly – Moroccan Muslim women ascribe illness to God in a negative way. As such, they view illness as a punishment by God as a result of wrongdoing. In contrast, several of our participants vehemently oppose this idea by explaining that it is not consistent with the Islamic belief, referring to the purifying effect of illness, but also to the 'special' status ascribed to an ill

person: supplications (*duʿāʾ*) of an ill person are more likely to be answered by God (*mustajāba*) due to his pure state and closeness to God.

> "Some say that it is a punishment. I don't see it like that. Because if it was a punishment, Allāh would never say that the angels are with him [the ill person]. If illness is a punishment, Allāh would never say that the supplication of an ill person is answered. If illness is a punishment, then Allāh would never say 'Go visit them, because then 70.000 angels will do *duʿāʾ* for you." Halima – middle-aged – good health condition

> "I think the majority says that it is a test from Allāh, so they might see that as something they have done wrong in the past and maybe now are being purified for, and that is something positive, and other women will say, among others things, 'No, God punished her.' So that perception also exists." Faysal – *ʾimām*/islamic teacher

Responses to Illness and Suffering

Interplay Between God and the Human Being/Physician

All participants are strongly convinced that cure is only in the hands of God. They unconditionally believe in predestination and in an almighty God who is the author of life, death, illness and cure. Similar to illness, cure is ascribed to the will of God (*al-qadr*).

> "We always say: God knows everything and everything is in God's hands. If it's meant to be, if God wants it, then the person will heal." Sabiha – middle-aged – fair health condition

> "He is the One who grants health, who gives illness, everything comes from God. He is the One that does everything, and He cures as well. Illness comes from God and cure comes from God." Aïcha – elderly – fair health condition

Nevertheless, the participants strongly stress that illness should be fought. Actively seeking treatment is considered a religious duty and therefore all participants heavily emphasize the importance of '*sabab*' (also called '*wasīla*' or '*niyya*'), which is understood by our participants, in this context, as undertaking efforts to heal, as they believe that God has created a cure for every illness. Life and body are perceived as a trust (*ʾamāna*) which has to be taken care of. Our participants' answers reflect a holistic framework in seeking a cure, in which both medicine and relying upon God are central. We observed here too a difference between our participants regarding the extensiveness of their answers based upon their educational level.

> "*Shifāʾ* (cure) always comes from God. You must do *sabab*. If you do nothing, then nothing will happen. God wants to help you. Perform *sabab*. If you say 'Yeah, I do this as *sabab*', to me, it's God who has given us a body. Yes? So we have to take care of it. We have to do everything to be healthy. This means that even when the physician says 'You're terminally ill,' you still must do everything to be healthy." Lamya – middle-aged – highly educated – good health condition

> "But God does say that we must see a physician when we're ill." Rahima – elderly – illiterate – poor health condition

> "I have the impression that women of the Moroccan community, of the Muslim community, actively seek treatment. […] they're not alienated from the health care system." Kamal – Muslim physician

Nearly all participants seek treatment by relying on biomedical medicine and thus on a physician. Physicians and medicine are perceived as means (*sabab*), instruments of God which are put at the disposal of mankind. They argue that the physician and medicine are created by God and thus it is God who provided knowledge and science for humanity.

> "God also said that we have to do something about it.[…]. God, the Exalted, did say 'I have given you physicians to help you further'." Louiza – middle-aged – good health condition

> "God created the physicians to help people. It's an instrument from God. It's God who gave them the knowledge to help people. So people have to perform *sabab* whenever they're ill, they have to look for a treatment and thus go to a physician." Aïcha – elderly – fair health condition

> "Well, because they also think 'Okay, I'm ill and in the *Qur'ān* it is written that when you're ill, you have to see a physician.' As I said, they see it as a means to heal." Farida – Muslim physician

Most participants express trust in medicine and physicians, linking this with the strong belief that cure only comes from God. Cure lies in the hands of God and cannot be effected by physicians only. They share the opinion that despite doctors' efforts, in the end cure is made effective by Allāh, meaning that God can grant cure by means of physicians and medication. Whether physicians' prescriptions and medication will be effective, depends completely on God's will. In this respect, participants highlight the contrast between God's omnipotence and omniscience and the human limitation of the physician. This impotency of physicians is strongly emphasized in the case of terminal illness and end-of-life issues. In this respect too, we found a difference in the elaborateness of our elderly participants' argumentations on the basis of their educational level and the extent of their religious literacy.

> "No, it is not the physician who heals a human being. It is God who cures." Naziha – elderly – illiterate – religious illiterate – fair health condition

> "The physician gives you medication and you're going to heal, but only with God's permission (*bi'idhni Allāh*). Cure comes from God. It's God who created the physician and gave him knowledge to treat ill people, but it's God who cures." Zohra – elderly – low educated – religious literate – fair health condition

Only a minority of participants seem to mistrust bio-medication and this for two reasons. First, due to the perceived side-effects of Western medication, they tend to rely upon alternative natural medication. Second, two participants refused the prescription for a psychological treatment based upon their total trust in God and the belief that cure is dependent on God's will, irrespective of physicians or medicine. Nonetheless, they did rely upon religious healers (e.g. *ʾimām*). Mental issues are still perceived as taboo and are often attributed to metaphysical explanations (like sorcery or possession).

Although a few experts mention that a fatalistic attitude can be found among a small minority of elderly Moroccan Muslim women, this perception was lacking among our participants. A passive attitude was only considered acceptable when a person is declared terminal. Indeed, a few

participants explicitly criticize a fatalistic attitude and emphasize that trusting God goes hand in hand with seeking remedy.

> "When I'm sick, who do I turn to? To God? That's true, but that doesn't mean we only have to look at God: 'yeah look, God will cure us. We don't have to do anything.' That's not the case! We have to do what is necessary. That means you have to see a physician. You must seek treatment." Haddad – elderly – poor health condition

> "Many, especially the older generation, see it as something separate. 'What I ask God is separate and this medication is also something else.' The first generation often says 'Oh you know, if it is meant to be [to be cured] then I will cure. That little pill won't make a lot of difference'." Laila – Muslim nurse

Besides bio-medical treatment, our participants also formulate other forms of performing *sabab*. Only a small minority of women mentions to frequently rely upon traditional health methods existing in Morocco such as *baghar* (also called *dwaʾ as-semith*), i.e. driving cold out of the body through warm smoke, and *dwaʾ an-nukhriʿ,* i.e. dispelling fear/shock by a wise woman. But also prophetic and religion-based medicine (*ruqiyya, ḥijāma,* natural remedies) seem to be frequently called upon by a minority of our middle-aged and elderly participants. These alternative healing methods are especially relied upon in case of mental problems, as these are often attributed to sorcery (*siḥr*) and possession (*jinn*).

Virtues

In addition to the great emphasis on the religious duty of seeking remedy, all participants strongly emphasize four virtues in coping with illness, which result in becoming closer to God. The importance of these virtues is also confirmed by our experts. Especially participants who were confronted with a severe illness themselves or within their immediate environment, heavily stress the centralities of these virtues when dealing with illness. It must be noted that these four virtues are strongly intertwined.

The first and most important virtue is *having full trust in God* (*tawakkul*). Muslims do not only put trust in medicine, they first and foremost rely upon the almighty God who governs over all matter. As mentioned before, here again, we observed a difference in the justification of our participants' answers on the basis of their educational level and the extent of their religious literacy.

> "If I'm sick, I put my trust in God." Laziza – elderly – illiterate – religious illiterate – poor health condition

> "Recently with my illness, too, and then I think: '*Subḥānallāh*, because of my faith and trust in God I'm very positive and so I healed very quickly.' Because I have put my trust in God. It was my fate. He chose to test me and made sure that I returned to him. I've always been concerned with my faith, but because of my illness I came even closer to God, Glory to Him the Exalted, and that has really helped me well." Kaltoum – middle-aged – low educated – religious literate – poor health condition

Second, *patience* is perceived as an extremely important virtue in coping with illness, as it is a sign of trust in God. In this respect, almost all participants emphasize that the ultimate attitude

towards illness, which is seen as a test, is being patient, as God is always with those who are patient (*ʾinna Allāha maʿa al-ṣābirīn*). Enduring patiently is considered a gift from God.

> "When you have patience, God will reward you." Radia – middle-aged – poor health condition

> "Yes, suffering is difficult. It's difficult. When you're suffering, you shout and scream. But it's important to have patience. That entails the test. Suffering is difficult, but in the meantime your sins are forgiven. It is important to have patience and to turn to God." Aïcha – elderly – fair health condition

> "I think that's their perception: 'You should just be patient and it will come to an end.' So you just have to endure it and you'll be rewarded." Imane – *Ḥijāma* practitioner

A third important attitude is *accepting God's will and decree* (*al-qadr*). All participants accept illness because of the divine decree, but also welcome anything that comes from God on the ground that God only offers good things for His servants. However, one older participant, Zoulikha, makes a distinction between suffering coming from God and coming from a human being. Moreover, she points out that suffering that comes from God is bearable and is acceptable, whereas for suffering that comes from a human being, no medication exists.

> "When you are ill, you have to persevere and rely upon God. If God has predestined something for you, then you have to endure it and persevere. You can't say 'If I had gone that way, this wouldn't have happened.' No, if God gives you something, you have to accept it. Everything that comes from God is welcome." Fatma – elderly – poor health condition

> "Suffering comes from God and I accept that, even if I'm suffering. But the real suffering is the suffering that comes from a human being. But if the suffering comes from God, we will have patience. It is God who gave it. But the most difficult is when the suffering comes from a human being. And especially when you haven't done anything. Suffering is hard and it doesn't have any medication. The suffering of God does have a medication." Zoulikha – elderly – good health condition

> "The first thing they always say is '*al-ḥamdulillāh* it's from God.' […]. 'Okay, I accept it, *al-ḥamdulillāh*' […]. Even if it's just a cold or the worst that can happen, which currently is having cancer. […]. If you believe in God, then you always say '*al-ḥamdulillāh'*. There's a time to come and there's a time to go." Myriam – Palliative care consultant

A final virtue is the virtue of *gratitude* (*ḥamd*). Nearly all participants stressed the importance of pronouncing *al-ḥamdulillāh* (praise be to God) when dealing with illness. This utterance seems to remind participants of the importance of being modest and fosters a relativizing of one's own situation. Almost one third of the participants vehemently denounce complaining as a sign of ingratitude and of mistrusting God. This is in keeping with our interviews with experts, who equated despair with a low faith (*ʾimān*).

> "I have also experienced that with my illness, you have to say *al-ḥamdulillāh*. That's our religion, you have to say *al-ḥamdulillāh*, thank God for all that He has given you." Loubna – middle-aged – poor health condition

> "You praise God (*thamdath rabbi)*. You praise God because you got the illness from God. Do you know the story of the Prophet ʾAyyūb? He healed him. He gave back his children. He gave back his property. If you praise God,

> you will get double of what you get from *ḥasanāt* (good marks). He gives you paradise if you praise Him. You cannot always say 'Oh no, I'm sick.' No, you cannot say that! You must not complain. No, no! You have to praise Him!" Alia – elderly – good health condition

> "Women are grateful for being ill because their sins are forgiven and they come closer to God. People who are less strong in practicing their faith or have less faith, will say: 'Yeah, and why me? Why am I sick? And yeah, it is taking long. It's been going on for so long'." Soumiya – Elderly care consultant

These abovementioned views strongly reflect an essentially *eschatological* perspective, where participants believe that by adopting these virtues good points (*ḥasanāt*) are earned, which leads to a better position in the afterlife (*al-ʾākhira*). These virtues are also accompanied by religious practices such as performing voluntary prayers (*ṣalāt*), pronouncing supplications (*duʿāʾ*) and reciting the *Qur'ān*, which are believed to be ways of turning to God. These practices are perceived as important healing powers and important ways of reaching God.

Discussion

The findings of our interviews with middle-aged and elderly Moroccan Muslim women are nearly identical to those of the interviews with our experts in the field. However, one difference was found. We noticed that a few experts made a distinction in the perception of and the way of dealing with illness between elderly and middle-aged Moroccan Muslim women in terms of religiosity. According to these experts, the elderly Moroccan Muslim women's religious belief seems to be characterized by a mixture of religion and Moroccan culture (folk religion). Furthermore, the experts attribute the limited knowledge of Islamic faith among elderly Moroccan Muslims to their illiteracy, in contrast to middle-aged women, who are assumed to have a higher knowledge of Islam due to a higher literacy.

However, this distinction was not confirmed in our sample of middle-aged and elderly participants, as both a minority of middle-aged and elderly participants referred to folk beliefs like the evil eye. Nor did our study show that the second generation of Muslim women, who grew up in Western society and were educated in the West – as secularisation theories might suggest – had developed a different, more secularised understanding of the relationship between God and the world, and God and health/illness.

Our study showed on the contrary that religion takes a central role in the answers of both groups. Moreover, no differences were observed between the religious views and attitudes of our elderly and middle-aged participants. Both groups understood health and illness as evidently and essentially linked to God. Both strongly emphasized theological and eschatological notions in their answers (cf. illness given by God as a test).

We did, however, notice one difference, though not a difference between first and second generation as such or between elderly and middle aged women as such. Nor was it a difference

regarding the essence of one's belief. We found that both elderly participants who are socially engaged in following religious and Arabic language courses in mosques and middle-aged participants tend to provide more elaborate, more 'sophisticated' religious argumentations and justifications for their beliefs and attitudes (e.g. referring to *ḥadīth*, *ʾimām*, stories on the prophets including ʾAyyūb). This might be explained by two independent factors i.e. the educational factor and the extent of (access to) religious knowledge (cf. mosques, satellites, internet, books) among the youngest part of the elderly group and the majority of the middle-aged group. As such, we noticed a difference in the strength of their argumentation between illiterate and higher educated participants. In other words, a higher literacy seems to result in a higher accessibility to religious sources (e.g. internet, books). Consequently, we noticed that elderly and middle-aged participants with a similar low educational profile and a rather withdrawn lifestyle tend to provide similar, less extensive arguments. We must be cautious not to generalize, though. A second difference was observed among participants who were religious illiterate and participants who show a higher religious literacy (cf. following religious courses, mosques etc.). In this respect, no differences were found between uneducated and educated participants. It must be said, however, that their beliefs are fundamentally not different at all and that the abovementioned difference regarding the depth of their justification was more strongly present in the participants' argumentations when dealing with the topic of death, dying and the afterlife. It must be noted that we also observed a more elaborate (though again not different) religious argumentation among participants who were confronted with illness, either personally or in their immediate environment.

Although there are essentially no differences in the *views and attitudes* of our middle-aged and elderly participants, we did observe a critical rejection of certain cultural *practices* (e.g. traditional healing practices; mourning practices) among the first group. Among middle-aged participants more emphasis is put on purifying oneself, in order to strive towards a total submission to God through what are now considered more 'authentic' and 'true' interpretations of Islam. These findings are in keeping with a study of Rozario (2011) among Bangladeshi young women in UK. She discovered a combination of a strong commitment to Islam with a rejection of the traditional Bangladeshi forms of Islamic observance and understanding of Islam among their parents' generation. The tendency of a quest for a real Islam that has been 'purified' of cultural specific practices and thus of the ethnic culture of the parental generation – which is often rejected as un-Islamic– is common in the West among young Muslims (Roy 2002; Voas & Fleischmann 2012). Second generation, middle-aged Moroccan Muslim women could probably be situated at a turning point between a "traditional" and a more diverse and "pure" interpretation and experience of Islam.

Our participants' line of reasoning was similar to the line of thought found in normative Islamic and scholarly literature on health, illness and medicine (Al-Jeilani 1987; Brockopp 2004; Fitzpatrick et al. 2016; Rassool 2000; Sachedina 2009; Sheikh and Gatrad 2008). In contrast to earlier empirical

studies that dealt with perspectives on health and illness among Muslims in a fragmented way, our study offers an encompassing, comprehensive perspective of how Moroccan Muslim women perceive and deal with health, illness and medicine. As such, our study corroborates more fragmentary findings from others studies.

The findings of our study are strongly consistent with the results of earlier studies of our own research group (Van den Branden 2006; Baeke 2012). Comparable to our findings, empirical studies among Muslims (Ahmad et al. 2011; Baeke 2012; Harandy et al. 2010; Nabolsi and Carson 2011; Padela 2007; Van den Branden 2006; Zeilani and Seymour 2010) confirm the interweaving of religion and illness and health perceptions. Similar theological elements came forward, including the centrality of God's almightiness and omniscience, God as the creator of life and death, health and illness as part of Allāh's immutable decree and the strong belief in predestination studies conducted among both Muslim women (Al-Azri et al. 2014; Arabiat et al. 2013; Baeke et al. 2012; Harandy et al. 2010; Ypinazar and Margolis 2006) and Muslim men (Nabolsi and Carson 2011; Van den Branden 2006).

Similar to our study, research conducted among both healthy and ill Muslims (Al-Azri et al. 2014; Arabiat et al. 2013; Baeke et al. 2012; Harandy et al. 2010; Nabolsi and Carson 2011; Van den Branden 2006; Zeilani and Seymour 2010) emphasized the central role of theological arguments in their perception of illness, including illness perceived as a test of God which results in the purification of one's sins (cleansing effect). Our participants strongly emphasized illness as a blessing from God which only benefits the human being and thus happens for a good reason, referring to the cleansing effect, the rapprochement of God and the reception of illness out of God's love. This latter notion was also found in a study among Malaysian Muslim women (Ahmad et al. 2011) who were dealing with a critical illness. They also perceived their illness as a gift from God, an expression of God's love and mercy.

Several studies among healthy and ill Muslims (Ahmad et al. 2011; Al-Azri et al. 2014; Baeke et al. 2012; Harandy et al. 2010; Jafari et al. 2013; Salman 2012) suggest the central significance of religion as a positive coping mechanism in the confrontation with illness. Furthermore, in a study among female Iranian Muslims who are diagnosed with breast cancer (Jafari et al. 2013) and a study among Omani Muslim women (Al-Azri et al. 2014) similar theological virtues in coping with illness came forward: acceptance of God's decree, trusting God, being patient and being grateful. Cultivating a faithful relationship with God and being patient guarantees reward (*ḥasanāt*) in this life or in the world to come. Worth noting with regard to the virtue of acceptance is that only one participant (Zoulikha) in our study experienced difficulties in accepting pain caused by a human being. As such, she made a distinction between pain coming from God and pain caused by a human being. This exceptional perception can be explained by her difficult life situation, in

particular her negative marital relationship and her feeling of abandonment by her children. In addition to the abovementioned virtues, the importance of religious practices that embody the turning to God (cf. supplication, prayers) when coping with illness is confirmed by several studies (Al-Azri et al. 2014; Nabolsi and Carson 2011; Padela et al. 2016; Zeilani & Seymour 2010).

The abovementioned meanings of illness and virtues are strongly linked to the belief in the afterlife. A study of Ahmad et al. (2011) endorses our finding that Muslim women perceive incurable/terminal illnesses as a means of total purification of a person who is promised entrance into paradise by God. The notion of earning *ḥasanāt* by trusting God and being patient in the light of the belief in the afterlife, which is perceived as the greatest motivator in following God's will, is confirmed by several studies (Ahmad et al. 2011; Baeke et al. 2012; Nabolsi and Carson 2011; Van den Branden 2006). In other words, eschatological beliefs and a teleological perspective (cf. life as a test; day of judgement etc.) seem to have a great impact on how Muslims perceive and deal with illness. In sum, for our participants and for many Muslims religion seems to be a powerful source of strength and hope.

Although it is suggested that a fatalistic attitude might result from the unconditional belief that God rules over all matters, the belief in predestination and the importance of surrendering to God's will, this was not the case among our participants. On the contrary, all participants stressed the importance of actively seeking medical treatment, which is not considered to be in conflict with trusting God *(tawakkul).* Similar to our findings, several studies (Ahmad et al. 2011; Baeke et al. 2012; Harandy et al. 2010; Nabolsi & Carson 2011; Padela et al. 2016; Van den Branden 2006; Ypinazar & Margolis 2006) confirmed that seeking treatment is considered a religious duty. In line with our findings, a recent study of Padela et al. (2016) among American Muslim women (40+), as well as a study among Afghan Muslim women (Shirazi, Bloom, Shirazi, & Popal, 2013) and young Arab Muslim women (Salman, 2012), saw ideas about the duty to God and about stewardship as the religious references for seeking treatment. A study of Ypinazar & Margolis (2006) among older Arabian Gulf Muslims and a study of Rozario (2009) among British Bangladesh Muslims resonate with our findings that physicians and traditional healers are perceived as mediums through whom God might decide to cure and thus decides the outcome of a treatment. It is in this respect that the physician's limitation in contrast to God's almightiness and omniscience is stressed (Van den Branden 2006, 2010; Baeke 2012).

Our exploratory findings should be interpreted with several limitations in mind. First, given the nature of our data (specific groups; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. However, our results were confirmed by earlier studies of our research group as well as the other available empirical studies. Second, given the fact that we only interviewed a healthy population –

although we found great similarities between our participants who nevertheless were confronted with aging symptoms or with severe illness (e.g. cancer) themselves or in their immediate environment on the one hand and situational qualitative studies on the other hand – it would still be interesting to do an in-depth investigation of Muslim patients personally confronted with terminal illness on the meanings they attribute to illness and suffering and the practices involved. Third, taking into account the specific situation of first generation Moroccan Muslims in Belgium characterized by a homogenous socio-economic situation and a more diverse socio-demographic background among second generation Muslims, it would be interesting to explore the views and practices among third generation Muslims who embody a stronger diversity socio-economically as well as religiously. Further studies could explore whether the impact of religion on coping with illness would differ among younger generations of (Moroccan) Muslims that have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and that in this context experience and construct their own (religious) identity.

Given the fact that contemporary Western societies are becoming increasingly multicultural and multi-religious, it is of great importance to provide adequate and respectful health care. As such, offering religious and cultural-sensitive care is of the utmost importance. This implies an adequate training of health care professionals in order to provide holistic care, where considerable attention is given to the patients' religious, ideological and cultural background. By offering insights into the actual attitudes and beliefs of Muslims towards health, illness and medicine, this study aims to offer tangible leads to health care professionals for a more adequate tailor-made care for Muslim patients. Our study shows that spiritual and religious resources can provide an important support for effectively coping with illness. Being acquainted with patients' ways of coping with meanings they attribute to illness may provide insights into patients' very concrete medical choices.

Conclusion

Our study reveals that religion is the most important and dominant framework through which health, illness and medicine are viewed among Muslim women. Theological and more specifically teleological considerations that centre on God's almightiness and the belief in the afterlife seem to be very crucial for Muslims. Illness is a test, influencing one's eternal fate, that must be patiently endured.

Rather surprisingly, no differences were found between the views and attitudes of middle-aged and elderly Moroccan Muslim women, despite their often very different socio-economic position, educational level and integration in Western society. We did, however, note a difference in the strength and depth of the participants' theological justification of their views and attitudes, probably influenced by their educational level and the extent of their religious knowledge and education.

Religion seems to offer Muslims a strong coping mechanism from which strength and hope are drawn. At the same time, Muslims seem to opt for a holistic approach, as relying on medicine and on God go hand in hand. In any case, religious beliefs and worldviews seem to have a strong impact on their attitudes concerning illness and medicine.

References

Ahaddour, C., & Broeckaert, B. (2016). Muslim Burial Practices and Belgian Legislation and Regulations: a Comparative Literature Review. *Mortality*, 1-18. doi: 10.1080/13576275.2016.1263943

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (2015). Institutional Elderly Care Services and Moroccan and Turkish Migrants in Belgium: A Literature Review. *Journal of Immigrant and Minority Health, 18*(5), 1216-1227.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-a). Between Quality of Life and Hope: Beliefs and Attitudes of Moroccan Muslim Women toward Withholding and Withdrawing Curative and Life-Sustaining Treatment. Manuscript submitted for publication.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-b). "Every Soul Shall Taste Death". Beliefs and attitudes of Muslim Women toward Dying, Death and the Afterlife. Manuscript submitted for publication.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-c). "God is the Giver and Taker of Life". Beliefs and Attitudes of Moroccan Muslim Women toward Assisted Suicide and Euthanasia. Manuscript submitted for publication.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-d). "God's Land is Vast". Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased. Manuscript submitted for publication.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-e). Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women. Manuscript submitted for publication.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-f). A Temporary Farewell. Attitudes, Beliefs and Practices of Muslim Women regarding Mourning and Remembrance. Manuscript submitted for publication.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (Forthcoming-g). "What Goes Around Comes Around". Attitudes and Practices regarding Care for the Elderly among Moroccan Muslim Women. Manuscript submitted for publication.

Ahmad, F., Muhammad, M., & Abdullah, A. (2011). Religion and Spirituality in Coping with Advanced Breast Cancer: Perspectives from Malaysian Muslim Women. *Journal of Religion and Health, 50*(1), 36-45.

Al-Azri, M. H., Al-Awisi, H., Al-Rasbi, S., & Al-Moundhri, M. (2014). Coping with a diagnosis of breast cancer among Omani women. *Journal of Health Psychology, 19*(7), 836-846.

Al-Jeilani, M. (1987). Pain: Points of View of Islamic Theology *Acta Neurochirurgica Supplementum, 38*, 132-135.

Arabiat, D. H., Al Jabery, M., Abdelkader, R. H., & Mahadeen, A. (2013). Jordanian Mothers' Beliefs About the Causes of Cancer in Their Children and Their Impact on their Maternal Role. *Journal of Transcultural Nursing, 24*(3), 246-253.

Baeke, G. (2012). *Religion and ethics at the end of life. A qualitative empirical study among elderly Jewish and Muslim women in Antwerp (Belgium).* (Unpublished doctoral dissertation) Katholieke Universiteit Leuven, Leuven.

Baeke, G., Wils, J. P., & Broeckaert, B. (2012). Be patient and grateful: elderly muslim women's responses to illness and suffering. *The Journal of Pastoral Care & Counseling, 66*(3-4), 5.

Brockopp, J. E. (2004). *Islamic Ethics of Life. Abortion, War and Euthanasia* Columbia: University of South Carolina Press.

Corbin, J., & Strauss, A. (2015). Basics of qualitative research: Techniques and procedures for developing grounded theory (4th ed.). California: SAGE Publications.

Fitzpatrick, S., Kerridge, I., Jordens, C., Zoloth, L., Tollefsen, C., Tsomo, K., . . . Sarma, D. (2016). Religious Perspectives on Human Suffering: Implications for Medicine and Bioethics. *Journal of Religion and Health, 55*(1), 159-173.

Gielen, J., Van den Branden, S., & Broeckaert, B. (2009). The Operationalisation of Religion and World View in Surveys of Nurses' Attitudes toward Euthanasia and Assisted Suicide. *Med Health Care Philos, 12*(4), 423-431.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine Publishing Company

Harandy, T. F., Ghofranipour, F., Montazeri, A., Anoosheh, M., Bazargan, M., Mohammadi, E., &Niknami, S. (2010). Muslim Breast Cancer Survivor Spirituality: Coping Strategy or Health Seeking Behavior Hindrance? *Health Care for Women International, 31*(1), 88-98.

Hertogen, J. (2015). Moslims in België per gewest, provincie en gemeente: Evolutie 2011, 2013 en 2015. Retrieved 20 October 2016 from http://www.npdata.be/

Jafari, N., Farajzadegan, Z., Zamani, A., Bahrami, F., Emami, H., & Loghmani, A. (2013). Spiritual well-being and quality of life in Iranian women with breast cancer undergoing radiation therapy. *Supportive Care in Cancer, 21*(5), 1219-1225.

Levecque, K., Lodewyckx, I., & Van den Eede, S. (2006). Gezondheid en gezondheidszorg bij allochtonen in Vlaanderen. Antwerpen: Steunpunt Gelijkekansenbeleid, Consortium Universiteit Antwerpen en Universiteit Hasselt.

Nabolsi, M. M., & Carson, A. M. (2011). Spirituality, illness and personal responsibility: the experience of Jordanian Muslim men with coronary artery disease. *Scandinavian Journal of Caring Sciences, 25*(4), 716-724.

Padela, A. I. (2007). Islamic Medical Ethics: a Primer. *Bioethics, 21*(3), 169-178.

Padela, A. I., Vu, M., Muhammad, H., Marfani, F., Mallick, S., Peek, M., & Quinn, M. T. (2016). Religious beliefs and mammography intention: findings from a qualitative study of a diverse group of American Muslim women. *Psycho-Oncology, 25*(10), 1175-1182.

Pew Research Center. (2015). The future of world religions: Population growth projections, 2010-2050. Retrieved 27 October 2016 from http://www.pewforum.org/2015/04/02/religious-projections-2010-2050/.

Rassool, G. H. (2000). The Crescent and Islam: Healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring. *Journal of Advanced* Nursing, 32(6), 1476–1484.

Roy, O. (2002). *L'islam mondialisé*. Paris: Editions du Seuil.

Rozario, S. (2009). Allah is the scientist of the scientists: Modern medicine and religious healing among British Bangladeshis. *Culture and Religion, 10*(2), 177-199.

Rozario, S. (2011). Islamic piety against the family: from 'traditional' to 'pure' Islam. *Contemporary Islam, 5*, 285-308.

Sachedina, A. (2009). Islamic biomedical ethics: Principles and application. Oxford: Oxford University Press.

Salman, K. F. (2012). Health Beliefs and Practices Related to Cancer Screening among Arab Muslim Women in an Urban Community. *Health Care for Women International, 33*(1), 45-74.

Shadid, W. A. R., & van Koningsveld, P. S. (2008). Islam in Nederland en België. Leuven: Peeters.

Sheikh, A., & Gatrad, A. R. (2008). Caring for Muslim patients. Oxford: Radcliffe.

Shirazi, M., Bloom, J., Shirazi, A., & Popal, R. (2013). Afghan immigrant women's knowledge and behaviors around breast cancer screening. *Psycho-Oncology, 22*(8), 1705-1717.

Strauss, A., & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory. Thousand Oaks, CA: Sage.

Van den Branden, S. (2006). *Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen.* (Unpublished doctoral dissertation), Katholieke Universiteit Leuven, Leuven.

Van den Branden, S., & Broeckaert, B. (2008). Medication and God at Interplay: End of Life Decision Making in Male Moroccan Migrants Living in Antwerp, Flanders, Belgium. In J. Brockopp & T. Eich (Eds.), *Muslim Medical Ethics: from Theory to Practice* (pp. 194-208). Columbia: University of South Carolina Press.

Voas, D., & Fleischmann, F. (2012). Islam Moves West: religious Change in the First and Second Generations. *Annual Review of Sociology, 38*, 525-545.

Ypinazar, V. A., & Margolis, S. A. (2006). Delivering culturally sensitive care: The perceptions of older Arabian Gulf Arabs concerning religion, health, and disease. *Qualitative Health Research , 16*(6), 773-787.

Zeilani, R., & Seymour, J. E. (2010). Muslim women's experiences of suffering in Jordanian intensive care units: a narrative study. *Intensive and Critical Care Nursing, 26*(3), 175-184.

"Whoever kills an innocent person it is as if he has killed all of humanity."

—Q5:32

3. "God is the Giver and Taker of Life". Muslim Beliefs and Attitudes regarding Assisted Suicide and Euthanasia

Introduction

A number of Western countries have actively debated euthanasia over the last 30 years. The debate has centered on a right to die based on the principles of autonomy, individuality, and the right to self-determination (Cohen et al. 2006a, b). More recently a number of publications have included discussions of contemporary bioethical issues including euthanasia from a normative Islamic point of view (Al-Bar and Chamsi-Pasha 2015; Arda and Rispler-Chaim 2012; Atighetchi 2007; Brockopp 2004; Brockopp and Eich 2008; Ghaly 2016; Rispler-Chaim 1993; Sachedina 2005, 2009; Shanawani and Khalil 2008) and a large number of legal opinions (*fatāwā/fatwas*) have been issued by Islamic scholars through different media (cf. Islamic organisation of Medical Sciences, Islamic *Fiqh* Academy, International Islamic *Fiqh* Academy, European Council for Fatwa and Research) (Al-Bar and Chamsi-Pasha 2015; Van den Branden and Broeckaert 2009, 2010a, b). However, the number of empirical studies that deal with the views of the rapidly growing number of Muslims living in the West on specific ethical dilemmas at the end of life is very limited (Ahaddour, Van den Branden and Broeckaert 2017a; Baeke 2012; Van den Branden 2006). Given the fact that Europe, and more specifically Belgium, are becoming more multicultural and –religious, care can no longer be provided solely from Christian or Western secular framework. Additionally, it is of great importance to provide adequate and dignified end-of-life care.

In this article we ask what the relationship is between normative Islamic views on assisted suicide and voluntary euthanasia on the one hand and real-world views and attitudes of Muslims living in a western, European society on the other hand. Is there a wide gap between normative Islamic viewpoints and what ordinary Muslims believe and think? And can we observe a shift in views and attitudes when we compare first and second generation Muslims in Belgium, given that in Belgium this second generation shows much more socio-economic diversity and has presumably been more strongly influenced by the Western society they live in and have been brought up in?

Normative Islamic Views on Assisted Suicide and Euthanasia

Islam has no central religious authority. Muslim scholars deploy a variety of approaches to ethics often resulting in a variety of opinions (*fatāwā/fatwas*) within Islamic jurisprudence (*fiqh*) (Al-Bar and Chamsi-Pasha 2015; Arda and Rispler-Chaim 2012; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2012). However, regarding the active termination of life a univocal negative answer is found within normative Islamic and international scholarly literature (see *fatwas* issued by Islamic organisation of Medical Sciences, Islamic *Fiqh* Academy, International Islamic *Fiqh* Academy, European Council for Fatwa and Research) (Al-Bar and Chamsi-Pasha 2015; Van den Branden and

Broeckaert 2009, 2010a, b). Any active form of life termination is radically rejected and prohibited on the basis of a number of theological arguments and convictions. First, Islam does not recognise the right to die voluntarily. Deliberately ending one's life is considered suicide and is equated with murder when there is a physician involved. Both murder and suicide are perceived as grave sins (Al-Shahri 2016; Atighetchi 2007; Ayuba 2016; Brockopp 2008; Choong 2015; Rahman 1998; Rispler-Chaim 1993; Sarhill et al. 2001; Van den Branden and Broeckaert 2010b). Yousuf and Fauzi (2012) and Al-Bar and Chamsi-Pasha (2015) explain that from a Quranic point of view, saving a person's life is equated with saving the lives of the whole of mankind and taking one's life unjustly is tantamount to the killing of mankind in its entirety. Rahman (1998) and Al-Jahdali et al. (2013) explicitly state that, in Islam, the concept of a life not worth living is unacceptable. On the other hand, Padela and Qureshi (2016, p.11) state that "one could argue that judgements about when a certain type of life need not be brought into this world and when a certain type of life can be allowed to expire are two sides of the same coin as they attend to a moral vision for what constitutes a life worth living (or a life worth preserving medically)." Indeed, withdrawal of life support when patients are not expected to recover, are terminally ill, or are declared brain dead is permitted by some Islamic scholars and judicial bodies (Ebrahim 2001; Padela & Qureshi 2016; Sachedina 2009). In the context of abortion, different perspectives exist within the Islamic legal schools and among the Islamic scholars (e.g. based on the idea of ensoulment) about when and in which (strict) circumstances an abortion can be initiated (Athar 2016; Atighetchi 2007; Brockopp 2004). According to Al-Bar & Chamsi-Pasha (2015) and Atighetchi (2007), in Islam, abortion is allowed for certain medical reasons including a serious disease of the expectant mother that makes continuation of the pregnancy hazardous to her health or even to her life. The mother is recognised as having a greater value than the foetus as a form of life that has already been developed and is possibly the source of a new life. According to the Islamic *Fiqh* Council (Saudi Arabia), in case of a severe congenital anomaly, abortion can be allowed if agreed upon by a committee of experts (Albar, 2007; Al-Bar & Chamsi-Pasha 2015; Al-Matary & Ali 2014).

The normative Islamic literature also upholds the notion of God's omnipotence and omniscience concerning life and death. God is the giver and taker of life (Al-Jeilani 1987; Atighetchi 2007; Brockopp 2008; Fitzpatrick et al. 2016), which implies human limitedness and the human impossibility of predicting one's moment of death (Al-Jeilani 1987; Lapidus 1996; Rahman 1998). In normative Islam we find an unconditional belief in predestination; the occurrence of death is attributed to the will of God (*al-qadr*) (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Atighetchi 2007; Baider 2012; Rispler-Chaim 1993; Sachedina 2005, 2012; Van den Branden and Broeckaert 2010a). Several scholars (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2005, 2012) argue that God is the creator of everything and the determiner of a person's life span (*ajl*). These arguments are in conflict with a secular right-to-die discourse.

Moreover, Atighetchi (2007) states that where the West emphasizes self-determination as a right, from an Islamic perspective autonomy is rather limited, as only God has the right to decide upon a person's life. From this perspective performing or requesting euthanasia or assisted suicide is perceived as denying God's rights over lives and is seen as an act of blasphemy (Sachedina 2005; Van den Branden and Broeckaert 2010a).

Regarding euthanasia and assisted suicide, normative Islamic and scholarly literature clearly emphasizes a *teleological* perspective. According to Brockopp (2004) and Van den Branden and Broeckaert (2010a) death, in the Islamic tradition, is merely seen as a transitory element in the larger eschatological scheme, i.e. what the soul is awaiting in the hereafter (e.g. paradise; hell). Badawi (2011) and Sachedina (2012) explain that in Islam the purpose of the worldly life is only to prepare a person for the eternal life in the hereafter, as life and illness are viewed as merely a test of God. The future perspective of judgement in the hereafter qualifies a person's action in this world. In Islam, each person has a free will and is thus responsible for his or her own actions (Al-Bar and Chamsi-Pasha 2015; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2005). Intention *(niyya)* is strongly emphasized in this respect. Atighetchi (2007) and Al-Bar and Chamsi-Pasha (2015) explain that each action will be judged according to the person's intention. Committing suicide would thus result in an eternal punishment in hell (Brockopp 2004; Rispler-Chaim 1993; Sachedina 2012; Van den Branden and Broeckaert 2010a). Through confrontation with illness and suffering Muslims are recommended to be aware of the earning of good marks (*ḥasanāt),* which pave the road to paradise (Al-Shahri 2016; Brockopp 2004; Rispler-Chaim 1993). In other words, the rejection of active termination of life is to be understood within a broader teleology, within the purposefulness of life and illness. From an Islamic perspective, cultivating a faithful relationship with God and being patient guarantees rewards (*ḥasanāt*) in this life or in the world to come (Al-Bar and Chamsi-Pasha 2015). Baider (2012) also affirms this Islamic perspective by stating that the belief in predestination and the afterlife helps Muslims to cope with severe illnesses. In this teleological and eschatological framework, euthanasia and assisted suicide are not acceptable options.

A final conviction that constitutes an argument against euthanasia and assisted suicide can be found in the sanctity of human life. The *Qurʾān* affirms that all human life is holy (*ḥurm*) and dignified (*karāma*) as God has created it (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Ghaly 2015). Islam attributes a great value to the preservation of human life. This is one of the five higher objectives of Islamic law (*maqāṣid al-Sharīa*), which entails preservation of faith, life, mind, progeny and property (Al-Bar and Chamsi-Pasha 2015; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2009). In Islam high importance is given to taking care of body and life, as they are a trust *(ʾamāna)* of God (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Ghaly 2015). Several scholars (Al-Bar and Chamsi-Pasha 2015; Atighetchi 2007; Badawi 2011; Brockopp 2004; Ghaly 2015; Rispler-Chaim 1993; Sachedina 2009; Van den Branden and Broeckaert 2010b) corroborate that in Islam the

relationship with the body is framed in terms of vicegerency: a human being does not own his or her body, but only has it in loan until death. Life and body are thus considered gifts from God. Therefore, seeking treatment is often considered important. In general, nearly all (*Sunni*) legal schools (*madhāhib*) are of the opinion that seeking remedy is obligatory (*farḍ*) in certain lifesaving situations and in treatable and curable illnesses. A treatment is considered optional or permissible (*mubāḥ*) when the overall benefit is not proven or even doubtful and when the effect of a therapy is uncertain. A therapy is discouraged (*makrūh*) when therapy is futile, unlikely to bring benefit, and when harm or even inconvenience from therapy may follow (Al-Bar and Chamsi-Pasha 2015; Al-Jahdali et al. 2013; Padela and Qureshi 2016; Padela and Mohiuddin 2015; Qureshi and Padela 2016; Saiyad 2009). However, the dominant classical position of the *Ḥanbalī* legal school is that seeking medical treatment is permissible, but not obligatory and that abstaining is superior. Preference is given for placing trust (*tawakkul*) over seeking medical treatment and thus refraining from therapy is seen as praiseworthy (Padela & Qureshi 2016; Qureshi & Padela 2016). Euthanasia and assisted suicide, on the other hand, are not an option.

Empirical study

Data collection

We used an exploratory approach to describe the attitudes and beliefs of Moroccan Muslim women regarding euthanasia and assisted suicide. Our goal was to reconstruct Moroccan Muslim's women way of thinking, not to formulate normative judgments about them. From October 2014 to September 2015, 30 semi-structured interviews were conducted with a snowball sample of middle-aged and elderly self-identified Muslim women in the Moroccan community in Antwerp (Belgium). This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. Because of the cultural characteristics of the research population, more specifically the common gender segregation in traditional Muslim societies, in particular among first and second generation Moroccan Muslim communities (Timmerman 2001), and the female gender of the interviewer (first author), purposive sampling for qualitative interviewing was limited to Moroccan Muslim women. The views of first generation Moroccan Muslim men in Belgium (Antwerp) have been addressed by Van den Branden (2006), who additionally conducted a theoretical analysis of Islamic sources on end-of-life-issues (Van den Branden & Broeckaert, 2008). In other words, we chose women of Moroccan descent as this population is one of the largest Muslim communities in Belgium (Hertogen, 2016). Our choice for Antwerp was based on two important reasons. First of all, this city has the largest Muslim population in Flanders: 19.2 % of Antwerp's population is Muslim (Hertogen 2016). Second, Antwerp as a port city is considered to be one of the most multicultural cities in the world. We chose elderly (first generation) women, as they are, given the aging of this population, confronted with more end of life and health care needs. We also included middle-aged

participants as they have been brought up in a Western context, in contrast to the first generation who grew up in a traditional Islamic context.

Different routes of recruitment (e.g. mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured interview protocol covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) and Dutch. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organization, or in a quiet tea house). To help us with the interpretation of our data, the interviewer (first author) also consulted with 15 experts in the field (e.g. Muslim physicians, Muslim nurses, palliative care consultants, a *ḥijāma* ["cupping" a body therapy that purifies that purifies blood by means of a vacuum] practitioneretc.)) about euthanasia and assisted suicide between September 2014 and September 2015. The information collected from these interviews provided context within which the data from our interviews could be considered. The data of our interviews with experts are not perceived as normative, but only as a description of their observations and experience with Moroccan Muslims. Experts were interrogated on the same topics as the Moroccan Muslim women via outlined semi-structured interview protocols. This approach was helpful as a comparative method to ensure reliability of the data and helped us to be more sensitive towards the data from our interviews.

The present study is part of a larger research project on the attitudes, beliefs, and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp).

Ethics Review

Our study was approved by the Social and Societal Ethics Committee (KU Leuven, Belgium). Informed consent was gathered from each participant. In order to guarantee the anonymity of our participants, we made use of pseudonyms.

Data analysis

On average, each interview took 120 minutes (range: 90 minutes to 150 minutes). Data collection continued until theoretical saturation was reached. This occurred after 13 interviews with middle-aged participants and after 12 interviews with elderly participants. Nevertheless, we conducted extra interviews to ensure the validity and reliability of our data. The interviews were audio recorded and transcribed verbatim, using Express Scribe.

Grounded theory methodology (Corbin and Strauss 2015; Glaser and Strauss 1967; Strauss and Corbin 1998) was used to code and analyse the interview data. Grounded theory methodology aims at thoroughly capturing the worldview of the individual respondent as a basis for constructing the world view of the social group to which the respondent belongs. Therefore, the methodology stresses the use of "taking the role of the other" and the "constant comparative method" as basic research techniques (Glaser and Strauss 1967). By adding codes to the data and through constant comparisons, key concepts –generated inductively– were identified in the interviews and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants.

The data were coded using grounded theory's three major steps of coding: open, axial, and selective coding. During open coding, the data were broken down, examined, and compared in order to identify similarities and differences while categorizing the data. Axial coding, the second step in the coding process, reflected the systematic process we used for grouping data, linking categories based on associative relationships and deriving conclusions from analysis and re-synthesis of data. The third step of coding was selective coding—a process in which relationships between the core category and other categories were systematically identified. This was a process of integrating and refining a theory as an answer to the research question (Corbin and Strauss 2015; Strauss and Corbin 1990). In our exploration of the attitudes and beliefs of Moroccan Muslim women towards euthanasia and assisted suicide, our coding frame consisted of notions against euthanasia and assisted suicide and notions of dilemma. For example, concepts describing the arguments against euthanasia were "God as author of death," "life as a trust," "blasphemy," "suicide," and "hell." These concepts were subsumed under categories including "theological considerations," "eschatological considerations," which were subsumed under the category label "contra euthanasia." The data collection was based on constant iterative analysis of each new interview ("theoretical sampling") which often involved the adaptation and further specification of interview guides. When certain categories were well developed and the relationship between categories was clear, theoretical saturation ("theorizing") was reached (Glaser and Strauss 1967; Strauss and Corbin 1998). A tentative theoretical conclusion was that there was a clear relation between religious beliefs and attitudes towards euthanasia and assisted suicide.

In order to facilitate data analysis, a qualitative data analysis software package (NVivo 10) was used. The data from the interviews with Muslim women and with experts were analysed separately in an NVivo project. The findings from our interviews with Muslim women were compared with those from the interviews with experts by concept and category and subsequently compared with other empirical studies (cf. discussion). Several control measures were taken to ensure reliability and validity of our data and to limit bias. First, all interviews were recorded and transcribed

ad verbum. Second, the interviewer made use of memos when collecting data, and analysing the data. Third, peer debriefing was performed by the guiding committee, consisting of researchers with an expertise in religious ethics and end-of-life issues. The guiding committee guided and reviewed all phases of the project from interview guide and research question development, to data collection, data analysis and dissemination. Double coding was also performed, in which interviews were coded independently by the interviewer and a member of the guiding committee and subsequently compared. Fourth, findings were regularly discussed with several members of the Moroccan Muslim community. Fifth, the data from the interviews with experts in the field as well as the literature were used to verify the reliability of our data.

Conceptual framework of Treatment Decisions in Advanced Disease

Attitudes towards treatment decisions at the end of life were explored by making use of hypothetical cases (Table 1) that were formulated on the basis of the typology of Broeckaert (Broeckaert 2008, 2009a, b; Broeckaert and Flemish Palliative Care Federation 2006). Broeckaert developed a typology of treatment decisions at the end of life in order to provide clarity regarding ethical dilemmas in end of life care. In this typology, choices with regard to euthanasia and assisted suicide constitute one category of treatment decisions (apart from choices with regard to curative/life-sustaining treatment and pain/symptom control). Broeckaert (2009a) distinguishes three kinds of acts belonging to this category: (1) assisted suicide, which means "intentionally assisting a person, at this person's request, to terminate his or her life"; (2) voluntary euthanasia, which is "the intentional administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable by the patient, at this patient's request"; (3) non-voluntary euthanasia, which is "the intentional administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable, not at this patient's request". This article is limited to the discussion of assisted suicide and voluntary euthanasia.

Case 1: Assisted Suicide
A terminal patient, having only a few more weeks to live, is in severe physical pain. The treating physician has been unable to adequately relieve his/her pain. That patient requests medication to end his/her life. Should the physician be allowed to provide drugs so that the patient can end his/her life?

Case 2: Voluntary euthanasia
A terminal patient, having only a few more weeks to live, is in severe physical pain. The treating physician has been unable to adequately relieve his/her pain. That patient requests his/her life to be ended. Should the physician be allowed to administer a lethal injection?

Results

Participants' (socio-)demographic information & health situation

The group of middle-aged Moroccan Muslim women (n=15) were between 41 and 55 years old, and the group of elderly women (n=15) were between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labour migration, family reunification, or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Among our middle-aged participants, twelve were married, two were divorced, and one was widowed. Among our elderly participants, eight were married, six were widowed, and one was divorced. Our elderly participants had noticeably larger families (with up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority were multilingual, mastering a total of three to five languages. Worth noting is that these participants pointed out that they did not have one, but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. In contrast to the middle-aged participants, they had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber Muslim women spoke Arabic, and only two Moroccan Arabic Muslim women had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them had not had the opportunity for education

and were illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque or sports center and taking Arabic and/or Dutch language classes.

Regarding employment, only two elderly participants worked outside the home as laborers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half had a high level of education. In contrast to elderly participants, ten of the fifteen middle-aged participants were economically active (from laborers to officials).

Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis, and geriatric migraines. The health issues of our middle-aged participants were limited to knee problems and migraine. Three elderly participants and one middle-aged respondent reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a previous coma, reported a poor health condition. In general, our middle-aged participants reported better health conditions than the elderly participants did. Five middle-aged and four elderly participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer, and severe chronic disease.

Attitudes towards Assisted Suicide and Euthanasia

Case 1: Assisted Suicide

Our participants immediately interpreted termination of life from a religious perspective. They all strongly condemned the idea of ending one's suffering in an active and direct way with the assistance of a physician, except for Nuria and Ikram (pseudonyms), who held rather intermediate positions. Nearly all participants unanimously argued that this act is unlawful (*ḥarām*) and is in fact in conflict and irreconcilable with being a believer, a Muslim, and for these reasons it is absolutely unacceptable.

> "No, that's suicide. No, that's *ḥarām*. You may not end your life. No. Being a Christian, a Muslim, or a Jew plays a role. A real Jew, Christian, or Muslim doesn't do that." Hannan – middle-aged – low level of education

> "If it's a non-Muslim, then the physician will give it. It's *ḥarām*! It's not allowed for the soul! […] That's not an Islamic conduct. No, a Muslim may not do that." Yamina – elderly – illiterate

Nearly all participants equated this act with suicide (*intiḥār*), and considered the physician an accomplice. In their opinion, the physician's task was to take care of the patient and not to help the patient with ending his or her life. In this respect, they highlighted that a Muslim is not allowed

to express a wish to die. These findings are in keeping with the results of the interviews with our experts.

> "It's still a sort of euthanasia. As a Muslim, I don't accept this, it's euthanasia, it's suicide. It's forbidden to hasten death. You may not wish that." Sarah – middle-aged – high level of education

> "No, they may not give him that. No no, because then he commits suicide. That's *intiḥār* [suicide]. It's not as if someone else gave it to him, but if he does it himself, then it's suicide. It's also not good if a physician does it. The physician is supposed to help a patient and not end his life." Aïcha – elderly – illiterate

> "No no, they see it as euthanasia, because you asked for it. No, it's suicide for both the first and second generation Muslim women." Fadila – Psychosocial consultant

A minority of – mainly elderly – participants considered ending one's life prematurely a sign of ignorance (*jahl*), blasphemy (*shirk*), and even disbelief/heresy (*kufr/kfa).* Indeed, throughout the interviews it was argued that a person who commits suicide turns away from God, is ungrateful, and an unbeliever (*kāfir*).

> "No no, that's not good, that's *jahl* [ignorance]. That's *shirk* [blasphemy]. You may not end your life." Zohra – elderly – low level of education

> "No no, then he stepped out of his religion [*kfa*]. Then he turned away [*kfa*] from God. Someone who does such a thing is not a Muslim, he's a *kāfir* [unbeliever]. It does happen to non-Muslims, for them it's nothing, but for us, this is impossible." Laziza – elderly – illiterate

The strong denouncement of this type of life termination by all our participants is based upon the belief, again shared by all, that only God has the right to end a person's life. This perception has to be viewed against the backdrop of their unconditional belief in the omnipotence of God, who governs over life and death, and predestination. Participants mentioned that only God determines a person's time of death (*ajl*), which is already predetermined. In other words, death is ascribed to God's will (*al-qadr*). They explained that a human being does not have any right to take (any) action to end his or her life, but rather must wait patiently until his or her time of death comes. In this way, humans can score good marks (*ḥaṣanāt*), which will be counted up after death.

> "That's also not allowed! Not at all. […] God decides about your death, your ending. We don't know what God has destined for her. Everything is predestined." Radia – middle-aged – low level of education

> "I don't want anything to do with it. This is not ok. He ended his life before his *ajl*. Like I said, it's God who gives and takes away life. We have no business with that." Malika – elderly – low level of education

Against this backdrop, two participants referred explicitly to the vicegerency of the human being in this worldly life. They explained that life and body have to be taken care of as they are a gift and a trust (*ʾamāna*) from God.

> "Yes, it's forbidden in my religion, so I'm also against it. And as you can see, a body is a gift and if you're sick, it's a part of it. You need to take care of it." Lamya – middle-aged – high level of education

> "Life is an *ʾamāna*. It's only God who can take back his *ʾamāna*." Zohra – elderly – low level of education

In their rejection of assisted suicide (and euthanasia) most participants explicitly referred to their belief in the afterlife, which seems to form a strong barrier against terminating one's life. Indeed, our participants believed in an eternal afterlife and that life and illness are merely part of God's test for entering the eternal life in paradise. In their opinion, assisted suicide (and euthanasia) entails severe implications in the hereafter. They argued that assisted suicide is merely a relief in this worldly life, but a greater punishment and extreme suffering are awaiting in the hereafter. Moreover, after death, God will judge human beings based on their actions and this action of taking your own life would lead to an eternal stay in hell, erasing all good deeds that were performed. Therefore, the focus is more on the purposefulness of pain, which is understood as a way of purifying one's sins. This is also confirmed by our experts.

> "We believe in life after death, which is eternal. You know, you're going there and you would want to do everything that's in your power to get there in a right way. Then you're not going to commit suicide. Even if the pain would be really painful." Nihad – middle-aged – high level of education

> "No, that is *ḥarām*. God says: 'the person who commits suicide is destined for hell.'[…] And what if you killed yourself in this world, but the hereafter is worse, you'll suffer more in hell? One who commits suicide goes to hell. It's not good. That's my opinion, the one who commits suicide goes to hell, that's what I hear in the *Qurʾān*." Alia – elderly - illiterate

> "I think this almost never happens among us. Because they know you'll be punished severely in the hereafter." Laila – Muslim nurse

Only a few participants nuanced this idea of severe eschatological implications and emphasized that a person cannot pass judgement on another human being's actions. Only God has the knowledge of intentions and can pass moral judgment on a person's actions. Thus, only God possesses knowledge (*Allāhu aʿlam)* and therefore knows a human being's destiny.

> "God says that if you commit suicide or jump out of a window or kill someone or take drugs to die, then you'll experience a rough path to God. Where you will go in the hereafter depends upon your deeds. But in this case, it's only God who knows." Khadija – elderly – low level of education

> "If they do that, they'll think they'll have found peace, but they'll not find it. If you commit suicide, you'll go as an unbeliever, as *jahl* to the hereafter. But God knows best [*Allāhu a'lam*]." Fatma – elderly – illiterate

Although we found a strong disapproval of assisted euthanasia among our participants, two participants expressed a more "understanding" attitude towards this case, though they still shared the dismissive attitude toward active termination of life. One elderly participant (Nuria) emphasized the right to self-determination, explaining that a human being has the right to decide for him- or herself,

though she still acknowledged that the soul is from God and therefore only God has the authority and power to take away a person's life. Besides Nuria, several elderly and middle-aged participants who did not approve of assisted suicide could actually "understand" the difficulty of dealing with unbearable pain. Our participants also mentioned that they could "understand" that human beings who do not have a faith or do not believe in a God would request assisted suicide. Among them, however, Ikram took an exceptional position. Her answer clearly illustrates a difficult dilemma between the removal of unbearable pain and God's ultimate role in matters of life and death. The notion of compassion fostering a dilemma is also confirmed by our experts. The exceptional answers of Nuria and Ikram will be explained later in the Discussion section.

> "Oh [silence]. If the patient decides it, so be it. If he decides it himself. It's his choice. Normally this is not permitted. Like I said before, the soul is from God. Normally we should die naturally." Nuria – elderly – low level of education

> "Yeah, that's terrible. For example, with labor pain I think 'God please!'. You would do anything in that moment. But only God can actually take life. I find it difficult. I don't know what I would do. I really find these extremely difficult situations." Ikram – middle-aged – high level of education

> "There is that emotional aspect on the one hand. They [the family] will have compassion with the patient. And on the other hand, they know we are not allowed to end our lives. So it will be a dilemma either way. But if the pain is unbearable, if you hear a person, constantly screaming in pain, they'll not be able to bear that anymore and it'll be a sort of peace and relief. These are really difficult issues." Nourdin – *ʾImām*

Case 2: Voluntary Euthanasia

The participants' opinions on voluntary euthanasia were similar to their views on assisted suicide. All of our participants, except for two (Nuria and Ikram), declared themselves to be absolute opponents of euthanasia, referring to it as a forbidden act (*ḥarām*) and considering it ethically on par with suicide and murder. This was again perceived as contrary to being a Muslim. They believed that Muslims would never commit such an act, and that a Muslim physician would never help terminating a person's life. In their opinion, requesting euthanasia was considered turning one's back on their faith, namely turning away from God (*kufr*). They believed that a Muslim should not wish for death. It is worth mentioning that compared with the former case, the physician in this case is not merely viewed as an accomplice, but rather as a murderer.

> "No, a Muslim may not do that. That's *ḥarām*.[...] We may not kill ourselves. Because then you have committed suicide.[…] God says that you may not kill yourself." Hannan – middle-aged – low level of education

> "Yeah, non-Muslims do that, but we Muslims don't. We may not ask for death. […] That lethal injection is *ḥarām*. The physician should help the patient to live and not to end a life. The physician then killed a soul. We Muslims don't approve of that." Laziza – elderly – illiterate

> "No, absolutely not. There's no one who would approve of that. Because according to Islam it's *ḥarām*, because it's suicide. And I really do not see any difference between those generations." Nora – Muslim nurse

Several participants viewed this act from within an eschatological framework, referring to the encounter with God, paradise and hell. Here, again, they mentioned eschatological implications when performing euthanasia and explained that it would lead to a severe punishment in the hereafter and thus would only offer a temporary worldly relief. This idea is also confirmed by our experts. Here, too, a few participants nuanced this idea of severe implications, referring to God as the only one possessing all knowledge.

> "It has also to do with religion. No matter how difficult it may be, how unbearable the pain can be, you say 'there comes an end.' But euthanasia as a Muslim remains difficult because how far is that a liberation? […] If you're a Muslim and you believe that when you die, we'll have an encounter with God, and we'll have paradise and so on." Sarah – middle-aged – high level of education

> "*Allāhu a'lam* [God knows best] but they say that you'll go to hell. But if you do that, I don't know what will happen. Only God knows that." Haddad – elderly – illiterate

> "I think that euthanasia is a step too far. That's suicide. They immediate link it with hell." Soumiya – Elderly care consultant

Nearly all participants strongly highlighted that only God has the right to take a person's life, as He is the creator of heaven and earth as well as life and death. Here, too, participants stressed that God determines a person's time of death *(ajl*) and that death only occurs with God's decree. In this respect, participants described God as the ultimate steward of life and body and pointed out the importance of patiently waiting until the time of death comes. In other words, the patient does *not* have a right-to-die.

> "Well, no, God has given you a life and He is the only One who may take it away. It's just that Islamic concept of 'God has given you a life, God created you.' You cannot decide when you will be born. You cannot decide when you'll die." Badria – middle-aged – high level of education

> "No no, you'll have to wait patiently until your times comes. […] The moment of death [*ajl*] comes from God. It's God who decides when you'll die, when you'll live. He created us. A human being may not take away his or her life, only God has the right." Zoulikha – elderly –low educated

> "They [Moroccan Muslim women] don't do that. They are radically against it. They also believe that death comes from God and that we shouldn't rush into it." Myriam – Palliative care consultant

Based upon the belief in an omnipotent God, who has everything in His hands (shared by all), half of our participants also explained their stance against active termination of life on the grounds that God is capable of everything (*al-Qādir*). Hence, they believed that God has the power to cure a person who is declared terminally ill, which as a result fosters hope and the belief in a miracle. This perspective is also closely related to the belief in God's decree (*al-qadr*).

> "That's why I'm against it. And if God doesn't allow it, then there's always a reason why. You know? So that means that there's still a chance of you healing. God is capable of everything." Lamya – middle-aged – high level of education

> "If God wants you to heal, you'll heal. Everything is in God's hands. There's a family member in France who had stomach cancer and the physicians said that they needed to remove his stomach, otherwise he would die. But he refused […]. He's still alive to this day. […] You must have *ṣabr* [patience] and believe in the *qadr* of Allah and perform your prayers." Yamina – elderly – illiterate

Noteworthy is that two participants explicitly pointed out that requesting and performing euthanasia are in fact sacrilege. To them, either the physician (cf. Loubna) or the patient (cf. Alia) was adopting the role of God. In their opinion, God's role as Creator of life and death was denied.

> "I'm against it. I think the physicians are playing God. And I find that sad, because God created us." Loubna – middle-aged – low level of education

> "People don't have a voice in that matter. It's God who'll end his life. If you do that, you're playing God. That's forbidden!" Alia – elderly – illiterate

Two middle-aged participants referred to a tendency in Western societies where aging and incurable illness are equated with a loss of dignity that results in the request for the termination of one's life. They actually feared a "normalisation" of euthanasia.

> "Now they tell everyone 'when you have Alzheimer, your life is worthless.' It's like 'oh, no, you don't have a life. You don't know anything anymore'. [...] And then the patient will also say 'my life is no life, it's worthless.' […] That's what you're told and it's frightening. Now it's even allowed for children, where do we draw the line? That's frightening." Halima – middle-aged – high level of education

> "Now it's only allowed for severe cases such as terminal illness, but in the long run it'll be for nothing. If they can't handle it anymore, they'll ask to end their life. In the long run it will be seen as a normal act." Narima – middle-aged – low level of education

Here, too, Nuria and Ikram had a different perspective. Similar to the former case, Nuria stressed that every person has the right to decide for oneself (self-determination), but at the same time referred to God's role in death. Ikram's answer reflected doubtfulness/incertitude. She was again in a clear dilemma between the difficulty of suffering unbearable pain and the belief in God as the ultimate author of creation and death. Here too Ikram argued that she would not know what to do in this situation and stated that a human being may not pass judgement on another human being's actions. Several other middle-aged and elderly participants shared their "understanding" for this situation, while at the same time acknowledging that this act is absolutely forbidden. This double perspective is also confirmed by our experts.

> "I find this difficult. In the end we can't judge about it, only God can. So I really don't know, I really have no clue. It would be a nightmare. Imagine that it's your own child or your husband and they can't bear it anymore and they say that they want to die, well, then it's like I end their life. […] But actually, it's God who created him.

> God will take away his life as He wants. Uhm, I find that difficult. No, I don't think I would do it. I don't know." Ikram – middle-aged – high level of education
>
> "The decision I make depends on my situation. It depends on what the patient wants. If the patient wants it [euthanasia], he's sick of it and he can't bear it anymore, poor guy, so be it. It's hard. It's God who gives and takes away the soul. Normally we can't interfere in that." Nuria – elderly – low level of education
>
> "It might be that there are people who suffer so much pain, that they express things that are not allowed. When the pain is so unbearable, they might say 'end it now'. But I think that only max 2% would consider that" Imane – *Ḥijāma* practitioner

Discussion

Cohen et al. (2006a, 2006b) argue that the acceptance of euthanasia tends to increase with the level of education, and tends to decrease with age. However, this was not observed in our study. Although there are differences in age, but also in level of education and socio-economic status between the first and second generation, surprisingly no differences were observed between our middle-aged and elderly participants in their attitudes towards active termination of life, nor between participants who were or were not confronted with severe illness, either personally or in their immediate environment. Although it could be assumed that second generation Muslim women, who were born or raised in Belgium, are more likely to be influenced by Western ideas, which might result in the decline of a theological understanding and in the development of a more secular, autonomy-oriented approach, this was not the case in our study. On the contrary, middle-aged women emphasized theological and eschatological notions to an equal degree as the generation above them. Indeed, no differences in attitudes were noted between our participants on the basis of age nor educational level. The findings of our interviews with middle-aged and elderly Moroccan Muslim women were also identical to those of the interviews with our experts in the field.

Our study showed that our participants are vehemently opposed to both assisted suicide and voluntary euthanasia based upon four arguments, which are strongly consistent with the lines of reasoning found in normative Islamic views and in earlier empirical studies (Van den Branden 2006, 2008; Baeke, 2012). Although these empirical studies contain small samples, we observed a strong consistent line in our findings. First, euthanasia and assisted suicide are considered forbidden acts, equated with suicide and/or murder. We noticed a shift in condemnation from suicide to murder from the perspective of the patient and from accomplice to murderer from the perspective of the physician (case 1 to case 2). Second, our participants strongly emphasized God's omnipotence and omniscience. Studies of Van den Branden & Broeckaert (2008), Kristiansen et. al (2014), and Ilkilic (2014), endorse our participants' line of reasoning that terminating a person's life denies God's role in matters of life and death. Our participants expressed an unconditional belief in an almighty God who is the ultimate author of illness and cure, life and death and a person's life span (*ajl*) (cf. no right to die). It is not up to a physician to make a medical prognosis of life span or up to a human being to

decide upon one's end of life (cf. blasphemy). Based upon this faith in an almighty God who is capable of everything, notions of hope and belief in a miracle were frequently mentioned by our participants. Third, reference was made to the viceregency of a human being which implies that human life and body are a trust from God and therefore must be taken care of. Fourth, our participants strongly emphasize a *teleological* perspective. Based upon their belief in an eternal afterlife (cf. life and illness as a test; day of judgement, paradise etc.), they believe that active termination of life entails severe eschatological repercussions (cf. punishment, hell). Noteworthy is that mainly elderly participants mention that these acts (might) result in heresy/disbelief (*kufr*), but also in an eternal stay in hell. One might deduce from this that elderly participants likely judge faster than middle-aged participants. However, several elderly and middle-aged participants were careful and mentioned in this respect that ultimately only God has the authority to judge a human being and possesses knowledge *(Allāhu a'lam*) on the destiny of each human being.

The answers of our middle-aged and elderly participants were very clear: assisted suicide and euthanasia are absolutely unacceptable and in fact taboo that firmly collides with their worldview. Although our participants vehemently denounced active termination of life, we noticed certain divergent positions marked by a more "understanding" attitude. Nearly one third of our participants adopted an attitude of "compassion" and "understanding" for the situation of the patient, while at the same time acknowledging explicitly that terminating life strongly contradicts Islamic beliefs. A striking finding is that the presented cases constituted a major dilemma for Ikram, one middle-aged participant, who argued repeatedly that she would not know what to do on the grounds of the difficult and sensitive nature of these cases. Ikram's attitude was clearly marked by doubt/uncertainty, but at the same time she explicitly expressed her belief in an almighty God, who governs over life and death. An understanding attitude toward active termination of life based upon the person's right to self-determination was only expressed by Nuria, an elderly participant. Although she strongly believed that decisions about life and death only belong to God, based on the idea that a personal decision remains a matter between God and the patient, she did mention that every human being has the right to decide for him- or herself. This is not surprising, as Nuria strongly viewed Islam and being a Muslim as a private matter between God and herself.

The exceptional views of both Ikram and Nuria might be explained or influenced by their particular interpretation or view of the afterlife. Contrary to the traditional interpretations shared by the other participants, they believed that notions such as the life in the grave and paradise should be interpreted metaphorically. Though acknowledged the judging role of God (*al-Hakam*), Ikram had her reservations concerning the severity of the punishment in the grave and strongly put forward the *image of God as Merciful* (*al-Rahīm*). Both Ikram and Nuria stressed that only God has knowledge of the afterlife. Interestingly, Ikram explicitly mentioned that she does not obey God's laws to receive

ḥasanāt (good marks) in order to enter paradise, but rather to receive God's love now (Ahaddour, Van den Branden & Broeckaert, 2017b).

> "Yes, I believe that God is All-Merciful and only wants what's best for His people. I repeat, those frightening stories, I take everything with a grain of salt, in which extent it's all true. 'There's a resurrection, there's a moment in the grave where you'll be tormented.' I'm not going to say that I don't believe that, because I've already said I'm Muslim. But I'm not sure if they're a hundred percent sure that it exists. […] I believe that when you die, that if you've done good, that you'll be in some sort of grace. You'll be sleeping and you'll feel good. […] On the other hand I think that Allah is Almighty. He can do everything. […] So I think it's beyond our imagination. It's like error, we cannot grasp it. My mother says 'it all exists, it exists!' She's so sure about that, when I'm not. It remains a mystery." Ikram – middle-aged

> "What will happen after death? Of course everyone thinks about paradise. 'There's hell and there's paradise.' I've known this since I was little, but Allah knows best. […] They say that there is punishment of the grave and punishment of hell and that all Muslims go to paradise. But I say that it isn't true. It's not true. […] My idea about this is that when someone dies, he'll become a new person. Voila, for me there will be a change of appearance. God knows best. I don't know if there's a hell. No one has ever returned from the dead to know what will happen." Nuria – elderly

Like us, Baeke and colleagues (Baeke 2012; Baeke, Wils, and Broeckaert 2012) also found a few "understanding" voices regarding euthanasia. Although the exceptional views in Baeke's study were based more upon the argument of self-determination, in our study this argument was only articulated by Nuria, whereas mainly Ikram but also several others expressed the feeling of "compassion" and "understanding." According to Baeke, the image of God might influence one's attitude towards active termination of life. As such, she suggests that "people who perceive God as an almighty, all-knowing, judging God, are more likely to disapprove of active termination of life" (Baeke, Wils, and Broeckaert 2012, p. 41). Our study suggests that reservations regarding the traditional representation of the afterlife (with a stress on punishment and hell) are influential here. Though in our study Ikram and Nuria still believed in an almighty and transcendent God, they did put the image of God as Merciful forward more than the image of God as Judge.

A second hypothesis suggested by Van den Branden and Broeckaert (2008) and Baeke, Wils, and Broeckaert (2012) is that confrontation with a palliative situation might lead to more openness towards euthanasia. Quite similar to our findings, Van den Branden and Broeckaert noticed that some of their participants, who were confronted with a palliative situation in their personal lives, experienced difficulties in answering the hypothetical cases. While we also found this same difficulty in a few participants (e.g. Ikram), these participants were not confronted with a palliative situation. While Baeke found the abovementioned hypothesis to be true for her participants Saida and Ayten, this was not the case for her participant Zohra. On the contrary, Zohra, whose husband and sister had died from cancer, radically opposed active termination of life. The participants in our study who were confronted with severe illness themselves or within their immediate environment strongly emphasized, as nearly all other participants did, that only God rules in matters of life and death and

that no human person may intervene within that domain, thus ruling out the possibility of euthanasia or assisted suicide. However, we must say that the aforementioned hypothesis does seem to make sense, based on other parts of our research, with regard to our participants' attitudes toward pain relief: there they seem to show a more open attitude than the other participants.

Other empirical studies with a Muslim sample –of which the majority is of a quantitative nature– endorse our finding that approval is rather exceptional (e.g. Aghababaei 2013; Ahmed et al. 2001; Ahmed, Sorum, and Mullet 2010; Qidwai et al. 2001; Roelands et al. 2015). The explanation that is provided most often for the denouncement of euthanasia is the reference made to religious beliefs. Only a small number of studies among (mostly Turkish) Muslims (in "more secular" Turkey) report a tolerant attitude toward euthanasia (Ahmed and Kheir 2006; Bugay, Sorum, and Mullet 2014; Cavlak et al. 2007; Gard et al. 2005; Koç 2012; Tepehan, Özkara, and Yavuz 2009).

Our findings should be interpreted with several limitations in mind. First, data might be biased due to social desirability. As such, expressing opinions that might deviate from the norm or opinions that could be seen as contrary to Islamic teaching might be difficult to express. As an interviewer, it is difficult to ascertain whether participants share truthful information. Although several measures were taken to guarantee anonymity (e.g. pseudonyms, deleting audio-tapes after transcribing), qualitative research cannot fully guarantee anonymity (e.g. face-to-face interviews). Both advantages and disadvantages are attached to the background of the interviewer (interviewer bias). On the one hand, being a member of the same community facilitated the gaining of trust and resulted in a certain openness and detailed conversations, but on the other hand this might also have influenced the answers of the participants, who might not have provided "deviate" answers out of fear of being judged.

Second, a possible bias is the mixed position of the expert between giving technical information and giving their own personal view on the matter. During coding, we took this into account and made a clear distinction between personal views and views of Moroccan Muslim women. Experts might have also given socially desirable answers. This bias is, however, limited due to the number and diversity in profiles of experts and due to the fact that we specifically interrogated experts on their professional opinion.

Third, the inclusion of the guiding committee also introduced a bias. The interviews conducted in *dārija* (Moroccan Arabic) and *tarifit* (a Berber language) had to be translated into Dutch and English, which might have influenced the data. As this was carried out to ensure validity and reliability so that the guiding committee could follow the coding and analyzing of the data, the first author sought to make accurate translations and verified their accuracy by relying on members of the Moroccan community when confronted with difficulties in the translation of a word or concept. To

assure reliability and validity and limit bias as much as possible, we adopted several strategies (e.g. data checking with members of the Moroccan Muslim community; peer debriefing; memos).

Fourth, given the nature of our data (specific groups; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. However, our results were confirmed by earlier studies of our research group as well as the other available empirical studies. Fifth, although we did not include terminally ill patients in this study, we found identical attitudes among our participants who were (still) confronted with aging symptoms or with severe illness (e.g. cancer) themselves or in their immediate environment. However, it would still be interesting to do an in-depth study of Muslim patients personally confronted with terminal illness. Sixth, taking into account the specific situation of first generation Moroccan Muslims in Belgium characterized by a homogenous socio-economic situation and a more diverse socio-demographic background among second generation Muslims, it would be interesting to explore the views among third generation Muslims who are assumed to embody a stronger diversity socio-economically as well as religiously. Further studies could explore whether the impact of religion on attitudes toward active termination of life would differ among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education, and work and who in this context experience and construct their own (religious) identity.

Conclusion

Religious beliefs have an important impact on attitudes towards end-of-life issues. Theological and more specifically teleological considerations centering on God's sovereignty in matters of life and death and the belief in the afterlife seem to be very crucial for Muslims. Strikingly, in our study no differences were observed between middle-aged and elderly Moroccan Muslim women. This can be explained by the fundamental and radical unacceptability of an active termination of life, as it intrinsically denies God's ultimate role in life and death, which was upheld by all our participants, regardless of age or level of education. As a result of these strong beliefs, we observed hardly any differences between the attitudes of our Muslim participants and the lines of reasoning found in normative Islamic views.

References

Aghababaei, N. 2013. The Euthanasia-Religion Nexus: Exploring Religious Orientation and Euthanasia Attitude Measures in a Muslim Context. *OMEGA — Journal of Death and Dying* 66 (4):333-341.

Ahaddour, C., S. Van den Branden, and B. Broeckaert. 2017a. Between Hope and Quality of Life: Beliefs and Attitudes of Moroccan Muslim Women toward Withholding and Withdrawing

Curative and Life-Sustaining Treatment. *Medicine, Health Care and Philosophy*, art.nr. https://doi.org/10.1007/s11019-017-9808-8.

Ahaddour, C., S. Van den Branden, and B. Broeckaert. (forthcoming). "Every Soul Shall Taste Death". Beliefs and attitudes of Muslim Women toward Dying, Death and the Afterlife. Accepted for publication in *Death Studies*.

Ahmed, A. M., and M. M. Kheir. 2006. Attitudes Towards Euthanasia among Final-Year Khartoum University Medical Students. *Eastern Mediterranean Health Journal* 12 (3/4):391-397.

Ahmed, A. M., M. M. Kheir, A. Abdel Rahman, N. H. Ahmed, and M. E. Abdalla. 2001. Attitudes towards Euthanasia and Assisted Suicide among Sudanese Doctors. *East Mediterranean Health Journal* 7 (3):551-555.

Ahmed, R. A., P. C. Sorum, and E. Mullet. 2010. Young Kuwaitis' views of the acceptability of physician-assisted suicide. *Journal of Medical Ethics* 36:671-676.

Albar, M. 2007. Seeking Remedy, Abstaining from Therapy and Resuscitation: An Islamic Perspective. *Saudi Journal of Kidney Diseases and Transplantation* 18 (4):629-637.

Al-Bar, M., and H. Chamsi-Pasha. 2015. Contemporary Bioethics. In *Islamic Perspective*. New York: Springer International Publishing. https://link.springer.com/book/10.1007%2F978-3-319-18428-9 (accessed 20th December 2016).

Al-Jahdali, H., S. Baharoon, A. Al Sayyari, and G. Al-Ahmad. 2013. Advance medical directives: a proposed new approach and terminology from an Islamic perspective. *Medicine, Health Care, and Philosophy* 16 (2):163-169.

Al-Jeilani, M. 1987. Pain: Points of View of Islamic Theology. *Acta Neurochirurgica Supplementum* 38:132-135.

Al-Matary, A. and J. Ali. 2014. Controversies and considerations regarding the termination of pregnancy for Foetal Anomalies in Islam. *BMC Medical Ethics* 15(10) https://doi.org/10.1186/1472-6939-15-10.

Al-Shahri, M. 2016. Islamic theology and the principles of palliative care. *Palliative and Supportive Care* 14 (6):635-640.

Arda, B., and V. Rispler-Chaim. 2012. Islam and Bioethics. In. Ankara: Ankara Üniversitesi Basımevi. http://kitaplar.ankara.edu.tr/dosyalar/pdf/846.pdf. (Accessed 20th December 2016).

Athar, S. 2016. Islam and Abortion. *Islamic Horizons* 45 (4):40-41.

Atighetchi, D. 2007. *Islamic Bioethics: Problems and Perspectives*. New York: Springer.

Ayuba, M.A. 2016. Euthanasia: A Muslim's Perspective. *Scriptura* 115 (0):1-13.

Badawi, G. 2011. Muslim Attitudes towards End-of-Life Decisions. *Journal of the Islamic Medical Association of North America* 43 (3):134–139.

Baeke, G. 2012. "Religion and ethics at the end of life. A qualitative empirical study among elderly Jewish and Muslim women in Antwerp (Belgium)." (Unpublished doctoral dissertation Theology, KU Leuven), Leuven.

Baeke, G., J. P. Wils, and B. Broeckaert. 2012. It's in God's hands: The Attitudes of Elderly Muslim Women in Antwerp (Belgium) toward Active Termination of Life. *AJOB Primary Research* 3 (2):36-47.

Baider, L. 2012. Cultural diversity: family path through terminal illness. *Annals of Oncology* 23 (3):62-65.

Brockopp, J. 2008. Islam and Bioethics. Beyond Abortion and Euthanasia. *Journal of Religious Ethics* 36 (1):3-12.

Brockopp, J. E. 2004. *Islamic Ethics of Life. Abortion, War and Euthanasia (Studies in comparative religion)*. Columbia: University of South Carolina Press.

Brockopp, J. E., and T. Eich. 2008. *Muslim Medical Ethics. From Theory to Practice, Studies in Comparative Religion*. Columbia: University of South Carolina Press.

Broeckaert, B. 2008. Treatment Decisions at the End of Life. A Conceptual Framework. In *Palliative Care Nursing Principles and Evidence for Practice. 2nd edition*, edited by S. Payne, J. Seymour and C. Ingleton, 402-421. Berkshire: Open University Press.

Broeckaert, B. 2009a. Euthanasia and Physician Assisted Suicide. In *Palliative Medicine*, edited by T. Walsh, A. Caraceni, R. Fainsinger, K. Foley, P. Glare, C. Goh, M. Lloyd-Williams, J. Olarte and L. Radbruch, 110-115. Amsterdam: Elsevier.

Broeckaert, B. 2009b. Treatment Decisions in Advanced Disease – A Conceptual Framework. *Indian Journal of Palliative Care* 15 (1):30-36.

Broeckaert, B., and Flemish Palliative Care Federation. 2006. *End of Life Decisions – A Conceptual Framework*. Brussels: FPZV.

Bugay, A., P. C. Sorum, and E. Mullet. 2014. The acceptability of physician-assisted suicide as a function of circumstances: a preliminary study of Turkish students' views. *Psicologica* 35 (3):715-728.

Cavlak, U., U..B. Aslan, S. Gurso, N. Yagci, and I. Yeldan. 2007. Attitudes of Physiotherapists and Physiotherapy Students towards Euthanasia: a Comparative Study. *Advances in Therapy* 24 (1):134-1445.

Choong, K. A. 2015. Islam and palliative care. *Global Bioethics* 26 (1):28-42.

Cohen, J., I. Marcoux, J. Bilsen, P. Deboosere, G. van der Wal, and L. Deliens. 2006a. European Public Acceptance of Euthanasia: Socio-Demographic and Cultural Factors Associated with the Acceptance of Euthanasia in 33 European Countries. *Social Science & Medicine* 63:743-756.

Cohen, J., I. Marcoux, J. Bilsen, P. Deboosere, G. van der Wal, and L. Deliens. 2006b. Trends in Acceptance of Euthanasia Among the General Public in 12 European Countries (1981-1999). *European Journal of Public Health* 16 (6):663-9.

Corbin, J., and A. Strauss. 2015. *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory*. (Fourth Edition), California: SAGE Publications.

Fitzpatrick, S., I. Kerridge, C. Jordens, L. Zoloth, C. Tollefsen, K. Tsomo, M. Jensen, A. Sachedina, and D. Sarma. 2016. Religious Perspectives on Human Suffering: Implications for Medicine and Bioethics. *Journal of Religion and Health* 55 (1):159-173.

Gard, G., U. Cavlak, B.T. Sundén, and A.R. Ozdingler. 2005. Life-Views and Ethical Viewpoints among Physiotherapy Students in Sweden and Turkey - A Comparative Study. *Advances in Physiotherapy* 7:20-31.

Ghaly, M. 2015. Euthanasia. In *Encyclopaedia of Islam*, edited by K. Fleet, G. Krämer, Matringe D., J. Nawas and E. Rowson. London: Brill Online. http://dx.doi.org/10.1163/1573-3912_ei3_COM_26254 (Accessed 15th December 2016).

Ghaly, M., ed. 2016. *Islamic perspectives on the principles of biomedical ethics*. Vol. 1, *Intercultural Dialogue in Bioethics*. London, UK: World Scientific Publishing.

Glaser, B. G., and A. L. Strauss. 1967. *The Discovery of Grounded Theory. Strategies for Qualitative Research.* New York: Aldine Publishing Company.

Hertogen, J. 2016. Marokkaanse-, Turkse- en islamachtergrond per gemeente Available at: http://www.npdata.be/ (Accessed 20 July 2017).

Ilkilic, I. 2014. End-of-life decisions at the beginning of life. In *Health, Culture and the Human Body. Epidemiology, Ethics, and History of Medicine, Perspectives from Turkey and Central Europe*, ed. I. Ilkilic, et al., 433-444. Istanbul: Betim Center Press.

Koç, A. 2012. Nursing Students' Attitudes Towards Euthanasia: A Study In Yozgat, Turkey. *International Journal of Caring Sciences*, 5 (1):66-73.

Kristiansen, M., T. Irshad, A. Worth, R. Bhopal, J. Lawton, and A. Sheikh. 2014. The practice of hope: a longitudinal, multi-perspective qualitative study among South Asian Sikhs and Muslims with life-limiting illness in Scotland. *Ethnicity & Health* 19 (1):1-19.

Lapidus, I.M. 1996. The Meaning of Death in Islam. In *Facing Death. When Culture, Religion and Medicine Meet*, edited by H.M. Spiro, M.G. McCrea and L. Palmer-Wandel, 148-159. New Haven-London: Yale University Press.

Padela, A. I., and O. Qureshi. 2016. Islamic perspectives on clinical intervention near the end-of-life: We can but must we? *Medicine, Health Care, and Philosophy*. doi: 10.1007/s11019-016-9729-y.

Padela, A., and A. Mohiuddin. 2015. Ethical Obligations and Clinical Goals in End-of-Life Care: Deriving a Quality-of-Life Construct Based on the Islamic Concept of Accountability Before

God (Taklīf). *The American Journal of Bioethics* 15 (1):3-13. doi: 10.1080/15265161.2014.974769.

Qidwai, W., H. Qureshi, S.S. Ali, M. Alam, and S.I. Azam. 2001. Physician Assisted Suicide Perceptions among Patients Presenting to Family Physicians at a Teaching Hospital in Karachi, Pakistan. *Journal of the Pakistan Medical Association* 51 (6):233-237.

Qureshi, O., and A. Padela. 2016. When must a patient seek healthcare? The perspectives of Islamic jurists and clinicians into dialogue. *Zygon* 15 (3):592-625.

Rahman, F. 1998. *Health and medicine in the Islamic tradition*. Chicago: Kazi Publications.

Rispler-Chaim, V. 1993. *Islamic Medical Ethics in the Twentieth Century* Vol. 46, *Social, economic and political studies of the Middle East.* Leiden: Brill.

Roelands, M., L. Van den Block, S. Geurts, Deliens L., and J. Cohen. 2015. Attitudes of Belgian Students of Medicine, Philosophy, and Law Toward Euthanasia and the Conditions for Its Acceptance. *Death Studies* 39 (3):139-150.

Sachedina, A. 2005. End-of-Life: the Islamic View. *Lancet* 366:774-779.

Sachedina, A. 2009. *Islamic biomedical ethics: principles and application*. Oxford: Oxford University Press.

Sachedina, A. 2012. Islam. In *Oxford Textbook of Spirituality in Healthcare*, edited by Cobb M., Puchalski C. M. and Rumbold B., 55-62. Oxford: Oxford University Press.

Saiyad, S. 2009. Do Not Resuscitate: A Case Study from the Islamic Viewpoint. *Journal of the Islamic Medical Association* 41 (3):109-113.

Sarhill, N., S. LeGrand, R. Islambouli, M. P. Davis, and D. Walsh. 2001. The terminally ill Muslim: death and dying from the Muslim perspective. *The American Journal of Hospice & Palliative Care* 18 (4):251- 255.

Shanawani, H., and M.H. Khalil. 2008. Reporting on "Islamic Bioethics" in the Medical Literature: Where Are the Experts? In *Muslim Medical Ethics. From Theory to Practice*, edited by J. Brockopp and T. Eich, 213-228. Columbia: University of South Carolina Press.

Strauss, Anselm, and Juliet Corbin. 1990. *Basics of qualitative research : grounded theory procedures and techniques*. Edited by Anselm Strauss and Juliet Corbin. Newbury Park : Sage, 1990.

Strauss, Anselm, and Juliet Corbin. 1998. *Basics of qualitative research : techniques and procedures for developing grounded theory*. Edited by Anselm Strauss and Juliet Corbin. Thousand Oaks (Calif.): Sage

Tepehan, S., E. Özkara, and M. F. Yavuz. 2009. Attitudes to Euthanasia in Icus and Other Hospital Departments. *Nursing Ethics* 16 (3):319-327.

Timmerman, C. 2001. Groeiende diversiteit op vele fronten. Het onderzoek naar de socio-culturele en religieuze praxis bij allochtonen in Vlaanderen. In *Komende generaties. Wat weten we*

(niet) over allochtonen in Vlaanderen, edited by J. Vranken, C. Timmerman and K. Van der Heyden, 297-312. Leuven-Leusden: Acco.

Van den Branden, S. 2006. "Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen." (Unpublished doctoral dissertation, Theology, KU Leuven), Leuven.

Van den Branden, S., and B. Broeckaert. 2008. Medication and God at Interplay: End of Life Decision Making in Male Moroccan Migrants Living in Antwerp, Flanders, Belgium. In *Muslim Medical Ethics: from Theory to Practice*, edited by J. Brockopp and T. Eich, 194-208. Columbia: University of South Carolina Press.

Van den Branden, S., and B. Broeckaert. 2009. The Ongoing Charity of Organ Donation. Contemporary English Sunni Fatwas on Organ Donation and Blood Transfusion. *Bioethics* 25(3):167-175.

Van den Branden, S., and B. Broeckaert. 2010a. Living in the Hands of God. English Sunni E-Fatwas on (non-)Voluntary Euthanasia and Assisted Suicide. *Med Health Care Philos* 14 (1):29-41.

Van den Branden, S., and B. Broeckaert. 2010b. Necessary Interventions. Muslim Views on Pain and Symptom Control in English Sunni e-Fatwas. *Ethical Perspectives* 17 (4):626-651.

Yousuf, R. M., and M. Fauzi. 2012. Euthanasia and physician-assisted suicide: a review from Islamic point of view. *International Medical Journal of Malaysia* 11 (1):63-68.

"Width of life is more important than length of life."

—Avicenna

4. Between Quality of Life and Hope. Attitudes and Beliefs of Muslim Women toward Withholding and Withdrawing Life-Sustaining Treatments

Introduction

Technological advances in medicine have placed an increased responsibility on the patient, the family and health care providers when it comes to making difficult end-of-life decisions (Cohen et al. 2014). Modern medical therapy has gone through major progress, resulting in the increased possibilities for prolonging life. However, this development has blurred many of the lines and the distinctions that once seemed so clear, including life and death (Zahedi et al. 2007; Padela and Qureshi 2016). These advancements generated questions regarding the worthiness and meaningfulness of a treatment. This discussion on forgoing treatment has arisen from the debate on euthanasia that is centred on the right-to-die. This debate resulted in an awareness of quality end of life and personal autonomy, particularly in relation to a patient's right to refuse or withdraw treatment (Al-Jahdali et al. 2013). Several normative and empirical studies report an absolute rejection of active termination of life in Islam and among Muslims on the basis of an unconditional belief in an afterlife (*cf.* eschatological implications) and in God's sovereign power over the domain of life and death (*cf.* God, author of life and death; vice-regency of life and body) (Rispler-Chaim 1993; Van den Branden 2006; Atighetchi 2007; Baeke et al. 2012; Baeke 2012; Van den Branden and Broeckaert 2008). These studies also underscore that Islam does not recognise the right-to-die voluntarily, in contrast to the West.

But what about withholding and withdrawing a life-sustaining treatment? According to Brown (2014), religion and culture have a great impact on the attitudes toward withdrawal of life-sustaining treatment at the end of life. In the West, these discussions are greatly influenced by medical efficacy and personal autonomy, marking a shift from 'quantity of life' to 'quality of life' and from paternalism to patient's autonomy (Cohen et al. 2006; Berger 2011). However, the practice of withholding and withdrawing a treatment is often discussed in terms of passive euthanasia. Brockopp (2004) argues on the basis of medieval Islamic texts that a greater acceptability of passive forms of euthanasia might be found compared with the clear stance toward active termination of life. He states that active vs. passive means of causing death address the question of an individual's perceived intervention in God's plan, since actively causing death could hasten a person's life span *(ajl)*, which is (pre)determined by God; passive means allow God's plan to run its course. There seems to be an ambiguous grey zone that might open the possibility for some (passive) forms of euthanasia in Islam. We seek to find out whether a tolerant and open attitude can be found among our participants and whether this might be explained by age, level of education *etc*.

Until this day, in the Western debates on end-of-life care, little attention is paid to the attitudes of ethnic and religious minorities, such as Moroccan Muslims. Several studies (Van den Branden 2006; da Costa et al. 2002; Gielen 2010; Padela and Qureshi 2016) argue that the way people view and deal with ethical issues at the end of life might be related to and influenced by their religious beliefs. The number of empirical studies that deal with the views on ethical dilemmas in health care and more specifically on withholding and withdrawing life-sustaining treatments of Muslims living in the West is very limited (Van den Branden 2006; Baeke 2012).

The aim of this article is fourfold. First, we seek to describe the attitudes and beliefs of middle-aged and elderly Moroccan Muslim women living in Antwerp (Belgium) toward withholding and withdrawing curative and life-sustaining treatments. Second, we are mainly interested whether a shift may be observed in the attitudes and beliefs between middle-aged and elderly Moroccan Muslim women. In contrast to the first generation elderly Moroccan Muslim women, who are mainly uneducated and illiterate, the second generation Moroccan Muslim women show much more socio-economic diversity. Another reason for the focus on middle-aged Muslim women is the assumed stronger influence of Western ideas, as they have been brought up in a Western society. They are no longer raised in a homogenous, rural, traditional Islamic environment and live less isolated from the broader Belgian society. Third, we aim to explore the role of religion in the attitudes of our participants. Fourth, we seek to document how our results are related to existing normative Islamic literature.

Methods

Design

Between October 2014 and September 2015, thirty semi-structured interviews were conducted with a purposive sampling of middle-aged and elderly women in the Moroccan community in Antwerp (Belgium) who self-identify as Muslim. This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. We have chosen Antwerp for two important reasons. First, this city has the largest Muslim population in Flanders: 19.2% of Antwerp's population is Muslim (Hertogen 2016). Second, Antwerp as a port city is considered to be among the most multicultural cities in the world.

Different routes of recruitment (*e.g.* mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball. Face-to-face interviews were based on a semi-structured topic list covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. The interviews were conducted in Moroccan Arabic (*dārija*), a Berber language (*tarifit*) and Dutch. Participants were interviewed one-on-one (*e.g.* in their own house, in a room made available by a local non-profit organization or in a quiet tea

house). To help us with the interpretation of our data, we also interviewed 15 experts in the field (*e.g.* Muslim physicians, Muslim nurses, palliative care consultants etc.) about particular topics of our study between September 2014 and September 2015. These interviews functioned as background information and were compared with the empirical data of our interviews with Moroccan Muslim women. Apart from interviewing, the first author also conducted participant observations between December 2014 and April 2017. Several visits of the sick, a *ḥijāma*-consultation, death prayers, ritual washings of the dead body, repatriation of a deceased, burial, mourning gatherings were attended and several Islamic cemetery plots were visited

In this study, we opted for a non-normative, descriptive, exploratory approach. This study was approved by the Social and Societal Ethics Committee (KU Leuven, Leuven). In order to guarantee the anonymity of our participants, we made use of pseudonyms.

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology was used to code and analyse the interview data (Glaser and Strauss 1967; Corbin and Strauss 2015; Strauss and Corbin 1998). By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated to grasp the real world experiences and meaning systems of our participants. In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. Findings were regularly discussed with our guiding committee and with several members of the Moroccan Muslim community. Findings of the interviews with Muslim women were compared with those of the interviews with experts and subsequently compared with normative and empirical studies (*cf.* discussion).

Conceptual Framework of Treatment Decisions in Advanced Disease

Attitudes towards treatment decisions at the end of life were explored by making use of hypothetical cases that were formulated on the basis of the typology of Broeckaert (Broeckaert and Federation 2006; Broeckaert 2008, 2009a, 2009b). Broeckaert, together with the Flemish Palliative Care Federation, developed a comprehensive typology of treatment decisions at the end of life in order to provide conceptual and terminological clarity regarding a number of ethical dilemmas in end-of-life care. This typology, also presented in a number of well-known international handbooks on palliative care (Broeckaert 2008, 2009a), illuminates the different kinds of treatment decisions that can be taken in advanced stages of life threatening illnesses. Each kind of treatment decisions generates specific ethical issues which can be misunderstood when no clear boundaries have been set. In this typology, choices with regard to curative/life-sustaining treatment constitute one category of treatment decisions (apart from choices concerning active termination of life and pain/symptom control).

Broeckaert (2009a) distinguishes three kinds of acts belonging to this category: (1) initiating or continuing a curative or life-sustaining treatment; (2) non-treatment decision, which is "withdrawing or withholding a curative or life-sustaining treatment, because in the given situation this treatment is deemed to be no longer meaningful or effective"; (3) refusal of treatment, which is "withdrawing or withholding a curative or life-sustaining treatment, because the patient refuses this treatment". The fundamental difference between what is called a *non-treatment decision* and a *refusal of treatment* lies in the reason why treatment is withdrawn or withheld. In the first case it is the medical team that stops a medical treatment because it is nog longer effective (doesn't do what it is supposed to do) and/or because it is no longer considered to be meaningful or proportionate. In the second case, therapy is stopped or withheld simply because a competent patient exerts his/her right (based on his/her right to physical integrity) *not* to give his/her informed consent and thus to refuse, for reasons that are his/hers, a treatment –even when the treatment is very effective indeed and considered to be totally meaningful by everyone else, including the medical team (Broeckaert and Federation 2006; Broeckaert 2009a). The hypothetical cases developed on the basis of this typology and presented to our participants are mentioned below (Table 1). This article is limited to the responses to *case 1* and *2* and the ensuing discussion.

Table 1: Hypothetical cases

Case 1: initiating or continuing a curative or life-sustaining treatment
There exists a cancer treatment that may prolong life with a few weeks. This treatment has many negative side-effects. Should a physician opt for this treatment?
Case 2: non-treatment decision
An unconscious patient is artificially kept alive (ventilator, artificial nutrition and hydration). The patient is in a deep and irreversible coma. Should the devices be switched off so that the patient dies? Who should decide about that?
Case 3: refusal of treatment
A physician has told his/her patient that chemotherapy may cure his/her cancer. Has the patient the right to refuse this treatment, even if he/she knows he/she will die soon if no treatment is administered?

Results

Participants' (socio-)demographic information & health situation

Our group of middle-aged Moroccan Muslim women (n=15) were between 41 and 55 years old, our group of elderly women (n=15) were aged between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through

family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of between three and five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber participants spoke Arabic, and only two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes. Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

The health issues of our middle-aged participants were limited to knee problems and migraine. By contrast, nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a bad health condition. Nine participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer and severe chronic disease.

Attitudes toward withholding and withdrawing life-sustaining treatments

Case 1: Initiating or continuing a curative or life-sustaining treatment

The participants have differing opinions on initiating treatment which may prolong a terminal cancer patient's life with a few weeks, but also has severe side-effects. Nearly two thirds of our participants –mainly middle-aged participants– are opposed to the prolongation of treatment. Arguments are centred on the one hand on medical futility and quality of life, on the other hand on theological arguments.

- *Contra*

First of all, the majority of our participants who are opposed to the prolongation of treatment hold the opinion that this treatment is futile and constitutes unnecessary suffering for the patient. They explain that a treatment should only be opted for if there is a chance of recovery. This is also confirmed by our experts.

> I've experienced it with my mother. I would 100% put a stop to everything. No, I would no longer want to live and suffer. I just want to prepare myself and pass away peacefully. Sarah – middle-aged

> Yes, prolonging life if it's worthwhile, if there's a good prospect, if you're not suffering, but in such a case, no. Then I would rather keep my health. I'd rather choose to die than to prolong my life with a few weeks. I've been through this with my uncle. Why should I suffer more? So no, no. Charifa– elderly

> I really think that 8 out of 10 would certainly refuse it. Yeah, they know they're already going to die uhm, they'd want to pass away peacefully and to not be tortured just to live another two weeks. It's not worth it.[…] No, they'd rather have a peaceful death. It sure may be short, but they'd want to pass away in a dignified way. Laila – Muslim Nurse

Additionally, these participants state that this treatment does not only constitute a burden for the patient but also for the family. They strongly express a preference for a dignified end of life, which is understood as enjoying the time left with their family, but at the same time also turning to God.

> No, no, I wouldn't choose this treatment. I'd rather go to the Lord who created me than undergoing the treatment that would make me suffer more. Why continue to suffer more pain? But if he's going to die anyway, then he doesn't have to suffer unnecessarily. His family suffers too. It's actually a good thing that you come to peace in those moments and take the time to say goodbye. Fatma – elderly

> Yes, that's hard, poor guy, it's better not to initiate it. There's no point. Why continue to make him suffer? That's not a good end of life. It's better to let him keep his health and enjoy the last moments with his family and turn to God. Haddad – elderly

Second, based upon their belief in an almighty God who rules over life and death, illness and cure, nearly all participants stress that only God determines a person's time of death *(ajl*) and that death only occurs with God's decree (*qadr*). In fact, they're of the opinion that in this situation the

end of a patient's lifespan has been reached. All participants believe that the time of a person's death depends completely upon God's will and predestination (*maktab* or *maktub*). This belief goes along with an acceptance of what God has decreed upon them and thus they accept the terminal situation and leave the matter to God. This is in keeping with the interviews with our experts.

> No, I would definitely refuse that. It's God who prolongs life. God has already determined when we'll die. If God wants me to live longer, then I'll still live, if God has predestined me to live a short life, than so it will be. Louiza – middle-aged

> No, I wouldn't choose it.[…] No matter what he does, fate is in God's hands. Whether you choose prolongation or not, it's God who decides when you'll die. The treatment cannot give you a certainty that you'll live longer. And if you do live longer, it means your day hasn't come yet. But should your day come, then the treatment won't do anything.[…] It means that God destined him from the beginning to this very moment. They may do to him as they please, but it's God who governs. The patient is going to die anyway, thus they shouldn't prolong it with pain. Laziza – elderly

> They're going to say 'no, it's unnecessary. We cannot prolong our life.' Why? Because of fate! This idea of everything is predestined, everything is written down. You're going to die that day or not and the physician won't be able to change that and they would certainly not choose it if it has negative side effects. Faysal – *Imām*/Islamic teacher

Closely related to the previous argument, our participants regularly explain that only God has the power and ability to prolong a person's life, not a physician. They contrast the physician's limitedness with God's absolute omnipotence and omniscience. In this respect, they mention the importance of having faith in God and leaving it up to God.

> No, the physician cannot prolong a life, only God can. Maybe I'll live a month longer without injecting myself with that chemical stuff. I'll turn to God and I'll ask Him to prolong my life and maybe I'll live two or three months or maybe even longer.[…] I've know someone, they gave him one month, while he lived another year. Kaltoum – middle-aged

> There's no treatment that can prolong life. Only God has this power. A physician is not God. It's God who cures and if God wants to, He'll cure you. Who says the treatment will give him additional weeks? The physician is not God. No, no, I'm against it. They're not God. I wouldn't choose this treatment. Zoulikha – elderly

- *Pro*

About one third of our participants –mainly elderly women– support the initiating or continuing of life-sustaining treatment based on three arguments. The most important reason to opt for treatment is the strong desire to live. They strongly believe that no person would want to die and thus would do anything to be kept alive. In their opinion, to bid farewell to family and life is very difficult. This is also shared by our experts. However, several experts hold the opinion that mainly middle-aged women would choose this treatment since they're still young and have small children, whereas others believe that mainly elderly women would opt for this treatment as they have difficulties in letting go of life.

> Yes, but if it were me, then I would choose it [treatment]. Because I'd like to busy myself with my faith and maybe perform *ḥajj* [pilgrimage to Mecca] or some other things, and also to be there for my kids. Yes, I would do that. Hannan – middle-aged

> Yes of course that's evident. Nobody wants to die. The soul is very precious. Yeah, always choose life. A human being wants to live.[…] Nobody wants to say goodbye to this world. That's very hard. It's always better to live longer, and also for our children. Rahima – elderly

> If a young lady in her forties still has young children, she'll seek to live a few more weeks, to provide care for her children.[…] They believe it's a good thing, because they can stay with the family longer. Farida – Muslim physician

Second, only a few participants –mainly elderly women– mention that seeking treatment is obvious, as it is a religious duty, and thus emphasize the importance of '*sabab*' (also called '*wasīla*'), which is understood by our participants as undertaking efforts in order to get better. Nevertheless, they leave the outcome of the therapy in the hands of God.

> That's *sabab*, everything is *sabab*. And I think, Allāh says you're obliged to seek solutions. You can't just say 'I'll die and that's it'. You're not allowed to do that in Islam. You should seek solutions, you should go and see physicians.[…] And we have to do that, but yeah, you do have side effects, but still I'd go for it. It's God who always decides. If He doesn't want me to initiate it, He'll end my life. But you need to do *sabab*. Radia – middle-aged

> Yeah, even though the treatment is hard, the patient must choose life. You never know how long the patient will live. It's better if he gets treated and God is *Al-Kabīr* (Great). We must seek treatment. Huda – elderly

A third reason to opt for treatment is based upon the belief in an omnipotent God. Our participants underscore that God is capable of anything (*al-Qādir*). Hence, they believe that God has the power to cure a person –even when the patient is declared terminally ill–, which as a result fosters hope and the belief in a miracle. This perspective is also closely related to the belief in God's decree (*al-qadr*). They explain that only God has knowledge of a person's lifespan (*ajl*) and refer in this sense explicitly to the inability of a physician to make a prognosis of a person's lifespan. This is also confirmed by our experts.

> *Ajl* comes from God, the Exalted. We all come and go. God is capable of everything and if God is willing. They [physicians] said to my neighbour's daughter that she wasn't going to live any longer. But *al-ḥamdulilāh* (All praise due to God), now she's still alive and she even has two kids. So God has given her time, her time hasn't come yet. A physician can never know when someone dies, only God has this knowledge. Malika – elderly

> It's better to get yourself treated. You never know, God is capable of doing anything. If God is willing, He'll cure you. I've heard many stories of physicians who said to an ill person that he'll die whilst they lived longer or are still alive. It's God who controls a person's soul. Alia – elderly

> We've also experienced that a physician says to his patient 'You don't have a month or even a year'. And he has lived for seven more years.[…] This story goes from door to door and from house to house.[…] And there are

> people who say 'No, I'll fight until the end. You never know, a miracle might happen. Our religion says never give up. Have hope.[…] The miracle exists that I'll heal'. Myriam – Palliative care consultant

Interestingly, three middle-aged participants take into account the context of the patient. In their opinion, the prolongation of treatment is only justified if the pain is bearable and in case of important affairs that need to be taken care of (*cf.* asking forgiveness, wedding of a son/daughter).

> I'd go for it if there was still something that needed to be done within the family, important business, asking forgiveness, to see each other again. If there's really something important. But other than that, I'd personally say no because of all the other negative things. Halima – middle-aged

> It all depends on the situation. I think for someone who's in a lot of pain and knows he/she will die in a few weeks and they prolong it with another week, there's no point, because he/she would still be in a lot of pain. It really depends on what kind of pain it is and if you can treat it or not. If it's bearable then I would go for it, but otherwise I wouldn't. It wouldn't be worth it if nothing special happens in that week. If your son were about to get married, then of course I'd want to attend it. Nihad – middle-aged

Case 2: Non-treatment decision

This case deals with switching off the devices of an unconscious patient who is in a deep and irreversible coma. In the case of a non-treatment decision, we noticed different positions. Half of our participants declare themselves to be absolute opponents of withdrawing life-sustaining treatment, while one third of our participants are in favour of switching off the devices and one sixth find themselves in a dilemma. Nearly all participants are aware of the ethical complexity of this case and of contextual elements that have to be taken into account.

- *Contra*

The disapproval of a non-treatment decision is based upon three arguments. First of all, here too, participants strongly highlight that only God has the right to take a person's life, as He is the creator of heaven and earth as well as life and death. Once again, our participants stress that God determines a person's time of death *(ajl*) and that death lies in the hands of God.

> No one should decide about this, only Allāh. If he dies, the devices will turn off. Even if there's a small chance that he'll wake up. No. Death lies in the hands of God. If you're religious then you should think this way. Radia – middle-aged

> No, God is the One who governs our soul, who controls our life. He has the knowledge of the day our soul will leave us. He decides upon life and death, we don't. The physician can do as he pleases, but if the time [of death] comes, then it comes. Yamina – elderly

> They won't allow it. I think, mainly religiously inspired, they're convinced that they're not allowed to end a life and that God is the one who gives and takes life and God decides either to end it or not and thus they don't have the right to do so. Imane – *Ḥijāma* practitioner

Second, a minority of our participants explicitly mention that God is omnipotent and thus life and cure lie in His hands. Based upon this belief, they hope for a miracle. Here too, they underline

that if God is willing, the patient will wake up from his/her coma and will be cured. In their opinion, only God, who is omniscient, knows the outcome of this treatment and it is ultimately depending upon God's decree (*al-qadr*). Here again, the contrast between the physician's limitedness and God's almightiness is highlighted.

> No, I would say to the physician 'You don't know that. You don't know, you're not God. This person breathes, his heart beats. What are you saying to me that I should pull the plug?' God has the power to awaken and cure the patient. Halima – middle-aged

> That's a very difficult one. No, no, just let him be. The Lord is Great (*Rabbi damekran*). He's *Ar-Rahmān* (Most Merciful). He is *Al-Qādir*. If God is willing, the patient will awaken. Leave him until God takes away his soul.[…] God has already decided when he'll die. Only God has this knowledge. Haddad – elderly

Third, a minority of our participants considers switching off the devices a forbidden act (*ḥarām*) and equate it with murder, as they perceive it as a life shortening act and in contrast with being a Muslim. They believe that Muslims would never commit such an act, but also that they should bear patiently until God takes away the patient's soul.

> I've been through this with my son. He was also in a coma and kept alive artificially and they've also asked me 'Do you want to pull the plug, because it won't get better?'[…] I said 'No, leave him'. I also said to my brothers 'No, it's *ḥarām*, you may not do it.' It's like murder, leave him. He still breaths. Let him breathe until God takes him away. And that's what actually happened. He died after two weeks. Warda – middle-aged

> We Muslims don't do that. The soul is in God's hands. We would never do such a thing. In our religion that's forbidden. You have to wait until the soul itself leaves the body. If you switch off the devices, it's as you have killed him. Khadija - elderly

> "I think that these women won't pull the plug.[…] Because it's as if you've ended a life yourself. They see that as killing. Do you see? Fadila – Psychosocial consultant

Noteworthy is that Narima in fact considers switching off the devices sacrilege/blasphemy. To her, the role of God in death is adopted and thus God's role as creator of life and death is denied.

> I don't accept that. I believe they're actually playing God's role more or less. Do you see? Ending a life is God's work. Narima – middle-aged

Although our opponents strongly acknowledge that switching off the devices is unacceptable, as only God decides upon a person's end of life, Sabiha, a middle-aged participant, and Malika, an elderly participant, nuance their perspective. Both participants could muster some understanding for switching off the devices based upon the high financial cost involved for the family to maintain the patient in coma.

> It's really difficult. I tell you, if you have the means to stay in a coma as long as possible, than ok, because I've heard often 'Yeah, after one month in a coma he woke up, or after two or three months'. So if you have financial support, if you can pay it, you let him/her stay in coma.[…] If you don't have the resources, because the hospitals, they don't work for free. So they'll say 'Yeah, we have to end this due to the lack of financial resources'.[…] I'm

> saying in worst case. If there's really nothing we can do, then you can choose to switch off the devices. Sabiha – middle-aged

> We Muslims, we don't do that. My husband was attached to the devices for five weeks and afterwards in a room without devices and then he stayed alive for another two weeks. God has taken the soul Himself. Well, I do understand that they can't keep the patient attached to the devices eternally, because yeah, it costs a lot of money. Malika – elderly

- *Pro*

One third of our participants approves of withdrawing life-sustaining devices on the basis of four arguments. First of all, all our participants believe that in this case no meaningful life is preserved by administering the life-sustaining treatment. Indeed, they argue that the patient does not benefit from this treatment. On the contrary, they heavily stress that it merely prolongs the patient's suffering and that it also constitutes a great suffering for the family.

> I would switch it off.[…] Yeah, because the patient is in an irreversible coma, then I wouldn't put him through hell. I'd rather let this person go in peace. Because that's torture (*al-ʿadhāb*) for the patient and for the family. Sarah – middle-aged

> It's better to remove it, otherwise he'll suffer. He suffers.[...] But someone who's in an irreversible condition, then there would be no hope. His heart keeps working thanks to the devices. But they don't know anything and they don't see anything. That's no life. Nuria – elderly

Second, once again, God's sovereignty over life and death is firmly emphasized. Nearly all supporters of withdrawing treatment believe that the patient has actually reached the end of his lifespan (*ajl*), determined by God. Indeed, they argue that the patient is already dead or in the dying state. Hence, they're convinced that the withdrawal of the devices allows a natural death to take course, in accordance with the divine decree (*qadr*) and predestination (*maktab*). This idea is also shared by our experts.

> He's just alive because of the medical [devices]. By pulling the plug he'll have a natural death, because they don't kill him. That's God's decree. Loubna – middle-aged

> Poor guy, the patient will die anyway. Once they switch off the devices, he'll die. The patient will die anyway, he's already at the end of his life. It's not that he'll awaken. It's his *maktab*. Laziza – elderly

> I think that both first and second generation see this as 'He/she is attached to the devices and breathes through it'. They'll say 'Okay, pulling the plug is a natural death, because you let nature take its course. Faysal – *Imām* /Islamic teacher

Third, based upon their strong belief in the afterlife, supporters argue that these devices should be removed in order to let the soul return to God and thus to let it rest in peace. Many participants explain that switching off the devices allows God to take back his *ʾamāna* (trust). It is in this context that reference is made to the vice-regency of a human being, namely that life and body are given by God as a trust. Strikingly, the devices are in fact perceived as a barrier in the dying

process of the patient. Indeed, some participants believe that the patient is already in a stage between the world and the afterlife called *barzakh*. In this respect, several participants mention that the soul suffers in this situation.

> But yeah, if you switch off the devices, he/she will die. Imagine it was my mother, I would remove the devices. Why should I let her suffer for years? That patient is already dead and it's better to switch off the devices so that he/she can go to God. It's better, otherwise he/she will suffer. Because you only see a body, the patient doesn't talk to you or look at you. That person is already in *barzakh*. Zoulikha – elderly

> If God wants to take His *ʾamāna* back, then why would you stop Him? It's better to let him/her go to God. The soul is trapped because of the devices. They want to keep him alive but he's dead. It's better to cut the wires.[…] The person is dead. This is not a solution. Alia - elderly

> The first and second generation would say 'Let him/her go to the Lord'. Laila – Muslim nurse

Fourth, only a few middle-aged participants mention the financial cost of this treatment. They argue that such devices are expensive and the prolonged use of it fosters a heavy financial burden on the family, while the patient him-/herself does not benefit from it. Though for Loubna, switching off the devices is only justified after having waited for a few months.

> I personally will say yes. That's better.[…] It all costs too much money. So there are so many reasons to stop this. It's hard for the family. Lamya – middle-aged

> Yeah, I wouldn't be against it. If it's a year or two months, a period. But the health insurance should intervene.[…] because it's financially unaffordable. Because you have to sell your house and this and that.[…] I'm not saying after a couple of weeks or months, but after several months, if it's really negative. Loubna – middle-aged

- *Dilemma*

Although there are both opponents and supporters of the idea of switching off the devices and nearly all participants acknowledge the difficult nature of this case, it is noteworthy that especially middle-aged participants were hesitant and experienced difficulties in answering to this case. Yet these 'hesitant' participants seem to lean, remarkably, more toward a supportive attitude that involves withdrawing life-sustaining treatment. Three dilemmas came to the fore. First, a few participants experience the struggle between the difficulty of bidding farewell to a loved one and letting the patient go to God.

> For me it's a mixed feeling. Personally, if I had to go through this with my kids, I would let them live longer so that I can look at them, even if it's artificial. But on the other hand I think it's better to switch it off, so they can leave for God in peace. You're torturing them and you're torturing yourself. Kaltoum – middle-aged

Second, Ikram, a middle-aged participant, clearly demonstrates a hesitant attitude due to the ethical complexity of this case. On the one hand, she questions whether the removal of devices is religiously justified, referring to the opinions of Islamic scholars (*ʿulamāʾ*). On the other hand, she argues that if the patient were in Africa, he/she would already have passed away due to the assumed inexistence of these devices. In this sense, to her these devices blur the borders between life and

death. Additionally, she also believes that this situation might be happening for a reason, unknown by human being.

> I find it important to know what *'ulamā'* think about that. Then I think 'Is that even allowed?' Can you just say 'yeah no, I want you to stop now'? Because stopping means that you're going to die right away? So I find it a very difficult issue.[…] Yes, but those devices they're here, but if I'm in Africa, then there are no devices, which means I would be long dead. What's the point if you're attached to that? Just put away the devices, but is it allowed?[…] But actually you don't know the reason why you lie there. For example Sharon, who was also in a coma for 7 or 8 years. Then I think, yeah, maybe he really suffered and it was meant to be or I actually don't know if it was meant to be that his family had to suffer as well, because he was such a bad person. I don't know, actually. For me it's a mystery in life. Ikram – middle-aged

Third, Aïcha, an elderly participant, clearly describes a dilemma between keeping the devices, because of which the patient and family suffer, and switching off the devices, which is considered murder.

> So it's someone who doesn't see his family, so it's like he's dead? I wouldn't know, I don't know. I wouldn't say to put away the devices, because if they do, then it's like you've murdered him/her. And if you let it [devices], then it will be no good for the patient nor the family. So it's really difficult. So I can't say that they should take away the devices to let him die or to let him stay like this. Aïcha – elderly

Discussion

Withholding treatment was considered more acceptable among our participants than withdrawing a life-sustaining treatment. Our study shows that our participants' views are mainly centred upon three elements. First, several arguments were put forward from a theological frame of reference. All participants expressed an unconditional belief in an omniscient and omnipotent God who is the ultimate author of life and death and who decides upon a person's lifespan (*ajl*). However, the latter notion is strongly put forward by both supporters and opponents of withholding and withdrawing treatment. As such, opponents stressed that only God has knowledge over *ajl*, which is already appointed, while not so differently, supporters believed that *ajl*, determined by God, had already been reached. Both groups emphasized the importance of having faith in an almighty God who is capable of everything –including prolonging life and curing the sick. However, this was interpreted differently by our participants. Whereas for opponents of withholding and withdrawing life-sustaining treatment this belief was a reason to opt for treatment and cultivated notions of hope and miracle, the supporters interpreted God's almightiness as a reason to forgo treatment by accepting God's decree (*cf.* terminal illness). Both groups, however, ultimately left the matter in the hands of God. Against the backdrop of God's sovereignty in life and death, opponents likened the removal of the mechanical devices to murder and blasphemy, while supporters believed that a natural death would take course, in which there is no interference with God's role in the occurrence of death. Interestingly, withdrawing life-sustaining treatment (*cf.* mechanical devices) is approached within

the context of God's role in the matter of life and death, in contrast to withholding a treatment, where there seems to be room for choice and which is thus less or not a matter of intervening with God's decree.

Second, in contrast to withholding treatment, the withdrawal of mechanical devices is strongly interpreted from within a teleological framework among our supporters. Noteworthy, these devices are actually perceived as a barrier for the soul leaving for God. It is exactly this situation which is viewed as a suffering state for the patient('s soul) and therefore switching off the devices is understood as a liberation of the soul. Some participants considered the patient already to be dead and to be situated in *barzakh*, which is understood as a stadium between the worldly life and the hereafter. These views –whether the patient's soul is still attached to the patient or is already in the intermediate state– can be linked to their eschatological beliefs, namely that a dead person still feels everything like a living person and that as long as the person is not buried, the soul suffers. This perspective is generated from other parts of our research.

Third, we seem to have found a different understanding of a dignified end of life between our supporters and opponents of withholding and withdrawing life-sustaining treatments. On the one hand, our opponents –mainly elderly women– put an absolute stress on prolonging a person's life, irrespective of the suffering, because of the strong desire to live in order to stay with their family longer and to approach God. This might be explained by our elderly participants' greater difficulty in bidding farewell to their family due to their strong habit of being surrounded, but also due to their greater fear of the afterlife (*cf.* solitude, torture of the grave, Judgment day etc.). We must be cautious not to generalize, however. Supporters, on the other hand, emphasized the medical futility and the unnecessary suffering for the patient and family. They put rather an absolute stress on a quality end of life by maintaining their health and enjoying the time they have got left with their family.

Against the background of the three aforementioned elements, we observed a strong ethical dilemma regarding withdrawing life-sustaining devices. Their attitudes were not black or white, but were largely contextual. Especially middle-aged participants were very much aware of the ethical complexity of the cases and the contextual nature of every ethical decision at the end of life (*cf.* age, financial situation, the extent of the desire to live).

The findings of our interviews with middle-aged and elderly Moroccan Muslim women are nearly identical to those of the interviews with our experts in the field. However, one main difference was found with some experts' views. A minority of our experts argued that mainly middle-aged women would be more likely to disapprove of withholding and withdrawing life-sustaining treatment on the basis of their young age and the fact that they have small children and thus would adopt a more hopeful attitude, contrary to elderly women who would be more likely to withdraw or withhold treatment because of their (old) age. This was not the case among our participants.

On the contrary, no radical differences were found between middle-aged and elderly participants. However, we did find some gradual differences. In general we found a strong approval of withholding and withdrawing life-sustaining treatments among the majority of middle-aged women and among nearly half of our elderly participants. According to our data, this difference cannot be explained by differences in level of education, socio-economic status, religious literacy, nor by differences between participants who were and who were not confronted with severe illness, either personally or in their immediate environment. On the contrary, our data suggest that this might be explained by the differences in age and their definition of a good end of life, but also by the influence of (secular) Western ideas such as quality of life and the right to self-determination. For example, we found that supporters of withholding treatment strongly express a preference for a dignified end of life (focus on quality of life), which is understood as enjoying the time left with their family, but at the same time also turning to God. In contrast to the supporters, our opponents understood, because of their strong desire to live, prolonging life –irrespective of the suffering– as a way to achieve a 'good' end of life. Their opinion is that by opting this treatment, they buy time and thus they can enjoy their time longer with their family. This desire to live was mainly found among elderly participants.

> Yes, that's hard, poor guy, it's better not to initiate it. There's no point. Why continue to make him suffer? That's not a good end of life. It's better to let him keep his health and enjoy the last moments with his family and turn to God. Haddad – elderly

> Yes of course that's evident. Nobody wants to die. The soul is very precious. Yeah, always choose life. A human being wants to live.[…] Nobody wants to say goodbye to this world. That's very hard. It's always better to live longer, and also for our children. Rahima – elderly

We observed that both middle-aged and elderly participants strongly interpret ethical dilemmas at the end of life from a religious framework. Participants with a more open attitude towards withholding and withdrawing life-sustaining treatment substantiated this open attitude both with religious arguments and with more western ideas such as quality of life and meaningfulness of a treatment. Our study did, however, not show at all that the second generation of Muslim women, who grew up in western society and were educated in the west –as secularisation theories might suggest– had developed a different, more secularised understanding of the relationship between God and world, and God and life/death. This was not the case at all.

The more tolerant attitude towards withholding and withdrawing treatment of several of our participants is not based upon a western or secularised understanding of autonomy. Autonomy is understood within a religious framework. Withdrawing or withholding treatment is for these participants not an intervention in God's scheme over life and death or God's decree: no contradiction is perceived in their lines of reasoning between ideas of autonomy/self-determination and their religious beliefs or religious worldview.

> He's just alive because of the medical [devices]. By pulling the plug he'll have a natural death, because they don't kill him. That's God's decree. Loubna – middle-aged

> Poor guy, the patient will die anyway. Once they switch off the devices, he'll die. The patient will die anyway, he's already at the end of his life. It's not that he'll awaken. It's his *maktab*. Laziza – elderly

This religious framing or understanding of autonomy is confirmed in their attitudes towards active termination of life, in which an autonomy-discours is completely lacking. We found an absolute rejection of euthanasia, which seems to collide strongly with the worldview of our participants. Unlike withdrawing and withholding, euthanasia is understood as a direct interference with God's plan and rule over life and death.

Comparison with Empirical Literature

Many studies show that religion is an important determinant of attitudes toward end-of-life issues (Van den Branden 2006; Baeke 2012; Brown 2014; da Costa et al. 2002; Gielen 2010). Although our participants approach medical issues mainly from a religious framework, arguments of medical futility and quality of life also emerged in our study.

Our findings show comparable conclusions to the studies conducted by Van den Branden (2006) among elderly Moroccan Muslim men and Baeke (2012) among elderly Moroccan and Turkish Muslim women in Belgium. Moreover, a similar line of theological reasoning emerged in their studies: the belief in God's sovereignty in the domain of life and death; God determining each person's lifespan; impotence of the physician to prolong or make a prognosis of a person's lifespan; leaving one's faith in God's hands. In keeping with our findings, several studies among European Muslims confirm that no situation is considered hopeless, as Muslims believe in the omnipotence of God, which fosters hope and belief in a miracle (Baeke 2012; Ilkilic 2014; Kristiansen et al. 2014; Lundqvist et al. 2003; Van den Branden and Broeckaert 2008). As in our study, Van den Branden (2006) and Lundqvist et al. (2003) confirmed the equation of switching off the devices with murder and with injustice to God's role. In contrast to the study of Iyilikçi et al. (2004) and Baeke (2012), for our participants the desire to live was a more important argument than the duty to seek treatment.

In keeping with our findings, Van den Branden (2006) and Baeke (2012) found a number of positive voices toward withholding and withdrawing treatment in their study. The general attitude of our participants was, however, more tolerant when compared to the more hesitant position of the majority of their participants. This can be explained by our inclusion of middle-aged participants, as mentioned before. In their study quality of life arguments were mainly provided to make a stance against prolonging treatment, while our participants also provided theological and eschatological arguments to substantiate their position. Van den Branden (2006) corroborates our findings that some participants perceive financial burden as a valid reason to forgo treatment.

Although we found positive attitudes toward withholding and withdrawing treatments in our study, other empirical studies (Iyilikçi et al. 2004; Damghi et al. 2011; Khalid et al. 2012; Ur-Rahman et al. 2013; Yazigi et al. 2005; da Costa et al. 2002) corroborate our findings that Muslims are more tolerant toward not initiating a treatment than toward withdrawing an initiated treatment, including mechanical devices. Similar to our findings, a study of da Costa et al. (2002) among Omani Muslim patients found that 70% agreed to not put their child on the ventilator and only for 11% of the patients withdrawal of ventilation was permitted. They also argued –in line with our findings– that the negative attitude towards withdrawal was based upon the cultural unacceptability and the refusal of the family to be responsible for the patient's death. In another study among patients in Morocco, Damghi et al. (2011) show that nearly 30.5% decided to withhold or withdraw life support based upon the absence of improvement. More specifically, 24.2% of the patients decided to withhold treatment and 6.2% decided to withdraw, for instance, mechanical ventilation which is comparable to our findings. In keeping with our findings, they found more openness toward the withdrawal of other life-sustaining therapies than towards switching off devices.

Comparison with Normative Islamic Views

Dealing with contemporary bioethical issues forms a challenge for Muslims. Islam has no central religious body and for that reason a variety of approaches to ethics is deployed, constituting varied (non-binding) opinions (*fatāwā*) within Islamic jurisprudence (*fiqh*). We provide a short overview here of (*Sunnī*) jurists' approaches in addressing (bioethical) issues. In ethico-legal deliberation, several foundational sources of Islamic law (*ʾusūl al-fiqh*/Islamic legal methodology) are deployed. First of all, jurists rely upon primary and authentic sources of rulings and principles, i.e. *Qurʾān* and *Sunna.* If no immediate ruling can be derived from these sources, secondary sources are employed, including *ʾijmāʿ* (consensus of religious scholars) and *qiyās* (analogical reasoning). Several principles are taken into account, depending on the issue, including *maslaḥa* (public welfare), *ʿadl* (justice), *ḍarūra* (necessity) and *lā ḍarara w-lā ḍirār* ('no harm shall be inflicted or reciprocated'). These principles are often used to discover and promote the objectives of Islamic law (*maqāṣid al-Sharīʿa*), which entails preservation of faith, life, mind, progeny and property (Rispler-Chaim 1993; Atighetchi 2007; Sachedina 2009; Al-Bar and Chamsi-Pasha 2015; Padela and Qureshi 2016). An important theological concept is that life is understood as given by God as a trust (*ʾamāna*) and is therefore holy and dignified (Rahman 1998).

Seeking treatment is often considered an important task. In general, nearly all (*Sunnī*) legal schools (*madhāhib*) are of opinion that seeking remedy is obligatory (*farḍ*) in certain lifesaving situations and in treatable and curable illnesses. A treatment is considered optional or permissible (*mubāḥ*) when the overall benefit is not proved or even doubtful and when effect of therapy is uncertain. A therapy is discouraged (*makrūh*) when therapy is futile, unlikely to bring benefit and

when harm or even inconvenience from therapy may follow (Al-Jahdali et al. 2013; Padela and Qureshi 2016; Al-Bar and Chamsi-Pasha 2015; Saiyad 2009). Classical *Ḥanbalī* sources, however, predominantly state that seeking medical treatment is permissible, but not obligatory and that abstaining is superior. Preference is given to having trust (*tawakkul*) over seeking medical treatment and thus in most *Ḥanbalī* classical sources refraining from therapy is seen as praiseworthy (Padela & Qureshi 2016; Qureshi & Padela 2016).

No unilateral position exist among scholars toward withholding and withdrawing treatments compared with their stance toward active termination of life. Our findings reflect the polyvocal answer found in normative Islamic, international and scholarly literature on this matter. We distinguish two main positions. There are scholars who believe that everything has to be done to keep the patient alive and those who believe that unnecessary and futile measures are inappropriate if the patient is going to die (Atighetchi 2007; Babgi 2009; Padela et al. 2011).

The negative position towards withholding and withdrawing treatment is based on two arguments. Withholding and withdrawing is first of all often seen as a form of (passive) euthanasia. Rispler-Chaim (1993), who analysed mainly Egyptian *fatāwā* (issued in 80-90's), found a strict negative position in the source material, identifying these treatments with passive euthanasia. Non-treatment decisions are indeed often termed as passive euthanasia (Brockopp 2004; Van den Branden and Broeckaert 2010; Ebrahim 2001). According to Atighetchi (2007) modern *fatāwā* do not go beyond the distinction between passive and active euthanasia but condemn both as murder, although many differences and nuances can be found within the condemnation. This was also the case among our participants who generally viewed withdrawal of a life-sustaining treatment as a life-shortening act.

A second argument has to do with a belief in God's miraculous powers. In line with our findings, Al-Jahdali et al. (2013) argue that Muslims sometimes request to continue treatment even in futile cases based upon the strong belief in God's miraculous cures, and that it is within God's power to heal and cure even if the medical professions believe the case is futile or hopeless. Similarly, Schultz et al. (2012) state that a physician should not give a specific estimated life expectancy at any point, since life is in the hands of God, not in the physician's hands. Sachedina (2009) and Al-Bar and Chamsi-Pasha (2015) confirm our findings that although withholding and withdrawing treatment is a legal and generally accepted medical practice in case of terminal illness and brain death, it is still very hard for many Muslims to accept fatal diagnoses and prognoses. This is also due to a lack of consensus on a definition on brain death, which is a complex matter. Those who do not accept brain death as death, do not permit withdrawal of life support (Padela et al. 2013).

The idea of murder and God's omnipotence were also found in our participants' line of reasoning. However, our participants also mentioned the religious duty to seek treatment –even if

there is a lack of medical efficacy– and the desire to live as arguments against withholding and withdrawing treatment.

On the other hand, today more nuanced and positive voices toward withholding and withdrawing life support at the end of life can also be found among Muslim scholars and (*Sunnī*) Islamic organisations (Van den Branden, 2006; Van den Branden and Broeckaert 2010), as among our participants. Several influential Islamic (biomedical) organisations allow refusing, withholding, withdrawing and discontinuing treatment when medication seems to be useless or futile, though under strict circumstances (Padela and Qureshi 2016). Furthermore, several scholars state that Islamic law actually encourages withholding and withdrawing (deemed) futile treatment –in accordance with the principle of *lā ḍarara w-lā ḍirār* ('no harm shall be inflicted or reciprocated'), which can be compared to the non-maleficence principle– in several cases under several conditions.

Withholding and withdrawing is first of all acceptable when physicians are certain that the treatment does not benefit or will not improve the condition or quality of life of the terminally ill patient (Atighetchi 2007; Sachedina 2009; Al-Bar and Chamsi-Pasha 2015; Ebrahim 2001; Bloomer and Al-Mutair 2013; Fitzpatrick et al. 2016; Padela & Qureshi 2016). The Islamic Code for Medical and Health Ethics (2004) art. 62 stipulates that the termination of treatment (e.g. mechanical devices) which is deemed useless by medical committee is allowed.

Second, when the physicians are certain about the inevitability of the death of a terminally ill patient withholding and withdrawing treatment is permissible too. According to Sachedina (2009) the consent of the family must be obtained in order to switch off the devices. The Islamic Organisation for Medical Sciences (IOMS), Islamic *Fiqh* Academy (IFA) and Islamic Medical Association of North America (IMANA) state that life support may be removed if three experts confirm that there is no brain activity and that damage is irreversible. For Ebrahim (2001), Hedayat and Pirzadeh (2001) and the European Council for Fatwa and Research (ECFR) withdrawal of life support is only permissible for a brain dead patient. In contrast with ECFR and IOMS, IMANA approves of withdrawing and withholding treatment when no recovery is possible –determined by three physicians– and thus does not limit it to brain death or terminal illness (Babgi 2009; Van den Branden 2006) – an opinion shared by many of our participants.

A third case in which according to a number of scholars withholding and withdrawing treatment is allowed is when the treatment delays death and thus prolongs the dying state or natural death (Sachedina 2009; Bloomer and Al-Mutair 2013; Hedayat and Pirzadeh 2001). Al-Bar and Chamsi-Pasha (2015, p.244) articulate that *Islam acknowledges that death is an inevitable phase of the life of a human being, medical management should not be given if it only prolongs the final stage of a terminal illness as opposed to treating a superimposed, life-threatening condition*. In this respect, referring to the Islamic Code for Medical and Health Ethics (2004), Ghaly (2015) argues that a

physician should endeavour the process of maintaining life and not the process of dying. Similarly and in line with our findings, IMANA dismisses the unnecessary prolonging of the dying process of terminal patients or PVS-patients and therefore support withdrawal in case the inevitability of death is determined by a team of physicians (Van den Branden 2006; Ebrahim 2001; Al-Bar and Chamsi-Pasha 2015).

Scholars such as Bloomer and Al-Mutair (2013) and Brockopp (2004) support our finding that switching off the devices can be understood as actually accepting God's decree/plan. Brockopp (2004) argues that death gains importance due to the teleology of death (*cf.* judgement, resurrection) and is perceived as God determining the moment of death (*ajl*). As such, the central concern is that Muslims should not arrogate themselves to God's position as author of life and death. However, passive euthanasia –allowing a patient's death to take its natural course– can in fact be viewed as allowing God's plan to run its course, by which no intervening is perceived with a person's predetermined lifespan. This argument was also found in the line of reasoning of our participants.

In line with these findings, Atighetchi (2007) found that in the Muslim tradition some comprehension seems to be reserved for so-called passive euthanasia, which may not be considered a crime if it is not considered equivalent to suicide. In this context, the importance of intention – which is known by God– is strongly emphasized in order to morally distinguish active from passive euthanasia (Ayuba 2016). Furthermore, a difference is made between the person's intention to deliberately end a life and allowing death to take its natural course (Sachedina 2009)– a line of reasoning that was also found among our participants. Al-Bar and Chamsi-Pasha (2015) explain that in Islam the intention is indeed central: each action will be judged according to the person's intention.

According to Ebrahim (2001) and Albar (2007) the financial burden is a valid reason for withholding or withdrawing treatment if the patient has reached the terminal stage. This line of thought was also found among our participants. Additionally, Al-Bar and Chamsi-Pasha (2015) add that futility of end-of-life treatment is indeed difficult to define due to several factors, such as the effect on the quality and length of life, financial costs, emotional costs and chances of succes. In this respect, Broeckaert (2009b) argues rightfully that futility is not a value-free concept and that choices are rarely black and white. Indeed, judgements about the desirability and meaningfulness of a treatment are very delicate decisions which not only entail an assessment of physiological benefit and burden, but are also influenced by personal characteristics of both patients and physicians, and thus involve very subjective value judgments.

When comparing the views of our participants with normative Islamic views, we found fundamental similarities. We did, however, observe among our participants more tolerant views regarding withholding and withdrawing life-sustaining treatments that are somehow contrary to normative Islamic views, where strict circumstances and conditions (*e.g.* brain death, terminal

illness) are imposed. Indeed, our empirical study shows a more open perspective that is still based upon theological arguments, but leaves more room for discussion. As mentioned before, this more open attitude toward non-treatment decisions was particulary present among middle-aged participants which might be explained by the influence of Western ideas such as quality of life arguments and autonomy. At the same time, however, this more tolerant attitude is substantiated with theological arguments: no interference is perceived in God's sovereignity over life and death (as also suggested by Brockopp). In other words, for them there is no contradiction at all between accepting non-treatment decisions and a firm belief in God's sovereignity.

Our exploratory findings should be interpreted with several limitations in mind. First, given the nature of our data (specific groups; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. For instance, it would still be interesting to do an in-depth investigation of Muslim patients who are personally confronted with terminal illness on their attitudes toward withholding and withdrawing life-sustaining treatments. Further studies could explore whether the impact of religion on the attitudes toward withholding and withdrawing life-sustaining treatments would differ among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

Conclusion

Our study reveals that religion and worldview (*e.g.* theological and teleological arguments) have a great impact on the ethical attitudes toward end-of-life issues. Divergent positions were found among middle-aged and elderly participants, reflecting the lines of reasoning found in normative Islamic literature. Theological and more specifically teleological considerations centring on God's role in matters of life and death (*cf.* determined person's lifespan by God) and God's omniscience (*cf.* hope), but also the belief in the afterlife, seem to be very crucial for Muslims, both for those who are in favour of and those who are against withholding and withdrawing treatment. Supporters did not only rely upon theological and eschatological arguments, but also on quality of life and financial arguments.

References

Al-Bar, M., and H. Chamsi-Pasha. 2015. *Contemporary Bioethics*. New York: Springer International Publishing. Available at: https://link.springer.com/book/10.1007%2F978-3-319-18428-9 [Accessed 20th December 2016]

Al-Jahdali, H., S. Baharoon, A. Al Sayyari, and G. Al-Ahmad. 2013. Advance medical directives: a proposed new approach and terminology from an Islamic perspective. *Medicine, Health Care, and Philosophy* 16 (2):163-169.

Albar, M. 2007. Seeking Remedy, Abstaining from Therapy and Resuscitation: An Islamic Perspective. *Saudi Journal of Kidney Diseases and Transplantation* 18 (4):629-637.

Atighetchi, D. 2007. *Islamic Bioethics: Problems and Perspectives*. International Library of Ethics, Law, and the New Medicine. New York: Springer.

Ayuba, M.A. 2016. Euthanasia: A Muslim's Perspective. *Scriptura* 115 (0):1-13.

Babgi, A. 2009. Legal Issues in End-of-life Care: Perspectives from Saudi Arabia and United States. *American Journal of Hospice & Palliative Medicine* 26 (2):119-127.

Baeke, G. 2012. Religion and ethics at the end of life. A qualitative empirical study among elderly Jewish and Muslim women in Antwerp (Belgium). *Bioethics* 25, (3):167-175Katholieke Universiteit Leuven, Leuven.

Baeke, G., J. P. Wils, and B. Broeckaert. 2012. It's in God's hands: The Attitudes of Elderly Muslim Women in Antwerp (Belgium) toward Active Termination of Life. *AJOB Primary Research* 3 (2):36-47.

Berger, J.T. 2011. Redefining the domains of decision making by physician and patient. *International Journal of Clinical Practice* 65 (8):828-830.

Bloomer, M. J., and A. Al-Mutair. 2013. Ensuring cultural sensitivity for Muslim patients in the Australian ICU: Considerations for care. *Australian critical care : official journal of the Confederation of Australian Critical Care Nurses* 26 (4):193-196.

Brockopp, J. E. 2004. *Islamic Ethics of Life. Abortion, War and Euthanasia* (Studies in Comparative Religion). Columbia: University of South Carolina Press.

Broeckaert, B. 2008. Treatment Decisions at the End of Life. A Conceptual Framework. In *Palliative Care Nursing Principles and Evidence for Practice. 2nd edition*, eds. S. Payne, J. Seymour, and C. Ingleton, 402-421. Berkshire: Open University Press.

Broeckaert, B. 2009a. Euthanasia and Physician Assisted Suicide. In *Palliative Medicine*, eds. T. Walsh, A. Caraceni, R. Fainsinger, K. Foley, P. Glare, C. Goh, M. Lloyd-Williams, J. Olarte, and L. Radbruch, 110-115. Amsterdam: Elsevier.

Broeckaert, B. 2009b. Treatment Decisions in Advanced Disease – A Conceptual Framework. *Indian Journal of Palliative Care* 15 (1):30-36.

Broeckaert, B., and Flemish Palliative Care Federation. 2006. *End of Life Decisions – A Conceptual Framework*. Brussels: FPZV.

Brown, E. 2014. Ethnic and Cultural Challenges at the End of Life: Setting the Scene. *Journal of Renal Care* 40 (1):2-5.

Cohen, J., I. Marcoux, J. Bilsen, P. Deboosere, G. van der Wal, and L. Deliens. 2006. European Public Acceptance of Euthanasia: Socio-Demographic and Cultural Factors Associated with the Acceptance of Euthanasia in 33 European Countries. *Soc Sci Med* 63:743-756.

Cohen, J., P. Van Landeghem, N. Carpentier, and L. Deliens. 2014. Public acceptance of euthanasia in Europe: a survey study in 47 countries. *International Journal of Public Health* 59 (143):156.

Corbin, J., and A. Strauss. 2015. *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory*. Fourth Edition California: SAGE Publications.

da Costa, D.E., H. Ghazal, and S. al-Khusaiby. 2002. Do Not Resuscitate Orders and Ethical Decisions in a Neonatal Care Unit in a Muslim Community. *Archives of Disease in Childhood. Fetal and Neonatal Edition* 86:F115-F199.

Damghi, N., J. Belayachi, Aggoug B., T. Dendane, K. Abidi, N. Madani, A. Zekraoui, A. Belabes, A. A. Zeggwagh, and R. Abouqal. 2011. Withholding and withdrawing life-sustaining therapy in a Moroccan Emergency Department. An observational study. *BMC Emergency Medicine* 11 (12):1-8.

Ebrahim, A.F.M. 2001. *Organ Transplantation, Euthanasia, Cloning and Animal Experimentation. An Islamic View*. Leicester: The Islamic Foundation.

Fitzpatrick, S., I. Kerridge, C. Jordens, L. Zoloth, C. Tollefsen, K. Tsomo, M. Jensen, A. Sachedina, and D. Sarma. 2016. Religious Perspectives on Human Suffering: Implications for Medicine and Bioethics. *Journal of Religion and Health* 55 (1):159-173.

Ghaly, M. 2015. Euthanasia. In *Encyclopedia of Islam*, eds. K. Fleet, G. Krämer, Matringe D., J. Nawas, and E. Rowson. London: Brill Online. http://dx.doi.org/10.1163/1573-3912_ei3_COM_26254 [Accessed 27th July 2017].

Gielen, J. 2010. Ethical Attitudes and Religious Beliefs at the End of Life. A Study of the Views of Palliative-Care Nurses and Physicians in Flanders (Belgium) and New Delhi (India). (Unpublished doctoral dissertation) Katholieke Universiteit Leuven, Leuven.

Glaser, B. G., and A. L. Strauss. 1967. *The Discovery of Grounded Theory. Strategies for Qualitative Research* New York: Aldine Publishing Company.

Hedayat, K.M., and R. Pirzadeh. 2001. Issues in Islamic Biomedical Ethics: A Primer for the Pediatrician. *Pediatrics* 108 (4):965-971.

Hertogen, J. 2016. Marokkaanse-, Turkse- en islamachtergrond per gemeente Available at: http://www.npdata.be/ [Accessed 13th April 2016]

Ilkilic, I. 2014. End-of-life decisions at the beginning of life. In *Health, Culture and the Human Body. Epidemiology, Ethics, and History of Medicine, Perspectives from Turkey and Central Europe*, ed. I. Ilkilic, et al., 433-444. Istanbul: Betim Center Press.

Islamic Code for Medical and Health Ethics. 2004. Available at: http://islamset.net/ioms/code2004/index.html.https://link.springer.com/book/10.1007%2F978-3-319-18428-9 [Accessed 20th December 2016]

Iyilikçi, L., S. Erbayraktar, N. Gokmen, H. Ellidokuz, H. C. Kara, and A. Gunerli. 2004. Practices of anaesthesiologists with regard to withholding and withdrawal of life support from the critically ill in Turkey. *Acta Anaesthesiol Scand* 48 (4):457-462.

Khalid, I., W.J. Hamad, T.J. Khalid, M. Kadri, and I. Qushmaq. 2012. End-of-Life Care in Muslim Brain-Dead Patients: A 10-Year Experience. *American Journal of Hospice and Palliative Medicine* 30 (5):413-418.

Kristiansen, M., T. Irshad, A. Worth, R. Bhopal, J. Lawton, and A. Sheikh. 2014. The practice of hope: a longitudinal, multi-perspective qualitative study among South Asian Sikhs and Muslims with life-limiting illness in Scotland. *Ethnicity & Health* 19 (1):1-19.

Lundqvist, A., T. Nilstun, and A. K. Dykes. 2003. Neonatal end-of-life care in Sweden: the views of Muslim women. *J Perinat Neonatal Nurs* 17 (1):77-86.

Padela, A. I., A. Arozullah, and E. Moosa. 2013. Brain death in islamic ethico-legal deliberation: Challenges for applied islamic bioethics. *Bioethics* 27 (3):132-139.

Padela, A. I., and O. Qureshi. 2016. Islamic perspectives on clinical intervention near the end-of-life: We can but must we? *Medicine, Health Care, and Philosophy*. doi:10.1007/s11019-016-9729-y.

Padela, A. I., H. Shanawani, and A. Arozullah. 2011. Medical Experts & Islamic Scholars Deliberating over Brain Death: Gaps in the Applied Islamic Bioethics Discourse. *Muslim World* 101 (1):53-72.

Qureshi, O., and A. Padela. 2016. When must a patient seek healthcare? The perspectives of Islamic jurists and clinicians into dialogue. *Zygon* 15 (3):592-625

Rahman, F. 1998. *Health and medicine in the Islamic tradition*. Chicago: Kazi Publications.

Rispler-Chaim, V. 1993. *Islamic Medical Ethics in the Twentieth Century* Social, Economic and Political studies of the Middle East. Leiden: Brill.

Sachedina, A. 2009. *Islamic biomedical ethics: principles and application*. Oxford: Oxford University Press.

Saiyad, S. 2009. Do Not Resuscitate: A Case Study from the Islamic Viewpoint. *Journal of the Islamic Medical Association* 41 (3):109-113.

Schultz, M., K. Baddarni, and G. Bar-Sela. 2012. Reflections on Palliative Care from the Jewish and Islamic Tradition. *Evidence-Based Complementary and Alternative Medicine*. doi:http://dx.doi.org/10.1155/2012/693092

Strauss, A., and J. Corbin. 1998. *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks (Calif.): Sage.

Ur-Rahman, M., S. Abuhasna, and F.M. Abu-Zidan. 2013. Care of terminally-ill patients: an opinion survey among critical care healthcare providers in the Middle East. *African Health Sciences* 13 (4):893-898.

Van den Branden, S. 2006. Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen. (Unpublished doctoral dissertation), Katholieke Universiteit Leuven, Leuven.

Van den Branden, S., and B. Broeckaert. 2008. Medication and God at Interplay: End of Life Decision Making in Male Moroccan Migrants Living in Antwerp, Flanders, Belgium. In *Muslim Medical Ethics: from Theory to Practice*, eds. J. Brockopp, and T. Eich, 194-208. Columbia: University of South Carolina Press.

Van den Branden, S., and B. Broeckaert. 2010. Living in the Hands of God. English Sunni E-Fatwas on (non-)Voluntary Euthanasia and Assisted Suicide. *Med Health Care Philos* 14 (1):29-41.

Yazigi, A., M. Riachi, and G. Dabbar. 2005. Withholding and withdrawal of life-sustaining treatment in a Lebanese intensive care unit: a prospective observational study. *Intensive care Medicine* 31 (4):562-567.

Zahedi, F., B. Larijani, and J. Tavakolly Bazzaz. 2007. End of Life Ethical Issues and Islamic Views *Iranian Journal of Allergy, Asthma and Immunology* 6 (5):5-15.

"You don't live on the earth, you are passing through it."

—Rūmī

5. "Every Soul Shall Taste Death". Attitudes and Beliefs of Moroccan Muslim Women living in Antwerp (Belgium) toward Dying, Death and the Afterlife

Introduction

Several studies argue that there is a clear link between the way people view and deal with death and and their religious beliefs (Baeke, 2012; Dessing, 2001; Kadrouch-Outmany, 2014; Renaerts, 1986; Van den Branden, 2006; Venhorst, 2013). Religious beliefs give meaning to death and dying by putting them within a transcendental framework (Kristiansen, Younis, Hassani, & Sheikh, 2016). Several studies show that religious beliefs and more specifically eschatological beliefs of people might determine how people think and act, for example regarding treatment decisions at the end of life (e.g. euthanasia, palliative sedation etc.) (Baeke, Wils, & Broeckaert, 2012a, 2012b; Van den Branden & Broeckaert, 2008). Eschatology is defined as the doctrine about the final things to come at the end of times (Smith & Haddad, 2002). Eliciting people's views and attitudes towards dying, death and the afterlife may thus help to understand their behaviour and the choices they make when for instance they are confronted with a life-threatening illness.

In Belgium, Muslim mass-migration began in the 1960s, with large-scale settlement of guest workers mainly from Morocco and Turkey. These communities have been living and aging and subsequent generations have been born and grown up in Belgium. In a few decades' time, Islam has become the second largest religion in Belgium and the fastest growing religion in Europe (Pew Research Center, 2015; Shadid & van Koningsveld, 2008). In 2016, it was estimated that Muslims counted for 7,2 % of the Belgian population. Nearly half of the Muslim population in Belgium is from Moroccan descent (Hertogen, 2016).

Until this day little attention has been paid to the real-world attitudes of Muslims living in West-Europe. Although death and dying among Muslims have been mainly addressed in anthropological, psychological or ritual studies (Abdel-Khalek, 2004; Dessing, 2001; Renaerts, 1986; Venhorst, 2013) and Islamic eschatological narrative has been thoroughly studied (Chittick, 1987; Smith & Haddad, 2002), a detailed descriptive and comprehensive account of the eschatological views of (Moroccan) Muslims, living in Belgium, is lacking to a great extent.

The aim of this article is threefold. First, we seek to describe the attitudes and beliefs of middle-aged and elderly Moroccan Muslim women living in Antwerp (Belgium) toward dying, death and the afterlife. Second, we focus on the middle-aged, mainly second generation population. In contrast to the first generation elderly Moroccan Muslim women, who are mainly uneducated and illiterate, this group shows much more socio-economic diversity. Moreover, they were not raised in a homogenous, rural, traditional Islamic environment but brought up in a western context and live less isolated from the broader Belgian society. What has been the effect of this assumed stronger

western influence on their beliefs and attitudes? Third, we seek to find out how the real-world attitudes of our participants relate to normative Islamic views. How present and 'vital' are these normative views in this population?

Methods

Design

Between October 2014 and September 2015, thirty semi-structured interviews were conducted with a sample of middle-aged and elderly women in the Moroccan community in Antwerp (Belgium) who self-identify as Muslims. This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. We have chosen Antwerp for two important reasons. First, this city has the largest Muslim population in Flanders: 19,2 % of Antwerp's population is Muslim (Hertogen, 2016). Second, Antwerp as a port city is considered to be among the most multicultural cities in the world.

Different routes of recruitment (*e.g.* mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured topic list covering the following items: demographic background, religion, care for the elderly, illness, treatment decisions in advanced disease, death and dying, mourning, remembrance and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) or Dutch. Participants were interviewed one-on-one (*e.g.* in their own house, in a room made available by a local non-profit organization or in a quiet tea house). Both advantages and disadvantages are attached to the background of the interviewer (interviewer bias). On the one hand, being a member of the same community facilitated the gaining of trust and resulted in a certain openness and detailed conversations, on the other hand this might also have influenced the answers of the participants by not providing 'deviating' answers out of fear of being judged. An interviewer can never be sure whether a participant said everything or did not tell the whole story. Although several measures were taken to guarantee anonymity (e.g. pseudonyms, deleting audio-tapes after transcribing), qualitative research cannot fully guarantee anonymity (e.g. interviews are face-to-face). Although biases cannot be fully avoided, we have sought to limit these as much as possible by adopting several strategies (e.g. data checking with members of the Moroccan Muslim community and experts; peer debriefing; memos).

We also interviewed 15 experts in the field between September 2014 and September 2015. The included experts in the field were identified by the interviewer and guiding committee and were selected on the technical knowledge the experts have on our research topics. More specifically, we interrogated imams, Muslim undertakers, a specialized corpse washer, Muslim physicians, a

palliative care consultant as they had specific knowledge on the topic dealt with and were familiar with the Moroccan Muslim community in Antwerp. Experts were interrogated about the same topics as the Moroccan Muslim women via outlined semi-structured interview protocols. While doing this, we didn't ask them about their own personal views but about the views of the women they were working with. This method was, firstly, helpful as it provided rich background information that could be added to the data of our interviews with women. Secondly, it helped us to be more sensitive towards the data of our interviews with Moroccan Muslim women. Thirdly, the data of the interviews with experts were used in a comparative way to limit biases and to check the reliability and credibility of our findings of the interviews with Moroccan Muslim women.

Apart from interviewing, the first author also conducted participant observations (December 2014 – April 2017). Several visits of the sick, death prayers, mourning gatherings, ritual washings of the dead body, and a *ḥijāma* ('cupping')-consultation –which is a body therapy that purifies blood by means of a vacuum– were attended and several Islamic cemetery plots were visited.

The present study is part of a larger research investigating the attitudes, beliefs and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp). In this research, themes such as care for the elderly; health, illness and medicine; end-of-life issues (e.g. active termination of life, palliative treatment and symptom control, withdrawing and withholding treatment); mourning and remembrance and burial practices were also addressed.

In this study, we opted for a non-normative, descriptive, exploratory approach. This study was approved by the Social and Societal Ethics Committee (KU Leuven, Leuven). To guarantee the anonymity of our participants, we made use of pseudonyms.

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology (Corbin & Strauss, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used to code and analyse the interview data. The specificity of the Grounded theory methodology can be explained in that it aims at thoroughly capturing the worldview of the individual respondent as a basis for constructing the world view of the social group to which the respondent belongs. Therefore, the methodology stresses the use of 'taking the role of the other' and the 'constant comparative method' as basic research techniques (Glaser and Strauss 1967). By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated in order to grasp the real-world experiences and meaning systems of our participants.

The data were coded using Grounded theory's three major steps of coding: open, axial and selective coding. During open coding, the data were broken down, examined and compared in order to identify similarities and differences while categorizing the data. Axial coding, the second step in

the coding process, reflected the systematic process we used for grouping data, linking categories based on associative relationships and deriving conclusions from analysis and re-synthesis of data. The third step of coding was selective coding—a process in which relationships between the core category and other categories were systematically identified. This was a process of integrating and refining a theory as an answer to the research question (Corbin and Strauss 2015; Strauss and Corbin 1990). The coding frames used in the present study consisted of our participant's views towards dying, death and the afterlife. Codes describing the participant's views were for example "life as a trust", "God as author of death", "life in the grave" "role of angels", "Judgment day", "paradise". These concepts were categorized under "theological considerations" and "eschatological considerations". The data collection was based on the analysis of previous data ('theoretical sampling') which often involved the adaptation and further specification of interview guides and topic lists. When certain categories were well developed and the relations between categories was clear, theoretical saturation ('theorising') was reached (Strauss & Corbin, 1998, Glaser Straus 1967). Our study did not aim to develop a theory, though, but sought to provide a detailed reconstruction of our participants' way of thinking and worldview.

In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. Findings of the interviews with Muslim women were compared with those of the interviews with experts and subsequently compared with the normative literature and the available empirical studies (cf. discussion). Our research findings were regularly discussed with our guiding committee and with several members of the Moroccan Muslim community.

Results

Participants' (socio-)demographic information & health situation

Our group of middle-aged Moroccan Muslim women (n=15) was between 41 and 55 years old, our group of elderly women (n=15) was aged between 61 and 86. When the ages are split into 10-year age groups, nine women were in their forties, six in their fifties, ten in their sixties, three in their seventies and two in their eighties. Nearly half of our middle-aged participants was born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Concerning marital status, twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of between three and five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber participants spoke Arabic, and only two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes. Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

The health issues of our middle-aged participants were limited to knee problems and migraine. Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a bad health condition. Nine participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer and severe chronic disease.

All our participants described themselves as practicing Muslims, who acknowledge the six pillars of faith (*arkān al-ʾimān*) and observe the five pillars of Islam (*arkān al-Islām*). The six pillars of faith consist of believing in God, His books, His angels, His messenger, the day of Judgment and predestination. The five pillars of Islam involve the declaration of faith (Islamic creed); performing daily prayers, fasting, alms-giving and performing pilgrimage to Mecca. Only one middle-aged participant mentioned to have experienced difficulties in observing the daily prayers (*ṣalāt).*

Attitudes towards Dying, Death and the Afterlife

Dying

Understanding of Dying

Our participants immediately and spontaneously interpret dying within a religious framework. All participants hold the opinion that dying is a normal process in one's lifecycle (*sunnat al-ḥayāt*), created by God. They explain that the only certitude in life is that 'every person shall taste death' (Q3:185). Half of our participants explicitly mention that life is meaningful as a temporary dwelling place with the purpose of worshipping God and earning good marks (*ḥasanāt/ajr*). Life is thus understood from an eschatological perspective: it is God's test for entering paradise. These views were also confirmed by our experts.

> "Dying is part of life and it awaits every person.[…] This is the only certainty that everyone agrees on, that we will all die. God has put us in this world for a reason, so that we worship Him. God also says in the *Qur'ān*: "Every soul shall taste death."" Kaltoum – middle-aged

> "Dying is *sunnat al-ḥayāt* ('natural lifecycle').[…] We've known from the very beginning that we will die one day. Dying is part of life. Every Muslim knows that he/she is in this world to work and will return to God." Huda – elderly

However, Khadija, an elderly participant, takes an exceptional position in this regard. She finds it difficult to share her ideas about death and dying. Her answer is to be understood within her difficult grief of her parents' and husband's loss.

> "No, please don't talk me about death [heavy sigh]. If I think about that, then I think about being buried under the ground. I don't want to think about death nor dying. Then I don't feel good. Because then I think: why do we have to die? Why can we not stay alive forever?" Khadija – elderly

All participants unconditionally believe in an omnipotent God, who is the ultimate author of life and death, of illness and cure. Hence, participants unanimously state that only God determines a person's time of death (*ajl*), which He has already appointed. In other words, dying is considered an act of God who takes away life of both young and old people.

> "It's God who gives and takes away life.[…] The moment of death (*ajl*) comes from God. It's God who decides when you will die, when you will live." Hannan – middle-aged

> "Death is for both young and old people. Death doesn't skip anyone, not even a baby in the womb of his mother. Everyone will die. I've lost two children, one was a year old and the other was 15 days old. That's what God had predestined for them. Everything comes from God." Rahima – elderly

Based upon the firm belief in predestination (*al-qadr*), the majority of our participants emphasizes that the moment of death is predestined (*maktab* or *maktūb*) by God and thus occurs only with God's decree and permission. A few participants underscore explicitly that God is the only one

who possesses knowledge (*Allāhu aʿlam*) of the place and time of death, which have been written down when the fetus was in the mother's womb. Additionally, they argue that God gives every person a particular means (*sabab*) to die (e.g. illness, accident). This too is confirmed by our experts.

> "God knows when you'll have to leave and when you came.[…] Everyone will die in its own way.[…] There are people who die in a train, airplane, others at home, others in their sleep, but it remains a decision of God, so the day and the timing is already determined." Sarah – middle-aged

> "The soul is in God's hands. Dying is a moment that God has already predestined for you. Everything is already written down (*maktab*).[…] Whatever happens to you, God has already written it down on the fortieth day in the womb of the mother.[…] What you will pass through, when you'll marry, when you'll get sick, when you'll die." Alia – elderly

A minority of middle-aged participants expresses the idea that God sends signs of a person's nearing death to the person who is about to die or to his/her relatives. These signs can be conveyed through dreams, or felt by the person about to die or by somehow preparing one's death unconsciously.

> "You also get these signs. She (her cousin) saw it coming.[…] Yeah, she really received signs like 'I have to go.' She felt that. And that's actually weird, because her mother, my aunt, had died two years before that.[…] The signs were there. She had also dreamed that her mother had saved her a seat and said 'Come. This is your spot.' It's unbelievable, a half year later she died." Badria – middle-aged

Dying Process

Death is defined by all our participants as the separation of the soul from the body by God, followed by the complete stopping of breathing. This definition is to be understood from their unconditional belief in an omnipotent God, who governs life and death. Only a small minority of our participants could provide more details on the dying process, which according to them consists of several stages. First, a few participants mention the visit of the angel of death (*malak al-mawt*, also often pronounced as *malik al-mawt*), who takes away a person's soul on behalf of God.

> "My husband was sleeping and suddenly he woke up, he saw *malik al-mawt* (angel of death). We knew that he saw something. We talked to him and the whole time he looked at us with frightened eyes. So it was *malik al-mawt* and then he closed his eyes, puffed his last breath and died." Lamya – middle-aged

Second, the moment of dying is believed to foster a difficult struggle for the human being, which is referred to as agony of death (*sakarat al-mawt*). A minority of our participants explains that the separation of the soul –which is a painful action– begins at the feet and moves upwards. It is in this respect, too, that participants refer to and literally interpret the *Qur'ānic* verse that each soul shall taste death. Interestingly, they believe that the struggle is related to the person's deeds during the earthly life. In other words, the way the soul leaves the body is a reflection of the way the person

has lived. The greater the good deeds, the softer the soul is extracted from the body. This view is confirmed by our experts.

> "We hope that the *sakarat al-mawt* (agony of death) will be painless. Everyone and animals too will taste death. You'll usually get really warm and when they die there's a last puff, as if the soul is coming out of the mouth." Radia – middle-aged

> "Death is hard. We ask God that He makes *sakarat al-mawt* (agony of death) easy on us. Death is difficult. The prophet said '*Sakarat al-mawt, sakarat al-mawt!'*. Even the prophet Muḥammad suffered when he died, let alone us. " Alia – elderly

However, Ikram, a middle-aged participant, nuances this idea of the agony of death. Indeed, she equates the dying process with the process of being born, explaining that the dying person might not feel the pain or be consciously aware of the transition, in analogical comparison with a baby who does not remember the transition to life or feel pain.

> "Dying is like being born. Maybe I didn't like it when I was born. They pulled me. I had to go through a hole that was only a few centimeters long. But I had to get out, but I just don't remember. I think the moment, that transition of being born, is painful for the mother, but I also think it is painful for the child. When he comes out of it, into this new form of life.[…] So the transition is just too physical, it is different. I don't know if that little baby is in pain or not. But I also know that the transition -prophet Muḥammad has also said this- hurts. It hurts when the soul is taken out of the body." Ikram – middle-aged

Third, several –mainly elderly– participants mention that the dying process is also accompanied by physical signs. They give examples such as the loss of consciousness and speech, speaking about dead people, turning the eyes and experiencing thirst. One elderly participant, Alia, narrates the challenging presence of the devil at the bedside who offers water to the dying person in return for letting down his/her faith (*kafara*) by not pronouncing the Islamic creed (*shahāda*). This is conceived as a clear test of one's personal faith. With regard to the facial expression, some participants explain that when a person dies with a smile it means that he/she has seen his/her final abode, paradise.

> "His eyes were closed. He couldn't talk anymore. Sometimes he gibbered something but I couldn't understand him. His eyes turned around and we saw a smile on his face. When the soul came out of my husband's body, a smile appeared on his face. Some people say that he saw his place in paradise." Yamina – elderly.

> "Once there was a person dying in the time of the prophet, but he didn't want to say the *shahāda* (Islamic creed).[…] They said to the dying 'You're dying and you don't want to say the *shahāda*.' He said 'I was busy with the devil. The devil came with a bucket of water that could take me to heaven and he told me to turn away (*kafara*) from prophet Muḥammad in exchange for water'."Alia – elderly

Death and the Afterlife

What happens after a person dies is, according to many participants, a great mystery. Nearly all participants strongly stress that only God, the creator of life and death, has the knowledge of death

and beyond. Therefore, they are rather hesitant in their depiction and description of death. All participants view death as merely a transition to a next phase. A few experts argue that a greater ignorance exists about Islamic eschatology among first generation women than among second generation women, who are assumed to have more knowledge on their faith, relating this to their higher level of education. However, this was not confirmed in our study. Both middle-aged and elderly find it equally difficult to imagine death.

> "Our soul will be taken out of our body. It's our body that we will leave here. We don't know where our soul will go. I always say 'God knows best' (*Allāhu aʿlam)*. I do know that there is a God and that the prophet awaits us. So the more we do good, the more we are rewarded. I can't tell you much more about what will happen after our death." Loubna – middle-aged

> "God knows best (*Allāhu aʿlam).* Death is something people cannot have an image of. No one has come back from the dead to know that. Only God has this knowledge." Huda – elderly

> "I think that the second generation is better informed than the first one. They're more ignorant in that respect. They only rely upon what their parents have told, such as hell, paradise, punishment and reward, but they have no clue what will happen in between. By contrast, the second generation is more concerned with their religion and they also know what will happen in the intermediate phase." Imane – *Ḥijāma* practitioner

The general understanding and depiction found among nearly all participants is that death means both taking leave of family, possession and worldly life and returning to God. In this respect, a few –mainly elderly– participants refer explicitly to the stewardship of the human being in this worldly life. Death is thus viewed as God, the ultimate owner of life, taking back His trust (*ʾamāna*).

> "When you die, you'll go home to God. God takes back His *ʾamāna* (trust)." Laziza – elderly

> "Death is the same thing as borrowing money from someone. Will you give it back or not? You'll give it back! Well, it's the same thing**.** A human being is just a guest. When death comes, you'll just go home to God. Whether you're non-Muslim or Muslim or Jew, they'll all return to God." Alia – elderly

Barzakh (Life in the Grave)

Here, again, only a few participants are able to elaborate on their image of death. Among elderly participants, these are mainly women who often go to the mosque and follow religious courses. In what follows, we have ordered their ideas chronologically. First, more than half of our participants express the idea that along with death, the soul resides in another world until the Day of Resurrection. Some articulated this phase as *barzakh*, whereas others designate it as 'life in the grave'. This was also confirmed by our experts.

> "When we die, we'll stay in our graves until Judgment Day. And when we're dead, we'll only get to see our family from Thursday to Friday. That's everything we've learned, etc. And yeah, we have to wait until Judgment Day to go to God." Radia – middle-aged

> "When you die, you go to *barzakh*. You go to the life of *barzakh*. First you have *ḥayāt al-dunyāʾ* (worldly life), and then *ḥayāt al-barzakh* (transitional life)." Zoulikha – elderly

A small minority of participants makes an analogical comparison of death and sleep. On the one hand, several participants likened sleeping to a short death, explaining that a person dies on a daily basis. On the other hand, two participants view the intermediate period (*barzakh*) as a sleep-like mode.

> "I've always thought that when you die, it's a moment that you won't feel anything. It's like you're asleep, a phase of peace. You get up and you actually don't know what you dreamed of or what you've done. It's a period where you sleep. Well, I've always thought that life after death will be like that." Ikram – middle-aged

> "We die every time, every day we die and we come back to life. And when you get up you say 'Praise is to God Who gives us life after He has caused us to die and to Him is the return'('*Al-ḥamdullilāh alladhī ʾahyānāʾ baʾda māʾ ʾamātanā wa ilayhi al-nushūr'*). Every night we die. We don't feel that. That's death of this world. Every day we die in our sleep." Alia – elderly

Second, a few elderly participants mention that at the moment of death the soul travels to God through the seven heavens in the company of angels and sees a glimpse of his/her destination. They believe that the experience of this journey of the soul reflects the fruits of his/her doing. After this journey, some believe that the soul immediately returns to the body and stays above the body until the burial. They argue that in the meantime the deceased is capable of hearing, seeing and feeling, but is unable to communicate with the living people.

> "The soul goes quickly to God, the angels will guide them to paradise. The angels ask God: 'Do we take him to paradise or to the hellfire? The believer that ascends to God sees either paradise or hell. Afterwards the soul returns to the grave. Our soul remains with our body until we are buried." Haddad– elderly

Third, nearly half of our participants state that when the body of the deceased is placed into the grave, his/her soul will be visited by two angels, Munkar and Nakīr. An interrogation will take place on matters of faith (e.g. who is your lord?; who is your prophet?; what is your faith and/or what is your book?). After the interrogation the deceased finds her/himself in an (un)pleasant situation depending on the answers given.

> "Yes, Munkar and Nakīr come to the grave and then they ask i.a. 'What is your religion? What is your book?' If you have a good *ʾimān (faith)*, you will be able to answer. But if you've been a bad person, you won't be able to answer." Warda – middle-aged

> "When someone dies, he goes to God. I don't have the knowledge to explain things, but they say that you end up in your grave and that you will be questioned by Munkar and Nakīr and if you have performed good deeds, you will feel good as if you're in paradise. If you have performed bad deeds you'll feel that in your grave, very tight, and you'll stay there until Judgment Day. God knows best." Aïcha – elderly

Fourth, nearly all participants express a dominant fear for the torture of the grave *(ʿadhāb al-qabr*), a fear which is also confirmed by our experts. This fear is nurtured by the feeling of having

worked or prepared insufficiently for the afterlife, but is also a result of the mystery of death. This fear is found among both middle-aged and elderly participants, though it is mostly associated with reaching old age, as they believe that death is more imminent then. Thus the life in the grave is understood and viewed as a reflection of one's deeds in the earthly life and as a foretaste of the final destination. The deceased experiences the grave either as a garden of paradise or as a hell pit until the Day of Resurrection.

> "Yes, first you have *ʿadhāb al-qabr* (torture of the grave) where you will suffer. If you have performed good deeds, your grave will be paradise. May God protect us. And if you have performed bad deeds, you'll also get a taste of your final abode and your grave will be very tight. So what awaits you, depends upon your life here. I'm afraid of that." Fawzia – middle-aged

> "No, I'm not afraid of death, but of my deeds. If you know that you have done good deeds, you'll be satisfied. But I'm afraid of my deeds. We're afraid of *ʿadhāb al-qabr* (torture of the grave). You know that death will come, but you don't know how it will come and it all has to do with your deeds. That's what I'm afraid of. Will I be okay or not?" Huda – elderly

Based upon the aforementioned depiction of death, remembering death and thus being aware of the fact that life is merely a test and temporary is expressed by half of our participants as a strong motivator to act righteously and take ethical responsibility. A few participants explain that they prepare themselves daily for the afterlife as death can strike at any time (e.g. uttering Islamic creed before sleep, visiting graves, reciting *sūrat al-kahf* on Friday). Some experts argue that second generation Muslims have a stronger awareness of death due to a higher knowledge of Islam, resulting in less fear, compared with first generation Muslims, with whom this awareness only emerges with old age. This difference between middle-aged and elderly participants could, however, not directly be observed in our study.

> "You don't know when death will come. Death comes without an appointment. You should always be prepared by performing your prayers, by being good with people. You should always live as if it's your last day." Naziha – elderly

> "The second generation is better prepared than the first generation Muslims. The younger generation is wiser and is concerned with death every day. Young Muslims think continually about death." Khawla – Muslim corpse washer

Interestingly, one third of our participants views death as a liberation and coming into peace. In this respect, they refer to the thorns of this worldly life ('*adhāb al-dunyāʾ*) and life's trials (e.g. illness, injustice, wars), of which they will be freed when safe with God. This notion of liberation is expressed mainly by participants who experience a difficult life (e.g. bad marriage, solitude, poor health).

> "For me, death is in fact an end to this world, this horrible, unfair world. Going to a world without lies, a real and sincere world. This is not a sincere world. So that's why I say 'I'd rather die today than tomorrow'." Lamya – middle-aged

> "I think death is peace (*rāḥa*). With death a person comes to rest with God. Done with the worldly tortures (*'adhāb al-dunyā'*). This world is all torture." Malika – elderly

Resurrection and Judgment

All participants firmly emphasize that only God, the creator of heaven and earth, has the knowledge of the afterlife. Noteworthy, again, is that many participants find it difficult to formulate elaborate views on the hereafter. However, this does not take away their unconditional belief in the existence of the hereafter. The majority of our participants upholds the traditional representation of the afterlife, whereas a minority believes that some eschatological narratives should not be interpreted literally.

> "The hereafter is not really clear for us. God knows best. We cannot know for one hundred percent. For example those seventy virgins, things like that are not true. I don't follow that.[…] You hear vague things, but for me only God knows best. " Lamya – middle-aged

> "Yeah, no one knows how the hereafter will be. But I ask God that our encounter with God will be good. No one knows where he/she will end." Malika – elderly

Again, the depiction of the afterlife consists of several stages/events. First, only a few participants mention that the beginning of the afterlife starts with the end of the world, preceded by several signs of the Hour (*ʿalāmāt al-sāʿa*) such as the wars between Muslims, the advent of the antichrist (*al-masīḥ al-dajjāl*) and of Gog and Magog (creatures who will bring destruction to earth). According to these participants, several signs are already present today.

> "The signs are here and there, but the major signs such as antichrist (*al-masīḥ al-dajjāl*), Gog and Magog and those things are yet to come." Narima – middle-aged

> "But if you look now, the signs of the Hour *(ʿalāmāt al-sāʿa*) are there, with all those wars, Muslims fighting against Muslims.[…] There's no shame anymore. Children who abandon their parents. There's a lot of unrest." Zoulikha – elderly

Second, the majority of our participants believes that the afterlife begins with the Day of Resurrection (*yawm al-qiyāma*). Several participants are of the opinion that human beings will be gathered naked and will only be concerned about themselves because of their fear for the upcoming judgment.

> "They say that your body will return on Judgment Day.[…] We will be naked, but we won't look at each other. We'll be more focused on our deeds, on what follows." Lamya – middle-aged

> "It's going to be difficult on Judgment Day. Everyone will say 'me, me, me'. In that moment everyone will be only thinking about themselves. In that moment your children and property won't matter, only your deeds (*'al-ʿamal'*)." Haddad – elderly

Third, nearly all participants mention the most central event in the afterlife, namely the judgment by God (*al-ḥisāb*). This is also referred to by many participants as *al-ḥisāb w-l-ʿiqāb* ('the

judgment and the torture'). All participants fear the confrontation with the fruits of their doing. Nearly all participants share the explicit belief that each individual person will have to give account of all his/her actions. A few participants narrate that each person's book of deeds –written by angels– will be read and weighed on the scale (*mīzān*). Good marks (*ḥasanāt*) and bad marks (*sayyi'āt*) will be balanced, followed by God's judgment regarding the human being's final destiny. This is also confirmed by our experts.

> "I don't think anyone will go to paradise with certainty. Your book will be weighed and there will be said 'Come to the front and read your book.' So I think that you'll always be afraid because not only your good deeds will be read, but also your bad deeds. You sin throughout the day, so to speak, sometimes without realizing. On the other hand, you also save *ajar* (good marks) throughout the day. But what will outweigh?" Nihad – middle-aged

> "*Al-ḥisāb w-l-ʿiqāb* ('the judgment and the torture') will take place. God will interrogate us. God will judge our actions. You'll even be held accountable for something small you've done. Only God knows where we will end up. It all depends on our actions." Yamina – elderly

Although the day of judgment is seen as a terrifying scene, a few participants stress that God is righteous, but also strongly underline God's attributes as All-forgiving (*al-ghafūr*) and All-Merciful (*al-Raḥmān*). This is also confirmed by our experts.

> "Nobody is perfect, nobody. We are humans and God also knows that. God is All-forgiving. So if you ask God 'Forgive me', God will forgive you." Lamya – middle-aged

> "May God protect us from the Day of Resurrection. May God stand with us on the Great Day (*yawm al-ʿaẓ īm).* We ask God that we will belong to the people of paradise. God is All-forgiving." Huda – elderly

Paradise or Hell

After God's judgment nearly all participants are convinced that each person goes either to paradise (*al-janna*) or to hell (*al-jahannam/al-nār*). Though they all acknowledge that only God knows every person's destiny, different ideas exist on who will be the inhabitants of paradise. A minority of our participants mentions that those who have performed good deeds ('*amal al-ṣāliḥa*), worship God, belong to the community *(umma)* of prophet Muḥammad, those who died as a result of an illness (*shahīd*/martyr) and People of the Book (*aḥl al-kitāb*) will enter paradise. Interestingly, a few participants are of the opinion that eventually every Muslim will enter paradise (some believe immediately, some believe after expiation of sins in hell).

> "The people that God chooses will go to Paradise. I'm not going to say who or what, I'm not God. If we dare to say 'that one but not that one'.[…] Then we're being assistant of God. God chooses! Period![…] We shouldn't interfere in those discussions. We have God for that. He chooses, He decides, He determines." Halima – middle-aged

> "They say that Muslims will eventually go to heaven, but we first have to atone for our sins and then go to paradise. Those who've worked good (*ʿamal al-ṣāliḥa*) go straight to Paradise. But God is All-forgiving, so we will all suffer and then we'll be allowed to go to paradise." Rahima – elderly

The dominant depiction of paradise among our participants is that one will finally encounter God and the prophet Muḥammad (other prophets too), but also that they will be reunited with their loved ones. They believe that paradise is the promised eternal reward of ultimate bliss and a peaceful place where all wishes will be fulfilled and no sorrow or pain will befall them.

> "In that moment, I wish that I go to God, that I'll see something positive, that I'll see my father, my mother and all those who returned to Him. I hope that I'll see them all in paradise. That's how I think about it and also during my illness 'when I die, I will see him and him.'[…] Paradise is actually something fun and beautiful. God describes this also in the *Qur'ān*. We won't work, we'll all get beauty. We'll get everything we want." Kaltoum – middle-aged

> "If you've done well in this earthly world, you'll find peace. I hope I'll see God, the Exalted, in the hereafter. What do you wish for more than seeing God? What would you want more? You want to see God![…] We don't pray to enter paradise to be busy with other things. No, but to be with God." Alia – elderly

The majority of our participants believe that the destination of hell –where the devil sojourns– will be the result of performing bad deeds or sins (*sayyi'āt/dhunūb*), including blasphemy (*shirk*), disbelief (*kufr*) and sorcery (*siḥr*). Nearly all participants express their fear for the tormenting punishment in hellfire (*ʿiqāb*). As aforementioned, some believe that human beings will stay temporarily in Hell until their sins are expiated, whereas other believes that those who have commited great sins (such as blasphemy or disbelief) will be in Hell eternally. Again, however, they all mention that only God has this knowledge.

> "Only God has knowledge about who goes to hell or paradise. I can't judge, I'm not allowed to judge. God is Omniscient, but I know that people who really do bad things, gossip or destroy people with *siḥr* (sorcery) and stuff, they won't enter paradise. They'll go to the hellfire, not even their grave will accept them." Radia – middle-aged

> "I always heard that in Hell people will suffer severely. Severe punishment ('*al-'adhāb al-shadīd'*) awaits those who did not worship God, such as unbelievers and those who do bad things." Yamina – elderly

Although nearly all participants firmly underscore that only God has the knowledge of the unseen, we found exceptional perspectives among two middle-aged and one elderly participant. Their divergent position is marked by doubt. Indeed, they have reservations concerning certain traditional eschatological narratives, but at the same time they acknowledge that God has all knowledge. Ikram and Louiza, two middle-aged participants emphasize that God is Almighty and therefore capable of anything, but find the traditional idea of torture of the grave difficult. Ikram has her personal idea on the afterlife. She strongly sees God as all-Merciful rather than as Judge. Therefore, she doubts the existence or severeness of torture in both grave and hell. Additionally, Ikram mentions that she does not obey God's law to earn good deeds (in order) to enter paradise, but more importantly to receive God's love now. Nuria clearly does not believe in torture of the grave or in the classical representation of hell and paradise, but leaves it up to God. However, she does believe in a further existence in

another shape. One expert argues that the traditional view of afterlife diminishes among younger generations of Muslims, though we did not find other signs of this.

> "Yes, I believe that God is All-Merciful and only wants what's best for His people. I repeat, those frightening stories, I take everything with a grain of salt, in which extent it's all true. 'There's a resurrection, there's a moment in the grave where you'll be tormented.' I'm not going to say that I don't believe that, because I've already said I'm Muslim. But I'm not sure if they're a hundred percent sure that it exists.[…] I believe that when you die, that if you've done good, that you'll be in some sort of grace. You'll be sleeping and you'll feel good.[…] On the other hand I think that God is Almighty. He can do everything.[…] So I think it's beyond our imagination. It's like error, we cannot grasp it. My mother says 'it all exists, it exists!' She's so sure about that, when I'm not. It remains a mystery." Ikram – middle-aged

> "What will happen after death? Of course everyone thinks about paradise. There's hell and there's paradise. I've known this since I was little, but God knows best.[…] They say that there is punishment of the grave and punishment of hell and that all Muslims go to paradise. But I say that it isn't true. It's not true.[…] My idea about this is that when someone dies, he'll become a new person. Voila, for me there will be a change of appearance. God knows best. I don't know if there's a hell. No one has ever returned from the dead to know what will happen." Nuria – elderly

> "You see that the second generation and certainly the third generation find it difficult to imagine the afterlife. To be honest, there is a small form of doubt. Not that they don't believe that it exists, but it's difficult to grasp and the fact that the afterlife is eternal. You do see that the traditional view of afterlife is diminishing." Faysal – *ʾimām*/Islamic teacher

Discussion

The findings of our interviews with middle-aged and elderly Moroccan Muslim women are nearly identical to those of the interviews with our experts in the field. However, one difference was found. We noticed that a few experts made a distinction between middle-aged and elderly Moroccan Muslim women in the perception of death and the afterlife in terms of religious literacy. According to these experts, elderly Moroccan Muslim women's religious knowledge is limited and therefore they are often referred to as being ignorant. The experts attributed their limited knowledge of Islamic faith to their illiteracy. Middle-aged women, on the contrary, are assumed to have a higher knowledge of Islam due to their higher literacy. This distinction was, however, not confirmed in our study. On the contrary, we found striking similarities between middle-aged and elderly participants in their attitudes towards dying, death, and the afterlife. Both emphasized theological and eschatological perspectives and among both groups, to an equal degree, some participants elaborated more extensively on their views. The latter might be explained by a combination of independent factors such as the (extent of) access to Islamic knowledge and the personal confrontation with death. We observed that mainly elderly women who are socially engaged in following religious and Arabic courses in mosques provided more elaborate argumentations and justifications for their beliefs, while this was not the case with middle-aged women. We must be cautious, however, not to generalize.

Indeed, no differences were noted between our participants based on age or educational level. Nor did our study show that the second generation of Muslim women, who grew up in Western society and were educated in the West –as secularisation theories might suggest– had developed a different, more secularised understanding of the relationships between God and the world and God and life/death. We did indeed not find a more secularised approach of death and dying that could have been the result of a much deeper interaction with Belgian/Western culture and society. Among the second generation the theological and teleological frame of reference did not lose its meaning or its central importance at all. This lack of more western views might be explained by a strong influence of religious education (in mosques/of by parents) (cf. see work of Güngör, Bornstein & Phalet, 2012 on religious family socialization).

Our study showed indeed, on the contrary, that our participants' view on dying, death and the afterlife is and remains strongly influenced by their religious beliefs. A clear shared eschatological framework was found among both our elderly and middle-aged participants: the belief in death predestined and appointed by God; in death as a transition; in the intermediate phase (*barzakh*); in Judgment Day and in the final abodes. Yet for many these representations were rather vague. One elderly participant, Khadija, refused to deal with this topic due to her difficult process of her parents' and husband's loss.

The views of our participants can be divided in three groups. First, only a minority of participants elaborated extensively on the several stages after dying, representing mainly the classical eschatological narratives. Second, the majority of our participants firmly believes in an afterlife (e.g. life in the grave, resurrection, judgment), but were not able or willing to provide details and strongly stressed that this knowledge only belongs to God. Third, only three participants' attitudes were marked by doubts regarding the classical interpretation of death and the afterlife (especially torture in the grave). Though Ikram and Nuria had personal views on the hereafter (sleeping-mode; existence in another shape), at the same time they agreed with the others participants that only God knows (best). Noteworthy, all our participants shared the belief that everything that happens after life relates to and centres around the actions performed in the worldly life for they determine how one will be judged by God. The way a person dies (the death struggle one may experience), the life in the grave and the final destination are all reflecting one's actions in the earthly life. All the participants thus believe in the lasting effects of their actions and the continued existence of the soul. This strongly suggests that eschatological beliefs of Muslims have a great impact on their daily life and strongly determine their attitudes and actions e.g. regarding treatment decisions in advanced disease. In other words, a strong interplay can be found between religious/eschatological convictions and ethical attitudes and choices (Baeke et al., 2012a, 2012b; Van den Branden & Broeckaert, 2008).

Comparison with Normative (Sunnī) Islamic Literature

Both our findings and normative Islamic literature support the idea that life is framed within God's ownership: the human life and body are God's property: a human being holds only the stewardship of body and life, which are entrusted by God (*ʾamāna*). Therefore, death is considered as God taking back what belongs to Him (Al-Bar & Chamsi-Pasha, 2015; Al-Shahri, 2016; Atighetchi, 2007; Brockopp, 2004; Rispler-Chaim, 1993; Sachedina, 2009). As creator, God is also the determiner of a person's life span (*ajl*). No person can die except by God's leave and at an appointed time (Al-Shahri, 2016; Al-Shahri, Fadul, & Elsayem, 2007; Ebrahim, 2001; Sachedina, 2009).

Both our findings and normative Islamic literature support the idea that the death is viewed as the only certitude and predictable element in human life, since every soul shall taste death (Al-Shahri et al., 2007; Sheikh & Gatrad, 2008). According to Sheikh and Gatrad (2008), the *Qur'ān* sees life as a part of a cycle: birth, death, resurrection and life after death. According to Brockopp (2004) and Van den Branden and Broeckaert (2010), similar to our findings, a strong teleological understanding of death exists in Islam: death is merely seen as a transitory element in the larger eschatological scheme. Of central importance is what the soul is awaiting in the hereafter (resurrection, judgment, paradise/hell). Thus life gains its meaning from this resurrection and judgment. In keeping with our findings, Rassool (2000) and Al-Shahri (2016) explain that in Islam illness and death are part of life and God's test, for only life after death renders human life bearable and meaningful and explains the mystery of human existence. The purpose of life is understood, as it is by our participants, as worshipping God and performing good acts (*ʿamal al-ṣāliḥa*), in preparation for the hereafter (Al-Bar & Chamsi-Pasha, 2015; Al-Shahri, 2016; Brockopp, 2004; Hedayat, 2006; Kramer, 1988; Sachedina, 2005, 2009; Sarhill, LeGrand, Islambouli, Davis, & Walsh, 2001).

In line with our findings, normative Islamic literature defines the moment of death as the separation of the soul from the physical body by God (Atighetchi, 2007; Brockopp, 2004; Hedayat, 2006; Miller, 2015; Sarhill et al., 2001). Bowker (1991) and Smith and Haddad (2002) state that in Islam the occurrence of death, which is considered to take place on God's order, is marked by the appearance of the angel of death (*malak al-mawt).* Although Islamic eschatological manuals also report the appearance of four angels taking away the soul, this was not mentioned by our participants. Similarly, several scholars (Al-Shahri et al., 2007; Chittick, 2008; Smith & Haddad, 2002) confirm our participants' line of thought that death, as transitory action, imposes moral and physical suffering (*sakarat al-mawt*) on the dying person. Depending on the person's deeds, the soul will be either extracted with gentleness or in a harsh way. The idea of the soul leaving the body through the nose or mouth is also confirmed by Chittick (1992) and Smith and Haddad (2002). Additionally, like our findings, Smith and Haddad (2002) state that classical and contemporary eschatological manuals

discuss the facial expression of a dying person in some detail. The observation of the dying person speaking about or seeing the dead and smiling is explained as an expression of the separation of body and soul. As in our results, eschatological manuals also narrate that during the dying process the person suffers from an unquenchable thirst, with the devil at the foot of the bed seeking to bring the dying to disbelief in exchange for water (Kramer, 1988; Smith & Haddad, 2002).

In keeping with our findings, Islamic (classical) eschatological manuals state that once a person dies, the soul ascends through seven heavens with the purpose of encountering God, before taking up residence in the grave (Jarrar, 2002; Kramer, 1988; Smith & Haddad, 2002; Van den Branden, 2006). According to Kramer (1988) and Smith and Haddad (2002), this view seems to be based upon the narrative on prophet Muḥammad's night-journey (*miʿrāj*). Chittick (1987) and Smith and Haddad (2002) support our finding that after death, the soul is still conscious of the body and sees how the dead body is treated.

Both normative Islamic literature and our interview responses support the idea of an interval, entitled *barzakh*, between death and resurrection at the end of times (Al-Shahri, 2016; Al-Shahri et al., 2007; Kramer, 1988; Smith & Haddad, 2002; Tesei, 2015; Van den Branden, 2006). This period between death (or burial) and resurrection, often portrayed as an abode for the living dead, is one of the most hotly debated subjects in eschatological narratives. The *Qur'ān* seems to mention little about this phase, while the *ḥadīth* and exegetes narrate extensively about it (Aggoun, 2006; Bowker, 1991; Lange, 2016; O'Shaughnessy, 1969; Smith & Haddad, 2002; Tesei, 2015). In keeping with our findings, divergent ideas exist on whether this condition can be interpreted as a sleeping condition or as a physical living world. Many reject the idea of the soul remaining in one place and being capable of experiencing any kind of pleasure or pain. Rather, they state that the deceased is in an unconscious state until Judgment Day. It is in this respect that the analogical comparison of sleep with death is often made. According to several scholars (Aggoun, 2006; Atighetchi, 2007; Chittick, 1987; Tesei, 2015), the *Qur'ān* explains sleep as a short death where the soul departs temporarily. Hence, this condition is also portrayed for the period between death and resurrection. These different lines of thought were also found among our participants.

In line with our findings, mainly *ḥadīth* literature reports that in the grave the deceased is interrogated by two angels, Munkar and Nakīr, on matters of faith, after which he/she will experience the grave as either a paradisiacal garden or a hell pit referred to as *ʿadhāb al-qabr* (Smith & Haddad, 2002; Van den Branden, 2006). With regard to the concept of torture in the grave (*ʿadhāb al-qabr*) and the 'little interrogation' dissident views exist as well. According to Aggoun (2006) and De Lange (2015) the period between death and the afterlife has become common knowledge mainly through popular imagery.

Our participants' views on the afterlife strongly resonate with the Islamic (classic) eschatological narratives (Chittick, 1992; Kadrouch-Outmany, 2014; Smith & Haddad, 2002). God's cosmic undoing of the world, the Day of Resurrection, followed by the last judgment and the final abodes are extensively dealt with in the *Qur'ān*, although no chronological representation of the events is presented (Chittick, 1987; Stowasser, 2004). Scholars state that the *ḥadīth* literature furnishes a vast variety of details on the portraits of the hour (*ʿashrāt al-sāʿa*), more specifically on the minor signs (appearance of the antichrist dajjāl, Gog and Magog, Mahdī/Jesus) and major signs (sun rising in the West, cosmological disasters,...) (Chittick, 1987; Lapidus, 1996; Smith & Haddad, 2002; Stowasser, 2004). Life in the grave comes to an end with the complete destruction of the earth. Eschatological manuals narrate that the angel ʿIsrafīl will blow the trumpet, two or three times, marking the start of the Day of Resurrection in which all souls will be resurrected from their grave and gathered (*al-Ḥashr*) for an unknown period (Chittick, 1992; Smith & Haddad, 2002). The advent of Jesus or Mahdī nor the trumpet was, however, mentioned by our participants.

Like our findings, the eschatological narrative of the Day of Judgment is centred on the book of deeds, the scales and the bridge, although the latter is not mentioned in the *Qur'ān*. Both our findings and normative Islamic literature stress the belief that on this day God will judge each person individually according to a person's intention (Al-Bar & Chamsi-Pasha, 2015; Atighetchi, 2007; Bowker, 1991; Chittick, 1987; Smith & Haddad, 2002). In Islam each person has a free will to choose between good and evil and is thus responsible for his/her own actions (Al-Bar & Chamsi-Pasha, 2015; Atighetchi, 2007; Chittick, 1987; Rispler-Chaim, 1993; Sachedina, 2005; Watt, 1979). Literature supports our findings that the book of deeds will be read and balanced by the angel Mikhā'īl. The book will be handed over to every individual either on the right-hand (paradise) or left-hand (hell) of a person, depending on the deeds performed in the worldly life (Al-Shahri et al., 2007; Chittick, 1992; Kramer, 1988; Smith & Haddad, 2002). Afterwards every person will walk across a bridge, as sharp as a sword and as fine as a hair, over the fires of Hell to reach one's final abode. The believers will be able to cross it easily, while unbelievers will fall into the depths of hell (Chittick, 2008; Smith & Haddad, 2002). These images, however, were not present among our participants. According to Bowker (1991) and Smith and Haddad (2002) several traditions hold the idea that the prophet Muḥammad will intercede (*shafāʿa*) for his community with God. However, no consensus exists here, nor was this mentioned by our participants. According to Baddarni (2010), the *Qur'ān* affirms the unlimited mercy, compassion and forgiveness of God. These ideas were also observed among our participants.

The judgment is followed by immortal life in the everlasting abode in hell or paradise, although the eternity of Hell is still a much debated topic among religious scholars (Khalil, 2015; Smith & Haddad, 2002). Similar to our findings, some scholars argue that every Muslim would only

stay temporarily in hell: every sin will be forgiven except for disbelief (*kufr*). However, different positions exist in Islam on the eternal stay in Hell by both Muslims and non-believers (Khalil, 2015; Smith & Haddad, 2002). Chittick (1987) and Lange (2016) argue that the *Qur'ānic* depiction of heaven and hell is rather physical (with the physicality and corporeality of human resurrection, of both heavenly delights and hellish torments).

In keeping with our findings, several scholars (Atighetchi, 2007; Kramer, 1988; Sarhill et al., 2001; Van den Branden, 2006) argue that death is a stimulus to be aware of the fact that one's actions in this world have a direct effect on the hereafter (judgment). This clearly indicates the continuing importance of one's actions and implies a sense of human responsibility and accountability. This belief is articulated by Smith and Haddad (2002) as eschatological immediacy: the important impact of eschatological beliefs on human conduct here and now. In other words, by focusing on human mortality and events and repercussions in the afterlife (e.g. torture in the grave and the judgment), a person's morality is enhanced.

We can conclude that our participants' line of reasoning on dying, death and the afterlife strongly resonates with the line of thought found in normative Islamic literature. Though some details were missing in the rather general and vague stories our participants told us, the key characteristics were clearly present: the belief in an afterlife, death as transition from one state of existence to the next, eschatological implications of one's actions (Judgment Day).

Comparison with the Empirical Literature

The findings of our study are consistent with the results of the limited number of existing empirical studies on the beliefs and attitudes of Muslims regarding dying, death and the afterlife (Assous, 2013; Baeke, 2012; Kadrouch-Outmany, 2014; Van den Branden, 2006). Most studies found on this object are mainly anthropological, psychoanalytical or ritual studies that elicit the attitudes of Muslims regarding dying, death and the afterlife only in a fragmented way (Baeke, 2012; Baeke et al., 2012a, 2012b; Dessing, 2001; Kristiansen et al., 2016; Renaerts, 1986; Suhail, Jamil, Oyebode, & Ajmal, 2011; Van den Branden, 2006; Van den Branden & Broeckaert, 2008; Venhorst, 2013). In this respect, our study offers a more detailed and comprehensive perspective of how both middle-aged and elderly Moroccan Muslim women, living in a European society, view dying, death and the afterlife. Our findings correspond with the (limited) views found in these studies. Similar theological and more specifically eschatological/teleological notions came forward including the centrality of God's omniscience and omnipotence, God's control over life and death, continuing existence of the soul, death as intermediate phase (*barzakh*), resurrection, judgment and the final abodes.

Kadrouch-Outmany (2014) observed that the views and ideas of her Dutch Muslim participants on death and the afterlife were less concerned with (details of) classic eschatological

narratives, but more with the lasting effects of one's actions in the afterlife and judgment day. This was also observed among our participants. The majority of our participants emphasized the centrality of one's actions and expressed their belief in an afterlife (cf. resurrection, judgment), but at the same time strongly stressed that only God has all knowledge about the afterlife. In the same way, Venhorst (2013) and Kadrouch-Outmany (2014) confirm that the ideas on life after death –how this will occur and in what form- among Muslims elicit a variety of ideas and opinions, sometimes resulting in a personal view. The latter was indeed the case for Nuria and Ikram. Venhorst (2013) and Kadrouch-Outmany (2014) support our finding that although participants strongly believe in life after death, many had difficulties in describing and even depicting them in detail. These scholars argue that although the events at the end of time and the fountains of paradise and the fire are often vividly depicted in eschatological manuals, for Muslims this phase remains the great unknown.

Several studies (Baeke, 2012; Kadrouch-Outmany, 2014; Renaerts, 1986; Van den Branden, 2006; Venhorst, 2013) corroborate our finding that the eschatological perspective plays a central role in the ethical mindset of Muslims. They confirm that it is exactly the perspective on the divine judgment that constitutes the most important imperative and stimulus for the ethical responsibility of a Muslim during his/her life, given that everything he/she does in this world will have a direct effect in the hereafter, indicating the lasting effect of one's actions. It is exactly this teleological perspective (the future judgment) that strongly influences and even determines the attitudes and choices of Muslims, for example regarding treatment decisions in advanced disease (e.g. the vehement denouncement of euthanasia and (assisted) suicide (Baeke et al., 2012b; Van den Branden & Broeckaert, 2008; Ahaddour, Broeckaert, Van den Branden, 2017b).

Given the nature of our data (specific groups; small sample sizes), we are of course prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. For instance, it would still be interesting to do an in-depth investigation of Muslim patients who are personally confronted with terminal illness on their beliefs and attitudes toward dying, death and the afterlife. Further studies could explore whether the impact of religion on the beliefs and attitudes regarding dying, death and the afterlife differs among younger generations of (Moroccan) Muslims who have been brought up in a Western environment, are much more diverse (both socio-economically and religiously) and have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

Conclusion

This study shows that Muslims shape their narrative of dying, death and the afterlife according to the outline of a religious framework. We have observed that when dealing with dying, death and the

afterlife, both first and second generation Muslims in Belgium adopt a theological line of reasoning very similar to the one that can be found in normative Islamic literature. Our participants strongly believe in an omnipotent and omniscient God, who is the creator of life and death as well as heaven and earth. They all strongly embrace the belief in predestination and the afterlife. Death is not viewed as an end, but as a transition from one state of existence to the next. Our participants see their daily life and actions within a teleological framework: deeds performed in the earthly world will determine the experience of death itself, the life in the grave and the final destination (heaven or hell). The eschatological implications of one's actions and the continued existence of the soul are thus strongly emphasized. The judgment –every Muslim knows he/she is going to be subjected to at the end– determines to a large degree what kind of behaviour during life is accepted or rejected, especially when confronted with old age and/or a life-threatening illness.

Given the fact that contemporary Western societies are becoming increasingly multicultural and multi-religious, eliciting the attitudes and beliefs of Muslims is of great importance. In order to be able to provide respectful, cultural-sensitive end-of-life care considerable attention should be given to the patients' religious and cultural background.

References

Abdel-Khalek, A. M. (2004). The Arabic Scale of Death Anxiety (ASDA): Its development, validation, and results in three Arab countries. *Death Studies, 28*(5), 435-457.

Aggoun, A. (2006). *Les Musulmans face à la mort en France* (Espace Ethique ed.): Vuibert.

Ahaddour, C., & Broeckaert, B. (2016). Muslim Burial Practices and Belgian Legislation and Regulations: a Comparative Literature Review. *Mortality, 22* (4), 356-373.

Ahaddour C., & Broeckaert B. (2017). "For Every Illness There Is A Cure". Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine. *Journal of Religion and Health.* https://doi.org/10.1007/s10943-017-0466-1

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (2015). Institutional Elderly Care Services and Moroccan and Turkish Migrants in Belgium: A Literature Review. *Journal of Immigrant and Minority Health, 18*(5), 1216-1227.

Ahaddour C., Van den Branden S., & Broeckaert B. (2017a). Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women. *Omega: Journal of Death and Dying.* https://doi.org/10.1177/0030222817729617

Ahaddour C., Van den Branden S., & Broeckaert B. (2017b). Between Quality of Life and Hope. Attitudes and Beliefs of Muslim Women toward Withholding and Withdrawing Life-Sustaining Treatments. *Medicine, Health Care and Philosophy*, https://doi.org/10.1007/s11019-017-9808-8.

Al-Bar, M., & Chamsi-Pasha, H. (2015). *Contemporary Bioethics*. In *Islamic Perspective*. Retrieved from https://link.springer.com/book/10.1007%2F978-3-319-18428-9 (Accessed 20th December 2016).

Al-Jeilani, M. (1987). Pain: Points of View of Islamic Theology *Acta Neurochirurgica Supplementum, 38*, 132-135.

Al-Shahri, M. (2016). Islamic theology and the principles of palliative care. *Palliat Support Care, 14*(6), 635-640.

Al-Shahri, M., Fadul, N., & Elsayem, A. (2007). Death, dying and burial rites in Islam. *European Journal of Palliative Care, 13*(4), 164-167.

Assous, A. B. (2013). Cultural and Islamic Values in Relation with Death. *European Scientific Journal, 9*(5), 1857-1881.

Atighetchi, D. (2007). *Islamic Bioethics: Problems and Perspectives* (Vol. 31). New York: Springer.

Baddarni, K. (2010). Ethical dilemmas and the dying Muslim patient. *Asian Pacific journal of cancer prevention, 11*(1), 107.

Baeke, G. (2012). *Religion and ethics at the end of life. A qualitative empirical study among elderly Jewish and Muslim women in Antwerp (Belgium).* (Unpublished doctoral dissertation) Katholieke Universiteit Leuven, Leuven.

Baeke, G., Wils, J. P., & Broeckaert, B. (2012a). Be patient and grateful: elderly muslim women's responses to illness and suffering. *The Journal of Pastoral Care & Counseling, 66*(3-4), 5.

Baeke, G., Wils, J. P., & Broeckaert, B. (2012b). It's in God's hands: The Attitudes of Elderly Muslim Women in Antwerp (Belgium) toward Active Termination of Life. *AJOB Primary Research, 3*(2), 36-47.

Baider, L. (2012). Cultural diversity: family path through terminal illness. *Annals of Oncology, 23*(3), 62-65.

Bowker, J. (1991). *The Meanings of Death.* Cambridge: Cambridge University Press.

Brockopp, J. E. (2004). *Islamic Ethics of Life. Abortion, War and Euthanasia*. Columbia: University of South Carolina Press.

Chittick, W. C. (1987). Eschatology. In S. H. Nasr (Ed.), *Islamic Spirituality* (Vol. 19, pp. 378-406). London: Routledge and Kegan Paul.

Chittick, W. C. (1992). "Your Sight Today is Piercing": The Muslim Understanding of Death and Afterlife In H. Obayashi (Ed.), *Death and Afterlife. Perspectives of World Religions* (pp. 125-139). Westport: Greenwood Press.

Chittick, W. C. (2008). Muslim eschatology. In J. L. Walls (Ed.), *Oxford handbook of eschatology*. New York: Oxford University Press.

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory* (Fourth Edition ed.). California: SAGE Publications.

Dessing, N. M. (2001). *Rituals of birth, circumcision, marriage, and death among Muslims in the Netherlands*. Leuven: Peeters.

Ebrahim, A. F. M. (2001). *Organ Transplantation, Euthanasia, Cloning and Animal Experimentation. An Islamic View*. Leicester: The Islamic Foundation.

Gatrad, A. R., & Sheikh, A. (2002). Palliative Care for Muslims and Issues After Death. *International Journal of Palliative Nursing, 8*(12), 594-597.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research* New York: Aldine Publishing Company.

Güngör, D., Bornstein, M. H., & Phalet, K. (2012).Religiosity, Values, and Acculturation: A Study of Turkish, Turkish-Belgian, and Belgian Adolescents. *International Journal of Behavioral Development, 36*(5), 367-373.

Hedayat, K. M. (2006). When the spirit leaves: Childhood death, grieving, and bereavement in Islam. *Journal of Palliative Medicine, 9*(6), 1282-1291.

Hertogen, J. (2015). Moslims in België per gewest, provincie en gemeente: Evolutie 2011, 2013 en 2015. Retrieved from http://www.npdata.be/

Jarrar, M. (2002). Heaven and Sky. In *Encyclopaedia of the Qur'an,* 410-412. http://dx.doi.org/10.1163/1875-3922_q3_EQCOM_00082

Kadrouch-Outmany, K. (2014). *Islamic burials in the Netherlands and Belgium. Legal, religious and social aspects.* (Unpublished doctoral dissertation), Leiden University, Leiden.

Khalil, M. H. (2015). Is Hell Truly Everlasting? An Introduction to Medieval Islamic Universalism. In C. Lange (Ed.), *Hell in Islamic Traditions* (pp. 166-174). New York: Cambridge University Press.

Kramer, K. P. (1988). *The Sacred Art of Dying. How World Religions Understand Death.* New YorkPaulist Press.

Kristiansen, M., Younis, T., Hassani, A., & Sheikh, A. (2016). Experiencing Loss: A Muslim Widow's Bereavement Narrative. *Journal of Religion and Health, 55*(1), 226-240.

Lange, C. (2016). *Paradise and Hell in Islamic Traditions*. New York: Cambridge University Press.

Lapidus, I. M. (1996). The Meaning of Death in Islam. In H. M. Spiro, M. G. McCrea, & L. Palmer-Wandel (Eds.), *Facing Death. When Culture, Religion and Medicine Meet* (pp. 148-159). New Haven-London: Yale University Press.

Miller, A. (2015). Opinions on the legitimacy of brain death among Sunni and Shi'a scholars. *Journal of Religion and Health* 55 (2), 394-402

O'Shaughnessy, T. S. J. (1969). *Muhammad's thoughts on death: a thematic study of the qur'anic data*. Leiden: Leiden : Brill, 1969.

Rassool, G. H. (2000). The Crescent and Islam: Healing, Nursing and the Spiritual dimension. Some Considerations Towards An Understanding of the Islamic Perspectives On Caring. *Journal of Advanced Nursing, 32*(6), 1476-1484.

Renaerts, M. (1986). *La mort, rites et valeurs dans l'Islam Maghrebin* Brussel: ULB. Institut de Sociologie.

Rispler-Chaim, V. (1993). *Islamic Medical Ethics in the Twentieth Century* (Vol. 46). Leiden: Brill.

Sachedina, A. (2005). End-of-Life: the Islamic View. *Lancet, 366*, 774-779.

Sachedina, A. (2009). *Islamic biomedical ethics: principles and application*. Oxford: Oxford University Press.

Sachedina, A. (2012). Islam. In Cobb M., P. C. M., & R. B. (Eds.), *Oxford Textbook of Spirituality in Healthcare* (pp. 55-62). Oxford: Oxford University Press.

Sarhill, N., LeGrand, S., Islambouli, R., Davis, M. P., & Walsh, D. (2001). The terminally ill Muslim: death and dying from the Muslim perspective. *The American Journal of Hospice & Palliative Care, 18*(4), 251-255.

Sheikh, A., & Gatrad, A. R. (2008). Death and Bereavement. An exploration and meditation. In A. G. Sheikh, A. R. (Ed.), *Caring for Muslim Patients* (2nd ed., pp. 103-113). Oxford: Radcliffe Publishing.

Smith, J. I., & Haddad, Y. Y. (2002). *The Islamic Understanding of Death and Resurrection*. Oxford: Oxford University Press.

Stowasser, B. F. (2004). The End is Near: minor and major signs of the hour in Islamic Texts and Contexts. In J. J. Collins & A. Amanat (Eds.), *Apocalypse and Violence* (pp. 49-52). New Haven: The Yale Center for International and Area Studies.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research : techniques and procedures for developing grounded theory*. Thousand Oaks (Calif.): Sage.

Suhail, K., Jamil, N., Oyebode, J., & Ajmal, M. A. (2011). Continuing bonds in bereaved Pakistani Muslims: effects of culture and religion. *Death Studies, 35*(1), 22-41.

Tesei, T. (2015). The barzakh and the Intermediate State of the Dead in the Quran. In C. Lange (Ed.), *Hell in Islamic Traditions* (pp. 31-55). New York: Cambridge University Press.

Van den Branden, S. (2006). *Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen.* (Unpublished doctoral dissertation), Katholieke Universiteit Leuven, Leuven.

Van den Branden, S., & Broeckaert, B. (2008). Medication and God at Interplay: End of Life Decision Making in Male Moroccan Migrants Living in Antwerp, Flanders, Belgium. In J. Brockopp & T. Eich (Eds.), *Muslim Medical Ethics: from Theory to Practice* (pp. 194-208). Columbia: University of South Carolina Press.

Van den Branden, S., & Broeckaert, B. (2010). Living in the Hands of God. English Sunni E-Fatwas on (non-)Voluntary Euthanasia and Assisted Suicide. *Med Health Care Philos, 14*(1), 29-41.

Venhorst, C. (2013). *Muslims Ritualising Death in the Netherlands. Death rites in a small town context*. Zurich: Litt.

Watt, W. M. (1979). Suffering in sunnite Islam. *Studia Islamica, 50*, 5-19.

"He has succeeded who purifies himself, remembers the name of His Lord, and prays."

— Q87:14

6. Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women

Introduction

Every religion and culture has its own understanding of and own rituals surrounding death and dying. In Islam, taking care of the dying and the dead is considered an important responsibility of the Muslim community (*farḍ kifāya*). Several studies argue that attitudes and practices related to dying, death and bereavement might be coloured and shaped by religious and cultural beliefs (Dessing, 2001; Kadrouch-Outmany, 2014; Renaerts, 1986; Van den Branden, 2006; Venhorst, 2013). Islamic rituals near and after death have been thoroughly described in large corpora of *ḥadīth* and *fiqh* (cf. *kitāb al-janā'iz* or *bāb al-janā'iz*) (al-Jazīrīʾ, 2009; Bakhtiar, 1996; Halevi, 2007; Renaerts, 1986). But how do contemporary Muslims express and ritualize their eschatological views in a context of migration? Several studies (Dessing, 2001; Kadrouch-Outmany, 2014; Venhorst, 2013) state that death rituals performed in a migrant context might be subject to change due to the social context. Although ritual prescriptions are uniform, the practice might be dynamic and subject to subtle changes. According to Sarhill, LeGrand, Islambouli, Davis, and Walsh (2001), migrants in a new society with a dominant non-Islamic religion and culture may adopt certain elements of this new culture, but at the time of death the original religion and the cultural customs will be practiced.

Till this day, however, scarce empirical studies exist on practices and rituals of Muslims near death and dying (Assous, 2013; Dessing, 2001; Jonker, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986; Venhorst, 2013). Most of these studies have been addressed from a (socio/cultural) anthropological perspective and focus on *rites de passage* theories and theories on identity and belonging. Nevertheless, a descriptive and comprehensive account of Muslim practices surrounding death and dying in a European setting, and more specifically in the Belgian context, is lacking to a great extent. In this respect, we seek to identify how practices regarding death and dying among Moroccan Muslims take shape in the particular context of migration and more specifically whether rituals survived or have been adapted in the European and Belgian setting. In this article, we will focus on practices performed before burial. Burial practices as well as mourning and remembrance practices will be both elaborated in detail in a separate article.

The aim of this article is twofold. First, we seek to clarify how the normative Islamic practices toward death and dying relate to the actual practices of Moroccan Muslim women. Second, we seek to compare middle-aged and elderly women's (views on) practices. In contrast to the first generation elderly Moroccan Muslim women, who are mainly uneducated and illiterate, the group of middle-aged women shows much more socio-economic diversity. Moreover, they have not been

raised in a homogenous, rural, traditional Islamic environment and live less isolated from the broader Belgian society than the previous generation. Our main point of focus is whether a shift towards a more secular approach may be observed in their views and practices when compared to those of the first generation elderly Moroccan Muslim women.

Normative Islamic literature: Islamic Prescriptions in Relation to Death and Dying

At the end of life

Pre- and postmortem rituals are mainly based upon *ḥadīth* literature and have been extensively dealt with by Muslim jurists, since the *Qur'ān* does not mention explicit rulings at the moment of dying or after death (Aggoun, 2006; Bakhtiar, 1996; Halevi, 2007; Kadrouch-Outmany, 2014; Renaerts, 1986). In this article, we focus only on *Sunnī*-perspectives on death and dying.

In Islam, someone who is in the state of dying is often called *mutadha* (Brockopp, 2004; Kramer, 1988; Sachedina, 2009). In this state, some acts become obligated and recommended. Normative Islamic literature sums up several rites or requirements at the end of life. In Islam, the importance of pronouncing the *shahāda* (Islamic creed) when death is imminent is strongly emphasized (al-Jazīrīʾ, 2009; Al-Shahri, 2016; Dessing, 2001; Harford & Aljawi, 2013; Sarhill et al., 2001; Tayeb, Al-Zamel, Fareed, & Abouellail, 2010; Van den Branden, 2006). Chittick (1992) and Bianquis (2012) explain that the dying person pronounces the *shahāda* whilst raising one finger of the right hand to re-affirm his belief in the unity of God (*tawḥīd*) for the last time. Smith and Haddad (2002) argue that it is believed that by uttering the *shahāda* the prophet Muḥammad will intercede on Judgment Day. According to Aggoun (2006), the Islamic creed is pronounced in order to be able to answer during the interrogation in the grave.

Normative Islamic literature also upholds the idea of mutually seeking forgiveness and reconciliation near the end of life, in order to go to God in a purified way (Bloomer & Al-Mutair, 2013; Gatrad & Sheikh, 2002a; Rassool, 2000; Renaerts, 1986; Schultz, Baddarni, & Bar-Sela, 2012; Sheikh, 1998; Sheikh & Gatrad, 2008; Van den Branden, 2006). Van den Branden (2006) also mentions the importance in Islam of the dying person dividing and distributing wealth (inheritance) as well as giving one third to charity *(ṣadaqa*). The idea of charitable giving is connected in the *Qurʾān* with self-purification (Lowry, 2017). According to several scholars (Al-Shahri, Fadul, & Elsayem, 2007; Schacht, 2012) writing a final will and testament is a religious obligation for all Muslims before death. Testaments can only be used for the transfer of property by way of bequest or legacy. The dying person should be mentally competent and witnessed by two mentally competent adults. There are no formal requirements for making a bequest: it may be done in writing, orally or even through intelligible signs (Schacht, 2012). In addition, normative Islamic literature urges the dying person to settle financial, material and spiritual debts (e.g. pilgrimage and alms-giving)

(Dessing, 2001; Harford & Aljawi, 2013; Van den Branden, 2006). If the deceased was not able to pay his or her debts, this becomes a duty of the family and has to be taken care of as soon as possible, as in the meantime the deceased remains burdened with it (Bot, 1998).

Visiting the sick and dying (*silāt al-raḥīm*) is seen as a *farḍ kifāya,* a collective duty, and a meritious practice in Islam by which the Muslim community offers support in various ways wherever possible (psychological, physical, financial, material) (Bot, 1998; Gatrad & Sheikh, 2002b; Harford & Aljawi, 2013; Rassool, 2000; Van den Branden, 2006). Rahman (1998) points out that the *ḥadīth* literature mentions a twofold beneficence of visiting the sick: on the one hand, it increases the mental condition of the ill/dying person and on the other hand, the visitor earns *ḥasanāt* (eschatological good marks). Several scholars also mention the pious act of supplications by both the dying person and those surrounding him or her. Praying for the dying's welfare and life to come would benefit the soul (Al-Shahri, 2016; Gatrad & Sheikh, 2002b; Hedayat, 2006). According to Al-Shahri et al. (2007) visitors are prompted to remind the dying person to pronounce *shahāda* or whisper it in his or her ear to make sure these are the last words he/she hears on earth. In this respect, Aggoun (2006) refers to the Islamic tradition of giving water to the dying person as it is believed that he/she experiences an extreme thirst, with the devil trying to bring the dying person in disbelief in return for water. Some replace regular water for *zamzam* water based on the belief that this purifies a person's sins.

Normative Islamic literature also articulates the importance of reciting the *Qur'ān,* more particularly *sūrat yāsīn* (Q:36), both for the dying person and for the people surrounding him/her, as it is supposed to be comforting (Aggoun, 2006; Al-Shahri, 2016; Al-Shahri et al., 2007; Dessing, 2001; Gatrad & Sheikh, 2002b; Harford & Aljawi, 2013; Hedayat, 2006; Renaerts, 1986; Sarhill et al., 2001; Tayeb et al., 2010). Several scholars (Campo, 2006; Renaerts, 1986) argue that according to the Islamic tradition, *sūrat yāsīn* is a remembering of God's mercy and the Last Day and is considered to be the heart of the *Qur'ān*. Therefore reading this chapter is a reward for both the living and the dead. Reciting this chapter would ease the pain of dying and expiate the dying person's sins (Renaerts, 1986). There is, however, no consensus here. While various scholars recommend the reading of *sūrat yāsīn*, others dispute that there is no (religious) basis for this (al-Jazīrīʾ, 2009). At the moment of dying, several scholars state that the dying person should be faced towards Mecca (ʾ*iḥtidār*), so that he or she might take the last breath facing Mecca, which is considered *sunna* (a recommended act) (al-Jazīrīʾ, 2009; Al-Shahri, 2016; Gatrad & Sheikh, 2002b; Halevi, 2007; Hedayat, 2006; Renaerts, 1986; Sachedina, 2009; Sarhill et al., 2001).

After death

When a Muslim dies, several obligations have to be met by the Muslim community. In fact, Islam has retained some ancient practices such as the washing of the dead, the shroud and interment

(Abdesselem, 2012; Halevi, 2007). The ritual of washing the corpse (*ghusl al-mayyit*), shrouding the corpse (*takfīn al-mayyit*), the performance of the death prayer (*ṣalāt al-janāza*) and burial *(dafn al-mayyit)* are considered the deceased's rights or ways of honouring the deceased (*ʾikram al-mayyit*), which are a responsibility of the Muslim community (*farḍ kifāya)*(Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Shahri, 2016; Gatrad & Sheikh, 2002a; Harford & Aljawi, 2013; Hedayat, 2006; Renaerts, 1986; Sarhill et al., 2001; Schultz et al., 2012; Van den Branden, 2006). In Islam, these rituals are encouraged to take place as soon as possible in order to hasten the transition to the afterlife (Al-Shahri, 2016; Harford & Aljawi, 2013). In *fiqh* manuals, death rituals have been described in detail by Muslim jurists (e.g. al-Qurṭubī, al-Suyūtī). However, small variations can be found between Islamic denominations and legal schools (*madhāhib*)(al-Jazīrīʾ, 2009; Dessing, 2001).

From the moment a person dies, the eyes and mouth are to be closed and the arms and legs should be straightened with the toes tied together by a thread (Al-Shahri, 2016; Dessing, 2001; Gatrad & Sheikh, 2002a; Harford & Aljawi, 2013; Kramer, 1988; Sarhill et al., 2001; A. Sheikh & Gatrad, 2000). This is followed by the washing of the dead, the first duty of the Muslim community. Halevi (2007) states that, in Islam, the washing of the corpse is performed to clean and honour the body. Other scholars link this also to the idea of the vicegerency of the human being, i.e. the fact that life and body are given by God as a trust (*ʾamāna*). God is the owner of the body and therefore it has to be given back in a pure state (Dessing, 2001; Renaerts, 1986). *Fiqh* especially calls upon direct family members to perform the ritual as it is considered an act of pious devotion (Bot, 1998; Dessing, 2001). The rule is that a female deceased is washed by women and a male deceased by men (al-Jazīrīʾ, 2009; Halevi, 2007). For the *Mālikī* legal school, which is mainly followed by Moroccan Muslims, a deceased can also be washed by his or her spouse, while for the *Ḥanafī* school this is not always permissible, as the wife's death ends the marital bond and thus makes her a stranger to the widowed man. Conversely, when the husband dies, according to *Ḥanafī* school, his wife is allowed to wash him because she is still considered in *ʿidda* (the waiting period for a widow or divorced woman before she can remarry). For a child, it is permissible to be washed by an adult of the opposite gender (al-Jazīrīʾ, 2009; Bot, 1998; Van den Branden, 2006).

People washing the dead must be in a state of ablution and must have pronounced their intention (*niyya*) (Kadrouch-Outmany, 2014). The ritual of washing the deceased's body is, according to Islamic law, generally understood to proceed as follows: covering the body (*ʿawra*), removing impurities, gently pressuring the stomach to empty the intestines, washing the intimate parts (*al-istinjāʾ*), performing minor ablution (*wuḍūʾ*), followed by major ablution (*ghusl*) with lukewarm water (Aggoun, 2006; Dessing, 2001; Kadrouch-Outmany, 2014; Renaerts, 1986). The washing of the corpse is performed an odd number of times (three, five or seven) by using water, lotus plant and camphor, starting on the right side of the body from the front to the back and from head to toe, followed by the left side; subsequently the body is dried (Aggoun, 2006; Dessing, 2001;

Kadrouch-Outmany, 2014). The seven spots of prostration during prayer are also perfumed with camphor or musk (Bakhtiar, 1996; Dessing, 2001; Halevi, 2007; Kadrouch-Outmany, 2014). According to Yasien-Esmael and Rubin (2005) spraying a pleasing aroma on the deceased is performed because of the deceased's encounter with angels. The normative Islamic literature strongly emphasizes that the body must be handled with dignity and respect, as it is the general belief that the deceased is still able to feel, hear and see and that the sanctity of the dead person is considered the same as that of the living (Aggoun, 2006; Al-Shahri, 2016; Halevi, 2007; Kadrouch-Outmany, 2014; Renaerts, 1986; Smith & Haddad, 2002).

The washing of the dead is followed by the shrouding of the deceased (*takfīn al-mayyit*). According to *fiqh* manuals, the requested shroud consists of at least one cloth that covers the entire body. Depending on the legal school (*madhab),* different numbers of cloths and descriptions of the *kafan* (shrouds) are formulated, though the majority of schools accept three cloths for men and five for women (Aggoun, 2006; al-Jazīrīʾ, 2009; Renaerts, 1986). *Fiqh* literature prescribes that cloths for the deceased should be clean, plain white and unsewn, symbolising equity between all believers before God and non-distinction in death, but also simpleness (Aggoun, 2006; al-Jazīrīʾ, 2009; Bot, 1998; Dessing, 2001). In general, *fiqh* manuals agree that the shroud consists of three parts: a large piece of cloth covers the body from head to feet (*lifāfa*), a piece that covers the body from the shoulder to the upper leg (*qamīṣ*) and a loincloth covering the body from navel to the feet (ʾ*izār*). However, according to the *Ḥanbalī* and *Shāfiʿīʾ* legal school no *qamīṣ* or turban is used. For a female deceased, an extra *lifāfa* and a *khimār* (headscarf) are wrapped around from the right to the left (al-Jazīrīʾ, 2009). The Islamic *fiqh* prescribes that the *kafan* must be purchased by the deceased or his/her family or must have been worn previously during *ḥajj* (al-Jazīrīʾ, 2009; Gatrad & Sheikh, 2000; Renaerts, 1986).

After washing and shrouding the deceased, normative Islamic literature reports that the family can take leave of the deceased. According to Al-Shahri et al. (2007) the face of the deceased remains uncovered when it needs to be seen and kissed by relatives. It is recommended that the *Qurʾān* is recited and more specifically *sūrat al-fāṭiḥa* (Q:01), *sūrat yāsīn* (Q:36), *sūrat al-Ichlāṣ* (Q:114) and *sūrat al-mulk* (Q:67) and that supplications are performed, as these would lead to purification of the deceased's sins and will be rewarded with paradise (Aggoun, 2006; Campo, 2017; Renaerts, 1986).

After washing and shrouding the corpse, *fiqh* manuals prescribe that a death prayer must take place. This public ritual is performed in order to ask for forgiveness for the deceased person, for which the Muslim community earns *ḥasanāt* (good marks) (Venhorst, 2013; Yasien-Esmael & Rubin, 2005). Conditions are the same as for the obligatory daily prayers i.e. one should be in a state of ritual purity and stand facing towards Mecca (*qibla*) (al-Jazīrīʾ, 2009). The prayer can be

performed at any time, but it is recommended at the time of noon, afternoon or evening daily prayer. The body of the deceased should be present -ritually washed and shrouded- and laid in front of people who will perform the prayer (al-Jazīrīʾ, 2009). Differences exist between legal schools in performing a death prayer for a baby. According to *Mālikī* and *Shāfiʿīʾ* school, a death prayer should be performed over a foetus that has cried upon being born, while *Ḥanbalī* and *Ḥanafī* legal schools consider this prayer obligatory for every foetus that has completed its fourth month in the womb (al-Jazīrīʾ, 2009; Bakhtiar, 1996).

With regard to the performance of the death prayer, the legal schools have all formulated different interpretations. Nevertheless, the essential parts remain the same: the prayer starts with a declaration of intention (*niyya*) to engage in prayer, which is followed by four loud pronouncements of *takbīr* (uttering 'God is the Greatest')(al-Jazīrīʾ, 2009). During this prayer no bows, prostrations nor *ʾiqāma* are performed (Bakhtiar, 1996). The prayer is led by an *ʾimām* in front of the attendees, all facing the deceased. The majority of Muslim jurists agree that the *ʾimām* is positioned in front of the head of a male deceased and in front of the waist of a female deceased (al-Jazīrīʾ, 2009). Differences exist upon the number of *takbīr*. *Mālikī* and *Ḥanafī* legal schools start the first *takbīr* with *sūrat al-fāṭiḥa* followed by a second *takbīr,* performing prayer of *Ibraḥīm*. After the third *takbīr*, a supplication is made for the deceased (Aggoun, 2006; al-Jazīrīʾ, 2009). However, this can vary, as often a supplication is made for all deceased. Prayer ends with salutations (*taslīm*) to the right and left while standing (al-Jazīrīʾ, 2009; Bot, 1998). The further contents of the prayer varies from one law school to another.

According to Gatrad and Sheikh (2000) the funeral prayer is traditionally held in the cemetery (or local mosque). Divergent views exist among *Mālikī* and *Ḥanafī* legal schools with regard to prayer in the mosque. These legal schools consider it undesirable to locate the prayer in the mosque itself or to perform the dead prayer twice. The disagreement stems from conflicting traditions (Aggoun, 2006; al-Jazīrīʾ, 2009). Several scholars argue that in Islam women are discouraged from participating in the dead prayer, as they are considered to be too emotional (Bakhtiar, 1996; Yasien-Esmael & Rubin, 2005).

Against the background of how death and dying should be dealt with according to (*Sunnī*) Islam, it is interesting to find out how the actual (views on) practices of Moroccan Muslims in Europe look like. How do practices regarding death and dying among Moroccan Muslims take shape in the context of migration? Are younger generations more influenced by the secular Western society they have been raised in? Is there a gap between the actual practices of Muslims in the West and the normative Islamic prescriptions related to death and dying?

Empirical Study

Methods

Design

Between October 2014 and September 2015, thirty semi-structured interviews were conducted with a sampling of middle-aged and elderly women in the Moroccan community in Antwerp (Belgium) who self-identify as Muslim. This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. We have chosen Antwerp for two important reasons. First, this city has the largest Muslim population in Flanders: 19.2 % of Antwerp's population is Muslim (Hertogen, 2016). Second, Antwerp as a port city is considered to be one of the most multicultural cities in the world.

Different routes of recruitment (e.g. mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured topic list covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) and Dutch. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organization or in a quiet tea house). To help us with the interpretation of our data, we also interrogated 15 experts in the field (e.g. Muslim physicians, Muslim nurses, imams, palliative care consultant etc.) between September 2014 and September 2015 about particular topics of the study including the (views on) practices of Moroccan Muslim women surrounding death and dying. These interviews functioned as background information and were compared with the empirical data of our interviews with Moroccan Muslim women. Apart from interviewing, the first author also conducted participant observations (December 2014 – April 2017). Several visits of the sick, a *ḥijāma*-consultation, death prayers, ritual washings of the dead body, burial, mourning gatherings, and several Islamic cemetery plots were visited.

In this study, we opted for a non-normative, descriptive, exploratory approach. This study was approved by the Social and Societal Committee (KU Leuven, Belgium). In order to guarantee the anonymity of our participants, we made use of pseudonyms.

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology (Corbin & Strauss, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used to code and analyse the

interview data. By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated to grasp the real world experiences and meaning systems of our participants. In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. Data of the interviews of Muslim women and experts were analysed separately in a *NVivo*-project. Moreover, the findings of our interviews with Muslim women were compared with those of the interviews with experts per concept and categories and subsequently compared with normative and empirical studies (cf. discussion). Findings were regularly discussed with our guiding committee and with several members of the Moroccan Muslim community.

Results

Participants' (socio-)demographic information & health situation

Our group of middle-aged Moroccan Muslim women (n=15) was between 41 and 55 years old; our group of elderly women (n=15) was aged between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labor migration, family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of between three and five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. A small minority of Moroccan Berber participants spoke Arabic, and two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Four elderly participants graduated from lower secondary school and one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes. Regarding employment, only two elderly participants worked outside

the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

The health issues of our middle-aged participants were limited to knee problems and migraine. Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a bad health condition. Nine participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer and severe chronic disease.

Practices surrounding Death and Dying

Dying: Purification of the Soul

The first and most important ritual at the end of life according to nearly all participants is the utterance of the *shahāda* (Islamic creed), which is considered an important ingredient of a good death. The *shahāda* is pronounced by the dying person and/or prompted by the family and while the forefinger is often raised at the same time. Our participants explain that by uttering these words, one dies as a Muslim and will therefore enter paradise. Interestingly, according to one participant the articulation of the *shahāda* symbolizes the completion of the life cycle: the *shahāda*, pronounced when a person is born and when he/she dies, is a memento that human beings belong to God. Our participants see it as a duty of the dying person as well as of the surrounding people to make sure that these are the dying person's last words. This is also confirmed by our experts.

> "Yes, the first thing is the *shahāda.* We come to life with the *shahāda* and we die with the *shahāda.*[…]We always say in our prayer 'Oh God, give me the strength *(thabbit*) to look death in the eyes and to pronounce the *shahāda'*.[…] Because the angel of death will be here, he takes your soul. If you ask God to give you strength (*thabbit),* you'll see the angels, you'll see the place where you're going. Saying "there is no God but Allāh, and Muḥammad is his messenger" is a *ni'ma* (blessing). Because very few people get this blessing from God." Kaltoum – middle-aged

> "Bystanders try to make the dying person remember to pronounce the *shahāda* and we make a *duʿāʾ* (supplication) that he will die with the *shahāda* of the prophet Muḥammad so that he gets a beautiful place in paradise. My mother couldn't speak anymore, but I always saw her saying the *shahāda* by raising her finger.[…] Every time we said the *shahāda*, she raised her finger." Laziza – elderly

> "They say the *shahāda* because they know it's very important. It's the first thing that they've learned.[laughs] 'Don't forget the *shahāda* if you want to die pure'." Myriam – Palliative care consultant

Against this backdrop, a few elderly participants mention the ritual of giving water to the dying person, as it is believed that a dying person suffers from an intensive thirst. This has to be viewed against their belief that the devil (*shayṭān*) is present at the bedside trying to keep the dying person from uttering the *shahāda* in return for water. Therefore, giving water to the dying is of great importance so that the dying person will not give in to the devil.

> "He says the *shahāda*. They give him water, because he's very thirsty then.[…] If he can't speak anymore, they give him water and say the *shahāda* for him until God takes back His *ʾamāna* (trust)." Rahima – elderly

> "And you always need to give water to the dying because they say that they're very thirsty. They would rather be in a water well in that moment. They are very hot and thirsty." Fatma – elderly

The second important ritual mentioned by the overwhelming majority of our participants is the practice of asking mutual forgiveness (*musāmaḥa*). Having resolved remaining issues and disagreements with family and friends before dying is considered an important part of a good death, as it fosters a sense of closure and shows the acceptance of impending death. However, this is not only interpreted from a psychological perspective, but also from a teleological perspective. Indeed, several participants explain that it is of the utmost importance to resolve issues and forgive one another, in order to come clean with God. As such, they are convinced that if no forgiveness has been asked (for a particular issue), this becomes a matter in which God will interfere. Another explanation is that as long as no forgiveness has been asked or accepted, the deceased will not rest in peace in the grave (*barzakh*). Hence, several participants emphasize that a person should always ask forgiveness and not postpone it until the end of life. This is confirmed by our experts.

> "Yes, many ask *musāmaḥa* and vice versa, not only the dying but also the other way around. Asking forgiveness in this worldly life is better, because it becomes more difficult in the hereafter. So [by doing this] you can go to God with a clear conscience." Hannan – middle-aged

> "We Muslims must ask forgiveness to each other. God says that the person who acted badly towards God, God will forgive you. But if there's something between this person and someone else, God won't forgive him until His servant did so. So if you have wronged someone, you need to ask forgiveness. God won't forgive you until you have asked forgiveness to this person. And you should not wait until someone is about to die to do that." Haddad – elderly

> "They hope to die with a clear conscience by having straightened things between them and other people, by asking forgiveness to people and by offering forgiveness and repentance to God." Nourdin – *ʾimām*

Third, settling debts is also mentioned by the majority of our participants and confirmed by our experts. It is believed that by doing so, the dying person can go to God peacefully and will find peace in his/her grave. Near the end of life the dying person often expresses his/her last wishes (*wassiya*), for example with regard to the distribution of wealth, and by doing so also mentions his/her unpaid debts to the family. We observed that this ritual of settling the dying/deceased person's debts is mainly taken care of by male members of the family (e.g. husband, brother, father). It is

believed that the debts must be settled before the death prayer. With regard to the living will (*wassiya*), interestingly, a few participants explain that the distribution of wealth or heritage is often *not* discussed, as it is a sensitive subject for the dying person if he is unable to distribute everything proportionally among the children, but also to avoid tension in the last moments of life. An example is the difficulty in proportionally dividing land among the children, as often discussion arises on who will get the best part of it. This was strongly observed during the participant observation.

> "Settling your debts, but they need to say this beforehand. God has reminded us that if you borrow money, you need to give it back as soon as possible and that you also must notify your partner about this." Radia – middle-aged

> "If someone dies and he's still in debt then you'll have to pay off those loans. My husband has had a business for three years. I went there and paid everything off. It's a duty. I did that so he can rest in peace in his grave. Both him and I can rest in peace now." Malika – elderly

Fourth, an important ritual which eases the pain and distress among the dying person and the family, articulated by nearly all participants, is turning to God by listening to and reading the *Qurʾān*. By doing this, our participants explain that the dying person and entourage find peace in God's words (and thus comfort), but also that it eases the pain that comes along with dying (*sakarat al-mawt*). At the same time, they believe that reading the *Qurʾān* is a way of expiating one's sins, but also a way of communicating with God. More specifically, several participants refer to the importance of reading *sūrat yāsīn* (Q:36), as it deals with hardship, death and afterlife, but also smaller chapters such as *sūrat al-ʾikhlāṣ* (Q:112), *sūrat al-nās* (Q: 114), *sūrat al-falaq* (Q:113) and *sūrat al-fātiḥa* (Q:01). During the participant observation, we observed that this practice is mainly performed by male members of the dying person who have memorized (part of) the *Qurʾān* and/or by an *ʾimām*. A second observation was that not only *sūrat yāsīn* seems to be given importance, but also *sūrat al-mulk (Q:67) and sūrat al-wāqiʿa* (Q:56), as they also deal with death and the afterlife.

> "The *ʾimām* reads the *Qurʾān* the entire time. And the *ʾimām* said that if you talk to her, read '*Qul huwwa Allāhu ʾaḥad'*[chapter *al-iIkhlāṣ*]. The more you recite, the better. It softens the pain of dying. We stayed around her and recited this *sūrat*. The *ʾimām* said not to cry, to let the contact with God be free and to let her go. He said if you cry then you make it more difficult for the soul. Sarah – middle-aged

> "Reciting the *Qurʾān* yourself or by others is a part of it. […] With *sūrat yāsīn*, the dying comes to rest and it relieves the pain. And also *sūrat al-mulk.* It makes sure that if you die, you'll find peace in your grave, but also that your sins are forgiven." Huda – elderly

> "They bring a person who knows the *Qurʾān*, so he can read it and prompt the *shahāda.* […] Mostly *sūrat yāsīn* and *al-ḥākim* […] yes, so they try to spend those last moments with the dying by trying to bring him to peace.[…] I think that this is also soothing for the family." Nourdin – *ʾimām*

Fifth, several –mainly elderly– participants mention the practice of giving *ṣadaqa* or *sedqeth* (voluntary charity) as a way of purifying the dying person's sins. Giving *ṣadaqa* can have different forms. First and best-known form is inviting people for a meal. However, this is contested by several

participants who explain that this has no benefice, as the invited people are often not needy people. Second, several participants prefer to give money or food to needy people, or contribute financially to the construction of a mosque or to charity organisations (e.g. orphans, water well). This is considered *ṣadaqa jāriyya* (ongoing charity), which is understood as bringing continuous rewards (*ḥasanāt*) even after death. This is also confirmed by our experts.

> "I would first give a lot of money to the poor, because I have to earn my place in paradise. For example, to orphans, the elderly, who can't afford much. That is *ṣadaqa jāriyya*." Loubna – middle-aged

> "Yes, some people give a *sedqeth* or *ṣadaqa* for the dying. They do this so their sins will be forgiven. They do everything so that if he dies, he goes to a beautiful place.[…] So that he can go to paradise. We also did that for my mother in the mosque on a Friday." Laziza – elderly

Sixth, half of our participants underline the importance of turning to God, asking forgiveness (*ʾistighfār*) and thus remembering God in the final days and hours. This again entails experiencing God's nearness and faithful relation with the dying person as he/she is about to return to God. Several participants point out the importance of fulfilling their religious duties such as performing their daily prayers (*ṣalāt*) and pelgrimage (*ḥajj),* but also of performing as many good deeds (e.g. voluntary prayers) as possible to purify oneself of his/her sins. Apart from this, more than half of our participants believe that uttering supplications (*duʿāʾ)* is an important medium to reach God. The dying person often asks God to strengthen his/her faith (*thabbit*) to be able to pronounce the *shahāda*, to answer the questions of the angels Munkar and Nakīr in the grave and to enter paradise. This has to be viewed against the backdrop of their eschatological beliefs that between death and the Day of Resurrection the dying person enjoys a life in the grave (*barzakh*). The family and Muslim community often utter *duʿāʾ* asking God for his mercy upon the dying person and to let him/her be one of the inhabitants of paradise. Through our interviews and participant observation, we learned that performing *duʿāʾ* is perceived as a very powerful medium. As a result, a *duʿāʾ* is often requested –as social support– from the Muslim community in mosques, but also on social media. The idea is that the more *duʿāʾ* is performed, the more it is answered by God.

> "Just remember God more often and do *ʿibāda* (deeds of worship) as much as you can. Just do good as much as you can and come closer to God. Purify yourself from your sins as much as possible and ask God to forgive you for everything and that you can go to a better place." Sabiha – middle-aged

> "The most important thing is that you return to God, that you ask God for forgiveness. Stop gossiping, make it up to people. The dying has to ask God for forgiveness. He must pray *nawāfil* [voluntary prayers]. He has to come closer to God. If you don't do that, you won't come closer to God. We ask God that He strengthens us with faith (*thabbit)* when dying and when the interrogation takes place." Yamina – elderly

Seventh, half of our participants mention visiting the sick/dying (*ṣilāt al-raḥīm*) as an important practice of social support, which is also considered to be a religious obligation. Participants highlight that this visit has several goals, including taking leave, comforting, showing compassion

and strengthening the moral of the sick or dying person by pronouncing supplications such as '*Allāh yishafīk/djaw abbi shifa'* ('May God heal you') or '*Allāh yarḥamak/djaw abbi rahma'* ('May God have mercy upon you'). Based upon the participant observation, visiting the sick or dying is also a way of restoring family ties, by which both the ill or dying person and the visitor earn good marks (*ḥasanāt*). This is also shared by our experts.

> "They [hospital] gave us a big room for those who wanted to say goodbye. I will never forget that. A lot of people who heard about it, visited my mom.[…] They made *duʿā* and we did as well, such as '*Allāh yarḥamak'* [cries]." Sarah – middle-aged

> "People perform *ṣilāt al-raḥīm.* That is a good thing. They utter a *duʿāʾ* for the dying." Charifa – middle-aged

> "Yes, what you often see is that people visit the sick or the dying to comfort them and tell them to be patient. You receive *ḥasanāt* as a Muslim if you visit a sick person." Myriam – Palliative care consultant

Death: Preparations for the Next Journey

All participants emphasize the importance of religious death rituals including washing the dead (*ghusl al-mayyit*), shrouding the corpse (*takfīn al-mayyit*), death prayer (*ṣalāt al-janāza*) and burial (*dafn al-mayyit*). As mentioned before, burial is discussed in a separate article. It must be noted that although all participants were aware of Islamic dead rituals, only a minority of our participants was able to explain the practices in detail. This minority consists mainly of elderly participants who have already been confronted with a dying person. These rituals were explained as the rights of a dead person that must be respected and taken care of by the Muslim community (*farḍ kifāya*).

> "There's always someone who washes the deceased (*ghusl al-miyyit*).[…] They pray for the deceased in our religion. They do a *janāza* (death prayer), *kafan* (shrouding) the deceased and bury him/her. They do what needs to be done. Those are things that are mandatory for us, we must stick to it. It's our duty to the deceased.[…] that's how it is in our religion." Haddad – elderly

Washing the dead (ghusl al-mayyit)

Nearly all participants explicitly mention the washing of the dead as an important ritual performed within the Muslim community. They explain that there are several reasons for this. First, against the background of their belief in an omnipotent God who governs life and death and is the ultimate owner of everything, they emphasize that purifying the body is a way to respectfully return the body to God. Man has only the vicegerency over life and body, which are given by God as a trust *(ʾamāna*). Second, this ritual is performed as it is believed that it purifies the deceased's sins. This is also confirmed by our experts.

> "The deceased is washed and wrapped in a shroud.[…] I experienced this with my mother, my father, my aunt and my neighbor. My husband was washed by his eldest son and the *ʾimām*." Yamina – elderly

> "Yes, they wash him. God requests that the deceased are washed so that they are clean and pure. Yes, this is a tradition, people wash the deceased." Malika – elderly

> "A known ritual for Muslims is the washing of the dead. This ablution ensures purification of the sins, but also that the deceased goes to God in a purified state. It's an *ʾamāna* that goes to God." Rachid – Muslim undertaker

Although washing the dead is considered a religious obligation, Ikram, a middle-aged participant, who miscarried a baby at nine months mentions that a stillborn is not washed, based upon the idea that he/she is pure and therefore a ritual washing is not needed.

> "If a child is born and it died in the womb, the child doesn't need to be washed because it is pure." Ikram – middle-aged

However, as aforementioned, only a few participants –whom themselves have been confronted with a death in their environment– are able to provide some details about the washing of the dead. Interestingly, they underline that the washing of the dead has to be performed with all gentleness, as the dead body is still able to (physically) feel, hear and see. At the same time they highlight the importance of respecting the deceased's dignity by covering the intimate parts *(ṣutra*). This has to be viewed against their teleological belief that when a person dies, the soul remains above the body until burial. Hence, they explain that dead washers –who often consist of specialists attached to a mosque or funeral organisation and one or two family members– ask the deceased for forgiveness during the washing based upon the idea that the deceased might feel pain. In most cases, men wash men and women wash women. Noteworthy, only two participants mention that they have washed the deceased themselves, while others left this task completely to the specialists.

> "They say that if you die, you still feel everything.[…] You feel everything very vividly. So if you feel something right now, you'll feel it 10,000 times worse when you're in a cold storage. That really hurts. That's why the person who washes the deceased asks for forgiveness in case he/she hurts the deceased, like 'sorry if I hurt you'." Hannan – middle-aged

> "Our custom is that if someone dies, you'll need to treat that person as if he's alive and you have to take good care of him, wash him/her gently and say the *shahāda*. You recite *sūrat yāsīn* or you put some *Qurʾān* on." Huda – elderly

> "The prophet said that breaking the bones of a deceased is the same as breaking the bones of a living. So the deceased feels everything. He feels the washing of the dead and it hurts." Khawla – Specialized corpse washer

During the participant observation, we observed that the washing of the dead performed on a living person consists of several steps. First of all, everything is removed from the deceased and the stomach is gently pushed on to empty all air. Second, before starting with the washing, the washers have to perform the ablution (*wuḍūʾ*) and must have the intention (*niyya*) to wash the deceased. The washing of the dead starts with covering the deceased's body (*ʿawra*) and performing the ablution (*wuḍūʾ*) for the deceased. Third, the dead body is washed with water and soap starting

from head to toe on the right side and then likewise on the left side of the body. The body is then washed again with *camphor* and water, and a third time with water only. Fourth, the body is dried and perfumed with musk on the parts that touch the ground when performing the daily prayer (*ṣalāt*). Interestingly, musk is in fact believed to be the scent of paradise. Two middle-aged participants mention that a deceased woman's hair is brushed in three braids, considering it a *sunna*-practice (meritious act). Noteworthy, the experience of washing the deceased seems to have a great impact on the bereaved. Indeed, this participation gives them a way to process their grief and to take care of their loved one for a last time. This seems to give the bereaved peace and is therefore viewed as a *raḥma* (mercy) of God. It is also believed that washing the deceased by a family member is considered a good virtue as it is a way of worshipping God by which one earns *ḥasanāt* (good marks).

> "I told the nurse to get a bandage because his mouth was open, so I could attach it. I gave instructions to the nurse to attach the bandage around his head so he could close his mouth. Then I told her to place his legs against each other. Because if you don't do that, the legs will stay stiff. So then the two big toes against each other so the feet stay stretched. And I also closed his eyes." Yamina – elderly

> "I heated some water in a bucket, took a towel and washed her entirely with gloves and we covered her with a sheet. Then there were people who came and they took her in a stretcher, in an ambulance. They washed her, wrapped her around in *kafan* (shroud) and buried her." Laziza – elderly

Shrouding the corpse (takfīn al-mayyit)

After washing the dead, shrouding the corpse is also mentioned by our participants as an important religious ritual. Our participants explain that five shrouds are used for a female deceased and three shrouds for a male deceased. During the participant observation, we learned that the shrouds are often brought by the specialists or bought by the family. The shrouding process of a female deceased consists of five steps. The first cloth is shrouded from head to feet, the second is wrapped around the middle, the third is shrouded from navel to feet, the fourth is wrapped around from head to feet again and the last shroud is used to cover the hair. The shrouds are also perfumed with musk. At the end only the face is left uncovered in order to give the bereaved the chance to take leave of their deceased. One expert argues that first generation Moroccan Muslims strongly uphold the tradition of placing a turban and a Moroccan dress (*jilbāb*) on the male deceased, which he considers un-Islamic. However, this is not mentioned by our participants, nor did we observe this during the participant observation.

> "No, it's the same for men and women. I think that women get more layers of shrouds to cover themselves than men. Women get five pieces of shroud and men get three. Women get five shrouds due to their figure. That's the difference." Kaltoum – middle-aged

> "They often put a *jilbāb* on the shroud, which is a long gown. That's according to Moroccan tradition. A turban is also common, it's traditional. We have seen that a lot of imams and first generation people who performed this, until we had educated imams. They have a different view. They perform actions of the prophet, peace be

> upon him, but the people from Morocco blend several things with cultural traditions that don't belong to Islam." Rachid – Muslim undertaker

Taking leave of the dead person

A minority of our participants point to the custom of taking leave of the deceased by relatives, which often takes place where the deceased person has been washed and shrouded. They mention that taking leave of the deceased would traditionally take place at home, but nowadays this often takes place in a mortuary.

> "After the washing of the dead, we were able to greet him and say our last farewell in the mortuary." Narima – middle-aged

> "Here in Belgium the corpse is kept in the hospital and that's also where the farewell of the deceased takes place. In Morocco the corpse is often washed at home and it is also there that the farewell can take place." Nihad – middle-aged

Through our interviews and participant observation, we observed that before repatriation or burial, family members, but also close neighbours and friends take the opportunity to visit the dead person, as it is the last time one can say goodbye and see the deceased at home or in the mortuary. This is often the last moment for women to physically take leave of the dead person. This goodbye is often in the shape of reading *Qurʾān* (individually or in group – headed by a male family member or the *ʾimām*) followed by uttering supplications, which often deal with asking God for His mercy upon the deceased, for forgiving his/her sins and for letting him/her enter paradise. At the end, each individual often moves closer to the deceased and performs an individual prayer followed by a kiss on the forehead. Interestingly, we observed that during this moment no separation between genders exists.

> "I said goodbye to my husband in the mortuary.[…] I kissed his forehead and left." Lamya – middle-aged

> "What people do? They read the *Qurʾān* for him. They utter a supplication for him. They read *sūrat yāsīn*." Alia – elderly

> "Yes, most of the time they [Muslims] recite *sūrat yāsīn*.It is also according to a *ḥadīth* which has a poor authenticity, uhm, the prophet, peace be upon him, would have said 'recite *sūrat yāsīn* for your deceased'. But it's a *ḥadīth* that not everyone follows because the authenticity is not so strong, but they do it anyway. There's actually much wisdom in *sūrat yāsīn*. It reminds you of the hereafter." Nourdin – *ʾimām*

Nearly half of our participants share the explicit belief that a deceased is in fact able to hear, see and feel. Therefore, they explain that one must not weep or cry in front of the deceased as this would torture his/her soul. Additionally, several participants point out that a person who is impure (e.g. no ablution or in period) may not touch the deceased as he or she is in a purified state. However, during the participant observation, we did observed tension between the bereaved and visitors

whether a deceased person can be touched by the living in general. Though the bereaved did give the deceased a last kiss.

> "After the washing, those who are pure, so that means that those who don't have their period, can enter the room where the deceased is. Those who have their period can't enter the room and have to stay at the door. Yes I have already experienced that, I couldn't enter the room. I had my period and I couldn't enter the room. I saw her, but I couldn't hug her." Radia – middle-aged

> "You recite *sūrat yāsīn* or you put some *Qurʾān* on. The deceased may not hear anyone cry or scream, otherwise his soul will be tormented. Only the words'*Allāhu akbar*'[God is the Greatest] and the *Qurʾān*. You understand? Because the deceased can hear everything." Huda – elderly

Death prayer (ṣalāt al-janāza)

All participants mention that the death prayer (*ṣalāt al-janāza* or *ṣalāt al-mayyit)* is an important obligation of the Muslim community (*farḍ kifāya*). Several participants also interpreted this ritual as a last mercy (*raḥma*) for the deceased as Muslims collectively ask God to expiate and forgive the deceased's sins and to welcome him/her under His mercy. The belief is that the more people pray for the deceased, the more God will accept the prayers. The number of people attending the prayer also has an influence on the grief and mourning of people. The dead body is placed in the male's prayer room, precisely in front of the *ʾimām*. One participant explains that if it is a female deceased, the *ʾimām* is positioned at the middle of the body and at the head if it is a male deceased. However, it is worth mentioning that only one third of our participants have effectively attended a death prayer. Some participants explain their non-participation with the fact that often the mourning visits start when the news goes around that the person has passed away. Others explain that women are discouraged from attending the burial (in cemetery) where traditionally the death prayer is performed and therefore they are often excluded from participation in the death prayer. We observed, however, that in Morocco women attend death prayers, albeit in the mosque, not in the cemetery.

> "They pray for the deceased and make supplication. We then ask God to forgive the deceased. The *ʾimām* is then positioned at the middle of a female body and at the head if it's a male body." Kaltoum – middle-aged

> "They pray for the deceased. So they bring the deceased to the mosque and pray for him. Women also go to the mosque to pray, but we don't go to the cemetery. We go to the mosque and pray and when they take the deceased to his grave, we go back home." Alia – elderly

> "The Muslim community prays for the deceased. They pray that God forgives the deceased and receives him well. By doing this [prayer], certain sins are forgiven. And *ṣalāt al-janāza*, the more people are present, the more that God forgives, Glorious and Exalted He is. That's also a sort of appreciation of God." Khawla – Specialized corpse washer

During the participant observation, we observed that attending a death prayer is not only important for the bereaved, but also for the entire Muslim community. In this regard, a few participants mention that all who attend a funeral prayer receive good marks (*ḥasanāt*). The death

prayer consists of four parts and does not entail prostrating, as is performed in the daily prayers. The *ʾimām* starts with pronouncing the *takbīr* (pronouncing '*Allāhu akbar'*), followed by reciting the opening verse of the *Qurʾān* (*sūrat al-fātiḥa),* all individually and silently. Subsequently, the second *takbīr* is pronounced, followed by the prayer of *Ibraḥīm* (*ṣalāt Ibraḥīm*). With the third *takbīr* supplications (*duʿāʾ*) are uttered for the deceased, followed by a fourth *takbīr* where supplications (*duʿāʾ*) are made for all deceased Muslims. The prayer ends with greeting the angels on both the right and the left side or only on the right side (*taslīm*). After this prayer the bereaved are greeted by all attendees and pronounce the following expressions: '*Inna lillāhi wa inna ilayhi rajiʿūn'* ('Surely, We belong to God and to Him we shall return'), '*Allāh yarziq sbar' (*'May God bestow patience') and *'Allāh yaʿdzam al-ʾajar'* ('May God multiply the good marks'). It must be noted that before the prayer the *ʾimām* introduces the dead person and his/her family and often shares positive qualities of the (male) deceased.

Although the death prayer is traditionally performed only once (before the burial), this is often not the case in the Belgian context. Indeed, as preference is often given to burials in the country of origin, resulting in the dead body being repatriated, the death prayer is performed twice. The death prayer is performed once with the Muslim community in a local mosque in Belgium and a second time in the country of origin, more specifically in the mosque or in the cemetery of the ancestral city. Although the death prayer in the country of origin is often performed on the cemetery, several participants mention they do attend the death prayer in Belgium, as this is performed in the mosque and not in a cemetery.

Discussion

The findings of our interviews with middle-aged and elderly Moroccan Muslim women are nearly identical to those of the interviews with our experts in the field. Although there are differences in age, but also in level of education and socio-economic status between the first and second generation, surprisingly no differences were observed between our middle-aged and elderly participants in their practices regarding death and dying nor between participants who were and who were not confronted with severe illness, either personally or in their immediate environment. Although it could be assumed that second generation Muslim women, who were born or raised in Belgium, are more likely to be influenced by Western ideas, which might result in a more secular understanding of death and dying and a decline in religious observance, this was not the case. However, we did observe that mainly elderly participants were more able to provide details on practices surrounding death and dying as compared to middle-aged participants. This might be explained by the fact they have been confronted with death more often due to their age. The few middle-aged participants that had lost a loved one were also able to provide more details on rituals and customs performed surrounding death and dying. The difference between elderly and middle-aged participants can also be explained by the

fact that over time death rituals have become more a task that is taken up by specialists (e.g. members of the mosque, funeral association), which leaves family and neighbours less involved. Another explanation might be that with institutionalization of death, a person often dies in the hospital and thus less in the familial domestic circle. As a result, the washing and shrouding of the deceased take place in a mortuary. This limited knowledge might also be explained by the fact that traditionally dying and death rituals are often performed by men by which an *ʾimām* is often involved (e.g. reading *Qur'ān* over the deceased or dying, the death prayer). However, when it concerns a female deceased, only the washing of the dead is fully performed by women and thus, in this context, they are in charge of knowing and passing this knowledge to other women. We observed an increasing development of formations in which Muslim women teach other Muslim women on end of life rituals (e.g. *shahāda*, giving water, facing the deceased towards Mecca) with main focus on washing and shrouding the dead.

Our study shows that practices regarding death and dying are performed according to the outline of a religious framework. In other words, our participants' (view on) practices embody their religious belief such as pronouncing the *shahāda* (Islamic creed) to confirm God's unity (*tawḥīd*). More specifically, death and dying rites are inextricably linked to eschatological beliefs. As such, nearly all rituals surrounding death and dying are centred upon purifying the dying or deceased. This can be understood in two ways. On the one hand, these rituals entail the purification of a person's sins, i.e. purification of the soul. On the other hand, the rituals entail a purification of the body, i.e. enhancing cleanliness of the body. This is strongly related to the concept of vicegerency and dignity. The body, which is a trust from God, must be taken care of and must be returned to God in a clean state. In fact, these rituals have to be understood within a teleological framework: preparations are made for the next journey.

Second, these rituals are not only intended for the dying or deceased, but also for the living people or the bereaved. Reading the *Qurʾān* or visiting the dying can be comforting. It is also a way to expiate one's sins and thus to earn good marks (*ḥasanāt*). These rituals seem to act as an important meaning-giving structure for Muslims. These prescribed structured rituals for the dying/deceased including reciting *Qurʾān*, washing the dead and the death prayer seem to give a certain direction and support, fostering a feeling of control and peace in these difficult times.

Third, many rituals including reciting the *Qur'ān* and uttering supplications also seem to be a way of communication with God and reaching out to the dying or deceased. These seem to be viewed as powerful ways of reaching God and enhancing the state of the deceased person in *barzakh* or on Day of Judgment through God. This indicates a continuous bond between the living and the dead.

Fourth, the Muslim community plays a major role in the period of death and dying and functions in fact as a supporting network upon which family of the dying or deceased can count. As such, members of Muslim community offer their help and support in various ways (e.g. visiting the sick, organisation of washing the dead, death prayer). Some practices surrounding dying are of great importance to both dying person and the community such as asking mutual forgiveness, settling debts and pronouncing or prompting the Islamic creed. At the same time, though, we observed social pressure related to the performance of rituals (e.g. discussion on touching a deceased).

Fifth, we observed that rituals have been influenced or adapted due to their embeddedness in a migration context. In Belgium, death prayers are performed in the mosque, unlike in the country of origin where the death prayer is traditionally performed in the cemetery. A second crucial adaption is that due to common choice among Muslims to be repatriated to the country of origin, death prayers are performed twice: once in Belgium, once in Morocco. This has enabled women to participate in death prayers as death prayers in Belgium are performed in a mosque, whereas in the country of origin they are held in the cemetery most of the time where women are discouraged from attending the burial.

Comparison with the Normative and Empirical literature

Our participants' line of reasoning and practices were strongly similar to the line of thought and Islamic prescriptions found in normative Islamic literature on death and dying. Both our interviewees and normative Islamic literature uphold the importance of praying, reading the *Qur'ān*, uttering supplications, giving to charity as well as asking mutual forgiveness, settling debts, and pronouncing the Islamic creed (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Shahri, 2016; Gatrad & Sheikh, 2002b). Similar to our findings, normative Islamic literature also strongly emphasizes the deceased's rights, which are a responsibility of the Muslim community (*farḍ kifāya*), including washing, shrouding and performing the death prayer for the deceased. Our participants' theological and eschatological line of thought is strikingly similar to that found in normative Islamic views. Rituals are performed to clean the body (e.g. washing), as the deceased is about to return to God, as well as to purify the dying or deceased's sins so he or she would find peace (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Shahri, 2016; Al-Shahri et al., 2007; Gatrad & Sheikh, 2002a; Halevi, 2007).

However, our participants did not mention the custom of positioning the dying towards Mecca (*ʾiḥtidār*). The performance of the death prayer seems to be a little different as well. Instead of performing only a supplication for the deceased, we observed that among the four *takbīr,* the last two were followed by a supplication for the deceased and a supplication for all deceased. Often the *taslīm* was only performed on the right side.

Until now, Muslim practices surrounding death and dying have been mainly addressed from an anthropological perspective. The main studies we found focus on Muslims of different ethnicities

and/or denominations in the West (Dessing, 2001; Gardner, 1998; Jonker, 1997; Venhorst, 2013) or on Muslims in Morocco (Dieste, 2012; Renaerts, 1986; Westermarck, 2013). However, a detailed descriptive account and overview of the practices regarding death and dying among Moroccan Muslims living in Belgium and more specifically first and second generation women is lacking to a great extent. Although these studies contain empirical data, it is, however, often not clear in their work which data are deduced from theoretical (normative) studies and which are found in their empirical studies. No systematic overview is provided in these studies.

Nevertheless, the findings of our study are strongly consistent with the results found in other empirical studies (Assous, 2013; Bot, 1998; Gardner, 1998; Jonker, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986; Van den Branden, 2006; Venhorst, 2013). Similar to our findings, the following elements came forward in abovementioned studies: pronouncing the Islamic creed which symbolizes God's unity; visiting the sick; asking for forgiveness, settling debts, turning to God as well as washing the dead corpse, shrouding and praying for the deceased and the crucial role of the Muslim community. Although the study of Kadrouch-Outmany (2014) focuses on Muslims of different denominations in the Netherlands, we observed great similarities, particularly with her Moroccan participants. These studies corroborate that theological and eschatological beliefs shape rituals surrounding death and dying. This is articulated by Venhorst (2013) with the term 'lived eschatology' as reflected in the practices, experiences and expressions of ordinary Muslims in everyday life. She explains that lived Islam shows that the religion of supposedly clear and uniform rules creates a diverse practice, lived by a variety of Muslims in a variety of contexts. Moreover, lived eschatology is described as a complex field where Muslim beliefs, Islamic myth and death rituals converge. Venhorst (2013) confirms our findings that the rituals embody their beliefs on death, dying and the afterlife, which was also found among our participants. Death rituals are viewed as a preparation to return the human body in a respectful way back to God, the ultimate owner of the human body and life.

Muslim death practices are understood as *rites de passage* (cf. Genepp 1961; Turner 1969 & 2002) i.e. rituals that mark changes, shifts and transitions in the human life-cycle (Dessing, 2001; Kadrouch-Outmany, 2014; Venhorst, 2013). The authors mentioned distinguish three major phases: rituals of separation, transition and incorporation. In line with our results, these studies suggest that in the preliminal phase preparations (dying rites) are made for the separation from the earthly life. In keeping with our findings, several studies (Assous, 2013; Bot, 1998; Dessing, 2001; Dieste, 2012; Jonker, 1997; Renaerts, 1986; Venhorst, 2013) confirm that in this phase, various rituals are performed in order to guide the deceased in his or her transition from one world to the other, including pronouncing *shahāda* and reciting the *Qurʾān*. In contrast to our findings, these studies observed the facing of the dying person towards Mecca among their participants. This practice was not mentioned by our participants or observed during the participant observation. Although several studies support

the practice of giving water to the deceased to protect the dying from the presence of the devil, studies conducted in Morocco show that often also honey is given to the deceased to be able to resist the devil's temptation. This was not mentioned by our participants or observed during the participant observation. Both Bot (1998) and Venhorst (2013) observed in their study that (Moroccan) Muslims in the Netherlands often dissolve *Qur'ānic* verses in the water for the deceased for two reasons. First, as it is believed this is a blessed way to hydrate the deceased as protection against the devil. Second, because many cannot read the *Qurʾān* and therefore dissolve some verses in the water for the deceased. This, too, was not mentioned by our participants or observed during the participant observation.

Similar to our findings, the studies by Dessing (2001) and by Kadrouch-Outmany (2014) show that the liminal phase entails rituals of transition, which include the detachment of the deceased from the larger group (from a previous world), as he or she belongs neither to the living nor the dead. In this context, the rites of transition entail preparations made for the deceased for his or her next journey. Here again, like our findings, studies (Assous, 2013; Dessing, 2001; Jonker, 1997; Renaerts, 1986; Venhorst, 2013) report that washing and shrouding the deceased and the funeral prayer are preparations for the encounter with God as well as rituals of purification. Studies (Assous, 2013; Dessing, 2001; Dieste, 2012; Jonker, 1997; Kadrouch-Outmany, 2014; Shaw, 2014; Venhorst, 2013) confirm the teleological perspective of the deceased's vulnerability found among our participants. These studies also found that those involved in performing the death rituals are very much aware of the deceased's vulnerability as the deceased is still sentient and aware of what is going on until burial and therefore a gentle approach is of the utmost importance. These studies also confirm our finding that this vulnerability is also derived from the understanding of sanctity of the body (*ḥurma*), as the body is viewed as a trust from God. Venhorst (2013) corroborates our finding that corpse washers apologise during the washing of the deceased. In keeping with our findings, the study of Renaerts (1986) shows that persons in a state of impurity are not allowed to access the space where the deceased body is placed. Similarly, Jonker (1997) found in her study that (Turkish) Muslims in Germany found it completely forbidden to touch the deceased, as touches could undo the deceased's purity.

In contrast to our findings, a study of Westermarck (2013) and Renaerts (1986) among Muslims in Morocco shows that after the washing of a deceased child or unmarried person, the hands of the deceased are painted with henna (right hand) and kohl is applied on the eyes based on the belief that such people were known as the bride or groom of the hereafter. This was, however, not mentioned by our participants. The lack of this custom might be explained by the fragmentation of the country of origin's cultural practices in the migration context. The postliminal phase, rites of incorporation, entails the actual burial and thus the fact that the deceased has completed the passage (Dessing, 2001; Kadrouch-Outmany, 2014). Nevertheless, Venhorst (2013) considers rituals at the

grave as rites of transition followed by incorporation rites at the end of times (e.g. day of judgment).

In contrast to our findings, several studies (Bot, 1998; Dessing, 2001; Jonker, 1997; Venhorst, 2013) show that Muslim women do not take part in the prayer, as they are more emotional and tender-hearted and therefore discouraged. Though Dessing (2001) does argue that women participate if this prayer occurs after the Friday prayer, as women are (already) present for this prayer. In contrast to abovementioned studies, our participants (one third) do actively participate in death prayers, not limiting their presence to Friday prayers. This was also observed during the participant observation. In contrast to our interviews and participant observation, in several studies (Dessing, 2001; Kadrouch-Outmany, 2014; Renaerts, 1986), the death prayer is described as the performance of four *takbīr* (uttering 'God is the Greatest'), where the third *takbīr* is followed by a prayer for the deceased and the fourth *takbīr* by *taslīm* performed on both the right and the left side. However, our findings show that the third *takbīr* is followed by a prayer for the deceased and the fourth *takbīr* followed by a prayer for all deceased Muslims. The prayer is ended by *taslīm* (greetings), often only on the right side.

Several studies (Assous, 2013; Bot, 1998; Dieste, 2012; Gardner, 1998; Jonker, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986; Van den Branden, 2006; Venhorst, 2013) corroborate our findings that death and dying rites are performed with the belief that the sins of the dying or deceased are purified while at the same time earning *ḥasanāt* (good marks). For example, Venhorst (2013) supports our finding that rituals such as the death prayer, are two sided: on the one hand rituals are directed to appease the deceased's soul, on the other hand they entail future salvation of the bereaved. In line with our findings, these rituals indicate or reflect the continuity of one's soul's existence. Venhorst (2013) and Kadrouch-Outmany (2014) confirm our findings that the rituals performed reflect a continued bond between the bereaved and the deceased, mediated by God (e.g. through prayers to God), but more importantly reflect a continued existence of the soul, as these are preparations for the next stadium of life (*barzakh*).

Studies on Muslims in the Netherlands (Dessing, 2001; Kadrouch-Outmany, 2014; Venhorst, 2013) confirm that rituals are influenced by the context in which they are embedded. They support our finding that Islamic rituals performed in a migration context are inevitably subject to change. Venhorst (2013) argues that there is always a degree of tension between what is prescribed and what people, in different contexts, perform. As in our results, the study of Dessing (2001) shows that a shift has been observed from dying at home (in the midst of the family) to dying in the hospital, which draws apart the dying person and the living. Consequently, several studies (Bot, 1998; Dessing, 2001; Gardner, 1998; Jonker, 1997) support our finding of a specialization of death, referring to the establishment of specialized washing rooms and growth of the number of specialized dead washers, which seems to be a typical development in migration situations. Although these

studies refer to this more specifically as a 'professionalization' of death rituals, we argue, however, that this term is not correct in this context. A professionalization indicates an existing professional structure of services (with paid employees or professionals), whereas this is not the case in Belgium (nor in the Netherlands). Washing the dead is often performed by specialized volunteers that are not paid, but see this task as a religious duty and a pious deed. However, this is mainly true for volunteers attached to mosques, as several funeral associations do give a small fee to corpse washers. These costs are often calculated in the repatriation insurances provided by funeral associations or banks. It is then up to the corpse washers whether they take the fee or donate it to the mosque. Jonker (1997) also found that in some Muslim communities in Germany dead washers are paid for their service, while other communities do not approve of this. It must be mentioned, however, that a professionalization of burial (e.g. professional burial undertakers; funeral associations) does exist. In addition, several studies (Bot, 1998; Dessing, 2001; Gardner, 1998; Jonker, 1997; Venhorst, 2013) observed, too, that washing and shrouding the deceased is withdrawn from the family sphere and is now commonly performed by specialists (volunteers attached to a mosque, funeral association). Bot (1998) and Gardner (1998) corroborate our findings that the specialization is a result of the lack of knowledge of the ritual purification among the family of the deceased.

Studies conducted in Western Europe (Dessing, 2001; Kadrouch-Outmany, 2014; Van den Branden, 2006; Venhorst, 2013) corroborate our findings that due to the migrant situation, the involvement in rituals is split up in both space and time. They explain that as a majority of (Moroccan) Muslims opt for repatriation, the number and location of performing the death prayer is adapted. The prayer is performed twice, both in the country of residence and in the country of origin, but also takes place in the mosque whereas in Morocco this traditionally takes place in the cemetery. Van den Branden (2006) explains that the performance of the death prayer in the mosque is due to the fact that a mosque has a much broader function than in Morocco, but also that in Belgian cemeteries no facilities exist such as a stone table upon which the body can be placed during prayer.

Our exploratory findings should be interpreted with several limitations in mind. First, data might be biased due to social desirability. As such, expressing opinions that might deviate from the norm or opinions that could be seen as contrary to Islamic teaching might be difficult to express. Although several measures were taken to guarantee anonymity (e.g. pseudonyms, deleting audio-tapes after transcribing), qualitative research cannot fully guarantee anonymity (e.g. face-to-face interviews). Both advantages and disadvantages are attached to the background of the interviewer. On the one hand, being a member of the same community facilitated the gaining of trust and resulted in a certain openness and detailed conversations, on the other hand this might also have influenced the answers of the participants by not providing 'deviated' answers out of fear of being judged.

Second, a possible bias is the mixed position of the expert between giving technical information and giving their own personal view on the matter. During coding, we have accurately taken this into account and made clear a distinction –where possible– between personal views and views of Moroccan Muslim women.

Third, the inclusion of the guiding committee might have also introduced a possible bias. The interviews conducted in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) had to be translated into Dutch and English, which might have influenced the data. As this was carried out to ensure validity and reliability so that the guiding committee could follow the coding and analyzing of the data, the first author sought to make accurate translations and verified their accuracy by relying on members of the Moroccan community when confronted with difficulties in the translation of a word or concept. To assure reliability and validity and limit bias as much as possible, several strategies were adopted (e.g. data checking with members of the Moroccan Muslim community; peer debriefing; memos).

Fourth, given the nature of our data (specific groups; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. For instance, it would still be interesting to do an in-depth investigation of Muslim patients who are personally confronted with terminal illness on their view on practices regarding death and dying. Further studies could explore whether the impact of religion on practices regarding death and dying differs among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

Conclusion

Our study reveals that religious beliefs and worldview have a great impact on the practices of Muslims at the end of life. Practices surrounding death and dying are strongly influenced by their theological and eschatological beliefs. We have observed that when dealing with death and dying, both first and second generation Muslims in Belgium adopt a theological and eschatological line of reasoning similar to the one that can be found in normative Islamic literature. The rituals are perceived as preparations for the hereafter, entailing purification of the soul and body. The rituals performed embody their teleological beliefs, stressing the continued existence of the soul. Religious beliefs seem to be an important framework through which Muslims understand health, illness, death and dying. Particularly, Muslims' teleological beliefs have a great impact on the way they view and act upon death and dying. Therefore, the organisation of adequate care for the dying is of the utmost importance. Providing quality end-of-life care entails meeting the cultural and religious needs of dying patients and their family members. By offering insights into the actual practices it aims to offer

tangible leads to professionals for a more tailor-made care for Muslim patients and their relatives. Availability of a Muslim chaplain at this difficult time will usually be of invaluable assistance to patients, families and healthcare professionals.

References

Abdesselem, M. (2012). Mawt. In P. Bearman, T. Bianquis, C. E. Bosworth, E. van Donzel, & W. P. Heinrichs (Eds.), *Encyclopaedia of Islam* (Second ed.), Leiden: Brill Online.

Aggoun, A. (2006). *Les Musulmans face à la mort en France* (Espace Ethique ed.): Vuibert.

al-Jazīrīʾ, A. (2009). *Islamic Jurisprudence According to the Four Sunni Schools Al Fiqh 'ala Al Madhahib Al Arba'ah*. In Vol. 1. *Modes of Islamic Worship*. Retrieved from https://archive.org/details/IslamicJurisprudenceAccordingToTheFourSunniSchoolsAlFiqhalaAlMadhahibAlArbaah (Accessed 15th March 2017).

Al-Sayyid, S. (1991). *Fiqh Us Sunnah*. In. Retrieved from http://mappingsharia.com/wp-content/uploads/2011/06/Saabiq-Fiqh-us-Sunnah.pdf (Accessed 15th March 2017).

Al-Shahri, M. (2016). Islamic theology and the principles of palliative care. *Palliative and Supportive Care, 14*(6), 635-640.

Al-Shahri, M., Fadul, N., & Elsayem, A. (2007). Death, dying and burial rites in Islam. *European Journal of Palliative Care, 13*(4), 164-167.

Assous, A. B. (2013). Cultural and Islamic Values in Relation with Death. *European Scientific Journal, 9*(5), 1857-1881.

Bakhtiar, L. (1996). *Encyclopedia of Islamic Law: A Compendium of the Major Schools* Chicago: ABC International Group.

Bianquis, T. (2012). Kafan. In P. Bearman, T. Bianquis, C. E. Bosworth, E. van Donzel, & W. P. Heinrichs (Eds.), *Encyclopaedia of Islam* (Second ed.).

Bloomer, M. J., & Al-Mutair, A. (2013). Ensuring cultural sensitivity for Muslim patients in the Australian ICU: Considerations for care. *Australian critical care : official journal of the Confederation of Australian Critical Care Nurses, 26*(4), 193-196.

Bot, M. (1998). *Een laatste groet : uitvaart- en rouwrituelen in multicultureel Nederland*. Rotterdam: Ef & Ef In Boeken.

Brockopp, J. E. (2004). *Islamic Ethics of Life. Abortion, War and Euthanasia*. Columbia: University of South Carolina Press.

Campo, J. E. (2006). Muslim Ways of Death: Between the Prescribed and the Performed. In K. Garces-Foley (Ed.), *Death and Religion in a Changing World*. New York - London: M.E. Sharpe.

Campo, J. E. (2017). Burial. In J. D. McAuliffe (Ed.), *Encyclopaedia of the Qurʾān*. Washington DC: Georgetown University.

Chittick, W. C. (1992). "Your Sight Today is Piercing": The Muslim Understanding of Death and Afterlife. In H. Obayashi (Ed.), *Death and Afterlife. Perspectives of World Religions* (pp. 125-139). Westport: Greenwood Press.

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory* (Fourth Edition ed.). California: SAGE Publications.

Dessing, N. M. (2001). *Rituals of birth, circumcision, marriage, and death among Muslims in the Netherlands*. Leuven: Peeters.

Dieste, J. L. M. (2012). *Health and Ritual in Morocco: Conceptions of the Body and Healing Practices*: Brill.

Gardner, K. (1998). Death, burial and bereavement amongst Bengali Muslims in Tower Hamlets, East London. *Journal of Ethnic and Migration Studies, 24*(3), 507-521.

Gatrad, A. R., & Sheikh, A. (2000). *Caring for Muslim Patients*. Oxford: Radcliffe Medical Press.

Gatrad, A. R., & Sheikh, A. (2002a). Palliative Care for Muslims and Issues After Death. *International Journal of Palliative Nursing, 8*(12), 594-597.

Gatrad, A. R., & Sheikh, A. (2002b). Palliative Care for Muslims and Issues Before Death *International Journal of Palliative Nursing, 8*(11), 526-531.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research* New York: Aldine Publishing Company.

Halevi, L. (2007). *Muhammad's grave: death rites and the making of Islamic society*. New York: Columbia University Press.

Harford, J. B., & Aljawi, D. M. (2013). The need for more and better palliative care for Muslim patients. *Palliative & Supportive* Care, *11*(1), 1-4.

Hedayat, K. M. (2006). When the spirit leaves: Childhood death, grieving, and bereavement in Islam. *Journal of Palliative Medicine, 9*(6), 1282-1291.

Hertogen, J. (2016). Marokkaanse-, Turkse- en islamachtergrond per gemeente. Retrieved from http://www.npdata.be/

Jonker, G. (1997). The many facets of Islam; death, dying and disposal between orthodox rule and historical convention. In C. M. Parkes, P. Laungani, & B. Young (Eds.), *Death and bereavement across cultures* (pp.147-165) . London-New York: Routledge.

Kadrouch-Outmany, K. (2014). *Islamic burials in the Netherlands and Belgium. Legal, religious and social aspects.* (Unpublished doctoral dissertation), Leiden University, Leiden.

Kramer, K. P. (1988). *The Sacred Art of Dying. How World Religions Understand Death.* New York: Paulist Press.

Lowry, J. E. (2017). Ritual Purity. In J. D. McAuliffe (Ed.), *Encyclopaedia of the Qurʾān*. Washington DC.: Georgetown University.

Rahman, F. (1998). *Health and medicine in the Islamic tradition*. Chicago: Kazi Publications.

Rassool, G. H. (2000). The Crescent and Islam: Healing, Nursing and the Spiritual dimension. Some Considerations Towards An Understanding of the Islamic Perspectives On Caring. *Journal of Advanced Nursing, 32*(6), 1476-1484.

Renaerts, M. (1986). *La mort, rites et valeurs dans l'Islam Maghrebin* Brussel: ULB. Institut de Sociologie.

Sachedina, A. (2009). *Islamic biomedical ethics: principles and application*. Oxford: Oxford University Press.

Sarhill, N., LeGrand, S., Islambouli, R., Davis, M. P., & Walsh, D. (2001). The terminally ill Muslim: death and dying from the Muslim perspective. *The American journal of hospice & palliative care, 18*(4), 251-255.

Schacht, J. (2012). Waṣīya. In M. T. Houtsma, T. W. Arnold, R. Basset, & R. Hartmann (Eds.), *Encyclopaedia of Islam* (First ed.), London: Brill online.

Schultz, M., Baddarni, K., & Bar-Sela, G. (2012). Reflections on Palliative Care from the Jewish and Islamic Tradition. *Evidence-Based Complementary and Alternative Medicine*. http://dx.doi.org/http://dx.doi.org/10.1155/2012/693092 (Accessed 15th October 2016).

Shaw, A. (2014). Rituals of Infant Death: Defining Life and Islamic Personhood. *Bioethics, 28*(2), 84-95.

Sheikh, A. (1998). Death and Dying - a Muslim Perspective *J R Soc Med, 91*, 138-140.

Sheikh, A., & Gatrad, A. R. (2000). *Caring for Muslim Patients.* Oxford: Radcliffe Medical Press.

Sheikh, A., & Gatrad, A. R. (2008). Death and Bereavement. An exploration and meditation. In A. G. Sheikh, A. R. (Ed.), *Caring for Muslim Patients* (2nd ed., pp. 103-113). Oxford: Radcliffe Publishing.

Smith, J. I., & Haddad, Y. Y. (2002). *The Islamic Understanding of Death and Resurrection*. Oxford: Oxford University Press.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks (Calif.): Sage.

Tayeb, M., Al-Zamel, E., Fareed, M., & Abouellail, H. (2010). A "good death": perspectives of Muslim patients and health care providers. *Annals of Saudi Medicine, 30*(3), 215-221.

Van den Branden, S. (2006). *Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen.* (Unpublished doctoral dissertation), Katholieke Universiteit Leuven, Leuven.

Venhorst, C. (2013). *Muslims Ritualising Death in the Netherlands. Death rites in a small town context*. Zurich: Litt.

Westermarck, E. (2013). *Ritual and Belief in Morocco: Vol. II (Routledge Revivals)*, Oxford: Routledge, 2013.

Yasien-Esmael, H., & Rubin, S. S. (2005). The meaning structures of Muslim bereavements in Israel: Religious traditions, mourning practices, and human experiences. *Death Studies, 29*(6), 495-518.

"*And when I die, bury me in the land of my ancestors*."

—Benamān

7. "God's Land is Vast". Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased

Introduction

In Islam, taking care of the dead is considered an important responsibility of the Muslim community (*farḍ kifāya*) (al-Jazīrīʾ, 2009; Dessing, 2001; Kadrouch-Outmany, 2014; Renaerts, 1986; Van den Branden, 2006; Venhorst, 2013). Islamic burial rituals have been described in detail in large corpora of *ḥadīth* and *fiqh* (cf. *kitāb al-janā'iz* or *bāb al-janā'iz*) (al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Bakhtiar, 1996; Halevi, 2007, 2013; Renaerts, 1986). Several studies argue that the choice of burial location might be influenced by familial, territorial and religious considerations (Attias-Donfut, Wolff, & Dutreuilh, 2005; Balkan, 2015; Kadrouch-Outmany, 2014). But what are the actual attitudes and practices of Moroccan Muslims regarding burial in a migrant context? Muslims in a migrant context are challenged in choosing a burial location and might be torn between either sharing ground with the ancestors or breaking bonds with the country of origin and remaining close to their children. Several studies (Aggoun, 2006; Ahaddour & Broeckaert, 2016; Ahaddour, Broeckaert & Van den Branden, 2017; Campo, 2006; Dessing, 2001; Halevi, 2007, 2013; Hunter, 2016; Kadrouch-Outmany, 2014; Venhorst, 2013) show that, although ritual prescriptions are uniform, death rituals performed in a migrant context might be subject to change due to the different social and legal context.

In Belgium, Muslim mass-migration began in the 1960s, with large-scale settlement of guest workers mainly from Morocco and Turkey. These communities have been living and aging and subsequent generations have been born and grown up in Belgium. In a few decades' time, Islam has become the second largest religion in Belgium and even the fastest growing religion in Europe (Pew Research Center, 2015; Shadid & van Koningsveld, 2008). In 2016, it was estimated that Muslims accounted for 7,2 % of the Belgian population. Nearly half of the Muslim population in Belgium is from Moroccan descent (Hertogen, 2016). Although the Muslim migrant population is still younger on average than the non-migrant population (Lodewijckx & Pelfrene, 2012), the question of funerary practices will gain importance because of the rapidly growing number of elderly Muslims. Though several public cemeteries in Belgium have Muslim plots in which graves are faced towards Mecca, no graves are guaranteed in perpetuity. Concessions are only granted for a maximum term of 50 years which can be renewed. Only in the region of Flanders, burial in shrouds is possible (Ahaddour & Broeckaert, 2016).

Until this day, however, few empirical studies exist on attitudes and practices of Muslims regarding burial and even less on the repatriation of the deceased. The study of death and burial in a migration context is a relatively recent development (Ansari, 2007; Attias-Donfut et al., 2005;

Balkan, 2015; Chaïb, 2000; Dessing, 2001; Gardner, 1998, 2002; Jonker, 1996, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986; Venhorst, 2013). Most of these studies have been done from an anthropological perspective and focus mainly on theories on identity and belonging. A descriptive and comprehensive account of (Moroccan) Muslim's attitudes and practices surrounding burial in a European setting, and more specifically in the Belgian context, is lacking to a great extent. In this study, we seek to identify how burial takes shape among Moroccan Muslims in the particular context of migration to Belgium and focus more specifically on the preference of burial location. We are also particularly interested whether rituals survived or have been adapted to the European and Belgian setting.

The aim of this article is fourfold. First, we seek to elicit the attitudes and practices of middle-aged and elderly Moroccan Muslim women towards burial and repatriation of the deceased. Second, we seek to compare middle-aged and elderly women's attitudes and practices. In contrast to the first generation elderly Moroccan Muslim women, who in Belgium are mainly uneducated and illiterate, the group of middle-aged women shows much more socio-economic diversity. Moreover, they have not been raised in a homogenous, rural, traditional Islamic environment and live less isolated from the broader Belgian society than the previous generation. Our main point of focus is whether a shift towards a more secular approach may be observed in their views, practices and choices when compared to those of the first generation elderly Moroccan Muslim women. Third, we aim to explore the role of religion in their attitudes and practices. Fourth, we seek to document how the actual attitudes of our participants relate to normative Islamic literature.

Normative Islamic literature: Islamic Burial Prescriptions

Burial rituals have been extensively dealt with by Muslim jurists, since the *Qur'ān* does not mention explicit rulings on burial (Aggoun, 2006; Bakhtiar, 1996; Campo, 2006, 2012; Halevi, 2007; Renaerts, 1986). In *fiqh* manuals, burial rituals (*janā'iz*) have been described in detail by Muslim jurists (Campo 2006, 2012). However, small variations can be found between Islamic denominations and legal schools (*madhāhib*)(al-Jazīrīʾ, 2009; Al-Sayyid, 1991). In this article, we focus only on *Sunnī*-perspectives on burial.

When a Muslim dies, several obligations have to be met by the Muslim community. In fact, Islam has retained some ancient practices such as washing and shrouding the deceased and interment (Abdesselem, 2012; Halevi, 2007). The ritual of washing the corpse (*ghusl al-mayyit*), shrouding the corpse (*takfīn al-mayyit*), the performance of the death prayer (*ṣalāt al-janāza*) and burial *(dafn al-mayyit)* are considered the deceased's rights or ways of honouring the deceased (ʾ*ikram al-mayyit*) and are a shared responsibility of the Muslim community (*farḍ kifāya)*(Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Al-Shahri, 2016; Gatrad & Sheikh, 2002; Halevi, 2013; Harford & Aljawi,

2013; Hedayat, 2006; Renaerts, 1986; Van den Branden, 2006). In this article, we will only focus on the internment and on preferences of burial location. Rites of washing and shrouding the corpse and the death prayer have been discussed extensively in a separate article (Ahaddour et al.2017).

Fiqh schools have divergent views with regard to the attendance of women at a burial. In general, women are discouraged (*makruh*) from participating in the burial, because they are considered to be too emotional. A second reason is to avoid lamentation, customary in the *jāhiliyya* (pre-Islamic period), from the belief that it tortures the deceased's soul (Al-Sayyid, 1991; Al-Shahri, Fadul, & Elsayem, 2007; Bakhtiar, 1996; Campo, 2006; Halevi, 2007, 2013; Morgan, 2002; Tritton, 2012; Yasien-Esmael & Rubin, 2005). All legal schools, except for the *Mālikī* school, disapprove of women's participation at a burial and even consider it forbidden if their attendance might cause temptation. The *Ḥanafī* school entirely forbids the presence of women at a burial. For *Mālikī* legal jurists, there is no objection for old women to participate, but also young women can attend if they are covered and if their presence will not lead to temptation (al-Jazīrīʾ, 2009; Al-Sayyid, 1991).

Inhumation is considered obligatory based on the *Qurʾān* (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991). This obligation stems from the belief in the afterlife and in God's sovereignty over life and body. Campo (2006, 2017) explains that in Islam, God urges burial in anticipation of the resurrection when Muslims will come forth from their graves for Judgement day. Islamic law strictly prohibits alternative ways of corpse-disposal such as cremation, as the body is perceived as God's creation and trust (*ʾamāna*) and therefore dignified (*karāma*) and holy (*ḥurma*) (Aggoun, 2006; Al-Shahri et al., 2007; Dessing, 2001; Halevi, 2007, 2013; Jonker, 1996; Lapidus, 1996).

In Islamic tradition burial is encouraged to take place as soon as possible in order to hasten the transition to the afterlife and the return to God (Aggoun, 2006; Al-Shahri, 2016; Al-Shahri et al., 2007; Harford & Aljawi, 2013; Sheikh & Gatrad, 2000). According to Halevi (2007), Muslim jurists explain this imperative to hasten the burial by conjuring the effect of a hot Middle-eastern climate on a rapidly putrefying body, but this explanation finds little support in Islamic tradition. The common belief is that this hurried process was advocated by the prophet to distinguish the practice of Muslims from that of the Jews (Halevi, 2007). Another explanation is that as long as the deceased is not buried, he/she will not find peace (Halevi, 2007; Renaerts, 1986; Smith & Haddad, 2002). If a person dies in the morning, he/she should be buried by afternoon. It is preferred that the body is buried within two intervals of prayer (Aggoun, 2006; Morgan, 2002; Renaerts, 1986). Al-Sayyid (1991) argues that most scholars consider the burial of the dead at night permissible, if the other rights of the deceased (death rituals: washing and shrouding the corpse, death prayer and burial) are not neglected. Legal schools state that it is undesirable to transfer the deceased from the place where he/she died to another place, unless it is necessary to guarantee a respectful treatment of the body, as it delays a speedy burial. A second reason is that transportation of the deceased was not common in

the time of the prophet and therefore not preferable (al-Jazīrīʾ, 2009; Al-Sayyid, 1991).

A deceased Muslim should be buried in a Muslim cemetery (Al-Sayyid, 1991; Al-Shahri et al., 2007). According to Aggoun (2006), this reflects and affirms solidarity and unity within the Muslim community. Legal schools state that it is prohibited to be buried alongside non-Muslims, i.e. because of the punishment to which the latter are subject in their graves. If Muslims were to be buried next to them they would be harmed and disturbed by their proximity to this punishment (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). However, a Muslim is allowed to be buried in a non-Muslim country, though only in a separate section of the cemetery (Philips, 2005).

In Islam, the public occasion of carrying a coffin and accompanying it to the cemetery is recommended. The procession of the body on an open bier usually starts from the deceased's house. Only men are recommended as participants in the procession and bearers of the coffin; each person takes his turn to carry the deceased at a fast pace to his/her grave (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Campo, 2006; Dieste, 2012; Halevi, 2013; Renaerts, 1986; Tritton, 2012). This ritual is considered a meritorious and recommended act as it would remind the living person of the hereafter (Aggoun, 2006; Al-Sayyid, 1991; Halevi, 2013). The legal schools consider it disrespectful for those in funeral processions to recite in a loud voice, raise their voice, carry blazing torches, sit down before those carrying the coffin, put the coffin down or remain seated when a funeral procession passes by (Aggoun, 2006; al-Jazīrīʾ, 2009; Campo, 2006; Dieste, 2012; Renaerts, 1986).

The Islamic *fiqh* prescribes that a deceased should be buried in shrouds (*kafan*) without a coffin (Aggoun, 2006; al-Jazīrīʾ, 2009; Sheikh & Gatrad, 2000). This stems from the belief that the body belongs to the earth and returns to the earth (Sheikh & Gatrad, 2000). According to Morgan (2002), the body is buried without a coffin in order to speed up decomposition. However, Islamic scholars seem to agree that there is no objection to burial in a coffin if necessity might occur due to an obligation by the authorities of the country or due to the instability of the soil which might result in a cave-in. Otherwise, burial in coffin is discouraged (*makruh*) (al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Campo, 2006). Nevertheless, the *Ḥanbalī* school forms an exception and conceives burial in a coffin as undesirable under any and all circumstances (al-Jazīrīʾ, 2009).

Two different types of grave constructions are known and accepted in Islamic tradition: a *lahd* construction, which consists of a niche dug at a side of the grave into which the body is placed, and a *shaqq*-construction, which consists of a deep vertical grave in which a trench is dug in the middle (*shaqq*) (Al-Sayyid, 1991; Tritton, 2012). Graves have to be deep enough to prevent them from being ravaged by animals or omitting noxious odors (Campo, 2006). A *lahd* is preferred, but only used when the ground is stable enough (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). In both constructions, Islamic *fiqh* prescribes that the body should be placed in the grave –in preference by

a pious relative– on its right side with the face turned towards Mecca, after which the grave cloths are loosened (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Al-Shahri et al., 2007; Campo, 2006; Halevi, 2013; Sheikh & Gatrad, 2000; Tritton, 2012). Thereafter, a flat brick or stone is placed over the body so that earth does not fall directly on the body or to prevent the body from coming into direct contact with the soil (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Campo, 2006; Dessing, 2001). Muslim jurists argue that it is disliked if more than one body is buried in a grave, unless there is a large number of corpses, there is a scarcity of graves and it is impossible to bury them separately (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). After placing the deceased in the grave, it is viewed desirable by Muslim scholars to throw three handfuls of earth into the grave into the direction of the deceased's head (al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Campo, 2006; Sheikh & Gatrad, 2000). According to *Mālikī*, *Ḥanbalī and Ḥanafī* legal school it is recommended that the dirt on top of the grave is shaped like a camel's hump. The *Shāfiʿīʾ* school, however, asserts that it is preferable to make the soil level evenly distributed (al-Jazīrīʾ, 2009; Al-Sayyid, 1991).

Islamic legal jurists differ concerning the legality of reciting the *Qurʾān* by the graveside or prompting the adult deceased with the correct answers to questions on faith matters asked by angels Munkar and Nakīr. The *Shāfiʿīʾ* school considers it desirable, because by doing this the deceased might be blessed, whereas the *Mālikī* and *Ḥanafī* school view this as undesirable, because the *Sunna* does not mention this practice (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). Though several scholars note the desirability of performing supplications (*duʿāʾ*) by asking God to forgive the deceased and show mercy or to make him/her steady (*thabbit*) when questioned by Munkar and Nakīr (Al-Sayyid, 1991).

With regard to grave decoration, Islamic *fiqh* only allows to place a mark, a stone or piece of wood over a grave for identification. This is done to make it easier for those who visit graves to pray for the deceased (al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Campo, 2006). Several scholars (Aggoun, 2006; Al-Shahri et al., 2007; Renaerts, 1986; Yasien-Esmael & Rubin, 2005) state that the Islamic requirements are simple, based on humility and meant to be low of cost so as not to burden the bereaved family. This is reflected in a simple shroud and a simple grave. Muslim jurists condemn tombstones being inscribed with *Qur'ānic* verses and discourage the writing of the deceased's name, except for *Ḥanbalī* school, which prohibits it entirely (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). Placing the *Qurʾān* and flowers on the graves is also considered forbidden (*ḥarām)* by Muslim jurists (al-Jazīrīʾ, 2009; Al-Sayyid, 1991).

Based on the eschatological beliefs and more specifically the idea of bodily resurrection, the Islamic tradition prescribes that the body should be left undisturbed perpetually after burial (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Bakhtiar, 1996; Halevi, 2007; Smith & Haddad, 2002). However, among Islamic scholars, various opinions exist about the question of legality of clearing out graves. Muslim scholars agree that a place where a Muslim is buried should not be disturbed if

flesh, bones or other parts of the body remain there. But if the entire corpse has disintegrated into dust, then the majority of scholars states that digging up a grave is prohibited unless there is a genuine reason to do so, for example to use the land for agriculture, for building or for other useful ends (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). However, the *Mālikī* legal school limits the use only for burial of other bodies (al-Jazīrīʾ, 2009).

Against the background of how burial should be dealt with according to (*Sunnī*) Islam, it is interesting to find out what the actual views and practices are of Moroccan Muslims in West-Europe. How do burial choices and practices among Moroccan Muslims take shape in the context of migration? Are younger generations more influenced by the secular Western society that they have been raised in? Is there a gap between the actual practices of Moroccan Muslims in Belgium and the normative Islamic burial prescriptions? To answer these questions we opted for a qualitative empirical methodology using mainly interviews and also participant observation.

Empirical Study

Methods

Design

Between October 2014 and September 2015, thirty semi-structured interviews were conducted with a sampling of middle-aged and elderly women in the Moroccan community in Antwerp (Belgium) who self-identify as Muslim. This study was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. Because of the cultural characteristics of the research population – more specifically the common gender segregation in traditional Muslim societies, in particular among first and second generation Moroccan Muslim communities (Timmerman, 2001) – and the female gender of the interviewer, purposive sampling for qualitative interviewing was limited to Moroccan Muslim women. We have chosen Antwerp for two important reasons. First, this city has the largest Muslim population in Flanders: 19,2 % of Antwerp's population is Muslim (Hertogen, 2016). Second, Antwerp as a port city is considered to be among the most multicultural cities in the world.

Different routes of recruitment (e.g. mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured topic list covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. For the present study, participants were interrogated more specifically about their views on burial; experience of a burial; choice of burial location; views on repatriation and experience of repatriation. The interviewer (first author)

conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) and Dutch. The interviews were conducted in the language chosen by the participant. With elderly participants, mainly *tarifit* (a Berber language) or *dārija* (Moroccan Arabic language) was spoken, whereas with middle-aged participants mainly Dutch was spoken with occasional interruptions in *dārija* or *tarifit*. As the interviewer masters these languages, there was no need for the involvement of an interpreter. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organization or in a quiet tea house).

To help us with the interpretation of our data, the interviewer (first author) also interviewed 15 experts in the field about particular topics of our study between September 2014 and September 2015. More specifically, we interrogated experts to find out more about the way Moroccan Muslim women view and deal with burial. However, the views of Moroccan Muslim women form the main focus of this study, and not the personal views of the experts in the field. The included experts in the field were identified by the interviewer and guiding committee and were based on the technical knowledge the experts have regarding our research topics. For the present study, we have interrogated a.o. Muslim undertakers, imams, a specialized corpse washer, Muslim physicians, a palliative care consultant as they had specific knowledge on the topic dealt with and were familiar with the Moroccan Muslim community in Antwerp. This method was, firstly, helpful as it provided rich background information that could be added to the data of our interviews with women. Secondly, it helped us to be more sensitive towards the data of our interviews with Moroccan Muslim women. Thirdly, the data of the interviews with experts were used as a comparative method to limit biases and to ascertain the reliability and validity of the findings of the interviews with Moroccan Muslim women.

Apart from interviewing, the first author also conducted participant observations between December 2014 and April 2017. Several visits of the sick, a *ḥijāma*-consultation, death prayers, ritual washings of the dead body, repatriation of a deceased, burial, mourning gatherings were attended and several Islamic cemetery plots were visited. The fact that she is a member of the Moroccan Muslim community in Belgium enabled the first author to gain information and access into difficultly accessible settings (Mortelmans, 2008). The participant observations conducted for the present study contains all stages between dying, death and mourning. More specifically, a number of death prayers, ritual washings of the dead body and mourning gatherings were attended by the first author as well as the repatriation of a dead body – from Belgium (Brussels) to Morocco (Trougout in Temsamane). She also attended a burial in Trougout and visited Muslim plots in Belgium (Antwerp and Ghent) and a cemetery in Morocco (Trougout). Field notes were taken of the activities observed and participated, capturing key verbal and nonverbal communication as well as analytical and reflexive notes. To assure reliability and validity and limit bias as much as possible, several strategies were adopted (e.g., data checking with members of the Moroccan Muslim community, peer debriefing,

and memos).

The present study is part of a larger research investigating the attitudes, beliefs and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp). In this research, themes such as care for the elderly; health, illness and medicine; end-of-life issues (e.g. active termination of life, palliative treatment and symptom control, withdrawing and withholding treatment); death, dying and the afterlife; mourning and remembrance were also addressed. The research itself is part of a research programme on religion and death and dying started in 2011.

In this study, we opted for a non-normative, descriptive, exploratory approach. This study was approved by the Social and Societal Ethics Committee (KU Leuven, Belgium). In order to guarantee the anonymity of our participants, we made use of pseudonyms.

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology (Corbin & Strauss, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used to code and analyse the interview data. By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants. In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. Findings of the interviews with Muslim women were compared with those of the interviews with experts and subsequently compared with normative and empirical studies (cf. discussion). The guiding committee guided and reviewed all phases of the project from interview guide and research question development, to data collection, data analysis and dissemination. Double coding was also performed by which interviews were coded independently by the interviewer and a member of the guiding committee and subsequently compared with each other. Our research findings were also regularly discussed with several members of the Moroccan Muslim community.

Results

Participants' (socio-)demographic information & health situation

Our group of middle-aged Moroccan Muslim women (n=15) was between 41 and 55 years old; our group of elderly women (n=15) was aged between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labor migration, family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of between three and five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber participants spoke Arabic and only two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes. Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

The health issues of our middle-aged participants were limited to knee problems and migraine. Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a bad health condition. Nine participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer and severe chronic disease.

Among our participants, only four women have ever attended a burial. Two middle-aged participants and one elderly participant have personally experienced a burial of a fetus/child in a Muslim plot in Belgium, and one middle-aged participant in Morocco.

Attitudes and Practices regarding Burial and Repatriation

Burial: Views and Rituals

All participants emphasize the importance of religious death rituals including washing the dead (*ghusl al-mayyit*), shrouding the corpse (*takfīn al-mayyit*), death prayer (*ṣalāt al-janāza*) and burial (*dafn al-mayyit).* These rituals are explained as the rights of a dead person that must be respected and taken care of by the Muslim community (*farḍ kifāya*). Burial is perceived as a dignified and respectful way of dealing with and honouring the dead body (*ikram al-mayyit dafnuh*) and giving back God's trust (*ʾamāna*), for man is only the vice-regent, not the owner of his body.

> "There's always someone who washes the deceased (*ghusl al-miyyit*).[…] They pray for the deceased in our religion. They do a *janāza* (death prayer), *kafan* (shroud) the deceased and bury him/her. They do what needs to be done. Those are things that are mandatory for us, we must stick to it. It's our duty to the deceased.[…] That's how it is in our religion." Haddad – elderly

> "They wash and shroud (*kafan)* the deceased. They pray for him/her and bring them to Morocco where he/she will be buried. God commanded that His *ʾamāna* must be dealt with like that." Alia – elderly

The overwhelming majority of our participants immediately states that participating in a burial ceremony and even visiting the graves is discouraged (*makruh*) or even forbidden (*harām*) for women, predominantly due to emotional reasons. Attending a burial is a male affair. Women are often too emotional by wailing, crying and complaining. Therefore, they are not encouraged to attend. Some participants perceive this non-obligation for women as a mercy of God to protect women's feelings. Others explain this with the idea that women are expected to stay at home and receive visitors who come to condole, as mourning visits often start when the news goes around that the person has passed away. However, one-sixth of the participants mention that women are allowed to visit the grave, though only after the burial (e.g. next day, third day or seventh day). Noteworthy, due to the non-participation of our participants in burial, they were not able to explain or elaborate on burial practices. This is also confirmed by our experts.

> "We don't mix with men. That's a task for the men, so they have to do it. That's good, because we women, we can't bury someone. That's not our task, we also can't do it. And *al-ḥamdulillāh* (all praise to God) because we are not strong enough to do that. It's painful to see someone being buried." Sabiha – middle-aged

> "No, not really. Women don't go to the funeral, only men. We stay at home and make dinner for when the men return from the funeral. Women receive mourning visits. God determined this as a protection for women. Women are very emotional." Haddad - elderly

> "Only during the burial itself, they ask to not have women present at the funeral, only because of the screaming and crying. You can feel sad and have tears, but you also have people who scream a lot and pull their clothes, get hysterical, and that's actually the reason why they made it forbidden for women to be present at funerals. And that is because a woman is very emotional, but other than this she can visit cemeteries." Rachid - Muslim undertaker

Only three participants mention to have attended the burial of a fetus or child on a Muslim plot in Belgium and one participant in Morocco from a distance. Based upon the participant observation, we viewed that indeed women do not generally attend the burial; nevertheless, we

observed that young women were present on the burial site –though still from a distance– to pay respect to their dead loved ones until the last moment.

> "They say that women need to stay at a distance, probably because they cry. But we didn't get too close to the grave. Men are stronger in that respect and that's why they get to be closer. And we just stay at the back while the men were burying the deceased up front." Narima – middle-aged

> "We were not allowed to be up front at the grave, with my daughter. Well, we are not allowed anyway. But I still remember that my mother-in-law went to my father-in-law and told him, 'let her go with her, don't do this to her'. And I went with her in the ambulance till we were at the entrance. I went inside and they were burying her. When they were burying her, I just went to the grave. I needed this." Halima – middle-aged

Nearly half of our participants explicitly mention the importance of a speedy burial, for which a teleological explanation is provided. Indeed, as long as the deceased is not buried, he/she does not find peace, nor does the bereaved family. They state that a deceased Muslim should preferably be buried within a day after death. However, this is often not the case, as the overwhelming majority of Muslims opts to be repatriated to the country of origin. This is also shared by our experts.

> "Yes, most of the time they get washed and shrouded (*kafan*) and after that they get buried as soon as possible." Hannan – middle-aged

> "If he died by *dohr* (noon prayer), then he needs to be buried by *'asr* (afternoon prayer). They need to bury him as soon as possible. Do you understand? If he dies in the evening, he will be buried the morning after because burying in the evening is impossible." Charifa – elderly

> "Here we say *ikram-al-miyyit*. A good thing to do for a deceased, is to bury him as soon as possible." Zakaria – Muslim undertaker

A small minority of our participants mentions the ritual of a funeral procession from the house of the deceased's family or from the mosque to the cemetery. Here again, participants express that only men follow the funeral procession and that women are not allowed due to the assumed heavy expression of grief such as wailing, crying and complaining. Nevertheless, participants mention that this public ritual is not practised in Belgium. During our participant observation in Morocco (Trougout) we viewed that all men try to take turns in carrying the deceased in a fast pace while silently uttering the Islamic creed (*shahāda*). Often a green carpet decorated with the Islamic creed is placed on the body. Interestingly, two participants also mention the ancient tradition of placing a scarf on the deceased male body when his widow is pregnant.

> "I remember when my grandfather died, my grandmother was pregnant of my mother. And in that time, it's not as if they told everyone that they were pregnant. She was pregnant and she knew that.[…] They put my grandfather on a wooden bier and laid a green cloth of *lā ilāha illallāh* on it. She had to throw a headscarf on it as well so that people wouldn't think that she got pregnant by someone else. And that's how people knew that she was pregnant. It's a sign of 'I am pregnant'. I know it was a ritual in the past, but I don't know if they still do that now." Hannan – middle-aged

> "Women can't participate in the procession, otherwise they would cry and complain and that's not allowed. In

> Morocco they go with the deceased from the house to the grave. They don't take the shortest, but the longest way to remind people of death. That doesn't happen here in Belgium, but this ritual exists in Morocco." Nihad – middle-aged

The procession is followed by placing the deceased in a grave towards Mecca which has been dug according to the deceased's length. We observed that graves in Belgium and Morocco are mainly *shaqq*-constructions. In Morocco, a clear difference can be observed among graves of those who were buried with or without a coffin. The first graves were wider and higher than other graves. These were mainly graves of people who have been repatriated in a coffin to their country of origin. Each grave is marked by two stones: one at the head and the other at the feet. Men's gravestones are placed in a parallel way and those of women vertical to the grave. Branches are put on the graves for forty days to keep animals away. The burial is often followed by reciting the *Qur'ān,* including *sūrat al-mulk* (Q:67) *sūrat yāsīn* (Q:36), *sūrat al-Ichlāṣ* (Q:114), and by making supplications (*duʿāʾ*). In this respect, one participant mentions that the nearest relative of the deceased stays after burial and utters supplications as the deceased is being questioned by Munkar and Nakīr, because of which both the deceased and the living person earn *ḥasanāt/ajar* (good marks). Only two participants explicitly mention the wish of having a gravestone with their names written on it to facilitate the remembrance for their visiting family.

> "The deceased is buried towards Mecca. They make a pit depending on the length. They say, if you have pious children *(durriya sāliḥa),* that if you have a son, or husband, or just someone who loves you, that if they bury you, that person has to be there near your head and make a *duʿāʾ*.[…] And then there's Munkar and Nakīr and then the interrogation. And you need someone, someone who loves you to make *duʿāʾ*[…] It's in a *ḥadīth*: the one who loves you, has to make *duʿāʾ*.[…] He receives *al-ajar* (rewards) and at the same time he helps the deceased." Kaltoum – middle-aged

> "If they bury them and you stay at home, you should turn to Mecca and recite *sūrat al-mulk* because the deceased will be questioned in the grave, at that moment. So it is important to make *du'ā*." Huda – elderly

> "One of the mandatory things is burying the deceased towards Mecca because we still believe in *yawm al- qiyāma* as you will be resurrected from within that direction." Rachid – Muslim undertaker

Choice of Burial Location

- Country of Origin

When participants are asked where they would like to be buried, the overwhelming majority gives preference to the country of origin. However, several participants strongly highlight that God's land is vast *('ard Allāh wāsiʿa')*. They explain that God has created the earth and therefore all ground is the same. They express the belief that the deceased should be buried where God takes away the soul. In this respect, a few middle-aged participants state that it actually does not matter where you are buried, given the fact that it is the situation of the soul in the afterlife that counts.

> "Whether you're here or in Morocco, it does not matter because it's your soul that leaves." Lamya – middle-aged

> "You should be buried where you die. It's all God's land." Huda – elderly

Our participants' wish to be buried in Morocco is based on several arguments. The first and foremost reason given is of a socio-emotional nature. The overwhelming majority of our participants cherishes the wish to be buried next to their deceased loved ones and also refers to the presence of their living family in the country of origin. They also choose burial in the country of origin because it is their country of birth or the country of their ancestors. Returning to their roots and being buried among those with whom they share the same culture, religion and nation was frequently mentioned, though less so by our middle-aged participants. All participants mention that their deceased loved ones were repatriated and buried in Morocco. Only two middle-aged participants mention to have buried their fetus/sibling in a Muslim plot in Belgium. This is also shared by our experts.

> "I want to be buried in Morocco. In my country of birth, next to my ancestors and next to my family. It's because of the presence of my [deceased] family. I will feel peace. I won't feel alone. You understand? And it's also my country of birth. This is my country." Sabiha – middle-aged

> Yes, in my country, in Morocco. That's my country and everyone wants to be buried there. I have my family there, my parents, my grandparents, my ancestors.[…] God is everywhere, but I would like to be buried with my family." Malika – elderly

> "The majority chooses to be buried in Morocco, because they say that 'it's the land of my ancestors. It's the land close to my father, mother and sisters, so close to my family, which is not here'." Fadila – Expert in psychosocial services

Second, the majority of our participants also provide religious reasons for their preference of being buried in Morocco. The most important reason given is that in Morocco Islamic burial prescriptions are taken into account and more specifically an eternal resting place is assured, in contrast with Belgium. Indeed, they mention that after a period of time Belgian burial grounds are emptied, which they consider un-Islamic and disrespectful. Apart from this, they also offer an eschatological explanation. Some participants explicitly refer to the bodily resurrection and therefore believe that a body should remain in the grave until Judgment Day. This is also confirmed by our experts.

> "I prefer in my own country. That's my wish. You know why? Because they leave us in the ground. And I'll find my peace there, close to family. You have your parents. That's different than here." Kaltoum – middle-aged

> "No, I don't want that. I don't want to be buried between non-Muslims. Also because I heard that you won't be buried in the ground forever. And that's an issue of course, for us Muslims. We are expected to stay in the grave until *yawm al-qiyāma*." Yamina – elderly

> "Yes, they all choose Morocco purely for the sake of perpetuity in the grave. So there was never a discussion about this." Rachid - Muslim undertaker

Another religious argument is the preference and importance given to being buried in

Morocco because it is an Islamic country. In this respect, they refer to a religious environment in which they are buried next to a mosque, in an Islamic cemetery and between Muslims. From a teleological perspective, several participants mention that a deceased Muslim would hear the Islamic prayer (*adhān*). These cemeteries are often visited by people who utter supplication for all deceased Muslims and therefore will offer more peace. Several participants associate being buried next to an unbeliever with hearing and even feeling the torture of the grave (*ʿadhāb al-qabr*) of their neighbour.

> "I want to be next to my deceased brothers, next to Muslims. You hear the *adhān*. But also they say that unbelievers will suffer and we would hear that and we would not be able to sleep. We want peace. We don't want to suffer. I don't want to feel it." Radia – middle-aged

> "Everyone wishes to be buried in a Muslim ground. They say that's it's good to be buried next to Muslims, but being buried in this country is not. There's no place for Muslims to be buried here. It's not a Muslim country. The land is God's, but its people are not Muslims. That's why we want to be buried with our Muslims and not with non-Muslims." Laziza – elderly

The third reason is of a financial nature. One-third of our participants mention that as they have been paying annually for a repatriation insurance and thus have been investing in a burial in Morocco, their choice for burial in Morocco is a logical one. A few participants also point out that a burial in Morocco is much cheaper, as no costs are charged for the grave and thus a burial is practically for free, compared to Belgium where concessions have to be paid. The latter was perceived as a burden for the family. This is also shared by our experts.

> "No, if you're buried in Morocco, you're buried. Here you have to pay concessions. Just imagine that your kids don't pay, you'll be surprised after five years. Who says that your son or daughter will pay? That's not right. That's why I choose Morocco.[…] If they remove concessions in Belgium[…] Most of them would choose to be buried here." Loubna – middle-aged

> "This country is different. If you don't pay for the grave, they will clear out the grave and burn you. Do you understand? They take out your bones and burn you. You have to pay for this, so why would you burden your children with this every time? Why would you let your family pay for your grave? In our country you are buried and that's it. You don't have to worry anymore." Alia – elderly

> "Burial in Morocco is more beneficial, you know why? Because the graves are for eternity and free in the home country. You only pay a tax in the beginning, but not here.[…] Here in Antwerp, a concession costs € 500 every 20 years. And every 20 years you need to follow that up and Moroccan people find it an obstacle at a financial level." Zakaria – Muslim undertaker

- Uncertainties

Although nearly all participants have a strong preference regarding burial location, the attitude of one-fifth of our participants is marked by incertitude or dilemma. A few participants mention not to have a clear answer or preference and therefore leave this decision up to God's will (*qadr/maktab*) and/or to their children.

> "My children can choose where to bury me.[…] Yes, if my children want me to be buried here, then that's fine

> even if I would prefer Morocco." Fawzia – middle-aged

> "If it's meant to be. I'm talking about fate. If it's meant to be here, it will be here. It's not in the hands of the person who dies. That's it, he/she will be gone. It will be the responsibility of the living people and they can do whatever they want. My children may decide." Nuria – elderly

One middle-aged participant, Sarah, was not able to respond as she has not been thinking yet about where she would like to be buried; at the same time she acknowledges that all land is from God. Khadija, an elderly participant, experiences difficulties in giving a response as she is struggling to cope with her parents' and husband' loss.

> "I really don't know. I never really thought much about it to be honest. If I say here [Belgium], it will be God's land and there [Morocco] is also God's land so I don't know. I have that insurance for more than 10 years now. We did it automatically and I'm also registered at the consulate. You live your life and you don't ask questions like 'what will happen when I die?'. So that question remains open." Sarah – middle-aged

> "I never really thought about it. My children wanted their father to be buried here, when they were younger. But their father didn't want that, he wanted to be buried in Morocco.[…] I never really thought much about it. I don't really think about it. I don't feel good to think about it either. It's hard. If I think about it, I'll cry." Khadija – elderly

Ikram, a middle-aged participant, has no clear idea of where she would like to be buried, but at the same time she shows a certain openness towards burial in Belgium, taking into account that graves are cleared out after a period of time. From an eschatological perspective, she explicitly articulates that the physical body is of little importance, as in time the body completely dissolves, but that the soul is central. Nevertheless, she still questions the corporeality of the afterlife, whether a deceased is able to feel pain.

> "I think I would like to be buried close to my family.[…]Yes, if my family is in Morocco, but for me it has nothing to do with the land. I think every land is God's. I don't want to be buried here because they take you out after so many years. It doesn't matter for me if you can't feel anything. Because those are just your bones. Your soul will be out of your body I think and you'll be in another stage of life. So who cares where I will be buried? Yes, yes, because they would take you out after so many years, but I'm thinking like 'yes, but it's just bones. That they'll just put the bones somewhere else'. Well, I don't know. It depends. If you feel something when they take you out, if your body is still connected to your soul and you feel the pain because of that. Otherwise if there's nothing then it doesn't matter." Ikram – middle-aged

Interestingly, Badria, a middle-aged participant, also mentions that she experiences difficulties in choosing a burial location within the country of origin itself. She explains that there often is a tension and expectation that a wife should be buried next to her husband, instead of her hometown. She prefers to be buried next to her family in her hometown.

> "But the problem is that, uhm, now I say that 'I want to be buried in Morocco', but I got married to al-Khmissath[…], it's somewhere in Rabat. That's my family-in-law and there are always discussions like 'look,

> you need to be buried where your husband is buried'. And I actually don't want that, I want to be buried in my hometown, next to my parents." Badria – middle-aged

Nihad, also a middle-aged participant, expresses her preference to be buried in Belgium due to her interracial marriage. As such, she cherishes the wish to be buried next to her Belgian husband, but also because she wishes to stay close to her children and to facilitate remembrance and visiting the graves.

> "I choose Belgium, because my husband is not a Moroccan [laughs], and he can't be buried in Morocco. I would like to be buried with him. He doesn't feel connected to Morocco. I wouldn't do it. We live here in Belgium, and with the kids. I think it's easier for them to visit here whereas in Morocco this is not the case." Nihad – middle-aged

- Burial in Belgium: An Option?

As aforementioned, the overwhelming majority opts for burial in the country of (ancestral) origin and only a few would consider burial in Belgium taking into account the existing burial facilities and regulations. But is the choice for repatriation to the country of origin really a free choice? Interestingly, one-third of our participants mention they would consider and even prefer burial in Belgium if an eternal resting place would be assured and this for several reasons. First, again, participants strongly argue that God's land is vast (*'ard Allāh wāsi'a'),* but also that the Islamic tradition prescribes that the deceased should be buried where he/she has passed away. They explain that a burial in Belgium would entail a speedier burial, as recommended by the Islamic tradition. This is also shared by our experts.

> "But if you think *'ard Allāh wāsi'a'*. All land is from God, then everywhere. The entire world is from God and if there's a place for Muslims to be buried without graves being cleared out, then why not? Why should we then go to Morocco?" Narima – middle-aged

> "The only reason I choose Morocco is because our grave will be emptied here and our bones will be thrown away. That's the only reason. Otherwise it would be more logical here. If graves would be here for eternity, then yes. Because from an Islamic point of view, you need to be buried where you died. So we would have a speedy burial. So that's why I would prefer burial in Belgium. But if they put you in a container, no I wouldn't want that." Halima – middle-aged

> "They say [Moroccan Muslims] that here we can't have graves in perpetuity, so we are forced to be buried in Morocco. Burial in Belgium is the wish of a lot of people, but because there are concessions, they are impeded.[…] But they're not sure that their family will extend it after 25 years." Rachid - Muslim undertaker

A second very important reason to choose burial in Belgium is the presence of the children. The most cherished wish among our participants is to stay close to the children and thus facilitate visiting the graves. In this respect, several participants mention the difficult experience of the deceased being repatriated to the country of origin as well as the distance between the bereaved and the deceased. This was mainly expressed by our middle-aged participants. They argue that a burial in Morocco often entails that his/her grave would be abandoned and would only be visited by the

family once a year. This is also confirmed by our experts.

> "The fact that my son was repatriated was very difficult for me and even now. Two years ago I went back to his grave, you almost can't see him. Because it's too populated, too close, yes. It would calm down my mind if I could be close to my children. It would be ideal if they made it possible, here in Belgium, to have a cemetery for Muslims according to Islamic rules. If that happens, they wouldn't have to go to Morocco, nor I." Warda – middle-aged

> "I wouldn't mind to be buried here in Belgium. It's also God's property (*mulk Allāh*), because when you die, it doesn't matter where your body is. It's just for the remembrance. Our children will stay here in Belgium." Louiza – middle-aged

> "There are a few who even say that yes 'I want to be buried here because my family is here'. Because there was a Muslim, for example, who said that he wanted to be buried here because his children will be here with him. And there [Morocco] they'll come visit him only once a year or two years." Myriam – Palliative care consultant

Third, all participants are of the opinion that Belgian burial places in accordance with Islamic prescriptions would be a good solution for Muslims who do not have a repatriation insurance, but more importantly for the future Muslim generations. Nevertheless, more than half of our participants wish that their children will be buried next to them in the country of origin. In this respect, our participants indicate that the future generations' bonds with the country of origin would decline and would prefer being buried in Belgium, but at the same time this would foster a dilemma, as this entails breaking bonds with their country of origin and not sharing the same burial ground as their family.

> "The younger generation wants to be buried here so that their children can visit them in the cemetery. That's one of the reasons, and the second reason is that people who have no insurance get buried here as well." Louiza – middle-aged

> "They need to have something for the Muslim community. Because not everyone has a connection with their country of origin. I personally would like to be buried in my birth country.[…] But that's not the case for everyone. I personally think that the people who have no insurance or those that find it too expensive to get repatriated should get buried here in Belgium. And for those who were born here and have no connection with their land. Then it's, yeah, I personally feel that there should be something for the Muslim community here in Belgium." Sabiha – middle-aged

> "Only 25% of second generation would choose burial in Belgium, but among third generation this is 90%. They have this idea of 'we don't have anyone in Morocco, our families are here [Belgium]'. They don't feel a connection. They will say that their children may not go to Morocco anymore because it's not their country. They feel no bond. They don't have their roots there." Fadila – Psychosocial services consultant

Repatriation: Journey of the Corpse

Professionalization of Burial

According to our participants, nearly all Moroccan Muslim deceased in Belgium have been repatriated to the country of origin. All our participants, except for Badria, are insured for repatriation

to the country of origin at a bank or a funeral fund. A few elderly participants did not have any clue which insurance they had, as it is mainly taken care of by their husband or son. The overwhelming majority of our participants has an insurance at a Moroccan Bank (e.g. *Attijariwafa Bank* or *Bank Chaabi*), as they were a pioneer in providing this type of assurance, whereas the others –mainly middle-aged participants– are insured at a funeral fund (e.g. *Janaza Funeral Care*; *Arrahma Assistance*). The main reason for taking an insurance for repatriation expressed by our participants is to save money, given the high costs of repatriation. Based upon our interviews and participant observation, we observed a professionalization of burial where an organization or company takes care of the dead body until burial, but also provides support care for the bereaved.

> "Yes, I have an insurance of *Arrahma* because being repatriated is very expensive if you have no insurance." Huda – elderly

> "Yes, of course. We have an insurance at *Bank Chaabi* and my kids as well. Having an insurance is something that I always told my children to do I also told other people.[…] For € 20 you have an insurance in Morocco and everything will be taken care of. It's important to have an insurance, it's necessary." Malika – elderly

Hannan, a middle-aged participant, points out that having an insurance is in fact forbidden (*ḥarām*), because it involves interest (*ribā*). Nevertheless, she does have an insurance, as otherwise the costs for repatriation would be very difficult to bear for the family. This is also confirmed by our experts.

> "Yes, I have insurance at the Bank Chaabi, well, even that's not good, it's *ḥarām,* but yeah.[…] Yes, insurances are all *harām*. But a repatriation is too expensive for someone who has no insurance." Hannan – middle-aged

> "Some Muslims say that this insurance involves interest and this is *ḥarām*. They say 'It's possible that I worked my entire life and earned my money the *ḥalāl* way and earned everything with my own sweat and if I die all those costs are made with interest money (*ribā)*. I don't want anything to do with that'." Zakaria – Muslim undertaker

Several participants mention that the decision for repatriation and taking insurance was and still is an automatism. They explain that the decision was made without additional consideration, but also has been taken over as a tradition of their parents, as it is evident that they would return for burial to their country of birth or origin.

> "Yes, this leaves us with the question whether we'll be repatriated, because we did it automatically without really thinking clearly." Sarah – middle-aged

> "I think they all get insurance automatically. I don't think that people really think about it. They saw their parents taking insurance and so did the children. Because there are a lot of youngsters who died and they were all repatriated." Narima – middle-aged

A few middle-aged participants express that it is mainly the elderly generation who makes sure that the younger generation takes a repatriation insurance. Based upon our interviews and participant observation, we found that the elderly generation would insure all their children and from the moment they would leave the house, the parents would strongly encourage their married children

to continue this.

> "Yes, everyone, except my son. He's married for about a year now and he still doesn't have it. I tell him every time to do so. I have completed an insurance policy with Arrahma Assistance." Kaltoum – middle-aged

> "Yes, they follow their parents. The parents point them to it, certainly when the children marry. But I think that almost everyone pays the insurance." Zoulikha – elderly

Experience of Repatriation of a Deceased Loved One

One-third of our participants mention to have experienced a well-organised and smooth repatriation of their deceased loved ones to the country of origin. They explain that everything was well taken care of by the insurance company or funeral fund. They are of the opinion that transferring the burial task to the professionals was a relief, as in that moment they were in a state of grief and chaos. A good repatriation was understood by our participants as having an insurance, a speedy handling of the administration (e.g. documents, tickets) and burial (e.g. washing the dead, taking care of a coffin and transportation to the mosque, airport and cemetery).

> "Yes, that was fast. There was Serrokh at that time, he took care of everything. He came here and took care of the documents. They took him, washed him and brought him to the airport. In Casablanca they took him to our house in an empty room." Yamina – elderly

> "It went well with my husband. My husband was here a day and the next day they came to pick him up. They took him to the hospital where he got washed. After that they brought him to the mosque where people prayed for him. When the prayer was done, he was immediately taken to the airport. We arrived by night so they buried him the morning after." Fatma – elderly

A few participants underline the important task and support of the community when confronted with death. As such, several participants mention that a deceased who did not have a repatriation insurance would be helped out by the Muslim community through donations via mosques and social media (e.g. Facebook) to guarantee the deceased a dignified burial, as this is a collective duty (*farḍ kifāya).* This is also confirmed by our experts.

> "My niece's husband had no insurance and that caused problems. But *al-ḥamdulillāh* (all praise to God), they raised money in the mosque and the family also gave him money so he could be repatriated." Huda – elderly

> "Yes, the Muslim community helps you if you have no money. If you have an insurance, then you're fine. But if you don't, the Muslim community will help cover the costs." Zohra – elderly

> "If they see that it's between three and five thousands euros only for the coffin and repatriation, they say 'I can't pay that.'[…] They'll go looking for their community, their brothers and sisters, look for me, for you. And if they come to us, it's our obligation to help. So *farḍ kifāya*." Zakaria – Muslim undertaker

However, based upon our interviews and participant observation, several difficulties with regard to the deceased's repatriation were observed. First of all, more than half of our participants refer to the inefficient administration. Although this is often taken care of by the funeral organisation, we

observed that male members of the deceased's family (e.g. husband, father, brother) often run along with the funeral consultant to retrieve documents from different agencies (e.g. hospital or general practitioner; town hall and Moroccan embassy).

> "Most of the time, they're not prepared. People are not prepared and that causes problems. Because they didn't prepare the administration. The passport is not ready. Uhm, there's no flight for example. You'll have to go back and forth for the documents." Sabiha – middle-aged

> "Yes, it's difficult. It takes a long time before the deceased is buried because there are a lot of documents that need to be taken care of. It's a lot of work, but that's just how it is." Nuria – elderly

Second, our participants explicitly refer to the time-consuming aspect of the inefficient administration, which is also confirmed by our experts. This process can be delayed when the person died during the weekend or holidays, when retrieving documents from several agencies is not possible. They argue that this way the bereaved's mourning process is also complicated or impeded and, here again, a teleological explanation is provided. Indeed, as long as the deceased is not buried, he/she does not find peace. However, based upon the participant observation, we observed that the waiting process was also considered a mercy. Indeed, the bereaved would be given more time to visit the deceased in the mortuary, to say goodbye and to read the *Qur'ān* and utter supplications in the presence of the deceased.

> "Yes, because you're here in Belgium. It's a bit more difficult, because you need to book a flight, but also when it's weekends you have to wait two to three days. Meanwhile, the deceased is in a cold storage, in the hospital. But for us, Muslims, that's not good because he is suffering then. And for us, a deceased needs to be buried immediately. You understand, you need to bury him as soon as possible so that he doesn't suffer." Sabiha – middle-aged

> "He died in the hospital and was washed that same day. He stayed two days in the cold storage, because they had to take care of the documents and go to the consulate etc. He only got repatriated to Morocco after four days and was buried on the fifth day, poor guy. That's a lot to go through, being in a coffin for so long." Yamina – elderly

> "The city hall is closed on weekends so that is a problem for the people who die on a Friday for example. We can't go to the consulate because that is also closed. They'll have to wait until Monday. Or if there's a holiday, it can be closed for more than three days. So that's causing a lot of problems when that happens." Zakaria – Muslim undertaker

Third, repatriation is strongly perceived as a torture for the deceased. In this respect, they refer to the painful experience of storing the body in a mortuary and more specifically in a cold storage, but also storing the body in a coffin. Therefore, nearly half of our participants, mainly elderly, express the wish to die in the country of origin, in order to avoid repatriation and be buried within the day. This is also closely related to the so-called dilemma of return (cf. Ahaddour, Van den Branden, & Broeckaert, 2015), as several of our elderly participants still cherish the wish to spend their old days in Morocco.

> "I would like to die in Morocco.[…] Because I told you that we feel everything, that cold storage. I don't want to sleep in a cold storage. I don't want to go through that because you feel everything. So whatever you feel at the moment, you'll feel 10,000 times more if you're in a cold storage. That really hurts." Hannan – middle-aged

> "That's my country, it's a Muslim country. You'll be buried warm. You won't be in a coffin or kept in a cold storage that then goes into a coffin to wait till there's a flight. Sometimes they take a deceased fast and sometimes not. That's why I prefer to die in Morocco. I'd be buried when I'm still warm, without a coffin or cold storage." Rahima – elderly

Discussion

The findings of our interviews with middle-aged and elderly Moroccan Muslim women are nearly identical to those of the interviews with our experts in the field. Although there are differences in age, but also in level of education and socio-economic status between the first and second generation, surprisingly no differences were observed between our middle-aged and elderly participants in their attitudes and practices regarding burial. Although it could be assumed that second generation Muslim women, who were born or raised in Belgium, are more likely to be influenced by Western ideas, which might result in a more secular understanding of death and dying and a decline in religious observance, this was not the case. In line with our findings, a study of Milewski and Otto (2016) among Turkish Muslims in Germany confirms that there is no impact of socio-demographic characteristics on attitudes towards the importance of a religious funeral ceremony among first and second generation. Turkish people continue to place considerable weight on religiosity at the end of life. In this context the funeral is perceived to be the most important tradition. However, we did observe a small shift in preferences of burial location between first and second generation Moroccan Muslim women. The latter generation shows more openness towards burial in Belgium than the older generation. This might be explained by their stronger attachment to Belgium as they were mainly brought up or born there. The idea of a permanent return to the country of origin at an old age (cf. myth of return) is lacking among middle-aged participants.

Our study shows that burial practices are performed according to the outline of a religious framework. In other words, our participants' attitudes and practices embody their theological and eschatological beliefs. Burial is understood as returning the body to God in a dignified way. This is to be understood from the belief that life and body are given as a trust (*ʾamāna*) by God, the ultimate owner of everything. Man is only a temporary vice-regent, nothing more. More importantly, burial rites are inextricably linked to eschatological beliefs. Rituals and prescriptions such as obligation of inhumation, a speedy burial, placing the deceased in the direction of Mecca, graves in perpetuity, reciting *Qur'ān* or uttering *duʿāʾ* after burial are understood as preparing the deceased for the interrogation in the grave by Munkar and Nakīr and/or the resurrection. Nevertheless, we did observe among our participants that their knowledge of the burial rites is limited, which can be explained by their exclusion from burial practices as they are considered to be a male affair. Although we observed

that women do not generally attend the burial, we observed that young women among second and third generation start to claim their presence at the burial site –though still from a distance– to pay respect to their dead loved ones until the last moment, but also as an important step for their mourning process. This might reflect a certain emancipation of women in Muslim communities in Belgium.

We observed that burial rituals have been influenced or adapted due to their embeddedness in a migration context. For example, in Belgium a deceased is transported to the country of origin in a coffin and subsequently buried with it, unlike in the country of origin where the deceased is buried in a shroud. A second crucial adaption is that a speedy burial is not possible as repatriation entails a time break between death rituals, more specifically between death prayer and burial. With regard to burial in the Belgian context, the funeral procession is limited from the cemetery to the grave, whereas in Morocco the deceased is transported on a bier from the house of the deceased to the cemetery.

In the migrant context Muslims are challenged in their choice of burial location. The overwhelming majority of our participants opt for repatriation to the country of origin. This choice was mainly based on religious, social and financial reasons. The main reason for returning was based on social aspects such as the importance of family and joining the ancestors and on religious considerations such as burial in an Islamic setting with graves in perpetuity. The elder generation provided more arguments for returning back to the roots, whereas this was less the case among middle-aged participants. Contrarily, middle-aged participants tended to provide more religious arguments for their choice for repatriation. Muslim identity was more at the forefront than one's ethnic identity. However, at the same time middle-aged women would also consider burial in Belgium to stay close to their living family (children), but also because of the weakening bonds with the country of origin which we could strongly observe, also in other parts of our study. Both middle-aged and elderly Muslim women agree that future Muslim generations would opt for burial in Belgium.

In this study, we have found that a minority of our participants has no clear answer where they want to be buried as it entails emotional and complex decisions. According to our participants and experts, only a small minority of Muslims are buried in Belgium, including fetuses, children and people of mixed marriages. Only one middle-aged participant (Ikram) shows openness regarding burial in a Muslim plot in Belgium, taking into account the issue of clearing out graves. This attitude is likely to be explained by her particular view on the afterlife. Indeed, she strongly expressed the belief in the soul's existence in the afterlife, though she has her reservations about the physicality of the afterlife (e.g. deceased being able to feel and hear; torture of the grave).

Comparison with the Normative and Empirical Literature

Our participants' line of reasoning and practices were strongly similar to the line of thought and Islamic prescriptions found in normative Islamic literature on burial. Both our interviewees and normative Islamic literature uphold the importance of speedy burial, funeral procession, placing the deceased and the grave towards Mecca, graves in perpetuity, reading the *Qur'ān* and uttering supplications (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Shahri, 2016; Gatrad & Sheikh, 2002). Similar to our findings, normative Islamic literature also strongly emphasizes burial as one of the deceased's rights, which are a responsibility of the Muslim community (*farḍ kifāya*). Our participants' theological and eschatological line of thought is strikingly similar to that found in normative Islamic literature. The burial rituals are performed on the one hand to prepare for the hereafter such as the life in the grave and resurrection (e.g. inhumation, graves towards Mecca, graves in perpetuity, reading *Qur'ān*), on the other hand to deal in a dignified way with God's trust (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Shahri, 2016; Al-Shahri et al., 2007; Halevi, 2007).

In contrast to the normative Islamic literature, we found that due to the migrant context and the dominant choice for repatriation, a speedy burial, burial without a coffin and laying the body on the right side is not entirely possible. Nevertheless, to meet the latter requirement, we observed that the face of the deceased is often placed on its right side during the washing of the corpse and the coffin is placed slightly on its right side in the grave. We have found that our participants' perspective on burial was more fragmented due to their lack of involvement in the burial. For example, our participants did not mention loosening grave cloths once the deceased is laid into the grave or throwing earth into the grave after burial, nor did they refer to prompting the deceased with answers for the interrogation in the grave (*talqin*).

Although legal schools denounce the practice of transporting the deceased from one place to another, Moroccan Muslims choose predominantly for repatriation, which not only reflects the dichotomy between prescribed and performed but also the fact that Moroccan Muslims in Belgium deal creatively with Islamic burial norms, preferring one above another. Our participants indeed prefer a grave in perpetuity and repatriation to the country of origin above a speedy burial in Belgium. Moreover, in contrast to *fiqh* manuals, our participants show significantly less flexibility and nuance concerning the issue of clearing out graves. Graves in perpetuity are perceived as an absolute norm by our participants, whereas *fiqh* manuals are more nuanced with regard to the idea of clearing out graves and accept this in a number of cases, especially in order to make place for new graves.

The findings of our study are consistent with the results found in other empirical studies (Assous, 2013; Bot, 1998; Gardner, 1998, 2002; Jonker, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986; Van den Branden, 2006; Venhorst, 2013). Similar to our findings, the following elements came forward in the abovementioned studies concerning burial: burial as a collective duty, religious

observances regarding burial including speedy burial, funeral procession, grave construction to Mecca, reading *Qur'ān* and uttering supplications.

In these studies, (Muslim) death practices are often understood as *rites de passage* (cf. Van Genepp 1960; Turner 1969 & 2002) i.e. rituals that mark changes, shifts and transitions in the human life-cycle (Dessing, 2001; Kadrouch-Outmany, 2014; Venhorst, 2013). The authors mentioned distinguish three major phases: rituals of separation, transition and incorporation. The rites of separation and transition entail the dying rites (e.g. pronouncing the Islamic creed) and the rites performed when the deceased belongs neither to the living nor to the dead (e.g. washing the deceased; death prayer). The rites of incorporation entail the burial and thus the fact that the deceased has completed the passage (Dessing, 2001; Kadrouch-Outmany, 2014). Nevertheless, Venhorst (2013) considers rituals at the grave as rites of transition followed by incorporation rites at the end of times (e.g. day of judgment).

Several empirical studies confirm that the burial of Moroccan men and women is to be understood from within a religious framework, as theological and eschatological beliefs shape the rituals performed at burials (Dessing, 2001; Kadrouch-Outmany, 2014; Venhorst, 2013). These authors also support that a Muslim's choice for inhumation is derived from the understanding of the body's sanctity (*ḥurma*), as the body is viewed as a trust from God. As such, the human body is returned to God in a dignified way. In keeping with our findings, study of Venhorst (2013) shows that the rituals embody Muslims' beliefs in the afterlife and entail preparations for the hereafter and facilitate the eschatological events to come. Similarly, Ansari (2007) found that the choice for burial among British Muslims is based on the belief in corporeal resurrection. This also applies for the ritual of placing the deceased towards the *qibla* as well as the importance of graves in perpetuity. Studies by Dessing (2001) and Venhorst (2013) indicate that graves are dug in such a way that the deceased can sit up straight when being interrogated or that room is available for the angels to do their preliminary questioning. However, both narratives were not mentioned by our participants.

Several studies confirm that burial rites are mainly a male affair and that (Moroccan and Turkish) Muslim women do not generally participate in funeral processions or attend burials as they are considered to be too emotional (Aggoun, 2006; Assous, 2013; Bot, 1998; Dessing, 2001; Dieste, 2012; Jonker, 1996, 1997; Kadrouch-Outmany, 2014; Venhorst, 2013). Hysterical behavior is considered a remains of pre-Islamic customs for grief (Dieste, 2012). However, Dessing (2001) argues in line with our findings that some Muslim women do attend burials from a distance if they are able to keep their emotions under control. Like our findings, several scholars (Aggoun, 2006; Assous, 2013; Kadrouch-Outmany, 2014; Renaerts, 1986) observed that Muslim women (and children) only visit the grave the next day or on the third day after burial.

Similar to our findings, many studies indicate the importance of a speedy burial for Muslims.

The actual burial is preceded by a funeral procession (Aggoun, 2006; Assous, 2013; Bot, 1998; Dessing, 2001; Dieste, 2012; Jonker, 1996, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986; Venhorst, 2013). Renaerts (1986) confirms that Moroccan Muslims discourage burial at night based on the risk of provoking the aggression of *jinns* when digging a grave. Research (Aggoun, 2006; Assous, 2013; Bot, 1998; Dessing, 2001; Renaerts, 1986) corroborates our finding that often the Islamic credo or *Qur'ānic* verses are recited during the funeral process. Like our findings, Renaerts (1986) observed that in some villages in Morocco a woman would indicate her pregnancy publicly by putting a scarf or belt on the deceased husband to indicate that she is carrying his child. Her study also shows –similar to ours– that people take another route to head back home from the burial site than during the funeral procession. Both Dieste (2012) and Renaerts (1986) observed that in Morocco an unmarried deceased is greeted with cheers (*zaghrat*) when leaving the parental house and a female is transported in a coffin. An unmarried girl's coffin would be decorated as if it were the litter (*'ammariyya*) in which the bride was transported to the home of her future husband. However, this was not mentioned by our participants. The lack of this custom might be explained by the fragmentation of the country of origin's cultural practices in a migration context. Similar to our findings, several studies (Dessing, 2001; Kadrouch-Outmany, 2014; Venhorst, 2013) support that a funeral procession in the migrant context often only involves a walk from the cemetery to the grave.

Studies confirm that Muslim graves are either a *lahd* or *shaqq* construction in which the deceased is laid in shrouds towards Mecca followed by filling the grave with earth (Bot, 1998; Dessing, 2001; Dieste, 2012; Jonker, 1996, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986; Venhorst, 2013). Kadrouch-Outmany (2014) confirms that in Belgium and Morocco, a *shaqq* is the prevailing variant of grave construction. Studies carried out in Morocco by Dieste (2012) and Renaerts (1986) support our findings that each grave is marked by two stones indicating the deceased's gender. Similar to our findings, Van den Branden (2006), Dessing (2001) and Kadrouch-Outmany (2014) observed that grave stones with names and *Qur'ānic* inscriptions are a common tradition in Belgium and Morocco. Dieste (2012) and Renaerts (1986) also mention that twigs of myrtle are deposited on the grave after burial to please the angels, because they were supposed to give off the aroma of paradise. This was, however, not mentioned by our participants or viewed during our participant observation.

Although several studies (Dessing, 2001; Jonker, 1997; Venhorst, 2013) mention prompting the answers to the deceased –often by an *imam*– as preparation for the interrogation *(talqin)*, this was not explicitly mentioned by our participants. Our participants did indicate a close person reciting the *Qur'ān* or uttering supplications after burial to help the deceased with his/her interrogation, but also so that God will forgive his/her sins and he/she would find peace in the grave. This is also confirmed by Renaerts (1986).

Studies carried out in Europe show that the overwhelming majority of Muslims opt for repatriation because of religious, social-emotional and financial considerations (Aggoun, 2006; Attias-Donfut et al., 2005; Balkan, 2015; Chaïb, 2000; Dessing, 2001; Gardner, 1998, 2002; Jonker, 1996; Kadrouch-Outmany, 2014; Venhorst, 2013). More specifically, study of Kadrouch-Outmany (2014) shows that 73% of first and second Moroccan generation Muslims in Belgium and the Netherlands opt for repatriation to country of origin, whereas study of Balkan (2015) found that 95% of Turkish migrants in Germany are repatriated.

In line with our findings, several studies indicate that religion has an impact on the preferred burial location. Muslims desire a religious burial including burial towards Mecca, graves in perpetuity and burial without coffin and therefore choose the country of origin (Aggoun, 2006; Attias-Donfut et al., 2005; Berdai, 2005; Milewski & Otto, 2016; Venhorst, 2013). Although Kadrouch-Outmany (2014) and Balkan (2015) argue that legal obstacles, including the fact that no graves are guaranteed in perpetuity, are only of secondary importance in the decision-making regarding the burial location, this was not what we found in our study. On the contrary, the fact that graves would eventually be cleared out was presented as an important obstacle and a compelling reason for our participants to forgo burial in Belgium. Moroccan Muslims in Belgium not only tend to perceive or construct this 'graves in perpetuity'-requirement as an absolute norm (which it was/is not, cf. supra), at the same time they also tend to exaggerate the contrast between Belgium and Morocco in this regard. Our participants are convinced that an eternal grave is assured in Morocco, whereas Belgium offers, according to them, a rather limited grave rest. Reality is, however, more nuanced as it must be noted that in big cities in Morocco graves are cleared out after a long amount of time and the Belgian law offers the possibility of concessions of 50 years that are renewable, so ideology and reality are not necessarily the same here.

Another religious consideration that is confirmed by Aggoun (2006), Dessing (2001) and Venhorst (2013) is the idea of Muslims wishing to be buried among Muslims rather than among non-Muslims based on the belief that they would not find peace, referring to the torture of the graves, but also because of the idea that burial in an Islamic setting guarantees that every time a Muslim passes by or visits the cemetery, his/her supplications address all deceased Muslims in the cemetery.

With regard to burial in a migrant context, Jonker (1997) and Ansari (2007) confirm our findings that the choice of burial in a Muslim plot would entail a speedy burial as recommended by the Islamic tradition. Nevertheless, a burial within a day, which is customary for Muslims and in general for people living in tropical areas, is still impossible due to legal and administrative formalities (Balkan, 2015; Kadrouch-Outmany, 2014).

Many studies corroborate our findings that both the family and a territorial connection have

a decisive impact on a Muslim's choice of burial location (Aggoun, 2006; Ansari, 2007; Attias-Donfut et al., 2005; Balkan, 2015; Berdai, 2005; Chaïb, 2000; Dessing, 2001; Jonker, 1997; Kadrouch-Outmany, 2014). These studies show that burial decisions are strongly influenced by the strength of kinship ties and feelings of descent or of belonging to a country. In line with our findings, the studies by Attias-Donfut et al. (2005) and Hunter (2015) show that Muslims have the desire to be buried next to their deceased parents and their living family in the country of origin. According to several scholars (Balkan, 2015; Kadrouch-Outmany, 2014), the choice also concerns national and cultural identity and the connection between place and identity. We observed among our elderly Moroccan Muslim women that the national (Moroccan) identity was more expressed, compared to our middle-aged Muslims who mainly emphasized their religious identity (e.g. wish to be buried with Muslims in an Islamic country). In line with our findings, Kadrouch-Outmany (2014) found that Moroccan and Turkish Muslims in Belgium and the Netherlands had a stronger sense of belonging to their country of (ancestral) origin in matter of burial, compared to a stronger sense to belonging to the adopted homeland in everyday matters. This sense of belonging entails returning to their roots and being buried among those with whom they share the same culture, religion and ethnicity.

Several studies (Balkan, 2015; Gardner, 1998; Hunter, 2015; Kadrouch-Outmany, 2014) confirmed the shift we observed in the preferences of burial location among Muslims in a migrant context. In the same way, many scholars (Attias-Donfut et al., 2005; Berdai, 2005; Chaïb, 2000; Dessing, 2001; Milewski & Otto, 2016), argue that Muslims and certainly future Muslims would prefer to be buried where their family lives so they can easily visit their grave and offer their prayers, but also due to the stronger identification with the adopted homeland and the weakening bond with the country of origin. This emphasizes the choice of location based on the maintenance of bonds between the dead and the living. Oliver (2004) argues that where kin-ties are strong, it is considered important that the remains are close enough to facilitate the continuing bond after death. Balkan (2015), Chaïb (2000) and Kadrouch-Outmany (2014) state that the link between burial and belonging is not simply about place, but also about lineage. Several scholars (Ansari, 2007; Balkan, 2015; Chaïb, 2000) argue that the strength of one's ties to the country of origin largely determines why any given individual would be buried in one place or another and also marks the migrant's integration. However, our study showed that other factors play a role too in determining the actual place of burial. Though several middle-aged Moroccan Muslims would actually prefer burial in Belgium, religious reasons, financial arguments and social pressure from family and parents make this choice very difficult. Several studies (Attias-Donfut et al., 2005; Hunter, 2016; Kadrouch-Outmany, 2014) confirm that (younger) Muslims face the dilemma of *either* choosing family members of the past (e.g. parents, ancestors) and hence breaking with the living and/or compromising their chance of being visited by family members of the future (e.g. children, grandchildren) *or* breaking with the dead and thus becoming the new first ancestor for future generations in the adopted homeland. The

dilemma is even stronger as middle-aged women are not only forced to choose between the family of the past (dead relatives) and those of the future, but actually between resting with their parents (who in many cases are still alive, will be buried in Morocco and want their children to do the same) or with their children and grandchildren. Aggoun (2006) confirms our finding that a number of people (a minority in our study) leave the decision regarding their burial location to their children. Similar to our findings, several studies (Aggoun, 2006; Balkan, 2015; Dessing, 2001; Jonker, 1996; Kadrouch-Outmany, 2014, 2016; Venhorst, 2013) show that at this time only a minority of Muslims –mainly Indonesian and Suriname Muslims, asylum seekers, people of mixed marriages and converts– choose burial in the adopted home country.

Research also confirms that economic factors have an impact on burial decisions. Several studies argue that the institution of funeral funds ensued from the wish of many (Moroccan and Turkish) Muslims to be buried in country of origin and from the considerable expenses involved in repatriation (Aggoun, 2006; Balkan, 2015; Chaïb, 2000; Dessing, 2001; Jonker, 1997; Kadrouch-Outmany, 2014; Venhorst, 2013). As a result, the vast majority of Muslims have been paying an annual fee for a funeral fund to ensure that all costs are covered (Kadrouch-Outmany, 2014; Venhorst, 2013). Whereas in Belgium concessions must be paid, graves are free in Morocco (Aggoun, 2006; Attias-Donfut et al., 2005; Chaïb, 2000; Venhorst, 2013). As the fee for the repatriation insurance would otherwise have been paid in vain and this for many years (usually from birth for the younger generations) and as burying in Belgium would entail significant extra costs, from a financial point of view the choice for Morocco is an easy one. Given the strong commercial character of funeral funds and the fact that this is an important business (as the vast majority of Moroccan Muslims in Belgium is a client), it is in the clear interest of these commercial companies (and this is what they actually do, as we also observed on social media) to promote burial in Morocco as the preferable and best Islamic option.

Studies conducted in Western Europe (Ahaddour et al. 2017; Ansari, 2007; Chaïb, 2000; Dessing, 2001; Kadrouch-Outmany, 2014; Van den Branden, 2006; Venhorst, 2013) corroborate our findings that due to the migrant situation, rituals are split up in both space and time, mainly by performing the death prayer in Belgium and the burial –a few days later– in Morocco. They support our finding that rituals are inevitably influenced by the context in which they are embedded and are subject to change due to the social and legal setting. Examples are the burial or repatriation in a coffin, preserving the corpse in a cold storage and delaying burial due to the choice for repatriation. Nevertheless, with regard to the latter Venhorst (2013) and Balkan (2015) argue that there is always a degree of tension or flexibility between what is prescribed and what is performed. In the same way, they explain that Muslims who decide to repatriate their deceased loved ones see no inconsistencies with the time it takes to transport a dead body, but find it more important to get the body back home.

Several studies (Aggoun, 2006; Bot, 1998; Dessing, 2001; Gardner, 1998; Jonker, 1997; Kadrouch-Outmany, 2014; Venhorst, 2013) support our finding of a specialization of death, referring to the growth of the number of specialized dead washers and a professionalization of burial (e.g. professional burial undertakers; funeral associations and funds). In keeping with our findings, several studies indicate that funeral funds and insurances are mainly institutionalized among Moroccan and Turkish Muslims in several European countries to help organize transnational funerals including Bank *Chaabi* and *Attijariwafa* Bank (Aggoun, 2006; Balkan, 2015, 2016; Dessing, 2001; Kadrouch-Outmany, 2014). In a similar way, these studies report that the majority of (Moroccan and Turkish) Muslims have a repatriation insurance. Similar to our findings, Balkan (2016), Jonker (1996) and Venhorst (2013) confirm that the undertakers' primary task is the disposal of the dead, which involves attending to the living by providing bereavement support and religious counselling. Kadrouch-Outmany (2014) and Dessing (2001) also support our findings that if the deceased has no insurance for repatriation to the country of origin, the Muslim community, including mosques, families, acquaintances and charitable organizations, offer financial help. Only Aggoun (2006) indicates, in keeping with our findings, that repatriation of a deceased loved one is often a difficult experience due to administrational bureaucracy and its time-consuming aspect which does not enhance the mourning process, but also mentions the feeling of unrest among the bereaved as long the deceased is not buried.

The question of funerary practices is gaining importance because of the rapidly growing number of elderly Muslims. As the second and subsequent generations Moroccan Muslims clearly intend to stay in Belgium, the issue of where to be buried will become even more pertinent. The organisation of adequate funeral care and burial facilities taking into account Islamic burial prescriptions is of utmost importance for younger and future (Moroccan) Muslims in the Belgian context. Providing quality funeral care entails meeting the cultural and religious needs of the deceased and their family members. By offering insights into the actual views and practices, our study aims to offer tangible leads to professionals for a more tailor-made funeral care for (Moroccan) Muslim deceased and their relatives while insisting that one should remain mindful of the diversity of lived experiences within each tradition. A close collaboration between hospital and funeral associations as well as policy-makers to ensure a dignified burial for this population is of utmost importance. The study is useful for professionals and policy-makers in understanding better the needs and dilemmas Moroccan families in Belgium are facing regarding their choices of burial location.

Our exploratory findings should be interpreted with several limitations in mind. First, data might be biased due to social desirability. Expressing opinions that might deviate from the norm or that could be seen as contrary to Islamic teaching might be difficult. As an interviewer, it is difficult to ascertain whether participants share truthful information. Although several measures were taken to guarantee anonymity (e.g. pseudonyms, deleting audio-tapes after transcribing), qualitative

research cannot fully guarantee anonymity (e.g. interviews are face-to-face). Both advantages and disadvantages are attached to the background of the interviewer (interviewer bias). On the one hand, being a member of the same community facilitated the gaining of trust and resulted in a certain openness and detailed conversations, on the other hand this might also have influenced the answers of the participants by not providing 'deviated' answers out of fear of being judged. Second, a possible bias is the mixed position of the expert between giving technical information and giving their own personal view on the matter. During coding, we have taken this into account and made a clear distinction between personal views of the expert and his/her description of the views of Moroccan Muslim women. Third, the translations we had to do also introduced a bias. The interviews conducted in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) had to be translated into Dutch and English, which might have influenced the data. As this was carried out to ensure validity and reliability so that others, including the guiding committee, could verify and follow the coding and analyzing of the data, the first author tried to make translations as accurate as possible and verified this accuracy by relying on members of the Moroccan community when confronted with difficulties in the translation of a word or concept. To assure reliability and validity and limit bias as much as possible, we adopted several strategies (e.g. data checking with members of the Moroccan Muslim community; peer debriefing; memos; interviews with experts). Fourth given the nature of our data (specific group; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. In any case, this work does not ignore the heterogeneity among Muslims in Belgium. For instance, it would still be interesting to do an in-depth investigation of Muslims from different ethnicities and/or denominations on their views and practices regarding burial. Taking into account the specific situation of first generation Moroccan Muslims in Belgium characterized by a strikingly homogenous religious, cultural, socio-economic and geographic background and an already more diverse socio-demographic background among second generation Muslims, it would be interesting to explore the views among third generation Muslims who are assumed to embody a stronger diversity socio-economically as well as religiously. Further studies could explore whether the impact of religion on attitudes and practices regarding burial differs among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

Conclusion

The overwhelming majority of our participants opts for repatriation to the country of origin because of socio-emotional (attachment to family and territory), religious and financial reasons, even if several middle-aged participants would actually prefer burial in Belgium to stay close to their children and to ensure remembrance through visiting the grave. We observed that Moroccan Muslims use traditional Islamic burial prescriptions in a creative way by giving weight and even absolutising

one prescription (graves in perpetuity) over others (speedy burial, not transporting the deceased). We did *not* find a more secular practice or understanding of burial among middle-aged women. We have observed that when dealing with burial, both first and second generation Muslims in Belgium adopt a theological and eschatological line of reasoning similar to the one that can be found in normative Islamic literature.

References

Abdesselem, M. (2012). Mawt. In P. Bearman, T. Bianquis, C. E. Bosworth, E. van Donzel & W. P. Heinrichs (Eds.), *Encyclopaedia of Islam* (Second ed.), Leiden: Brill Online. http://dx.doi.org/10.1163/1573-3912_islam_SIM_5064 (Accessed May 20 2017).

Aggoun, A. (2006). *Les Musulmans face à la mort en France* . Paris: Vuibert.

Ahaddour, C., & Broeckaert, B. (2016). Muslim Burial Practices and Belgian Legislation and Regulations: a Comparative Literature Review. *Mortality, 22* (4), 356-373.

Ahaddour, C., Van den Branden, S., & Broeckaert, B. (2015). Institutional Elderly Care Services and Moroccan and Turkish Migrants in Belgium: A Literature Review. *Journal of Immigrant and Minority Health, 18*(5), 1216-1227.

Ahaddour C., Van den Branden S., & Broeckaert B. (2017). Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women. *Omega: Journal of Death and Dying.* https://doi.org/10.1177/0030222817729617

al-Jazīrīʾ, A. (2009). *Islamic Jurisprudence According to the Four Sunni Schools - Al Fiqh 'ala Al Madhahib Al Arba'ah* Vol. 1. *Modes of Islamic Worship.* Retrieved from https://archive.org/details/IslamicJurisprudenceAccordingToTheFourSunniSchoolsAlFiqhalaAlMadhahibAlArbaah (Accessed 15th March 2017).

Al-Sayyid, S. (1991). *Fiqh Us Sunnah.* Retrieved from http://mappingsharia.com/wp-content/uploads/2011/06/Saabiq-Fiqh-us-Sunnah.pdf (Accessed 15th March 2017).

Al-Shahri, M. (2016). Islamic theology and the principles of palliative care. *Palliative and Supportive Care, 14*(6), 635-640.

Al-Shahri, M., Fadul, N., & Elsayem, A. (2007). Death, dying and burial rites in Islam. *European Journal of Palliative Care, 13*(4), 164-167.

Ansari, H. (2007). 'Burying the dead': making Muslim space in Britain. *Historical Research, 80*(210), 545-566.

Assous, A. B. (2013). Cultural and Islamic Values in Relation with Death. *European Scientific Journal, 9*(5), 1857-1881.

Attias-Donfut, C., Wolff, F. C., & Dutreuilh, C. (2005). The Preferred Burial Location of Persons Born outside France. *Population, 60*(5/6), 699-720.

Bakhtiar, L. (1996). *Encyclopedia of Islamic Law: A Compendium of the Major Schools* Chicago: ABC International Group.

Balkan, O. (2015). Burial and Belonging. *Studies in Ethnicity and Nationalism, 15*(1), 120-134.

Balkan, O. (2016). Between Civil Society and the State: Bureaucratic Competence and Cultural Mediation among Muslim Undertakers in Berlin. *Journal of Intercultural Studies, 37*(2), 147-161.

Berdai, S. (2005). Vergrijzing...een kleurrijk gegeven! Brussel: Brusselse Welzijns- en gezondheidsraad vzw.

Bot, M. (1998). *Een laatste groet : uitvaart- en rouwrituelen in multicultureel Nederland*. Rotterdam: Ef & Ef In Boeken.

Campo, J. E. (2006). Muslim Ways of Death: Between the Prescribed and the Performed. In K. Garces-Foley (Ed.), *Death and Religion in a Changing World* (pp. 147-177). New York - London: M.E. Sharpe.

Campo, J. E. (2017). Burial. In J. D. McAuliffe (Ed.), *Encyclopaedia of the Qurʾān*. Washington DC: Georgetown University. http://dx.doi.org/10.1163/1875-3922_q3_EQSIM_00065 (Accessed May 20 2017)

Chaïb, Y. (2000). *L'émigré et la mort: La morte musulmane en France*. Saint-Rémy-de-Provence: Edisud.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). California: SAGE Publications

Dessing, N. M. (2001). *Rituals of birth, circumcision, marriage, and death among Muslims in the Netherlands*. Leuven: Peeters.

Dieste, J. L. M. (2012). *Health and Ritual in Morocco: Conceptions of the Body and Healing Practices*: Brill.

Gardner, K. (1998). Death, burial and bereavement amongst Bengali Muslims in Tower Hamlets, East London. *Journal of Ethnic and Migration Studies, 24*(3), 507-521.

Gardner, K. (2002). Death of a migrant: transnational death rituals and gender among British Sylhetis. *Global Networks, 2*(2), 191-204.

Gatrad, A. R., & Sheikh, A. (2002). Palliative Care for Muslims and Issues After Death. *International Journal of Palliative Nursing, 8*(12), 594-597.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing Company

Halevi, L. (2007). *Muhammad's grave: death rites and the making of Islamic society*. New York: Columbia University Press.

Halevi, L. (2013). Funerary Practices. In K. Fleet, G. Krämer, D. Matringe, J. Nawas & E. Rowson (Eds.), *Encyclopaedia of Islam, THREE*. Leiden: Brill Online. http://dx.doi.org/10.1163/1573-3912_ei3_COM_27205 (Accessed May 20 2017)

Harford, J. B., & Aljawi, D. M. (2013). The need for more and better palliative care for Muslim patients. *Palliative & Supportive* Care, *11*(01), 1-4.

Hedayat, K. M. (2006). When the spirit leaves: Childhood death, grieving, and bereavement in Islam. *Journal of Palliative Medicine, 9*(6), 1282-1291.

Hertogen, J. 2016. Marokkaanse-, Turkse- en islamachtergrond per gemeente Available at: http://www.npdata.be/ Accessed 20 July 2017

Hunter, A. (2015). Deathscapes in diaspora: contesting space and negiotiating home in contexts of post-migration diversity. *Social & Cultural Geography, 17*(2), 247-261.

Hunter, A. (2016). Staking a Claim to Land, Faith and Family: Burial Location Preferences of Middle Eastern Christian Migrants. *Journal of Intercultural Studies, 37*(2), 179-194.

Jonker, G. (1996). The knife's edge: Muslim burial in the diaspora. *Mortality, 1*(1), 27-43.

Jonker, G. (1997). The many facets of Islam; death, dying and disposal between orthodox rule and historical convention. In C. M. Parkes, P. Laungani & B. Young (Eds.), *Death and bereavement across cultures* (pp 147-165). London-New York: Routledge.

Kadrouch-Outmany, K. (2014). *Islamic burials in the Netherlands and Belgium. Legal, religious and social aspects.* (Unpublished doctoral dissertation), Leiden University, Leiden.

Kadrouch-Outmany, K. (2016). Religion at the cemetery Islamic Burials in the Netherlands and Belgium. *Contemporary Islam, 10*(1), 87-105.

Lapidus, I. M. (1996). The Meaning of Death in Islam. In H. M. Spiro, M. G. McCrea & L. Palmer-Wandel (Eds.), *Facing Death. When Culture, Religion and Medicine Meet* (pp. 148-159). New Haven-London: Yale University Press.

Lodewijckx, E., & Pelfrene, E. (2012). Huishoudensstructuur en solidariteit tussen de generaties bij personen van vreemde afkomst. In L. Vanderleyden & M. Callens (Eds.), *Generaties en solidariteit in woord en daad* (pp. 51-76). Brussel: Studiedienst van de Vlaamse Regering.

Milewski, N., & Otto, D. (2016). The Importance of a Religious Funeral Ceremony Among Turkish Migrants and Their Descendants in Germany: What Role do Socio-demographic Characteristics Play? *Journal of Intercultural Studies, 37*(2), 162-178.

Morgan, J. D. (2002). Islam. In J. D. Morgan & P. Laungani (Eds.), *Death and bereavement around the world* (Vol. 1, pp. 153-157). Amityville: Baywood Publishing.

Mortelmans, D. (2008). *Handboek kwalitatieve onderzoeksmethoden*. Leuven: Acco.

Oliver, C. (2004). Cultural Influence in Migrants' Negotiation of Death. The Case of Retired Migrants in Spain. *Mortality, 9*(3), 235-254.

Pew Research Center. (2015). The Future of World Religions: Population Growth Projections, 2010-2050. Retrieved 27 October 2016, from http://www.pewforum.org/2015/04/02/religious-projections-2010-2050/

Philips, B. (2005). *Funeral rites in Islam* (Second ed.). Saudia-Arabia: International Islamic Publishing House.

Renaerts, M. (1986). *La mort, rites et valeurs dans l'Islam Maghrebin* Brussel: ULB. Institut de Sociologie.

Shadid, W. A. R., & van Koningsveld, P. S. (2008). *Islam in Nederland en België*. Leuven: Peeters.

Sheikh, A., & Gatrad, A. R. (2000). *Caring for Muslim Patients.* Oxford: Radcliffe Medical Press.

Smith, J. I., & Haddad, Y. Y. (2002). *The Islamic Understanding of Death and Resurrection*. Oxford: Oxford University Press.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, CA: Sage.

Timmerman, C. (2001). Groeiende diversiteit op vele fronten. Het onderzoek naar de socio-culturele en religieuze praxis bij allochtonen in Vlaanderen. In *Komende generaties. Wat weten we (niet) over allochtonen in Vlaanderen*, edited by J. Vranken, C. Timmerman and K. Van der Heyden, 297-312. Leuven-Leusden: Acco.

Tritton, A. S. (2012). Djanāza. In P. Bearman, T. Bianquis, C. E. Bosworth, E. van Donzel & W. P. Heinrichs (Eds.), *Encyclopaedia of Islam* (Second ed.). Leiden: Brill Online. http://dx.doi.org/10.1163/1573-3912_islam_SIM_1985 (Accessed May 20 2017)

Turner, V. (1969). *The Ritual Process: Structure and Anti-structure.* London: Routledge and Kegan Paul. (The Lewis Henry Morgan Lectures 1966).

Turner, V. (2002). Liminality and Communitas. In M. Lambek (Ed.), *Reader in the Anthropology of Religion* (pp. 358-374). Oxford: Blackwell Publishing.

Van den Branden, S. (2006). *Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen.* (Unpublished doctoral dissertation), Katholieke Universiteit Leuven, Leuven.

Van Gennep, A. (1960). *The Rites of Passage.* Chicago: University of Chicago Press.

Venhorst, C. (2013). *Muslims Ritualising Death in the Netherlands. Death rites in a small town context*. Zurich: Litt.

Yasien-Esmael, H., & Rubin, S. S. (2005). The meaning structures of Muslim bereavements in Israel: Religious traditions, mourning practices, and human experiences. *Death Studies, 29*(6), 495-518.

"Surely, God loves those who put their trust in Him."

— Q3:159

8. Submitting to God's Will. Attitudes and Beliefs of Muslim Women regarding Mourning and Remembrance

Introduction

Responses to loss are unique for each individual. Every religion, culture, community and person has its own way of dealing with loss. Several studies (Benore & Park, 2004; Kristiansen & Sheikh, 2012; Kristiansen, Younis, Hassani, & Sheikh, 2016; Murshidah & Kalyani, 2010; Suhail, Jamil, Oyebode, & Ajmal, 2011) argue that attitudes related to mourning and grief may be shaped and rationalized through a religious framework. The way people view and deal with bereavement may in particular be influenced by their eschatological beliefs.

In the Islamic tradition, considerable attention is given to the topic of mourning and memorial within the *fiqh* manuals. The Islamic approach to death is organized into a set of beliefs and rituals that structure the initial response to death, the funeral and the formal mourning periods (al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Yasien-Esmael & Rubin, 2005).

However, until this day few empirical studies exist on views of Muslims regarding mourning and remembrance (Assous, 2013; Dessing, 2001; Jonker, 1997; Kadrouch-Outmany, 2014; Murshidah & Kalyani, 2010; Renaerts, 1986; Suhail et al., 2011; Venhorst, 2013). Most of these studies have been done from an anthropological, psychological and psycho-analytical approach. Nevertheless, a comprehensive descriptive account of Muslim views regarding mourning and remembrance in a European setting, and more specifically in the Belgian context, is lacking to a great extent. In this article, we will focus on our participants' views on mourning and remembrance. Practices surrounding mourning and remembrance are discussed in detail in a separate article.

The aim of this article is fourfold. First, we seek to describe the views and beliefs of middle-aged and elderly Moroccan Muslim women towards mourning and remembrance. Second, we aim to identify any differences between middle-aged and elderly women's views.In contrast to the first generation elderly Moroccan Muslim women, who are mainly uneducated and illiterate, the group of middle-aged women shows much more socio-economic diversity. Moreover, these women are no longer raised in a homogenous, rural, traditional Islamic environment and live much less isolated from the broader Belgian society. Third, we aim to explore the role of religion in their views.Fourth, we seek to document how the actual views of our participants relate to the normative Islamic literature**.**

Normative Islamic and Scholarly literature: Sunnī Perspectives on Mourning and Remembrance

In Islam, a set of beliefs and rituals organizes the response to loss. Mourning and remembrance have been adressed in *ḥadīth* and legal literature (Aggoun, 2006; Halevi, 2007; Motzki, 2017). However, some small variations can be found between Islamic denominations and legal schools (*madhāhib*) in

their prescriptions regarding mourning and remembrance (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). In this article, we only focus on *Sunnī*-perspectives on mourning and remembrance. Nearly 85% of Muslims consider themselves to be *Sunnī* (Pew Research Center, 2011). While *Sunnī* and *Shiʿī* theology share much in common, *Sunnī* and *Shīʿa* denominations have their own legal methodology/theory (*ʾusūl al-fiqh*). The *Sunnī* denomination has four legal schools (*Malikī, Ḥanafī, Ḥanbalī* and *Ḥanafī).* The overwhelming majority of Moroccan Muslims are *Sunnī* and follow in particular the *Malikī* legal school. We define normative Islamic literature as works that report *in casu* on mourning and remembrance from an Islamic viewpoint or frame of reference based on Islamic tradition and scripture.

Normative Islamic literature emphasizes the importance of accepting one's loss with patience and resignation, and of gracefully accepting God's decree, as life and death are decreed by God and death is inevitable (Al-Shahri, Fadul, & Elsayem, 2007; Halevi, 2007; Smith & Haddad, 2002; Yasien-Esmael & Rubin, 2005). According to Gatrad and Sheikh (2002a) *ṣabr* (patience) represents one of the greatest heights of spiritual development that a Muslim can attain. The *Qur'ān* repeatedly asserts that life is only a test and that death is not the end but merely a transition to the afterlife. In Islam the inevitable sense of loss that occurs at the time of death is tempered by the belief that any separation is temporary and one will find solace in the reunion with God and one's deceased loved ones.

Muslim jurists -experts in Islamic jurisprudence (*fiqh*) and Islamic law (*sharīʿa*)- strongly discourages and criticizes loud weeping and wailing over the deceased as this would torture the deceased (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Branca, 2017; Halevi, 2013; Hedayat, 2006; Yasien-Esmael & Rubin, 2005). According to Halevi (2007), many attempts have been made to bring an end to the female practice of wailing for the dead. This custom of expressing the sense of loss consists of physical gestures and verbal utterances such as scratching the face, tearing one's hair, performing ululation and singing lamenting songs in which the good qualities of the deceased are enumerated (Aggoun, 2006; al-Jazīrīʾ, 2009; Halevi, 2013; Yasien-Esmael & Rubin, 2005). According to al-Jazīrīʾ (2009), this is considered a relic from pre-Islamic times (*jāhiliyya*) and suggests an insolent questioning of God's wisdom. The *Mālikī and Ḥanafī* legal schools consider these acts forbidden (*harām*); the *Shāfiʿīʾ* and *Ḥanbalī* school, however, consider them acceptable. All legal schools agree that shedding tears silently is acceptable (al-Jazīrīʾ, 2009).

Methods

Design

Between October 2014 and September 2015, thirty semi-structured interviews were conducted with a sampling of middle-aged and elderly women in the Moroccan community in Antwerp (Belgium)

who self-identify as Muslim. This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. We have chosen Antwerp for two important reasons. First, this city has the largest Muslim population in Flanders: 19, 2 % of Antwerp's population is Muslim (Hertogen, 2016). Second, Antwerp as a port city is considered to be among the most multicultural cities in the world.

Different routes of recruitment (e.g. mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured topic list covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) and Dutch. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organization or in a quiet tea house). To help us with the interpretation of our data, the interviewer (first author) also interviewed 15 experts in the field (e.g. Muslim undertakers, professional Muslim death washers, palliative care consultant etc.) about particular topics of our study between September 2014 and September 2015. These interviews functioned as background information and were compared with the empirical data of our interviews with Moroccan Muslim women. In this study we interrogated experts to find out more about the way Moroccan Muslim women view and deal with mourning and remembrance. This method helped us to be more sensitive regarding the data of our interviews with Moroccan Muslim women and to ensure the reliability of our data and interpretations.

Apart from interviewing, the first author also conducted participant observations between December 2014 and April 2017. Several visits of the sick, a *ḥijāma*-consultation, death prayers, ritual washings of the dead body, repatriation of a deceased, burial, mourning gatherings were attended and several Islamic cemetery plots were visited. The fact that she is a member of the Moroccan Muslim community in Belgium enabled the first author to gain information and access into difficultly accessible settings (Mortelmans, 2008). Field notes were taken of the activities observed and participated, capturing key verbal and nonverbal communication as well as analytical and reflexive notes. To assure reliability and validity and limit bias as much as possible, several strategies were adopted (e.g., data checking with members of the Moroccan Muslim community, peer debriefing, and memos).

The present study is part of a larger research on the attitudes, beliefs and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp). In this research, themes such as care for the elderly, health, illness, medicine, end-of-life issues (e.g. active termination of life; palliative treatment and symptom control; withholding and withdrawing treatment), death and dying, the afterlife and burial practices were also addressed.

In this study, we opted for a non-normative, descriptive, exploratory approach. This study was approved by the Social and Societal Ethics Committee (KU Leuven, Leuven). In order to guarantee the anonymity of our participants, we made use of pseudonyms.

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology (Corbin & Strauss, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used to code and analyse the interview data. By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants. In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. Findings of the interviews with Muslim women were compared with those of the interviews with experts and subsequently compared with normative and empirical studies (cf. discussion). Our research findings were regularly discussed with our guiding committee and with several members of the Moroccan Muslim community.

Participants' (socio-)demographic information & health situation

Our group of middle-aged Moroccan Muslim women (n=15) was between 41 and 55 years old; our group of elderly women (n=15) was aged between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labor migration, family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of between three to five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber participants spoke Arabic and only two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes. Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

The health issues of our middle-aged participants were limited to knee problems and migraine. Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a bad health condition. Nine participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer and severe chronic disease.

The selection of experts in the field was based on the technical knowledge that the experts had regarding our research topics and their familiarity with the research population in their professional capacity. In particular, we recruited Muslim physicians, Muslim nurses, imams, burial undertakers, a palliative care consultant, a psychosocial consultant, a specialised corpse washer, a *ḥijāma* practitioner and elderly care consultants.

Name	Gender	Level of Education	Profession	Ethnicity
Nora	Female	High	Nurse	Moroccan
Laila	Female	High	Nurse	Moroccan
Soumiya	Female	High	Elderly care consultant	Moroccan
Khawla	Female	Low	Specialized corpse washer	Moroccan
Farida	Female	High	Physician	Afghan
Myriam	Female	Low	Palliative care consultant	Moroccan
Fadila	Female	High	Psychosocial care consultant	Moroccan
Imane	Female	High	*Ḥijāma* practitioner	Moroccan
Salima	Female	High	Elderly care consultant	Moroccan
Nourdin	Male	Low	Imam	Moroccan
Faysal	Male	Low	Imam/Islamic teacher	Moroccan
Kamal	Male	High	Physician	Moroccan

Zakaria	Male	Low	Burial undertaker	Moroccan
Rachid	Male	High	Burial undertaker	Moroccan
Daniel	Male	High	Expertise in burial and policy	Dutch

Results

Attitudes towards Mourning and Remembrance

Experience of Loss

According to our participants, the way one experiences grief strongly differs from person to person, but also depends upon other factors. First, more than half of our participants mention that the way a person dies has a great impact on the way one mourns. They make a distinction between dealing with a natural cause of death (e.g. ageing) and a sudden death (e.g. accident). They explain that the first is much easier to cope with, whereas the latter fosters a stronger shock and feelings of disbelief. They also indicate that dying in a good state (e.g. during prayer, on a Friday, as 'a good Muslim') or the way the person wished for (e.g. in Morocco, before becoming care-dependant), fosters an easier mourning process and acceptance of loss. When the deceased was suffering from a severe illness (e.g. cancer) or had reached a very old age, the loss would often be perceived as a relief, as it entails the end of his/her suffering. This was also observed during the participant observation and confirmed by our experts.

> "My aunt's husband has Alzheimer and he is completely beaten up by this illness[…] I think it's easier for them to bid farewell because they're mentally prepared for it. For us, it was a total shock, my father's death was a shock. He was not sick[…]. My world collapsed. On the one hand it was comforting because he died in Morocco, on a Friday after *fajr*. That was his wish. But I miss him and I always will. It's so difficult, also because we couldn't say goodbye to each other." Hannan – middle-aged
>
> "My mother was sick and old and nobody could take care of her. I told her it's fine. She had her time. She became sick and we told her it's better to leave than to live in torture (*ʿadhāb*). It's a relief for me that my mother didn't gossip, she gave *ṣadaqa*, she gave a lot. She was a good woman." Laziza – elderly
>
> "Yes, I've often heard bereaved say 'my mother left well, she did her five prayers, she did everything that a Muslim should be doing and I am relieved'." Rachid – Muslim undertaker

Second, participants make a distinction in the experience of grief based upon the deceased's age. They argue that mourning over an adult or elderly person is more difficult than over a baby or young child. Mainly participants who experienced a miscarriage or lost a child explicitly offer a teleological perspective. Indeed, they believe that a child will directly enter paradise as he/she is a pure human being. In addition, they also stress that their child is safe with God and therefore feel reassured.

> That was with ups and downs. With my son's loss, my brother said 'Are you becoming crazy or what?' I told him 'No, *al-ḥamdulillāh* (all praise to God) he is in *al-janna* (paradise).' And also, children are pure." Warda – middle-aged

> "Yes, they [her children] went back to God. They were here temporarily. They went back and they are safe with God.[…] Children are pure, so I don't need to worry about that[…] and that feeling inside, that was like 'It's fine mom' [cries].[…] 'I arrived well'.[…] I became normal. Peaceful. My daughter joined her brother and they were safe." Halima – middle-aged

Third, the way one experiences loss is also heavily influenced by the relation the bereaved had with the deceased. Our participants argue that the closer the relationship, the more painful and difficult the mourning process is. In this respect, nearly all participants explicitly refer to the loss of parents or children. More specifically, mainly elderly participants underline that losing one's parents is the most painful experience. one can have in this earthly world and also entails a disintegration of the family, as they were the fundament. The most difficult part of mourning expressed by our participants is the feeling of emptiness and separation (*al-firāq*). This is also shared by our experts.

> "You don't know what death means until your parents die.[…]. There's no love in this world bigger than that between a parent and a child. The day that they die, everything perishes, the Sacrifice feast goes by, then the festival of breaking the fast goes by and the family doesn't come together anymore. It's the parents that bring the family together." Yamina – elderly

> "It's a big loss. You miss them. Death is hard. We know that we are all going to die, but separation (*al-firāq)* is the hardest part. I can't find my mother, father and brother anymore [cries]. Death is painful, but it's a part of life." Aïcha – elderly

> "We experienced that. They cry and feel the absence of 'he left me'. The sorrow is big, whether he/she is young or old. You can clearly see that the separation (*al-firāq)* hurts, like 'I'm not going to see him/her anymore'." Khawla – Specialized corpse washer

The majority of our participants mention that they experienced feelings of shock, disbelief and intense sadness after losing a loved one. Through our interviews and participant observation, we learned that among those who had a lesser relationship with the deceased, feelings of guilt were strongly present. Especially when it concerns a sudden death, the feeling of not being able to restore one's relationship or to ask for forgiveness burdens the living person. Apart from this, several participants also mention that the emotions felt when losing someone are also strongly dependent on whether one was able to take leave of the dying/deceased. Mainly elderly participants told us about their difficulties in coping with the loss of their loved ones back in the days, due to the migrational setting and lack of communication. They often would hear the news of a person's death much later and therefore were not able to be present at the moment of death or the burial. Noteworthy, two elderly participants mention that often the family in the country of origin will not say that someone is severely ill or is about to die to avoid worries and panic.

> "There's a difference between witnessing death and not witnessing it. I didn't witness it with my father, I had just arrived in Belgium and I couldn't go back. And that was very difficult for me. You cannot compare loss with

> something else." Fatma – elderly

> "My sister called me on a Saturday to tell me that he [father] died. I was in shock. I was going crazy.[…] I asked my mother 'why my sister kept it from me that he was sick'.[…] Yes, I was very sad.[…] It took me an entire day to get to Marrakesh, but I was too late. My father was already buried, because it was too hot. I wanted to see him but I was too late. I was really sad, I couldn't bid farewell. It's difficult when you can't say goodbye." Zoulikha – elderly

Sarah, a middle-aged participant, and Khadija, an elderly participant, explicitly mention that they experienced a depression and felt world-weary after the loss of their loved ones. Although Khadija's loss of her parents dates back fifteen years, she still has not been able to give it a place in her daily life. This also has to be viewed against the backdrop of her experiencing solitude and feeling abandoned by her children.

> "Afterwards [her mother's loss] I was not myself anymore. I hated everyone. That was bad. That was like a depression. I was like a robot to my children. Just making food, getting the clothes ready, but showing no emotion at all, no love, nothing. I was not myself. I took medication for two years. And the day after that, when I went outside, I thought 'wow, how much time did I waste?[…] Death remains a hard word. And especially the death of your parents, that's a difficult farewell." Sarah – middle-aged

> "Since my husband died.[…] I'm not well. They can take me everywhere, to Washington, to Morocco, but I'm broken on the inside. Especially when it's almost September, and then October when my mother died. It's hard and it's only getting harder.[…] Even if you have a house, the house needs a family (*rahbab).* I have nowhere to go so I stay at home.[…] And yes I feel lonely." Khadija – elderly

One participant, Ikram, who had a miscarriage at seven months, mentions that she did not experience sadness, nor did she cry. She explains that this lack of emotions was because she did not have a connection yet with the baby. She also adds that she has never felt maternal love at birth, but that it is something that has to grow over time.

> "Giving birth was heavy because I had a big belly.[…] You gave birth, you didn't feel so well physically, but spiritually I came out stronger.[…] Normally you would mourn and feel sad. I didn't have that. I called my physician and told him that I'm abnormal, I don't feel sadness, I don't cry.[…] You know, when I give birth, I don't have that maternal love with my children. It's something that has to grow.[…] I never thought I would react that way to the death of a child. I reacted that way because I didn't know that child." Ikram – middle-aged

Dealing with loss

Virtues

All participants strongly emphasize three virtues in coping with loss, which are also confirmed by our experts. Especially participants who were confronted with a loss heavily stress the centralities of these virtues. It must be noted that these three virtues are strongly intertwined. A first important and ultimate attitude is accepting God's will and decree (*al-qadr/maktab*). Although a loss is difficult, our participants underline that it is of utmost importance to accept it because of the divine decree, but also because death is part of life (*sunnat al-ḥayāt*). They believe that the moment of death is predestined by God and therefore there is a time to be born and a time to die. Several participants

state that this acceptance is based on God's right over a human being. As such, they consider death as God, the ultimate owner of life and death, taking back what belongs (cf. *ʾamāna/*trust*)* to Him and Him alone. This is often expressed by Muslims as 'God wanted him/her more than we' ('*Rabbi igsit kta'*). They strongly express the belief that each soul shall return to God and therefore has to accept God's will. From an eschatological perspective, they strongly share the belief that separation (*al-firāq*) is only temporary and therefore their hope is centred on the reunion that will take place in the afterlife. This is also confirmed by our experts.

> "Just accept what God gives. We say 'we all have an end, but this is not the end'. I will see my two children again, they are safe with God. I won't be kept awake at night. I don't have any worries.[…] That's how I was talking: 'God, there's no safer place than with You. They are Yours and I only hope that I will see them again'." Halima – middle-aged

> "What can you do about it in that moment? It's God's will.[…] It's a difficult situation. But it comes from God and it's a part of life that someone dies. We have to accept that situation. God has predetermined it that way." Yamina – elderly

> "It's important to be satisfied with God's destiny, the predestination of God.[…] That you also accept God's decision. They say then that we come from God and to Him shall we return." Nourdin – *ʾimām*

A second important virtue is the virtue of *gratitude* (*ḥamd*). Several participants uttered *al-ḥamdulillāh* (praise be to God) when confronted with death. Despite the circumstances, they argue one must still praise God and may not complain. This utterance is used even more when a person has died in a good state or the way he/she wished for.

> "My father always wanted to die in Morocco, *subḥānallāh* (glory to God). And that coffin, that cold storage etc., he was always scared of that.[…] He actually died, was washed and buried there. I was really really sad, but when I think of his wish, I say '*al-ḥamdulillāh*. God actually fulfilled his wish." Halima – middle-aged

> "You cry, you cry and then you say *al-ḥamdulillāh*. Yes, in that moment you turn to your faith and then you immediately say *al-ḥamdulillāh, al-ḥamdulillāh* . It comes from God. God took back His *ʾamāna*." Haddad – elderly

Third, *patience (ṣabr/eswa)* is perceived as an extremely important virtue in coping with death, as it is a sign of trust in God. In this respect, almost all participants emphasize that the ultimate attitude towards loss, which is seen as a test, is being patient. In this respect, they express that God is always with those who are patient (*ʾinna Allāha maʿa al-ṣābirīn*). Enduring patiently is considered a mercy (*raḥma*) from God. Participants believe that by adopting the aforementioned virtues, good points (*ḥasanāt*) are earned, which leads to a better position in the afterlife (*al-ʾākhira*). This is also shared by our experts.

> "They called me from Morocco to tell me that my mother died *Allāh yarḥamhā (May God have mercy upon her).*[…] I was really sick back then and there was nobody home, everyone was working. And I kept telling God to give me patience. And I felt it *subḥānallāh* that God gave me patience. I felt his *raḥma* bestowed upon me." Huda – elderly

> "May God make us belong to those who are patient. You need to have patience with death. You need to have patience in difficult cases. Even if you don't accept something, you need to have patience. God is with the patient. You understand? If God gives you a test, you need to have patience. God says 'I love the one who shows patience'." Alia – elderly

> "Yes, they say that you have to be patient. They can cry but they can't do crazy things.[…] They often say 'God will reward you if you show patience. God will give you a lot'." Khawla – Specialized corpse washer

Vices

In contrast to virtues, several participants strongly denounce hysterical behaviour as a response to loss. More specifically, they vehemently disapprove of wailing, crying and complaining, which they consider 'cultural' (and not Islamic) practices and behaviour showing ignorance (*jahl)*. Such behaviour is understood as a sign of not accepting God's will and mistrusting God. In this respect, our participants also provide a teleological explanation. Indeed, they share the belief that the deceased is able to hear, see and feel, and therefore crying or weeping would burden and even torture the deceased's soul. However, they do highlight that shedding tears and expressing grief is a normal reaction and therefore acceptable, but not in a disproportional way. This is also confirmed by our experts. However, a few experts also argue that especially first generation women have the tendency to act hysterically, which they then relate to their lack of knowledge of Islam, compared to second generation women, who are assumed to have more knowledge on their faith. We did not observe this in our own interviews, however, nor in our participant observation.

> "You can't cry or scream. That's a cultural custom. You may cry, but like they say, your tears may not touch the ground. We always learned that the person who died, feels it. He is tortured by the tears." Narima – middle-aged

> "I know that women scream, they pull their hair and they're angry. If you borrow money from someone, will you give it back or not? You will! Well, that's the same with death. You are not going to fight God." Alia – elderly

> "Among Moroccans, there is a lot of screaming.[…] Yes, the hysterical part I don't see that often among the second generation. I think that's because they have more knowledge about their faith. The first generation shows it to the outside world, there has to be screaming, they pull their hair, you still see that." Faysal –ʾimām/Islamic teacher

Noteworthy, a few middle-aged participants mention to have experienced social pressure with regard to the expression of grief. They explain that the bereaved were also expected to 'publicly' express their pain and loss. As they were in shock and not able to cry or had other concerns (e.g. preparation of repatriation), their behaviour was seen as abnormal by some.

> "People came to condole me and I stood there stiff as a stick. The only thing I was thinking of was that I had to do the administration so that my mother could go to Morocco.[…] And there were a lot of people who came to condole us and at one moment I was sick of their hysteria and I told them to stop and they said 'wow, it's as if it isn't your mother that died'. I said 'you need to keep quiet and not scream. Let her go in peace'. I couldn't cope with the screaming and the pulling of the hair. These are not our manners." Sarah – middle-aged

> "I was in shock with my miscarriage.[…] For me it was disbelief, just disbelief. I was in shock.[…] My sister in law, everyone was crying. I had nothing. I didn't cry, nothing. I was in shock. And yes, everyone found it strange and abnormal." Ikram –middle-aged

Remembering the Deceased

Nearly all participants are of the opinion that the deceased's remembrance strongly depends on the relationship he/she had with the bereaved (e.g. parents, friends, neighbour). Several participants mention that especially good people will be remembered and this particularly by their good children. The majority of our participants state that not one day passes by without them thinking about their deceased loved ones –this is especially true during prayer (*ṣalāt*), when another family member dies, when one's children marry and on birthdays.

> "I always think of the good sides of my husband, my father and father-in-law. You always think of the place they left behind. You sometimes find their stuff, so you can't forget it. It's a big loss in everything. For example my father's house in the Rif was a beautiful refurbished house when he was still alive and now it's totally abandoned and then I always think about the times when my father was still alive." Fatma – elderly

> "I often think about them. I don't forget them.[…] I have a picture of him [father] on the laptop, and I always look at him. But even when I don't see the pictures, I always think about them.[…] The ones that you love the most, stay in your heart." Nuria – elderly

Noteworthy, a participant who had a miscarriage and a participant who lost two children explicitly said they did not commemorate their deceased child due to their innocence and the belief that they are in good hands and safe with God.

> "Our son for example, I never went to his grave. Uhm, I know I have a child who is with God, I know that. I'm always conscious about that but when I die, I will see him.[…] But I don't really commemorate him. That's because I didn't really lose someone." Ikram – middle-aged

> "I don't like commemorating. I told you, they are safe with God, their Creator. I don't worry about them, I am not worried about them. I don't need to remember them." Halima – middle-aged

Discussion

The findings of our interviews with middle-aged and elderly Moroccan Muslim women are nearly identical to those of the interviews with our experts in the field. Although there are differences in age, but also in level of education and socio-economic status between the first and second generation, surprisingly no differences were observed between our middle-aged and elderly participants in their views and experiences regarding mourning and remembrance, nor between participants who were confronted with loss in their immediate environment and those who were not. Although it could be assumed that second generation Muslim women, who were born or raised in Belgium, are more likely to be influenced by Western ideas, which might result in a secular understanding of death and a decline in following religious observance, this was not the case.

Attitudes regarding mourning and remembrance are strongly shaped by a religious framework. Theological and more specifically teleological considerations centring on God's sovereignity in matters of life and death and the belief in the afterlife seem to be very crucial for both middle-aged and elderly Moroccan Muslims in accepting and dealing with loss. Both strongly emphasized theological and eschatological notions in their answers. In this respect, the inevitability of death and the belief in predestination is strongly emphasized. Muslims underscore that God is the ultimate creator and owner of life and therefore has every right to take back His trust (ʾ*amāna*). Man is only the vice-regent, not the owner of his body. From an eschatological perspective, Muslims believe that the separation with loved ones is only temporary as death is not perceived as the end, but merely a transition from one state of existence to the next.

Finally, we observed that the migration context has a great influence on the mourning process Mainly elderly Moroccan Muslim women could not witness the death of their deceased loved ones in the country of origin due to the geographical distance. Because of the dominant choice for repatriation to the country of origin, both middle-aged and elderly Moroccan Muslims experienced difficulty in mourning and commemorating their deceased loved ones because of the distance between the bereaved and the deceased.

Comparison with Normative and Empirical Literature

Our participants' line of thought are strongly consistent with the line of reasoning and Islamic prescriptions found in normative Islamic literature on mourning and remembrance (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Al-Shahri et al., 2007; Gatrad & Sheikh, 2002a; Halevi, 2007, 2013; Sheikh & Gatrad, 2008). In both our findings and normative Islam we find the the belief in life and death as decreed by God, the belief in afterlife and the importance of accepting one's loss and showing patience.

Most studies on mourning and remembrance focus on theories and models of grief and bereavement, for example the continuing bond with the deceased (cf. Freud 1917; Neimeyer 1999; Klass & Walter, 2002) and coping strategies (Benore & Park, 2004; Pargament, 2001). The main empirical studies we found focus on Muslims of different ethnicities and/or denominations in the West (Bot, 1998; Dessing, 2001; Gardner, 1998; Hussein & Oyebode, 2009; Jonker, 1997; Kadrouch-Outmany, 2014; Kristiansen et al., 2016; Suhail et al., 2011; Venhorst, 2013) or on Muslims in Morocco (Dieste, 2012; Renaerts, 1986). For example Dessing (2001), Venhorst (2013) and Kadrouch-Outmany (2014) conducted a qualitative study and Bot (1998) an ethnographic study among Muslims of different ethnicities (e.g. Moroccan Turkish and Surinamese people) in the Netherlands. Gardner (1998) and Hussein & Oyebody (2009) focused on Pakistani Muslims in the United Kingdom. Jonker (1997) conducted ethnographic research among Turkish Muslims in Germany. In contrast to the abovementioned studies that deal with perspectives on mourning and

remembrance in a fragmented way, our study offers an encompassing, comprehensive and detailed perspective on experiences and views of Moroccan Muslims living in Belgium regarding mourning and remembrance. In others words, our study provides more detailed elaboration of the (religious) line of reasoning of our participants.

Nevertheless, the findings of our study show strong similarities to the findings of the abovementioned studies. Like our findings, several studies (Hussein & Oyebode, 2009; Koshen, 2015; Kristiansen & Sheikh, 2012; Murshidah & Kalyani, 2010; Suhail et al., 2011) found that the experience of loss and coping with bereavement is influenced by the specific nature of death, (including dying on a Friday or death of a child that is seen as innocent and therefore will enter paradise), was found to bring a comforting relief.

In keeping with our findings, these studies also found that the coping with loss depends on the relationship one had with the deceased. An example is the study of Hussein and Oyebode (2009), who also found feelings of guilt or worries among bereaved, such as apologizing to the deceased before death or the doubt whether they had tried hard enough in the relation.

Several studies (Assous, 2013; Dessing, 2001; Hussein & Oyebode, 2009; Kristiansen et al., 2016; Murshidah & Kalyani, 2010; Suhail et al., 2011; Yasien-Esmael & Rubin, 2005) support our finding that the Islamic belief help Muslims to ascribe meaning to loss. This religious framework indeed constitutes a source of meaning and of dealing with loss by articulating death as predetermined by God and part of God's will. Many scholars (Benore & Park, 2004; Kristiansen et al., 2016; Pargament, 2001; Yasien-Esmael & Rubin, 2005) endorse our findings that loss and grief are perceived and understood from an eschatological framework that facilitates the recovery process. More specifically, Kristiansen and Sheikh (2012) confirms that the inevitable sense of loss that occurs at the time of death is tempered by the belief that any separation is only temporary and that it is a test from God. Several scholars (Aggoun, 2006; Assous, 2013; Hussein & Oyebode, 2009; Jonker, 1997; Murshidah & Kalyani, 2010; Suhail et al., 2011) also found similar virtues in coping with loss, including the importance of accepting/submitting to God's decree/plan and showing patience.

In line with our findings, several studies (Aggoun, 2006; Dieste, 2012; Jonker, 1997; Renaerts, 1986; Yasien-Esmael & Rubin, 2005) also indicate the practice of loud expressions of grief including wailing, lamentations and tearing hair or clothes. Moreover, Aggoun (2006) and Jonker (1997) confirm that a moral local code exists which involves an expectation of women to cry loudly, whereas men are expected to refrain themselves (from crying). Similar to our findings, we also found a cultural expectation that the bereaved would cry and those who did not were judged for not crying. Interestingly, although the participants in our study as well as as normative Islamic literature (cf. introduction section) denounce the behaviour of loud expressions of grief, we also found at the same

time -and confirmed by abovementioned studies- that there is also a social pressure for the bereaved to publicely express her pain and loss. Although a few scholars (Aggoun, 2006; Dieste, 2012; Renaerts, 1986; Yasien-Esmael & Rubin, 2005) mention the practice and existence of professional mourners (*ḥazzanāt*), who sing songs about the deceased's life, this was not mentioned by our participants nor observed during the participant observation. Kadrouch-Outmany (2014) and Jonker (1997) confirm that Muslims in migrant settings seldom lament loudly.

Our exploratory findings should be interpreted with several limitations in mind. First, data might be biased due to social desirability. Expressing opinions that might deviate from the norm or that could be seen as contrary to Islamic teaching might be difficult. As an interviewer, it is difficult to ascertain whether participants share truthful information. Although several measures were taken to guarantee anonymity (e.g. pseudonyms, deleting audio-tapes after transcribing), qualitative research cannot fully guarantee anonymity (e.g. interviews are face-to-face). Both advantages and disadvantages are attached to the background of the interviewer (interviewer bias). On the one hand, being a member of the same community facilitated the gaining of trust and resulted in a certain openness and detailed conversations, on the other hand this might also have influenced the answers of the participants by not providing 'deviated' answers out of fear of being judged. Second, a possible bias is the mixed position of the expert. During coding, we have taken this into account and made a clear distinction –where possible– between personal views of the expert and his/her description of the views of Moroccan Muslim women. Third, the translations we had to do also may have introduced a bias. The interviews conducted in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) had to be translated into Dutch and English, which might have influenced the data. As this was carried out to ensure validity and reliability so that others, including the guiding committee, could verify and follow the coding and analyzing of the data, the first author sought to make accurate translations and verified their accuracy by relying on members of the Moroccan community when confronted with difficulties in the translation of a word or concept. To assure reliability and validity and limit bias as much as possible, we adopted several strategies (e.g. data checking with members of the Moroccan Muslim community; peer debriefing; memos). Fourth, given the nature of our data (specific group; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. In any case, this work does not ignore the heterogeneity among Muslims. For instance, it would still be interesting to do an in-depth investigation of Muslims from different ethnicities and/or denominations on their views regarding mourning and remembrance. Taking into account the specific situation of first generation Moroccan Muslims in Belgium characterized by a strikingly homogenous religious, cultural, socio-economic and geographic background and a more diverse socio-demographic background among second generation Muslims, it would be interesting to explore the views among third generation Muslims who are assumed to embody a stronger diversity socio-economically as well as religiously.

Further studies could explore whether the impact of religion on views on mourning and remembrance differs among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

The organisation of adequate and quality bereavement care which takes into account the religious and cultural needs of the bereaved is of utmost importance. By offering insights into the actual experiences and attitudes, our study aims to offer tangible leads to professionals for a more tailor-made care for bereaved Muslims while insisting that practitioners remain mindful of the diversity of lived experiences that exist within cultures as well as across them. The availability of a Muslim chaplain at this difficult time will usually be an invaluable assistance to the bereaved family and health care professionals.

Conclusion

Our study reveals that religious beliefs and worldviews have a great impact on the views of regarding mourning and remembrance. Religious beliefs seem to be powerful sources in coping with death and loss. More specifically, theological and eschatological considerations take up a central role. Muslims express an unconditional belief in an omnipotent and omniscient God, who governs over life and death, and the belief in an afterlife. We have observed that when dealing with mourning and remembrance, both first and second generation Moroccan Muslims living in Antwerp (Belgium) adopt a theological line of reasoning similar to the one that can be found in normative Islamic literature. We did *not* find a more secular view of mourning and remembrance among middle-aged women.

References

Ahaddour C., & Broeckaert B. (2016). Muslim Burial Practices and Belgian Legislation and Regulations: a comparative literature review. *Mortality, 22* (4), 356-373.

Ahaddour C., & Broeckaert B. (2017). "For Every Illness There Is A Cure". Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-017-0466-1,

Ahaddour C., Van den Branden S., & Broeckaert B. (2017a). Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women. *Omega: Journal of Death and Dying.* https://doi.org/10.1177/0030222817729617.

Ahaddour C., Van den Branden S., Broeckaert B. (2017b). "God's Land is Vast". Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased. *Mortality*. https://doi.org/10.1080/13576275.2017.1413543.

Aggoun, A. (2006). *Les Musulmans face à la mort en France* (Espace Ethique ed.): Vuibert.

al-Jazīrīʾ, A. (2009). *Islamic Jurisprudence According to the Four Sunni Schools - Al Fiqh 'ala Al Madhahib Al Arba'ah*. In Vol. 1. *Modes of Islamic Worship*. Retrieved from https://archive.org/details/IslamicJurisprudenceAccordingToTheFourSunniSchoolsAlFiqhalaAlMadhahibAlArbaah

Al-Sayyid, S. (1991). *Fiqh Us Sunnah*. In. Retrieved from http://mappingsharia.com/wp-content/uploads/2011/06/Saabiq-Fiqh-us-Sunnah.pdf

Al-Shahri, M., Fadul, N., & Elsayem, A. (2007). Death, dying and burial rites in Islam. *European Journal of Palliative Care, 13*(4), 164-167.

Assous, A. B. (2013). Cultural and Islamic Values in Relation with Death. *European Scientific Journal, 9*(5), 1857-1881.

Benore, E. R., & Park, C. L. (2004). Death-Specific Religious Beliefs and Bereavement: Belief in an Afterlife and Continued Attachment. *International Journal for the Psychology of Religion, 14*(1), 1-22.

Bot, M. (1998). *Een laatste groet : uitvaart- en rouwrituelen in multicultureel Nederland*. Rotterdam: Ef & Ef In Boeken.

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory*. Fourth Edition Aufl. California: SAGE Publications.

Branca, P. (2017). Weeping. In J. D. McAuliffe (Ed.), *Encyclopaedia of the Qurʾān*. Brill Online: Brill.

Dessing, N. M. (2001). *Rituals of birth, circumcision, marriage, and death among Muslims in the Netherlands*. Leuven: Peeters.

Dieste, J. L. M. (2012). *Health and Ritual in Morocco: Conceptions of the Body and Healing Practices*: Brill.

Gardner, K. (1998). Death, burial and bereavement amongst Bengali Muslims in Tower Hamlets, East London. *Journal of Ethnic and Migration Studies, 24*(3), 507-521.

Gatrad, A. R., & Sheikh, A. (2002a). Palliative Care for Muslims and Issues After Death. *International Journal of Palliative Nursing, 8*(12), 594-597.

Glaser, B. G., and A. L. Strauss. (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research.* New York: Aldine Publishing Company.

Halevi, L. (2007). *Muhammad's grave: death rites and the making of Islamic society*. New York: Columbia University Press.

Halevi, L. (2013). Funerary Practices. In K. Fleet, G. Krämer, D. Matringe, J. Nawas, & E. Rowson (Eds.), *Encyclopaedia of Islam, Three*. Brill Online: Brill.

Hedayat, K. M. (2006). When the spirit leaves: Childhood death, grieving, and bereavement in Islam. *Journal of Palliative Medicine, 9*(6), 1282-1291.

Hertogen, J. (2016). Marokkaanse-, Turkse- en islamachtergrond per gemeente. Retrieved from http://www.npdata.be/ [Accessed 20 April 2016]

Hussein, H., & Oyebode, J. (2009). Influences of religion and culture on continuing bonds in a sample of British Muslims of Pakistani origin. *Death Studies, 33*(10), 890-912.

Jonker, G. (1997). The many facets of Islam; death, dying and disposal between orthodox rule and historical convention. In C. M. Parkes, P. Laungani, & B. Young (Eds.), *Death and bereavement across cultures*. London-New York: Routledge.

Kadrouch-Outmany, K. (2014). *Islamic burials in the Netherlands and Belgium. Legal, religious and social aspects.* (Doctoral thesis), Leiden University, Leiden.

Koshen, H. (2015). A Somali Perspective On Death, Grief and Culture. Culture Perspectives on Death in Families. In J. Cacciatore & J. DeFrain (Eds.), The World of Bereavement. Switzerland: Springer International Publishing. doi:DOI 10.1007/978-3-319-13945-6_2

Kristiansen, M., & Sheikh, A. (2012). Understanding faith considerations when caring for bereaved Muslims. *Journal of Royal Society of Medicine, 105*(12), 513-517.

Kristiansen, M., Younis, T., Hassani, A., & Sheikh, A. (2016). Experiencing Loss: A Muslim Widow's Bereavement Narrative. *Journal of Religion and Health, 55*(1), 226-240.

Mortelmans, D. (2008). *Handboek kwalitatieve onderzoeksmethoden*. Leuven: Acco.

Motzki, H. (2017). Waiting Period. In J. D. McAuliffe (Ed.), *Encyclopaedia of the Qurʾān*. Brill Online.

Murshidah, H., & Kalyani, M. (2010). Grief experience of bereaved Malay/Muslim youths in Singapore: the spiritual dimension. *International Journal of Children's Spirituality,, 15*(1), 45.

Pargament, K. I. (2001). *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: Guilford.

Renaerts, M. (1986). *La mort, rites et valeurs dans l'Islam Maghrebin.* Brussel: ULB - Institut de Sociologie.

Sheikh, A., & Gatrad, A. R. (2008). Death and Bereavement. An exploration and meditation. In A. G. Sheikh, A. R. (Ed.), *Caring for Muslim Patients* (2nd ed., pp. 103-113). Oxford: Radcliffe Publishing.

Smith, J. I., & Haddad, Y. Y. (2002). *The Islamic Understanding of Death and Resurrection*. Oxford: Oxford University Press.

Suhail, K., Jamil, N., Oyebode, J., & Ajmal, M. A. (2011). Continuing bonds in bereaved Pakistani Muslims: effects of culture and religion. *Death Studies, 35*(1), 22-41.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research : techniques and procedures for developing grounded theory*. Thousand Oaks (Calif.): Sage.

Van den Branden, S. (2006). *Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen.* (Unpublished doctoral dissertation), Katholieke Universiteit Leuven, Leuven.

Venhorst, C. (2013). *Muslims Ritualising Death in the Netherlands. Death rites in a small town context*. Zurich: Litt.

Yasien-Esmael, H., & Rubin, S. S. (2005). The meaning structures of Muslim bereavements in Israel: Religious traditions, mourning practices, and human experiences. *Death Studies, 29*(6), 495-518.

"Goodbyes are only for those who love with their eyes. Because for those who love with heart and soul there is no such thing as separation."

—Rūmī

9. A Temporary Farewell. Practices of Muslim Women regarding Mourning and Remembrance

Introduction

Every religion, culture, community and person has its own way of dealing with loss. Research (Benore & Park, 2004; Kristiansen & Sheikh, 2012; Kristiansen, Younis, Hassani, & Sheikh, 2016; Murshidah & Kalyani, 2010; Renaerts, 1986; Suhail, Jamil, Oyebode, & Ajmal, 2011) shows that attitudes and practices related to mourning and grief may be shaped and rationalized through a religious framework. The way people deal with bereavement may in particular be influenced by their eschatological beliefs.

In Islamic tradition, considerable attention is given to the topic of mourning and memorial within the *fiqh* manuals. The Islamic approach to death is organized into a set of beliefs and rituals that structure the initial response to death, the funeral and the formal mourning periods (al-Jazīrīʾ, 2009; Al-Sayyid, 1991).

But how do contemporary Muslims mourn and commemorate their deceased loved ones in a context of migration? Several studies (Ahaddour & Broeckaert, 2016; Ahaddour, Van den Branden & Broeckaert 2017a, 2017b; Bot, 1998; Dessing, 2001; Venhorst, 2013) state that rituals performed in a migrant context may be subject to change due to the different social context. Several scholars (Aggoun, 2006; Halevi, 2013; Jonker, 1997) argue that although ritual prescriptions are uniform, the practice might by dynamic and subject to subtle change. According to Al-Shahri (2007) the practice of death and funeral rites may vary from one family to another based on cultural and subcultural variations.

However, until this day few empirical studies exist on practices of Muslims regarding mourning and remembrance (Assous, 2013; Dessing, 2001; Jonker, 1997; Kadrouch-Outmany, 2014; Murshidah & Kalyani, 2010; Renaerts, 1986; Suhail et al., 2011; Venhorst, 2013). Most of these studies have been done from an anthropological, psychological and psycho-analytical approach. Nevertheless, a comprehensive descriptive account of Muslim practices regarding mourning and remembrance in a European setting, and more specifically in the Belgian context, is lacking to a great extent. In this study we seek to show how the practices regarding mourning and remembrance among Moroccan Muslims take shape in the particular context of migration and more specifically to find out whether rituals survived or have been adapted in the Belgian setting. In this article, we will focus on practices surrounding mourning and remembrance. Views and attitudes regarding mourning and remembrance are discussed in detail in a separate article.

The aim of this article is fourfold. First, we seek to describe the practices of middle-aged and elderly Moroccan Muslim women towards mourning and remembrance. Second, we aim to identify

possible differences between middle-aged and elderly women's (view on) practices. In contrast to the first generation elderly Moroccan Muslim women, who are mainly uneducated and illiterate, the group of middle-aged women shows much more socio-economic diversity. Moreover, these women are no longer raised in a homogenous, rural, traditional Islamic environment and live much less isolated from the broader Belgian society. Third, we aim to explore the role of religion in these practices. Fourth, we seek to document how the actual practices of our participants relate to the normative Islamic literature**.**

Normative Islamic and Scholarly literature: Sunnī Perspectives on Mourning and Remembrance

In the Islamic tradition, a set of beliefs and rituals organizes the response to loss. Rituals concerning mourning and remembrance have been dealt with extensively in *ḥadīth* and legal literature (Aggoun, 2006; Halevi, 2007; Motzki, 2017). However, small variation can be found between Islamic denominations and legal schools (*madhāhib*) in their prescriptions regarding mourning and remembrance (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). In this article, we focus only on *Sunnī*-perspectives on mourning and remembrance. Nearly 85% of Muslims consider themselves to be *Sunnī* (Pew Research Center, 2011). While *Sunnī* and *Shiʿī* theology share much in common, *Sunnī* and *Shīʿa* denominations have their own legal theory (*ʾusūl al-fiqh*). The *Sunnī* denomination has four legal schools (*Malikī, Ḥanafī, Ḥanbalī* and *Ḥanafī).*

Collective rites

The normative Islamic literature emphasizes the important role of the Muslim community in response to the loss of a fellow Muslim. An important collective duty *(farḍ kifāya)* is the ritual of visiting the bereaved and offering condolences (*taʿziyya),* which is considered a recommended and meritorious Practice. *Fiqh* manuals prescribe that the deceased's family should be offered condolences once within a period of three days (al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Al-Shahri et al., 2007). Legal schools consider it undesirable to offer condolences more than three days after the death unless the bereaved was absent before this (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). The *Mālikī* school claims that condolences should only be offered after the burial, whereas the *Shāfiʿīʾ*, *Ḥanbalī* and *Ḥanafī* legal school consider it possible to offer condolences before the burial (Al-Sayyid, 1991). There is no particular formula for such condolences; rather, each individual is to be spoken to in a manner which is appropriate to his/her situation (Al-Sayyid, 1991; Al-Shahri et al., 2007). Nevertheless, according to Al-Sayyid (1991) the *Sunna* points out that one should offer condolences to the bereaved family and leave afterwards without taking a seat. According to Al-Sayyid (1991), legal schools hold the view that practices such as gathering for condolences, setting up tents, spreading carpets and incurring a lot of expenses out of arrogance and to show off are all despicable innovations (*bidʿa*) that are forbidden and must be avoided.

The Muslim community offers support in various means wherever possible such as

psychological, physical, financial, or material help (Bot, 1998; Gatrad & Sheikh, 2002a; Morgan, 2002; Sheikh & Gatrad, 2008; Van den Branden, 2006). Offering one's condolences entails praying for a blessing that the bereaved can achieve patience, sharing in the grief of the family and praying for the deceased's wellbeing in the afterlife (Al-Sayyid, 1991). In the Islamic tradition, it is recommended that members of the Muslim community (e.g. neighbours, friends) serve food and unburden the deceased's family during this difficult time (al-Jazīrīʾ, 2009; Al-Shahri et al., 2007; Hedayat, 2006). Al-Shahri et al. (2007) also point out the twofold beneficence of condoling the bereaved: on the one hand, it increases the mental condition of the bereaved and on the other hand, the visitor earns *ḥasanāt* (eschatological good marks).

The Islamic *fiqh* prescribes no collective commemorative acts to honour the dead (Halevi 2007, 2013). Charity in the form of sacrificing animals and preparing food for those who gather to offer condolences and memorial gatherings, as they do at weddings and other festive occasions, are strongly denounced by Muslim jurists (al-Jazīrīʾ, 2009; Halevi, 2013). According to Halevi (2007), commemorative rituals to relieve the deceased from a tortured afterlife have been heatedly debated in Islamic tradition, more specifically between Sunnī puritanists (e.g. Wahhābī) and traditionalists. Traditionalists defended funerary meals and *Qur'ānic* recitations for the deceased as legitimate and praiseworthy rites to assist the dead, whereas puritanists considered this an innovation, a pre-Islamic custom. In contrast to traditionalists, puritanists seek to purify their religion of cultural influences, considering practices with no Islamic basis as *bidʿa* (innovation), in order to strive towards a total submission to God through what are now considered more "authentic" and "true" interpretations of Islam.

There is, however, a consensus among legal schools that a deceased person benefits from all good deeds he/she performed in his/her life. More specifically, they hold the view that all good deeds of a deceased cease after death except for the following: a continuous charity (*ṣadaqa jāriyya*), beneficial knowledge and righteous children who pray for the deceased (Al-Sayyid, 1991). Moreover, *fiqh* manuals agree that righteous deeds performed by others can be beneficial to the deceased when the performer has the intention of performing the act on behalf of the deceased. Recommended acts of which the rewards (*ḥasanāt*) reach the deceased are charity, fasting, performing the pilgrimage, supplications and recitation of the *Qur'ān* (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). In Islam, giving charity *(ṣadaqa*) is strongly encouraged, as the *Qur'ān* connects it with self-purification (Lowry, 2017).

Individual rites

The Islamic tradition emphasizes several rites for the bereaved. The Islamic *fiqh* prescribes a mourning period of three days for relatives in which no activity should take place at home (Halevi, 2007, 2013; Morgan, 2002). The deceased's children and parents are under no legal obligation to act

for some period in an extraordinary way. For widows, the Islamic tradition prescribes a mourning period of four months and ten days, also known as the *'idda* i.e. a waiting period to ascertain pregnancy, which functions as a mourning period that should be respected by men wishing to marry the widow (Halevi, 2013; Motzki, 2017; Sheikh & Gatrad, 2008). According to Motzki (2017) this waiting period (Q 2:234), as well as the ban to propose a marriage to a widow or to arrange it during this period (Q2:235), is ordained in the *Qur'ān*. When a woman is pregnant, the mourning period terminates with the delivery of the baby, irrespective of the amount of time since her husband's death (Halevi, 2013; Motzki, 2017; Sheikh & Gatrad, 2008). During the waiting period ('*idda*) women must not beautify themselves by wearing jewellery and perfume (Al-Sayyid, 1991). A surviving husband does not need to observe a period of mourning before marrying again.

Normative Islamic literature also stresses the importance of reciting the *Qur'ān* and this both for the deceased and the bereaved (Aggoun, 2006; Gatrad & Sheikh, 2002b; Hedayat, 2006; Morgan, 2002). According to Gatrad and Sheikh (2002a) this reciting represents an occasion to reflect on social and spiritual relationships and indeed on the purpose and meaning of life itself. Halevi (2013) argues that the *Qur'ān* is recited for the benefit of the deceased in the belief that doing so might alleviate his/her suffering in the afterlife (Halevi, 2013). More specifically, reciting *sūrat al-fāṭiḥa* (Q:01), *sūrat yāsīn* (Q:36), *sūrat al-Ichlāṣ* (Q:114), *sūrat al-mulk* (Q:67) is recommended as well as performing supplications, as these will lead to the purification of the deceased's sins and will reward him/her with paradise (Aggoun, 2006; Renaerts, 1986). Various scholars recommend the reading of *sūrat yāsīn*, whilst others dispute that there is a (religious) basis for this (al-Jazīrīʾ, 2009). Muslim jurists encourage Muslims to make supplications (*duʿā)* –a prayer of invocation addressed to God– for the deceased, beseeching God's mercy for all Muslims . The hope is that God, as ultimate Judge, will forgive individuals for their sins (Halevi, 2007, 2013). Morgan (2002) states that these acts are also encouraged because they give strength to the bereaved.

The Islamic *Fiqh* recommends Muslims to visit the graves (*ziyārat al-qubūr*) as a remembrance of death and the afterlife (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Al-Shahri et al., 2007; Halevi, 2013; Sheikh & Gatrad, 2008). However, divergent views exist among legal schools with regard to grave visits by women. This disagreement stems from conflicting traditions. In general, the *Mālikī* and *Ḥanafī* schools deem it permissible for women to visit graves as the purpose is to remember the Hereafter, which is beneficial for both men and women. However, they consider their visit forbidden if there is fear that it would cause others temptation or would lead to lamentation, weeping or wailing. Some scholars discourage women from visiting graves as they are seen as less patient and too emotional. The *Ḥanbalī* and *Shāfiʿīʾ* school consider it forbidden for women to visit graves under any circumstances, whether they are elderly or young, unless it is known that their presence will not lead to temptation (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). With regard to timing, according to the *Shāfiʿīʾ* and *Mālikī* school it is considered *Sunna* to visit graves from mid-

afternoon on Thursday until sunrise on Saturday, while *Ḥanbalī* does not give a particular recommendation at all (al-Jazīrīʾ, 2009). Several scholars encourage performing supplications, seeking God's mercy and reciting the *Qur'ān* when visiting graves, as it benefits the deceased. An important prayer when entering the cemetery that addresses all deceased Muslims is "May peace be upon you, o abode of believing people. God willing, we shall be joining you" –a prayer which affirms the solidarity or unity between Muslims, but also reminds the person of the Hereafter (Aggoun, 2006; al-Jazīrīʾ, 2009; Al-Sayyid, 1991; Halevi, 2007; Sheikh & Gatrad, 2008). Sheikh and Gatrad (2008) explain that this greeting ('peace be upon you') is the same that is used to greet the living, which reflects the belief that the relationship with the deceased continuous and reunion will take place.

Fiqh manuals strongly denounce circumambulation around the grave, wiping hands over the graves and tombs, kissing a stone, or making requests from the deceased (al-Jazīrīʾ, 2009; Al-Sayyid, 1991). Puritanists (e.g. Wahhabi) oppose any interaction with the dead. They view venerating the saints or praying at graves as *bidʿa* (innovation) and asking the saints for intercession as *shirk* (disbelief/blasphemy) (Halevi, 2007). Yasien-Esmael and Rubin (2005) and Klass and Goss (2002), on the other hand, argue that bonds with the dead and prayers to the saints have been an integral part of Muslim folk religion for centuries. These folk beliefs entail that a living person can intercede through a saint and that a broad range of beliefs and activities is performed to interact with the dead.

Methods

Design

Between October 2014 and September 2015, thirty semi-structured interviews were conducted with a sampling of middle-aged and elderly women in the Moroccan community in Antwerp (Belgium) who self-identify as Muslim. This was conducted by the interviewer (first author) who herself is a member of the Moroccan Muslim community. We have chosen Antwerp for two important reasons. First, this city has the largest Muslim population in Flanders: 19, 2 % of Antwerp's population is Muslim (Hertogen, 2016). Second, Antwerp as a port city is considered to be among the most multicultural cities in the world.

Different routes of recruitment (e.g. mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semi-structured topic list covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) and Dutch. Participants were interviewed one-on-one (e.g. in their own house, in a room made available by a local non-profit organization or in a quiet tea house). To help us with the interpretation of our data,

the interviewer (first author) also interviewed 15 experts in the field (e.g. Muslim undertakers, professional Muslim death washers, palliative care consultant etc.) about particular topics of our study between September 2014 and September 2015. These interviews functioned as background information the empirical data of our interviews with Moroccan Muslim women. In this study, we interrogated experts to find out more about the way Moroccan Muslim women deal with mourning and remembrance. The data of the interviews with experts were used to limit biases and to ascertain the reliability and validity of the findings of the interviews with Moroccan Muslim women.

Apart from interviewing, the first author also conducted participant observations between December 2014 and April 2017. Several visits of the sick, a *ḥijāma*-consultation, death prayers, ritual washings of the dead body, repatriation of a deceased, burial, mourning gatherings were attended and several Islamic cemetery plots were visited.

The present study is part of a larger research on the attitudes, beliefs and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp). In this research, themes such as care for the elderly, health, illness, medicine, end-of-life issues (e.g. active termination of life; palliative treatment and symptom control; withholding and withdrawing treatment), death and dying, the afterlife and burial practices were also addressed.

In this study, we opted for a non-normative, descriptive, exploratory approach. This study was approved by the Social and Societal Ethics Committee (KU Leuven, Leuven). In order to guarantee the anonymity of our participants, we made use of pseudonyms.

On average, each interview took 120 minutes, making up for a total of 90 hours of interview time. Data collection continued until theoretical saturation was reached. The interviews were audio recorded and transcribed verbatim, using Express Scribe. Grounded theory methodology (Corbin & Strauss, 2015; Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used to code and analyse the interview data. By adding codes to the data and through constant comparisons, key concepts were identified in the interviews and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants. In order to facilitate data analysis, a qualitative data analysis software package (*NVivo* 10) was used. Findings of the interviews with Muslim women were compared with those of the interviews with experts and subsequently compared with normative and empirical studies (cf. discussion). Our research findings were regularly discussed with our guiding committee and with several members of the Moroccan Muslim community.

Results

Participants' (socio-)demographic information & health situation

Our group of middle-aged Moroccan Muslim women (n=15) was between 41 and 55 years old; our group of elderly women (n=15) was aged between 61 and 86. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first generation migrants who came to Belgium between the early 1960's and early 1990's, in the context of labor migration, family reunification or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Twelve middle-aged participants were married, two were divorced and one was widowed. Among our elderly participants, eight were married, six were widowed and one was divorced. Our elderly participants had noticeably larger families (up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority was multilingual, mastering a total of between three to five languages. Worth noting is that these participants pointed out that they did not have one but two mother tongues, namely Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. They had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber participants spoke Arabic and only two Moroccan Arabic participants had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them were uneducated and illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque, sports centre and taking Arabic and/or Dutch language classes. Regarding employment, only two elderly participants worked outside the home as labourers. Much more diversity in socio-economic status was observed among our middle-aged participants. Nearly half of them were highly educated. Ten of the fifteen middle-aged participants were economically active (from labourers to officials).

The health issues of our middle-aged participants were limited to knee problems and migraine. Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis and headache. Three elderly participants and one middle-aged participant reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a coma, reported a bad health condition. Nine participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer and severe chronic disease.

Practices surrounding Mourning and Remembrance

Collective rites

When the news goes round that someone died, nearly all participants mention the importance of paying condolences to the bereaved family (*taʿziyya* or *rehzeyyith*) within a period of three days. This can take place at home or in the mosque after the death prayer. Nevertheless, we learned from our interviews and participant observation that a mourning visit can be done until seven days –mainly in Morocco– and even after this period visits can be expected. Noteworthy, among middle-aged participants we observed the difficulty to condole within the period of three days due to their busy lifestyle and economic activity (e.g. young children, work). Our participants view a mourning visit as an important practice of religious social support which is considered a religious obligation (*farḍ kifāya*). Participants highlight that this visit has several goals including comforting, showing compassion and strengthening the bereaved's moral by pronouncing supplications (*duʿāʾ)*. In this respect, a well-known Qur'ānic verse (Q2:156) is frequently uttered: '*Inna lillāhi wa inna ilayhi rajiʿūn*' ('Surely, we belong to God and to Him we shall return'). Throughout the participant observation we saw that this visit is a strong and important way of restoring family ties, which benefits both the receiver and visitor as well as the deceased, as they all gain *ḥasanāt* (good marks).

> "People condole the family. That is mandatory (*farḍ)*. You have three days. On the first day the person who lives and condoles receives more rewards than the deceased. People say '*Allāh yaʿdzam al-ʾajar'."* Kaltoum – middle-aged

> "People come to condole. People say '*Allāh yaʿdzam al ajar'* ('may God multiply the good marks'), *' Allāh yaʿtik sbar'* ('may God bestow patience'), *'Allāh yarḥam'('may God have mercy')*."[...] You also need to condole in the first three days and not after the third day. Then you just need to greet normally." Zohra - elderly

During the participant observation, we found that the number of people condoling or visiting is strongly appreciated by the bereaved, as it seems to reflect the good relationship between the deceased and the visitor. This paying of respect helps the bereaved's mourning process. However, several participants argue that the large number of visitors might also burden the family, as they do not have the time to mourn and therefore often feel a void after the condolence period. Due to the precarious situation of the bereaved, a few participants mention that sometimes the bereaved do not feel the need to be surrounded by people. Therefore, several participants point out that visits should not take long. During this visit, often the good qualities of the deceased and the way the person died are narrated, but there is often also a silence in which the *Qur'ān* is played on the background or recited by an individual. Talking about other topics is viewed disrespectful towards the dead and bereaved. This, too, is confirmed by our experts.

> "That's a sign of compassion, because we like to have people around that you would want to see the most when missing someone.[…] Everyone enjoys people around them in moments of sadness. They tell how the person died and often the deceased's positive qualities are being narrated." Louiza – middle-aged

> "When I condole someone, I don't stay that long. It's better to pay a small visit so that you're not a burden for these people. There's no laughter or speaking. Sometimes you see people talk about something else while there are people mourning. You must have respect for the deceased." Aïcha – elderly

> "They [the bereaved] usually don't have a lot of time to mourn. The house is full.[…] They are being occupied, they go to Morocco and then there they receive a lot of visits. They come back and then fall into a void." Myriam – Palliative care consultant

Nearly all participants mention that during the mourning visits food is often provided. The variety of food strongly depends on the ancestral region of origin, but also differs from family to family. Several participants mention that in Belgium milk and dates are often served for the visitors, while in Morocco, depending on the region, bread with figs or olives or Moroccan pastries are served. Serving milk and dates is considered a *sunna*-practice and the best way to give *ṣadaqa* (voluntary charity) on behalf of the deceased. Interestingly, visitors often bring milk and sugar. The explanation given is that everything that is white entails *baraka* (blessing). This was also observed during our participant observation. However, several participants mention that visitors should not burden the family by staying long and expecting a meal. In this respect, a few participants mention the feeling of social pressure to spend money and provide meals for visitors.

> "When a person dies, they put bread, figs or dates on the table and not a meal because it's not a party. And also milk and water. In Morocco you feel pressure to put food on the table, otherwise people will see you as greedy. You need to spend money, while Islam teaches us to bring food to the family of the deceased." Zohra – elderly

> "It is not good if people stay long. When someone dies, you usually need to bring food or something and you give it to them and then leave as soon as possible. You don't need to stick around and expect them to make food for you. It's not a party." Fatma – elderly

During the mourning period, the (Moroccan) Muslim community –often family, relatives and neighbours– offers its (moral) support by visiting and helping the bereaved in financial and material ways through providing or cooking food for the bereaved as well as for the visitors. This is also shared by our experts.

> "Yes, people come over to support.[…] And also to offer help, like 'do you need something?'. They help financially, they help by preparing food." Badria – middle-aged

> "My neighbors told me to do nothing and just stay with the visitors. They took care of dinner, they also took care of the insurance *al-ḥamdulillāh*." Malika – elderly

> "The bereaved don't prepare food for three days. People take care of that, like the neighbors and family members. So community members prepare food and take away the burden." Imane - *Ḥijāma* practitioner

Nearly all participants mention the practice of giving *ṣadaqa/sedqeth* (voluntary charity) as a way of honouring the deceased and purifying the deceased's sins and 'transferring' good marks (*ḥasanāt)*. Giving *ṣadaqa* can have different forms. The foremost public form known is mourning or memorial gatherings, where the bereaved family invites relatives, friends and neighbours for a meal. This gathering is often organized on the first day (day of burial), the third day and on the fourtieth

day after death. To a lesser extent mourning gatherings are sometimes even organised on the seventh day and after a year to remember the deceased. In our participant observation, we viewed that on these occasions men and women sit separately, and an *ʾimām* is often invited to recite the *Qurʿān* with loud voice and perform supplications for the deceased, also known as *ṭolba* or *tarba*. This mourning gathering often takes place once in Belgium and once in Morocco, as Muslims have relatives and friends in both countries. This was also noted during our participant observation.

> "When my husband died, I gave *ṣadaqa*.[…] We did it here in Morocco. In Morocco on the third day and in Belgium on the fortieth day. It has to be that way because we have family here and there." Naziha – elderly

> "I also did that when my husband died. The best thing to do is a meal in the evening. There's also *Qur'ān* being recited in the evening. Then I went to Morocco where my brothers took care of everything. They also took care of the dinner on the day of the funeral. On the third and seventh day my cousin took care of everything." Malika – elderly

However, this abovementioned form of *ṣadaqa* is strongly opposed by one third of our participants, who hold the opinion that, firstly, this is not meaningful, as the invited people are often not needy people, and thus consider it a waste of money. Secondly, they believe that it has no benefit for the deceased. They are convinced that the deceased does not receive *ḥasanāt* with this practice, that it's only meaningful for the living people. A minority of our participants argues that a mourning gathering on the fortieth day is an innovative practice (*bidʿa*), which is understood as a practice that has no basis in Islam and is therefore rejected –though often they still perform it. Instead, nearly half of our participants prefer to give money or food to needy people or contribute financially to build a mosque or to charity organisations (e.g. orphans, water well). This is considered *ṣadaqa jāriyya* (ongoing charity), which is understood as receiving continuous rewards (*ḥasanāt*) even after death. Besides this form of *ṣadaqa*, several participants emphasize the importance of performing acts in the name of the deceased, including praying (*ṣalāt*), fasting (*ṣawm*) and performing the pelgrimage (*ḥajj*), as the best way to help and commemorate the deceased.

> "I recently followed *ḥadīth* lessons and they told us that if a person dies, that everything ends there. The *ṣadaqa*, the couscous, the sacrificing, that's all not needed, that is *bidʿa,* she said. So what we do is giving people something to eat. Someone who comes to visit gets food served. But the woman said that the *ḥasanāt* don't go to the deceased but to yourself. What the person did, he did for himself." Yamina – elderly

> "Yes, they give *ṣadaqa* after forty days, but scholars say that this is not permitted. We still do the *ṣadaqa* after forty days. But they say it's nonsense. That's what the scholars say." Haddad – elderly

Individual rites

According to nearly all participants, the bereaved family must observe a mourning period of three days for the loss of a relative (e.g. mother, father, child, brother) and a period of four months and ten days for the loss of a husband, known as *ʿidda* i.e. a waiting period to ascertain pregnancy and to remarry. Noteworthy, one fifth of our participants –mainly elderly– mentions the observance of a

mourning period of forty days when the husband dies. This is understood as a way of paying respect to the deceased, but also as a religious duty towards God. In this mourning period, several observances should be taken into account according to our participants. First of all, they mention the importance of dressing and behaving moderately (e.g. no make-up, jewellery or colourful clothes). More than half of our participants –mainly elderly– refer to the tradition of wearing white clothes as a sign to the community that one is mourning. Second, they also mention the importance of abstaining from listening to music, attending celebrations and even leaving the house unless it is necessary. The ritual of wearing white clothes and not leaving the house is particularly addressed to the widow. This is also confirmed by our experts.

> "They wear white clothes. Women don't wear make-up or gold. She doesn't leave the house, only if it's necessary. If she needs to take care of something, and even then she needs to be home before sunset. She doesn't attend feasts. That only applies to the spouses, but if it's someone else, they may not mourn more than three days." Huda – elderly

> "I couldn't leave the house for four months and I always had to dress in white. I didn't attend feasts or gatherings. I just stayed at home. People did come to visit me. We didn't listen to music in that period, there was also no singing involved. That was done out of respect for the deceased." Rahima – elderly

> "Yes, you have a mourning period of four months and ten days to see if she is pregnant and she also needs to be home by sunset. You see this especially among the first generation." Myriam – Palliative care consultant

Several participants, both elderly and middle-aged, considered some observances (e.g. mourning period of forty days, wearing white clothes) as a cultural (i.e. not Islamic) practice and some even as fabrication. Among them, here again, a few participants strongly criticized the wearing of white clothes as an innovative practice (*bidʿa*). During our participant observation, we viewed that these rites (forty days, white clothes) are much less observed by middle-aged participants.

> "It didn't exist in the time of our prophet. Why do I need to wear white? I will not wear it. Honestly speaking: it is a cultural tradition and I don't want it. Those white clothes and those forty days are fabrications." Loubna – middle-aged

> "Those forty days, four months and ten days and the white clothes are all fabrications. They still do that in Morocco and they also wear white clothes and don't leave the house in the evening. That is *bidʿa*, that doesn't exist in the *Qur'ān*, it isn't *Sunna*." Fatma – elderly

A few participants who themselves were confronted with the loss of their husband experienced difficulties in observing the ritual of not leaving the house after afternoon prayer, because of their work and other obligations (e.g. taking care of children, administrative tasks etc.), but also due to the lack of family presence as a safety net.

> "They told me not to leave the house'. I didn't go outside in Morocco, but when I got back here in Belgium, the rules did no longer apply because sometimes I just had to go outside. I was told not to go outside after *'asr* (afternoon prayer), but I couldn't. I am a single woman. Who's going to take care of me? Of my kids?[…] In these times you can't." Lamya – middle-aged

> "Yes, I was told about those four months and ten days of mourning and that you have to dress in white and may not leave the house after *'asr* (afternoon prayer). But I went back and forth for papers. I had no one here from the family. I had to go to the consulate, to the health service and to the bank to take care of everything." Khadija – elderly

In our interviews and participant observations, we noticed that when losing a loved one, Muslims often experience a 'wake-up call' and start to reflect upon one's life, behaviour and conduct towards oneself, others and God. More specifically, they state they are reminded of the purpose and temporality of life, of the importance of being modest and of restoring their relationship with God and with their entourage. In this respect, the majority of our participants mentions and emphasizes the importance of turning to God by remembering God (*dhikr*), performing (voluntary) prayers *(ṣalāt)* and listening and reading the *Qurʾān.* By reciting the *Qurʾān*, our participants explain, the bereaved and their entourage –during mourning visits and gatherings– find peace in God's words. At the same time, they believe that reading the *Qurʾān* is an important medium to communicate and bond with God.

> "If you read the *Qur'ān*, I did that often when my mother died. I did that daily, I found comfort, got close to God, that peaceful feeling of 'I will die one day, but we don't know when and where'. But anyways, you read the *Qurʾān* to find comfort and guidance." Sarah – middle-aged

> "Yes, you turn to God, you find support therein. By reading the *Qur'ān* we find peace. But also by occupying ourselves with prayer (*ṣalāt*)." Fatma – elderly

> "People that are religious take death as an example. And they say that 'tomorrow is our turn' and that no one escapes death. And they are motivated to pull themselves together and to do their best.[…]" Rachid – Muslim undertaker

Although nearly all participants found their solace in listening to the *Qurʾān,* this was not the case for Halima, a middle-aged participant, and Khadija, an elderly participant. They mention that after the mourning period, they found it difficult to listen to the *Qurʾān* or a specific reciter, as this reminded them of their lost loved ones, since the *Qur'ān* was often played the whole day long during that period. Halima argues that by playing the *Qur'ān* when someone died, a negative association is created between the *Qurʾān* and death.

> "I was once on a mourning visit and there was *Qur'ān* in the background which I am against, because I find that, after that, the *Qur'ān* receives a negative connection. You hear the *Qur'ān*, you think of death. No, the *Qur'ān* is peaceful. But why playing the *Qur'ān* when someone dies? That way, it will remain in your life as something negative, a bad reminder.[…] One time I heard *Qur'ān* in that period. It was Sudais. I can't hear that man anymore. Anybody but him, because when I hear him I think of Imade [her deceased son]." Halima – middle-aged

> "In the beginning I couldn't listen to the *Qur'ān*. It was as if something stopped me from doing it. I wasn't well and my son made me a CD with *sūrat yūsuf*. There are chapters that remind me of the death of my husband. When my husband died, we put on the *Qur'ān* the entire time in that period and when I listen to it, it reminds me of that period and when that happens, I have a difficult time again." Khadija – elderly

According to the overwhelming majority of our participants, uttering *duʿāʾ* (supplications) for themselves and for the deceased, but also expressing words of mercy (*raḥma*) for the deceased, are important practices of commemoration. This consists of supplications, giving charity and speaking well about the deceased. The bereaved often utter *duʿāʾ,* asking God for his mercy upon the deceased and to let him/her be one of the inhabitants of paradise. In our interviews and participant observation, we observed that performing *duʿāʾ* is perceived as a very powerful medium in coping with loss, as one is communicating with God and in this way also indirectly reaching the deceased. Performing *duʿāʾ* or expressing words of *raḥma* for the deceased is not only limited to the mourning period, but is in fact continuously performed by participants to commemorate their deceased loved ones. They explain that no displacement is needed for this form of commemoration and that all this reaches the deceased from wherever you are. This is also confirmed by our experts.

> "I think about them every moment.[…] And also while praying, you think of them through supplications. They say that the supplications reach the deceased.[…] I supplicate for them. I give charity in their name, for example in the name of my husband or in the name of my mother, my father." Haddad - elderly

> "I remember her by the good deeds she did. There's not one moment that I don't think about her. When she died I stayed calm.[…] and I read the *Qurʾān* a lot and did supplications. God kept me strong.[…] You ask God that He shows mercy (*raḥma)* upon the deceased and that they enter paradise. So it is important to do a *duʿāʾ*." Huda – elderly

> "Yes, those women turn to God in their prayers and perform supplications. They ask God to give patience and to give the deceased a good place. They also cherish the good memories and the acts of the deceased." Myriam – Palliative care consulant

Another important ritual of remembering the deceased, is visiting the grave. However, only a minority of our participants effectively visits the grave of their deceased loved ones. Participants mention that when entering the cemetery, not only the deceased is greeted (in form of a supplication), but all deceased Muslims, symbolizing the solidarity of the Muslim community (*ʾumma*). This supplication also reminds the living that they will follow the dead. Several participants say they commemorate the deceased by visiting them on the third day after burial or when visiting their country of origin. A few –mainly elderly– participants underscore the importance of visiting the deceased on specific days such as on Thursday and Friday and on religious celebrations (e.g. day of '*Arafa, Mawlid*), and this from a teleological perspective. Indeed, they believe that on these days the deceased descends from heaven to the physical grave and is able to hear and see those who come to visit him/her. For many participants, visiting the grave is a way to bond with the deceased, while talking or uttering supplications, but also by reciting the *Qurʾān.* More specifically *sūrat al-fāṭiḥa* (Q:01), *sūrat yāsīn* (Q:36), *sūrat al-Ichlāṣ* (Q:114) and *sūrat al-mulk* (Q:67), as these lead to purification of the deceased's sins, but also bring peace to the deceased. A few participants mention that often a reciter (*muhāfiẓ /tālib*) on the cemetery (in Morocco) is asked and paid to read for the

deceased. Interestingly, Sarah, a middle-aged participant, also mentions that the grave is sprinkled with rosewater based on the belief that this symbolizes the scent of paradise, but also because this would be a blessing for the deceased.

> "I visit his grave every year on Thursday and Friday when we go to Morocco.[…] The souls come down and they see you." Radia – middle-aged

> "There are people who read the *Qur'ān*, we sometimes pay someone to read the *Qur'ān*. We put rosewater on the grave and we clean it. Yes, that's actually a tradition.[…]. It's the smell of the perfume in paradise. That's what they say, but God knows best.[…] It's a blessing for the deceased." Sarah – middle-aged

Here again, a minority of our participants denounces the grave visits, viewing them as not meaningful for the deceased, but only for the living people who in this way are reminded of death. Another reason for not visiting the grave, mainly given by elderly participants, is that women are forbidden (*ḥarām*) or discouraged (*makruh*) to visit the graves due to their emotional crying and wailing, which is perceived as a form of ignorance (*jahl*) and of torturing the deceased. In addition to this, they also underline that it is forbidden to read from the *Qurʾān* for the deceased, as this is only for the living, nor is it allowed to pay people to read the *Qurʾān*. This is also confirmed by our experts. However, one expert states that visiting the graves is discouraged among elderly generation Muslims due to superstitious practices such as asking the deceased for intermediation. However, this was not mentioned by our participants.

> "I don't visit graves. I never went to my mother's grave, or that of my father or brothers. Visiting the graves is forbidden by God. You need to send them *raḥma*. You want to do something for your family, then read '*Qul huwa Allāhu ʾaḥad'*[chapter *al-ʾIkhlāṣ*] three times." Alia – elderly

> "They say that you may not read the *Qur'ān* on the grave, but you can perform supplications. They say that the *Qur'ān* is for the living.[…] And you may not organize a *tarba* (memorial gathering) or give money, that's not what God says. You may not pay someone to read the *Qur'ān* by the grave. And you may not pay an *ʾimām* on the memorial gathering either because he recited *Qur'ān*, that is *ḥarām*." Rahima – elderly

> "The first generation is ignorant and is also superstitious. What you see is that women go to the graves and say 'why did you leave me?' and they start complaining, which you may not do. Or that they ask for mediation among dead people, like 'Ask God to cure me'." Khawla – Specialized corpse washer

Nearly all participants are of the opinion that the deceased's remembrance strongly depends on the relationship he/she had with the bereaved (e.g. parents, friends, neighbour). Several participants mention that mainly good people will be remembered and particularly by their good children. The majority of our participants state that not one day passes by without them thinking about their deceased loved ones –this is especially true during prayer (*ṣalāt*), when another family member dies, when one's children marry and on birthdays. The deceased is often remembered in stories about his/her good qualities and deeds or while looking at pictures to keep the image of the deceased alive.

> "I always think of the good sides of my husband, my father and father-in-law. You always think of the place they left behind. You sometimes find their stuff, so you can't forget it. It's a big loss in everything. For example my father's house in the Rif was a beautiful refurbished house when he was still alive and now it's totally abandoned and then I always think about the times when my father was still alive." Fatma – elderly

> "I often think about them. I don't forget them.[…] I have a picture of him [father] on the laptop, and I always look at him. But even when I don't see the pictures, I always think about them.[…] The ones that you love the most, stay in your heart." Nuria – elderly

Noteworthy, a participant who had a miscarriage and a participant who lost two children explicitly said they did not commemorate their deceased child due to their innocence and the belief that they are in good hands and safe with God.

> "Our son for example, I never went to his grave. Uhm, I know I have a child who is with God, I know that. I'm always conscious about that but when I die, I will see him.[…] But I don't really commemorate him. That's because I didn't really lose someone." Ikram – middle-aged

> "I don't like commemorating. I told you, they are safe with God, their Creator. I don't worry about them, I am not worried about them. I don't need to remember them." Halima – middle-aged

Only a minority of our participants mentioned having dreams about the deceased. This was often interpreted as a sign of communication or a message being conveyed. Seeing the deceased wearing white clothes or smiling would often be interpreted as a good sign of the deceased having found peace. Only two middle-aged participants said they had consulted an *ʾimām* as they kept dreaming about the deceased. The *ʾimām* would often explain or translate their dreams. One participant, Lamya, was told to read the *Qurʾān* and give *ṣadaqa* (charity) for this deceased as response to her dreams, while another participant, Sarah, was also told to read the *Qurʾān.* A few participants said they had relied upon an *ʾimām* for *roqiyya* i.e. reading the *Qurʾān* for the person who is having difficulties in coping with loss (e.g. insomnia, depression).

> "I dreamt about my husband a few times.[…] I saw him suffering in my dreams. And that he was calling me and he was screaming, he got hurt.[…] He yelled and screamed 'help me, help me, help me.' I'm never going to forget that pain. That's how I woke up. And then I went and asked the *ʾimām* and he told me that I didn't forgive him. People told me, when he was dying 'forgive him, forgive him'. You know? The pressure. And I said 'I forgive him', but I actually didn't.[…] That's what I felt in that moment. But forgiveness is important.[…] But after my dreams I said 'I forgive you for everything'.[…] That's what I want, I didn't want to see him suffer. And after that he was looking much better and happier when I saw him in my dreams.[…] I also gave *ṣadaqa* in his name after that." Lamya – middle-aged

> "I told the *ʾimām* 'I can't sleep anymore and when I sleep then I see my mother and I talk to her'.[…] I said 'Why do I have all these dreams?'[…] The *ʾimām* said 'she needs a *ṣadaqa*'. And he also said 'You need to do a lot of *raḥma* and read a lot of *Qur'ān* for her, because that is their gift.[…] So if you read more, they'll have more points there'. The *ʾimām* told me that she's worried that we forgot about her. I told him 'no, no, of course we didn't forget her. We always recite *sūrat yāsīn* on Friday and we also give *ṣadaqa'*.[…] The best *ṣadaqa* is giving water and that's what we do. We also gave money to someone from the countryside in Morocco for a water well." Sarah – middle-aged

Discussion

The findings of our interviews with middle-aged and elderly Moroccan Muslim women are nearly identical to those of the interviews with our experts in the field. Although there are differences in age, but also in level of education and socio-economic status between the first and second generation, surprisingly no fundamental differences were observed between our middle-aged and elderly participants in their (views on) practices regarding mourning and remembrance, nor between participants who were confronted with loss in their immediate environment and those who were not. Although it could be assumed that second generation Muslim women, who were born or raised in Belgium, are more likely to be influenced by Western ideas, which might result in a secular understanding of death and a decline in following religious observance, this was not the case.

However, we did observe small differences between middle-aged and elderly participants. First, we found that mainly elderly participants were more able to provide details on practices regarding mourning and remembrance when compared to middle-aged participants. This might be explained by the fact that they have been confronted with death more often due to their age. Second, this difference between elderly and middle-aged participants might also be explained by the fact that in this Western context, younger Muslims are not aware of or familiar with some mourning rituals performed in the country of origin (e.g. mourning period of forty days; wearing white clothes), but also due to the decline of the bond with the country of origin. This trend is also strengthened by the fact that in the contemporary migration context, less importance is given to what our participants consider as merely a cultural practice from the country of origin (e.g. mourning period of forty days; white mourning clothes) 'that has no basis in Islam' and thus should not be retained. Third, we observed that in contrast to elderly participants, the economic activity of middle-aged participants seems to have an impact on their practices. Indeed, because of the fact that these women work and have a busy lifestyle (e.g. young children), it was very difficult for them to observe the practice of condoling the family's deceased within three days and observing (the curfew of) a widow's mourning period (four months and ten days). Fourth, we also observed that middle-aged participants rely more upon an *ʾimām* than elderly participants. This can be explained by the stronger gender segregation that existed among first generation Moroccan Muslims and certainly in the migrant context. In contrast to elderlyparticipants, middle-aged participants show much more need and give more importance to visiting the graves of their deceased loved ones.

Rituals and customs regarding mourning and remembrance are also inextricably linked to Muslims' religious beliefs. These practices include mourning visits, observing a mourning period, visiting the graves, reading the *Qur'ān*, uttering supplications and giving charity in the name of the deceased. Most of these rites are two-sided: they do not only benefit the deceased, but at the same time also enable the living people to earn good marks (*ḥasanāt*). Nearly all rituals (e.g. reciting *Qur'ān*, giving charity, performing supplication) surrounding mourning and remembrance are

centred upon purifying the deceased's sins and bringing him/her peace. Rituals thus seem to act as an important meaning-giving structure for Muslims that helps them to deal with their loss. These structured rituals seem to give a certain direction and support, fostering a feeling of peace in these difficult times. Many rituals, including reciting the *Qur'ān* and uttering supplications, also seem to be an important way of communicating with God and reaching out to the deceased. These seem to be viewed as powerful media in reaching God and improving the the deceased's state (e.g. purification of sins; finding peace). The rituals performed seem to reflect a continued relationship and a maintained bond between the deceased and bereaved.

Among a minority of our participants –both middle-aged and elderly, we observed a strong *criticism* towards a few mourning/commemorating rites, including memorial gathering on the forthieth day, mourning period of forty days and wearing white clothes. Some participants refer to these rituals as meaningless and a (financial) burden for the bereaved family, whereas a few participants strongly frame this denouncement and meaninglessness in terms of *bidʿa* (innovation). The latter was also the case for reading the *Qur'ān* for the deceased on the graves. Among our middle-aged participants, we also noted a decline of observing practices which they consider merely a cultural (not Islamic) tradition or not compatible with their Western lifestyle (e.g. working outside the home), such as the mourning period of four months and ten days in which the widow does not leave the house (after afternoon prayer). The Muslim community plays a major role in the period of mourning and functions as a supporting network that the bereaved family can count upon. Members of the Muslim community offer support in various ways (e.g. mourning visits; providing food), though at the same time we observed what our participants consider as cultural expectations. Indeed, we observed social pressure related to the performance of rituals including the expectation of wearing white clothes. Another example is the social pressure to spend money and provide meals for the mourning visitors.

Finally, we observed that the migration context has a great influence on mourning rituals. The memorial culture in the country of origin is lacking in the migration context, including visiting the deceased's grave on Friday and during religious celebrations. Another example is that for a few participants, certain practices could not be observed (e.g. curfew) due to a lack of a family safety net in the migration context. Rituals have also been influenced or adapted due to their embeddedness in the migration context. Because of the dominant choice among Moroccan Muslims to be repatriated to the country of origin, mourning visits and gatherings are often performed twice, once in Belgium and once in Morocco. Another example is the decline of organizing mourning gatherings on particular days in the migrant context.

Comparison with Normative and Empirical Literature

Our participants' line of thought and practices are strongly consistent with the line of reasoning and Islamic prescriptions found in normative Islamic literature on mourning and remembrance (Aggoun, 2006; al-Jazīrī', 2009; Al-Sayyid, 1991; Al-Shahri et al., 2007; Gatrad & Sheikh, 2002a; Halevi, 2007, 2013; Sheikh & Gatrad, 2008). In both our findings and normative Islam we find the important role of the Muslim community during mourning, of mourning visits, observance of a mourning period; of giving charity, reciting the *Qur'ān*, uttering supplications and visiting graves.

However, small differences were found which indicate that the actual practice often differs from the Islamic normative view. We found that it is very common to condole after three days although *fiqh* manuals discourage this. In contrast to Islamic prescriptions, we observed that culture strongly influences the religious response (e.g. wearing white clothes, not leaving the house after a certain hour,…). Although mourning gatherings in the form of a meal, for example on the fortieth day, are not encouraged by Islamic scholars, we observed that this is, however, common among Moroccan Muslims in Belgium and Morocco.

Most studies on mourning and remembrance focus on theories and models of grief and bereavement, for example the continuing bond with the deceased (cf. Freud 1917; Neimeyer 1999; Klass & Walter, 2002) and coping strategies (Benore & Park, 2004; Pargament, 2001). The main studies we found focus on Muslims of different ethnicities and/or denominations in the West (Bot, 1998; Dessing, 2001; Gardner, 1998; Hussein & Oyebode, 2009; Jonker, 1997; Kadrouch-Outmany, 2014; Kristiansen et al., 2016; Suhail et al., 2011; Venhorst, 2013) or on Muslims in Morocco (Dieste, 2012; Renaerts, 1986). In contrast to the abovementioned studies that deal with perspectives on mourning and remembrance in a fragmented way, our study offers an encompassing, comprehensive and detailed perspective on practices of Moroccan Muslims living in Belgium regarding mourning and remembrance.

Nevertheless, the findings of our study show strong similarities to the findings of the abovementioned studies: the crucial role of the Muslim community, mourning visits, mourning periods, holding mourning/remembrance gatherings, performing acts in behalf of the deceased. In line with our findings, several scholars (Aggoun, 2006; Al-Shahri et al., 2007; Dieste, 2012; Yasien-Esmael & Rubin, 2005) argue that mourning rites function as coping mechanisms in anticipation of death and are guidelines for grieving people as they offer support and a certain direction. Many studies (Bot, 1998; Dessing, 2001; Dieste, 2012; Gardner, 1998; Hussein & Oyebode, 2009; Kadrouch-Outmany, 2014; Koshen, 2015; Kristiansen & Sheikh, 2012; Renaerts, 1986; Venhorst, 2013) corroborate our finding that the Muslim community plays an important role after the death of a person, offering moral, emotional and financial support and solidarity by providing food for the bereaved family, which is perceived as a meritorious act. This to relieve the bereaved from their

duties and enable them to focus on coping with bereavement. Koshen (2015) supports our findings that visitors often wear simple garments in solidarity with the bereaved. Hussein and Oyebode (2009) and Kadrouch-Outmany (2014) also endorse our findings that prayers are performed and *Qur'ān* is recited live by community members during mourning visits. Several scholars (Bot, 1998; Dessing, 2001; Renaerts, 1986) confirm that Moroccan Muslims often bring sugar to the bereaved.

Similar to our findings, many studies (Assous, 2013; Bot, 1998; Dessing, 2001; Dieste, 2012; Hussein & Oyebode, 2009; Jonker, 1997; Murshidah & Kalyani, 2010; Renaerts, 1986; Venhorst, 2013) found that although memorial gatherings are discouraged by Muslim scholars to avoid reviving grief, they are very common. These studies confirm that mourning gatherings are often held by the bereaved family to offer prayers for the deceased and to remember the deceased, accompanied by a meal, and this on specific days (e.g. third, seventh, tenth, fortieth day and one year after death). According to Dessing (2001), Kadrouch-Outmany (2014) and Venhorst (2013), these gatherings mark the end of condoling and/or mourning period, after which normal life resumes (cfr. *rites de passage* of Genepp 1961; Turner 1969 & 2002), whereas Bot (1998) and Renaerts (1986) state that this is to thank the community for their support. However, neither of these explanations was mentioned by our participants. Like our findings, studies among Moroccan Muslims (Dessing, 2001; Dieste, 2012; Kadrouch-Outmany, 2014; Renaerts, 1986) show that on the fortieth day after death relatives and neighbours are invited for a meal to honour the deceased, during which reciting the *Qur'ān* by an *imam'* (*ṭolba*) and prayers are central. However, Bot (1998), Dessing (2001) and Renaerts (1986) also corroborate our findings that some Muslims view these gatherings as a waste of money or a burden for the bereaved while the deceased does not benefit from it. In the same way, they found criticisms that the invited people are not needy people and therefore this gathering is not meaningful. Nevertheless, this does not withhold people from organizing it. These scholars also confirm that in the migration context there is a tendency to reduce the number of gatherings, but also in cities in the country of origin.

In keeping with our findings, research (Dessing, 2001; Hussein & Oyebode, 2009; Jonker, 1997; Kadrouch-Outmany, 2014; Koshen, 2015; Renaerts, 1986; Venhorst, 2013) shows that Muslims mourn for a period of three days and a woman who lost her husband mourns for four months and ten days (‘*idda*). Studies (Dessing, 2001; Kadrouch-Outmany, 2014; Renaerts, 1986) also found that Moroccan Muslims observe a mourning period of forty days. As in our study, several studies (Dessing, 2001; Jonker, 1997; Kadrouch-Outmany, 2014; Renaerts, 1986) found that when mourning Muslims abstain from normal life by not accepting invitations or listening to music and that Moroccan Muslim women have the tradition of wearing white clothes and do not leave the house unless absolutely necessary. In contrast to our study, Dessing (2001) and Renaerts (1986) found that during the mourning period one may not bathe or change their clothes. This was, however, not mentioned by our participants or observed during the participant observation.

Similar to our findings, many studies (Hussein & Oyebode, 2009; Kristiansen et al., 2016; Murshidah & Kalyani, 2010; Suhail et al., 2011) show that the bond with the deceased is maintained through uttering supplications, reading the *Qur'ān*, performing acts on behalf of the deceased (e.g. charity) and visiting the graves. These scholars confirm that these rites reflect the continuity of the soul as well as the continuing bonds with the deceased. These rites are performed to improve the state of the deceased, but also hint at a future reunion in the afterlife. Hussein and Oyebode (2009) and Suhail et al. (2011) confirm that the relationship with the deceased is also maintained by talking about him/her and remembering his/her good qualities and deeds.

Transformational aspects following death were also confirmed by several studies (Bot, 1998; Hussein & Oyebode, 2009; Koshen, 2015; Kristiansen & Sheikh, 2012; Murshidah & Kalyani, 2010; Suhail et al., 2011). They endorse our findings that during the mourning period Muslims often turn to and seek connection with God through prayers, uttering supplications and reading the *Qur'ān*. Similarly, they also found that when confronted with loss, Muslims reflect on the temporality of life, seek to restore their relationship with God and people, but also seek to become a better person (e.g. by forgiving) and conduct a more pious life.

Like our findings, performing acts on behalf of the deceased including undertaking *hajj*, fasting, giving charity (*ṣadaqa)* and reciting *Qur'ān* to benefit the deceased's journey and as a way to maintain close bonds with the deceased, were also found in other studies (Bot, 1998; Dessing, 2001; Hussein & Oyebode, 2009; Jonker, 1997; Kadrouch-Outmany, 2014; Koshen, 2015; Murshidah & Kalyani, 2010; Renaerts, 1986; Venhorst, 2013). As in our study, Hussein and Oyebode (2009) found that their participants also dreamt about the deceased wearing white clothes, perceiving it as good news, but also that less comforting dreams were often followed by giving charity on behalf of the deceased.

Many studies support our findings (Bot, 1998; Dessing, 2001; Dieste, 2012; Hussein & Oyebode, 2009; Murshidah & Kalyani, 2010; Renaerts, 1986) that visiting the grave is an important ritual to remember deceased loved ones, but also to remember death. Dieste (2012) and Murshidah and Kalyani (2010) confirm the ritual of greeting all deceased Muslims with a supplication and seeking forgiveness for the deceased, indicating a future reunion in the afterlife. As in our study, several scholars (Bot, 1998; Dieste, 2012; Renaerts, 1986) found that Moroccan Muslims often visit the graves on particular days including Thursday, Friday and religious holidays. Dieste (2012) also found in his study that women often visit the graves three days after burial. In keeping with our findings, studies carried out in Morocco (Dieste, 2012; Renaerts, 1986) also confirm that Moroccan Muslims often pay a person (*ṭālib)* to recite the *Qur'ān* and perform supplications at the grave of their deceased loved ones, though Bot (1998) also supports our finding that some Muslims do not visit the graves based on the belief that it has no benefit for the deceased and is thus unmeaningful.

Studies on Muslims in the Netherlands and Germany (Dessing, 2001; Jonker, 1997; Kadrouch-Outmany, 2014; Venhorst, 2013; Ahaddour, Van den Branden & Broeckaert 2017a, 2017b) confirm that rituals are influenced by the context in which they are embedded. They support our finding that Islamic rituals performed in a migration context are inevitably subject to change, set in motion by different social realities. Jonker (1997) and Venhorst (2013) argue that there is always a degree of tension between what is prescribed and what people, in different contexts, perform. Studies conducted in Western Europe (Dessing, 2001; Van den Branden, 2006; Ahaddour, Van den Branden & Broeckaert 2017a, 2017b) corroborate our findings that due to the migrant situation, the involvement in rituals is split up in both space and time. They explain that as the majority of (Moroccan) Muslims opts for repatriation, the ritual of mourning visits and gatherings is often performed twice: once among the Muslim community in the adopted home country before burial and once among the Muslim community in the country of origin after burial.

Our exploratory findings should be interpreted with several limitations in mind. First, data might be biased due to social desirability. Expressing opinions that might deviate from the norm or that could be seen as contrary to Islamic teaching might be difficult. As an interviewer, it is difficult to ascertain whether participants share truthful information. Although several measures were taken to guarantee anonymity (e.g. pseudonyms, deleting audio-tapes after transcribing), qualitative research cannot fully guarantee anonymity (e.g. interviews are face-to-face). Both advantages and disadvantages are attached to the background of the interviewer (interviewer bias). On the one hand, being a member of the same community facilitated the gaining of trust and resulted in a certain openness and detailed conversations, on the other hand this might also have influenced the answers of the participants by not providing 'deviating' answers out of fear of being judged. Second, a possible bias is the mixed position of the expert. During coding, we have taken this into account and made a clear distinction –where possible– between the personal views of the expert and his/her description of the views of Moroccan Muslim women. Third, the translations we had to do also introduced a bias. The interviews conducted in *dārija* (Moroccan Arabic), *tarifit* (a Berber language) had to be translated into Dutch and English, which might have influenced the data. As this was carried out to ensure validity and reliability so that others, including the guiding committee, could verify and follow the coding and analyzing of the data, the first author sought to make accurate translations and verified their accuracy by relying on members of the Moroccan community when confronted with difficulties in the translation of a word or concept. To assure reliability and validity and limit bias as much as possible, we adopted several strategies (e.g. data checking with members of the Moroccan Muslim community; peer debriefing; memos). Fourth, given the nature of our data (specific group; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. In any case, this work does not ignore the heterogeneity among Muslims. For instance, it would still be interesting to do an in-depth

investigation of Muslims from different ethnicities and/or denominations on their practices surrounding mourning and remembrance. Taking into account the specific situation of first generation Moroccan Muslims in Belgium characterized by a strikingly homogenous religious, cultural, socio-economic and geographic background and a more diverse socio-demographic background among second generation Muslims, it would be interesting to explore the views and practices among third generation Muslims who are assumed to embody a stronger diversity socio-economically as well as religiously. Further studies could explore whether the impact of religion on practices surrounding mourning and remembrance differs among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

The organisation of adequate and quality bereavement care which takes into account the religious and cultural needs of the bereaved is of utmost importance. By offering insights into the actual practices, our study aims to offer tangible leads to professionals for a more tailor-made care for bereaved Muslims while insisting that practitioners remain mindful of the diversity of lived experiences that exist within cultures as well as across them. The availability of a Muslim chaplain at this difficult time will usually be an invaluable assistance to the bereaved family and health care professionals.

Conclusion

Our study reveals that religious beliefs and worldviews have a great impact on how Muslims mourn and commemorate their loved ones. Religious beliefs and practices seem to be powerful sources in coping with death and loss. More specifically, theological and eschatological considerations take up a central role. Rituals performed embody their teleological beliefs, stressing the continued existence of the soul, but are also a way to maintain bonds with the deceased, which often entails rites to purify the deceased's soul and bring peace. We have observed that when dealing with mourning and remembrance, both first and second generation Moroccan Muslims living in Antwerp (Belgium) adopt a theological line of reasoning similar to the one that can be found in normative Islamic literature. We did *not* find a more secular practice of mourning and remembrance among middle-aged women.

References

Ahaddour C., & Broeckaert B. (2016). Muslim Burial Practices and Belgian Legislation and Regulations: a comparative literature review. *Mortality, 22* (4), 356-373.

Ahaddour C., & Broeckaert B. (2017). "For Every Illness There Is A Cure". Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-017-0466-1,

Ahaddour C., Van den Branden S., & Broeckaert B. (2017a). Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women. *Omega: Journal of Death and Dying.* https://doi.org/10.1177/0030222817729617.

Ahaddour C., Van den Branden S., Broeckaert B. (2017b). "God's Land is Vast". Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased. *Mortality*. https://doi.org/10.1080/13576275.2017.1413543

Aggoun, A. (2006). *Les Musulmans face à la mort en France* (Espace Ethique ed.): Vuibert.

al-Jazīrīʾ, A. (2009). *Islamic Jurisprudence According to the Four Sunni Schools - Al Fiqh 'ala Al Madhahib Al Arba'ah*. In Vol. 1. *Modes of Islamic Worship*. Retrieved from https://archive.org/details/IslamicJurisprudenceAccordingToTheFourSunniSchoolsAlFiqhalaAlMadhahibAlArbaah

Al-Sayyid, S. (1991). *Fiqh Us Sunnah*. In. Retrieved from http://mappingsharia.com/wp-content/uploads/2011/06/Saabiq-Fiqh-us-Sunnah.pdf

Al-Shahri, M., Fadul, N., & Elsayem, A. (2007). Death, dying and burial rites in Islam. *European Journal of Palliative Care, 13*(4), 164-167.

Assous, A. B. (2013). Cultural and Islamic Values in Relation with Death. *European Scientific Journal, 9*(5), 1857-1881.

Benore, E. R., & Park, C. L. (2004). Death-Specific Religious Beliefs and Bereavement: Belief in an Afterlife and Continued Attachment. *International Journal for the Psychology of Religion, 14*(1), 1-22.

Bot, M. (1998). *Een laatste groet : uitvaart- en rouwrituelen in multicultureel Nederland*. Rotterdam: Ef & Ef In Boeken.

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory*. (Fourth Edition) California: SAGE Publications.

Dessing, N. M. (2001). *Rituals of birth, circumcision, marriage, and death among Muslims in the Netherlands*. Leuven: Peeters.

Dieste, J. L. M. (2012). *Health and Ritual in Morocco: Conceptions of the Body and Healing Practices*: Brill.

Gardner, K. (1998). Death, burial and bereavement amongst Bengali Muslims in Tower Hamlets, East London. *Journal of Ethnic and Migration Studies, 24*(3), 507-521.

Gatrad, A. R., & Sheikh, A. (2002a). Palliative Care for Muslims and Issues After Death. *International Journal of Palliative Nursing, 8*(12), 594-597.

Glaser, B. G., and A. L. Strauss. (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research.* New York: Aldine Publishing Company.

Halevi, L. (2007). *Muhammad's grave: death rites and the making of Islamic society*. New York: Columbia University Press.

Halevi, L. (2013). Funerary Practices. In K. Fleet, G. Krämer, D. Matringe, J. Nawas, & E. Rowson (Eds.), *Encyclopaedia of Islam, THREE*. Brill Online: Brill.

Hedayat, K. M. (2006). When the spirit leaves: Childhood death, grieving, and bereavement in Islam. *Journal of Palliative Medicine, 9*(6), 1282-1291.

Hertogen, J. (2016). Marokkaanse-, Turkse- en islamachtergrond per gemeente. Retrieved from http://www.npdata.be/ [Accessed 20 April 2016]

Hussein, H., & Oyebode, J. (2009). Influences of religion and culture on continuing bonds in a sample of British Muslims of Pakistani origin. *Death Studies, 33*(10), 890-912.

Jonker, G. (1997). The many facets of Islam; death, dying and disposal between orthodox rule and historical convention. In C. M. Parkes, P. Laungani, & B. Young (Eds.), *Death and bereavement across cultures*. London-New York: Routledge.

Kadrouch-Outmany, K. (2014). *Islamic burials in the Netherlands and Belgium. Legal, religious and social aspects.* (Doctoral thesis), Leiden University, Leiden.

Klass, D., & Goss, R. (2002). The politics of the grief and continuing bonds with the dead. The cases of Maoist China and Wahhabi Islam. *Death Studies, 27*(9), 787-811.

Koshen, H. (2015). A Somali Perspective On Death, Grief and Culture. Culture Perspectives on Death in Families. In J. Cacciatore & J. DeFrain (Eds.), The World of Bereavement. Switzerland: Springer International Publishing. doi: 10.1007/978-3-319-13945-6_2

Kristiansen, M., & Sheikh, A. (2012). Understanding faith considerations when caring for bereaved Muslims. *Journal of Royal Society of Medicine, 105*(12), 513-517.

Kristiansen, M., Younis, T., Hassani, A., & Sheikh, A. (2016). Experiencing Loss: A Muslim Widow's Bereavement Narrative. *Journal of Religion and Health, 55*(1), 226-240.

Lowry, J. E. (2017). Ritual Purity. In J. D. McAuliffe (Ed.), *Encyclopaedia of the Qurʾān*. Washington DC.: Georgetown University.

Morgan, J. D. (2002). Islam. In J. D. Morgan & P. Laungani (Eds.), *Death and bereavement around the world* (Vol. 1, pp. 153-157). Amityville: Baywood Publishing.

Mortelmans, D. (2008). *Handboek kwalitatieve onderzoeksmethoden*. Leuven: Acco.

Motzki, H. (2017). Waiting Period. In J. D. McAuliffe (Ed.), *Encyclopaedia of the Qurʾān*. Brill Online.

Murshidah, H., & Kalyani, M. (2010). Grief experience of bereaved Malay/Muslim youths in Singapore: the spiritual dimension. *International Journal of Children's Spirituality,, 15*(1), 45.

Pargament, K. I. (2001). *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: Guilford.

Pew Research Center (2011). Sunni and Shia Muslims. Retrieved from http://www.pewforum.org/2011/01/27/future-of-the-global-muslim-population-sunni-and-shia/[Accessed 10 October 2017]

Renaerts, M. (1986). *La mort, rites et valeurs dans l'Islam Maghrebin* Brussel: ULB -Institut de Sociologie.

Sheikh, A., & Gatrad, A. R. (2008). Death and Bereavement. An exploration and meditation. In A. G. Sheikh, A. R. (Ed.), *Caring for Muslim Patients* (2nd ed., pp. 103-113). Oxford: Radcliffe Publishing.

Smith, J. I., & Haddad, Y. Y. (2002). *The Islamic Understanding of Death and Resurrection*. Oxford: Oxford University Press.

Suhail, K., Jamil, N., Oyebode, J., & Ajmal, M. A. (2011). Continuing bonds in bereaved Pakistani Muslims: effects of culture and religion. *Death Studies, 35*(1), 22-41.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks (Calif.): Sage.

Van den Branden, S. (2006). *Islamitische ethiek aan het levenseinde. Een theoretisch omkaderde inhoudsanalyse van Engelstalig soennitisch bronnenmateriaal en een kwalitatief empirisch onderzoek naar de houding van praktiserende Marokkaanse oudere mannen in Antwerpen.* (Unpublished doctoral dissertation Theology), Katholieke Universiteit Leuven, Leuven.

Venhorst, C. (2013). *Muslims Ritualising Death in the Netherlands. Death rites in a small town context*. Zurich: Litt.

Yasien-Esmael, H., & Rubin, S. S. (2005). The meaning structures of Muslim bereavements in Israel: Religious traditions, mourning practices, and human experiences. *Death Studies, 29*(6), 495-518.

"Everything has to come to an end, sometime."

— L. Frank Baum, The Marvelous Land of Oz

Conclusion

In our dissertation, we examined attitudes, beliefs and practices of Moroccan Muslim women regarding death and dying. More specifically, we focused on a presentation and discussion of the data obtained from a small-scale, exploratory, descriptive, qualitative empirical study conducted among middle-aged and elderly Moroccan Muslim women in Antwerp (Belgium). At the same time, considerable attention has been given to normative (*Sunnī*) Islamic views on death and dying in the introduction or discussion section of the empirical chapters, which were systematically compared with our participants' way of thinking. In our study, we aimed to fill an important gap, as hardly no empirical data exist on death and dying among European Muslims. This study provides a rich, comprehensive and detailed reconstruction of Moroccan Muslim women's way of thinking and practices with regard to a) ageing and care for the elderly; b) illness, health and medicine; c) bioethical issues at the end of life; d) dying, death and the afterlife; e) burial and repatriation; and f) mourning and remembrance.

We have answered **our first research question** (*what are the attitudes, beliefs and practices of middle-aged and elderly Moroccan Muslim women regarding death, dying and the afterlife*) in part two, chapter five. We discovered that religious beliefs, and more specifically *theological and teleological considerations* that centre on God's almightiness and the belief in the afterlife, seem to be very crucial for Muslims in the way they understand death and dying. The belief in predestination and God's will are central in our participants' views as well. Especially the eschatological beliefs of Muslims have a great impact on Muslims' daily lives and strongly determine their attitudes, choices and practices. Death is not viewed as an end, but as a transition from one state of existence to the next. Our participants see their daily life and actions within a teleological framework: deeds performed in the earthly world will determine the experience of death itself, the life in the grave and the final destination (heaven or hell) (cf. P2§5, page 200). The judgment that every Muslim knows he/she is going to be subjected to in the afterlife, determines to a large degree what kind of behaviour during life is accepted or rejected. This clearly indicates the continuing importance of one's actions and implies a sense of human responsibility and accountability. By focusing on human mortality and especially on events and repercussions in the afterlife (e.g. torture in the grave and the judgment), a person's morality is enhanced (cf. P2§5, page 204). Not only do religious beliefs and worldviews have an impact on our participants' views, but also their practices regarding death and dying are strongly coloured and shaped by their theological and, in particular, eschatological beliefs. Rituals surrounding death and dying strongly embody their teleological beliefs, stressing the continued existence of the soul, and often entail rites to purify the dying or deceased's soul. This can be understood in two ways. On the one hand, these rituals entail the purification of a person's sins, i.e. purification of the soul. On the other hand, the rituals entail a purification of the body, i.e. enhancing

cleanliness of the body. This is strongly related to the concept of vice-regency and dignity. The body, which is a trust from God, must be taken care of and must be returned to God in a clean state. Indeed, these rituals have to be understood within a teleological framework: preparations are thus made for the next journey (cf. P2§6, page 230).

The second research question (*what are the attitudes and beliefs of middle-aged and elderly Moroccan Muslim women towards health, illness, medicine and end-of-life issues*) has been tackled in part two, chapter two, three and four. All participants share the unconditional belief in a transcendent reality, in an omnipotent and omniscient God who governs over life, death, illness and cure. The idea of vice-regency is also strongly present here: they do not own their body and life, but have these only in loan as God is the ultimate owner of everything. It is the duty of humans to take care of the bodies and lives given to them (cf. P2§2, page 116 + 120; P2§3, page 143 + 159; P2§4, page 166 + 169). In other words, the attitudes and practices of Moroccan Muslim women seem to be strongly determined by their theological and eschatological frame of reference. We found a clear link between the way Moroccan Muslim women view and deal with ethical issues at the end of life and their religious beliefs. All actions that deliberately and voluntarily end a life are strongly condemned by all our participants, regardless of age or level of education, as it intrinsically denies God's ultimate role in life and death (cf. P2§3, page 148-149). However, with regard to withdrawing life-sustaining treatments, divergent positions were found among middle-aged and elderly participants, reflecting the lines of reasoning found in normative Islamic literature. Considerations centring on God's role in matters of life and death (*cf.* determined person's lifespan by God) and God's omniscience were central among our participants. Not only did participants rely upon theological and eschatological arguments, but also on quality of life and financial arguments in their support of withdrawing life sustaining treatments (cf. P2§4, page 174). Here, autonomy is understood within a religious framework. No contradiction is perceived in their lines of reasoning between ideas of autonomy/self-determination and their religious beliefs or religious worldview (cf. P2§4, page 173-174). An autonomy discourse, however, is completely lacking in the context of active termination of life, as this collides strongly with our participants' worldview of our participants. Unlike withdrawing and withholding, euthanasia is understood as a direct interference with God's plan and rule over life and death. In other words, a strong interplay can be found between religious/eschatological convictions and ethical attitudes.

We have responded to the **third research question** (*what is the reality of elderly care for Muslims in Belgium and in Europe with regard to organization and policy and what are the attitudes and practices of Muslims in Belgium regarding care for the elderly*) in part one, chapter one and part two, chapter one. With regard to the reality of elderly care (cf. P1§1), we found in our review that till now little attention has been given to this topic. The effective use of and access to the available

care services among elderly Moroccan and Turkish migrants in Belgium is hindered by a number of factors such as a language barrier, a low level of education, a financial barrier, a series of cultural and religious barriers, lack of knowledge of the health care system and the so-called return and care dilemmas. The return dilemma entails the experience of a dilemma with regard to the idea of a permanent return to the country of origin. On the one hand elderly people would like to return to Morocco due to the presence of family, property and the climate and on the other hand they prefer Belgium due to the presence of (grand)children and well-organised health care. The care dilemmas implies the choice between family and professional care services. Elderly Muslims rely upon their children when care is needed, which is seen as a religious duty. Despite the fact that children acknowledge this duty, they seem, however, not always able to fulfil this wish (cf. P1§1, page 42-46). Elderly care facilities are not easily accessible and they correspond insufficiently to their specific needs, which are mainly religiously and culturally rooted (e.g. gender relations, *ḥalāl* food etc.). As a result, Muslim migrants from Turkey and Morocco seem to fall into the gap between the inaccessible provision of elderly care services by the State and the fragmentation of traditional family caregiving (cf. P1§1, page 52). The inclusive and neutral Belgian policy on the elderly seems to give insufficient attention to the aforementioned issues. By using the general word *allochthonous* when in fact specifically referring to Moroccan and Turkish people, ethnicity and nationality are given less emphasis and religious beliefs and needs are ignored (cf. P1§1, page 46 + 52). Our empirical study reveals that religious beliefs do play a crucial role in how Moroccan Muslim women perceive and deal with ageing and care for the elderly (cf. P2§1, page 98-99). Religious beliefs seem to be an important framework through which Muslims understand life, ageing and death. We observed strong care uncertainties and tensions among our participants and a shift in traditional care expectations of the son towards the daughter (cf. P2§1, page 98-99). Access and utilisation of professional elderly care is impeded by religious, cultural, financial and language barriers and by a lack of knowledge of professional elderly care facilities (cf. P2§1, page 93-95). We did, however, find a more open attitude towards professional elderly care among middle-aged Moroccan women and among women confronted with illness or high care needs (cf. P2§1, page 99).

We have answered our **fourth research question** (*what are the burial practices of Muslims in Belgium and Europe and how are the practices influenced by the burial regulations of each country*) in part one, chapter two and in part two, chapter seven. In our review on Muslim burial practices in Belgium and Europe from a policy/legal perspective (cf. P1§2), we found that the available studies mainly focus on repatriation to the country of origin as a result of a number of factors including religious barriers (e.g. burial in shrouds, grave in perpetuity etc.), financial constraints, lack of knowledge of the existing burial facilities and a sense of belonging (cf. P1§2, page 58-60). Till today no Islamic burial is possible in the Belgian context that is completely in accordance with the religious and cultural beliefs of Muslims in Belgium. Only recently, several

measures have been taken at different policy levels to accommodate the Islamic burial practices such as the establishment of Islamic plots, the permission of burial in shrouds and the renewal of concession. Nevertheless, the current status differs from region to region and from municipality to municipality (cf. P1§2, page 60-65). The extent of adapting regulation and arranging cemeteries is dependent of the interpretation of neutrality and religious freedom. Different interpretations have led to different options provided by Belgian municipalities (cf. P1§2, page 69). Our empirical study shows that the overwhelming majority of our participants opts for repatriation to the country of origin because of socio-emotional (attachment to family and territory), religious and financial reasons, even if several middle-aged participants would actually prefer burial in Belgium to stay close to their children and to ensure remembrance through visiting the grave (P2§7, page 262-263). Our participants strongly view burial from a religious framework: theological and eschatological beliefs are again central. The idea of vice-regency is also present here and exerts a very important influence on their choice of burial location (e.g. importance of eternal grave rest) (P2§7, page 262). We also found that Moroccan Muslims use Islamic burial prescriptions in a creative way by giving weight and even absolutising one prescription (graves in perpetuity) over others (speedy burial, not transporting the deceased) (cf. P2§7, page 264 + 267).

In part two, chapter eight and nine, we have answered our **fifth research question** (*what are the attitudes, beliefs and practices of Moroccan Muslim women regarding mourning and remembrance*). Our study reveals that religious beliefs and worldviews have a great impact on how Muslims mourn and commemorate their loved ones. Religious beliefs and practices seem to be powerful sources in coping with death and loss. More specifically, here too theological and eschatological considerations (e.g. vice-regency; death is not perceived as the end, but merely a transition from one state of existence to the next) take up a central role. Muslims express an unconditional belief in an omnipotent and omniscient God, who governs over life and death, and the belief in an afterlife (cf. P2§8, page 288). Not only do religious beliefs and worldviews have an impact on our participants' views, but also their practices regarding death and dying are strongly coloured and shaped by their theological and, in particular, eschatological beliefs. Rituals performed embody their teleological beliefs, stressing the continued existence of the soul, but are also a way to maintain bonds with the deceased, which often entails rites to purify the deceased's soul and bring him/her peace. Religion (and rituals) seem to offer Muslims a strong coping mechanism from which strength and hope are drawn when confronted with loss (cf. P2§9, page 311-312).

The answer to our **sixth research question** (*does religion play a role in our participants' way of thinking regarding death and dying and can we observe a shift in the views and practices of first and second generation Moroccan Muslim women*) can be found in part two, chapter one till eight. Indeed, our empirical study (cf. part 2) unveils that religion plays a central role in the lives of middle-aged

and elderly Moroccan Muslim women. We discovered that religious beliefs, and more specifically *theological and teleological considerations* that centre on God's almightiness, God's sovereignty in matters of life and death and the belief in the afterlife, seem to be very crucial for Muslims in the way they understand and deal with ageing, illness, end-of-life ethics, dying, death, mourning, remembrance and burial. In other words, the attitudes and practices of Moroccan Muslim women seem to be strongly determined by their theological and eschatological frame of reference. All participants share the unconditional belief in a transcendent reality, in an omnipotent and omniscient God who governs over life, death, illness and cure. A strong interplay can be found between religious/eschatological convictions and ethical attitudes and choices (cf. P2§1, P2§2, P2§3, P2§4, P2§5, P2§6, P2§7, P2§8 and P2§9). This study shows clearly that when dealing with care for the elderly, illness, dying, death, the afterlife, burial, and mourning, both first and second generation Moroccan Muslims in Belgium adopt a theological line of reasoning very similar to the one that can be found in normative Islamic views. Rather surprisingly, *hardly any differences were found between the views and attitudes of middle-aged and elderly Moroccan Muslim women*, despite their often very different socio-economic position, educational level and integration in Western society, nor did we find a more secular understanding of (practices) regarding death and dying. In this study, secularisation is understood as a decline of meaning and importance of (Islamic) religion for the (Muslim) individual. In sum, no decline in a theological understanding of life and death or in religious observations was observed when comparing first and second generation Moroccan Muslim women (cf. P2§1, page 98; P2§2, page 124-125; P2§3, page 148; P2§4, page 173; P2§5, page 200; P2§6, page 229; P2§7, page 262; P2§8, page 287 and P§9, page 311).

However, the inclusion of middle-aged Moroccan Muslim women has certainly offered us new perspectives in this study. Where there is rather a strong homogeneity regarding attitudes and beliefs –with a few exceptions– among elderly participants, this appears to be the case slightly less among middle-aged participants. First, we found small differences in the attitudes towards illness and dying, death and the afterlife which might be explained based on the differences in educational level among our participants as well as the differences in religious literacy. A difference was observed in the strength and depth of the participants' theological justification of their views and attitudes (e.g. illness; death, dying and afterlife), probably influenced by their *educational level and religious literacy*. The higher the religious education (acquiring knowledge about the Islamic faith through attending mosque and following religious and Arabic language courses), the stronger the religious elaboration of their argumentations and justification for their beliefs (though fundamentally not different) and attitudes (e.g. references to the *Qur'ān* and *ḥadīth*) (cf. P2§2, page 125; P2§5, page 199). However, middle-aged women who are higher educated and/or are active in the labour market, show more openness towards the utilization of professional elderly care (cf. P2§1, page 98). The

impact of the education level was, however, not observable in the participants' attitudes towards active life termination, non-treatment decisions, burials and mourning.

Secondly, we observed a shift in Muslims' attitudes, which consisted of a more open attitude, mainly among middle-aged participants, towards the acceptance of professional elderly care and non-treatment decisions (cf. P2§1, page 99; P2§4, page 166-167), which might be explained by the *influence of the Belgian/Western context* (e.g. individualism, autonomy). In this respect, the secular/western views adopted by our participants were not perceived as contradicting their religious beliefs (cf. P2§4, page 166-167).

Thirdly, a *personal confrontation with a palliative situation / high care needs* or in the direct environment seem to have an influence on the attitudes towards care for the elderly as well, resulting in a tolerant attitude towards professional elderly care (cf. P2§1, page 99). However, this does not seem to have an influence on the more religiously charged topics such as active termination of life or non-treatment decisions.

Finally, we noticed that a few participants (e.g. Ikram, Nuria) who did not endorse the traditional representation of the afterlife (life in the grave, Judgment, paradise / hell) adopted a doubtful, but still disapproving attitude towards euthanasia and assisted suicide (cf. P2§5, page 149-150) and showed an open attitude towards the idea of being buried in Belgium even if an eternal grave is not assured (cf. P2§7, page 263). *Reservations regarding the traditional representation of the afterlife* (e.g. the physicality of life in the grave) might thus have an influence on attitudes and practices. Although these participants have reservations, they still acknowledge God as almighty and omnipotent, the author of life and death as well as the belief in an afterlife.

We have responded to our **final research question** (*how do practices and rituals of Muslims take shape in the particular context of migration to Belgium*) in part two, chapter six, seven and nine. We found that certain religious and cultural practices regarding death, burial, mourning and remembrance have been influenced and adapted due to their embeddedness in a migration context. Our study reveals that rituals are inevitably influenced by the context in which they are embedded and are subject to change due to the social and legal setting (cf. P2§6; P2§7 and P2§9). With regard to death rituals, our study shows that in Belgium, death prayers are performed in the mosque, unlike in the country of origin where the death prayer is traditionally performed in the cemetery. A second crucial adaption is that due to common choice among Muslims to be repatriated to the country of origin, death prayers are performed twice: once in Belgium, once in Morocco (cf. P2§6, page 231). With regard to burial, our study unveils that in Belgium a deceased is transported to the country of origin in a coffin and subsequently buried with it, unlike in the country of origin where the deceased is buried in a shroud. Another adaption is that a speedy burial is not possible as repatriation entails a time break between death rituals, more specifically between death prayer and burial (cf. P2§7, page

263). With regard to mourning and remembrance, our study shows that because of the dominant choice among Moroccan Muslims to be repatriated to the country of origin, mourning visits and gatherings are often performed twice, once in Belgium and once in Morocco. Another example is the decline of organizing mourning gatherings on particular days in the migrant context. The memorial culture in the country of origin is lacking in the migration context, including visiting the deceased's grave on Friday and during religious celebrations. Another example is that for a few participants, certain practices could not be observed (e.g. a widow's curfew) due to a lack of a family safety net in the migration context (cf. P2§9, page 312). In sum, we observed a fragmentation of the country of origin's cultural practices in the migration context. Younger Muslims are often not aware of or familiar with certain rituals performed in the country of origin, which might also be explained by the decline of the bond with the country of origin (cf. P2§6, page 229-230; P2§7 page 263; P2§9, page 311-312). This implies an influence of the migrational context and a reduced influence of the culture of the country of origine. In this context, our participants give less importance to what they consider as merely a cultural practice from the country of origin 'that has no basis in Islam' and thus is not mandatory to be observed (cf. P2§9, page 311).

Our study shows that a *great consensus and strong continuity* exists in the views, attitudes and practices of and between middle-aged and elderly Moroccan Muslim women with regard to death and dying, though we cannot speak of a monolithic block, especially among middle-aged women. Although middle-aged participants are mostly higher educated, have a higher socio-economic position and are more socially active – and thus more influenced by the Belgian / Western context – one could assume that they would adopt a more secularised understanding of illness and death. This was clearly not the case. On the contrary, among all our participants, the general (religious) frame of reference remained firm. The theological or more specifically teleological frame of reference did not lose its meaning nor its central importance among the second generation.

We did observe an even *stronger religious 'discourse'* among a few middle-aged and elderly participants. Among these women we observed a more 'reflexive' approach of Islam which might be explained by the confrontation with the western context and a higher level of education (and thus often higher access to knowledge about Islamic faith, *ḥadīth*, *Qur' ān,* stories about the prophets) on the one hand and the more 'purified' form of Islam they adhere to on the other hand. In their search to observe a more 'purified' form of Islam – which they consider as 'the authentic/real Islam', they criticised some 'cultural' practices and rituals surrounding illness and mourning and remembrance in terms of innovation and idolatry (as not compatible with the strict interpretation of Islam) (cf. P2§2, page 125 and P2§9, page 312).

Limitations

Our findings should be interpreted with several limitations in mind. First, a researcher can never know the full extent of his/her biases (Corbin & Strauss, 2015 p.46). I tried to suspend my personal judgment as much as possible whilst engaged in this research and acknowledge the possibility of its influence on the study.

Second, data might be biased due to social desirability. As such, expressing opinions that might deviate from the norm or opinions that could be seen as contrary to Islamic teaching might be difficult to express. As an interviewer, it is difficult to ascertain whether participants share truthful information. Although several measures were taken to guarantee anonymity (e.g. pseudonyms, deleting audio-recordings after transcribing), qualitative research cannot fully guarantee anonymity (e.g. face-to-face interviews). Both advantages and disadvantages are attached to the background of the interviewer.

Third, a possible bias is the mixed position of the expert between giving technical information and giving their own personal view on the matter. During coding, we have accurately taken this into account and made clear a distinction between personal views of the expert and his/her description of the views of Moroccan Muslim women. Experts might have also given social desirable answers. This bias is, however, limited due to the number and level of diversity in profiles of experts and due to the fact that we specifically interrogated experts about their professional opinion.

Fourth, the translations we had to do, might also have introduced a possible bias. The interviews conducted in *dārija* (Moroccan Arabic) and *tarifit* (a Berber language) had to be translated into Dutch and English, which might have influenced the data. As this was carried out to ensure validity and reliability so that others, including the guiding committee, could verify and follow the coding and analysis of the data, I sought to make accurate translations and verified their accuracy by relying on members of the Moroccan community when confronted with difficulties in the translation of a word or concept. To ensure rigour and credibility and limit bias as much as possible, we adopted several strategies (e.g. transcribing *ad verbum*; data checking with members of the Moroccan Muslim community; peer debriefing; memos).

Fifth, given the nature of our data (specific groups; small sample sizes), the specificity of Moroccan Muslims in Belgium has to be taken into account, including their often quite problematic socio-economic position. Many elderly or first generation Moroccan women are uneducated and illiterate, and are living quite isolated from Belgian society. Our findings cannot be generalized for all (Moroccan) Muslim women in Flanders or Belgium. This does not mean, though, that our findings are not significant. Our study is essentially explorative and descriptive. Therefore, we are prudent in generalizing our findings and we acknowledge that further in-depth investigations of the matter are

necessary. Yet, our findings may be useful to enhance the understanding of the meaning Moroccan Muslims give to death and dying.

Sixth, taking into account the specific situation of first generation Moroccan Muslims in Belgium, characterised by a strikingly homogenous religious, cultural, socio-economic and geographic background and a more diverse socio-demographic background among second generation Muslims, it would be interesting to explore the views among third generation Muslims who are assumed to embody a stronger diversity socio-economically. Further studies could explore whether the impact of religion on the attitudes and practices regarding death and dying would differ among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education and work and who in this context experience and construct their own (religious) identity.

Seventh, another limitation is that although the choice for a PhD on publications is recommendable and suitable for a better dissemination and distribution of knowledge, we were confronted with several limitations. For example, articles were limited in the content's extensiveness and depth due to the often very limited number of words allowed. This meant that not all our empirical data regarding a topic could be included in the article (e.g. attitudes towards ageing; refusal of treatment and non-voluntary euthanasia; practices regarding illness and medicine). It is important to bear in mind that we all to quickly reached the maximum of words allowed due to the inclusion of quotes. Second, articles have been written in view of the journal's style and content which might have influenced the way our findings were presented in the articles.

Implications for practice and policy

We are convinced that our findings can make valuable contributions. First, it points to the gaps that exist in European political, social and academic debates on the topics dealt with in this dissertation. In these debates, voices of Muslims are lacking.

Second, our study points to the importance of knowledge about Islamic and Muslim views and practices on death and dying. This study shows that the theological and more specifically the eschatological framework is very central in a Muslim's way of thinking.

Third, given the fact that contemporary Western societies are becoming increasingly multicultural and multi-religious, it is of great importance to provide adequate and respectful health care. Ascertaining and attempting to meet individuals preferences remains part of a good practice and a marker of quality in the provision of health care. By offering insights into the actual views and practices of Muslims regarding death and dying, this study offers tangible leads to professionals for a more tailor-made care for Muslims.

Fourth, offering religious and cultural-sensitive care is of the utmost importance. This implies an adequate training of health care professionals in order to provide holistic care, where considerable attention is given to the patients' religious, ideological and cultural background. For healthcare and palliative care, it is particularly relevant to take into account a Muslim's religious frame of reference, its importance and the sensitivities that come along with it. For example, Moroccan Muslims wishes to get older and receive care in a familiar environment in which they can experience and practice their religion. Specific attention should be devoted to vulnerable groups (people in high need of care; widow; childless) among elderly Moroccan Muslims in receiving tailored and affordable care. The use of professional care for the elderly by this group is hampered by religious, cultural, financial and language barriers and by a lack of knowledge of professional elderly care facilities.

With regard to end-of-life care, Moroccan Muslims reject euthanasia, assisted suicide and other medical acts that knowingly and willingly shorten the patient's life. These actions are seen as a direct intervention with God's plan about life and death. Therefore, adequate palliative care is of utmost importance for this population.

With regard to mourning care, our study shows that spiritual and religious resources can provide an important support for effectively coping with illness and loss. Religion helps Moroccan Muslims in coping with the loss of a loved one. For example, religious rituals, such as reciting the *Qur' ān* and uttering prayers, give support and guidance to many. Being acquainted with patients' ways of coping with the meanings that they attribute to illness may provide insights into patients' very concrete medical choices. Adequate and respectful care can only be provided and guaranteed if the religious beliefs of Moroccan Muslim patients are taken into account, which, as our study shows, have a considerable influence on their views and attitudes towards death and dying. Nevertheless, at the same time practitioners should remain mindful of the diversity of lived experiences that exist within cultures and traditions.

With regard to burial, the organization of adequate funeral care and burial facilities taking into account Islamic burial prescriptions is important for (Moroccan) Muslims in Belgium. Moroccan Muslims find it important to be buried as soon as possible, but the vast majority chooses to be repatriated to the country of origin. The main reason for this choice is that graves in perpetuity are more guaranteed in the country of origin, in contrast to the situation in Belgium. A close collaboration between hospital and funeral associations as well as policy-makers to ensure a dignified burial for this population is of utmost importance.

This doctoral research is useful for professionals and policy makers in understanding better the needs and dilemmas Moroccan Muslims are facing in Belgium in care for the elderly, palliative care and regarding their choices of burial location.

Summary/Samenvatting

This interdisciplinary study aims to provide a deeper insight into and detailed account of the actual attitudes and practices of Moroccan Muslim women in Belgium regarding death and dying. This research focuses on the following specific topics: (1) care for the elderly; (2) health, illness and medicine; (3) treatment decisions at the end of life (euthanasia, assisted suicide and withholding and withdrawing curative and life-sustaining treatment); (4) views on dying, death and the afterlife; (5) burial and repatriation; (6) mourning and remembrance. On the one hand, we present a review based on the available normative/theoretical and empirical literature on these topics. On the other hand, a qualitative empirical study was conducted consisting of semi-structured in-depth interviews (2014 – 2016) with specialists in the field (n=15) and middle-aged and elderly Moroccan Muslim women (n=30), living in Antwerp, Belgium. The method of participant observation (2014 – 2017) was also adopted, while observing and participating in visiting the sick and the dying, in mourning visits, death prayers, repatriation of the deceased etc. This study reveals that religious beliefs and worldview have a crucial impact on the attitudes and practices of Moroccan Muslims in Belgium towards death and dying. An unconditional belief in God's omnipotence and omniscience, in predestination, in God's will (illness as a test by God) and in the afterlife (eschatology) shape the views and practices of Moroccan Muslim women. Our study shows that a great consensus and strong continuity exists among the views, attitudes and practices of middle-aged and elderly Moroccan Muslim women with regard to death and dying, which are at the same time very similar to the ones found in the normative Islamic literature.

Dit interdisciplinair onderzoek handelt over de religieuze en ethische houdingen, het geloof en de praktijken ten aanzien van sterven en dood bij Marokkaanse moslimvrouwen van middelbare en gevorderde leeftijd in Antwerpen, België. Dit onderzoek beoogt een dieper inzicht te verschaffen en een gedetailleerde beschrijving te geven van de werkelijke houdingen en praktijken ten aanzien van sterven en dood bij deze specifieke populatie. In dit doctoraatsproject ligt de focus op de volgende specifieke aspecten: (1) ouderenzorg; (2) gezondheid, ziekte en geneeskunde; (3) bio-ethische kwesties aan het levenseinde (euthanasie, hulp bij zelfdoding en het weigeren van curatieve en levensverlengende behandeling); (4) sterven, dood en het hiernamaals; (5) begraven en repatriëring; (6) rouwen en herdenking. Het onderzoek bestaat enerzijds uit een theoretisch luik waarbij een uitgebreide review werd gemaakt van de beschikbare normatieve/theoretische en empirische literatuur. Anderzijds werd er een kwalitatief empirisch onderzoek uitgevoerd bestaande uit semi-gestructureerde diepte-interviews (2014 – 2016) met specialisten in het veld (n=15) en Marokkaanse moslimvrouwen van middelbare en gevorderde leeftijd (n=30). Hiernaast werd ook de methode van participerende observatie (2014 – 2017) aangewend waaronder het bijwonen en participeren in, zieken-, stervens- en rouwbezoeken; dodengebeden; repatriëring van een lichaam etc. Uit ons onderzoek kunnen wij concluderen dat religie een zeer centrale rol speelt in het leven

van Marokkaanse moslimvrouwen van middelbare en gevorderde leeftijd uit Antwerpen en dus zeker ook in de manier waarop ze omgaan met en aankijken tegen leven, ziekte, genezing, sterven en dood. Wij merkten op dat de houdingen met betrekking tot sterven en dood sterk gekleurd worden door een theologisch en meer specifiek een eschatologisch referentiekader. Marokkaanse moslims geloven heel sterk in het hiernamaals en zien het leven en zeker ook de laatste levensfase als Gods test. Alle respondenten delen het geloof in een transcendente realiteit, namelijk in een almachtige en alwetende God die over genezing en ziekte, over leven en dood, regeert. Het geloof in predestinatie en Gods wil staan centraal in de visie van de respondenten. Deze gegevens oefenen een zeer belangrijke invloed uit op o.a. ethische beslissingen aan het levenseinde. We merkten een grote consensus en sterke continuïteit op in de opvattingen, houdingen en praktijken van en tussen respondenten van middelbare en gevorderde leeftijd ten aanzien van sterven en dood, waarbij deze opvattingen, houdingen en praktijken tevens grote gelijkenissen vertonen met deze die gevonden kunnen worden in de normatieve islamitische literatuur.

Statements

- (Moroccan) Muslims reject euthanasia, assisted suicide and other medical acts that knowingly and willingly shorten the life of the patient, because these acts are perceived as interfering with God's divine plan and rule over life and death, thus contradicting their unconditional belief in *God's ultimate role as giver and taker of life.*
- The *image (Moroccan) Muslims have of the afterlife* might have an impact on the attitudes and choices they make. Muslims who have a less traditional representation of the afterlife are more likely to have a more positive attitude towards active termination of life and the idea of being buried in a grave without an eternal concession.
- A higher involvement with western society and a larger diversity with regard to socio-economic position and educational level among middle-aged Moroccan Muslims in Belgium (when compared to elderly Moroccan Muslims) does not seem to imply *a more secular approach of* death and dying.
- Given the increasing multicultural and multireligious diversity in Belgian society, it is of great importance to provide and guarantee *adequate and respectful care*, by taking into account the religious beliefs of Moroccan Muslim patients, which have a significant impact on their views on treatment decisions at the end of life.

Biography

Chaïma Ahaddour (Lokeren, 1988) studied Arabic and Islamic studies at the Faculty of Arts (Katholieke Universiteit Leuven). From December 2013 till December 2017 she worked as a doctoral researcher at the Faculty of Theology and Religious Studies (Katholieke Universiteit Leuven) on a doctoral dissertation *The Attitudes, Beliefs and Practices regarding Death and Dying among Middle-aged and Elderly Moroccan Muslim Women in Antwerp (Belgium).* This project was supervised by prof. dr. Bert Broeckaert (Faculty of Theology and Religious Studies, Katholieke Universiteit Leuven).

Recent publications are:

- Ahaddour C., Van den Branden S., Broeckaert B. (2017). "God's Land is Vast". Attitudes and Practices of Moroccan Muslims regarding Burial and Repatriation of the Deceased. *Mortality,* art.nr. https://doi.org/10.1080/13576275.2017.1413543.
- Ahaddour C., Broeckaert B. (2017). "For Every Illness There Is A Cure". Attitudes and Beliefs of Moroccan Muslim Women regarding Health, Illness and Medicine. *Journal of Religion and Health,* art.nr. https://doi.org/10.1007/s10943-017-0466-1, 1-19.
- Ahaddour C., Van den Branden S., Broeckaert B. (2017). Purification of Body and Soul for the Next Journey. Practices Surrounding Death and Dying among Muslim Women. *Omega: Journal of Death and Dying* , art.nr. https://doi.org/10.1177/0030222817729617, 1-32.
- Ahaddour C., Van den Branden S., Broeckaert B. (2017). Between Quality of Life and Hope. Attitudes and Beliefs of Muslim Women toward Withholding and Withdrawing Life-Sustaining Treatments. *Medicine, Health Care and Philosophy, Epub ahead of print,* art.nr. https://doi.org/10.1007/s11019-017-9808-8.
- Ahaddour C., Van den Branden S., Broeckaert B. (2017). "God is the Giver and Taker of Life". Muslim Beliefs and Attitudes regarding Assisted Suicide and Euthanasia. *AJOB Primary Research,* art.nr. https://doi.org/10.1080/23294515.2017.1420708.
- Ahaddour C., Van den Branden S., Broeckaert B. (2017). "Every Soul Shall Taste Death". Attitudes and Beliefs of Moroccan Muslim Women living in Antwerp (Belgium) toward Dying, Death and the Afterlife. *Death Studies, 16,* art.nr. 16.
- Ahaddour C., Broeckaert B. (2016). Muslim Burial Practices and Belgian Legislation and Regulations: a comparative literature review. *Mortality, 22* (4), 356-373.
- Ahaddour C., Van den Branden S., Broeckaert B. (2015). Institutional elderly care services and Moroccan and Turkish migrants in Belgium: a literature review. *Journal of Immigrant and Minority Health, 18* (5), 1216-1227