ASEAN Journal of
Religion, Education, and Society

Journal homepage: https://ejournal.bumipublikasinusantara.id/index.php/ajores

Understanding Cultural Competence in Non-Muslim Nurses Caring for Muslim Patients in the Philippines

Mark Ryan Y. Contaoi

Sultan Kudarat State University, the Philippines
Correspondence: E-mail: mark.contaoi@gmail.com

ABSTRACT

This study investigated the cultural competence of non-Muslim nurses caring for Muslim patients, focusing on their knowledge of Islamic beliefs and practices related to pregnancy, diet, family roles, communication, healing, and death. Using a descriptive-correlational and comparative design, 250 non-Muslim nurses from eight hospitals in Cotabato, Philippines, were surveyed through validated instruments: Cultural Awareness and Sensitivity (CAS), Cultural Competence Behaviors (CCB), and Cultural Competence Assessment (CCA). Results showed that the nurses possessed good knowledge and high cultural competence. A significant positive relationship was found between knowledge of Islamic healing practices and overall cultural competence. Previous diversity training was the only personal factor significantly associated with cultural competence. Because religion shapes Muslim patients' health behaviors, nurses' understanding of these beliefs enhances their ability to deliver culturally congruent care. The findings highlight the importance of incorporating culture-specific training in nursing education and practice to ensure respectful, safe, and effective care for diverse populations.

ARTICLE INFO

Article History:
Submitted/Received 26 Dec 2024
First Revised 28 Jan 2025
Accepted 14 Mar 2025
First Available online 15 Mar 2025
Publication Date 01 Apr 2025

Keyword:
Correlates,
Cultural competence,
Descriptive-correlational and comparative,
Islamic belief and practices,
Muslim patients,
Non-muslim nurse.

1. INTRODUCTION

Cultural diversity presents a profound challenge for healthcare systems worldwide, particularly in multicultural nations like the Philippines (Kawaguchi-Suzuki *et al*., 2019; Cruz *et al*., 2016). Health practitioners, especially nurses, are increasingly confronted with the need to deliver culturally competent care to individuals from various ethnic, linguistic, and religious backgrounds (Anderson *et al*., 2003; Renzaho *et al*., 2013). Clinical interactions with culturally diverse patients can be complex and occasionally strained due to language barriers, stereotypes, implicit biases, and misinterpretations (Rothlind *et al*., 2018; Archuleta *et al*., 2024). These issues may lead to misdiagnosis, inadequate treatment, or the exclusion of minority groups in healthcare access and provision, thereby reinforcing systemic inequalities while favouring dominant cultural groups (Caricati *et al*., 2015).

In the Philippine context, the diversity in cultural and ethnic compositions of the population imposes daily demands on nurses to tailor care according to the sociocultural needs of their patients. Among the various ethnic groups, the Muslim community stands out due to the unique and integrative role of Islam in shaping their worldviews on health, illness, and treatment. Islam not only informs religious beliefs but also prescribes detailed guidelines for food consumption, gender relations, modesty, healing rituals, and death rites. These cultural nuances are deeply intertwined with healthcare experiences and require sensitivity and understanding from caregivers, particularly non-Muslim nurses. Despite this, many healthcare professionals continue to administer generalized care, often overlooking cultural and religious differences that may significantly impact the patient's comfort, compliance, and healing process.

Nurses who are not culturally informed risk imposing their values on patients, which can result in unintentional cultural violations and patient dissatisfaction. The significance of understanding a patient's cultural background cannot be overstated, particularly in achieving holistic and individualized care. For instance, in the experience (a clinical instructor based in Mindanao), several situations revealed a lack of awareness regarding Muslim customs. People recalled discomfort with large family visits for Muslim patients, being corrected for assigning a male nurse to a female patient, and being rejected when offering a handshake to a Muslim woman, all of which underscore the consequences of limited cultural knowledge in clinical settings.

Such missteps, though unintended, point to a broader issue in healthcare: cultural blindness. Some researchers (Kitota, 2023) cited a case where a Muslim patient, who was an Imam, had his beard shaved as part of routine grooming care. When the patient's family visited, they were deeply disturbed and refused to see him due to a breach of a religious taboo. The act of shaving the Imam's beard (a symbol of piety) had severe religious implications, which could have been avoided through basic cultural knowledge. Such incidents highlight the necessity of including cultural considerations in nursing care plans.

Cultural competence is thus not just an academic concept but a practical necessity in nursing practice. Without it, nurses risk alienating patients and undermining the quality of care. Bias, stereotyping, and a lack of cultural understanding contribute to patient mistrust, elevated stress, and communication barriers. These dynamics often result in lower patient satisfaction, increased anxiety, and suboptimal health outcomes.

Despite the increasing importance of culturally competent care, there remains a lack of standardized tools and procedures to assess nurses' awareness of religious and cultural components that may influence care delivery. Most existing efforts in cultural training focus on interpersonal communication among nurses rather than on nurse–patient interactions

that account for cultural backgrounds (O'Neil, 2011). This gap suggests the need for studies focused on understanding how nurses interact with patients of specific cultural backgrounds, particularly Muslims, whose religious beliefs significantly influence healthcare choices and expectations.

This study was designed to address this gap by assessing the cultural competence of non-Muslim nurses in caring for Muslim patients in Cotabato, Philippines—a region with a significant Muslim population. While Islam is one of the world's major religions, its impact on clinical care remains underexplored from the perspective of non-Muslim healthcare providers. Previous literature has primarily examined healthcare provision from a Western or secular viewpoint, neglecting the lived realities of caregivers and patients in religiously pluralistic societies (Halligan, 2006; Chapman *et al*., 2014; Noll, 2014).

Understanding Islamic principles is particularly important in areas like Mindanao, where Islam is widely practiced. However, healthcare workers—including nurses—often come from diverse religious or secular backgrounds and may not be sufficiently familiar with Muslim values, traditions, or health-related beliefs. This discrepancy in knowledge can hinder the development of trust and rapport between patients and providers, particularly when dealing with sensitive matters such as gender roles, dietary restrictions, or healing rituals.

Islam prescribes holistic approaches to health and wellness, viewing illness not merely in physical terms but also as a spiritual trial. For example, beliefs around modesty may restrict a female patient's interaction with male caregivers, and certain rituals—such as daily prayers or dietary laws—may be prioritized even during hospitalization. Without awareness of these practices, non-Muslim nurses may inadvertently disrupt the patient's spiritual well-being, which is considered integral to healing in Islamic teachings. The implications extend beyond patient discomfort; they can cause psychological distress for families, as seen in the aforementioned case of the shaven Imam.

The direct encounters with cultural challenges in clinical settings reinforce the urgency of institutionalizing cultural competence training. Nurses often report inadequate preparation for delivering culturally congruent care, especially for Muslim patients whose health behaviours are deeply influenced by religion. In some hospitals, nurses admit to providing care without fully understanding the patient's spiritual needs, resulting in a transactional, rather than transformative, healthcare experience.

This study intends to contribute to the growing body of literature on cultural competence by exploring the knowledge and behaviours of non-Muslim nurses working with Muslim patients. It seeks to assess the relationship between nurses' knowledge of Islamic beliefs and practices (including domains such as pregnancy and childbearing, dietary restrictions, family dynamics, healing rituals, and death rites) and their level of cultural competence. The study also explores whether personal factors, such as educational attainment, work experience, and prior diversity training, influence cultural competence.

The ultimate goal is to inform the development of training programs and clinical guidelines that promote culturally appropriate nursing care. By identifying key correlates of cultural competence, this research can support policy initiatives aimed at integrating cultural education into nursing curricula and continuing professional development. This is particularly critical in multicultural societies like the Philippines, where nurses serve patients from various ethnic and religious backgrounds.

Moreover, the findings may help create a reference guide for healthcare professionals tasked with caring for Muslim patients. Such a guide would not only enhance the quality of care but also strengthen the therapeutic relationship between nurse and patient. In turn, this

contributes to improved health outcomes, greater patient satisfaction, and a more inclusive healthcare system. As the healthcare sector continues to evolve in response to demographic changes, the ability to provide culturally congruent care will remain a defining feature of nursing excellence and professional responsibility.

In recent years, many researchers have increasingly emphasized the need to move beyond general multicultural training towards a more nuanced, religion-specific cultural competence—particularly about Islam. Scholars (Hussein, 2013; AlYateem & AlYateem, 2014) have emphasized that there is not enough research detailing how Islamic values, principles, and beliefs impact nursing care. As Islam encompasses specific rulings on physical care, dietary restrictions, modesty, prayer, healing, and death rituals, a deep understanding of these cultural norms is critical for nurses to avoid care that is unintentionally offensive or spiritually distressing to Muslim patients. In health care settings, this lack of awareness can lead to alienation or even rejection of treatment.

Mindanao, being home to a significant Muslim population, serves as a particularly relevant context for this study. Despite the region's unique cultural and religious landscape, many nurses assigned in Mindanao are non-Muslims and may come from parts of the Philippines where Islamic practices are not commonly encountered. As a result, there is an evident knowledge gap that may hinder the delivery of effective, culturally congruent care. This discrepancy presents a potential risk not only to the nurse-patient relationship but also to patient safety and outcomes.

The need for culturally competent healthcare has been further underlined by global organizations. The United Nations in 2008 stated that professional nurses must acquire specific knowledge about the major cultural groups they serve, including beliefs about health and illness, biological variations, and culturally influenced life experiences. This aligns with other works (Jackson, 2007), who asserts that health beliefs (especially those related to religion) are essential components in shaping a patient's perception of healthcare and influence their interaction with the healthcare system.

In this light, cultural knowledge of Islamic practices becomes foundational to achieving broader goals of cultural competence. As proposed in the literature (Campinha-Bacote, 1999), cultural knowledge is one of five essential components of culturally competent care, along with cultural awareness, skill, encounters, and desire. Cultural knowledge enables the nurse to understand health practices, family roles, gender dynamics, and dietary needs within a specific cultural or religious context. This understanding lays the groundwork for the development of cultural sensitivity and appropriate care behaviours.

Furthermore, Filipino nurses are uniquely positioned to achieve cultural competence due to inherent traits rooted in Filipino culture, such as modesty, respect for elders, value for family, and adaptability. These traits influence how Filipino nurses interact with patients from diverse cultural backgrounds (Ordonez and Gandeza, 2016). The values of "pakikipagkapwa" (regard for others) and "hiya" (modesty or shame) often encourage Filipino nurses to be respectful and considerate in their interactions, traits that align with the requirements of culturally sensitive care. Similarly, Filipino nurses' strong emphasis on family-oriented care resonates with the collectivist values of Muslim patients, which prioritize family involvement in health decisions.

This cultural synergy, however, needs to be supported by formal education and training. As shown by multiple studies (Delgado *et al*., 2013; Schim *et al*., 2005; Starr & Wallace, 2009), participation in cultural diversity training significantly enhances nurses' cultural awareness and improves care delivery. Unfortunately, despite widespread agreement on the value of such training, many nurses continue to lack structured opportunities to learn about specific

cultures and religions, especially Islam. In some cases, hospital policies and healthcare curricula do not adequately address the practical challenges nurses face in delivering culturally sensitive care to Muslim patients.

Moreover, the growing Muslim population and the frequent hospitalization of Muslim patients necessitate that health institutions embed cultural competence into policy and practice. Nurses, being on the frontlines of patient care, must understand the implications of religious practices such as ablution, prayer schedules, fasting during Ramadan, and rules around gender interaction. These religious obligations often influence the timing of procedures, medication schedules, and dietary intake, all of which require coordination and flexibility from nursing staff.

The consequences of overlooking these cultural aspects are more than theoretical. Studies have documented how a lack of cultural understanding can lead to negative patient experiences, noncompliance, and treatment refusal. Muslim patients may experience healthcare disparities due to providers' unfamiliarity with Islamic values, which can result in miscommunication, distrust, or substandard care (Padela *et al*., 2011). Therefore, culturally congruent care is not just ethically appropriate—it is essential for reducing disparities and improving health equity.

This study is also grounded in literature (Leininger, 2022), which posits that culturally competent care can only be achieved when nurses understand and incorporate patients' cultural values and practices into their care plans. Culturally congruent care is care that fits with the patient's cultural beliefs and lifeways, leading to better healing, satisfaction, and overall well-being. For Muslim patients, this may mean accommodating prayer times, using gender-congruent caregivers, and understanding the spiritual significance of illness and healing rituals.

Thus, the significance of this study lies in its potential to enhance the cultural competence of nurses by identifying key factors that contribute to their understanding and behaviours. It also aims to determine whether knowledge of Islamic beliefs and practices is significantly related to the nurses' cultural awareness, sensitivity, and behaviours in care delivery. This relationship, once established, can serve as a basis for the development of targeted training programs and clinical guidelines that support culturally congruent care.

By focusing specifically on non-Muslim nurses in Cotabato (a region where Muslim patients are common), this study offers context-specific insights that may be generalizable to other multicultural healthcare settings. It recognizes the complexity of culture in clinical encounters and seeks to improve not only the patient experience but also the nurses' confidence, satisfaction, and professional competence.

Ultimately, the study supports the broader goal of integrating cultural competence into healthcare education, policy, and practice. As healthcare becomes increasingly globalized and diverse, the ability to understand and respond to patients' cultural and religious needs will continue to define quality, safety, and equity in care. This research contributes to building that foundation by identifying the correlates of cultural competence among nurses, deepening the understanding of how knowledge informs practice, and promoting culturally sensitive nursing care for Muslim patients in the Philippines and beyond.

2. METHOD

This study employed a descriptive-correlational and comparative research design. The descriptive approach was utilized to examine the personal factors of non-Muslim nurses, including their educational attainment, years of nursing experience, cultural diversity

encounters within the past 12 months, and previous diversity training. This design was appropriate for evaluating both the level of knowledge and the level of cultural competence of non-Muslim nurses in providing care to Muslim patients.

The correlational design aimed to determine the relationship between nurses' knowledge of Islamic beliefs and practices and their level of cultural competence. Meanwhile, the comparative component analysed whether significant differences in cultural competence emerged when nurses were grouped according to personal variables.

The study utilized two instruments to gather quantitative data: a 46-item knowledge questionnaire and a 25-item Cultural Competence Assessment (CCA) tool. The knowledge questionnaire was designed to assess non-Muslim nurses' understanding of Islamic beliefs and practices, while the CCA measured their cultural awareness, sensitivity, and competence behaviours.

The research was conducted in eight hospitals—both public and private—located in the Province of Cotabato, Philippines. Among these institutions, four were Level I hospitals, three were Level II, and one was a Level III facility. Hospital bed capacities ranged from 30 to 150. The inclusion criteria required participants to be non-Muslim registered nurses who had previously provided care to Muslim patients, regardless of their employment status or whether they worked in public or private hospitals.

Using purposive sampling, a total of 250 non-Muslim nurses were selected from the eight hospitals. These individuals voluntarily agreed to participate after being approached during the data collection phase. The self-report survey method was employed to collect data from participants regarding their knowledge of Islamic beliefs and practices, as well as their cultural competence in nursing care. Participants were asked to answer the survey questions based on their real-life experiences, behaviours, thoughts, and feelings.

The study maintained strict confidentiality and anonymity throughout the research process. Participants were informed about the nature of the study, its objectives, and their rights, including voluntary participation. Informed consent was obtained before the distribution of questionnaires. Because the identities of respondents were protected, participants were able to respond honestly without fear of judgment or coercion.

Ethical approval for the study was granted by the Ethics Review Committee of San Pedro College, Davao City, following the evaluation and revision of the research instruments. Before formal data collection, we also secured permissions from the Chiefs of the Hospital and the Chief Nurses of the eight study sites. Coordination with key hospital personnel ensured access to the non-Muslim nursing staff for survey administration.

To ensure content validity, the modified instrument was reviewed by three experts with doctoral qualifications. A pilot study was also conducted with non-Muslim nurses from hospitals that were not part of the actual study. This allowed for refinement of the survey instrument and testing of its internal consistency.

The resulting Cronbach's alpha coefficients confirmed the reliability of the instruments:

(i) Knowledge of Islamic beliefs and practices: $\alpha = 0.82$
(ii) Cultural Awareness and Sensitivity (CAS): $\alpha = 0.78$
(iii) Cultural Competence Behaviours (CCB): $\alpha = 0.76$

The final questionnaire was divided into three main sections:

Section 1: Personal Profile. This section collected demographic and background information, including the nurses' level of education, years of experience, number of culturally diverse encounters in the past year, and any previous diversity training.

Section 2: Knowledge of Islamic Beliefs and Practices. This part of the questionnaire contained 40 true-or-false items adapted and modified from Domocmat's research on nurses'

competency in caring for Muslim patients. The instrument assessed knowledge in five domains (Domocmat, 2016):

(i) Pregnancy and childbearing
(ii) Dietary practices
(iii) Family roles, organization, and communication
(iv) Religious beliefs and practices
(v) Healing beliefs and practices
(vi) Death rituals

Eleven of the 40 items were false statements. These items included two from the pregnancy domain (Items 3 and 5), three from dietary (Items 4, 6, 8), one from family roles (Item 4), one from religious beliefs (Item 2), one from healing beliefs (Item 1), and three from death rituals (Items 2, 6, 7). A higher score indicated greater knowledge in the given domain.

Section 3: Cultural Competence Assessment (CCA). The third section employed a 25-item tool originally developed by Schim & Doorenbos (2010). This instrument measured the nurses' self-perceived cultural awareness, sensitivity, and competence behaviours across two subscales:

(i) Cultural Awareness and Sensitivity (CAS). The 11-item CAS subscale was rated using a 5-point Likert scale (strongly agree to strongly disagree). It assessed knowledge of cultural values and beliefs across diverse groups, as well as attitudes and personal insights related to cultural sensitivity. Four items (Items 1, 2, 5, and 8) were reverse scored. A higher score reflected greater cultural awareness and sensitivity.
(ii) Cultural Competence Behaviours (CCB). This 14-item subscale was rated on a 5-point Likert scale (always to never) without reverse scoring. It focused on observable behaviours and practices such as incorporating cultural assessments in care, seeking out information about patients' cultural needs, and reducing cultural barriers during treatment.

The survey instrument was administered in English, and participants were instructed to respond with complete honesty. They were also informed that their responses could contribute to the improvement of transcultural nursing education and practice.

Finally, based on the findings of the study, we developed a training program aimed at enhancing the cultural competence of non-Muslim nurses when caring for Muslim patients. This program was designed to address the gaps identified in knowledge and practice, especially concerning culturally sensitive and religion-informed care.

The overall process of data collection began once all necessary approvals were obtained. We initiated communication with hospital administrators and chief nurses to schedule visits and provide orientation regarding the purpose of the study. During the orientation sessions, participants were briefed on the study's goals, the structure of the questionnaire, and ethical considerations such as voluntary participation, anonymity, and confidentiality of responses.

After obtaining informed consent, we distributed the validated questionnaires to the eligible participants. The participants completed the questionnaires at their convenience within the hospital premises. This strategy ensured minimal disruption to their clinical responsibilities while allowing ample time for honest and thoughtful responses.

The self-report format was selected because it encourages participants to reflect on their knowledge and behaviours, allowing for more accurate data collection regarding personal insights and professional practices. Furthermore, the anonymity of responses was emphasized to foster trust and honesty. Participants were informed that their responses

would not be used to evaluate their performance or shared with their supervisors or institutions.

To enhance the trustworthiness of the study, several validation techniques were employed. The content validity of the knowledge and cultural competence tools was ensured by three expert validators who assessed the instruments for clarity, relevance, and comprehensiveness. These experts were professionals with doctoral degrees and experience in nursing, transcultural healthcare, and Islamic cultural practices. Based on their feedback, minor revisions were made to enhance item clarity and cultural appropriateness.

To establish reliability, a pilot test was conducted involving 30 non-Muslim nurses from hospitals outside the selected research sites. The results of the pilot testing confirmed acceptable internal consistency for all subscales. The Cronbach's alpha values (0.82 for knowledge, 0.78 for CAS, and 0.76 for CCB) suggested that the instruments were reliable for use in the main study.

The data collected were encoded, organized, and analysed using statistical tools suitable for descriptive, correlational, and comparative analyses. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarize the personal and demographic characteristics of the participants, as well as their level of knowledge and cultural competence.

To determine the relationship between knowledge of Islamic beliefs and practices and cultural competence, the study employed the Pearson product-moment correlation coefficient (r). This allowed us to measure the strength and direction of the linear relationship between knowledge (as the independent variable) and the subscales of cultural competence: Cultural Awareness and Sensitivity (CAS) and Cultural Competence Behaviours (CCB), as well as the overall Cultural Competence Assessment (CCA).

Additionally, inferential statistics such as t-tests and one-way ANOVA were used to compare cultural competence scores across various personal factors (i.e., educational attainment, years of nursing experience, cultural diversity encounters, and prior diversity training). These statistical tests were appropriate for identifying significant differences in cultural competence when respondents were grouped based on different characteristics.

The significance level for all statistical tests was set at $p < 0.05$, ensuring that the conclusions drawn were statistically valid. All analyses were conducted using statistical software (e.g., SPSS), which allowed for efficient computation and minimized human error during data processing.

One of the major strengths of this study lies in its contextual relevance. Conducted in Mindanao, a region with a high Muslim population, the study's findings provide valuable insights into how non-Muslim nurses interact with, perceive, and deliver care to Muslim patients. The purposive sampling of non-Muslim nurses from various hospitals across Cotabato ensured that the data reflected diverse experiences and institutional practices, increasing the generalizability of the results within the region.

In addition, the development of the training program as a final output of the study addresses the practical application of the research findings. This proposed training aims to fill identified gaps in nurses' knowledge and behaviours by incorporating key components of Islamic health beliefs, cultural rituals, and culturally competent communication strategies.

Throughout the research process, ethical standards were upheld following the principles of respect for persons, beneficence, and justice. These ethical principles were especially important in a culturally sensitive topic involving both religious and professional values. We ensured transparency in communication, provided options to withdraw from the study at any time, and protected participant privacy in the analysis and reporting of results.

In conclusion, the study's method was rigorous and multifaceted, combining validated instruments, systematic sampling, and robust data analysis techniques. The descriptive-correlational and comparative design provided a comprehensive picture of the cultural competence of non-Muslim nurses and their knowledge of Islamic health practices. The findings served as a basis for actionable strategies, such as culturally relevant training programs, aimed at improving patient outcomes and fostering inclusive healthcare environments.

3. RESULTS

Table 1 shows the knowledge of Non-Muslim Nurses on Islamic Beliefs and Practices and revealed that their knowledge on dietary practices obtained the highest mean of 77.64 with a verbal description of Good. On the other hand, their knowledge of Family roles and organization and communication generated the lowest mean of 58.87, having a verbal description of Fair. Having an overall mean of 68.84, all six domains of cultural knowledge on Islamic beliefs and practices, when summed up, have a verbal description of Good. This implies that the non-Muslim nurses in the Province of Cotabato, Philippines, have a high knowledge of Islamic beliefs and practices.

Table 1. Overall mean for knowledge of non-muslim nurses in islamic beliefs and practices.

	Mean	Description	Interpretation
Pregnancy and Childbearing Practices	69.71	Good	High
Dietary Practices	77.64	Good	High
Family Roles and Organization	58.87	Fair	Moderate
Religious Beliefs and Practices	65.40	Good	High
Healing Beliefs and Practices	65.33	Good	High
Death Rituals	76.10	Good	High
Total	68.84	Good	High

Table 2 is the summary of results of the cultural competence of the non-Muslim nurses. The data showed that the cultural competence assessment (CCA) (obtained from adding the Cultural Awareness and Sensitivity) and Cultural Competence Behaviours (CCB) has a mean of 3.88 (the non-Muslim nurses have high cultural competence).

Table 2. Summary table of non-muslim nurses cultural competence.

Cultural Competence	Mean	Description
Cultural Awareness and Sensitivity (CAS)	3.94	High
Cultural Competence Behaviors (CCB)	3.82	High
Cultural Competence Assessment (CCA)	3.88	High

Table 3 is the summary table for the results of a significant relationship between the knowledge of non-Muslim nurses on Islamic beliefs and practices and cultural competence. The data showed that the overall knowledge of non-Muslim nurses has a significant relationship with cultural awareness and sensitivity (CAS) with a strong emphasis on the domain for healing beliefs and practices. However, there is no significant relationship between knowledge and cultural competence behaviours (CCB).

In terms of the overall cultural competence as indicated by the Cultural Competence Assessment (CCA), the results revealed that only the domain for healing beliefs and practices has a significant relationship with cultural competence but not on the overall knowledge.

Table 3. Summary for the test of significant relationship between knowledge of non-muslim nurses on islamic beliefs and practices and cultural competence.

Cultural Competence Overall	Knowledge Domains	r-value	p-value	Remarks
Cultural Awareness and Sensitivity	Pregnancy & childbearing	0.030	0.637	Not Significant
	Dietary practice	0.008	0.898	Not Significant
	Family roles	0.098	0.122	Not Significant
	Religious beliefs	0.025	0.692	Not Significant
	Healing beliefs	0.180**	0.004	Significant
	Death rituals	0.065	0.303	Not Significant
Subtotal		0.131*	0.038	Significant
Cultural Competence Behaviors (CCB)	Pregnancy & childbearing	0.066	0.296	Not Significant
	Dietary practice	-0.036	0.576	Not Significant
	Family roles	0.051	0.425	Not Significant
	Religious beliefs	0.043	0.501	Not Significant
	Healing beliefs	0.121	0.057	Not Significant
	Death rituals	-0.028	0.659	Not Significant
Subtotal		0.077	0.225	Not Significant
Cultural Competence Assesment (CCA)	Pregnancy & childbearing	0.061	0.335	Not Significant
	Dietary practice	-0.021	0.737	Not Significant
	Family roles	0.082	0.195	Not Significant
	Religious beliefs	0.042	0.506	Not Significant
	Healing beliefs	0.171***	0.007	Significant
	Death rituals	-0.011	0.468	Not Significant
Total		0.116	0.066	Not Significant

Table 4 is the summary table for the test of significant difference in cultural competence when grouped according to personal factors. The data showed that the Cultural Competence Behaviours (CCB) subscale differed significantly when analysed by previous diversity training. The overall cultural competence or CCA showed significant difference when previous diversity training was also analysed. It only implies that having diversity training will significantly influence the non-Muslim nurses' cultural competence.

Table 4. Summary for the test of significant difference in cultural competence when grouped according to personal factors.

Cultural Competence	Personal Factors	F/t	p-Value	Remarks
Cultural Awareness and Sensitivity (CAS)	Educational attainment	F=6.30	0.596	Not Significant
	Yrs. of nursing. experience	F=0.612	0.608	Not Significant
	Previous diversity training	t=1.439	0.151	Not Significant
Cultural Competence Behaviors (CCB)	Educational attainment	F=1.371	0.252	Not Significant
	Yrs. of nursing. experience	F=2.155	0.094	Not Significant
	Previous diversity training	t=3.585	0.000	Not Significant
Cultural Competence Assessment (CCA)	Educational attainment	F=0.742	0.528	Not Significant
	Yrs. of nursing. experience	F=1.247	-0.593	Not Significant
	Previous diversity training	t=3.221	0.001	Significant

4. Discussion

4.1. Knowledge of Non-Muslim Nurses on Islamic Beliefs and Practice

This study revealed that non-Muslim nurses in Cotabato Province, Philippines, generally possess a good level of knowledge regarding the beliefs and practices of Muslim patients. The average score across six domains—pregnancy and childbearing, dietary practices, family roles and communication, religious beliefs, healing practices, and death rituals—demonstrates a relatively high level of familiarity. This finding is notable considering that the nurses surveyed were from a non-Muslim background, yet they work in a region where Muslims constitute a significant portion of the population. It suggests that prolonged interaction with Muslim patients may lead to the informal acquisition of culturally relevant knowledge through direct clinical experience and interpersonal engagement (Domocmat, 2014).

The highest scoring domain was dietary practices, with a mean of 77.64. This domain's prominence likely stems from the visible and tangible nature of food-related practices, which are more likely to be encountered and remembered by healthcare providers. Islamic dietary laws, such as halal food, the prohibition of pork and alcohol, and fasting during Ramadan, are commonly known and often directly impact patient care, especially in meal planning and medication timing. This finding also suggests that non-Muslim nurses may have developed an instinctive sensitivity to the dietary needs of Muslim patients through their routine responsibilities in hospital settings.

In contrast, the lowest scoring domain was family roles and organization and communication, with a mean of only 58.87. This indicates a knowledge gap that may hinder effective communication and collaboration between nurses and Muslim patients' families. In Islamic culture, family plays a central role in decision-making processes, and healthcare decisions are often made collectively rather than individually. Misunderstanding or overlooking this cultural aspect can lead to breakdowns in communication, decreased patient satisfaction, and even non-compliance with care plans. Some researchers (Kelly & Papadopoulos, 2009) highlight the strong connection between cultural competence and improved communication in clinical encounters, emphasizing the necessity for nurses to be trained in this area.

This gap may be rooted in cultural differences related to hierarchical family structures, gender roles, and expectations for deference to elders or male relatives, which may be unfamiliar to non-Muslim nurses. In some cases, decisions about treatment or consent may need to be deferred to a family elder or male guardian, which could conflict with Western ideals of individual patient autonomy unless understood and respected by the attending nurse. This underscores the need for targeted training in family dynamics and communication within the Islamic cultural framework.

Despite this, the overall knowledge rating of "Good" indicates a promising level of cultural awareness. The nurses' high level of familiarity with religious beliefs and death rituals, scoring above 65 and 76 respectively, suggests that more spiritually associated domains are well understood. These results may reflect the broader societal recognition of the importance of religion in Filipino and Muslim cultures. It is worth noting that respect for religious diversity is a common feature of Filipino culture, which may have enabled nurses to approach Muslim patients with empathy and open-mindedness.

This finding is consistent with studies that emphasize the crucial role of religious and spiritual knowledge in transcultural nursing. Health beliefs and rituals often stem from religious foundations and can significantly shape patient behaviour, expectations, and acceptance of care. When nurses understand the religious and cultural background of their

patients, particularly those from Muslim cultures, care is more holistic and respectful (AlYateem & AlYateem, 2014). Furthermore, misunderstanding religious norms, such as gender-based interactions or prayer requirements, may lead to inadvertent disrespect, thereby affecting the therapeutic relationship and health outcomes.

Nurses' knowledge of healing beliefs and practices also showed a significant positive relationship with cultural competence, especially with the Cultural Competence Assessment (CCA) measure (Drame *et al*., 2021; Jongen *et al*., 2018; Walkowska *et al*., 2023; Alizadeh & Chavan, 2016). This domain includes beliefs around traditional or spiritual healing, the role of prayer, the use of Quranic verses, and the rejection of specific treatments considered haram (forbidden). Such practices may at first appear unfamiliar to nurses trained solely in biomedical paradigms. However, knowledge of these beliefs enhances the nurse's ability to create care plans that do not contradict the patient's worldview and may integrate spiritual care where appropriate.

This result affirms the claim by other researchers (Jackson, 2007) that understanding patients' health beliefs is fundamental to achieving cultural competence. Health beliefs determine how patients perceive illness, how they explain their symptoms, and how they evaluate healthcare professionals' interventions. A nurse unaware of a patient's belief system may unknowingly undermine trust or apply culturally inappropriate care.

Knowledge is the essential precursor to building a complete model of cultural competence (Campinha-Bacote, 1999). It serves as the basis for awareness, skill development, and cultural encounters, which together contribute to the delivery of patient-centered, respectful, and effective care. In this regard, the nurses in this study have demonstrated the ability to begin and progress through this competency model.

From a broader perspective, the Filipino cultural context may also contribute to these findings. Filipino nurses are known for their compassion, adaptability, and interpersonal warmth—qualities that align well with the expectations of culturally diverse and religious patients (Ordonez & Gandeza, 2004). Deeply ingrained values such as pakikisama (getting along with others), paggalang (respect), and hiya (modesty/shame) resonate with Islamic values like humility, modesty, and respect for authority and family. These cultural parallels may create a more fertile ground for culturally competent care, even without extensive formal training.

Nevertheless, the "Good" level of knowledge should not be a stopping point. Cultural competence is not a static achievement but a dynamic, ongoing process. As the population continues to diversify and religious beliefs become increasingly significant in clinical settings, nurses must continue to educate themselves about the evolving cultural landscapes they work within. The study's recommendation that nurses pursue deeper understanding, particularly in underdeveloped domains like family roles and communication, is thus justified.

Furthermore, organizations and hospitals must invest in structured diversity training programs that go beyond superficial awareness and into applied practice. Culturally competent care is no longer optional; it is a mandate aligned with ethical nursing practices and international quality standards in healthcare. Incorporating Islamic cultural education into both pre-service training and continuing professional development would not only improve patient outcomes but also reduce errors and enhance nurse-patient relationships.

This study also reinforces the concept that cultural knowledge is not simply about accumulating facts but also about nurturing an attitude of respect, openness, and adaptability. The knowledge that non-Muslim nurses bring to their encounters with Muslim patients should serve as a foundation for further development of cultural awareness, sensitivity, and ultimately, culturally congruent behaviours.

4.2. Cultural Competence of Non-Muslim Nurse in Caring for Muslim Patients

The results of the study show that non-Muslim nurses in Cotabato Province demonstrated a high level of cultural competence, as evidenced by scores in the subscales of Cultural Awareness and Sensitivity (CAS) and Cultural Competence Behaviours (CCB), which led to a high total score in the Cultural Competence Assessment (CCA). This indicates that these nurses possess a strong understanding of cultural differences and are capable of integrating this understanding into their practice when interacting with culturally diverse patients, especially Muslims.

The nurses' high level of cultural awareness and sensitivity reflects their understanding that differences exist among cultural groups and that these differences influence health beliefs and care expectations. Importantly, cultural sensitivity also means refraining from assigning value judgments to these differences, acknowledging instead that no culture is inherently superior to another. This aligns with the definition of cultural competence as a process of becoming, which requires nurses to continuously evaluate and expand their understanding of various cultural practices in order to provide respectful, individualized care.

The high mean scores in this subscale suggest that nurses are aware of how culture influences the care environment and are willing to adapt their attitudes and practices to ensure culturally congruent care. Such self-awareness and willingness to learn are foundational to transcultural nursing practice, which emphasizes respecting the cultural beliefs and lifeways of clients while tailoring care that fits those values in a meaningful way (Schim *et al*., 2007; Douglas *et al*., 2011).

One important finding was that nurses reported a high agreement with statements recognizing the role of spirituality and religious beliefs as core components of culture. This is particularly important in the context of Islamic patients, for whom religion often plays a central role in determining appropriate care and acceptable medical interventions. Religion influences dietary preferences, gender-specific care norms, modesty in clothing, and end-of-life rituals. Non-Muslim nurses who understand and respect these religious imperatives are better able to meet the needs of Muslim patients and provide care that is not only medically effective but also spiritually supportive (AlYateem & Al-Yateem, 2014; Charles & Daroszewski, 2012).

Furthermore, the Cultural Competence Behaviours (CCB) subscale demonstrated that these nurses frequently engage in culturally responsive actions. For instance, they reported regularly conducting cultural assessments during patient evaluations and welcoming feedback from clients about their cultural preferences. These findings are encouraging, as they reflect a movement beyond theoretical awareness toward active implementation of culturally competent behaviours. This behavioural dimension is critical in bridging the gap between cultural understanding and its practical application in clinical care (Capell *et al*., 2008; Campinha-Bacote, 2002).

However, one of the least performed behaviours involved the use of resource materials to learn about other cultures. This highlights an area of improvement, as the availability and utilization of cultural reference materials can significantly enhance nurses' ability to respond to diverse patient needs. This behaviour is especially important in multicultural regions where populations are diverse and culturally dynamic. Encouraging the institutional availability of books, pamphlets, posters, and digital resources on cultural care can help nurses maintain cultural competence over time (Papadopoulos & Lees, 2002; Delgado *et al*., 2013).

In the context of the Philippines, the high levels of cultural competence demonstrated by non-Muslim nurses may also reflect the intrinsic Filipino values such as empathy, respect, and humility, which align with the principles of cultural care. Filipino nurses are known for their compassionate and respectful approach to patient care, regardless of the patient's race, religion, or social status. Traits such as pakikisama (getting along with others), paggalang (respect), and bayanihan (communal unity) are deeply embedded in Filipino culture and foster a natural inclination toward accepting cultural differences (Ordonez & Gandeza, 2004; Davidhizar & Vance, 1999).

In addition, nursing education in the Philippines includes cultural care concepts in the curriculum, which may explain why cultural competence among nurses is relatively high. Courses in transcultural nursing and community health nursing emphasize the importance of respecting patients' cultural and religious beliefs and preparing future nurses to work effectively in multicultural settings. This integration of cultural content into nursing education ensures that nurses are not only clinically competent but also culturally responsive (Andrews, 2003).

The current findings further support the idea that exposure to diverse patients is a powerful driver of cultural competence. In regions such as Mindanao, where Muslims make up a significant portion of the population, non-Muslim nurses are regularly exposed to Islamic cultural practices and norms. This direct contact helps to dismantle stereotypes, reduce prejudice, and promote empathy. When nurses repeatedly interact with Muslim patients, they are more likely to gain firsthand insight into Islamic cultural values, which in turn improves their ability to provide respectful and individualized care (Giger & Davidhizar, 2002).

Yet, it is important to note that cultural competence does not solely rely on exposure or personal values—it also requires structured training and continuing education. In this study, cultural competence was significantly related to previous participation in diversity training. This finding suggests that training programs focused on cultural diversity can enhance nurses' competence by improving their knowledge, awareness, and behavioural responses. Structured training allows nurses to reflect on their own cultural biases, learn evidence-based practices for cultural care, and acquire the skills needed to interact effectively with patients from different backgrounds (Schim *et al*., 2005; Starr & Wallace, 2009; Beach *et al*., 2005).

This result aligns with international research showing that nurses who undergo cultural competence training are more confident and effective in delivering care to culturally diverse patients. Training programs can range from short courses and seminars to online modules and immersive cultural simulations. These interventions not only improve nurse–patient relationships but also lead to better patient outcomes, increased satisfaction, and reduced health disparities (Weech-Maldonado *et al*., 2012).

The study further revealed a significant relationship between nurses' knowledge of healing beliefs and practices in Islam and their overall cultural competence. This finding is crucial, as it indicates that understanding the healing-oriented worldview of Muslim patients contributes directly to nurses' ability to provide culturally congruent care. In Islam, healing is often holistic, integrating physical, emotional, and spiritual elements. When non-Muslim nurses are aware of this, they can align their care practices with patient expectations, thus fostering trust and enhancing therapeutic relationships (Leininger, 2002; Douglas *et al*., 2014).

Traditional Islamic healing practices, such as the use of herbal remedies, supplications (du'a), and reliance on divine intervention (tawakkul), are deeply embedded in Muslim communities. Failure to recognize these practices could lead to miscommunication, patient dissatisfaction, or even refusal of medical interventions. By contrast, culturally informed nurses can engage in dialogue with Muslim patients about their beliefs, negotiate mutually

acceptable care plans, and integrate traditional healing practices when safe and appropriate. This is the foundation of Leininger's Transcultural Nursing Theory, which emphasizes culturally congruent care as key to promoting health and preventing illness (du Preez, 2012).

The significance of religious beliefs and healing traditions was also echoed in global literature, which shows that religion often influences patients' decisions about consent, privacy, medication, diet, modesty, gender concordance, and end-of-life care. Therefore, nurses who lack this understanding may inadvertently provide care that violates religious values or undermines patient autonomy (Padela *et al*., 2011; Mohamed *et al*., 2014).

While knowledge alone does not guarantee competence, it is an essential precursor to other dimensions such as cultural skill, cultural encounters, and cultural desire as outlined in the Campinha-Bacote model. This model asserts that acquiring specific cultural knowledge about a group—such as Muslim patients—equips the nurse to engage in meaningful cross-cultural encounters, reflect on personal biases, and develop a deeper motivation to provide culturally appropriate care (Campinha-Bacote, 1999; Campinha-Bacote, 2002).

Interestingly, the study found no significant relationship between cultural competence and personal factors such as educational attainment, years of experience, and cultural diversity encounters, except for previous diversity training. This aligns with other studies that have questioned the assumption that longer clinical experience or higher academic degrees automatically equate to greater cultural competence. In reality, without deliberate and focused training, nurses may continue to deliver care based on stereotypes or personal biases, despite years of clinical exposure (Glass, 2013).

The significant impact of diversity training on cultural competence highlights the importance of institutional support in fostering an inclusive and culturally competent health workforce. Hospitals and nursing schools must embed cultural competence education into both initial training and continuing professional development, using evidence-based strategies and practical simulations. These efforts should not only include didactic content but also opportunities for experiential learning, self-reflection, and cross-cultural interaction (Starr & Wallace, 2009; Schim & Doorenbos, 2010).

Ultimately, this study affirms that cultural competence is not an innate trait but a dynamic, learnable process that requires commitment, education, and openness. While the nurses in this study displayed high levels of awareness and competence, ongoing training and institutional support remain critical to maintaining and improving culturally congruent care. In multicultural healthcare settings like Cotabato, where nurses and patients often differ in religious and cultural backgrounds, this commitment becomes even more vital to ensure equity, respect, and positive health outcomes.

4.3. Relationship between Knowledge of Islamic Beliefs and Practices and Cultural Competence of Non-Muslim Nurses

This study identified a statistically significant relationship between the overall knowledge of Islamic beliefs and practices and the Cultural Awareness and Sensitivity (CAS) subscale of cultural competence. This implies that the more knowledgeable non-Muslim nurses are about Muslim patients' cultural and religious practices, the more culturally aware and sensitive they become. This aligns with the foundational premise in transcultural nursing literature that knowledge is a prerequisite for cultural understanding and respect (Giger *et al*., 2002; Campinha-Bacote, 1999; Andrews, 2003).

Specifically, knowledge of healing beliefs and practices among Muslims was found to be significantly and positively correlated with both CAS and overall Cultural Competence

Assessment (CCA) scores. This indicates that the domain of healing—which is often spiritual and holistic in Islam—plays a central role in how nurses approach and deliver culturally congruent care. It suggests that as non-Muslim nurses understand and appreciate these healing perspectives, they are more likely to exhibit culturally appropriate behaviors and attitudes (Leininger, 2002; Padela *et al*., 2011).

The significance of this relationship reflects the broader notion that religion is not a peripheral factor in healthcare but is often central to how patients understand illness, healing, suffering, and death. When nurses are equipped with this knowledge, they are more capable of negotiating care plans, avoiding cultural offenses, and fostering therapeutic partnerships with Muslim patients and their families. Failure to understand these elements can result in misunderstanding, mistrust, or care refusal, which ultimately compromises health outcomes (Douglas *et al*., 2011; Foronda, 2008; Jaber *et al*., 2011).

Furthermore, this finding reinforces Campinha-Bacote's model which emphasizes that cultural knowledge enhances the ability to perform culturally responsive assessments, interact appropriately in cross-cultural encounters, and develop meaningful care strategies. It is not enough to generalize care; a nurse's familiarity with specific health-related cultural beliefs—such as traditional Islamic healing—enables individualized, safe, and respectful nursing practice (Campinha-Bacote, 2002; Snyder & Niska, 2003).

In summary, this study emphasizes that cultural competence is deeply rooted in knowledge, particularly in domains that intersect with patients' deeply held values and spiritual practices. Increasing nurses' understanding of Islamic perspectives on healing, illness, and care not only improves individual competence but also contributes to a more inclusive and equitable healthcare system overall.

4.4. Significant Difference in the Cultural Competence of Non-Muslim Nurses when Analyzed According to Personal Factors

This study investigated whether cultural competence among non-Muslim nurses varied significantly based on selected personal factors such as highest educational attainment, years of nursing experience, cultural diversity encounters within the last year, and previous diversity training. The findings revealed no significant differences in cultural competence scores when grouped by educational attainment, nursing experience, and frequency of cultural diversity encounters. However, previous diversity training showed a significant influence, particularly on the Cultural Competence Behaviours (CCB) subscale and the overall Cultural Competence Assessment (CCA) score.

The absence of a significant relationship between educational attainment and cultural competence in this study contrasts with earlier findings which suggested that educational level contributes to higher cultural awareness and sensitivity among nurses. Prior studies indicated that nurses holding higher educational qualifications often scored higher in cultural competency measures due to more comprehensive exposure to transcultural nursing concepts (Cooper *et al*., 2007; Doorenbos *et al*., 2005; Schim *et al*., 2006a). Yet, in this research, such differences were not statistically significant, possibly due to the homogeneity of educational backgrounds in the sample or the exclusion of doctorate-level nurses from the data pool.

Similarly, years of nursing experience did not appear to significantly influence cultural competence. This is in contrast to previous research showing that prolonged clinical experience enhances cultural knowledge and fosters more competent behaviour in diverse care settings (Bauce *et al*., 2023). It has been proposed that over time, nurses develop greater

cultural sensitivity through repeated exposure to patients from different backgrounds, but this relationship was not confirmed in the present study.

Contrastingly, previous diversity training emerged as a significant determinant of cultural competence, specifically in the areas of cultural behaviors and overall competence scores. Nurses who had attended diversity or cross-cultural training sessions exhibited higher CCB scores and overall CCA scores. This finding aligns with several previous studies that assert training interventions positively impact nurses' knowledge, attitudes, and practices toward culturally competent care (Starr & Wallace, 2009; Schim *et al*., 2006b; Delgado *et al*., 2013). It supports the notion that exposure to formal cultural education builds critical awareness and skill sets, encouraging nurses to adopt inclusive and respectful care behaviors across diverse cultural interactions.

Moreover, it reinforces that structured diversity training programs provide nurses with practical tools, including strategies for cultural assessments, patient-centered care planning, and effective cross-cultural communication. These improvements were observed in international studies, such as in Italy, Canada, and the United States, where nurses who underwent cultural training performed better in multicultural patient settings (Cicolini *et al*., 2015; Beach *et al*., 2005; Paez *et al*., 2009).

The findings underscore the importance of institutionalizing cultural competence training in continuing education and professional development frameworks. In particular, healthcare institutions and nursing education providers in the Philippines and similar multicultural settings may consider embedding religious and cultural awareness modules into the core nursing curriculum. As demonstrated in this study, knowledge acquisition through diversity training directly enhances nurses' ability to perform culturally appropriate behaviors, particularly when engaging with Muslim patients whose practices are guided by religious doctrine.

Notably, the lack of significant differences across other personal factors like educational attainment and years of experience may suggest that cultural competence is not automatically acquired over time or through general academic progress. Instead, it likely results from intentional and targeted educational interventions that address specific cultural domains such as those involved in Muslim beliefs and practices.

These findings corroborate with existing literature emphasizing the need for context-specific training. For instance, a phenomenological study on non-Muslim nurses in Saudi Arabia concluded that religious and cultural misunderstandings were frequent and could have been prevented through Islamic-specific training initiatives (Alosaimi *et al*., 2013). The study concluded that culturally tailored training is more effective than generalized multicultural education in equipping nurses for culturally competent practice.

In summary, this study affirms that among all personal factors examined, previous diversity training is the most influential variable affecting the cultural competence of non-Muslim nurses caring for Muslim patients. Other factors such as education level and experience did not yield significant differences. This highlights the critical role of professional training programs in building nurses' cultural responsiveness and ensuring equitable, respectful, and competent healthcare delivery.

5. CONCLUSION

The following conclusions are drawn from this study:

(i) Indeed, the nurses in this study have engaged in cross-cultural interactions with patients from culturally diverse backgrounds which implies that care was rendered to patients regardless of their race or religion.
(ii) The nurses in this study possessed "Good" level of knowledge on Islamic beliefs and practices which is quite impressive, hence, they can make use of this information to provide culturally appropriate nursing care to patients since having to know and understand one's culture is one of the first steps in attaining cultural competence.
(iii) The nurses' knowledge on Islamic beliefs and practices in general helps the nurses to become more aware and sensitive to the similarities and differences across cultures. Hence, it recognizes religion as an important factor that impacts nurses' role in building cultural competence.
(iv) The nurses' knowledge on healing beliefs and practices of Muslim patients, the more that these nurses become culturally competent and will likely report or display competent behaviors in their actual care of patients.
(v) The nurses in this study have" High" cultural competence, hence, these nurses are aware of their own cultural beliefs and values, so the more that they understand other's culture as well thereby promoting respect for individual's differences. This implies further that the nurses possess the ability to provide culturally appropriate nursing care to patients with a diverse cultural background.

6. AUTHORS' NOTE

The authors declare that there is no conflict of interest regarding the publication of this article. Authors confirmed that the paper was free of plagiarism.

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