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BARRIERS TO DELIVERY OF CULTURALLY COMPETENCE CARE AMONG NURSING STAFF WORKING IN TERTIARY CARE HOSPITAL IN PESHAWAR

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Abstract

Globalization, migration, and increased cultural diversity pose significant challenges to nursing practice and education worldwide, making culturally competent care essential. Cultural competency involves understanding and addressing patients' diverse cultural contexts to improve care and reduce health disparities. In regions like Pakistan, where cultural and linguistic diversity is pronounced, the need for effective transcultural nursing practices is particularly critical. However, barriers such as communication difficulties, language differences, and lack of proper training continue to hinder the provision of culturally sensitive care.This study employed a quantitative, descriptive cross-sectional design to explore barriers to culturally competent care among nurses in three tertiary hospitals in Peshawar, with a sample size of 313 nurses. Data were collected through a structured questionnaire covering demographic data, knowledge, and practice, and analyzed using descriptive statistics and SPSS to identify associations. Ethical considerations were maintained through institutional permissions, informed consent, and confidentiality assurances.The findings revealed that the majority of participants were aged 26–30 years (52.7%), predominantly female (76.0%), and mostly diploma-qualified (66.1%). More than half were married (55.91%), and most served as charge nurses (89.8%), reflecting a youthful, diploma-based workforce with significant family responsibilities. While participants acknowledged the importance of cultural competence, many expressed concerns about inadequate training and restrictive organizational policies that limit culturally appropriate care.The study concludes that prolonged nursing staff shortages, coupled with the challenge of balancing urgent needs with cultural considerations–particularly in trauma ICUs–significantly hinder the delivery of culturally competent care. Language barriers and insufficient communication training further obstruct culturally sensitive practice, underscoring the urgent need for sustained staffing, enhanced cultural competence education, and strong organizational support.

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INTRODUCTION

Globalization, migration, and increased diversity in culture among patients present significant challenges to nursing practice and education worldwide. These reasons have made the provision of culturally competent care an essential component of healthcare services, particularly for nurses. (Rahimi et al., 2023) Cultural competency in healthcare is a continuous process in which healthcare workers attempt to work effectively within the cultural contexts of patients, families, or communities from various origins. This competency is distinguished by cultural awareness, sensitivity, knowledge, and expertise. Cultural variety is a key cause of health disparities worldwide, and studies have shown that culturally competent care is an effective strategy for eradicating these longstanding inequities (Berie et al., 2021)

Cultural diversity refers to variations in customs, habits, ethical and moral standards, beliefs regarding health and sickness, and linguistic ability, all of which can have an impact on an individual's health and well-being (Songwathana et al., 2021) . In the 1960s, nursing theorist Madeleine M. Leininger founded trans-cultural nursing care as a field of study and practice by combining nursing and anthropology. The purpose of Transcultural nursing is to create a body of knowledge that can be used to provide both culture-universal and culture-specific nursing care. Leininger's trans-cultural nursing theory acknowledges culture's major influence on health and illness, emphasizing the importance of nurses understanding their own and their patients' cultures in order to deliver culturally appropriate treatment. Being compassionate, empathy, sincerity, supporting health and autonomy, and valuing patients' choices all influence how nurses engage with them (Berhanu et al., 2024)

Nurses are required to provide clinically safe and culturally appropriate care to patients from a variety of backgrounds on a regular basis. To acquire cultural competency, healthcare practitioners must be committed and capable of providing family- and patient-centered care while adapting their attitudes and behaviors to the requirements of varied patient groups.(De Beer & Chipps, 2014)According to studies, when nurses deliver culturally sensitive care, clients are more likely to report higher levels of satisfaction. As a result, nurses must be culturally aware of their clients' unique requirements and adjust their practice to ensure culturally safe and equitable care for all (JanyaaMcCalman RoxanneeBainbridge AntonnClii ord & Singapore, n.d.) . However, many nurses and other healthcare professionals may lack the information, abilities, and attitudes required to deliver equitable care to patients from diverse cultural backgrounds (Berie et al., 2021)

In Pakistan, the demand for transcultural nursing care is particularly critical. Pakistan is divided into five provinces: Punjab, Sindh, Khyber Pakhtunkhwa, Balochistan, and Gilgit-Baltistan, as well as the Federally Administered Tribal Areas. Each of these regions has distinct cultural and linguistic aspects, including languages like Sindhi, Balochi, Pashto, Saraiki, Punjabi, and Hindko. There are also disparities in family structure, gender preferences, and food choices (Berie et al., 2021) . Understanding cultural variations is critical to providing successful healthcare. Peshawar, the capital of Khyber Pakhtunkhwa province, demonstrates cultural variety. It is a significant juncture for several ethnic groups, including Pashtuns, Punjabis, and Hindko speakers (De Beer & Chipps, 2014). The city's tertiary care facilities serve a diverse population from various cultural origins and health concepts. Nurses in these institutions are at the forefront of patient care, thus their role in providing culturally competent care is critical. However, these nurses frequently face major challenges that limit their capacity to offer culturally sensitive and appropriate care.

Language disparities, cultural practices, the use of home cures, and spiritual leaders' prayers are all examples of hurdles.

Background:

Despite the critical role of cultural competence in healthcare, the majority of studies on cultural competency among nurses have been done in the United States, Canada, the United Kingdom, and Australia (Geleta et al., 2021) Only a few research has been done conducted in Pakistan, and no study have found on the barriers to cultural competency among Pakistani nurses. According to studies conducted in developed countries, several barriers to providing culturally competent care exist, including the organization and complexity of healthcare systems, legal restrictions on access to certain health services,

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linguistic and cultural barriers, discrimination, and healthcare providers' limited competencies or unawareness. These barriers are frequently related to individual variables such as poor health literacy, job position, stigma fear, language barriers, or disparities in health views and behaviors (Handtke et al., 2019)

Problem statement:

This study aims to identify and analyze barriers to delivery of culturally competence care among nursing staff working in tertiary care hospital in Peshawar

Study significance:

In Pakistan research on barrier to delivery of culture competence care among nurses in health care system is not well developed specially in the area of health. There is a little information of nurses with patients in culture competence care in tertiary care hospitals. This study aims to improve these barriers of CCC in health care system. The finding from this research to identify barriers and gap in culture competence care among nurses and patients. This will lead to better quality of care and

strong nurse-patient relationship. The result will also help to develop better CCC and strategies to improve patient's adherence to treatment, increase their satisfaction and reduce their complain**.**

Rational of study:

Delivering culturally competent care is crucial in today's diverse healthcare environment but many nurses face challenges like inadequate training, language barriers, and limited institutional support Understanding these barriers is key to improving patient outcomes and addressing health disparities.

This study aims to identify and analyze these challenges, providing insights to enhance nursing education, policies, and practices for more inclusive healthcare.

Research Objective:

To Identify and categorize the primary barriers to culturally competent care as perceived by nurses.

Research question:

What are the key barriers to delivering culturally competent care identified by nurses in Peshawar?

Operational definition:

Cultural competence care refers to the ability of healthcare providers to deliver care that is sensitive to and responsive to the cultural and linguistic diversity of their patients. It involves understanding and respecting the cultural beliefs, values, and practices of diverse patient populations, and incorporating this knowledge into healthcare delivery. The question quantified by a validated Likert scale questionnaire consisted of 21 questions. Each questionnaire item had 5 possible Reponses of 1=Strongly Disagree (SD) 2=Disagree (D). 3=Neutral (N). 4=Agree (A). 5=Strongly Agree (A).

Summary of introduction

The need for cultural competence is especially acute in Pakistan, where diverse cultural and linguistic backgrounds present unique challenges to healthcare providers, especially nurses working in Peshawar's tertiary care hospitals. The introduction highlights the growing importance of cultural competence in nursing due to globalization, migration, and the increasing cultural diversity among patients. It emphasizes that providing culturally competent care, characterized by cultural awareness, sensitivity, and knowledge, is essential in addressing health disparities. The introduction also underscores the significance of Madeleine Leininger's transcultural nursing theory, which integrates cultural understanding into healthcare to ensure safe and appropriate patient care in develop countries there are a lot of researches on a range of challenges, such as low healthcare professional competence, discrimination, and language hurdles, has been done in affluent nations; however, not much has been done in Pakistan. By identifying and examining the obstacles to culturally competent care among Peshawar's nursing staff, this study seeks to close this gap and enhance patient satisfaction, nurse-patient relationships, and care quality**.**

LITRATURE REVIEW

This chapter examines the most recent research to determine what barriers nurses' face in providing care that is culturally competent and how those barriers may impact patient outcomes. Numerous studies with a diverse spectrum of nurses conducted in a variety of settings and cultures were found through the literature

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search. Numerous studies dispute the experiences of nurses from diverse linguistic, cultural, and religious backgrounds working in the health care industry. The impediments to providing treatment that is culturally competent for nurses working Peshawar's tertiary hospitals were the subject of the literature search.

Search Strategies

Research strategies ware undertaken to identify search papers related to identify barriers of Culturally competence care among nurses in tertiary care hospital in Peshawar. Recourse from multiple databases, SEMANTIC SCHOLAR including CINAHL plus, EMB,AMED and GOOGLE SCHOLAR ,SCI HUB ware use in literature review search. There were no restriction on the study design, all qualitative and quantitative research met the search inclusion and exclusion criteria. 1430 result ware returned from the initial search, including that it was overly broad after that duplicated article ware removed from all result bringing the total into 984 articles. After that the search was limited to articles released between 2010 to 2023. The 437 articles came from this. Eligibility was determined by using inclusion and exclusion, English language articles and the kind of respondent's ware among the requirements. There were 113 articles as a result.in order to gain a quick summary of the paper and identify the most pertinent research (see Table 2.1) the remaining 36 full text articles ware reviewed and evaluated for eligibility by reading the title,
keywords, abstract and the first two or three sentences following each subheading. Consequently, a few places were removed, in the end 18 studies were judged and appropriate ware used to assess the research quality. The following inclusion and exclusion were applied.

Inclusion

Articles published between 2010 and 2023 English language articles
Nurse and Patients
All those study materials related to my research study.

Exclusion

Non-English Articles Duplicated articles
All those study materials that not related to my research topic

2.1 literature review on to identify barriers to delivery of culturally competence care among nursing staff working in tertiary care hospital in Peshawar

This literature review will contain introduction of culture competence care among nursing staff then model of culture competence care , Barriers to delivery of culture competence care, improvement of these barriers and last Summary of the literature review

Culture competence care

An individual's health and well-being may be impacted by cultural diversity, which Includes variations in customs, behaviors, moral and ethical beliefs, attitudes toward health and Sickness, and language proficiency. Globalization, rising migratory trends, technological development, fertility rates, diversity in races and ethnicity, and shifting demographics all Contribute to the world's population's multicultural makeup and demand an evolution in Culture (Sharifi et al., 2019) The term "cultural competency" refers to a broad category of interventions meant to increase the efficacy and accessibility of health care services for members of racial and ethnic minorities. Cultural competency is not a destination; rather, it is a continuous process of being and becoming that aims to expand one's capacity to deliver great patient care that is relevant to the culture of the patient. When a patient's views, habits, or values directly Contradict accepted medical and nursing criteria, this strategy enables nurse practitioners to treat them successfully. (Truong et al., 2014)

Pakistan is made up of five provinces: Federally Administered Tribal Areas (FATA), Baluchistan, Khyber Pukhtoon Khawa, Sindh, Punjab, and Gilgat Baltistan. Depending on their geographic location and linguistic variances, cultural or ethnic groups such as Sindhi, Balochi, Pashto, Saraiki, Punjabi, and Hindco have several variations. Other differences might exist in food choices, gender preferences, and family structure. It is crucial to understand their cultural distinctions considering these discrepancies. A continuous process of seeking cultural awareness, cultural knowledge, cultural skill, and cultural competency" was the widely accepted definition of cultural competence (A. F. Almutairi et al., 2017) . A

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system that is culturally competent incorporates knowledge of how various patient communities' health attitudes and behaviors, disease incidence and prevalence, and treatment outcomes interact (Castillo & Guo, 2011) interactions in which the medical professional is constantly working to develop the capacity to function well within the patient's, families, individual's, or community's cultural context (Hashish et al., 2020)

Since every culture has unique traits, people from different cultures might differ greatly from one another. Each person should be regarded as an individual and their peculiarities appreciated. In fact, cultural differences might exist even between members of the same race (Balcazar et al., 2009)

Models of Cultural competence care

Munoz and Campinha-Bacote proposed a five-component model for fostering cultural competency. There were five suggested elements of cultural competency:

1. Cultural awareness,
2. Cultural knowledge,
3. Cultural skill,
4. Cultural encounter,
5. Cultural desire. (Castillo & Guo, 2011)

Culture awareness

Identifying one's own prejudices and potential biases when working with particular client groups; Conducting a thorough analysis of one's own cultural and professional background (Castillo & Guo, 2011)

Cultural knowledge

Cultural knowledge is the ongoing process of learning about various cultures. Learning theoretical and conceptual frameworks is part of it, as they aid in data processing. Cultural understanding is based on cultural knowledge (Sharifi et al., 2019) .Locating and gathering data on various cultural and ethnic groups, as well as comprehending the Worldviews of these groups, to explain how members of a group understand their sickness and how membership influences their behavior, thinking, and being (Castillo & Guo, 2011)

Cultural skills

Capacity to effectively conduct culturally specific assessments and gather pertinent cultural data regarding patients' current issues; includes performing cultural assessments and physical evaluations based on cultural norms (Castillo & Guo, 2011) The capacity to communicate effectively with people from different cultures is known as cultural skill. This skill is the ability to organize and deliver care while taking various values, beliefs, and approaches into account (Sharifi et al., 2019)

Cultural encounter

The method that pushes nurses to have direct cross-cultural encounters with patients from culturally varied backgrounds; having direct interactions with such patients will help nurses improve or change preconceived notions about a particular cultural group and avoid any potential stereotyping. (Castillo & Guo, 2011)

Culture desire

It relates to the drive to seek out and develop cultural interactions and awareness. Being open to others, accepting and respecting cultural differences, and being eager to pick up new skills from others are all ingrained in cultural desire. drive to actively seek out and participate in the process

of becoming culturally aware, knowledgeable, and skilled rather than feeling compelled to do so; consists of a sincere desire to be receptive to people, to tolerate and value diversity, and to be open to picking up cultural knowledge from others. (Sharifi et al., 2019)

Barriers to delivery of culturally competence care

The study identified obstacles to the provision of culturally competent treatment by nurses in Peshawar's tertiary care hospitals. The three composite barriers identified in this study were **Lack of culturally relevant policies.**

Participants reported that not having enough time was another reason why they thought receiving culturally appropriate care would be difficult. According to the answers, time is a crucial requirement for offering each patient high-quality care. Because of the present cost-cutting measures, professionals have less time to complete tasks that are deemed more labor-intensive (Claeys et al., 2021) . Our findings show that there are

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insufficient culturally competent policies in place, which is consistent with the lack of emphasis placed on providing culturally competent treatment. The results of this study may indicate that there is a lack of a comprehensive national minority healthcare policy in Ghana, which would require providers to put strategies in place to assist the country's diverse population in navigating the intricate healthcare systems. Ghana's shortcomings in tackling CCC issues can be attributed to a number of circumstances the nation faces. First, there are insufficient funds and value for staff education and training, in addition to a dearth of culturally appropriate health education tools. The absence of comprehensive educational curricula and policies at the national, regional, and institutional levels that enable culturally competent care rank second and third, respectively. The absence of culturally competent care policies to direct care left midwives in South Africa vulnerable as patients blamed providers for
providing culturally incompetent care during labors. This shows that the lack of culturally appropriate regulations is not unique to Ghana (Abubakari et al., 2024a)

Factors related to training.

For medical practitioners, it is a necessary ability many patients' initial point of contact is a nurse, who makes up most of the medical workforce. In order to properly care for international patients, nurses must be aware of their customs and behaviors (Ahn, 2017) The majority of interviewees stated that this was their first experience working abroad and that they had no prior knowledge or background information. Many of them used their own resources, such as websites, to obtain the necessary information about the new cultures they would likely encounter. Theme 1 identified a number of components, including knowledge, understanding, education, and learning, as being crucial to nursing care's ability to be culturally competent.
(Al-Wahbi et al., n.d.) As they gained more years of expertise in their field, nurses were able to adapt their vocabulary and tone and use active listening techniques to better communicate with patients from different ethnic backgrounds. Beyond the very skilled intercultural communication abilities of seasoned nurses as promoted. it's possible that nurses lacking sufficient cultural competency training lack the knowledge and abilities necessary to provide patients from a variety of backgrounds with high-quality treatment. Culturally competent care cannot be provided in the healthcare industry due to a lack of training in the subject, which can lead to miscommunication, misconceptions, and inadequate treatment. (Abubakari et al., 2024)

Factors related to nursing staffing.

The three composite barriers are the result of multifaceted variables including the healthcare system and the foundational training provided to nurses. This result aligns with the conclusions of a previous study that suggested a variety of issues, such as nurse-related training
and the ambiguity of a policy on culturally competent care, were impediments to providing culturally respectful care.(Hashish et al., 2020) Owing to staffing issues and work stress, nurses have prioritized illness or crisis treatment over having the resources necessary to adequately address the cultural requirements of minorities. (Abubakari et al., 2024).

Language barriers

Patients and nursing staff reported that one of the biggest obstacles to building a strong rapport was communication difficulties (K. M. Almutairi, 2015) Most often, people said that the biggest obstacle to providing care for a varied range of patients and their families was language. Language was generally thought to be the biggest obstacle in the treatment process (Antón-Solanas et al., 2020) After analyzing several US studies on language barriers among Asian and Latino patients, Ramirez discovered that these barriers can have a number of detrimental effects, including a higher likelihood of non-compliance, depressive and anxious sentiments, and difficulties building rapport. Moreover, a major barrier to receiving care may be a patient's incapacity to comprehend and communicate in their doctor's language. His conclusions are corroborated by findings from a few European research, which demonstrate that low language competency has a negative relationship with patients' opinions of the effectiveness of doctor-patient communication as well as compliance. Poor language skills will undoubtedly impede effective doctor-patient communication (Douglas et al., 2014).

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Inadequate Training of cultural competence care (CCC).

Additional training inadequacies were shown to be a significant barrier to nurses' capacity to incorporate culturally appropriate care in this study. One of the organizational obstacles to cultural competency in hospice care is the absence of funds for nurse training, as was mentioned in a similar issue in Chicago, Illinois. (Hashish et al., 2020).

Lack of knowledge and skills regarding cultural competence care.

A lack of knowledge and skills to appropriately care for patients from varied backgrounds may experience by nurses who have not received adequate training in cultural competency. Insufficient training in cultural competency within the healthcare industry can hinder the provision of culturally appropriate care, leading to misinterpretations, inadequate treatment, and miscommunication (Hashish et al., 2020) Several nurses mentioned that neither they nor their coworkers knew enough about a variety of cultures (Hart & Mareno, 2014) In this case, staff were unaware of any barriers or that anyone was underserved. They had an inability to transcend stereotypes to understand what diverse clients and cultural groups really need and want. They had a lack of knowledge of other cultures, including beliefs about death and dying, and how to work within diverse belief systems to provide better awareness through public information sessions there was lack of knowledge about how to access resources, including written materials and videos for patients (Reese & Beckwith, 2015)

How to improve Barriers to culture competence care

Following are the strategies to improve culture competence care **Nurse receives professional Training**

Nurses receive professional training in treating patients with dignity and compassion. However, dealing with patients who have diverse demographics, ethnic backgrounds, and socioeconomic statuses have become more difficult for healthcare professionals in recent years, particularly for nurses (K. M. Almutairi, 2015) . Both certified nurses and student nurses should receive ongoing education and training in cultural competency (Bunjitpimol et al., 2015) Nurses must have the educational background necessary to deliver healthcare that is culturally sensitive. The information and abilities required to guarantee that nursing care is culturally appropriate will be

Included in international health care agendas that involve clinical training, formal education, and continual education for all professional nurses. (Douglas et al., 2014)

Understanding different cultures.

Understanding different cultures is essential for nurses to provide culturally sensitive care to their clients because different cultures have different conceptions of health and illness. This helps nurses better understand their patients' needs and prevents misunderstandings. (K. M. Almutairi, 2015) Numerous research on knowledge, attitudes, and practices have been conducted globally to date, but none on Pakistani nurses' awareness of cultural competency. Three district head quarter hospitals—D.G. Khan, Muzaffargarh, and Lahore, Pakistan—were used for this study's execution. The study's goal was to assess Punjab's three chosen hospitals' nurses' knowledge in providing culturally appropriate treatment. (A. F. Almutairi et al., 2017) It is imperative that nurses possess the requisite educational background to provide culturally competent healthcare. The knowledge and skills necessary to ensure that nursing care is suitable for the patient's culture will be incorporated into global health care objectives pertaining to formal education, ongoing education, and clinical training for all registered nurses. (Douglas et al., 2014)

Summary

Chapter 2 is about literature review. Previous studies are mentioned in this chapter. On the other hand, information about the search engines on which the studies are searched is mentioned. Previous studies reported that there are many barriers face by nursing staff to deliverer culture competence care among tertiary care hospital including language barriers lack of knowledge and skills regarding culture and culture competence care, inadequate training of culture competence care (CCC) factor related to nursing staff and hospital management policies regarding culture competence care

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This chapter examines current studies on the challenges nurses encounter in providing care that is culturally competent and how those challenges affect patient outcomes. Studies from a variety of contexts and cultural backgrounds are included in the review, with a special emphasis on tertiary hospitals in Peshawar, Pakistan. The primary obstacles found are: Lack of Policies That Are Relevant to Culture: Time restrictions and inadequate rules are major barriers to providing care that is culturally competent. Cost-cutting strategies increase the pressure on time and lower the standard of care. Knowledge and Training Deficits: One of the main obstacles is inadequate training in cultural competency. Many nurses are not equipped with the cultural awareness and management techniques needed to work well with patients from different backgrounds. Language Barriers: One of the biggest obstacles to building rapport and providing effective communication is language barrier The ability of nurses to deliver culturally competent care is severely hampered by inadequate training in cultural competency care (CCC). Important problems found include: Training Gaps: One of the main obstacles is a lack of training, which is made worse by organizational restraints such inadequate funds for nurse education. This problem has also been noted in other contexts, such as Chicago. information and Skill Deficiencies: As a result of insufficient CCC training, nurses frequently lack the information and abilities needed to provide patients from varied cultural backgrounds with effective treatment. Several nurses who noticed a lack of cultural knowledge among themselves and their coworkers pointed out that this leads to misinterpretations, inappropriate treatment, and miscommunication.

MATERIAL AND METHODOLOGY

Introduction:

This chapter details the research methods used for this quantitative cross-sectional study. As described earlier, the study explored the barriers to the delivery of culturally competent care among nurses in tertiary care hospitals in Peshawar. The chapter commences with a summary of the research design, aim and questions.

Study Design

Quantitative, descriptive cross-sectional study design was used.

Study Setting

The study setting was three tertiary hospitals in Peshawar, KPK, including Lady Reading Hospital, Khyber Teaching Hospital and Hayatabad Medical Complex, which are the most culturally and ethnically diverse hospitals in Peshawar. Patients from different races and cultures come here for treatments from healthcare providers from different cultures and races.

Study Duration

This study was completed in six months.

Study Population

The study population was consists of nurses who are culturally and ethnically diverse and work in three tertiary care hospitals in Peshawar. The total population is 1681 in the three tertiary cae hospitals.

Sample Size

The total sample at the selected hospitals is n = 313.So, using a sample calculator and taking a 95% confidence interval with a 5% margin of error, the sample size for the study is (n = 313).

Sampling Technique

A Random sampling technique was used to select participants from target settings.

Sample Selection

On the basis of inclusion and exclusion criteria

Inclusion Criteria

All nurses working for at least 3 months and registered with the Nursing and Midwifery Council of Peshawar for at least 3 months. Willing and consented to participate in the study.

Exclusion Criteria

All students and nursing interne, Nurses that are on leave from hospital.

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Data Collection

The data was collected through a structured questionnaire adapted from a published article, having three sections: demographic data, knowledge, and practice. A five-point Linkert scale was used to assess barriers that hindered nurses from rendering culturally competent care, where 1 = Strongly Disagree (SD) 2 = Disagree (D) 3 = Neutral (N) 4 = Agree (A) 5 = Strongly Agree (SA).

Data Analysis

The data was analyzed by descriptive statistics using tables, graphs, and presentations in the form of frequencies and percentages (%). SPSS (T-test) was used to establish an association between demographic data and nurses' knowledge and practices regarding barriers to the delivery of culturally competent care among nurses in tertiary care hospitals.

Ethical Consideration

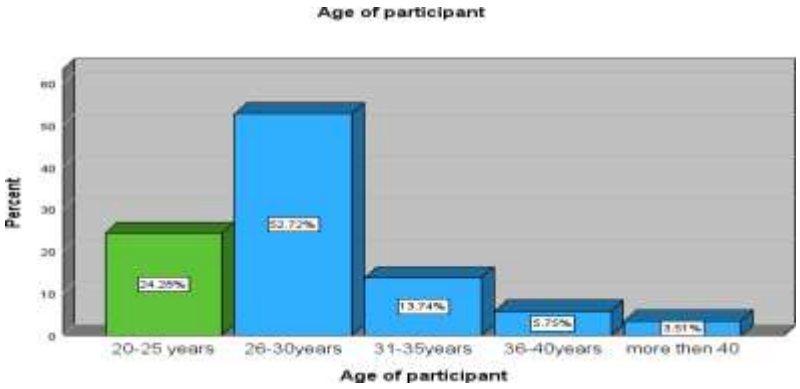
A written letter of permission was obtained from the Principal of Farkhanda Institute of Nursing and Public Health Gandhara University Peshawar for data collection. After gaining the permission letter we take permission from HMC, LRH AND KTH Hospitals Director. Written consent was taken from subjects for participation voluntarily and the right to refuse. The subjects' information and all data should be kept confidential, and data just be used for academic purposes was clearly written in the consent form

Summary of Methodology

The research methodology for a quantitative cross-sectional study that looked at nurses in Peshawar's tertiary hospitals' hurdles to providing culturally competent care is described in this chapter. The study was carried out over a period of six months at Lady Reading Hospital, Khyber Teaching Hospital, and Hayatabad Medical Complex using a descriptive cross-sectional methodology. 1,681 nurses made up the study population, and a sample size of 313 was established via statistical calculations. Individuals were chosen at random according to predetermined inclusion and exclusion standards. A standardized questionnaire with three sections— demographic, knowledge, and practice—that was scored on a five-point Likert scale was used to gather the data. Descriptive statistics and SPSS were used in the analysis to investigate relationships between demographic factors and obstacles to culturally competent treatment. Relevant authorities granted ethical approval, and participants provided written consent

CHAPTER FOUR RESULTS

In the chapter the research was document all relevant result of the study it was being display in graphs and tables forms for easily representing.



Graph: 01 Age of the Study Precipitants.

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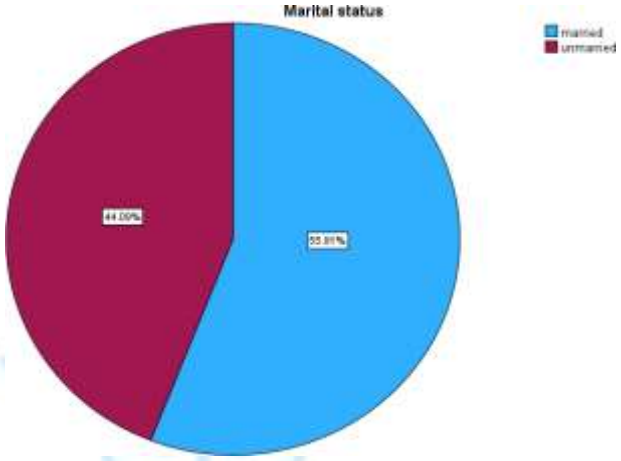
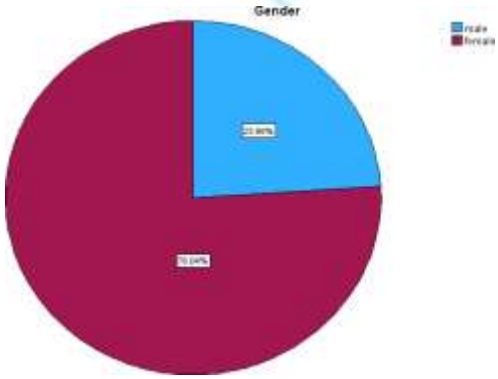
The above table showing that results shown a comprehensive breakdown of the age groups of the participants. The largest portion of respondents, making up 52.7% of the total sample, were in the 26-30 years category. Following this, 24.3% fell into the 20-25 years age group, making it the second largest segment. A smaller percentage, 13.7%, were in the 31-35 years range. Participants aged 36-40 years made up 5.8% of the total, while those over 40 years constituted the smallest group at 3.5%. These results indicate a predominantly youthful demographic among the survey participants, with a significant representation of individuals in their late twenties and early thirties.

Graph: 02: Marital status of study precipitants.



In the below graph No 02 the majority of the participants, 55.91% are married, while 44.91% are married. This shows a significant skew towards married participants in the study.

Graph: 03: Gender of the study precipitants.



The data from the above graph shows that among the 313 participants, 24.0% were male while 76.0% were female. This breakdown emphasizes a notable majority of female participants in the research.

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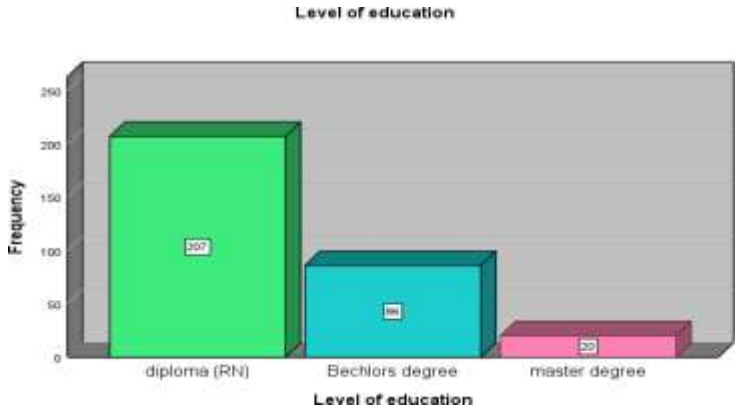
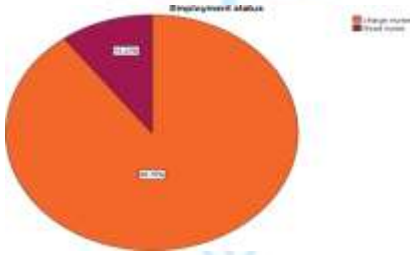
Graph: 04: Level of education of the study participants.



The above study revealed that out of 313 participants, 66.1% held a diploma (RN), 27.5% had a bachelor's degree, and 6.4% possessed a master's degree, providing insight into the educational achievements of the surveyed group.

Graph: 05: Employment status of the study participant.



According to the above survey results, 281 people (89.8%) or the majority of the 313 respondents hold the role of charge nurse. On the other hand, 32 respondents (10.2%) of the smaller group identified as head nurses. These results highlight the fact that charge nurses constituted the majority of the surveyed group, indicating a significant imbalance in the distribution of nursing roles.

Table: 06: Ethnic affiliation in the study of participants.

		Frequency	Percent	Valid Percent
Valid	Pushtoon	198	63.3	63.3
	chitrali	98	31.3	31.3
	christen	10	3.2	3.2
	others	7	2.2	2.2
	Total	313	100.0	100.0

In the above survey's data indicates that respondents' racial or cultural backgrounds are widely represented. 198 respondents, or 63.3 percent of the sample, identified as Pashtoon, while 98 respondents, or 31.3 percent, identified as Chitrali. Ten respondents, or 3.2% of the total, identified as Christians, while the remaining

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seven respondents, or 2.2% of the sample, were classified as "others." These findings show the diversity of identities among the participants and the wide range of ethnic composition within the population surveyed.

Table: 07: I focus more on patient's diseases rather than the cultural aspects of care during my day-to-day practice.

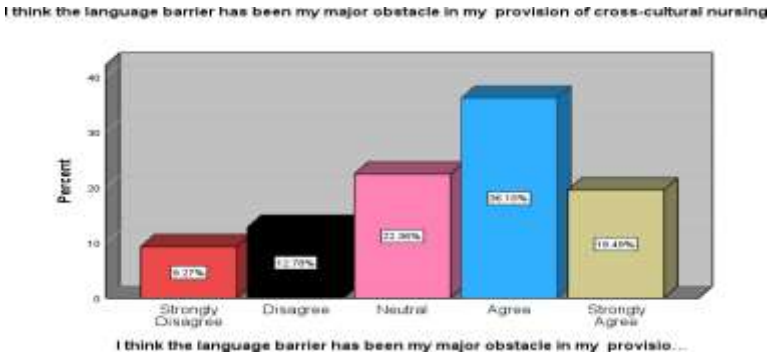
		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	20	6.4	6.4
	Disagree	30	9.6	9.6
	Neutral	44	14.1	14.1
	Agree	116	37.1	37.1
	Strongly Agree	103	32.9	32.9
	Total	313	100.0	100.0

In the above survey's findings show that the 313 participants' degrees of agreement with a given statement or problem varied. Significantly more respondents—116 people, or 37.1%—than disagreed with the statement, with fewer respondents—103, or 32.9%—strongly agreeing. By comparison, 20 respondents (6.4%) strongly disagreed, while 30 people (9.6%) disagreed. Furthermore, a neutral stance was indicated by 44 respondents (14.1%). These results show that the surveyed group held a variety of opinions, from strong agreement to disagreement, with a significant percentage taking a neutral stance.

Table: 08: I think the availability of a culturally diverse workforce will impact positively my ability to provide culturally congruent care.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	12	3.8	3.8
	Disagree	37	11.8	11.8
	Neutral	73	23.3	23.3
	Agree	153	48.9	48.9
	Strongly Agree	38	12.1	12.1
	Total	313	100.0	100.0

In the above survey show that 313 participants had varying opinions about a particular issue or statement. Out of the total respondents, 153 people (48.9%) indicated agreement with the statement, and 38 people (12.1%) indicated strong agreement. However, 12 respondents (3.8%) strongly disagreed, while 37 people (11.8%) disagreed. Furthermore, twenty-three (33.3%) of the participants took a neutral position. These findings demonstrate a range of opinions among the participants in the survey, with the majority indicating a tendency toward agreement but significant subgroups expressing disagreement or neutrality



Graph: 09: I think the language barrier has been my major obstacle in my provision of cross- cultural nursing.

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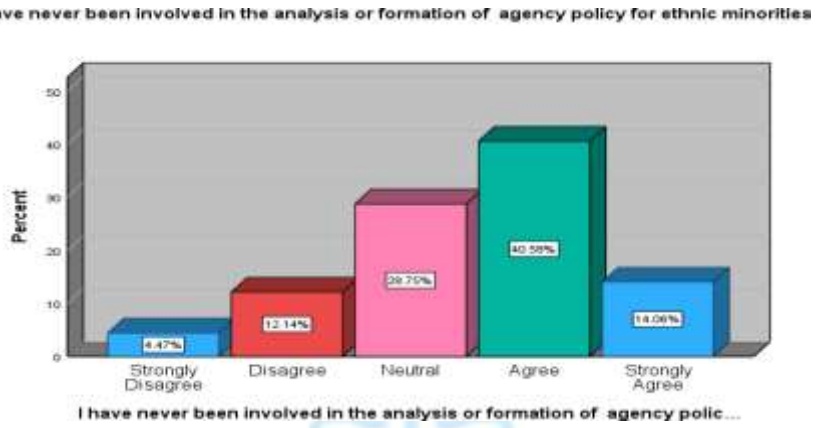
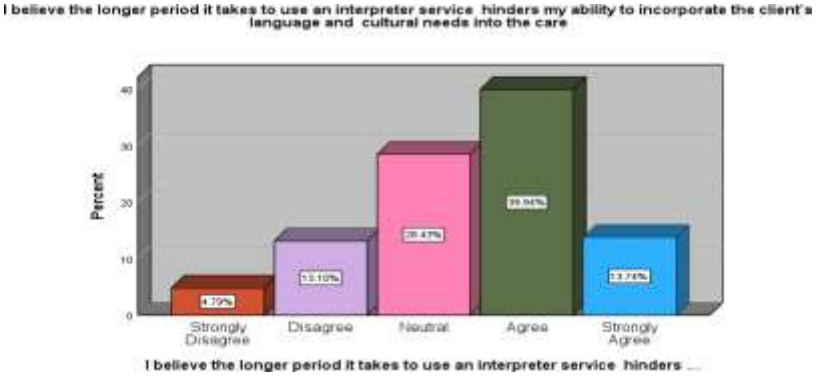
In the above graph the opinions of the 313 respondents to the survey show differing perspectives on a particular statement or problem. Among the participants, 113 people (36.1%) indicated agreement with the statement, and 61 respondents (19.5%) strongly agreed. On the other hand, 29 respondents (9.3%) strongly disagreed, while 40 people (12.8%) disagreed. Furthermore, 70 individuals (22.4%) selected a neutral position. These results highlight the range of viewpoints among the sample population; while a sizable majority of respondents tended to agree or strongly agree, there was also a sizable representation of non-agreers and neutral respondents.

Graph: 10: I have never been involved in the analysis or formation of agency policy for ethnic minorities.



In the above survey's findings show that the 313 participants' perspectives on a particular topic or assertion varied. A considerable percentage of respondents—127 people, or 40.6%—said they agreed with the statement, and 44 respondents, or 14.1%, strongly agreed. However, 14 respondents (4.5%) strongly disagreed, while 38 people (12.1%) disagreed. Furthermore, ninety- nine individuals (28.8%) chose to adopt a neutral position. These results show that the population under study held a variety of opinions, with the majority leaning toward agreement. Notable representations from those who disagree, strongly disagree, or had no opinion at all are included in the data.

Graph: 11: I believe the longer period it takes to use an interpreter service hinders my ability to incorporate the client's language and cultural needs into the care.



In the above graph the information gathered from the 313 respondents' survey shows a variety of viewpoints on a particular statement or problem. 43 respondents (13.7%) strongly agreed with the statement, making up a sizable portion of the sample—125 people, or 39.9%—who agreed. On the other hand, 15 respondents (4.8%)

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strongly disagreed, while 41 respondents (13.1%) disagreed. Furthermore, 89 people (28.4%) made the decision to stay neutral. These results highlight the diversity of opinions within the sample, with a sizable fraction disagreeing or remaining undecided juxtaposed with a noteworthy majority expressing agreement or strong agreement

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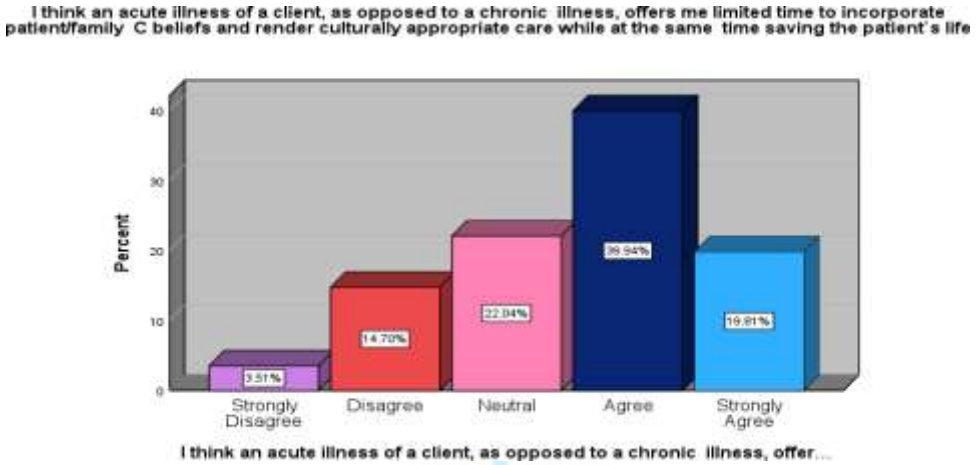
Graph:12: I think an acute illness of a client, as opposed to a chronic illness, offers me limited time to incorporate patient/family C beliefs and render culturally appropriate care while at the same time saving the patient's life.



In the above graph the opinions of 313 respondents regarding a particular statement or issue are reflected in the survey results. Among the respondents, 125 people (or 39.9%) indicated agreement with the statement, and 62 people (19.8%) strongly agreed. On the other hand, 11 respondents (3.5%) strongly disagreed, while 46 people (14.7%) disagreed. Furthermore, twenty-nine individuals (22.0%) chose to adopt a neutral position. These results demonstrate a variety of viewpoints among the sample population, with the majority indicating agreement or strong agreement and a significant portion expressing disagreement or neutrality

.

Table: 13: I feel my organization policies supports any initiatives to incorporate interventions that have been scientifically tested and noted to be most effective for culturally diverse populations.

Frequency			Percent	Valid Percent
Valid	Strongly Disagree	18	5.8	5.8
	Disagree	53	16.9	16.9
	Neutral	74	23.6	23.6
	Agree	114	36.4	36.4
	Strongly Agree	54	17.3	17.3
	Total	313	100.0	100.0

In the above table 313 respondents' survey results show different points of view on a particular statement or problem. Of the respondents, 114 people (36.4%) expressed agreement with the statement, and 54 people (17.3%) strongly agreed with it. On the other hand, 18 respondents (5.8%) strongly disagreed, while 53 respondents (16.9%) disagreed. Furthermore, twenty-four individuals (23.6%) selected a neutral position. These results highlight the range of opinions held by the participants in the survey, as most expressed agreement or strong agreement while a significant portion disagreed or remained neutral.

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Table: 14: I believe the rigid policies and procedures in my work environment- lack of flexibility do not create a better understanding of culturally and linguistically diverse patients (CALDs) and impact day-to-day activities and building therapeutic relationsh.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	17	5.4	5.4
	Disagree	56	17.9	17.9
	Neutral	85	27.2	27.2
	Agree	112	35.8	35.8
	Strongly Agree	43	13.7	13.7
	Total	313	100.0	100.0

In the above survey responses from 313 participants show a variety of viewpoints regarding a particular claim or problem. Notable numbers included 112 respondents (35.8%) who said they agreed, and 43 respondents (13.7%) who said they strongly agreed with the statement. On the other hand, 17 respondents (5.4%) strongly disagreed, while 56 people (17.9%) disagreed. Furthermore, twenty-five individuals (27.2%) chose to adopt a neutral position. These results demonstrate the range of opinions held by the participants in the survey, with a sizeable majority indicating agreement or strong agreement and a noteworthy representation from those who hold opposing or neutral opinions.

Table: 15: I feel my health facility offers me the structures and resources to analyze and accommodate the cultural and language needs of diverse patients.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	12	3.8	3.8
	Disagree	39	12.5	12.5
	Neutral	88	28.1	28.1
	Agree	128	40.9	40.9
	Strongly Agree	46	14.7	14.7
	Total	313	100.0	100.0

In the above table different viewpoints on a particular issue or statement are revealed by the survey data collected from 313 respondents. Of the respondents, 128 people (40.9%) expressed agreement with the statement, and 46 people (14.7%) strongly agreed with it. Conversely, 12 respondents (3.8%) strongly disagreed, while 39 people (12.5%) disagreed. Furthermore, 88 individuals (28.1%) selected a neutral position. These results highlight the diversity of opinions held by the participants in the survey; while the majority expressed agreement or strong agreement, there were also notable examples of disagreement, strong disagreement, and neutrality toward the subject matter.

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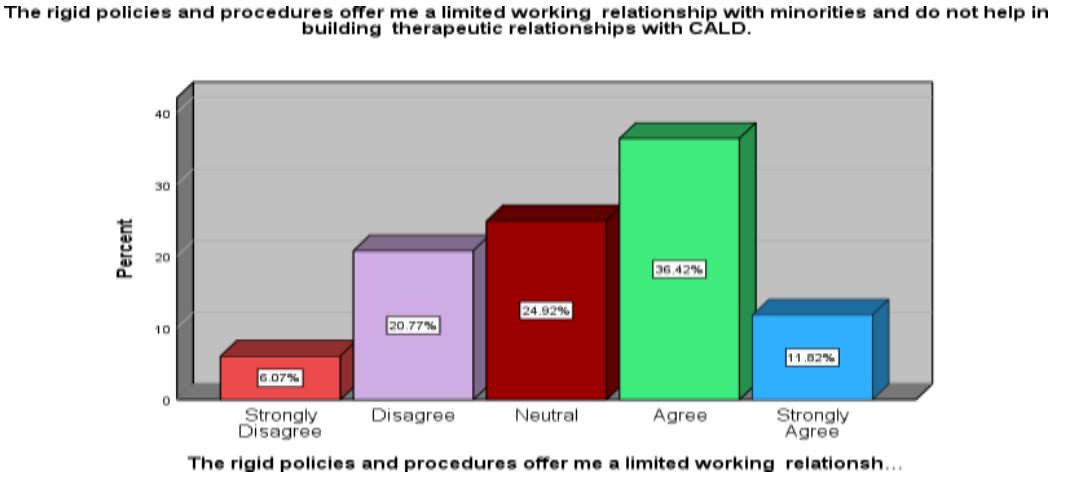
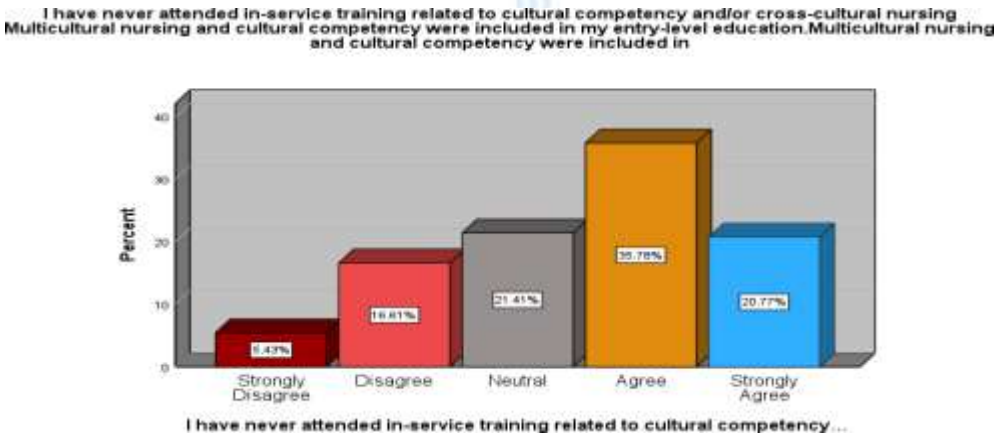
Graph:16: The rigid policies and procedures offer me a limited working relationship with minorities and do not help in building therapeutic relationships with CALD**.**



In the above graph 313 respondents' survey results show a variety of viewpoints on a particular statement or problem. 37 respondents (11.8%) strongly agreed with the statement, and 114 respondents (36.4%) agreed in a substantial percentage. In contrast, 19 respondents (6.1%) strongly disagreed, while 65 people (20.8%) disagreed. Furthermore, 78 individuals (24.9%) chose to adopt a neutral posture. These results demonstrate the diversity of opinions held by the participants in the survey, as most of them tended to be in agreement or strong agreement. There was also a noteworthy representation of disagreement, strong disagreement, and neutrality about the subject matter.

Graph: 17: I have never attended in-service training related to cultural competency and/or cross- cultural nursing Multicultural nursing and cultural competency were included in my entry-level education. Multicultural nursing and cultural competency were included in.



In the above graph the opinions of 313 respondents regarding a particular statement or issue are revealed in the survey results. Of the respondents, 112 people (35.8%) indicated agreement with the statement, and 65 people (20.8%) strongly agreed with it. On the other hand, 17 respondents (5.4%) strongly disagreed, while 52 respondents (16.6%) disagreed. Furthermore, twenty-seven individuals (21.4%) selected a neutral position. These results highlight the range of viewpoints held by the participants in the survey, with a

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considerable proportion expressing agreement or strong agreement and a noteworthy representation from those who disagree, strongly disagree, or have no opinion.

Graph: 18: The cultural competency training I have received was very inadequate in addressing practice gaps.

A variety of viewpoints on a particular statement or issue are presented in the survey results from 313 respondents. 42 respondents (13.4%) strongly agreed with the statement, while 106 respondents (33.9%) indicated agreement. In contrast, 15 respondents (4.8%) strongly disagreed, while 52 respondents (16.6%) disagreed. Furthermore, 98 individuals (31.3%) chose to adopt a neutral position. These results highlight the range of opinions held by the participants in the survey, with a considerable proportion expressing agreement or strong agreement and a noteworthy representation from those who disagree, strongly disagree, or have no opinion. The respondents' varied perspectives and complexity surrounding the topic are reflected in the balanced distribution across these categories.

Table:19: I use the services of a licensed medical interpreter whenever I encounter language barriers with patients during my work.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	21	6.7	6.7
	Disagree	61	19.5	19.5
	Neutral	92	29.4	29.4
	Agree	110	35.1	35.1
	Strongly Agree	29	9.3	9.3
	Total	313	100.0	100.0

In the above table 313 respondents to the survey expressed a range of opinions on a particular statement, with 110 (35.1%) agreeing and 29 (9.3%) strongly agreeing. On the other hand, 92 participants (29.4%) chose a neutral position, while 61 respondents (19.5%) disagreed and 21 (6.7%) strongly disagreed. These findings show a balanced range of viewpoints on the topic at hand, reflecting different points of view within the surveyed group.

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Table: 20: I do not think the organization I work for prioritizes culturally competent care and cross-cultural nursing.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	16	5.1	5.1
	Disagree	56	17.9	17.9
	Neutral	69	22.0	22.0
	Agree	123	39.3	39.3
	Strongly Agree	49	15.7	15.7
	Total	313	100.0	100.0

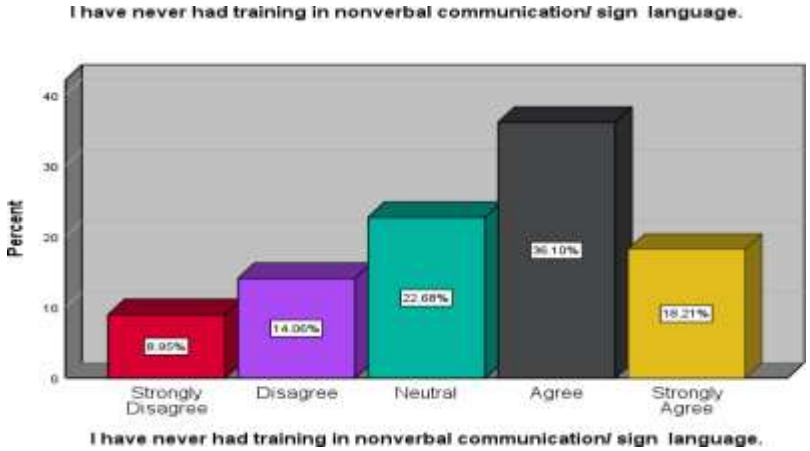
In the above table the survey data shows that people's opinions on the statement are not all the same. A sizable percentage of respondents—39.3% agreeing and 15.7% strongly agreeing— expressed agreement. On the other hand, a smaller percentage disagreed, making up 5.1% of those who strongly disagreed and 17.9% of those who disagreed. Notably, 22.0% took a neutral position. These results indicate that, while a sizeable minority of the surveyed population hold differing opinions, there appears to be a general tendency towards agreement with the statement. With 313 respondents in total, the sample size represented a wide range of viewpoints on the issue at hand.

Table: 21: I think the heavy client volumes negatively impact my ability to provide culturally appropriate care.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	26	8.3	8.3
	Disagree	54	17.3	17.3
	Neutral	65	20.8	20.8
	Agree	113	36.1	36.1
	Strongly Agree	55	17.6	17.6
	Total	313	100.0	100.0

In the above table the survey results show a range of opinions on the subject at hand. Of the 313 participants, the majority—36.1%—expressed agreement, with an additional 17.6% indicating strong agreement. On the other hand, 20.8% took a neutral stance. 17.3% of respondents disagreed, with 8.3% strongly disagreeing. The majority of respondents, or 53.7%, showed a positive inclination towards the topic overall, suggesting that the topic was generally well-received by the group that was surveyed.

Graph: 22: I have never had training in nonverbal communication/ sign language.



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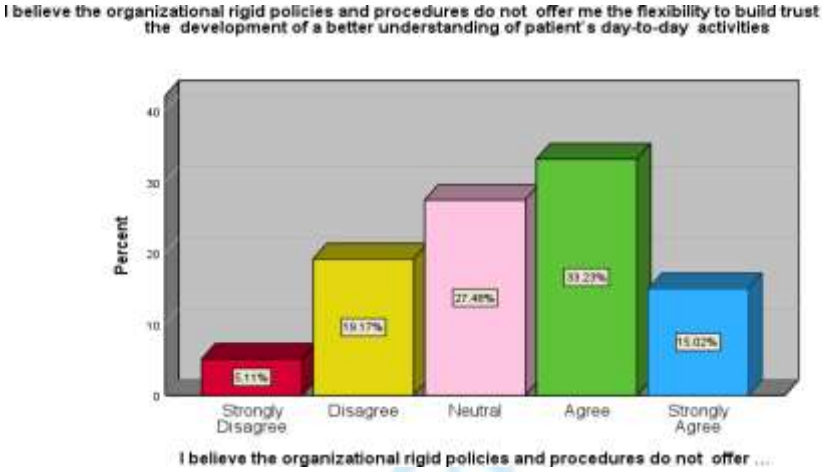
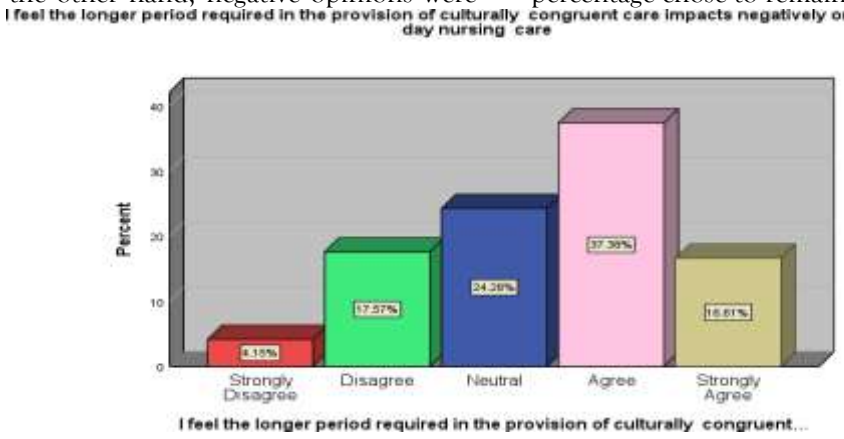
In the above graph the survey's findings show that the 313 respondents had a wide range of perspectives on the subject at hand. A significant percentage, consisting of 36.1%, indicated agreement, and another 18.2% strongly agreed with the topic. However, 22.7% took a neutral position, meaning they were neither in favor nor against. 14.1% of respondents disagreed, with 8.9% strongly disagreeing. Overall, 54.3% of respondents showed a positive attitude toward the subject, indicating that people who were surveyed generally had a positive opinion of it.

Graph: 23: I believe the organizational rigid policies and procedures do not offer me the flexibility to build trust and hinder the development of a better understanding of patient's day-to-day activities.



In the above graph the survey data presents a variety of perspectives on the subject matter from 313 respondents. A sizable percentage—33.2%—said they agreed, and 15.0% said they strongly agreed. On the other hand, 27.5% took a neutral position. 19.2% of respondents disagreed, with 5.1% strongly disagreeing. The majority of respondents, or 48.2%, had positive opinions overall about the subject, indicating that the group surveyed had a generally positive response.

Diverse perspectives on the subject matter are revealed by the survey responses obtained from 313 respondents. Positive opinions were expressed by a sizable majority, totaling 54% (37.4% agreeing and 16.6% strongly agreeing). On the other hand, negative opinions were held by 21.8% (17.6% disagreeing and 4.2% strongly disagreeing). Notably, 24.3% expressed no opinion. Overall, the data shows that most respondents had a positive opinion of the topic, though a sizable percentage chose to remain neutral or disagree



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In the above graph diverse perspectives on the subject matter are revealed by the survey responses obtained from 313 respondents. Positive opinions were expressed by a sizable majority, totaling 54% (37.4% agreeing and 16.6% strongly agreeing). On the other hand, negative opinions were held by 21.8% (17.6% disagreeing and 4.2% strongly disagreeing). Notably, 24.3% expressed no opinion. Overall, the data shows that most respondents had a positive opinion of the topic, though a sizable percentage chose to remain neutral or disagree.

Table: 25: I believe the shortage of nursing staff is negatively impacting my ability to deliver culturally appropriate care.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	14	4.5	4.5
	Disagree	36	11.5	11.5
	Neutral	54	17.3	17.3
	Agree	114	36.4	36.4
	Strongly Agree	95	30.4	30.4
	Total	313	100.0	100.0

In the above table the survey's findings show that the 313 participants had differing opinions on the subject at hand. Positive opinions were expressed by a sizable majority, consisting of 66.8% (36.4% agreeing and 30.4% strongly agreeing). On the other hand, 15.9% expressed negative opinions (11.5% disagreeing and 4.5% strongly disagreeing). Notably, 17.3% stayed indifferent. Overall, the data shows that the surveyed group had a generally positive attitude toward the topic, with a sizable portion agreeing or strongly agreeing, and a minority expressing disagreement or neutrality.

Table: 26: I have not had any Pashto language training.

		Frequency	Percent	Valid Percent
Valid	Strongly Disagree	35	11.2	11.2
	Disagree	46	14.7	14.7
	Neutral	49	15.7	15.7
	Agree	94	30.0	30.0
	Strongly Agree	89	28.4	28.4
	Total	313	100.0	100.0

In the above table a variety of viewpoints on the subject are highlighted by the 313 survey respondents' responses. Positive sentiment was expressed by a sizable portion, totaling 58.4% (30.0% agreeing and 28.4% strongly agreeing). On the other hand, negative opinions were held by 26.9% (14.7% disagreeing and 11.2% strongly disagreeing). 15.7% of respondents said they had no opinion. Overall, the data points to a slightly positive but balanced inclination towards the subject among those surveyed, with a notable minority expressing disagreement or neutrality and a significant majority agreeing or strongly agreeing.

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One-Sample Test						
	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
I focus more on patient's diseases rather than the cultural aspects of care during my day-to-day practice	57.005	312	.000	3.805	3.67	3.94
I think the availability of a culturally diverse workforce will impact positively my ability to provide culturally congruent care	63.829	312	.000	3.537	3.43	3.65
I think the language barrier has been my major obstacle in my provision of cross-cultural nursing	50.472	312	.000	3.438	3.30	3.57
I have never been involved in the analysis or formation of agency policy for ethnic minorities	60.156	312	.000	3.476	3.36	3.59
I believe the longer period it takes to use an interpreter service hinders my ability to incorporate the client's language and cultural needs into the care	58.824	312	.000	3.447	3.33	3.56
I think an acute illness of a client, as opposed to a chronic illness, offers me limited time to incorporate patient/family C beliefs and render culturally appropriate care while at the same time saving the patient's life	59.072	312	.000	3.578	3.46	3.70
I feel my organization policies supports any initiatives to incorporate interventions that have been scientifically tested and noted to be most effective for culturally diverse populations.	53.616	312	.000	3.425	3.30	3.55

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I believe the rigid policies and procedures in my work environment- lack of flexibility do not create a better understanding of culturally and linguistically diverse patients (CALDs) and impact day-to-day activities and building therapeutic relationsh	54.290	312	.000	3.345	3.22	3.47
I feel my health facility offers me the structures and resources to analyze and accommodate the cultural and language needs of diverse patients	61.147	312	.000	3.502	3.39	3.61
The rigid policies and procedures offer me a limited working relationship with minorities and do not help in building therapeutic relationships with CALD.	52.452	312	.000	3.272	3.15	3.39
I have never attended in-service training related to cultural competency and/or cross-cultural nursing Multicultural nursing and cultural competency were included in my entry-level education.Multicultural nursing and cultural competency were included in	53.714	312	.000	3.498	3.37	3.63
The cultural competency training I have received was very inadequate in addressing practice gaps	55.976	312	.000	3.345	3.23	3.46
I use the services of a licensed medical interpreter whenever I encounter language barriers with patients during my work	53.015	312	.000	3.208	3.09	3.33

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I do not think the organization I work for prioritizes culturally competent care and cross-cultural nursing.	54.726	312	.000	3.425	3.30	3.55
I think the heavy client volumes negatively impact my ability to provide culturally appropriate care	49.852	312	.000	3.374	3.24	3.51
I have never had training in nonverbal communication/ sign language.	50.426	312	.000	3.406	3.27	3.54
I believe the organizational rigid policies and procedures do not offer me the flexibility to build trust and hinder the development of a better understanding of patient's day-to-day activities	53.514	312	.000	3.339	3.22	3.46
I feel the longer period required in the provision of culturally congruent care impacts negatively on my day-to-day nursing care	56.052	312	.000	3.447	3.33	3.57
I believe the shortage of nursing staff is negatively impacting my ability to deliver culturally appropriate care	58.711	312	.000	3.767	3.64	3.89

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I have not had any Pushto language training	46.271	312	.000	3.498	3.35	3.65

The table you've provided presents descriptive statistics for various statements regarding cultural competency in nursing practice. Here's a summary of the key results:

- **Focus on Patient's Diseases vs. Cultural Aspects**: With a mean score of 3.81 (SD = 1.181), respondents slightly agree that they focus more on patient diseases than cultural aspects in their daily practice.
- **Impact of a Culturally Diverse Workforce**: The mean score of 3.54 (SD = 0.980) indicates moderate agreement that a culturally diverse workforce positively impacts the ability to provide culturally congruent care.
- **Language Barrier as an Obstacle**: Respondents moderately agree that the language barrier is a significant obstacle in providing cross-cultural nursing, with a mean score of
- 3.44 (SD = 1.205).
- **Involvement in Policy Formation for Ethnic Minorities**: The mean score of 3.48 (SD
- = 1.022) reflects moderate agreement that respondents have not been involved in the analysis or formation of agency policies for ethnic minorities.
- **Interpreter Service Hindrance**: A mean score of 3.45 (SD = 1.037) suggests moderate agreement that delays in interpreter services hinder the ability to incorporate cultural needs into patient care.
- **Limited Time for Cultural Care in Acute Illness**: The mean score of 3.58 (SD = 1.072) indicates moderate agreement that acute illness limits the time available to incorporate cultural beliefs into care.
- **Organizational Support for Culturally Diverse Interventions**: Respondents are neutral to slightly agree that their organization's policies support initiatives for culturally diverse interventions, with a mean score of 3.42 (SD = 1.130).
- **Rigid Policies Affecting Therapeutic Relationships**: A mean score of 3.35 (SD = 1.090) shows moderate agreement that rigid policies hinder understanding and therapeutic relationships with culturally and linguistically diverse patients.
- **Resources for Cultural and Language Needs**: Respondents moderately agree that their facility offers resources to accommodate cultural and language needs, with a mean score of 3.50 (SD = 1.013).
- **Impact of Heavy Client Volumes**: The mean score of 3.37 (SD = 1.197) suggests moderate agreement that heavy client volumes negatively impact the ability to provide culturally appropriate care.
- **Shortage of Nursing Staff**: A relatively high mean score of 3.77 (SD = 1.135) indicates a moderate to strong agreement that nursing staff shortages negatively impact the delivery of culturally appropriate care.

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Paired Samples Statistics between every variable					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Marital status	1.44	313	.497	.028
	Level of education	1.40	313	.608	.034
Pair 2	Employment status	1.10	313	.303	.017
	Ethnic affiliation	1.44	313	.668	.038
Pair 3	I focus more on patient's diseases rather than the cultural aspects of care during my day-to-day practice	3.81	313	1.181	.067
	I think the availability of a culturally diverse workforce will impact positively my ability to provide culturally congruent care	3.54	313	.980	.055
Pair 4	I think the language barrier has been my major obstacle in my provision of cross-cultural nursing	3.44	313	1.205	.068
	I have never been involved in the analysis or formation of agency policy for ethnic minorities	3.48	313	1.022	.058
Pair 5	I believe the longer period it takes to use an interpreter service hinders my ability to incorporate the client's language and cultural needs into the care	3.45	313	1.037	.059
	I think an acute illness of a client, as opposed to a chronic illness, offers me limited time to incorporate patient/family C beliefs and render culturally appropriate care while at the same time saving the patient's	3.58	313	1.072	.061

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	life				
Pair 6	I have never been involved in the analysis or formation of agency policy for ethnic minorities	3.48	313	1.022	.058
	I think the language barrier has been my major obstacle in my provision of cross-cultural nursing	3.44	313	1.205	.068
Pair 7	I believe the longer period it takes to use an interpreter service hinders my ability to incorporate the client's language and cultural needs into the care	3.45	313	1.037	.059
	I use the services of a licensed medical interpreter whenever I encounter language barriers with patients during my work	3.21	313	1.070	.061
	I feel my organization policies supports any initiatives to incorporate interventions that have been scientifically tested and noted to be most effective for culturally diverse populations.	3.42	313	1.130	.064
	I believe the rigid policies and procedures in my work environment- lack of flexibility do not create a better understanding of culturally and linguistically diverse patients (CALDs) and impact day-to-day activities and building therapeutic relationsh	3.35	313	1.090	.062

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Pair 9	I feel my health facility offers me the structures and resources to analyze and accommodate the cultural and language needs of diverse patients	3.50	313	1.013	.057
	The rigid policies and procedures offer me a limited working relationship with minorities and do not help in building therapeutic relationships with CALD.	3.27	313	1.103	.062
Pair 10	I have never attended in-service training related to cultural competency and/or cross-cultural nursing Multicultural nursing and cultural competency were included in my entry-level education. Multicultural nursing and cultural competency were included in	3.50	313	1.152	.065
	The cultural competency training I have received was very inadequate in addressing practice gaps	3.35	313	1.057	.060
Pair 12	I use the services of a licensed medical interpreter whenever I encounter language barriers with patients during my work	3.21	313	1.070	.061
	I do not think the organization I work for prioritizes culturally competent care and cross-cultural nursing.	3.42	313	1.107	.063

These results reflect the perceptions of nurses regarding various aspects of cultural competency and the challenges they face in providing culturally congruent care in their practice. The standard deviations indicate varying degrees of agreement or disagreement among respondents.

The Paired Samples Statistics table provides descriptive statistics for pairs of related variables The pairs and their statistics:

Pair 1: Marital Status vs. Level of Education

- **Marital Status**: Mean = 1.44, N = 313, SD = 0.497, SE = 0.028
- **Level of Education**: Mean = 1.40, N = 313, SD = 0.608, SE = 0.034

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Interpretation: Both marital status and level of education have relatively low means, suggesting that respondents are more likely to have similar responses for these variables. The standard deviations indicate moderate variability, with education showing slightly higher variability.

Pair 2: Employment Status vs. Ethnic Affiliation

- **Employment Status**: Mean = 1.10, N = 313, SD = 0.303, SE = 0.017
- **Ethnic Affiliation**: Mean = 1.44, N = 313, SD = 0.668, SE = 0.038

Interpretation: Employment status has a much lower mean than ethnic affiliation, indicating that respondents may be more homogenous in their employment status. Ethnic affiliation shows higher variability.

Pair 3: Focus on Diseases vs. Cultural Workforce Impact

- **Focus on Diseases**: Mean = 3.81, N = 313, SD = 1.181, SE = 0.067
- **Cultural Workforce Impact**: Mean = 3.54, N = 313, SD = 0.980, SE = 0.055

Interpretation: Respondents tend to agree more with focusing on patient diseases than the impact of a culturally diverse workforce, with a higher mean for the former. The standard deviations suggest moderate variability in responses for both variables.

Pair 4: Language Barrier vs. Policy Formation

- **Language Barrier**: Mean = 3.44, N = 313, SD = 1.205, SE = 0.068
- **Policy Formation**: Mean = 3.48, N = 313, SD = 1.022, SE = 0.058

Interpretation: The means for language barrier and policy formation are very close, indicating similar levels of agreement among respondents. The language barrier has slightly higher variability.

Pair 5: Interpreter Service vs. Acute Illness and Cultural Care

- **Interpreter Service**: Mean = 3.45, N = 313, SD = 1.037, SE = 0.059
- **Acute Illness and Cultural Care**: Mean = 3.58, N = 313, SD = 1.072, SE = 0.061

Interpretation: There is a slight preference for focusing on acute illness and cultural care over concerns with interpreter services, reflected in the higher mean for the former. The standard deviations are similar, indicating comparable variability.

Pair 6: Policy Formation vs. Language Barrier

- **Policy Formation**: Mean = 3.48, N = 313, SD = 1.022, SE = 0.058
- **Language Barrier**: Mean = 3.44, N = 313, SD = 1.205, SE = 0.068

Interpretation: This pair is a repetition of Pair 4, with the same mean, standard deviation, and standard error values, showing consistency in responses.

Pair 7: Interpreter Service vs. Use of Medical Interpreter

- **Interpreter Service**: Mean = 3.45, N = 313, SD = 1.037, SE = 0.059
- **Use of Medical Interpreter**: Mean = 3.21, N = 313, SD = 1.070, SE = 0.061

Interpretation: Respondents slightly agree more with the impact of interpreter services than with actually using a licensed medical interpreter, with a lower mean for the latter. The standard deviations are similar.

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Pair 8: Organizational Policy Support vs. Rigid Policies

- **Organizational Policy Support**: Mean = 3.42, N = 313, SD = 1.130, SE = 0.064
- **Rigid Policies**: Mean = 3.35, N = 313, SD = 1.090, SE = 0.062

Interpretation: Respondents have a slightly higher mean for organizational policy support compared to the perception of rigid policies. The variability in responses is comparable.

Pair 9: Health Facility Support vs. Rigid Policies

- **Health Facility Support**: Mean = 3.50, N = 313, SD = 1.013, SE = 0.057
- **Rigid Policies**: Mean = 3.27, N = 313, SD = 1.103, SE = 0.062

Interpretation: There is a moderate agreement that health facilities provide support for cultural and language needs, with a higher mean than the perception of rigid policies hindering relationships. The standard deviations indicate moderate variability.

Pair 10: Cultural Competency Training vs. Addressing Practice Gaps

- **Cultural Competency Training**: Mean = 3.50, N = 313, SD = 1.152, SE = 0.065
- **Addressing Practice Gaps**: Mean = 3.35, N = 313, SD = 1.057, SE = 0.060

Interpretation: Respondents slightly agree more with the inclusion of cultural competency training in their education than with the adequacy of this training in addressing practice gaps. The variability in responses is similar.

Pair 11: Use of Medical Interpreter vs. Organizational Priority on Cultural Care

- **Use of Medical Interpreter**: Mean = 3.21, N = 313, SD = 1.070, SE = 0.061
- **Organizational Priority on Cultural Care**: Mean = 3.42, N = 313, SD = 1.107, SE = 0.063
-

Interpretation: There is a slight preference for believing that the organization does not prioritize culturally competent care, with a higher mean for this statement compared to the actual use of medical interpreters. The standard deviations suggest similar variability in responses.

Overall, these statistics provide insights into respondents' perceptions of various aspects related to cultural competency in nursing, revealing both similarities and differences in their views across different paired variables.

SUMMARY OF RESULT

Graph 01: Age of Study Participants

The largest age group among the participants was 26-30 years old, representing 52.7% of the total sample. Following this, 24.3% were aged 20-25 years, 13.7% were 31-35 years old, 5.8% were 36-40 years, and only 3.5% were over 40 years old. This indicates a predominantly youthful demographic, with most respondents in their late twenties and early thirties.

Graph 02: Marital Status of Study Participants

The marital status data reveals that 55.9% of the participants were married, while 44.1% were unmarried, showing a slight majority of married individuals in the study.

Graph 03: Gender of Study Participants

Among the 313 participants, 24.0% were male, while 76.0% were female, highlighting a significant majority of female respondents.

Graph 04: Educational Level of Study Participants

The study revealed that 66.1% of the participants held a diploma (RN), 27.5% had a bachelor's degree, and 6.4% had a master's degree, indicating a strong prevalence of diploma holders among the group.

Graph 05: Employment Status of Study Participants

The majority of respondents, 89.8%, identified as charge nurses, while 10.2% were head nurses. This suggests a significant imbalance in nursing roles among the participants.

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Table 06: Ethnic Affiliation of Study Participants
The data shows that 63.3% of respondents were Pashtoon, 31.3% were Chitrali, 3.2% were Christians, and 2.2% were classified as "others," reflecting the ethnic diversity among participants.

Table 07: Focus on Disease vs. Cultural Aspects of Care
Participants showed varied responses regarding their focus on patients' diseases over cultural aspects of care. A total of 37.1% strongly agreed with the focus on disease, while 32.9% strongly disagreed. Neutral responses accounted for 14.1%, indicating a diversity of opinions on this issue.
Table 08: Impact of Culturally Diverse Workforce
The majority of participants (48.9%) agreed that a culturally diverse workforce positively impacts their ability to provide culturally congruent care, with 12.1% strongly agreeing, 11.8% disagreeing, and 3.8% strongly disagreeing.

Graph 09: Language Barrier in Cross-Cultural Nursing
The survey showed that 36.1% of participants agreed that language barriers are a significant obstacle, with 19.5% strongly agreeing. Neutral responses accounted for 22.4%, highlighting a broad spectrum of opinions.

Graph 10: Involvement in Agency Policy for Ethnic Minorities
Most participants (40.6%) agreed they had never been involved in policy formation for ethnic minorities, with 14.1% strongly agreeing, 28.8% neutral, 12.1% disagreeing, and 4.5% strongly disagreeing.

Graph 11: Impact of Interpreter Services on Care
The data revealed that 39.9% of participants agreed that the longer period required to use interpreter services hinders their ability to meet patients' cultural and linguistic needs, with 13.7% strongly agreeing, 28.4% neutral, and 13.1% disagreeing.

Graph 12: Acute vs. Chronic Illness and Cultural Care
Among respondents, 39.9% agreed that acute illness limits their ability to incorporate cultural care, with 19.8% strongly agreeing. Neutral responses were 22.0%, and 14.7% disagreed.

Table 13: Organizational Support for Culturally Diverse Care
The results indicate that 36.4% agreed their organization supports culturally diverse care, with 17.3% strongly agreeing, 23.6% neutral, 16.9% disagreeing, and 5.8% strongly disagreeing.

Table 14: Organizational Policies and Flexibility in Cultural Care
35.8% of participants agreed that rigid organizational policies limit their ability to understand culturally and linguistically diverse patients, with 13.7% strongly agreeing, 27.2% neutral, and 17.9% disagreeing.

Table 15: Organizational Structures Supporting Cultural Needs
The majority of participants (40.9%) agreed their organization provides the necessary structures and resources to accommodate cultural and language needs, with 14.7% strongly agreeing, 28.1% neutral, and 12.5% disagreeing.
Graph 16: Impact of Organizational Policies on Therapeutic Relationships
The data shows that 36.4% of participants agreed that rigid policies negatively impact their ability to build therapeutic relationships with minority groups, with 11.8% strongly agreeing, 24.9% neutral, and 20.8% disagreeing.

Graph 17: Training in Cultural Competency
In the survey, 35.8% agreed that they had never attended in-service training on cultural competency, with 20.8% strongly agreeing, 21.4% neutral, and 16.6% disagreeing.

Graph 18: Inadequacy of Cultural Competency Training
The survey revealed that 33.9% of participants agreed that their training in cultural competency was inadequate, with 13.4% strongly agreeing, 31.3% neutral, and 16.6% disagreeing.

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DISCUSSION

In this discussion chapter, we will carefully examine and interpret the results of our research project, which aimed to identify the barriers to delivery culturally competent care among nurses

.That nurses encounter when trying to deliver care that is sensitive to the cultural backgrounds of their patients at a large hospital in Peshawar. We will then place our findings within the context of existing knowledge on this topic, by comparing and contrasting them with the results of previous studies. This will enable us to see how our research contributes to the broader understanding of this issue, where it agrees or disagrees with previous findings, and what new perspectives or insights it might offer.

he survey participants are mostly young, with over half (52.7%) aged 26 to 30 and nearly a quarter (24.3%) aged 20 to 25. Only 13.7% are between 31 and 35, and 3.5% are over 40. Most respondents (55.91%) are married, 44.91% are single, with a significant majority (76.0%) being female. Regarding education, 66.1% have an RN diploma, 27.5% hold a bachelor's degree, and 6.4% have a master's degree. Ethnically, 63.3% identify as Pashtoon, 31.3% as Chitrali, 3.2% as Christian, and 2.2% as "other."

The first major barrier to providing culturally competent care identified in this study was that nurses tend to focus more on the patient's disease rather than the cultural aspects of care, with 69% of participants agreeing.

I realize that in Ganna the study highlighted key barriers to delivering culturally competent care, with the most significant being the emphasis on patients' diseases over their cultural needs in everyday practice. This approach often overlooks the cultural context of care, pointing to the

necessity for a more integrated method that balances medical treatment with cultural sensitivity.(Abubakari et al., 2024b)

In our study Nursing Staff Shortage emerged as the second significant factor, with 66% of participants acknowledging that it hinders their ability to deliver culturally appropriate care, highlighting a critical issue that needs addressing to ensure patients receive adequate care

Summary

Same in the United States of America: The study found that the prolonged nursing staff shortages adversely affect care quality and can lead to poor patient outcomes. Persistent inadequate staffing undermines care effectiveness, raising the risk of negative impacts on patients. The study emphasizes the crucial need to sustain appropriate staffing levels to maintain high care standards. Without sufficient staffing, patient experience and safety may be notably compromised. (Janiszewski Goodin, 2003)

In our study Participants also noted that dealing with acute illness, as opposed to chronic conditions, limits their time to incorporate patient and family cultural beliefs while simultaneously saving the patient's life, with 59% agreeing this is a third major barrier

In a level one trauma ICU, balancing urgent medical needs with cultural respect is challenging. The critical condition of patients limits time for cultural considerations, creating ethical dilemmas. As a result, immediate life-saving efforts often overshadow cultural practices.(Janiszewski Goodin, 2003)

Lastly, a lack of training in language skills was the fourth most prominent barrier, with 58% of participants indicating that it is a significant obstacle in cross-cultural nursing, emphasizing the importance of effective communication strategies.

Language skills are vital in transcultural nursing for effective patient and colleague communication. Despite a noted lack of language training in nursing education, students are enhancing their cultural competence by learning about and engaging with diverse cultures. Increased experience with various cultures helps nurses better manage transcultural challenges.

This study also identified several other barriers to culturally competent care. A lack of in-service training related to cultural competency was reported by 56% of participants,

The study shows that nurses with cultural competence training score higher, yet there's a significant gap in such training. This gap may limit their ability to offer culturally sensitive care. Variations by education and experience levels emphasize the need for integrating cultural competence training in nursing education and professional development.

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In our study while 55% cited language barriers as a significant challenge.

Nurses recognized language barriers as a significant problem. These included patients having trouble understanding key information and medical terminology, challenges with the complex Japanese language, and responding to questions without full comprehension. Additionally, nurses were worried about how well patients were grasping the information provided.(Kamau et al., 2023)

Similarly, 55% of respondents stated that they use licensed medical interpreters when facing language difficulties with patients. In emergency situations, if a bilingual nurse is not available, family members, friends, or other bilingual staff can assist with communication. However, it's
important to quickly confirm the information with a professional interpreter to ensure it is accurate.(Mihu et al., 2024)

Additionally, 55% of participants felt that their organization does not prioritize culturally competent care

Hospital-based cultural competence courses not only enhance nurses' cultural competence but also focus on improving their cultural intelligence and intercultural communication skills. These skills are vital for forming effective therapeutic relationships with multicultural patients and their families indicating a systemic issue. Finally, 54% highlighted the lack of training in nonverbal communication, such as sign language, as another obstacle. These are some other barriers and point to the need for better training and organizational support to improve culturally competent care.

Healthcare providers require training in essential verbal and nonverbal communication skills, along with situational and self-awareness. They must also be adaptable and knowledgeable about relevant issues. Such training helps them interact effectively with diverse patients and manage different scenarios. (Baratipour et al., 2022)

This chapter investigates the obstacles to delivering culturally competent care among nurses at a major hospital in Peshawar. The survey indicates that the majority of participants are young, female, and hold an RN diploma, with diverse ethnic backgrounds. Significant barriers include an emphasis on treating medical conditions rather than addressing cultural needs, as reported by 69% of nurses. Staffing shortages are a major concern for 66% of respondents, impacting the ability to provide culturally sensitive care. Additionally, 59% of nurses find it difficult to balance urgent medical needs with cultural considerations. A lack of language skills training is noted by 58% as
a key issue. Other challenges include inadequate in-service cultural training for 56% of participants and insufficient organizational support. The results highlight the urgent need for better training in communication and cultural competence.

Conclusion:

In conclusion, this study highlights several critical barriers to delivering culturally competent care among nurses, both in Peshawar and the United States. Key challenges include prolonged nursing staff shortages, which compromise care quality and patient outcomes, and the difficulty of balancing urgent medical needs with cultural considerations, particularly in high-pressure environments like trauma ICUs. Language barriers and a lack of training in both verbal and nonverbal communication further hinder nurses' ability to provide culturally sensitive care. The findings emphasize the necessity of sustained staffing levels, enhanced cultural competence training, and organizational support to ensure that healthcare providers can effectively address the diverse cultural needs of their patients. Addressing these barriers is essential for improving patient experience, safety, and the overall quality of care in multicultural healthcare settings

- **Recommendations**
- **Cultural Training**: Regular workshops on cultural competence.
- **Language Support**: Interpretation services and multilingual materials.
- **Diverse Workforce**: Recruit and retain nurses from various backgrounds.
- **Patient-Centered Care**: Encourage asking about patients' cultural beliefs.
- **Mentorship**: Pair experienced nurses with diverse backgrounds for guidance.

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Limitation

Limited demographic representation: The study may not have had a diverse range of participants , which can limit the applicability of the findings to different demographic groups.

- Cross-sectional design: The study was conducted at a single point in time, which can make it difficult to establish cause-and-effect relationships.
- Limited generalizability: The study was conducted in a specific setting or population, which can limit the generalizability of the findings to other settings or populations

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PARTICIPANT INFORMATION SHEET

Annexure I Data collection instrument

Annexure II (b): Informed Consent Form INFORMED CONCENT FORM

TITLE OF STUDY

Barriers to delivery of culturally competent care among nurses in a tertiary care hospital in Peshawar cross-sectional study

PURPOSE OF STUDY

The purpose of this research study is to examine the Barriers to culturally competence care of nursing staff in tertiary care hospital Peshawar

VOLUNTARY PARTICIPATION:

Your participation in this study is voluntary. If you decide to take part in this study, you will be asked to sign a consent form. Your decision to participate or decline participation will not affect your current or future relationship with affiliated institutions.

CONSENT:

I have read and understand the information provided above. I voluntarily agree to participate in this study
and consent to the collection and use of my data for research purposes.
Participant's signature _____Date _____
Investigator's signature _____Date _____

By signing this form, you are granting your informed consent to participate in the interview. Your privacy and confidentiality will be upheld throughout the research process. Thank you for your participation.
The questions was quantified by a validated Likert scale questionnaire consisted of 21 questions. Each questionnaire item had 5 possible Reponses of 1=Strongly Disagree (SD) 2=Disagree (D). 3=Neutral (N). 4=Agree (A). 5=Strongly Agree (A).

Questionaries

1. I focus more on patient's diseases rather than the cultural aspects of care during my day-to- day practice
2. I think the availability of a culturally diverse workforce will impact positively my ability to provide culturally congruent care
3. I think the language barrier has been my major obstacle in my provision of cross-cultural nursing
4. I have never been involved in the analysis or formation of agency policy for ethnic minorities
5. I believe the longer period it takes to use an interpreter service hinders my ability to incorporate the client's language and cultural needs into the care.
6. I think an acute illness of a client, as opposed to a chronic illness, offers me limited time to

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incorporate patient/family C beliefs and render culturally appropriate care while at the same time saving the patient's life.

7. I feel my organization policies supports any initiatives to incorporate interventions that have been scientifically tested and noted to be most effective for culturally diverse populations.

8. I believe the rigid policies and procedures in my work environment- lack of flexibility do not create a better understanding of culturally and linguistically diverse patients (CALDs) and impact day-to-day activities and building therapeutic relationships.

9. I feel my health facility offers me the structures and resources to analyze and accommodate the cultural and language needs of diverse patients.

10. The rigid policies and procedures offer me a limited working relationship with minorities and do not help in building therapeutic relationships with CALD.

11. I have never attended in-service training related to cultural competency and/or cross-cultural nursing Multicultural nursing and cultural competency were included in my entry-level education.

12. Multicultural nursing and cultural competency were included in my entry-level education.

13. The cultural competency training I have received was very inadequate in addressing practice gaps

14. I use the services of a licensed medical interpreter whenever I encounter language barriers with patients during my work

15. I do not think the organization I work for prioritizes culturally competent care and cross-cultural nursing.

16. I think the heavy client volumes negatively impact my ability to provide culturally appropriate care

17. I have never had training in nonverbal communication/ sign language.

18. I believe the organizational rigid policies and procedures do not offer me the flexibility to build trust and hinder the development of a better understanding of patient's day-to-day activities

19. I feel the longer period required in the provision of culturally congruent care impacts negatively on my day-to-day nursing care

20. I believe the shortage of nursing staff is negatively impacting my ability to deliver culturally appropriate care

I have not had any Pushto language training.

Annexure III: Gantt chart

	Months	April 2024	MAY 2024	June 2024	JULY 2024	August 2024
Phase I	Approval from F.I.N					
Phase II	Approval from LRH,KTH,HMC					
	Completion of Data collection					
Phase III	Data analysis					
	Data interpretation					
	Results Formulation					
Phase IV	Completion of the project					
	Submission of the thesis					

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FARKHANDA INSTITUTE OF NURSING AND PUBLIC HEALTH
GANDHARA UNIVERSITY, PESHAWAR

Ref. No. 11624/2024 /FIN&PH/GU Dated: 15-06-2024

To,
The Director,
Lady Reading Hospital,
Peshawar.

Subject: **Request for permission to conduct data collection for research project**

Dear Sir/Madam,

I am writing to seek your kind permission on behalf of our College Farkhanda Institute of Nursing and Public Health Peshawar to conduct data collection for our college students' final research projects in your esteemed Hospital.

As part of their academic requirements, our college students are undertaking final research projects that aim to contribute valuable insights to the field of Nursing. To ensure the success and relevance of their research, they require access to pertinent data that is available exclusively within a hospital setting. After careful consideration, our students have chosen Lady Reading Hospital, due to its outstanding reputation for excellence in healthcare and research.

We understand the significance of safeguarding patients' privacy and the importance of adherence to ethical research practices. I want to assure you that our students will strictly adhere to all hospital policies, regulations, and confidentiality protocols. Additionally, the data collected will only be used for academic purposes. Our students will work closely with the hospital staff to ensure that the data collection process does not interfere with the hospital's daily operations.

We would be immensely grateful if you could review and approve our request at your earliest convenience. Please let us know if you require any additional information or have any specific guidelines that we need to follow during the data collection process.

Sincerely,

Principal
FIN & PH

Forwarded to Research Dear
29/6/2024
DIRECTOR NURSING
Lady Reading Hospital
MTI Peshawar.

Feb. 9 allowed for data collection from 29 Jun 2024 to 2nd July 2024 with the supervision of EO supervisor and Manager.
22.6.2024

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FARKHANDA INSTITUTE OF NURSING AND PUBLIC HEALTH
GANDHARA UNIVERSITY, PESHAWAR

Ref. No. 11625/2024 /FIN&PH/GU Dated: 15-06-2024

To,
The Director,
Hayatabad Medical Complex,
Peshawar.

Subject: **Request for permission to conduct data collection for research project**

Dear Sir/Madam,

I am writing to seek your kind permission on behalf of our College Farkhanda Institute of Nursing and Public Health Peshawar to conduct data collection for our college students' final research projects in your esteemed Hospital.

As part of their academic requirements, our college students are undertaking final research projects that aim to contribute valuable insights to the field of Nursing. To ensure the success and relevance of their research, they require access to pertinent data that is available exclusively within a hospital setting. After careful consideration, our students have chosen Hayatabad Medical Complex, due to its outstanding reputation for excellence in healthcare and research.

We understand the significance of safeguarding patients' privacy and the importance of adherence to ethical research practices. I want to assure you that our students will strictly adhere to all hospital policies, regulations, and confidentiality protocols. Additionally, the data collected will only be used for academic purposes. Our students will work closely with the hospital staff to ensure that the data collection process does not interfere with the hospital's daily operations.

We would be immensely grateful if you could review and approve our request at your earliest convenience. Please let us know if you require any additional information or have any specific guidelines that we need to follow during the data collection process.

Sincerely,

Principal
FIN & PH

Approved for Data Collection