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Nurses' Cultural Competence in Sub-Saharan Africa:

A Scoping Review

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ABSTRACT

Background: Sub-Saharan Africa (SSA) carries a disproportionate share of the global disease burden while simultaneously being one of the most ethnically and linguistically diverse regions on earth. The nursing workforce that delivers most first-contact care across this region operates largely without culturally grounded professional frameworks, standardized training structures, or measurement tools validated in its specific context. The downstream effects, including reduced care-seeking, fractured therapeutic alliances, and inequitable health outcomes among culturally marginalized groups, are increasingly documented but remain poorly understood at the health-systems level.

Objective: This scoping review maps the nature and extent of published evidence on nurses' cultural competence in sub-Saharan Africa, examining how the concept is defined, measured, and supported through training, and characterizing the structural gaps that constrain both knowledge accumulation and practical progress.

Methods: Following the Arksey and O'Malley (2005) framework, as refined by Levac et al. (2010), and adhering to the PRISMA Extension for Scoping Reviews (PRISMA-ScR) reporting guidelines, five databases were searched: PubMed, CINAHL, Scopus, African Journals Online (AJOL), and Google Scholar. Peer-reviewed, English-language studies published between January 2015 and December 2025 that addressed nurses' or midwives' cultural competence in a sub-Saharan African context were eligible for inclusion.

Results: Forty-four studies met the inclusion criteria, drawn from nine SSA countries. Ethiopia (31.8%) and South Africa (20.5%) dominated the evidence base. Five cross-cutting

themes were identified: the uncritical application of Western measurement tools in unvalidated SSA contexts; a consistent gap between cultural awareness and actionable cultural knowledge; the systematic exclusion of traditional and indigenous health knowledge from nursing curricula; language and communication as under-theorized structural barriers; and a near-absence of rigorously evaluated training interventions. No SSA-specific cultural competence framework was identified across the 44 included studies.

Conclusions: The evidence base on nurses' cultural competence in sub-Saharan Africa is expanding but remains conceptually fragmented, geographically narrow, and methodologically dependent on frameworks developed for fundamentally different healthcare contexts. The field's most pressing need is the co-development of an SSA-grounded cultural competence model that reflects the region's indigenous knowledge systems, collectivist illness frameworks, and post-colonial healthcare relationships.

Keywords*: cultural competence; nursing; sub-Saharan Africa; trans-cultural nursing; scoping review; PRISMA-ScR; indigenous health knowledge; nursing education; cultural sensitivity; cultural humility*

1. Introduction

Across Sub-Saharan Africa, spanning 46 countries and more than 2,000 distinct ethnic groups, the region holds a degree of cultural, linguistic, and religious heterogeneity that is unmatched anywhere else on earth [29]. Within this context, healthcare is not a culturally neutral activity, every clinical interaction is shaped by the patient's understanding of illness causation, the legitimacy they ascribe to biomedical authority, the degree to which family mediates decision-making, and the competing standing of traditional healing systems. None of these dimensions are incidental to quality of care, but they help determine it.

Cultural competence in nursing refers to the capacity of individual practitioners and care systems to engage meaningfully and safely with patients whose cultural frameworks differ from those embedded in standard clinical training [27]. Since Campinha-Bacote's formulation in the early 2000s, the construct has accumulated theoretical elaboration through Leininger's Culture Care Theory [28] and Purnell's model for cultural competence [31]. These frameworks share a broadly developmental architecture in which cultural competence unfolds across stages of awareness, knowledge, skill acquisition, and self-directed encounter. What they equally share, and what matters considerably for their application across sub-Saharan Africa, is that all three were developed in the United States, primarily to address clinical encounters between majority-culture providers and immigrant or ethnic minority patients in Western healthcare systems.

The transplantation of these frameworks to SSA has proceeded largely without critical examination. Cross-sectional studies measuring nurses' cultural competence in Ethiopia [1, 4, 5], South Africa [2, 3, 6], and Kenya [7] consistently deploy instruments validated in North American contexts, most frequently Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence among Healthcare

Professionals-Revised (IAPCC-R), without documented psychometric re-validation in SSA populations. The assumptions embedded in these tools, including individual patient autonomy, the patient's right to full diagnostic disclosure, and the epistemological primacy of biomedicine, sit in unresolved tension with healthcare realities across much of the region, where family-mediated decision-making is routine, traditional healers are often consulted before biomedical providers, and institutional mistrust carries a deep historical weight.

The consequences of this mismatch has not been theoretical, for example, qualitative evidence from Uganda documents the profound moral distress experienced by nurses in Ebola treatment contexts when patients' cultural practices around death and bodily integrity collided with infection prevention protocols, with no institutional framework available to navigate the collision [8]. In Kenya, birth attendants described cultural sensitivity as something they learned at home, not in training, suggesting that the nursing profession has effectively outsourced cultural competence to personal biography and circumstance [7]. In Ghana, nurses caring for women with breast cancer found themselves structurally caught between biomedical disclosure norms and the cultural imperative to protect patients from distressing prognosis, without guidance from either clinical policy or professional frameworks [14]. Each of these accounts describes improvisation in place of competence, and improvisation, however well-intentioned, does not constitute a sustainable approach to culturally safe care.

This scoping review was conducted to map what the published literature actually knows about nurses' cultural competence in sub-Saharan Africa, how the concept has been defined, which frameworks have been applied, how competence has been measured, what training exists, and where the evidence is structurally absent.

1.1 Broad Objectives

1. To systematically map the extent and nature of published evidence on nurses' cultural competence across sub-Saharan African healthcare settings, published between 2015 and 2025.
2. To characterize the conceptual, methodological, and geographic landscape of the existing evidence base, identifying its dominant patterns and its most significant silences.

1.2 Specific Objectives

1. To identify peer-reviewed studies that address nurses' or midwives' cultural competence in sub-Saharan Africa and describe their country of origin, healthcare setting, and study design.
2. To examine how 'cultural competence' is defined, or left undefined, across the included literature, and to document the terminological variation that complicates cross-study synthesis.
3. To map the measurement instruments applied in SSA nursing cultural competence research and assess the degree to which these tools have been validated in the populations and contexts where they are used.
4. To identify what training interventions have been designed, implemented, or evaluated to improve nurses' cultural competence in SSA, and to appraise the rigor of available evaluative evidence.
5. To identify the healthcare settings, clinical specialties, and geographic regions that remain underrepresented in the evidence base, and to articulate what this absence means for knowledge translation and policy.

1.3 Review Question

What is the extent and nature of published evidence on nurses' cultural competence in sub-Saharan Africa, and how is the concept defined, measured, and supported through training within this context?

2. Methods

This review follows the scoping review methodology developed by Arksey and O'Malley [24] and refined through the substantive contributions of Levac et al. [26], who introduced more rigorous standards for team-based screening, iterative charting, and knowledge translation. Reporting adheres to the PRISMA Extension for Scoping Reviews (PRISMA-ScR) checklist [25]. A scoping review design was selected over a systematic review because the primary aim was to map and characterize a literature rather than to synthesize effect sizes or generate pooled estimates. The diversity of study designs encountered during preliminary searching confirmed this as the appropriate methodological choice.

2.1 Population, Concept, Context (PCC) Framework

The PCC framework was used to structure eligibility criteria. The population of interest was registered nurses and midwives working in any clinical or educational capacity across sub-Saharan Africa. The concept was cultural competence, defined inclusively to encompass cultural awareness, cultural knowledge, cultural sensitivity, trans-cultural self-efficacy, cultural humility, and related constructs that appear interchangeably in the nursing literature. The context was any sub-Saharan African country, across hospital, primary care, community health, mental health, nursing education, and public health settings.

2.2 Eligibility Criteria

Studies were included if they: (1) addressed cultural competence or a directly related construct among nurses or midwives; (2) were conducted in a sub-Saharan African country; (3) were published between

January 2015 and December 2025; (4) appeared in a peer-reviewed journal published in English; and (5) involved primary data collection (quantitative, qualitative, or mixed-methods) or constituted an SSA-focused evidence synthesis. Studies were excluded if they were editorials, opinion pieces, or letters without original data; if they focused on non-nursing health workers without dis-aggregating nurse-specific findings; if they examined SSA-origin populations studied outside the region; or if they were conference abstracts not accompanied by a full-text publication.

2.3 Search Strategy

Structured searches were conducted across five databases: PubMed, CINAHL, Scopus, African Journals Online (AJOL), and Google Scholar (first ten pages, hand-screened). The deliberate inclusion of AJOL was intended to reduce the systematic under-representation of African-authored and African-published research that characterizes major Northern databases [30]. Search terms were developed around three concept clusters: (1) cultural competence, trans-cultural nursing, cultural sensitivity, cultural humility, cultural awareness, intercultural health, cultural safety; (2) nurse, nursing, midwife, midwifery, nurse educator, nursing student; and (3) sub-Saharan Africa, Africa, followed by the names of all 46 SSA countries. Within-cluster terms were combined using OR; clusters were linked using AND. MeSH headings were applied in PubMed; equivalent controlled vocabulary was used in CINAHL and Scopus. Searches were conducted in January 2025.

2.4 Study Selection

All records were exported to Rayyan for deduplication and screening management. Two reviewers independently screened titles and abstracts against the eligibility criteria, with discrepancies resolved through discussion and a third reviewer available for adjudication. Full texts of all potentially eligible records were retrieved and assessed by both reviewers. Reasons for exclusion at the full-text stage

were documented systematically. The selection process is presented in Table 1 in accordance with PRISMA-ScR [25].

Table 1: Study Selection Summary (PRISMA-ScR Flow)

Phase	Study Selection Stage	n
Identification	Records identified through database searches	
	PubMed	**612**
	CINAHL	**538**
	Scopus	**471**
	African Journals Online (AJOL)	**284**
	Google Scholar (first 10 papers, hand-screened)	**317**
	Total records before deduplication	**2,222**
	Duplicates removed	**489**
	Records after deduplication	**1,733**
Screening	Records screened at title and abstract level	**1,733**
	Records excluded at title/abstract stage	**1,471**
	Full texts retrieved for eligibility assessment	**262**
Eligibility	Full texts excluded (reasons documented below)	**218**
	— Did not address nurses'/midwives' cultural competence	**71**

Phase	Study Selection Stage	n
	— Conducted outside sub-Saharan Africa	**58**
	— Outside 2015–2025 publication window	**39**
	— Not peer-reviewed or grey literature	**28**
	— Conference abstracts without full text	**22**
Included	Studies included in final synthesis	**44**

2.5 Data Charting

Data were extracted using a standardized charting form developed iteratively and piloted across ten studies before full application. Variables captured included: author(s) and year; country of origin; healthcare setting; study design; sample size and characteristics; the cultural competence construct used and whether it was formally defined; the measurement instrument or data collection tool; key findings relevant to cultural competence; and whether a theoretical or conceptual framework was explicitly stated. The form was refined following piloting to better capture the range of instrument types and competence domains encountered.

2.6 Data Synthesis

Synthesis used descriptive statistics and thematic analysis. Frequency counts were generated for country, study design, setting, instrument, and competence domain. Thematic analysis proceeded inductively, themes were developed from the data rather than from a predetermined coding framework, consistent with the exploratory intent of scoping review methodology. Gaps in the

evidence were identified through systematic comparison of what the literature covered against the full scope of the PCC framework.

3. Results

Forty-four studies met the eligibility criteria. Table 2 presents fifteen representative studies selected to illustrate the methodological and geographic range of the full dataset. Table 4 presents the complete country distribution. Table 3 maps the theoretical frameworks and measurement instruments applied across the literature.

3.1 Geographic Distribution and Healthcare Settings

Ethiopia accounted for 14 of 44 included studies (31.8%) [1, 4, 5, 11], and South Africa for nine (20.5%) [2, 3, 6, 10, 18, 22, 23]. Kenya, Nigeria, Uganda, Namibia, and Ghana together contributed the remainder. Conspicuously absent were the DRC, Tanzania, Côte d'Ivoire, Cameroon, Angola, and Mozambique, countries that collectively account for hundreds of millions of people and substantial nursing workforces, yet whose nursing communities remain invisible in this literature. The concentration of evidence in two countries is not a minor bibliometric imbalance; it means that the field's practical knowledge base substantially reflects the healthcare systems of Ethiopia and South Africa, whose nurse training traditions, regulatory frameworks, and patient demographics are not representative of SSA as a whole.

Acute hospital settings dominated, appearing in 29 of 44 studies. Primary care and community health settings featured in nine. Nursing education settings, schools of nursing, university programmes, and pre-service institutions, appeared in six [9, 10, 19, 21, 33]. Mental health nursing, palliative care, and public

health each appeared in fewer than three studies, and pediatric nursing was absent entirely as a distinct setting category. Table 4 summarizes the full country and setting distribution.

Table 4: Geographic Distribution of Included Studies (n = 44)

Country	Studies (n)	% of Total	Primary Healthcare Settings Covered
Ethiopia	14	31.8%	Public hospitals (federal, regional, zonal), primary health units
South Africa	9	20.5%	Tertiary hospitals, psychiatric units, maternal care, community health centers
Kenya	4	9.1%	County referral hospitals, primary care facilities, coastal clinics
Nigeria	4	9.1%	Teaching hospitals, PHC facilities, maternity units
Uganda	3	6.8%	Regional referral hospitals, Ebola treatment units
Namibia	3	6.8%	University nursing schools, government hospitals
Ghana	3	6.8%	Oncology clinics, antenatal care units, teaching hospitals
Senegal	1	2.3%	Community health clinics
Multi-country / SSA-wide review	3	6.8%	Various (narrative and review-level analysis)
Total	44	100%	—

3.2 Measurement Tools and Theoretical Frameworks

The IAPCC-R [27] was the most frequently used instrument, applied in four studies [4, 5, 11]. The Transcultural Self-Efficacy Tool (TSET) appeared in one study [11]. Several studies employed adapted

or modified versions of Western instruments without documenting the adaptation process or re-assessing psychometric properties in their study population [1, 12]. Of the 44 included studies, 33 reported no explicit theoretical or conceptual framework for their investigation. Of the eleven that did, Campinha-Bacote's process model [27] was cited most often, followed by Leininger's Culture Care Theory [28] and Purnell's model [31]. Critically, not one study reported using or developing a cultural competence framework specific to SSA nursing. Table 3 maps the frameworks and instruments systematically.

Table 3: Theoretical Frameworks and Measurement Tools Across Included Studies

Framework / Model	Origin & Year	Studies Applying it in SSA	Documented Limitations for SSA Context	n
Campinha-Bacote IAPCC-R	USA, 2002	Birhanu et al. (2023); Zeleke et al. (2024); Berhanu et al. (2021)	Validated exclusively in Western contexts; lacks dimensions for traditional healer integration and collectivist illness models	4
Purnell Model for Cultural Competence	USA, 2000	Maboko et al. (2024); Shopo et al. (2023)	Assumes individual patient autonomy that conflicts with family-centered decision-making norms across SSA	2
Leininger's Culture Care Theory	USA, 1988	Khumoetsile Daphney et al. (2023); Ngunyulu et al. (2020)	Pre-dates the HIV era; sunrise model not adapted for resource-constrained or post-colonial SSA environments	2

Framework / Model	Origin & Year	Studies Applying it in SSA	Documented Limitations for SSA Context	n
Transcultural Self-Efficacy Tool (TSET)	USA, 1999	Berhanu et al. (2021)	Items not validated in multilingual, low-resource SSA settings; psychometric properties unconfirmed in African populations	1
Adapted or modified instruments	Various	Berhanu et al. (2024); Nabil et al. (2023)	Adaptation processes are largely undocumented; construct validity rarely re-assessed after modification	2
No explicit framework stated	—	Ngotie et al. (2022); Okello Wonyima et al. (2022); Gyasi (2018); Agyemang et al. (2021); and 29 others	Conceptual drift, 'cultural competence' is either undefined or loosely operationalized across these studies	33

3.3 Cultural Competence Levels Reported

Across the quantitative studies, competence scores clustered at moderate levels with marked variability both between and within countries. found that only 34.4% of nurses in southwest Ethiopia reached 'culturally competent' or above on the IAPCC-R. Using an adapted version of the same instrument in a different Ethiopian region, Birhanu et al. [4] found 44.8% at competence level. Zeleke et al. [5], in a multi-center northeast Ethiopian study, reported a mean overall score of 72.4 out of 100. This variation within a single country, across studies using similar instruments, points to substantial contextual influence on competence levels, a finding these studies corroborate through multivariate

analyses that identify institutional context, rurality, and prior in-service training as independent determinants.

Sub-scale analyses told a consistent story across countries. Cultural awareness reliably scored higher than cultural knowledge, which consistently exceeded cultural skill, in South African studies [2, 3] and Ethiopian studies alike [1, 11]. This gradient, awareness preceding knowledge preceding actionable skill, suggests that exposure to diversity raises awareness without automatically producing structured knowledge, and that structured knowledge does not automatically produce clinical skill. The step from awareness to competent practice requires sustained pedagogical investment, and that investment is what the SSA training landscape has not yet made.

The qualitative evidence provided texture that quantitative subscales cannot capture. Midwives in South Africa navigated the cultural dimensions of maternal care through personal intuition, entirely without formal frameworks [6]. Birth attendants in Kenya recalled that they learned cultural sensitivity at home, but not in training [7]. Nurses in Ugandan Ebola units described the collision between infection control protocols and patients' cultural practices around dying as a sustained source of moral distress for which nothing in their professional formation had prepared them [8]. These unique accounts taken together, they describe a nursing workforce managing cultural complexity through improvisation, a form of practice that is personal, unverifiable, unsustainable, and incapable of being taught.

Table 2: Characteristics of Representative Included Studies (n = 15 of 44)

Author & Year	Country	Setting	Study Design	Sample	Measure / Tool	Key Finding	Competence Domain
Berhanu et al. (2024)	Ethiopia	SW Ethiopia hospitals	Cross-sectional	n = 390	Cultural sensitivity scale	63.8% scored high cultural sensitivity; nurses with no in-service training scored lower	Awareness, attitudes
Maboko et al. (2024)	South Africa	Gauteng public hospitals	Descriptive survey	n = 200 patients	Patient perception tool	Patients rated nurses' competence moderate; communication subscale was consistently weakest	Communication, skills
Shopo et al. (2023)	South Africa	North-West Province	Cross-sectional	n = 196 midwives	Self-report scale	Cultural awareness scored highest; cultural knowledge subscale was lowest	Awareness, knowledge
Birhanu et al. (2023)	Ethiopia	Benishangul Gumuz region	Cross-sectional	n = 281	Adapted IAPCC-R	44.8% culturally competent; urban posting	Knowledge, skills

Author & Year	Country	Setting	Study Design	Sample	Measure / Tool	Key Finding	Competence Domain
						and prior training significantly associated	
Zeleke et al. (2024)	Ethiopia	NE Ethiopia hospitals	Multi-centre survey	n = 345	IAPCC-R	Mean score 72.4/100; education level and training exposure were independent predictors	Knowledge, awareness
Khumoetsile Daphney et al. (2023)	South Africa	Maternal care units	Qualitative (IDIs)	n = 16 midwives	Semi-structured interviews	Nurses navigated cultural births without formal frameworks; relied on intuition alone	Skills, attitudes
Ngotie et al. (2022)	Kenya	Primary care, coast region	Phenomenological	n = 14 birth attendants	In-depth interviews	Cultural sensitivity seen as a personal virtue, not a professional competency; no institutional guidance	Awareness, skills

Author & Year	Country	Setting	Study Design	Sample	Measure / Tool	Key Finding	Competence Domain
Okello Wonyima et al. (2022)	Uganda	Ebola treatment units	Qualitative	n = 12 nurses	Narrative interviews	Cultural rituals around death created moral distress; nurses had no culturally safe protocols	Knowledge, attitudes
Nuuyoma et al. (2024)	Namibia	School of nursing	Qualitative descriptive	n = 20 students	Focus group discussions	Students valued multicultural exposure but curricula contained no transcultural nursing content	Knowledge, awareness
Ngunyulu et al. (2020)	South Africa	University nursing programme	Qualitative	n = 15 nurse educators	Participatory inquiry	African traditional knowledge entirely absent from curricula; educators called for decolonial reform	Knowledge, attitudes
Berhanu et al. (2021)	Ethiopia	Ethiopian hospitals	Cross-sectional	n = 310	TSET instrument	Transcultural self-efficacy moderate	Self-efficacy, skills

Author & Year	Country	Setting	Study Design	Sample	Measure / Tool	Key Finding	Competence Domain
						(mean 3.4/5); negatively associated with rural deployment	
Nabil et al. (2023)	Senegal	Community health clinics	Quasi-experimental	n = 40	Pre/post knowledge test	Targeted training raised culturally competent care scores significantly ($p < 0.001$)	Knowledge, skills
Gyasi (2018)	SSA (multi-country)	Various clinical settings	Narrative review	N/A	Literature synthesis	Intercultural nursing in SSA largely undocumented and systematically undervalued by health systems	Awareness, attitudes
Agyemang et al. (2021)	Ghana	Oncology clinics	Ethnography	n = 30 women	Observation + interviews	Cultural norms suppressed disclosure; nurses had no frameworks to navigate	Communication, knowledge

Author & Year	Country	Setting	Study Design	Sample	Measure / Tool	Key Finding	Competence Domain
						family-patient dynamics	

3.4 Training Interventions

Evidence on structured training interventions to improve nurses' cultural competence in SSA was sparse. Only three included studies examined any deliberate training programme. Nabil et al. [12] designed and evaluated a culturally competent psycho-social care training programme for health workers in Senegal, finding significant post-training improvements in knowledge scores ($p < 0.001$) using a quasi-experimental pre-post design with a sample of 40 participants. The study's small sample and absence of a control group limit its generalizability, but it stands out as one of the only examples in the entire SSA nursing literature of a training intervention accompanied by any evaluative data.

Ngunyulu et al. [10] engaged nurse educators in South Africa through participatory inquiry, documenting strong consensus that African traditional and indigenous knowledge was absent from nursing curricula, despite its centrality to patients' health beliefs, care-seeking behavior, and responses to treatment. Nuuyoma et al. [9] reported parallel findings from Namibia: nursing students in a multicultural training environment valued the cross-cultural exposure their setting provided, but their formal curriculum contained no trans-cultural nursing content at all. These three studies together reflect a curricular architecture that has not yet engaged seriously with the cultural realities of the communities these nurses are being prepared to serve.

3.5 Language and Communication as Structural Barriers

Language-related barriers to culturally competent care were documented across multiple countries and clinical settings. In South Africa, where eleven official languages are recognized and a substantial proportion of patients do not speak the language in which their nurse was trained, communication breakdown was the most consistently reported obstacle to effective, culturally safe care [2, 19]. Ndawo's [19] study of nurse educators documented the language of instruction as a persistent impediment to both teaching quality and professional identity formation among students whose home language differed from the institutional medium of instruction.

In oncology settings across SSA, Lounsbury et al. [16] found that nurses and physicians navigating disclosure conversations with cancer patients faced culturally specific constraints around directness, prognosis, and the role of family that standard communication training had not equiped them to manage. Baum et al. [20] described, in the context of Somali pastoralists in the Horn of Africa, how pain management was systematically compromised when health professionals lacked the cultural and linguistic frameworks to understand how suffering, stoicism, and the body are socially constructed in pastoralist communities. The recurring pattern across these studies is that language barriers are treated as logistical inconveniences, when in fact they represent larger epistemological obstacles.

3.6 Factors Associated with Cultural Competence

The quantitative literature consistently identified years of nursing experience and educational level as positively associated with cultural competence scores in Ethiopia [4, 5] and South Africa [3]. Exposure to formal in-service or continuing professional education was the most consistently reported independent predictor across studies [1, 4]. Rural deployment was negatively associated with cultural competence in Ethiopia [5, 11], though this association requires careful interpretation: rural nurses often serve more

ethnically homogeneous communities, where the salience of cultural difference may be less visible to the practitioner, even when it remains fully operative in shaping how patients understand and respond to care.

Several qualitative studies foregrounded institutional context as a powerful moderator of individual practice. In settings where facilities had no interpreter services, no formal policies acknowledging cultural diversity, no mechanisms for engaging traditional health practitioners, and no quality indicators tied to cultural care, nurses who wished to practice culturally were required to do so at personal cost and without institutional support [6, 7, 8]. This pattern points to a gap that extends beyond individual competence measurement: the institutional and systems-level dimensions of cultural capacity in SSA nursing have barely been studied at all.

4. Discussion

This scoping review set out to map what is known about nurses' cultural competence in sub-Saharan Africa, how much, in what form, from where, and measured by what means, and the short answer is that the literature is growing but has not yet achieved the coherence, geographic breadth, or theoretical grounding that the scale of the problem demands. Three structural features of the evidence base account for this.

4.1 The Framework Problem: Using Tools Built for Other Questions

The most consequential limitation in the existing literature is the absence of any cultural competence framework developed for, or validated within, the SSA nursing context. Every theoretical model applied across the 44 included studies originated in the United States [27, 28, 31]. The IAPCC-R [27] operationalizes 'cultural desire' as an individual professional attribute, an internal motivation to

become culturally competent. In SSA contexts, where cultural sensitivity is embedded in community obligation, inter-generational knowledge transmission, and relational accountability rather than individual professional identity, this framing does not simply translate awkwardly, but it may miss the operative mechanism entirely. Leininger's sunrise model [28] was designed to represent the totality of cultural influences on human care, an ambitious and genuinely humanistic project, but it was designed before HIV restructured the care ecology of sub-Saharan Africa, before post-colonial critiques became analytically unavoidable in nursing theory, and before the governance questions around formal traditional healer integration entered health systems policy. Its application to SSA requires adaptation that the field has not yet undertaken.

The practical consequence of framework transplantation without validation is measurement distortion. When an instrument normed on North American healthcare populations is administered to nurses in rural Ethiopia or coastal Kenya, the scores produced measure how those nurses compare to a North American reference, not how effectively they navigate the cultural dimensions of care within their actual clinical world. This is a fundamental validity problem that most included studies acknowledged, if at all, only in a limitations paragraph.

4.2 The Curricula Gap: What Nurses Were Never Taught

Nurse educators in South Africa [10] and nursing students in Namibia [9] reported, independently and in different institutional contexts, that trans-cultural nursing had no presence in their formal curricula, a gap produced by curricular design. The architecture of nursing education in SSA was shaped

substantially by colonial professional norms in which African traditional medicine was positioned as the foil to modern scientific nursing, and cultural difference was a barrier to be managed rather than a dimension of care to be engaged.

The curricula gap also generates a secondary problem for the research literature. When nurses have received no formal instruction in cultural competence and have no shared professional vocabulary for the concept, the construct validity of self-report instruments assessing their competence becomes uncertain. A nurse who has never been introduced to 'cultural desire', 'cultural encounter', or 'cultural knowledge' as distinct professional constructs, may score low on an instrument not because they lack the underlying capacity but because the question does not translate into a meaningful self-assessment in their professional context. Conversely, a nurse who has spent decades working within their own ethnic community may self-rate as culturally aware through a form of familiarity that current instruments cannot distinguish from competence.

4.3 Geographic Concentration and Its Consequences

Ethiopia and South Africa together account for just over half of all evidence on nurses' cultural competence across a continent of 47 countries and a nursing workforce exceeding one million [30]. Ethiopia and South Africa have distinctive nurse training traditions, distinctive regulatory structures, and patient populations whose cultural configurations differ substantially from those in Central Africa, the Sahel, or the Indian Ocean island states. A policy framework or curriculum model derived primarily from Ethiopian and South African evidence may fit other SSA contexts poorly, and the field currently has insufficient data to know.

The setting concentration compounds this problem. Primary care nurses, community health workers with nursing qualifications, mental health nurses, and pediatric nurses collectively deliver the majority

of first-contact care across SSA, yet they are almost entirely absent from the cultural competence literature. The people who most depend on culturally competent nursing, rural communities, marginalized ethnic groups, patients navigating chronic illness alongside traditional healing, are cared for precisely in the settings the evidence is yet to be reached.

4.4 Implications for Research

The most pressing research priority is the development and empirical validation of a cultural competence framework grounded in SSA nursing realities. Such a framework must engage substantively with the role of traditional healing alongside biomedical care, with collective and family-centered models of decision-making, with linguistic plurality as a structural feature of the healthcare environment as compared to it being an exceptional challenge, and with the historical legacies of colonial medicine that continue to shape both patient-provider relationships and the professional identity of nurses trained in post-colonial institutions. This is a crucial task that requires sustained interdisciplinary collaboration across the region, involving nursing researchers, medical anthropologists, health systems scholars, and practicing nurses whose clinical experience is the primary data.

The lone quasi-experimental study in the included literature [12] shows that targeted training can shift cultural competence scores, but what remains unknown is whether score changes translate into different clinical behavior, stronger therapeutic alliances, or improved patient outcomes. Answering these questions requires studies with longer follow-up, validated behavioral outcomes, culturally adapted intervention content, and designs capable of isolating the mechanisms of change.

4.5 Implications for Policy and Practice

For nursing regulatory bodies, accreditation authorities, and ministries of health across SSA, this review makes a direct case for action: cultural competence is not currently required, assessed, or systematically taught as part of nursing education or continuing professional development in most SSA countries, and given the documented relationship between cultural incompetence and avoidable harm, care-seeking delays, non-adherence, sub-optimal outcomes among culturally marginalized populations [14, 15, 17] , this is a regulatory gap with measurable health costs. The integration of indigenous knowledge into pre-service nursing curricula [10] does not require waiting for a validated regional framework to be developed.

For healthcare facility managers, the qualitative evidence on institutional moderators makes a clear argument: individual training gains are unlikely to be sustained where the broader institutional environment provides no interpreter services, no policies for engaging traditional practitioners, no cultural safety standards, and no performance indicators that make cultural care visible and accountable [6, 7, 8]. System-level change requires institutional will and policy direction more than it requires additional funding.

4.6 Limitations

This review carries several limitations that should inform how its findings are used. The restriction to English-language publications means that research published in French, Portuguese, or Swahili, languages widely used across francophone, lusophone, and East African SSA countries, was not captured, likely underestimating the evidence base from West and Central Africa. The Google Scholar search was limited to the first ten papers, which introduces the possibility that relevant studies were

missed. Charting and categorization involve interpretive judgments, and a different reviewer team might have classified some studies differently, particularly around the definitional boundary between cultural competence, cultural safety, and cultural humility. Finally, as is inherent in scoping review methodology, the quality of included studies was not formally appraised, meaning that findings from studies of varying methodological rigor are synthesized without quality-based weighting.

5. Conclusion

The nursing workforce of sub-Saharan Africa works at the intersection of extraordinary cultural plurality and a set of professional frameworks that were not designed to navigate it. Across 44 studies from nine countries, this review has documented both the growing recognition of cultural competence as a clinical and policy priority in the region and the structural conditions, borrowed frameworks, absent curricula, geographically uneven evidence, that prevent that recognition from producing substantive change. Cultural competence for nurses in SSA will be built by going back to first principles: asking what cultural competence actually means in a healthcare environment shaped by 2,000 languages, pervasive traditional healing, historical institutional mistrust, and a nursing workforce that has been professionally trained to look away from culture rather than towards it.

Abbreviations

SSA: Sub-Saharan Africa; PRISMA-ScR: Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews; PCC: Population, Concept, Context; IAPCC-R:

Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals-Revised; TSET: Transcultural Self-Efficacy Tool; AJOL: African Journals Online; PHC: Primary Health Care; IDIs: In-depth Interviews

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Ethics declaration

Ethics approval and consent to participate - Not applicable since this study is a scoping review of published literature and did not involve human participants or primary data collection.

Competing Interests

The authors declare that they have no competing interests.

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Authors Contribution

Both authors, Joel Musyoki and Brian Simba, contributed equally to the development of this work.

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Availability of data and materials

All data generated and analyzed during this study are included in this article and its supplementary information files

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