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Original article

Cultural competence of nurses in caring for women-mothers and their hospitalized children

Competência cultural de enfermeiros no cuidado à mulher-mãe e seu filho durante a hospitalização

Competencia cultural de los enfermeros en el cuidado de la mujer-madre y de su hijo durante la hospitalización

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Abstract

Objective: To describe the process through which nurses develop cultural competence in caring for women-mothers and their hospitalized children, based on the constructs of the Nurses' Cultural Competence Care Model. **Method:** This qualitative study was conducted using semi-structured interviews and thematic analysis with descending hierarchical classification, supported by the *IRAMUTEQ*® software. **Results**: Twenty nurses involved in providing direct and indirect care to women-mothers and their children participated in the study. Six distinct thematic classes were identified and named according to the adopted theoretical framework. **Conclusion:** The development of nurses' cultural competence begins with a genuine willingness to provide culturally sensitive care to women-mothers and their children from diverse ethnic and cultural backgrounds. This process requires awareness of one's own culture, the active pursuit of cultural knowledge, and the skillful collection of information to support appropriate nursing assessment while overcoming the structural and communication barriers that arise in interactions between nurses and women-mothers with their hospitalized children.
Descriptors: Nursing Care; Hospitalization; Healthcare Models; Cultural Competency; Maternal and Child Health

Resumo

Objetivo: Descrever o processo de desenvolvimento da competência cultural vivenciado por enfermeiros no cuidado à mulher-mãe e seu filho, à luz dos constructos do Modelo de Cuidado de Competência Cultural de Enfermeiros. **Método:** Estudo qualitativo realizado por meio de entrevista semiestruturada e análise temática com classificação hierárquica descendente, apoiada no uso do *software* IRAMUTEQ®. **Resultados**: Participaram 20 enfermeiros que prestavam cuidado direto e indireto à mulher-mãe e filho e foram identificadas seis classes distintas, as quais receberam a nomenclatura apoiada no referencial teórico adotado.

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Conclusão: O desenvolvimento da competência cultural de enfermeiros inicia-se fundamentalmente com o desejo genuíno de cuidar de mulheres-mães e seus filhos com diversidade étnico-cultural, com consciência sobre a própria cultura, buscando conhecer e levantar informações de forma habilidosa que visem à avaliação de enfermagem adequada, contornando as barreiras estruturais e comunicacionais que se apresentam no encontro entre o enfermeiro e a mulher-mãe com seu filho hospitalizado.
Descritores: Cuidados de Enfermagem; Hospitalização; Modelos de Assistência à Saúde; Competência Cultural; Saúde Materno-Infantil

Resumen

Objetivo: Describir el proceso de desarrollo de la competencia cultural de los enfermeros en el cuidado de la mujer-madre y de su hijo hospitalizado, a la luz de los constructos del Modelo de Competencia Cultural para el Cuidado de Enfermería (Nurses' Cultural Competence Care Model). **Método:** Estudio cualitativo realizado mediante entrevistas semiestructuradas y análisis temático con clasificación jerárquica descendente, apoyado por el software IRAMUTEQ®. **Resultados:** Participaron 20 enfermeros que brindaban atención directa e indirecta a la mujer-madre y a su hijo. Se identificaron seis clases temáticas diferenciadas, denominadas de acuerdo con el marco teórico adoptado. **Conclusión:** El desarrollo de la competencia cultural de los enfermeros comienza con una disposición genuina para brindar una atención culturalmente sensible a mujeres-madres y a sus hijos pertenecientes a diversos contextos étnicos y culturales. Este proceso requiere conciencia de la propia cultura, la búsqueda activa de conocimientos culturales y la recopilación hábil de información para fundamentar una valoración de enfermería adecuada, superando las barreras estructurales y de comunicación que surgen en la interacción entre el enfermero y la mujer-madre con su hijo hospitalizado.
Descriptores: Atención de Enfermería; Hospitalización; Modelos de Atención de Salud; Competencia Cultural; Salud Materno-Infantil

Introduction

Nursing is grounded in conceptual and scientific foundations that emphasize comprehensive care for women-mothers and their children, encompassing the biological, social, and cultural dimensions that influence the health–disease process.[1] In the context of increasing global migration, one of the most significant phenomena of contemporary society, reshaping social and healthcare dynamics worldwide, nursing is called upon to play a central role in achieving the Sustainable Development Goals (SDGs), particularly those related to ensuring healthy lives and promoting well-being (SDG 3) and reducing inequalities (SDG 10) for all populations, especially those in vulnerable situations.[1-2]

The cultural identity of women-mothers and their children becomes increasingly dynamic and complex in the context of postmodernity and global migration. These factors directly influence perceptions of health, illness, and care,

requiring nurses to adopt culturally sensitive and responsive approaches. [2-3] In this context, nurses are expected to develop cultural competence to address the challenges posed by demographic and socioeconomic changes in an increasingly multicultural world, particularly in countries marked by persistent health inequities among populations from diverse ethnic and cultural backgrounds. The Nurses' Cultural Competence Care Model provides a conceptual framework to guide the development and implementation of culturally responsive healthcare services. [4-9]

This model has four domains or constructs, namely:

1) Cultural Awareness refers to understanding oneself and recognizing how one's own culture shapes worldview, values, and potential biases.

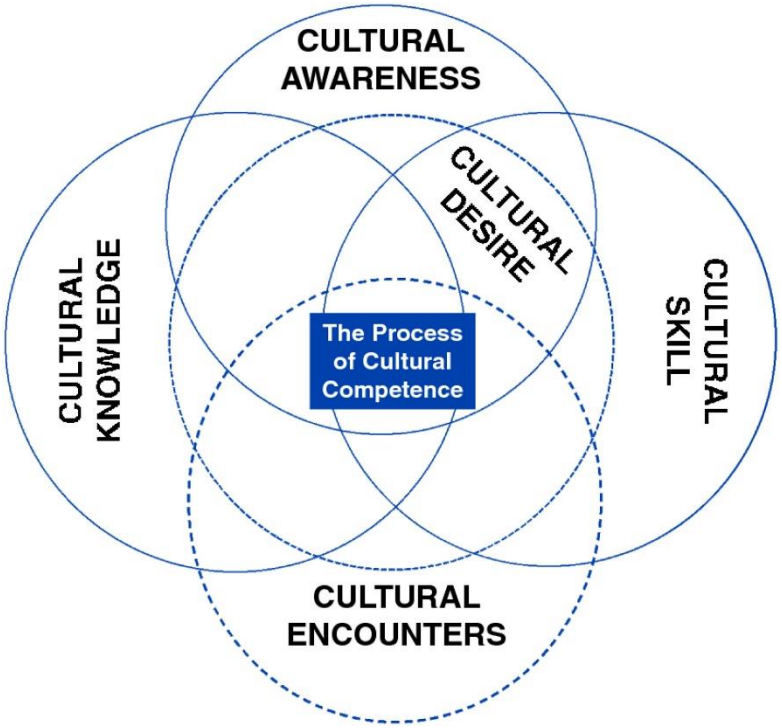
2) Cultural Knowledge involves acquiring an understanding of another person's cultural context and belief system, as well as seeking knowledge about the biological, ethnic, hereditary, and genetic factors that may influence health needs and the health-illness process.

3) Cultural Skill is the ability to collect culturally relevant information during patient assessment, recognizing that perceptions of health and illness vary across individuals and cultures. Nurses are encouraged to use assessment tools that facilitate the sensitive exploration of patients' beliefs, values, and cultural practices.

4) Cultural Encounters, refer to meaningful interactions with individuals from diverse cultural backgrounds. Such encounters help nurses recognize both similarities and differences among cultural groups, refine their cultural understanding, and avoid stereotyping.

The fifth construct, Cultural Desire, was introduced later and is defined as the motivation and willingness to work with individuals from diverse cultural backgrounds and to actively engage in the process of developing cultural competence. According to the model, without cultural desire, the remaining constructs are insufficient to achieve the development of cultural competence. The relationship among these five constructs is illustrated in Figure 1.[10]

Figure 1 – Model of the cultural competence process[10]



In maternal, child, and pediatric care and management, culturally competent and culturally responsive care represents a valuable therapeutic approach that fosters the integration of patients' and families' cultural knowledge with professional healthcare practices, ultimately promoting their well-being and satisfaction. Furthermore, culturally competent care has been recognized as an evidence-based approach to improving healthcare quality. Therefore, investing in continuing education programs that promote the development of nurses' cultural competence is essential to addressing the challenges of providing nursing care in an increasingly globalized, multicultural, and diverse society.[9-11]

Given the importance of developing nurses' cultural competence to promote culturally responsive care, this study aimed to describe how nurses develop cultural competence in caring for women-mothers and their hospitalized children, based on the constructs of the Nurses' Cultural Competence Care Model.

Method

This exploratory, descriptive qualitative study was guided by the theoretical framework and constructs of the Nurses' Cultural Competence Care Model[10] and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research guidelines.[12]

The study was conducted at a large tertiary pediatric hospital in Curitiba, Paraná, Brazil, that exclusively provides pediatric care. The hospital serves patients through Brazil's Unified Health System (SUS), private health insurance, and self-paying patients. It is currently ranked among the world's 250 best specialized hospitals by Newsweek, placing among the top 70 pediatric hospitals worldwide and ranking first among pediatric hospitals in Brazil. The institution has 460 beds across a wide range of pediatric specialties and serves as a referral center for pediatric care in Brazil and Latin America.[13]

As a referral center for specialized pediatric care, the hospital serves patients from diverse ethnic and cultural backgrounds, including migrants and immigrants. Consequently, nurses routinely provide care to women-mothers and their children from diverse cultural backgrounds, offering opportunities for cultural encounters and the development of culturally competent care. This setting therefore provided an appropriate context for the present study.

To gain an in-depth understanding of how participants experienced the phenomenon under investigation, it was essential to explore the context and the meanings they attributed to their experiences. Accordingly, data were collected through semi-structured, audio-recorded interviews.[14]

The inclusion criterion was registered nurses who had been employed at the institution for at least six months, ensuring sufficient experience and adaptation to the workplace context. The exclusion criteria included nurses who were unavailable to participate in the study because they were on vacation, on leave, or otherwise absent during the data collection period. The sample size was not predetermined. Participant recruitment continued until theoretical saturation was achieved, that is, until no new information or insights emerged to further contribute to the development of the analysis.[15]

Semi-structured interviews were conducted with 20 nurses who provided care to women-mothers and their hospitalized children. Data were collected using an interview guide developed based on the constructs of the Nurses' Cultural Competence Care Model. [10,14] in the care of the woman-mother and her child during hospitalization. To ensure participants' anonymity, each nurse was assigned the identifier "Nurse" followed by a sequential number: Nurse1, Nurse2 [...] Nurse20. All participants voluntarily agreed to take part in the study after receiving information about its objectives, methodology, their right to access the study information, and their right to withdraw at any time without penalty. Written informed consent was obtained from all participants prior to data collection (ICF).

The interviews were conducted in a private setting within the institution where the study took place. Each interview lasted approximately 30 minutes, totaling 10 hours of data collection over a 22-day period between October and November 2024. Following approval of the ethical procedures, participants were asked for permission to audio-record the interviews. During each interview, patient care was ensured by other members of the nursing team.

The data were analyzed in light of the Nurses' Cultural Competence Care Model and according to the stages of thematic analysis proposed by Creswell and Creswell. This approach enabled the interpretation of the data and the identification of meaningful themes, which were subsequently compared with the existing literature. To support data coding and organization, the qualitative data analysis software Interface de *R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ®) was used. [14,16]

For lexical analysis using IRAMUTEQ®, the textual corpus was prepared according to the software recommendations. This process included standardizing spelling, correcting grammatical inconsistencies, standardizing compound terms using underscores (e.g., "*woman_mother*"), and removing special characters that could interfere with text processing. The interviews were compiled into a single textual corpus comprising all participants' narratives, without prior categorization based on the theoretical framework. The corpus was segmented by word occurrences, with the text segment length set at 37 words, allowing the software to divide the corpus into analyzable text segments. Each interview was treated as an

Initial Context Unit (ICU), which was subsequently segmented into Elementary Context Units (ECUs). This procedure resulted in a corpus utilization rate of 90.16%, indicating excellent suitability for robust lexical analysis.

It is important to note that the identification and naming of the classes generated through Descending Hierarchical Classification (DHC) were performed a posteriori, based on the interpretation of the lexical outputs produced by IRAMUTEQ®. Only after the classes had emerged were they interpreted in light of the Nurses' Cultural Competence Care Model[10], resulting in an inductive analytical approach followed by theoretical interpretation. This strategy ensured that the analysis remained grounded in the empirical data while strengthening the theoretical consistency of the findings.

All stages of the study were conducted in accordance with Resolution No. 466/2012 of the Brazilian National Health Council, which establishes the ethical guidelines for research involving human participants.[17] The study was reviewed and approved by the Research Ethics Committee under Certificate of Presentation for Ethical Consideration (CAAE) No. 22534819.8.0000.0102. Ethical approval was granted in April 2024 under Opinion No. 6,786,250.

Results

Based on the analysis of the sociodemographic and professional characteristics of the 20 study participants, the majority were female (95%), while only one participant was male (5%). Participants ranged in age from 24 to 51 years, with a mean age of 35.8 ± 9.2 years. Regarding nationality, 19 participants were Brazilian, and one was Venezuelan.

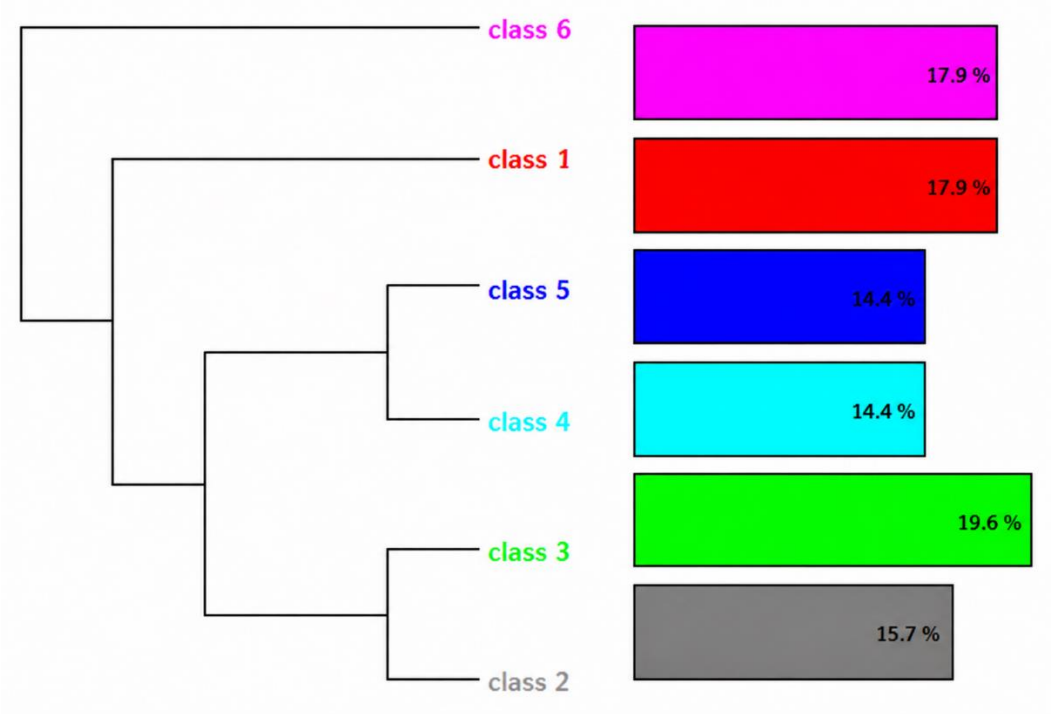
Four professionals were identified as migrants, three from different regions of Brazil and one from another country. The length of professional experience ranged from 1 to 19 years, with a mean of 9.7 ± 5.3 years. Regarding the length of employment at the current institution, a pediatric hospital, the mean duration was 6.9 ± 4.8 years.

Regarding language proficiency, 11 nurses spoke only one language, their native language; nine spoke two languages, eight spoke three, two spoke four, and one participant spoke five languages. Regarding work activities, 16 nurses (80%) provided direct patient care in pediatric intensive care units, inpatient wards, and outpatient clinics, whereas four (20%) performed indirect care activities related to service coordination and management.

Regarding the lexical content analysis using the Descending Hierarchical Classification (DHC) method, 20 initial context units (ICUs), corresponding to the 20 interviews analyzed, were identified in the textual corpus using the IRAMUTEQ® software. The software segmented the corpus into 254 text segments (TSs), of which 229 (90.16%) were retained for analysis. A total of 8,429 occurrences (words) were identified. The corpus contained 1,608 reduced forms and 1,054 lemmatized forms, corresponding to word reductions based on their lexical roots. Of these, 965 were classified as active forms, representing analyzable words that convey semantic content, and 80 were classified as supplementary forms.

Based on the analyzed text segments, the content was organized into six classes, representing the nurses' cultural competence constructs and the barriers to the development of this competence. The classes were distributed as follows: Class 1, 41 text segments (17.9%); Class 2, 36 text segments (15.72%); Class 3, 45 text segments (19.65%); Class 4, 33 text segments (14.41%); Class 5, 33 text segments (14.41%); and Class 6, 41 text segments (17.9%), as shown in Figure 2.

Figure 2 – Dendrogram illustrating the organization of the classes generated by the Descending Hierarchical Classification (DHC) of the textual corpus using IRAMUTEQ. Brazil, 2025

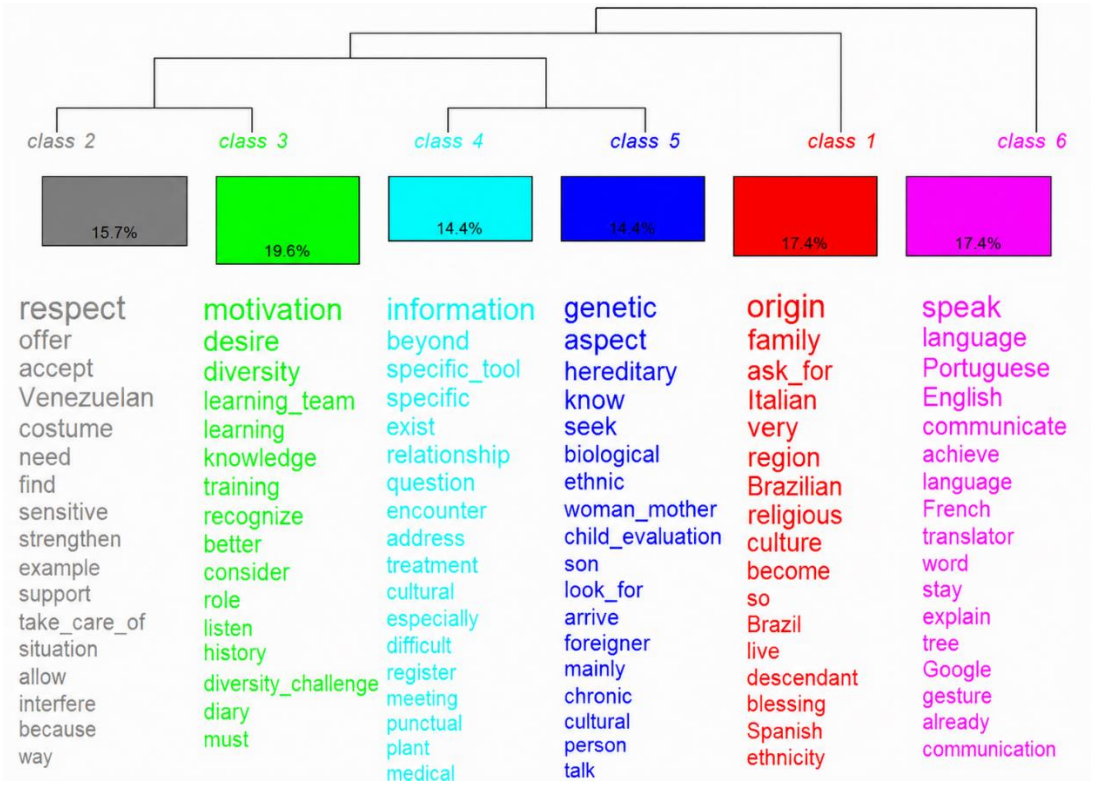


The dendrogram was analyzed from right to left. Initially, the corpus was partitioned, resulting in the formation of Class 6. A second partition subsequently generated Class 1. Finally, the remaining corpus was divided into Classes 2 and 3 and Classes 4 and 5.

As shown by the DHC, Classes 4 and 5 were closely related, as were Classes 2 and 3. The relationship between Classes 4 and 5 suggests that the development of cultural skills is grounded in previously acquired cultural knowledge. Likewise, Classes 2 and 3 represent the constructs of cultural desire and cultural encounters, indicating that the desire to engage with culturally diverse patients precedes meaningful cultural encounters. In contrast, Class 1 is not directly related to patient interactions but reflects the participants' self-reflection on their own cultural backgrounds and how these influence their professional practice. Finally, Class 6 underlies the other classes, indicating that communication and structural barriers may hinder the development and consolidation of cultural competence.

Figure 3 The dendrogram shows the lexical items with the highest chi-square values, indicating the strongest associations with each class.

Figure 3 – Dendrogram showing the distribution of classes and the lexical items with the highest chi-square values. Brazil, 2024



In the dendrogram, the first 17 words from the typical text segments of each class were selected according to the descending order of association, based on the χ^2 value and class membership.

From the six identified classes, six major themes emerged. The first theme, represented by Class 6, was named "Communicational and Structural Barriers" because it encompasses the practical and structural challenges involved in the intercultural communication process, including language difficulties, the absence of interpreters, and institutional limitations as barriers to the provision of culturally responsive care, as evidenced by the statements of the interviewed nurses:

> *I do not speak any other languages, and this makes me feel insecure as a nurse. I rely on resources such as writing, gestures, and slower speech to communicate with the mother-woman and her child. (Enf_11)*
>
> *I have already provided care to an Arab mother-woman and her son, and it was a great challenge because she did not speak Portuguese. Therefore, it was necessary to use a translation application on the cellphone. (Enf_16)*
>
> *We have experienced challenging situations, such as a patient who spoke Mandarin and for whom no interpreter was available. We used Google Translate to communicate. In another case, there was a Haitian patient, and I was able to rely on a nursing colleague who spoke French. Sometimes, the family itself acts as an interpreter. (Enf_9)*
>
> *The indigenous mother-woman and her son have their own rituals, beliefs, and practices. As a nurse, I had difficulty communicating when they were admitted because they only spoke Guarani. Over time and through daily interaction, we were able to improve communication, with each of us learning the other's language. (Enf_17)*

The second theme, represented by Class 1, was named "Cultural Awareness." This class reflects self-reflection on the participants' own values, beliefs, and prejudices. Such awareness is described as the starting point for the development of cultural competence, according to the Cultural Competence Care Model.[10]

> *Regarding my origins, my family is Portuguese; my parents came from Portugal as teenagers. My culture is very religious. When I arrive home, I must ask the elders for their blessing. (Enf_20)*
>
> *My ethnic and cultural background is Italian and African, which allows me to better understand and value cultural differences in a broader perspective. (Enf_4)*
>
> *I am of Italian descent and have African ancestry from enslaved people, so I am a mixture of different races and ethnic backgrounds. (Enf_18)*

The third theme, represented by Class 5, was named “Cultural Knowledge.” This class refers to theoretical and scientific knowledge regarding cultural, ethnic, and biological factors that influence healthcare practices.

> *When the woman-mother and child arrive, we perform the Nursing Assessment and request genetic testing. (Enf_18)*

> *I seek to understand the ethnic, cultural, genetic, and hereditary aspects of the woman-mother and her child, as I believe that these factors influence their worldview and nursing care. (Enf_1)*

The fourth theme, represented by Class 4, was named “Cultural Skill.” This class reflects the practical application of acquired knowledge and skills, as well as the use of strategies and instruments to address culturally diverse situations.

> *There is no formal instrument for recording cultural aspects; communication is the main means of obtaining this information. (Enf_9)*

> *As a nurse, I use a specific instrument to collect information on cultural aspects, including hereditary, genetic, and cultural questions, which is attached to the patient's medical record. (Enf_3)*

> *There is no instrument to identify cultural aspects during the nursing assessment; however, this information is recorded in the patient's medical record. The nursing assessment performed by nurses is a valuable opportunity to identify cultural diversity during hospitalization, preventing difficulties throughout the treatment process. (Enf_1)*

Class 2, in turn, was named “Cultural Encounters.” This class represents direct interactions with woman-mother and child dyads from diverse ethnic and cultural backgrounds, characterized by different cultural values and experiences.

> *I have already experienced difficulties communicating with a woman-mother and her indigenous son regarding medications, schedules, and dosages. I held a meeting with them, and from this discussion emerged the idea of developing [the nurse and the nursing team] a playful booklet organized by medication type, administration times, and meals to facilitate communication. (Enf_17)*

> *I believe that when we are willing to engage in cultural encounters, we create a connection with the woman-mother and her child. The team is already aligned with the hospital’s values and provides care to the woman-mother and her Brazilian child with the same empathy that it extends to woman-mother and child dyads from diverse ethnic and cultural backgrounds. (Enf_19)*

> *For certain cultures, treatment is not the path to healing; instead, faith, prayer,*

> *natural teas, priests, pastors, or religious rituals represent sources of hope. During cultural encounters, it is common for nurses to need to address these cultural aspects in their practice. (Enf_13)*

The fifth theme, represented by Class 3, was named "Cultural Desire." This class reflects nurses' genuine desire to understand the woman-mother and her child in the context of ethnic and cultural diversity, as well as their motivation for self-improvement based on personal commitment and collective engagement. Cultural desire emerges as a powerful driver in the development of cultural competence, arising from an internal willingness to engage with ethnic and cultural differences.

> *I would not say that there is motivation or desire to provide care to woman-mother and child dyads from diverse cultural backgrounds, in the sense of something that inspires us. Rather, there is a concrete need. Ethnic and cultural diversity is a reality, and nursing needs to address it every day. (Enf_9)*

> *I have a desire to work with woman-mother and child dyads while considering their social, cultural, and socioeconomic aspects. I recognize that not all members of the nursing team are open to understanding others, and it is often necessary to create spaces for clear and direct communication, avoiding embarrassment or judgment. (Enf_6)*

The classes presented reflect the process of developing cultural competence experienced by nurses in caring for hospitalized woman-mother and child dyads, characterizing the constructs proposed by the Cultural Competence Care Model.[10]

Discussion

Nursing care in maternal-infant and pediatric contexts responds to the needs of woman-mother and child dyads, with a focus on comprehensive care. In an increasingly globalized world and in inherently multicultural societies, healthcare professionals, particularly nurses, are challenged to provide care that transcends language barriers and sociodemographic differences.[3,9-10,18-19]

Communication barriers encompass practical and structural challenges in the intercultural communication process. Linguistic difficulties, the absence of interpreters, and institutional limitations directly affect the effectiveness of culturally responsive care provided by nurses, potentially resulting in misunderstandings, limitations, refusal, or

non-adherence to the proposed care plan. Therefore, implementing strategies aimed at minimizing the impact of communication barriers is essential to understanding the meaning that women-mothers and their children attribute to care, in order to respond to their needs, anxieties, and expectations.[2,10]

Nurses' self-reflection on their own values, beliefs, and prejudices, that is, their awareness of themselves as cultural beings, is presented and described as the starting point in the process of developing cultural competence.[10,20] Cultural Awareness is crucial because, without it, nurses may consciously or unconsciously impose their own values and beliefs on the woman-mother and her child, reducing the effectiveness and responsiveness of care. It is not merely about learning about other people's cultures, but rather about a process of introspection and self-awareness among healthcare professionals.[10]

In the process of developing cultural competence, the Cultural Knowledge construct represents nurses' theoretical and scientific knowledge regarding the cultural, ethnic, and biological factors that influence the care provided to woman-mother and child dyads. In this context, the Nursing Process, through the Nursing Assessment [21], becomes a fundamental tool for collecting this information, as reported by the interviewed nurses. Relying on current legislation and developing strategies to seek information that enhances care in the context of ethnic and cultural diversity are, therefore, essential elements in the continuous process of developing cultural competence.

Cultural Ability is the third construct of the Cultural Competence Model of Nurses[10] and represents the practical and action-oriented dimension of the process of developing cultural competence. It reflects the practical application of cultural awareness, acquired knowledge, and skills, as well as the use of strategies and instruments to address culturally diverse situations. Although the nurses interviewed described different approaches to seeking such information, they identified the patient's medical record and nursing assessment as important sources of information, while discussions with the multidisciplinary team were described as opportunities for knowledge exchange.[21]

It is, therefore, the nurse's ability to collect relevant data on the health problem and conduct a nursing assessment that addresses the woman-mother and her child as a whole, encompassing their physical, psychological, spiritual, and cultural dimensions in a sensitive and accurate manner. This ability involves technical and linguistic skills, as well as clinical reasoning for planning the interventions to be implemented.

The Cultural Meeting constitutes the fourth construct in the continuous process of developing cultural competence.[10,20] The nurses interviewed described it as direct contact with woman-mothers and their children from diverse ethnic and cultural backgrounds, with different origins and cultural values. In other words, it represents the practical and direct experience nurses gain through interactions with women-mothers and their children from different cultural backgrounds. Cultural Meeting is a fundamental construct and the "source of energy" for the process of developing cultural competence, as it provides an opportunity for cultural awareness, knowledge, and skills to be applied, challenged, and enhanced.[10,]

The fifth construct in the development of cultural competence is Cultural Desire [10,19], described as the genuine willingness and desire that transform technical expertise into humanized and effective care, enabling nurses to understand the woman-mother and her child in the context of ethnic and cultural diversity. It stems from personal motivation and fosters collective engagement.

However, this desire may also arise from the perceived need to provide care, as recognized by nurses when caring for woman-mothers and their children from diverse cultural backgrounds. This need may awaken, strengthen, and enhance a humanized and empathetic perspective, thereby fostering Cultural Desire in the face of diversity.

Cultural Desire emerges as a powerful driver of the development of cultural competence, rooted in an internal readiness to engage with ethnic and cultural differences.[10,19] According to the author, within the Cultural Competence Model of Nurses, Cultural Desire is considered "the key to unlocking" the development of cultural competence, as it provides the motivation necessary to engage with the other constructs: cultural awareness, knowledge, skills, and cultural encounters.

As limitations, although the study aimed to describe the process of developing nurses' cultural competence, the findings reflect the experiences of a specific group of 20 nurses who were intentionally selected. Therefore, the transferability of the findings should be considered in relation to the similarity of contexts, as the study prioritized depth of analysis over breadth of participation. Although efforts were made to achieve saturation of the information collected through the interviews, the inclusion of participants with different sociodemographic or professional profiles might have revealed additional analytical categories. Finally, participants' accounts and experiences are deeply embedded in their cultural and organizational contexts, which may have influenced the findings.

The development of nurses' cultural competence through the Cultural Competence Care Model[10] is an important contribution to promoting culturally responsive healthcare services in maternal, infant, and pediatric settings. Cultural competence emerges not only as a professional asset but also as an ethical and professional imperative, reflecting nurses' ability to recognize, understand, and respect the beliefs, values, and health practices of women and mothers from diverse cultural backgrounds, while adapting the Nursing Process to ensure culturally relevant and acceptable care. The Nurses' Cultural Competence Care Model has the potential to improve nursing care in the context of ethnic and cultural diversity by promoting accessible, culturally responsive, collaborative, and interprofessional care, thereby contributing to the reduction of health disparities.

Conclusion

This study described the process of developing the cultural competence of nurses working in maternal, infant, and pediatric settings in light of the Cultural Competence Care Model. The lexical analysis of the nurses' narratives enabled the identification of six thematic classes, which not only validated the five constructs of the theoretical model – Cultural Awareness, Cultural Knowledge, Cultural Skill, Cultural Encounters, and Cultural Desire – but also revealed a sixth class of equal or even greater practical relevance, related to the communication and structural barriers encountered by the participants.

The results demonstrated that the development of cultural competence is a continuous, complex, and non-linear process. Although Cultural Desire (Class 3) and Cultural Awareness (Class 1) serve as internal drivers for nurses, their practical application, reflected in Cultural Encounters (Class 2) and Cultural Skill (Class 4), is directly mediated by Cultural Knowledge (Class 5). However, the findings also showed that Communication and Structural Barriers (Class 6) act as cross-cutting obstacles that may hinder nurses' cultural desire and cultural skill. The lack of professional interpreters, reliance on technological resources (such as mobile applications), and the absence of institutional tools for intercultural nursing assessment interfere with the collection of essential information regarding the cultural aspects of women, mothers, and their children and, consequently, with the process of developing nurses' cultural competence.

It is concluded that, although nurses demonstrate a desire to actively develop their cultural competence, often driven by the needs they perceive in clinical practice, they are limited by a healthcare system that does not provide the necessary structural support. Therefore, culturally responsive care cannot be viewed solely as an individual responsibility but must also be supported as an institutional policy.

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