EAS Journal of Nursing and Midwifery
Abbreviated Key Title: EAS J Nurs Midwifery
ISSN: 2663-0966 (Print) & ISSN: 2663-6735 (Online)
Published By East African Scholars Publisher, Kenya

OPEN ACCESS

Volume-2 | Issue-6 | Nov-Dec -2020 | DOI: 10.36349/easjnm.2020.v02i06.008

Research Article

Study on Cultural Competence in Nursing: Strategies for Delivering Inclusive Patient Care in Osmanabad

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Article History
Received: 03.10.2020
Accepted: 21.12.2020
Published: 30.12.2020

Journal homepage:
https://www.easpublisher.com

Quick Response Code

Abstract: ***Background:*** Nursing cultural competency is sine qua non for the provision of equitable, respectful, and quality care, especially in rural and culturally diverse places like Osmanabad, Maharashtra. In such health care settings, nurses are frequently coming into contact with patients from diverse linguistic, religious, and traditional health backgrounds, and culturally appropriate care is a vital element of the patient-centred care approach. ***Objectives:*** The purpose of this study was to develop and evaluate the level of cultural competence (CC) among nurses in Osmanabad, barriers to inclusive care, and nurse-led interventions to provide culturally congruent care. It also aimed to provide practical recommendations for policy and educational reform in rural health systems. ***Methods:*** A descriptive cross-sectional mixed methods design was used. Sixty registered nurses from six PHCs and two CHCs were recruited using purposive sampling. Data were collected through a structured questionnaire based on Campinha-Bacote's model, and qualitative information was also collected from 15 participants. SPSS for descriptive statistics and thematic analysis for qualitative narratives was used for data analysis. ***Results:*** Nurses had higher levels of cultural awareness (mean score: 4.1/5), yet cultural encounters and skills mean scores were lower. The main obstacles were a lack of formal training (78.3%), language difficulties (66.7%), and time pressure. Qualitative themes included emotional labour, adaptive communication, and the role of institutions in supporting participants. The nurse-led methods, multilingual teaching, visual tools, and community involvement were found to be valuable for equal care. ***Conclusion:*** The study highlights that cultural competence is not a discretionary skill but is integral to ethical nursing in rural India. Enhancing training, institutionalizing cultural frameworks into policy, and empowering nurses as cultural intermediaries can greatly improve health equity and patient trust in marginalized places such as Osmanabad.

Keywords: Cultural competence, rural nursing, inclusive care, health equity, patient engagement, nurse-led strategies, communication barriers.

1. INTRODUCTION

1.1 Background

Cultural competence in nursing is the ability to provide patient care that recognizes and respects patients' diverse cultural identities, beliefs, practices, attitudes, and behaviours [1]. In rural districts of India, such as Osmanabad, where healthcare communication interfaces with traditional healing systems, gendered social norms, and linguistic variation, a culturally competent nursing approach is necessary to build trust and enhance outcomes [2]. Nurses are, in particular, at the primary health centres (PHCs), the first and for many times the only person contacted. As such, the culture sensitivity of the nurse assumes significance in patient interaction [3].

1.2 Rationale

Osmanabad has a predominantly rural population with a considerable proportion of SC/ST communities and heavy dependence on agriculture. Low levels of health literacy persist, and cultural issues continue to influence childbirth, mental health, and chronic disease [4]. For example, women may avoid seeking care because of patriarchal norms, and older people may prefer traditional over biomedical treatments [5]. Without culturally responsive care, these

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relationships can manifest in low adherence, risk for delay in treatment, and systemic mistrust.

1.3 Problem Statement

In spite of policy-level interventions to improve rural healthcare, there is minimal incorporation of cultural competence in nursing practice in Osmanabad. Standardized protocols usually do not cater for local dialects, customs, and health beliefs, rendering care objectively correct but mismatching the culture. This divide is unethical, and it has contributed to the sustained disparities in health status [6].

1.4 Objectives

This study aims to:

- Examine the sociocultural factors that shape health care practice in Osmanabad.
- Determine the obstacles to providing culturally competent nursing care in rural Maharashtra.
- Suggest nurse-driven, empirically supported initiatives to provide equitable and ethical care.

Culture proficiency, founded on the lived experiences of communities in Osmanabad, would help 'localise the nursing practice' with ethical and desirable sustainability. It supports policy advocacy to incorporate cultural competence in nursing education and rural health programs to achieve equitable and dignified care.

2. REVIEW OF LITERATURE

2.1 Conceptualizing Cultural Competence in Nursing

Professional Practice is commonly acknowledged as it is also dynamic, continual, and a lifelong process of acquiring, by health-care providers, awareness, skills, and knowledge, attitudes, and skills or competencies on how to appropriately take care of clients from diverse cultural backgrounds. Campinha-Bacote's framework is still considered foundational and focuses on five interconnected concepts: cultural awareness, knowledge, skill, encounters, and desire [7]. These constructs are of particular relevance in rural Indian settings, as nurses negotiate linguistic diversity, traditional health beliefs, and gendered power relations.

2.2 Cultural Competence and Patient Outcomes

Evidence has demonstrated that when patients receive culturally competent care, they are more satisfied and trusting of their provider and are likely to adhere to the prescribed treatment plan. In rural areas, such as Osmanabad, patients often seek folk or spiritual healers, and hence, culturally insensitive care may contribute to disconnection or non-adherence [8]. Nurses showing empathy and cultural humility are more likely to develop therapeutic relationships that contribute to positive results, particularly with those who are marginalised.

2.3 Barriers to Cultural Competence in Rural India

Cultural competency of rural health care providers is generally poor, yet culturally competent care is an important expectation of patients, particularly non-white patients who may experience barriers to care access due to race/ethnicity. In Maharashtra, a study found that while nurses were not formally trained in cultural communications, they followed their intuition rather than actual guidelines [9]. Language, time, and institutional ethnocentrism are other barriers to culturally sensitive care [10]. These are further exacerbated in Osmanabad due to low health literacy and patriarchal constructs that limit women's autonomy in health matters.

2.4 Educational Interventions and Training Models

Evidence indicates that targeted educational programs, such as simulation-based learning, case study, and reflective journaling, have been known to enhance cultural competence in nurses. The connection of local case studies and community stories into nursing education has been demonstrated to enhance empathy and understanding. However, such interventions are few in rural India, which is often characterised by nursing education that is not contextualised, and does not get to see diversity and culture, resulting inability with practical exposure.

2.5 Nurse-Led Strategies for Inclusive Care

Nursing-led interventions, including community health education in vernacular languages and participatory rural appraisal (PRA), have also demonstrated successes in narrowing the cultural divide. These strategies enable nurses to serve as cultural intermediaries, translating biomedical truths into culturally effective messages. In Osmanabad, where PHCs are often the only point of care available, such strategies can be game-changing for maternal health, NCD management, and mental health outreach.

3. RESEARCH METHODOLOGY

3.1 Study Design

This was a descriptive cross-sectional mixed-methods design study combining quantitative and qualitative techniques to investigate the cultural competence of nurses and how they deliver culturally inclusive care to clients in rural areas of Osmanabad. The form of design was selected in order to capture tangible as well as subtle, lived experiences of nursing professionals.

3.2 Study Setting

The study was carried out in six Primary Health Centres (PHCs) and two Community Health Centres (CHCs) in the district of Osmanabad, Maharashtra. These sites were chosen for their rural facilities and catchment area, patient population diversity, and ease of data collection.

3.3 Study Population

Study population: The study population consisted of the registered nurses employed in PHCs and CHCs under the government of Osmanabad. Inclusion criteria were:

- At least one year of rural health clinic experience.
- Readiness to participate and sign an informed consent document.
- Good knowledge of Marathi or Hindi to enable communication.

3.4 Sample Size and Sampling Technique

60 nurses were selected through purposive sampling, with distribution of them across sex, years of experience, and facility type. This size was considered sufficient to achieve thematic saturation in the qualitative analysis and simple statistical inference in the quantitative component.

3.5 Data Collection Tools

3.5.1 Quantitative Tool

We used an instrument of our creation based on Campinha-Bacote's cultural competence model. It included:

- Demographic profile
- Self-ratings of cultural sensitivity, competency, and experiences
- Likert-scaled items about confidence and barriers

The tool was pilot-tested in an adjacent district for comprehensibility and local content-scale relevance.

3.5.2 Qualitative Tool

Fifteen participants from the sample were interviewed in depth, in a semi-structured interview guide was employed. Questions explored:

- Personal encounters with culturally different patients
- Approaches to managing barriers in a cross-cultural situation
- Reflections on institutional support and training requirements

3.6 Data Collection Procedure

On-site visits took place over a period of six weeks, and notes were taken. In-person questionnaires were conducted, and then audio-recorded interviews were conducted (hereafter, "interviews") (with consent). Interviews were in Marathi (or Hindi) and then translated into English for analysis.

3.7 Data Analysis

- Descriptive statistics (mean, SD, frequency) and cross-tabulations were used to describe quantitative data(Austin and Sutton2014).
- The sociodemographic questionnaire was a structured one, while the qualitative data were transcribed and analysed through themes. Inductive codes were created, and themes were confirmed through peer debriefing.

3.8 Ethical Considerations

- Informed consent was obtained from all participants.
- Confidentiality and anonymity were kept during the study.
- It was explained to the participants that they had the right to withdraw at any time without disadvantages.

4. RESULTS AND ANALYSIS

4.1 Overview

This investigation looks at how nurses in Osmanabad deliver culturally sensitive care in a rural, heterogeneous environment. Using a convergent mixed-methods design, involving 60 registered nurses, it examines barriers, facilitators, and pragmatic consequences of inclusive, patient-centred care. The objective is to support ethically defensible interventions and enhance rural nurse practice through contextual understanding.

4.2 Demographic Profile of Participants

The study surveyed 60 qualified nurses. Demographics of those who came here." It contains the following breakdown.

Table 1: Demographic Profile of Participants

Variable	Category	Frequency (n=60)	Percentage (%)
Gender	Female	48	80.0
	Male	12	20.0
Years of Experience	1–5 years	22	36.7
	6–10 years	28	46.7
	>10 years	10	16.6
Language Proficiency	Marathi only	24	40.0
	Marathi + Hindi	30	50.0
	Marathi + Hindi + English	6	10.0

The majority of the participants were females with an experience of 6-10 years. Most of them were bilingual, which is a plus when teaching elementary school in a linguistically diverse district like Osmanabad.

4.3 Self-Assessment of Cultural Competence

Cultural competence for the four domains was rated on a 5-point Likert scale by respondents.

Table 2: Self-Assessment of Cultural Competence

Domain	Mean Score (out of 5)	Standard Deviation
Cultural Awareness	4.1	0.6
Cultural Knowledge	3.5	0.8
Cultural Skills	3.2	0.9
Cultural Encounters	2.9	1.0

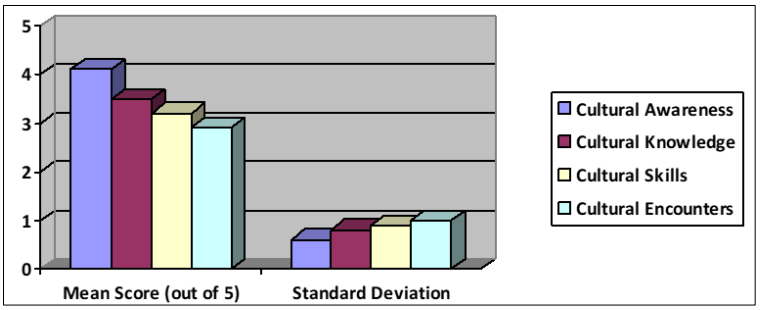

Figure 1: Self-Assessment of Cultural Competence

A high proportion of the nurses reported awareness, and lack of practical experience with multicultural encounters and skills appeared to be the most important barrier, suggesting a potential gap between knowledge and practice.

4.3 Perceived Barriers to Culturally Competent Care

Table 3: Perceived Barriers to Culturally Competent Care

Barrier	% of Nurses Reporting
Lack of formal training	78.3%
Language barriers with patients	66.7%
Time constraints in clinical settings	61.7%
Absence of culturally adapted materials	53.3%

The most common barrier cited was lack of formal training; the second most common was communication difficulties, both modifiable through interventions.

4.4 Qualitative Themes from In-Depth Interviews

We interviewed 15 nurses, using semi-structured interviews. Thematic analysis revealed the following:

- Theme 1: Navigating traditional beliefs. Nurses discussed the difficulty in aligning biomedical advice with patients' trust in traditional healers, particularly in maternal and mental health.
- Theme 2: Gendered Decision-Making Female patients are frequently subordinated to male relatives, diminishing their autonomy in making care decisions.
- Theme 3: Adaptive Communication Nurses used visual aids, narratives, and local metaphors to describe diagnosis and treatment.
- Theme 4: Emotional Labour and Empathy. Emotional Labour. Involving oneself in emotional labour in order to understand and manage differences, which often transpired between GPs and EIVs, was brought up by participants.

These findings highlight the importance of culturally-embedded communication strategies and institutional recognition for nurses managing complex social relations.

5. DISCUSSION

5.1 Interpretation of Key Findings

The finding of the study was that nurses from Osmanabad had a sound understanding of the importance of cultural awareness, but they lacked practical interaction with different cultural groups or structured learning experiences. These findings are consistent with an international perspective that awareness does not equal culturally competent care unless the local institutional system and opportunities for experiential learning support it. The low results of cross-cultural encounters and skills indicate probably the focus for a more community-based and intense learning model.

The qualitative themes, especially those around brokering traditional constructs with gendered decision-making, demonstrate the emotional work hospital nurses undertake to negotiate biomedical protocols with local practices. These results mirror existing research that has highlighted the need for cultural humility and empathy in rural nursing settings.

5.2 Comparison with Existing Literature

Consistent with studies in rural Nepal and sub-Saharan Africa, this research highlights the position of

nurses as cultural brokers in low-resource settings [11]. However, unlike urban studies, diversity is something that, when it comes up, is frequently dealt with in institutional diversity training materials for many larger institutions: rural nurses in Osmanabad often lean heavily on personal experience and informal approaches [12,13]. This disparity in policy and implementation has also been observed elsewhere in Indian districts, where cultural competence tends to be seen as something for the individual as opposed to collective responsibility [14].

Furthermore, as in Southeast Asia, where a similarly high number of nurses reported a lack of formal training, cultural competence is not included in nursing training, despite its being acknowledged as key to nursing [15].

5.3 Implications for Practice

It is to be emphasized that transposition of nurse-led interventions like health multilingual education, visual Aids to Health communication, and Participatory Rural Appraisal in cross-cultural settings can be effective. These approaches not only increase patient comprehension but also build trust, which is particularly important in settings such as those where formal healthcare is met with distrust.

Institutional support is critical. Incorporating cultural competence teachings in the nursing education curriculum, making periodic in-service training available, and developing culturally tailored care protocols can greatly enhance the quality of care. Nurses also should be encouraged to use reflective practice, journaling, and colleague conversations as a venue to process cultural challenges and alleviate burnout.

5.4 Policy and System-Level Recommendations

- Curriculum Revision: Simulation laboratories and context-specific cultural case studies learning should be incorporated in all the nursing curricula of India
- Capacity building, Government health departments need to provide resources for workshops and mentoring schemes on cultural communication and ethics.
- Monitoring and Evaluation: Indicators of cultural competence should be integrated into PHC performance audits and QI systems.
- Community partnership: Health systems should intentionally partner with local leaders and traditional healers to co-create culturally aligned interventions.

5.5 Strengths and Limitations

A major strength of this study is its mixed-methods approach, which permitted statistical analyses as well as rich qualitative accounts. Concentrating on Osmanabad, the book fills a significant lacuna in area-based writings. On the other hand, generalizability may be restricted as purposive samples were used, and private sector nurses were not included. Also, self-report data can be biased by social desirability.

6. CONCLUSION

This study highlights the great potential of cultural competence to improve the quality of and access to nursing care in rural areas such as Osmanabad. Although cultural awareness was strong, there were also marked deficits observed in terms of practical skills, structured training, and institutional support. These barriers impede both clinically effective and culturally relevant and ethically sound care from being delivered.

The convergent mixed-methods design provided insights into quantifiable trends and the lived experiences of frontline nurses. Large-scale quantitative data illuminated gaps in cultural exchanges and translation devices, and qualitative narratives showcased emotional labor incurred when traversing common religious beliefs, gender roles, and language differences. This knowledge validates the fact that being culturally competent is something that is not stagnant, but instead is a fluid and situational process that can necessitate ongoing introspection, adjustment, and guidance.

Crucially, it is suggested by the study that nurse-led, community-integrated practices, i.e., multilingual health education, participatory rural appraisal, and image-generated aids to communication, be followed as effective means to close cultural gaps. These methods allow nurses to play cultural brokers, developing trust and engaging patients in resources in underserved populations.

At the policy level, incorporation of cultural competence in nursing curricula, institutional self-audits, and rural health planning is a must. Systemic backup for individual attempts to cope may remain unsustainable. The pursuit of equity in healthcare systems needs to incorporate cultural competence as a fundamental, rather than an optional, component of ethical patient-centred care.

In conclusion, culturally competent nursing in Osmanabad is challenging as well a rewarding. Through investments in training at the local level, and the opportunity for reflective practice, along with the development of policies that are inclusive, a health system can be envisioned that does honour to diversity, supports dignity, and heals.

7. CONFLICTS OF INTEREST

The author has no conflicts of interest related to this study. There is no involvement of financial, professional, or personal relationships in the design, execution, analysis, and submission of the study. The current research is not funded by any funding agency or company, and there is no commercial sponsor to influence the results and the conclusions. Ethical and

academic issues have all been respected during the research process.

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