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Awareness and Acceptance of Cultural Diversity in Healthcare Settings

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Abstract

Background: Nepal's multi-ethnic and multilingual society is characterized by a deep-rooted caste-based hierarchy, which has historically led to the marginalization of groups like Dalits, Janajatis, and Madhesis. This social stratification creates significant barriers to equitable healthcare access and utilization. Cultural competence among healthcare providers is therefore essential for ethical practice and quality care, yet factors limiting access for ethnic minorities remain poorly understood.

Objectives: This study aimed to (1) assess the awareness and acceptance of cultural and religious diversity in healthcare among individuals in Nepal, and (2) examine gender-based differences in this awareness and acceptance.

Methods: A quantitative cross-sectional study was conducted with a sample of 247 participants, including the general public, healthcare providers, patients, and students. Data were collected via an online questionnaire using simple random sampling. The instrument included a demographic section, a diversity awareness scale, and a diversity acceptance and inclusivity scale based on a Likert scale. Data were analyzed using descriptive statistics and independent samples t-tests to compare gender differences.

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Findings: Participants demonstrated a strong consensus (Mean=3.77) that healthcare institutions must cater to diverse patient needs. Awareness of how cultural/religious backgrounds affect healthcare preferences was moderate (Mean=3.17). A significant gender difference was found in awareness, with females (M=2.89) scoring significantly higher than males (M=2.73, p=0.030). However, no significant gender difference was observed in the level of acceptance of diversity (p=0.280).
Conclusion: While there is a strong overall acceptance of the need for diversity in healthcare, awareness of its specific impact is only moderate and varies by gender. Females show a significantly greater understanding of diversity issues compared to males.
Implication: The findings highlight a critical need for targeted educational interventions and cultural competence training for both healthcare professionals and the public, with a specific focus on improving awareness among male demographics. This is vital for developing more inclusive and equitable healthcare services in Nepal's diverse society.
Keywords: Cultural Competence, Healthcare Diversity, Gender Differences, Health Equity, Nepal, Caste System, Access to Healthcare

Introduction

Nepal is a multi-ethnic (142 ethnic groups) and multilingual (125 spoken languages) country with caste-based hierarchies (Central Bureau of Statistics, 2021). The caste-based hierarchies officially began in 1854 when socially, culturally, and linguistically distinct ethnic minorities and indigenous groups were merged to produce five groups. The groups of Brahmin and Chhetri occupied the high caste group and the remaining were classified beneath them with Dalit occupying the bottom of the Hindu caste system (Gurung, 2005).

In the Hindu caste system, Dalits are considered untouchable and are widely discriminated against, although caste-based discrimination was officially abolished in 1963 (Gurung, 2005). Similarly, indigenous groups such as Chepang and Tamang in the hill region, and ethnic minorities such as Muslim and Madhesi, in the Terai occupy low social status and continue to underuse healthcare services (Gurung, 2005).

In a multicultural society, the delivery of quality healthcare hinges on providers' ability to understand, communicate with and care for patients from various ethnic backgrounds. The essence of cultural competence lies in the acknowledgement of the significance of culture in lives, respect and minimizing any repercussions due to cultural differences. Having culturally competent clinicians supports the idea of ethical medical practice by advancing patient autonomy and justice. (Panthi, et al., 2022). The ability of healthcare professionals to comprehend, interact with, and treat patients from a variety of ethnic origins is fundamentally linked to the delivery of high-quality healthcare in such a heterogeneous environment.

Despite the efforts of community health workers to increase access to healthcare among ethnic minority groups in low- and -middle income countries, members of ethnic minorities are less likely than women from other ethnic groups to use maternal and child healthcare services. However, much less is known about the factors that limit access of ethnic minorities to

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healthcare services, including the services of community health workers in Nepal, who are known as Female Community Health Volunteers (FCHVs) (Panday, Bissell, Teijlingen, & Simkhada, 2019).

Ethnomedical healthcare practices also play a significant role in Nepal, with many individuals utilizing indigenous healing and curing practices alongside or instead of conventional medicine (Adhikari, Menaria, & Gartoulla, 2019). This occurs even with the government's policy of providing free primary healthcare services at the basic administrative levels (Adhikari, Menaria, & Gartoulla, 2019). Factors such as education, distance to health facilities, affordability, and waiting times also play a crucial role in access to and utilization of healthcare services (Shrestha, Phuyal, Pant, & Kumar, 2019)

Objectives of Study

To assess the awareness and acceptance of cultural, religious diversity in healthcare among individuals.

To examine gender-based differences in the awareness and acceptance of diversity within healthcare settings.

Research Methodology

This study adopted a quantitative research method using both descriptive and comparative research designs to explore awareness and acceptance of religious diversity in healthcare. The study population included diverse groups to provide a comprehensive understanding of the topic, comprising:

- General public aged 18 and above from various ethnic, gender, and socioeconomic backgrounds
- Healthcare providers such as doctors, nurses, and community health workers
- Patients who access healthcare services at health centers
- Students enrolled in different institutions

The final calculated sample size was 247 to ensure adequate representation. A simple random sampling technique was employed to select participants, enhancing the generalizability of the results.

Data were collected through an online questionnaire consisting of a demographic section to gather basic participant information, a diversity awareness scale to measure understanding of diverse needs, and a diversity acceptance and inclusivity scale based on a Likert scale. Prior to participation, informed consent was obtained from each respondent. The data collection period spanned two weeks to provide sufficient time for participants to respond. The use of electronic surveys ensured convenience for respondents and helped achieve a higher response rate.

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Results

Table 1 Gender

Gender					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	104	42.1	42.1	42.1
	Male	136	55.1	55.1	97.2
	Prefer not to say	7	2.8	2.8	100.0
	Total	247	100.0	100.0	

Source: Field Survey 2025

The above table shows the gender distribution of 247 respondents in the study on level of awareness and openness among Nepalese people toward diverse and inclusive healthcare services. Out of total respondents, 104 were female, representing 42.1% of the total respondents meanwhile, 136 were male representing 55.1% of the same, and 7 of them representing 2.8% preferred not to disclose their gender. When adding the male, female and other respondents, the cumulative total reaches 100%. This demographic breakdown helps ensure a balanced representation of genders in the analysis, providing insights into the study.

Table 2 Role

Role					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Healthcare provider	51	20.6	20.6	20.6
	Student	96	38.9	38.9	59.5
	Patient	71	28.7	28.7	88.3
	Others	29	11.7	11.7	100.0
	Total	247	100.0	100.0	

Source: Field Survey 2025

The table categorizes the distribution of respondents based on their roles, which reveals important insights into the perspectives represented. Among the 247 participants, the largest group comprises students (38.9%), followed by patients (28.7%), healthcare providers (20.6%), and others (11.7%).

Table 3 Cultural background

Cultural background					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Brahmin	68	27.5	27.5	27.5
	Chhetri	103	41.7	41.7	69.2
	Janajati	51	20.6	20.6	89.9
	Others	25	10.1	10.1	100.0
	Total	247	100.0	100.0	

Source: Field Survey 2025

The table examines the cultural background of respondents, among different ethnic groups in Nepal. The largest group is Chhetri (41.7%), followed by Brahmin (27.5%), Janajati (20.6%), and others (10.1%). This distribution suggests that traditionally dominant groups (Brahmin and Chhetri) together constitute nearly 70% of respondents. Janajati communities, representing 20.6%, may have different

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perspectives due to their distinct cultural practices and past marginalization, possibly making them more sensitive to the need for inclusive healthcare. The smaller "others" category (10.1%) likely includes marginalized and minority groups, whose underrepresentation could indicate limited participation in discussions on healthcare inclusivity, possibly due to systemic barriers.

Table 4 Education Level

Education Level					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	High school	56	22.7	22.7	22.7
	Undergraduate	97	39.3	39.3	61.9
	Postgraduate	64	25.9	25.9	87.9
	Illitrate	30	12.1	12.1	100.0
	Total	247	100.0	100.0	

Source: Field Survey 2025

The above table indicates that all 247 respondents in the survey are from general population of Nepal, representing the largest group which consists of undergraduate-educated individuals (39.3%), followed by postgraduates (25.9%), high school graduates (22.7%), and illiterate respondents (12.1%). This distribution suggests that a majority of respondents (over 85%) have at least a high school education, which likely correlates with higher awareness of healthcare inclusivity due to greater exposure to health literacy.

Table 5 Interaction with healthcare services

Have you interacted with healthcare services in past 12 months?					
		Gender			Total
		Female	Male	Prefer not to say	
Have you interacted with healthcare services in past 12 months?	Yes	66	105	2	173
	No	20	15	1	36
	Maybe	18	16	4	38
Total		104	136	7	247

Source: Field Survey 2025

The table examines healthcare service interactions over the past 12 months, categorized by gender. A majority of respondents both male, i.e. 105 and female i.e. 66 reported having interacted with healthcare services, suggesting that direct experience with the healthcare system is common, which could influence their awareness of inclusivity issues. However, the higher number of male respondents compared to females accessing healthcare contrasts with global trends where women typically use healthcare services more frequently, possibly indicating cultural, economic, or accessibility barriers for women in Nepal. Those who answered No i.e. 36 of the respondents or maybe i.e. 38 of the respondents may have limited engagement with healthcare, possibly due to financial constraints, distrust in the system, or perceived lack of culturally sensitive care.

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Table 6: Age

	N	Minimum	Maximum	Mean	Std. Deviation
Age in years	247	17	43	27.28	5.189

The descriptive statistics for the variable "Age in years" among the 247 participants reveal that the minimum age recorded was 17 years and the maximum age was 43 years. The mean (average) age of the participants is 27.28 years, indicating that most respondents are in their late twenties. The standard deviation is 5.189, which reflects the extent of variability in the ages.

Descriptive Statistics

Table 7: Awareness Diversity

Particulars	N	Minimum	Maximum	Mean	Std. Deviation
Have you interacted with healthcare services in past 12 months?	247	1	3	1.45	.747
I understand how cultural/religious backgrounds can affect healthcare preferences.	247	1	5	3.17	.985
Healthcare institutions must be aware of and cater to the diverse needs of patients.	247	1	5	3.77	.877

The descriptive statistics under the theme "Awareness of Diversity" provide insights into participants' interactions with healthcare services and their understanding of cultural sensitivity in healthcare. Out of 247 respondents, the mean score for the question "Have you interacted with healthcare services in the past 12 months?" is 1.45 on a scale of 1 to 3, indicating that a majority had recent interactions with healthcare services. Regarding cultural competence, the statement "I understand how cultural/religious backgrounds can affect healthcare preferences" received a mean score of 3.17 with a standard deviation of 0.985, suggesting a moderate level of awareness among participants. The highest agreement was observed for the statement "Healthcare institutions must be aware of and cater to the diverse needs of patients", which had a mean score of 3.77 and a relatively low standard deviation of 0.877, indicating strong consensus. Overall, the data suggests that while interaction with healthcare services is common, there is a growing but varied understanding of the importance of cultural and religious diversity in healthcare settings.

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Table 8 Acceptance Diversity

Particulars	N	Minimum	Maximum	Mean	Std. Deviation
Healthcare institutions must be aware of and cater to the diverse needs of patients.	247	1	5	3.77	.877
Healthcare providers in my area are trained to serve diverse populations (ethnic, LGBTQ+, disabled, etc.).	247	1	5	4.03	1.070
Which forms of diversity you believe are important in health institutions? (select all that apply)	207	1	5	3.34	1.452
I would feel comfortable with a healthcare provider with a different cultural background from my own.	247	1	5	3.42	.888
If staff understand the patient's diverse background, it can lead to better experience for the patients.	247	1	5	3.86	.918

The descriptive statistics on Acceptance of Diversity in healthcare highlight participants' views regarding inclusivity and cultural competence within healthcare institutions. With a sample size of 247 respondents, the statement "Healthcare institutions must be aware of and cater to the diverse needs of patients" received a mean score of 3.77 (SD = 0.877), indicating general agreement on the importance of institutional awareness and accommodation of patient diversity. Respondents showed even stronger agreement (M = 4.03, SD = 1.07) that healthcare providers in their area are trained to serve diverse populations, including ethnic minorities, LGBTQ+ individuals, and persons with disabilities.

Regarding perceptions of which forms of diversity are important in health institutions, a slightly lower mean score of 3.34 (SD = 1.45) was reported from 207 respondents, reflecting variability in opinions or awareness about specific diversity categories. Comfort levels with healthcare providers from different cultural backgrounds averaged at 3.42 (SD = 0.888), suggesting moderate openness to cross-cultural care. Finally, participants largely agreed that staff understanding of patients' diverse backgrounds can lead to better patient experiences, with a mean score of 3.86 (SD = 0.918). Overall, these findings point to a positive attitude toward diversity acceptance, emphasizing the role of training and cultural sensitivity in improving healthcare outcomes.

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Gender difference

Table 9 Gender difference towards Awareness Diversity

Group Statistics					
	Gender	N	Mean	Std. Deviation	Std. Error Mean
Awareness Diversity	Female	104	2.8910	.49907	.04894
	Male	136	2.7279	.62223	.05336

Independent Samples Test										
		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
AwarnessDiversity	Equal variances assumed	.910	.341	2.188	238	.030	.16308	.07453	.01625	.30992
	Equal variances not assumed			2.253	237.437	.025	.16308	.07240	.02046	.30571

The independent samples t-test was conducted to compare the levels of awareness of diversity between female and male participants. The results from the group statistics show that females (N = 104) had a higher mean score (M = 2.89, SD = 0.50) compared to males (N = 136), who had a mean score of 2.73 (SD = 0.62). This suggests that, on average, female participants demonstrated a slightly greater awareness of diversity issues in healthcare settings than their male counterparts.

To determine if this difference was statistically significant, Levene's Test for Equality of Variances was first examined, yielding a significance value of 0.341, which is greater than 0.05. This indicates that the assumption of equal variances was not violated. Based on this, the t-test assuming equal variances was used, resulting in a t-value of 2.188 with 238 degrees of freedom and a p-value of 0.030. Since the p-value is less than 0.05, the difference in means between females and males is statistically significant. The mean difference of 0.163 suggests that gender plays a meaningful role in shaping awareness of diversity, with females reporting higher levels of awareness.

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Table 10 Gender difference towards Acceptance Diversity

Group Statistics					
	Gender	N	Mean	Std. Deviation	Std. Error Mean
AcceptanceDiversity	Female	104	3.7524	.54369	.05331
	Male	136	3.6640	.68312	.05858

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
AcceptanceDiversity	Equal variances assumed	2.793	.096	1.083	238	.280	.08843	.08162	-.07236	.24923
	Equal variances not assumed			1.116	237.602	.265	.08843	.07921	-.06760	.24447

The independent samples t-test was performed to compare acceptance of diversity in healthcare between female and male participants. The group statistics indicate that females (N = 104) reported a slightly higher mean acceptance score (M = 3.75, SD = 0.54) compared to males (N = 136), who had a mean score of 3.66 (SD = 0.68).

Levene's Test for Equality of Variances showed a significance value of 0.096, which is above the 0.05 threshold, indicating that the assumption of equal variances was met. The t-test assuming equal variances yielded a t-value of 1.083 with 238 degrees of freedom and a two-tailed p-value of 0.280. Since the p-value is greater than 0.05, the difference in acceptance of diversity between females and males is not statistically significant. This suggests that both genders have similar levels of acceptance regarding diversity in healthcare institutions.

Conclusion

The findings from the study on Awareness and Acceptance towards Religious Diversity in Healthcare among Individuals indicate that participants generally recognize the importance of cultural and religious diversity in healthcare settings. The descriptive statistics showed that individuals are moderately aware of how cultural and religious backgrounds affect healthcare preferences and strongly agree that healthcare institutions should cater to diverse patient needs. Females demonstrated significantly higher awareness of diversity compared to males, suggesting gender differences in understanding cultural competence. However, when it comes to acceptance of diversity, both genders showed similar attitudes, with no significant difference observed between males and females. This suggests that while awareness levels may vary by

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gender, acceptance of religious diversity in healthcare is broadly shared. These results emphasize the need for ongoing education and training in healthcare to foster both awareness and acceptance, ultimately leading to improved healthcare experiences for diverse populations.

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