Profile Predictors of Clinical Cultural Competence among Pediatric Nurses in a Government Hospital

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ABSTRACT

This study aimed to assess whether the profile of pediatric nurses predicted their clinical cultural competence in a government hospital in Surigao City. A quantitative descriptive-correlational-predictive design was employed. The study utilized a total enumeration sampling design, wherein all 112 registered nurses who met the inclusion criteria and were affiliated with the Pediatric Intensive Care Unit, Pediatric Ward, and Pediatric Respiratory Unit were included as respondents. Data were collected using a structured questionnaire adapted from the Campinha-Bacote Model of Cultural Competence, measuring cultural awareness, knowledge, skills, encounters, and desire. Descriptive statistics summarized the profile and competence levels, while regression analysis examined the predictive relationship between nurse characteristics and cultural competence. Findings revealed that the respondents demonstrated very high levels of clinical cultural competence across all domains, with cultural awareness being the highest. Regression analysis showed that age, civil status, current area of assignment, and frequency of caring for patients from diverse cultures significantly predicted cultural competence. Other variables, including sex, educational attainment, years of experience, and employment status, were not significant predictors. Although the pediatric nurses exhibited high overall competence, certain demographic and experiential factors influenced their cultural competence. The results highlight the need for targeted interventions to strengthen cultural responsiveness. Based on the findings, a Clinical Cultural Competence Enhancement Plan was proposed to guide hospital-based initiatives aimed at improving culturally sensitive pediatric care.

Keywords: Pediatric nurses, Clinical cultural competence, Cultural awareness, Campinha-Bacote model, Predictive study

INTRODUCTION

Cultural competence is an essential skill in nursing that enables healthcare providers to deliver care that respects the beliefs, values, and practices of patients from diverse backgrounds. It goes beyond cultural knowledge and includes effective communication, respect, and the ability to adapt care based on the unique needs of patients and their families (Young & Guo, 2020). In pediatric nursing, this becomes even more critical because care involves not only the child but also parents or guardians whose cultural beliefs strongly influence decision-making (Yoo & Cho, 2020). When nurses demonstrate cultural sensitivity, families are more likely to trust healthcare providers, adhere to treatment, and achieve better health outcomes. In the Philippine context, particularly in government hospitals serving diverse ethnolinguistic groups, cultural differences may lead to misunderstandings or hesitation in following medical advice. Nurses with strong cultural competence can build trust and improve cooperation, ultimately enhancing patient satisfaction and quality of care (Stubbe, 2020; Alquwez, 2023).

Despite its importance, there is limited research on cultural competence among Filipino nurses, especially in Mindanao where cultural diversity is more pronounced. Existing studies are largely international and may not fully reflect local realities. While previous research suggests that personal characteristics such as age, experience, and cultural training influence cultural competence (Zhang et al., 2022; Lin et al., 2021), there is insufficient local evidence focusing on pediatric nurses in government hospitals. This gap makes it difficult for healthcare leaders to design context-specific programs. In pediatric settings, cultural competence is

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particularly complex because nurses must address both the child's clinical needs and the parents' cultural beliefs, which can affect treatment decisions, consent, and compliance. Challenges such as reliance on traditional practices, resistance to procedures, and differing health beliefs highlight the need for culturally responsive care. Including both current and previously assigned pediatric nurses provides a more comprehensive understanding of these experiences and how nurses adapt to culturally diverse and emotionally sensitive situations.

This study aims to determine whether the profile of pediatric nurses can predict their level of clinical cultural competence in terms of knowledge, skills, encounters, and awareness. The findings are expected to guide nursing management in developing targeted interventions such as training programs, cultural sensitivity workshops, and mentorship initiatives. This aligns with broader goals of improving patient-centered care and reducing health disparities, supporting SDG 3 (Good Health and Well-Being) and SDG 10 (Reduced Inequalities) (Antón-Solanas et al., 2021). The study also offers practical value in enhancing workforce development, performance evaluation, and service quality in pediatric units. Grounded in the researcher's firsthand experience as a pediatric nurse in a government hospital, the study ensures that its insights are relevant, realistic, and applicable to actual clinical practice.

RESEARCH QUESTIONS

This study aimed to assess whether the profile predicted the clinical cultural competence among pediatric nurses in a government hospital in Surigao City for the year 2025. Specifically, it sought to answer the following questions:

1. What was the profile of the pediatric nurses in terms of:
   1.1. age;
   1.2. sex;
   1.3. civil status;
   1.4. highest educational attainment;
   1.5. total number of years as pediatric nurse;
   1.6. total number of years of experience as pediatric nurse in current hospital;
   1.7. current area of assignment;
   1.8. employment status;
   1.9 cultural competency training attended; and
   1.10 frequency of caring for patients from diverse cultures?
2. What was the level of Clinical cultural competence of pediatric nurses in terms of:
   2.1 cultural knowledge;
   2.2 cultural skills;
   2.3 cultural encounters/experience; and
   2.4 cultural awareness?
3. Which among the profile predicted the clinical cultural competence of the pediatric nurses?
4. What clinical cultural competence enhancement plan could be proposed based on the findings of the study?

Statement of Null Hypothesis

H_{o1}: There profile did not predict the clinical cultural competence of the pediatric nurses.

REVIEW OF RELATED LITERATURE AND STUDIES

Clinical Cultural Competency. Cultural competency is an essential aspect of healthcare and is recognized as a multidimensional process involving cultural awareness, knowledge, skills, and encounters that enable providers to deliver respectful and effective care across diverse populations (Asadizaker et al., 2021). Its development is shaped by varied learning experiences such as immersion, observation, and reflection, while disparities in healthcare are often linked to bias and cultural misunderstandings, highlighting the need for cultural competence and humility (Stubbe, 2020; Liu & Li, 2023). In pediatric nursing, cultural competence is

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critical for ensuring equitable care, as nurses must address both the child's needs and the cultural beliefs of families, although inconsistencies in defining and assessing these competencies remain a challenge (Jiménez et al., 2021). Studies further emphasize that while pediatric nurses demonstrate awareness of cultural diversity, gaps in theoretical knowledge and training persist, and continuous reflection, education, and clinical exposure are necessary to enhance culturally responsive care (Golsäter et al., 2023; Chen et al., 2023). In the Philippine setting, cultural competence is strongly associated with improved quality of care and patient satisfaction, reinforcing the need for targeted training programs that address cultural beliefs and practices (Barral et al., 2023). Religion and tradition, particularly in Muslim populations, significantly influence care delivery, and nurses with prior diversity training demonstrate higher competence, supporting the integration of culture-specific education in nursing practice (Contaoi, 2025). Moreover, Filipino nurses' ability to adapt in multicultural environments is influenced by cultural attitudes, awareness, comfort, and knowledge, underscoring the importance of structured training initiatives in enhancing cultural competence both locally and globally (Salinda, 2025).

Cultural Knowledge. Cultural knowledge is a core component of cultural competence, enabling healthcare professionals to understand and respond to patients' beliefs, practices, and values, with perceptions of diversity shaping care delivery (Bamgbose et al., 2023). In nursing, enhancing cultural knowledge through training programs improves awareness, reduces health disparities, and supports better patient outcomes (Akins, 2021). Its development requires both individual learning and structured frameworks in academic and clinical settings, addressing multiple domains of competence. Together with skills, awareness, and attitudes, cultural knowledge forms a holistic foundation for delivering culturally responsive care (Liu et al., 2021; Miller, 2024).

Cultural Skills. Cultural skills refer to the ability of healthcare providers to gather relevant cultural information and apply it effectively in patient care, including identifying patients' health beliefs, adapting care strategies, and recognizing implicit biases (Brottman et al., 2020). These skills are developed through varied educational approaches and strengthened by clinical exposure and observation of culturally appropriate practices (Liu & Li, 2023). However, gaps remain when training is limited to theory, as cultural competence requires continuous practice and application in dynamic clinical settings.

Cultural encounter/experience. Cultural encounters or experiences involve direct interactions with individuals from diverse backgrounds, enabling healthcare professionals to move beyond stereotypes and develop competence in cross-cultural care (Lau & Rodgers, 2021). These encounters enhance communication skills, build confidence in managing cultural and language barriers, and support cross-cultural adaptation (Liu, Xu, & Wang, 2025). Through reflection on these experiences, providers refine their behaviors and approaches, emphasizing that cultural competence requires continuous exposure and experiential learning (Liu & Li, 2023).

Cultural awareness. Cultural awareness is the self-reflective process through which healthcare providers recognize their own cultural values, biases, and assumptions and how these influence patient care, serving as a foundation for cultural humility and reducing stereotyping (Lekas et al., 2020). It is developed through immersion and reflective practices that highlight how culture shapes health behaviors and outcomes (Liu & Li, 2023). Awareness also includes recognizing systemic inequities and structural barriers affecting vulnerable populations, enabling providers to deliver care with greater sensitivity and respect for diversity (Lau & Rodgers, 2021).

Profile Predictors of Clinical Cultural Competence. Predictors of cultural competence among healthcare professionals are associated with both individual and work-related characteristics, including age, gender, years of practice, training, language ability, and professional role, with greater experience, exposure, and education enhancing competence (Preziosi et al., 2025; Ogunlana et al., 2023). Cultural competence also influences patient outcomes, as perceived provider sensitivity reduces negative healthcare experiences and promotes continued care (Flynn et al., 2020), although some studies report no significant differences across professional groups (Payne & Wagner-Loera, 2024). Recent international evidence further shows that cultural competence is shaped by a combination of demographic, educational, experiential, and organizational factors, such as international exposure, academic progression, foreign-language proficiency, and experience with diverse populations (Visiers-Jiménez et al., 2025; Urbanavičė et al., 2025). In addition, professional identity, values, and spiritual well-being contribute to competence, while supportive work environments and organizational culture enhance culturally congruent care (Chou et al., 2025; Nazari et al., 2025; Teixeira et al., 2024).

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Training and educational exposure remain the most consistent predictors, alongside cultural encounters and organizational support, with attitudinal factors such as empathy, humility, and professional values acting as mediators in translating these characteristics into effective culturally responsive care (Abou Hashish et al., 2025).

RESEARCH METHODOLOGY

Design. The study employed a quantitative descriptive–correlational–predictive research design. In this study, the descriptive component was utilized to determine and describe the personal and professional profile of pediatric nurses in a government hospital, including age, sex, civil status, educational attainment, years of experience, employment status, and area of assignment. It also assessed their level of clinical cultural competence in terms of cultural awareness, knowledge, skills, encounters, and desire. The correlational component, on the other hand, was employed to determine the extent to which significant relationships existed between the respondents' profile variables and their level of clinical cultural competence. The predictive aspect of the design further examined which profile variables best predicted clinical cultural competence, thereby identifying the most influential factors contributing to variations in competence levels. In this context, predictive correlation went beyond establishing mere association, as it determined the extent to which one or more independent variables could statistically forecast the dependent variable, which in this study was clinical cultural competence.

Environment. This study was conducted in a government hospital located in Surigao City, Surigao del Norte, which served as a referral hospital for the Caraga Region.

Respondents. The respondents of this study were 112 registered nurses affiliated with the pediatric units of the hospital.

Sampling Design. This study used a complete enumeration.

Inclusion Criteria and Exclusion Criteria. The study included registered nurses who were currently assigned or had previously been assigned or rotated in pediatric units, specifically the Pediatric Intensive Care Unit (PICU), Pediatric Ward, and Pediatric Respiratory Unit, provided they had at least three months of employment in the hospital and voluntarily gave informed consent. Including both current and former pediatric nurses allowed for a more comprehensive understanding of experiences, insights, and cultural challenges in pediatric care. The study excluded nurses on extended leave or with pending resignation, as well as those assigned to non-pediatric areas or holding purely administrative or supervisory roles, such as Nurse Supervisors or Head Nurses, to ensure that the data accurately reflected the perspectives of staff nurses directly involved in pediatric patient care.

Instrument. This study utilized a structured questionnaire adapted from the Campinha-Bacote Model of Cultural Competence (2011) to collect both demographic and professional data and to measure the level of clinical cultural competence of pediatric nurses. The instrument consisted of two parts: Part I gathered respondents' profile variables, including age, sex, civil status, educational attainment, years of pediatric nursing experience, area of assignment, employment status, training attendance, and frequency of caring for culturally diverse patients, to identify potential predictors of competence; while Part II assessed clinical cultural competence across four domains Cultural Awareness, Cultural Knowledge, Cultural Skill, and Cultural Encounters each with five items rated on a five-point Likert scale, where higher scores indicated greater competence. The instrument demonstrated high reliability with Cronbach's alpha values ranging from 0.80 to 0.94, and its applicability was confirmed through pilot testing among ten nurses. Scoring involved computing the mean per domain and an overall mean score across 20 items, interpreted using a scale from very low to very high clinical cultural competence.

Data Gathering Procedures. The data gathering procedure was conducted in three phases: pre-data gathering, actual data collection, and post-data gathering. In the pre-data gathering phase, the researcher secured approval from the Dean of the Graduate School of Allied Health Sciences, obtained a transmittal letter addressed to the Chief of Hospital, and acquired ethical clearance from the Institutional Review Board, followed by title defense and coordination with the Nursing Service Office to identify eligible pediatric nurses and schedule data

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collection. In the actual data gathering phase, both online and face-to-face methods were utilized, where participants were informed of the study's purpose, voluntary participation, and confidentiality, and were required to sign an informed consent form before completing the questionnaire, with the researcher personally collecting the accomplished forms to ensure completeness. In the post-data gathering phase, the data were reviewed, encoded, and organized for statistical analysis, with results presented in tabular and narrative forms, to address identified gaps and improve culturally responsive pediatric nursing care. After manuscript completion, the study was presented for final defense before the same panel of experts, and all completed questionnaires were destroyed or shredded after the final defense.

Statistical Treatment of Data. The statistical treatment of data utilized frequency and percentage distribution to describe the demographic and professional profile of the respondents, including age, sex, civil status, educational attainment, years of experience, area of assignment, employment status, training attendance, and frequency of caring for culturally diverse patients. Weighted mean and standard deviation were used to determine the level of clinical cultural competence across the domains of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire, as well as to measure the variability of responses. Linear regression analysis was employed to identify which profile variables significantly predict clinical cultural competence, determining the extent and direction of influence of independent variables on the dependent variable.

Ethical Considerations. Ethical considerations are an essential component of any research study. The study was submitted to the ethics committee of both the university and the hospital. Ethical approval was sought prior to the start of data gathering to ensure that the welfare of the respondents was protected.

PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

Table 1 Profile of the Respondents

Profile	*f*	*%*
Age		
20–25 years old	21	18.80
26–30 years old	36	32.10
31–35 years old	25	22.30
36–40 years old	19	17.00
41 years old and above	11	9.80
Sex		
Male	2	1.80
Female	110	98.20
Civil Status		
Single	80	71.40
Married	32	28.60
Highest Educational Attainment		
Bachelor of Science in Nursing	77	68.80
With Master's Units	25	22.30
Master's Degree Holder	10	8.90
Years of Pediatric Nursing Experience		
Less than 1 year	23	20.50
1 – 3 years	40	35.70
4–6 years	36	32.10
7–9 years	3	2.70
10 years and above	10	8.90
Years of Experience in Pediatric Department of Current Hospital		
Less than 1 year	24	21.40
1 – 3 years	39	34.80
4–6 years	36	32.10

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7–9 years	6	5.40
10 years and above	7	6.20
Current Area of Assignment		
Pedia-R	25	22.30
Pedia-M	48	42.90
Pedia-W	10	8.90
Pediatric Intensive Care Unit (PICU)	29	25.90
Employment Status		
Job Order	59	52.70
Permanent	53	47.30
Cultural Competency Training Attended		
No	112	100.00
Yes	0	0.00
Frequency of Caring for Patients from Diverse Cultures		
Rarely	1	.90
Sometimes	12	10.70
Often	24	21.40
Very Often	3	2.70
Always	72	64.30

Note. *n=112.*

As shown in Table 1, the presents the demographic and professional profile of pediatric nurse respondents, showing that the workforce is predominantly composed of early- to mid-career nurses aged 26–35, mostly female, single, and holding a Bachelor of Science in Nursing, with limited postgraduate education. Most have fewer than six years of pediatric experience and similar tenure in their institutions, indicating that many are still developing specialty practice and professional identity while frequently assigned to diverse pediatric units, including high-acuity areas where cultural beliefs influence care decisions. The near-equal distribution of job order and permanent employment reflects varying levels of job security, while the absence of formal cultural competence training despite regular exposure to culturally diverse patients highlights a significant gap in structured preparation. These findings suggest that although nurses encounter diverse cultural situations, their responses may remain inconsistent without formal guidance. Existing literature supports that age, education, and experience influence cultural competence but do not guarantee it, as both early-career and experienced nurses require continuous training to translate exposure into effective practice (BMC Nursing, 2025). Additionally, repeated cultural encounters alone are insufficient without reflection and formal education, and reliance on informal learning may lead to superficial competence, emphasizing the need for structured institutional programs to ensure culturally responsive pediatric care (Asian Journal of Research in Nursing and Health, 2025; BMC Nursing, 2025.

Table 2 Level of Clinical Cultural Competence of Pediatric Nurse

Dimensions	Mean score	SD	Interpretation
A. Cultural Knowledge			
1. I understand the meaning of culture and how it affects health.	4.42	0.693	Very much
2. I know common health beliefs and practices of major cultural groups in my hospital.	4.47	0.684	Very much
3. I am aware of cultural factors that influence the health of children.	4.51	0.615	Very much
4. I understand how cultural beliefs can affect pediatric patient care.	4.47	0.643	Very much
5. I am knowledgeable about culturally appropriate treatment interventions.	4.41	0.766	Very much
Factor mean	4.46	0.528	Very high competence

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B. Cultural Skills			
1. I can assess cultural needs when planning patient care.	4.39	0.820	Very much
2. I include cultural beliefs and practices in pediatric care planning.	4.28	0.725	Very much
3. I use culturally appropriate communication techniques with patients and families.	4.29	0.832	Very much
4. I adapt interventions to fit the child's cultural background.	4.39	0.727	Very much
5. I document cultural factors that affect care.	4.41	0.665	Very much
Factor mean	4.35	0.643	Very high competence
C. Cultural Encounters / Experience			
1. I have experience interacting with patients from culturally diverse backgrounds.	4.47	0.697	Very much
2. I ask patients and families about their cultural beliefs regarding health and illness.	4.36	0.721	Very much
3. I have managed culturally-based conflicts in patient care.	4.41	0.637	Very much
4. I frequently work with patients from a culture different from mine.	4.44	0.668	Very much
5. I collaborate with colleagues from diverse cultural backgrounds.	4.46	0.670	Very much
Factor mean	4.43	0.588	Very high competence
D. Cultural Awareness			
1. I am aware of my own cultural values and biases.	4.53	0.697	Very much
2. I understand how my cultural background influences my professional practice.	4.53	0.684	Very much
3. I recognize when cultural bias may interfere with care.	4.60	0.703	Very much
4. I respect patients' cultural beliefs even if they differ from mine.	4.64	0.613	Very much
5. I reflect on my interactions to identify cultural sensitivity gaps.	4.63	0.615	Very much
Factor mean	4.59	0.582	Very high competence
Grand mean	4.46	0.480	Very high competence

Note. *n=112.*

Legend: 1.00–1.80 Very Low Clinical Cultural Competence (not at all), 1.81–2.60 is Low Competence (slightly), 2.61–3.40 Moderate Competence (somewhat), 3.41–4.20 is High Competence (quite a bit), and 4.21–5.00 is Very High Competence (very much)

The results in Table 2, shows that pediatric nurses demonstrated a very high level of clinical cultural competence (grand mean = 4.46), indicating strong self-perceived ability to integrate cultural considerations into care; however, this should be interpreted cautiously due to the self-rated nature of the instrument, which may lead to overestimation influenced by social desirability and professional expectations. Cultural Awareness ranked highest, reflecting nurses' strong self-reflection and recognition of personal biases in clinical situations, followed by Cultural Knowledge, which supports understanding of culturally influenced health practices, Cultural Encounters, which reflect frequent interaction with diverse patients but require reflection to translate into competence, and Cultural Skills, which, although very high, ranked lowest due to the challenge of consistently applying knowledge into practice. These findings suggest that nurses are more confident in reflective and cognitive aspects than in practical application.

Literature supports that awareness is foundational but may be inflated without structured reflection (Soumya et al., 2025; BMC Nursing, 2025), that knowledge enhances culturally appropriate care but may not reflect actual understanding without training (Ali Jaber Mohammed Haqawi et al., 2024; Grinberg & Nissim, 2025), and that encounters and skills require guided reflection, mentorship, and deliberate practice to ensure competence (Salinda, 2025; Asian Journal of Research in Nursing and Health, 2025; BMC Nursing, 2025). Overall, while nurses perceive themselves as highly competent and frequently engage with culturally diverse patients, the results emphasize the need for structured training, simulations, mentorship, and reflective supervision to ensure that perceived competence translates into consistent, evidence-based, and culturally responsive practice.

Table 3 Profile Predicting Clinical Cultural Competence of Pediatric Nurses

Variables	B	Std Error	Beta	t	*p* value	Decision	Interpretation
(Constant)	4.358	.681		6.396	.000		
Age	.088	.044	.227	2.010	.047	Reject Ho	Significant
Sex	-.127	.303	-.035	-.420	.675	Failed to reject Ho	Not significant
Civil Status	-.367	.093	-.347	-3.936	.000	Reject Ho	Significant
Highest education attainment	.018	.074	.025	.247	.805	Failed to reject Ho	Not significant
Years of Pediatric Nursing Experience	.020	.169	.047	.120	.905	Failed to reject Ho	Not significant
Years of Experience in Pediatric Department of Current Hospital	.076	.175	.170	.433	.666	Failed to reject Ho	Not significant
Current Area of Assignment	-.076	.038	-.174	-2.013	.047	Reject Ho	Significant
Employment Status	-.004	.108	-.004	-.038	.970	Failed to reject Ho	Not significant
Frequency of Caring for Patients from Diverse Cultures	.124	.033	.298	3.731	.000	Reject Ho	Significant

Legend: Significant if p value is < .05. If R-squared value < 0.3 is None or Very weak effect size, if R-squared value 0.3 < r < 0.5 is Weak or low effect size, if R-squared value 0.5 < r < 0.7 is Moderate effect size, and if R-squared value r > 0.7 is Strong effect size.

The model summary revealed the following values: R = .606, R Square = .367, Adjusted R Square = .311, Std. Error of Estimate = .39851, F = 6.563, Sig. = .000. Therefore, the regression model created is as follows:

Cultural Competence = 4.358 + 2.010 (age) – 3.936 (civil status) – 2.013 (current area of assignment) + 3.371 (frequency of caring for patients from diverse cultures)

Table 3 presents a statistically significant regression model ($F = 6.563$, $p < .001$) showing that pediatric nurses' profile variables collectively predict clinical cultural competence, with a moderate association ($R = .606$) and 36.7% explained variance ($R^2 = .367$), indicating that while demographic and professional characteristics contribute meaningfully, a substantial portion is influenced by organizational and environmental factors. Age and frequency of caring for culturally diverse patients emerged as positive predictors, highlighting that professional maturity and repeated exposure enhance competence, while civil status and current area of assignment also significantly influenced competence through personal life experiences and clinical context, particularly in high-acuity, family-centered units. Literature supports that competence develops through experiential learning, reflection, and sustained exposure rather than time alone (Ali Jaber Mohammed Haqawi et al., 2024; Kaihlanen et al., 2019; Campinha-Bacote, 2011; Soumya et al., 2025; Salinda, 2025; Douglas et al., 2014).

In contrast, sex, educational attainment, years of experience, and employment status were not significant predictors, reinforcing that cultural competence is not determined by static characteristics but by context-dependent learning and engagement (Shen, 2018; Kaihlanen et al., 2020; Papadopoulos et al., 2018). Overall, the findings emphasize that cultural competence is driven more by exposure, unit-specific demands, and personal maturity than by demographics, highlighting the need for structured training, reflective practice, mentorship, and institutional support to ensure consistent and culturally responsive pediatric care.

CONCLUSION AND RECOMMENDATIONS

Conclusion. Based on the findings, it was concluded that pediatric nurses in the government hospital demonstrated a high level of clinical cultural competence, indicating their capacity to deliver culturally responsive care within a diverse pediatric population. This competence appeared to have developed largely through experiential learning, frequent cultural encounters, and reflective practice rather than through formal training program.

Recommendations. The recommendations emphasize strengthening clinical cultural competence through coordinated efforts in nursing practice, education, policy, and research. In practice, hospitals should implement structured programs such as the Pediatric Nurse Cultural Competence Enhancement Program (PN-CCEP), supported by mentorship, cross-unit rotations, and regular reflective practice to enhance exposure and culturally sensitive decision-making. In education, continuous professional development through workshops, webinars, and simulation- and case-based learning, along with partnerships with academic institutions, is recommended to reinforce both theoretical and experiential learning. At the policy level, cultural competence training should be mandated during onboarding and sustained through regular evaluation, feedback, and integration into hospital quality and accreditation standards to ensure consistent application across pediatric units. For research, further studies are encouraged to examine factors such as mentorship, patient diversity, organizational culture, and reflective practice, including longitudinal designs to assess competence development and the effectiveness of structured interventions.

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