

Cultural Competence Training and Delivery of Culturally Responsive Care Among Nurses at Msambweni County Referral Hospital, Kwale County, Kenya

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Abstract

Cultural competence training is widely recognized as a foundation for nursing care that respects patients' cultural beliefs, languages, and values, yet evidence on how training shapes practice remains limited in rural, multicultural Kenyan hospitals. This study examined the association between cultural competence training and the delivery of culturally responsive care among nurses at Msambweni County Referral Hospital (MCRH), Kwale County, Kenya. A mixed-methods design was employed, combining quantitative and qualitative approaches. Data were collected using pretested structured questionnaires from a stratified random sample of 84 nurses and key informant interviews involving seven charge nurses and the nursing officer in charge. Seventy-seven questionnaires were returned, a response rate of 91.7%. Training was measured using a nine-item Likert-type scale (Cronbach's α 0.88) covering pre-service instruction, in-service workshops, orientation, and application in daily care. Quantitative data were analyzed in SPSS version 26 using descriptive statistics, Pearson correlation, and multiple linear regression; interviews were analyzed thematically. Findings showed that formal training exposure was low overall (composite $M = 2.46$, $SD = 0.96$); only 14.3% of nurses had attended a cultural sensitivity workshop and 13.0% reported regular workplace training, yet 70.1% believed all nurses should receive such training regularly. Training was the strongest correlate of cultural competence among the variables examined ($r = 0.807$, $p < .001$) and remained an independent, statistically significant predictor in the regression model ($\beta = 0.403$, $p < .001$). These findings indicate that structured, practice-focused training is associated with, and may meaningfully improve, culturally responsive nursing care at MCRH; quarterly in-service training anchored in institutional policy is recommended.

Keywords: *Cultural competence, training, culturally responsive care, nursing, Kenya*

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1.0 Introduction

Cultural competence has emerged as a critical pillar in the delivery of quality healthcare in the 21st century. Nehargh et al. (2025) define cultural competence as "the ability of healthcare providers to effectively understand, communicate with, and respond to patients from diverse cultural backgrounds." Cultural competence involves more than knowledge of cultural customs; it includes self-awareness, cross-cultural communication, and the ability to offer healthcare delivery in ways that respect patients' beliefs, values, and needs (Deering, 2024; Ličen & Prosen, 2023). In multicultural settings, nurses without this skill may misinterpret their patients' needs, overlook significant health beliefs, or fail to build trust, which decreases the quality of care received from patients. The skill is primarily developed through training. This involves pre-service nursing education, in-service workshops, orientation programs, and other organized learning activities designed to provide nurses with the knowledge, skills, and attitudes needed for culturally responsive care (Kaihlanen et al., 2019). Cultural competence requires continuous professional development. It enables nurses to reflect on their own beliefs, communicate effectively inter-culturally, and respect other health beliefs (Campinha-Bacote, 2011; Kaihlanen et al., 2019).

In Leininger's Theory of Culture Care Diversity and Universality, cultural competence is shaped jointly by individual attributes and structural, educational conditions, represented in the Sunrise Model as interacting technological, religious, kinship, and educational factors, among others. This study's variables—personal background, training, communication challenges, and institutional support—were selected to reflect this framework: training and institutional support represent the structural/educational dimensions the theory identifies as necessary conditions for culturally congruent care, while personal background and communication challenges represent the individual and interactional dimensions. The

present analysis focuses on the training dimension.

Globally, healthcare systems in countries such as the US, Australia, Canada, and the UK have mainstreamed cultural competence into nursing education, clinical guidelines, and accreditation frameworks. For instance, in the U.S., ongoing cultural learning was found to benefit minority patients (Campinha-Bacote, 2011). In Finland, nurses who had attended cultural competence training stated that it increased their awareness of their own culture and understanding of patient needs (Kaihlanen et al., 2019). Findings from these two contexts suggest a consistent pattern: cultural competence training is associated with how nurses approach cross-cultural care.

Regionally, a similar pattern is observed across Africa. Nursing students in Ghana with cultural competence training reported greater confidence in caring for patients from different ethnic groups (Abubakari et al., 2024). In Ethiopia, the absence of training, rather than a lack of willingness among nurses, was identified as a primary factor limiting culturally competent care (Berie et al., 2021). Put together, these findings suggest that limited training availability is associated with constrained culturally responsive care, regardless of individual nurses' willingness to provide it.

In Kenya, training in cultural competence is not readily available. Some urban hospitals offer cultural sensitivity training for nurses, while such training is largely unavailable in rural Kenyan hospitals. The Nursing Council of Kenya (2023) has also emphasized the importance of developing cultural competence among nurses during their education. According to Musembi and Affey (2024), nurses who have attended cultural competence seminars have demonstrated an improvement in their interaction with patients and the number of cultural errors they make. However, such training remains far less available in rural areas than in major towns and cities.

“Cultural competence training is likely to be most effective when it is supported by institutional policy and resourcing”

At Msambweni County Referral Hospital (MCRH), which serves the Digo, Duruma, Giriama, and Swahili communities of Kwale County, this training gap appears pronounced. Preliminary hospital data indicated that only 10 of 43 nurses surveyed (23.3%) had received any formal cultural competence training, despite most reporting regular cultural and communication difficulties with patients (Ministry of Health, 2025). Despite the apparent size of this gap, there is little published evidence on how training, or its absence, is associated with the delivery of culturally responsive care in rural, multicultural Kenyan hospitals such as MCRH.

This study therefore examined the association between cultural competence training and the delivery of culturally responsive care among nurses at MCRH. It sought to offer local evidence to inform training investment, curriculum development, and institutional policy in comparable rural healthcare environments.

2.0 Materials and Methods

Research Design and Study Setting

The study used a mixed-methods research design, combining quantitative and qualitative approaches (Creswell, 2018; Kazdin, 2021). This design was chosen because cultural competence involves both measurable factors (such as training exposure) and personal experiences (such as attitudes and perceptions) that are best captured through complementary methods. The study was conducted at MCRH, a major public referral facility in Kwale County, on Kenya's coast, serving a catchment population drawn from the Digo, Duruma,

Giriama, and Swahili communities, among others.

Population and Sampling

The target population comprised all 120 qualified nurses employed across MCRH's six clinical departments (medical, surgical, maternity, pediatric, outpatient, and renal). Using Yamane's (1967) formula, a sample of 84 nurses was determined and allocated proportionally to each department through stratified random sampling, with simple random sampling used to select individual participants within each stratum. Eligible nurses held a BScN, KRCHN, or ECN qualification, had worked at MCRH for at least six months, and gave written informed consent. Seven key informant interviews were additionally held with charge nurses from each department and the hospital's nursing officer in charge.

Instrumentation

Data were collected using a structured, self-administered questionnaire developed from a review of existing cultural competence training scales and refined through alignment with Leininger's theoretical framework and expert review by the supervisors. Apart from the demographic section, the instrument included a nine-item, five-point Likert scale (1=SD to 5=SA) measuring training exposure, covering pre-service instruction, in-service workshops, orientation content, access to reference materials, and the application of training in daily practice. Composite training scores were calculated as the mean of the nine items. Composite and item-level means were interpreted using five equal bands derived by dividing the 1–5 scale range into five equal intervals: 1.00–1.80 (very low), 1.81–2.60 (low), 2.61–3.40 (moderate), 3.41–4.20 (high), and 4.21–5.00 (very high).

A semi-structured key informant guide explored training practices and institutional support in greater depth. Content and construct validity were determined through expert review by the supervisors and alignment of questionnaire items with Leininger's theoretical framework. Furthermore, validity for the training scale was

determined from a pilot study that involved ten nurses. The pilot Cronbach's α was 0.86, confirmed as 0.88 in the main study.

Data Collection Procedure

The questionnaires were personally distributed by the researcher to the nurses, who were informed about the study and its voluntary nature. The questionnaires were collected within a period of two to three days. Interviews with key informants were carried out in a private setting. The interviews were conducted using audio recorders with the consent of the interviewees and were transcribed within 24 hours of the interviews.

Data Analysis

Quantitative data were analyzed using SPSS version 26. Descriptive statistics summarized the data collected. Multiple linear regression was selected because the dependent variable, cultural competence, was a continuous composite score, and the aim was to determine the independent contribution of training relative to the other three predictor variables (personal background, communication challenges, and institutional support). Assumptions of linearity, normality of residuals, and homoscedasticity were checked through residual scatterplots and a normal P-P plot prior to running the regression model, and no material violations were observed. Multicollinearity among predictors was assessed using Variance Inflation Factors (VIF); all VIF values were below 3, indicating no problematic multicollinearity. Cases with missing responses on any study variable were excluded listwise from the regression analysis.

Pearson's product-moment correlation was used to determine bivariate relationships between variables. Interview transcripts were analyzed using Braun and Clarke's (2021) six-phase thematic analysis approach.

Ethical Considerations

Ethical approval was obtained from KeMU-IERC and NACOSTI, with further authorization from the Kwale County Health Department and MCRH management. Written informed consent was obtained from all participants, and confidentiality was maintained through anonymous questionnaire coding and the use of non-identifying labels for interview informants.

3.0 Results and Discussion

Respondent Profile

A total of 84 questionnaires were distributed in all of MCRH's 6 departments and 77 of them were returned completed. This means that the response rate was 91.7%, which is above the 70% threshold considered acceptable for survey-based nursing research (Mugenda & Mugenda, 2003).

Most respondents were female (70.1%), with a mean age of 39.34 years, and most were diploma-trained Kenya Registered Community Health Nurses (71.4%), consistent with the typical workforce composition of Kenyan county referral hospitals. Nineteen different ethnic groups were represented among respondents (Table 1), indicating that the nursing workforce itself is culturally diverse, not only the patients it serves.

Table 1

Ethnic Group of the Respondents (N=77)

Ethnic Group	Frequency (n)	Percentage (%)
Digo	13	16.9
Luhya	10	13.0
Kikuyu	7	9.1
Mijikenda	6	7.8
Kisii	6	7.8
Kamba	6	7.8
Meru	6	7.8
Kalenjin	4	5.2
Maasai	3	3.9

Ethnic Group	Frequency (n)	Percentage (%)
Luo	3	3.9
Duruma	3	3.9
Chonyi	2	2.6
Giriama	2	2.6
Others	6	7.8
Total	77	100.0

Cultural Competence Training and the Delivery of Culturally Responsive Care

This section examines the association between cultural competence training and nurses' delivery of culturally responsive care at MCRH. Structured training was reported by very few nurses, with a composite mean of 2.46 (SD = 0.96), falling in the "low" band; it was

nonetheless the strongest correlate of nurses' level of cultural competence at the facility among the variables studied.

Nine items assessed the extent to which nurses had experienced training related to cultural competence, covering exposure during nursing education, employment, job orientation, and application of training in daily work (Table 2).

Table 2
Training Exposure Items (N=77)

Item	Mean	SD	Agree (%)	Neutral (%)	Disagree (%)
I received formal cultural competence training	2.66	1.50	42.9	6.5	50.6
I have participated in at least one training on cultural competence	2.12	1.28	14.3	24.7	61.0
Cultural care was included in my job orientation	1.84	1.27	13.0	6.5	80.5
I have access to reference materials on cultural care	2.10	1.35	19.5	10.4	70.1
Cultural training helped me identify cultural barriers early	2.34	1.42	36.4	9.1	54.5
I believe all nurses should receive cultural training regularly	3.86	1.18	70.1	15.6	14.3
I apply knowledge from cultural training in daily practice	2.25	1.38	24.7	11.7	63.6
My training prepared me to handle cultural practices in healthcare	2.31	1.41	28.6	10.4	61.0
Composite (Overall)	2.46	0.96			

Note: Items were rated on a 5-point Likert scale (1 = SD to 5 = SA).

Only 13.0% of nurses reported that their workplace organized regular cultural competence training (M = 1.84, SD = 1.27), and 15.6% received such content during job orientation. Access to reference materials on cultural care was similarly limited (19.5%). Despite this, 70.1% of nurses indicated that all nurses should receive cultural competence training regularly, suggesting a mismatch between nurses' expressed demand for training and the training currently made available to them. This pattern is consistent with findings

from other public hospitals in Kenya and in northern Ethiopia, where nurses similarly expressed a desire for training they had not received (Musembi & Affey, 2024; Berie et al., 2021).

Where training had been received, primarily during pre-service nursing education rather than during employment, it did not appear to translate strongly into applied competence: only 36.4% of nurses felt their training had helped them identify patients' cultural practices, and only

24.7% reported applying training in daily practice. This suggests that training received during initial nursing education alone may be insufficient without reinforcement through in-service and orientation programmes.

Statistical Relationship Between Training and Cultural Competence

The relationship between training and cultural competence was examined using Pearson's

Table 3

Pearson Correlation Coefficients Between Study Variables and Cultural Competence (N=77)

Variable	1	2	3	4	5
1. Cultural competence	1.00				
2. Training	0.807***	1.00			
3. Personal background	0.776***	0.654***	1.00		
4. Communication challenges	-0.342**	-0.298**	-0.312**	1.00	
5. Institutional support	0.567***	0.705***	0.523***	-0.287**	1.00

*Note: Two-tailed significance. *p < 0.05, **p < 0.01, ***p < 0.001.

The regression model was statistically significant ($F(4,72) = 165.3$, $p < .001$) and accounted for 90.2% of the variance in cultural competence scores among nurses ($R^2 = 0.902$, adjusted $R^2 = 0.896$). Training remained significantly and independently associated with cultural competence after accounting for personal background, communication challenges, and institutional support ($B = 0.357$, $SE = 0.072$, $\beta = 0.403$, $t = 4.945$, $p < .001$, 95% CI [0.213, 0.501]). This confidence interval indicates that, with 95% confidence, each one-unit increase in training score was associated with an increase of between 0.21 and 0.50 units in cultural competence, holding other variables constant.

Training was the second-strongest predictor in the model ($\beta = 0.403$), after personal background ($\beta = 0.711$) and ahead of institutional support ($\beta = 0.303$), indicating an independent association between training and cultural competence beyond what is explained by the other factors. This finding is consistent with prior studies examining the relationship between cultural competence training and nurses' cultural competence in other settings

product-moment correlation and multiple linear regression. Training showed a statistically significant, strong positive correlation with cultural competence ($r = 0.807$, $p < .001$), the strongest of the four variables examined, compared with personal background ($r = 0.776$, $p < .001$) and institutional support ($r = 0.567$, $p < .001$). Training was also strongly correlated with institutional support ($r = 0.705$, $p < .001$), suggesting these two structural factors tend to co-occur within a facility (Table 3).

(Campinha-Bacote, 2011; Kaihlanen et al., 2019).

This finding is consistent with Leininger's Sunrise Model, in which educational and institutional factors are theorized to jointly shape culturally congruent care; the present data empirically support the model's proposition that structural learning opportunities, rather than individual disposition alone, are associated with culturally responsive practice. Training may build cultural sensitivity by improving knowledge, shaping attitudes, and modelling respectful communication (Aririguzoh, 2022; Gradellini et al., 2021). Where training was largely absent, as it was at MCRH, this pathway had little to draw on, regardless of individual nurses' reflectiveness or willingness.

Qualitative Data Analysis

Seven key informant interviews were conducted with charge nurses across six clinical departments and the facility's nursing officer in charge. To protect anonymity, each participant was assigned a unique code following the format KII-0X (Key Informant Interview,

sequential number). The interview transcripts were analyzed thematically following Braun and Clarke's (2021) six-phase process. One theme, Training Gaps Experienced as Systemic Failures, helped explain the statistical association reported above. Informants described the absence of structured pre-service or in-service training and indicated that cultural knowledge is instead acquired informally:

"In all the years I have worked here, I have never once attended a workshop on how to handle patients from different cultures. We depend entirely on what little we covered in college, and even that was barely a chapter." (KII-03)

"During my induction, nobody mentioned cultural competence. We were shown where the equipment is kept and that is it." (KII-05)

"I have asked about training related to cultural competence in the past, but the hospital informed me that there is no budget for providing such training. Yet we encounter many cultural issues daily within the hospital and nursing care facility." (KII-02)

"New nurses come here without any preparation for the cultural realities of this place. We are expected to figure it out ourselves." (KII-07)

This account is consistent with the finding that only 13.0% of nurses reported regular workplace training and 15.6% received cultural competence content during orientation. These findings are consistent with Musembi and Affey (2024), who established that training gaps in Kenyan public hospitals tend to be structurally embedded rather than incidental, persisting in the absence of institutional policy. Berie et al. (2021) similarly found that the majority of nurses in their Ethiopian samples had never received formal cultural competence training, and that this absence directly constrained the quality of culturally responsive care they could deliver. Gradellini et al. (2021) further argued that without deliberate integration of cultural competence content into both pre-service curricula and in-service programs, nurses are left to develop cross-cultural skills through trial and error, a process that is inconsistent and potentially unsafe.

Within the Kenyan policy setting, these findings support the Nursing Council of Kenya's view that cultural competence needs to be built more firmly into nursing curricula and continuing professional development, and extend Ndirangu's observation that training in Kenya remains concentrated in urban tertiary hospitals by showing, with converging survey and interview evidence, the scale of this gap at a rural, multicultural county referral hospital (Nursing Council of Kenya, 2023; Ndirangu, 2021). For county-level health systems in Kenya, this suggests that budget allocation for in-service training may be as important a lever for improving culturally responsive care as pre-service nursing curricula.

4.0 Conclusion

This study examined the association between cultural competence training and the delivery of culturally responsive care among nurses at MCRH. Structured cultural competence training was independently associated with higher cultural competence, even after accounting for personal background, communication challenges, and institutional support. However, significant gaps in training provision exist at the facility: most nurses reported little or no exposure to structured cultural competence training during employment, orientation, or continuing professional development, despite expressing willingness to participate in such training. The association between training and institutional support ($r = 0.705$) suggests these two factors may need to be strengthened together. These findings support institutional strengthening of cultural competence training as a priority area for MCRH and comparable rural, multicultural county referral hospitals in Kenya.

5.0 Recommendations

For nurses, these findings suggest value in seeking cultural competence training opportunities beyond initial nursing education to support the care of patients from diverse backgrounds. For hospital administration, the findings suggest that cultural competence training is likely to be most effective when it is

supported by institutional policy and resourcing; training introduced without such support may have more limited impact. For nursing education programs, the findings support

continued emphasis on cultural competence content, alongside mechanisms to reinforce this learning during early clinical practice.

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