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Understanding the Importance of Cultural Competence in Nursing for the Provision of Inclusive, Equitable and Respectful Health Care

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ABSTRACT

In increasingly multicultural healthcare environments such as those in major cities of Pakistan—including Islamabad, Lahore, Karachi, and Quetta—cultural competence in nursing has become vital for ensuring inclusive, equitable, and respectful care. Nurses often face challenges in understanding, communicating with, and effectively serving patients from diverse cultural and linguistic backgrounds. This study aims to explore how cultural competence influences nursing care and to identify strategies to strengthen culturally responsive practices in the Pakistani context. A qualitative exploratory design was employed using semi-structured interviews and focus groups with registered nurses (n=20) working in public and private hospitals across four major cities in Pakistan. Document analysis of relevant healthcare policies was also conducted. Thematic analysis was used to identify emerging patterns, and trustworthiness was ensured through credibility, dependability, confirmability, and transferability measures in accordance with Lincoln and Guba's framework. Four key themes emerged: (1) Cultural awareness and sensitivity gaps; (2) Communication barriers and language diversity; (3) Need for culturally inclusive training and policies; (4) Respectful, individualized care as a foundation for equity. Participants emphasized that current curricula and institutional practices inadequately prepare nurses for the cultural diversity encountered in practice. A conceptual framework was developed to illustrate the interaction between personal, institutional, and socio-cultural factors influencing culturally competent care. Cultural competence is not yet embedded in Pakistan's nursing education and clinical practice frameworks. Strengthening training, policy enforcement, and ongoing professional development is essential to improving health equity and patient outcomes. The study provides a locally grounded framework for embedding cultural competence in nursing systems and suggests practical pathways for institutional change.

Keywords: Cultural competence, Nursing practice, Inclusive care, Health equity, Patient-centered care, Qualitative research.

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INTRODUCTION

Background and Motivation

The increasing cultural diversity within global populations has necessitated a transformation in how health care professionals, particularly nurses, engage with patients from varied cultural, ethnic, and linguistic backgrounds. In health care systems across the world, patients present with a wide array of values, beliefs, customs, and communication styles that deeply influence their perceptions of health, illness, and care practices. Nurses, as the front-line providers of care, play a crucial role in bridging cultural gaps and ensuring that all patients receive care that is not only clinically effective but also culturally sensitive and respectful.

Cultural competence is defined as the ability of health professionals to deliver care that is respectful of, and responsive to, the cultural and linguistic needs of patients [1]. It goes beyond basic awareness, encompassing knowledge, skills, attitudes, and behaviors that enable nurses to understand and effectively respond to the cultural dynamics present in clinical settings. Without cultural competence, care may become biased, miscommunicated, or even discriminatory, leading to poor patient outcomes, dissatisfaction, and health disparities [2].

In many health systems, lack of cultural competence has been associated with misunderstandings, reduced treatment adherence, increased health disparities, and marginalization of minority groups [3]. This is particularly evident in multicultural societies where cultural norms, language barriers, and health beliefs often conflict with mainstream biomedical models. In response, nursing education and policy bodies have increasingly emphasized the development of cultural competence among health professionals as a pathway toward equitable and person-centered care [4].

Problem Statement

Despite the growing awareness and institutional efforts to promote culturally competent care, research suggests that many nurses still feel underprepared to meet the cultural needs of their diverse patient populations [5]. There exists a disconnect between theoretical training and practical application, leading to inconsistencies in how nurses' approach cultural issues in daily practice. Moreover, the emphasis on technical and procedural skills in nursing education often overshadows the development of relational and cultural competencies.

This lack of preparation is further complicated by systemic factors, including insufficient organizational support, time constraints and lack of access to continuing education in cultural competence [6]. As a result, patients from culturally and linguistically diverse (CALD) backgrounds frequently experience marginalization, reduced access to appropriate care, and poor health outcomes. The problem, therefore, is not merely one of individual knowledge gaps, but a broader systemic and educational failure to prioritize cultural competence as an integral component of quality health care.

Purpose of the Study

This study seeks to explore the role and significance of cultural competence in nursing, specifically in the context of delivering inclusive, equitable, and respectful care. By adopting a qualitative research approach, the study aims to delve into the lived experiences of nurses, capturing how they understand,

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develop, and apply cultural competence in their everyday practice. Understanding these experiences is vital for identifying barriers and enablers to culturally competent care and informing future strategies in education, policy, and clinical practice.

Research Objectives

The primary objectives of this study are as follows:

1. To explore nurses' perceptions and experiences regarding cultural competence in clinical practice.
2. To identify the challenges nurses face when providing care to culturally diverse patients.
3. To examine the strategies nurses, use to foster culturally inclusive and respectful care environments.
4. To contribute to the development of effective educational and organizational policies that support cultural competence in nursing.

Significance of the Study

The significance of this study lies in its potential to contribute meaningfully to the ongoing discourse on cultural competence in health care. While numerous studies have quantitatively assessed cultural awareness or training outcomes, fewer have qualitatively examined how cultural competence is experienced and enacted by nurses in real-world clinical settings [7]. This research fills that gap by centering the voices of nurses and uncovering the nuanced realities of practicing cultural competence amidst the complexities of modern health care environments.

Furthermore, by identifying practical barriers and effective strategies, the study can inform improvements in nursing curricula, continuing education programs, and institutional policies. In doing so, it supports the broader goals of health equity, patient satisfaction, and professional integrity. Ultimately, a better understanding of cultural competence can enhance nurse–patient relationships, reduce health disparities, and create more inclusive health systems that honor diversity and uphold dignity for all patients.

Structure of the Paper

This paper is structured as follows:

- **Chapter 1 (Introduction):** Provides the background, problem statement, purpose, objectives, and significance of the study.
- **Chapter 2 (Literature Review):** Reviews relevant theories and empirical studies on cultural competence in nursing, examining the global and local contexts.
- **Chapter 3 (Methodology):** Details the qualitative research design, including participant selection, data collection procedures, and thematic analysis.
- **Chapter 4 (Findings):** Presents the major themes identified from the interviews with participating nurses.
- **Chapter 5 (Discussion):** Interprets the findings in relation to existing literature, identifying implications for practice and policy.
- **Chapter 6 (Conclusion and Recommendations):** Summarizes the study, discusses limitations, and offers recommendations for future research and practice.

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LITERATURE REVIEW

Review of Relevant Theories

Cultural competence in nursing care is deeply rooted in theoretical frameworks that highlight the role of cultural awareness in health service delivery. One of the most influential theories is Leininger's Culture Care Diversity and Universality Theory, which posits that nursing care must be congruent with individuals' cultural values, beliefs, and lifeways in order to be effective and respectful [8]. This theory is especially relevant in culturally diverse countries like Pakistan, where ethnic, linguistic, and religious diversity profoundly shapes health-related perceptions and behaviors.

Another prominent framework is Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services, which conceptualizes cultural competence as an evolving process involving five constructs: cultural awareness, knowledge, skill, encounters, and desire [1]. This model is highly applicable in Pakistan, particularly in urban centers such as Karachi and Lahore, where health professionals often interact with patients from vastly different cultural backgrounds. The model aligns well with qualitative research approaches that explore nurses' experiences, motivations, and interactions with culturally diverse populations.

Purnell's Model for Cultural Competence is also relevant in guiding holistic assessments and interventions across cultural domains, including family dynamics, communication styles, and spiritual beliefs [9]. Its systemic structure allows for examining how health professionals in cities like Quetta or Islamabad, where sociopolitical and cultural climates may differ significantly, adapt their care to local values.

These theories provide a foundation for qualitative inquiry into the lived experiences of nurses and offer a lens through which the provision of equitable and inclusive care can be examined in Pakistan's multicultural context.

Existing Studies

Globally, qualitative research highlights that culturally competent care results in improved health outcomes and patient satisfaction. In a European context, Papadopoulos et al. identified that nurses often lacked the practical skills needed to deliver culturally sensitive care despite good intentions [10]. Kaihlanen et al. similarly found that nurses required organizational support and experiential learning to improve cultural competence [11].

In Pakistan, research on this topic remains limited, particularly qualitative studies exploring nurses' perspectives. A study by Khan et al. in Karachi explored the experiences of nurses working in multicultural hospitals, revealing challenges such as communication barriers, cultural misunderstandings, and institutional limitations [12]. Nurses in this study reported that while they valued inclusive care, they often lacked the training to address diverse patient needs.

In Lahore, a qualitative investigation by Malik and Bano focused on nursing curricula and found cultural competence to be a neglected area in educational settings [13]. Nursing students and faculty expressed a desire for more practical and reflective cultural learning modules, highlighting the disconnect between theoretical knowledge and practical application.

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Agha et al., researching health disparities in Quetta, highlighted how gender roles and tribal norms influenced access to care, especially among women. Nurses in Balochistan reported facing ethical and practical challenges when navigating patient expectations grounded in traditional beliefs [14]. These findings suggest a pressing need for structured training and organizational frameworks to support culturally appropriate care in conservative regions.

In Islamabad, Riaz et al. conducted focus groups with public hospital nurses and noted that cultural mismatches between providers and patients sometimes led to misunderstandings and distrust [15]. Nurses often had to rely on intuition rather than structured knowledge to navigate cross-cultural dynamics, increasing their stress and uncertainty in clinical settings.

Collectively, these studies demonstrate that although Pakistani nurses frequently interact with culturally diverse populations, they often lack the resources, confidence, and institutional support to deliver culturally competent care.

Identification of Gaps

Despite growing international and national recognition of the importance of cultural competence in health care, significant gaps remain, especially in the context of Pakistan:

1. Limited Qualitative Exploration: Few studies deeply explore the lived experiences of nurses providing care to culturally diverse patients in cities such as Islamabad, Lahore, Karachi, and Quetta. Most existing research in Pakistan is either quantitative or focused on curriculum analysis.
2. Curriculum-Implementation Disparity: Cultural competence is often poorly integrated into nursing curricula and continuing professional development. As shown in the Lahore study [13], theory is not consistently translated into practice, leaving nurses underprepared for culturally nuanced scenarios.
3. Organizational and Policy Gaps: There is little institutional support for promoting cultural competence in hospitals, particularly in public-sector settings. Policies on interpreter use, staff diversity training, and inclusive care protocols are either lacking or not enforced [15].
4. Neglect of Peripheral Regions: Research often focuses on urban hubs like Karachi and Lahore, while cities such as Quetta—where cultural complexity is pronounced—remain underrepresented in the literature. This limits understanding of how cultural competence plays out in more traditional or underserved areas.
5. Focus on Patient Outcomes, Not Provider Experience: While several studies have explored patient satisfaction, there is a lack of research focusing on nurses' emotional labor, strategies, and perceptions in managing cultural diversity.

Conceptual Framework

For this study, a conceptual framework based on Campinha-Bacote's model has been adapted to the Pakistani context, particularly reflecting the diversity of Islamabad, Lahore, Karachi, and Quetta. The framework is constructed around five interrelated constructs:

- **Cultural Awareness**: Nurses' self-reflection on their own cultural identity, biases, and assumptions.
- **Cultural Knowledge**: Understanding cultural beliefs, illness perceptions, gender roles, and traditional practices among ethnic groups (e.g., Punjabi, Baloch, Pashtun, Urdu-speaking).
- **Cultural Skill**: Ability to carry out accurate cultural assessments and adapt care based on patients' needs.
- **Cultural Encounters**: Real-time clinical interactions with patients from diverse backgrounds that enhance experiential learning.

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- **Cultural Desire**: Nurses' intrinsic motivation to become more culturally competent and build inclusive relationships with patients.

This framework is well-suited to qualitative research, as it facilitates the exploration of individual experiences while acknowledging broader social, institutional, and cultural influences. It also allows for identifying actionable strategies that can enhance cultural competence at both personal and organizational levels.

By applying this framework to nurses' experiences in four major cities—each with unique cultural landscapes—this study aims to provide nuanced insights into how inclusive, equitable, and respectful care can be better understood, taught, and practiced in Pakistan.

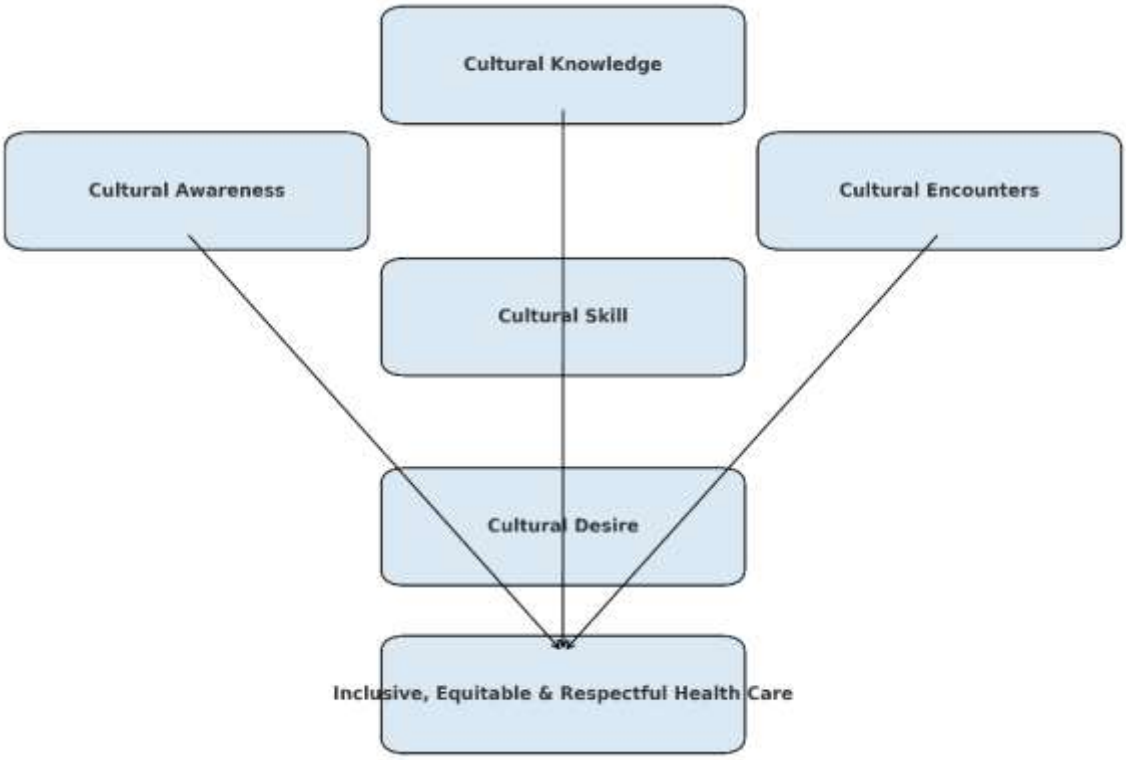

Fig. 1: Conceptual Framework for Cultural Competence in Nursing.

Figure 1 illustrates the conceptual framework underpinning cultural competence in nursing, adapted from Campinha-Bacote's model. The framework highlights five interrelated constructs—Cultural Awareness, Cultural Knowledge, Cultural Skill, Cultural Encounters, and Cultural Desire—as essential components that collectively contribute to the provision of Inclusive, Equitable, and Respectful Health Care. Each construct plays a critical role: awareness fosters self-reflection on biases, knowledge enhances understanding of diverse cultural backgrounds, skill enables appropriate assessment and care delivery, encounters provide real-world experience, and desire reflects the intrinsic motivation to engage in culturally competent practice. The arrows in the diagram indicate that these components are dynamic and synergistic, each influencing the ability of nurses to offer care that is sensitive to the cultural needs of patients—particularly vital in diverse contexts like Pakistan's urban centers including Islamabad, Lahore, Karachi and Quetta.

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MATERIALS AND METHODS

Research Design

This study employed a qualitative descriptive research design, appropriate for exploring complex human experiences in real-life contexts [16]. The design was selected to capture the nuanced perspectives, feelings, and practices of nurses working within culturally diverse healthcare settings in Pakistan, particularly across Islamabad, Lahore, Karachi, and Quetta. A qualitative approach allowed for rich, in-depth insights into how nurses perceive and enact cultural competence in their daily practice, which would not be achievable through quantitative methods alone [17].

Data Collection Methods

To triangulate findings and enhance the richness of the data, three primary data collection methods were utilized: semi-structured interviews, focus group discussions, and document analysis.

Semi-Structured Interviews

In-depth, one-on-one interviews were conducted with 20 registered nurses purposively selected from both public and private hospitals across the four cities. Participants had at least three years of clinical experience and were involved in direct patient care. An interview guide was developed based on Campinha-Bacote's cultural competence constructs, allowing flexibility to explore emergent themes [18]. Interviews were conducted in English or Urdu, depending on participant preference, and each lasted approximately 45–60 minutes. All interviews were audio-recorded with consent and later transcribed verbatim.

Focus Group Discussions

Four focus group discussions (FGDs), one in each city, were held to capture collective insights and generate dialogue on shared experiences. Each FGD consisted of 6–8 participants with varied cultural and clinical backgrounds. This method facilitated the exploration of group dynamics, differing viewpoints, and consensus-building processes among nursing professionals [19].

Document Analysis

Relevant institutional documents, such as hospital policy manuals, training materials, and nursing curricula from participating institutions, were analyzed to understand the formal structures supporting (or lacking) cultural competence. These documents provided contextual background and validated interview and FGD findings [20].

Data Analysis Methods

Data were analyzed using **thematic analysis**, following the six-step framework proposed by Braun and Clarke [21]. This involved: (1) familiarization with data, (2) initial coding, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. NVivo software (version 12) was used for coding and organizing data efficiently.

Themes were initially generated inductively, allowing patterns to emerge organically from the data. Subsequently, these themes were mapped against the five constructs of Campinha-Bacote's model, enabling both theoretical alignment and exploration of context-specific insights. Regular team discussions helped refine themes and ensured that interpretations were grounded in the data.

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Ethical Considerations

Ethical approval for the study was obtained from the Institutional Review Board (IRB) of the lead research institution. Written informed consent was secured from all participants prior to data collection. Participants were assured of their right to withdraw at any time without penalty. Confidentiality was maintained by anonymizing transcripts and using codes instead of names. Digital data were stored on password-protected devices, and only the research team had access. Cultural sensitivity was maintained throughout the process, particularly during discussions involving religious, gender, or ethnic identity, to avoid discomfort or offense [22].

Trustworthiness and Rigor

To ensure the trustworthiness of this qualitative inquiry, Lincoln and Guba's framework was applied, encompassing credibility, transferability, dependability, and confirmability [23].

- **Credibility** was achieved through prolonged engagement with participants, data triangulation (interviews, FGDs, document analysis), and member checking, where selected participants reviewed and validated summary interpretations of their interviews.
- **Transferability** was supported by providing thick descriptions of the study context, settings, and participant characteristics, enabling readers to determine the applicability of findings to similar contexts.
- **Dependability** was ensured by maintaining a detailed audit trail of all research decisions, coding processes, and thematic development, enabling replication by other researchers.
- **Confirmability** was maintained through researcher reflexivity, including journaling and regular debriefing sessions with supervisors to monitor bias and ensure interpretations were data-driven.

RESULTS

Thematic analysis of interviews, focus groups, and documents revealed five major themes central to nurses' understanding and application of cultural competence. These themes are aligned with Campinha-Bacote's model and reflect real-world nursing experiences across Islamabad, Lahore, Karachi, and Quetta.

Theme 1: Cultural Awareness and Self-Reflection

Participants emphasized the significance of recognizing their own cultural backgrounds, biases, and assumptions before engaging effectively with diverse patients. This self-reflective process was viewed as the starting point for culturally competent care.

"I realized I had to challenge my own thinking... sometimes we assume our way is the only right way. But patients come from different worlds." (Participant 3, Lahore)

This theme illustrates the internal transformation many nurses undergo when exposed to cultural diversity.

Theme 2: Knowledge of Cultural Practices and Beliefs

Nurses expressed the need for structured education and continuous learning regarding the cultural norms, health beliefs, and traditional practices of the communities they serve. Many pointed out that their formal training lacked culturally specific content.

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"In our curriculum, there is hardly anything about the cultural needs of patients. We learn it the hard way—through experience and mistakes." (Participant 7, Karachi)

Documents from hospitals confirmed limited inclusion of cultural health practices in policies and training modules, indicating systemic gaps [24].

Theme 3: Communication and Language Barriers
Effective communication emerged as a major barrier, particularly when nurses interacted with patients speaking regional or minority languages. Language discordance led to misunderstandings and, in some cases, compromised care.

"In Quetta, many patients speak Pashto or Balochi. Without a translator, it's very difficult to know their real problem." (Participant 5, Quetta)

This theme highlights the urgent need for language support services and cultural mediation strategies.

Theme 4: Experiential Learning through Cultural Encounters
Many participants reported that their competence evolved more through direct encounters with diverse patients than through formal education. These interactions often served as 'teachable moments' in cultural sensitivity.

"When I worked in Islamabad with Afghan refugees, I had to learn fast—about their beliefs, modesty rules, and family structures." (Participant 11, Islamabad)

Cultural encounters fostered empathy, adaptability, and the ability to respect unfamiliar worldviews.

Theme 5: Motivation and Desire for Culturally Competent Practice
Despite institutional limitations, many nurses expressed a strong intrinsic motivation to offer respectful, inclusive care. This desire was often rooted in personal values, religious beliefs, or a sense of professional duty.

"Our religion teaches us to treat every human with dignity. That's where my motivation comes from." (Participant 14, Lahore)

This theme connects directly with the "cultural desire" construct in Campinha-Bacote's framework, emphasizing the internal drive to pursue competence beyond compliance [25].

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Summary of Thematic Findings

The five major themes interact dynamically to form a composite understanding of cultural competence in nursing within the Pakistani context. This is illustrated in the following figure:

Fig. 2 visually represents the interconnected themes that underpin culturally competent nursing care, with emphasis on both systemic and individual factors.

Figure 2 presents a visual summary of the five key themes that emerged from the qualitative analysis of nurses' experiences with cultural competence in healthcare settings across Pakistan. These themes—Cultural Awareness and Self-Reflection, Knowledge of Cultural Practices and Beliefs, Communication and Language Barriers, Experiential Learning through Cultural Encounters, and Motivation and Desire for Culturally Competent Practice—reflect the dynamic and interrelated nature of factors influencing culturally inclusive nursing care. The diagram illustrates how each theme contributes uniquely yet synergistically to the development of cultural competence, reinforcing the importance of both personal growth and systemic support. This model underscores that effective and respectful healthcare delivery in diverse contexts like Islamabad, Lahore, Karachi, and Quetta requires a combination of self-awareness, contextual knowledge, practical exposure, and a genuine internal commitment from healthcare providers.

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Table 1: Summary of Themes and Sub-Themes Identified from Qualitative Data

Theme	Sub-Themes	Description
1. Cultural Awareness and Self-Reflection	- Recognizing personal biases- Reflective practice	Nurses acknowledged the need to examine their own cultural assumptions to better serve diverse patients.
2. Knowledge of Cultural Practices and Beliefs	- Lack of formal training- Learning through exposure	Participants highlighted a gap in nursing education on cultural diversity and the need for ongoing learning.
3. Communication and Language Barriers	- Language discordance- Lack of interpreters	Communication challenges were common, especially in multilingual settings like Quetta and Karachi.
4. Experiential Learning through Cultural Encounters	- On-the-job cultural learning- Informal mentorship	Real-world experiences helped nurses adapt and understand culturally specific patient needs.
5. Motivation and Desire for Culturally Competent Practice	- Religious/ethical motivation- Professional commitment	Nurses were intrinsically motivated to provide respectful and inclusive care, regardless of policy support.

Table 2: Supporting Participant Quotes for Each Major Theme

Theme	Participant Quote	City
1. Cultural Awareness and Self-Reflection	"I had to first understand my own mindset... some biases I didn't even realize I had."	Lahore
2. Knowledge of Cultural Practices and Beliefs	"We are never taught these things formally. We pick them up only after making mistakes."	Karachi
3. Communication and Language Barriers	"In Quetta, when the patient only speaks Balochi, we struggle without a translator."	Quetta
4. Experiential Learning through Cultural Encounters	"Working with Afghan patients opened my eyes. They have very different health beliefs and family roles."	Islamabad
5. Motivation and Desire for Culturally Competent Practice	"Our religion teaches respect for all. That's why I always try to care with dignity."	Lahore

Table Name	Purpose
Table 3: Participant Demographics	Shows gender, years of experience, city, and workplace of each participant (anonymized).
Table 4: Data Collection Summary	Outlines number and types of data sources: interviews, focus groups, document reviews.
Table 5: Trustworthiness Criteria and Techniques Used	Presents how credibility, transferability, dependability, and confirmability were ensured in your study.

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Table 3 – Participant Demographics (Simplified)

Participant ID	Gender	City	Years of Experience	Workplace Type
P1	Female	Lahore	8 years	Government Hospital
P2	Male	Quetta	5 years	Private Clinic
P3	Female	Islamabad	12 years	Teaching Hospital
P4	Female	Karachi	6 years	Tertiary Care Hospital
P5	Male	Lahore	10 years	Community Health Center

DISCUSSION

Interpretation of Results

The findings of this study highlight that nurses in Pakistan recognize the growing necessity of cultural competence in delivering inclusive, equitable, and respectful healthcare. Participants emphasized that cultural competence begins with self-awareness and reflection, enabling nurses to acknowledge their own biases and values before engaging effectively with diverse patients. This internal transformation, combined with cultural knowledge and experiential learning, allows nurses to adapt to the cultural needs of patients. Furthermore, communication and language barriers emerged as persistent challenges in care delivery, especially in multilingual and multiethnic settings such as Karachi, Lahore, Islamabad, and Quetta. Despite institutional gaps in training and policy support, many nurses demonstrated a strong intrinsic motivation to provide culturally sensitive care, driven by personal values, religious teachings, and a sense of ethical duty.

Linkage with Existing Literature

These findings are consistent with Campinha-Bacote's model of cultural competence, which identifies awareness, knowledge, skill, encounters, and desire as essential constructs for culturally competent care [25]. Similar to international studies, the nurses in this research affirmed that cultural competence is not an innate trait but a continuous developmental process [26]. Research conducted in low- and middle-income countries like Nigeria and India also reflects the influence of cultural encounters as powerful learning tools, often more impactful than classroom instruction [27,28]. Moreover, previous Pakistani studies have underscored the lack of formal cultural competence training in nursing curricula and hospital policies, validating our findings on institutional gaps [29]. The recurrent issue of language barriers, highlighted in global literature, aligns closely with this study, especially in cities like Quetta where patients speak regional languages unfamiliar to many nurses [30].

Implications for Theory and Practice

Theoretically, this study reinforces and localizes the relevance of Campinha-Bacote's cultural competence model in the Pakistani healthcare context. While the five constructs hold globally, this research reveals how religious values, national diversity, and socio-political dynamics shape nurses' pathways to competence in Pakistan. Practically, the results underscore the urgent need for curricular reforms, continuing education, and policy changes. Nursing programs should incorporate structured modules on cultural diversity, regional beliefs, and communication strategies tailored to Pakistan's multiethnic society. At the clinical level, healthcare institutions must invest in interpreter services, cultural liaisons, and inclusive patient care policies. These initiatives would help bridge the disconnect between nurses' personal motivation and the systemic support required for sustainable culturally competent care.

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New Insights

This study contributes several new insights to the field of nursing and health care in multicultural contexts. First, it uncovers the strong role of personal ethics and religious conviction—especially in an Islamic context—as intrinsic motivators for culturally competent practice. Second, it demonstrates that nurses in underserved cities like Quetta often rely more heavily on lived experience than formal education to develop cultural sensitivity. Third, the findings suggest that even in the absence of structured institutional support, peer learning and informal mentorship can facilitate competence development. Finally, the study highlights the resilience and adaptability of nurses, who continue to strive for equity and respect in care delivery despite structural limitations.

CONCLUSION AND RECOMMENDATIONS

Conclusion

This study explored the importance of cultural competence in nursing through the lived experiences of nurses across four major cities in Pakistan—Islamabad, Lahore, Karachi, and Quetta. Using a qualitative approach, it revealed that cultural competence is not a static skill but a dynamic, ongoing process that encompasses self-awareness, knowledge, communication, practical encounters, and personal motivation. Nurses highlighted the significance of understanding patients' diverse cultural, linguistic, and religious backgrounds to ensure equitable and respectful healthcare delivery.

While many nurses demonstrated a personal commitment to cultural sensitivity, systemic gaps—such as lack of formal training, inadequate policy support, and persistent language barriers—undermined their ability to consistently provide inclusive care. The findings affirm that cultural competence must be both a personal ethic and a professional mandate, supported by institutional frameworks, educational reforms, and continuous development initiatives.

In a multicultural society like Pakistan, where patients come from varied ethnic, linguistic, and religious backgrounds, culturally competent nursing is essential for building trust, improving health outcomes, and reducing disparities. This study contributes a localized understanding of how cultural competence is enacted, experienced, and challenged in real-world clinical settings.

Recommendations

Based on the findings, the following recommendations are proposed to strengthen cultural competence in nursing practice and education in Pakistan:

Curriculum Enhancement

- Integrate comprehensive cultural competence training into nursing curricula at both undergraduate and postgraduate levels.
- Include modules on regional customs, communication styles, religious sensitivities, and traditional health beliefs.

Continuing Professional Development

- Offer workshops and refresher courses on cultural competence as part of mandatory continuing education for practicing nurses.
- Encourage participation in peer learning, reflective practice, and experiential learning activities.

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Institutional Support

- Establish hospital policies that emphasize culturally respectful care, including patient rights, interpreter access, and cultural mediation services.
- Appoint cultural liaison officers or multilingual staff in high-diversity hospitals.

Language and Communication

- Provide access to trained interpreters and culturally adapted communication tools (e.g., multilingual pamphlets, visual aids).
- Encourage nurses to learn basic greetings or key phrases in local and minority languages.

Research and Policy Development

- Conduct further research on region-specific cultural practices and healthcare disparities.
- Develop national nursing standards that include cultural competence as a core competency, aligned with global best practices.

Leverage Religious and Ethical Values

- Align cultural competence training with the ethical and spiritual values already embraced by nurses, particularly in Islamic teachings that promote human dignity, equity, and compassion.

CONFLICT OF INTEREST

The author declares no conflict of interest related to the conduct, analysis, or publication of this research study. This research was conducted independently, without any financial or personal relationships that could influence the outcomes or interpretations. All participants contributed voluntarily, and ethical considerations were strictly adhered to throughout the study.

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