

CHAPTER 6

DEVELOPING A CULTURAL COMPETENCE TRAINING PROGRAMME FOR NURSING PROFESSIONALS IN SOUTH AFRICA

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Abstract

Cultural competence has emerged as a vital strategy for improving healthcare providers' ability to deliver culturally appropriate care and achieve positive patient outcomes. In South Africa, a country rich in linguistic and cultural diversity, the integration of cultural competence across healthcare disciplines is essential. However, existing research has highlighted a significant gap: midwives often lack sufficient cultural knowledge and insight into their patients' practices. To address this, a cultural competence training programme was designed to equip midwives with the necessary knowledge, skills, and attributes for culturally congruent care. This manuscript discusses the development of a cultural competence programme for midwives.

The programme's development was grounded in a multi-method study conducted between 2018 and 2019. This research encompassed concept analysis, quantitative and qualitative approaches, and literature integration. The programme was developed following the ADDIE model, providing a systematic framework for design and implementation. Validation involved expert review through the Delphi technique, with consensus reached after two iterative rounds involving a panel of five selected experts ($n = 5$).

As this manuscript reports on the third and last phase of a multi-method study, results from the first and second phases were synthesised to reach the objective. Programme content was informed by thematic analysis of interview data and a literature review, and was structured into three focused study units: (1) Introduction to cultural competence, (2) Utilising cultural competence skills, and (3) Application of cultural competence. The resulting programme offers both theoretical and practical guidance, making it suitable for integration into undergraduate nursing education and as a professional development course for practising nurses.

Keywords: cultural competence, culturally diverse, eDelphi, midwives, programme development

1 Introduction and background

The global landscape is characterised by a culturally and linguistically diverse (CALD) population owing to decreasing geographic boundaries due to migration (Pham, Berecki-Gisolf, Clapperton, O'Brien, et al., 2021). Nurses and midwives consequently need theoretical knowledge and practical skills to provide culturally competent, congruent and sensitive care to this diverse population (Wehbe-Alamah, 2019). Cultural competence and the achievement of culturally congruent care are imperative for nurses and other healthcare professionals (Jeffreys, 2019). Govere and Govere (2016) argued that providing culturally competent healthcare is critical to increasing patient satisfaction, which is a key determinant of quality of care that is correlated with patients adhering to treatment. Similarly, cultural competence is a strategy that attempts to make healthcare services more accessible, acceptable and effective for persons from culturally and linguistically diverse communities (Kirmayer, 2012).

According to the Merriam-Webster dictionary (2025), competence is defined as the state of having sufficient knowledge, judgement, skill or strength in a particular respect. Cultural competence as a concept is defined as an ongoing learning process in which a nurse or midwife working with culturally diverse patients intentionally engages, and is empowered with the cultural knowledge, cultural awareness, cultural skills, cultural encounters, and cultural desire to become a culturally competent practitioner and consequently improving healthcare quality as well as patient outcomes (Shopo, Du Preez, Rabie & Bester, 2023a). While cultural competence is also identified as a strategy to improve the capacity of healthcare systems and providers to render culturally congruent healthcare and achieve positive patient outcomes (Shopo, Rabie, Du Preez, & Bester, 2024), it is also a dynamic and evolutionary process that requires personal desire and effort from the healthcare professionals (Sharifi, Adib-Hajbaghery & Najafi, 2019). The healthcare professionals in the context of this study refers to midwives. Wehbe-Alamah (2019), in her review, concluded that providing culturally congruent care that is respectful of diverse cultural beliefs, values, and

practices is a moral and ethical responsibility for healthcare professionals as well as a human right for patients.

According to the Nursing Act 33 of 2005, the title of midwife may only be used by a person who has met the prescribed education requirements for registration as a midwife, has acquired and maintained the competence to practise as a midwife, and is registered in terms of section 31(1)(b) of the Nursing Act of 2005. Upon completion of the Advanced Diploma in Midwifery or a Bachelor's degree in Nursing and Midwifery, the Professional Nurse is registered with the South African Nursing Council (SANC), which is a regulatory body, and the license to practise is renewed annually. The SANC, as the responsible body for regulating nursing education, training and practice, has prescribed competencies for midwives in that regard. According to Jeffreys (2019), preparing these nursing professionals to provide quality healthcare in the culturally and linguistically diverse population requires a comprehensive approach that emphasises cultural competence education in undergraduate as well as professional education and professional life. Competence will be evidenced by performance demonstrating effective application of knowledge, skills, judgement, and personal attributes required to practise safely and ethically as health professionals.

Nurse educators play a significant role in developing undergraduate nursing students' knowledge and attitudes regarding diverse cultural issues in nursing, including the strategies and programmes needed to develop their cultural competence (Sharifi et al., 2019). Similarly to these authors, Betancourt and Green (2010) suggested that an educational intervention has the best chance of having an impact on healthcare if it is multifaceted. Within the South African context, nurses and midwives undergo basic undergraduate training at either colleges or universities; the duration of training is three years and four years, respectively. Several researchers have indicated that the curriculum for undergraduate training for nurses in South Africa (SA) lacks a component on cultural competence (Shopo et al., 2024; Moeta, Mogale, Mgozolazi, Moagi, & Pema-Bhana, 2019; Mhlongo, 2016; De Beer & Chipps, 2014).

In heeding the call for a culturally competent workforce, various countries have developed programmes that integrate cultural competence at policy level and consequently guideline documents within healthcare organisations. Researchers who have laid a foundation regarding frameworks and models that are currently being used in the field of cultural competence include Madeleine Leininger, who coined the Theory of Culture Care Diversity and Universality in the early 1950s upon realising a need for transcultural nursing (Leininger, 1999). Following that, other researchers built on the foundation laid, and Campinha-Bacote (2002) developed a model named “The Process of Cultural Competence in the delivery of Healthcare Services”. This model outlines the five constructs that are applied by many researchers: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. These constructs form the basis of several developmental phases in the field of cultural competence. Marianne Jeffreys, who is also an expert in cultural competence, further advocated for an inclusive, caring framework within a healthcare system where diversity is embraced by creating culturally safe environments (Jeffreys, 2019). She developed a Cultural Competence and Confidence model, primarily focusing on the self-efficacy of nursing students and other healthcare professionals.

Literature confirms that exposing nurses, nursing students and other healthcare professionals to a well-structured cultural competence learning programme has the potential to improve their cultural competence skills. In a study by Fair et al. (2021), the Operational Refugee and Migrant Maternal Approach (ORAMMA) project developed a cultural competence training programme for health professionals to aid in providing perinatal care for migrant women. The training resulted in a significant increase in the knowledge, self-perceived cultural competence levels, and skills scores amongst midwives. In another study, Choi and Han (2020) developed a Global Multicultural Nursing Competency Enhancement (GMNCE) Program, which was implemented with nursing students in Malaysia. These authors concluded that the program is effective in the improvement of cultural competence of nursing students, which included the five constructs (cultural knowledge, cultural awareness, cultural skill, cultural encounters

and cultural desire). In Finland, Kaihlanen et al. (2019) provided focused cultural competence training for nurses, and their results confirmed that training increased awareness of one's own cultural features, which can be useful for easing cross-cultural encounters in a healthcare setting and improving the cultural competence of nurses.

In SA, Shopo and colleagues identified that midwives lack knowledge of cultural competence when providing care to women in maternity (Shopo, Rabie, Du Preez, & Bester, 2023b). Led by evidence-based research, a programme for cultural competence was developed to enhance the skills of midwives in the North West Province (NWP) of SA. To the best of the author's knowledge, no cultural competence programme for midwives could be located in scientific literature within SA.

2 Problem statement and aim

Nurses and midwives in SA are exposed to a culturally and linguistically diverse population, they need to be capacitated with cultural competence skills and knowledge. This gap was identified in theory and practice, whereby the researcher could not identify a cultural competence programme for midwives within the SA context. Evidence from literature confirms that provision of culturally competent care is linked to improved quality of maternal care, improved patient outcomes and adherence to medication by patients from diverse cultures. The overall aim of the study was to develop a cultural competence programme for midwives in the North West Province to empower them in the process of providing culturally competent care. Following the outlined background and the problem statement, a research question was posed: What knowledge and skills should be included in a cultural competence programme for midwives in the SA context?

3 Research design and methodology

This manuscript reports on the fifth and final objective from a doctoral study; the methodology for objectives 1 to 4 is described in the published

manuscripts. The basis for developing the programme was on the findings of a multi-method, multi-phase research design. The multi-method included a concept analysis, a quantitative research design, a qualitative descriptive research design, and a literature synthesis to develop a programme. The description below follows the depiction of Figure 6.1 for ease of reference.

3.1 Step 1: Phase 1

Phase 1 had one objective, and the researcher applied the concept analysis process by Walker and Avant (2014) to explore and describe the conceptual meaning of cultural competence within midwifery (Shopo et al., 2023a). The steps by Walker and Avant (2014) included concept selection (step 1), determining the aims or purpose of analysis (step 2), identifying uses of the concept (step 3), determining the defining attributes (step 4), identifying a model case (step 5), identifying additional cases (step 6), identifying antecedents and consequences (step 7), and defining empirical referents (step 8). In this process, multiple data sources were consulted in search of relevant scientific information to inform the programme development.

3.2 Step 1: Phase 2

Phase 2 had three objectives, with five hospitals in the NWP selected for the empirical part of the study. Firstly, a descriptive, cross-sectional survey design determined the midwives' self-reported levels of cultural competence towards women receiving maternal care (Shopo et al., 2023c) using the Transcultural Self-Efficacy Tool (TSET) questionnaire (Objective 2). An all-inclusive sample of midwives (N = 104, n = 82) participated in the survey; the response rate was 79% (Shopo et al., 2023c). Secondly, a qualitative descriptive approach was then applied to explore and describe the experiences of women receiving maternal care regarding the cultural practices and competency of midwives in providing culturally competent care (Objective 3). A qualitative research design was employed to explore perspectives of diverse stakeholders and to uncover the meanings they ascribed to culturally competent care (Creswell & Poth, 2018:45). Purposive sampling of women receiving maternal care in the selected hospitals was done; these women participated in in-depth interviews. The women were

admitted in maternity wards and postnatal wards and had at least two pregnancies or more; first-time pregnant women were excluded as they would not be able to inform the study. In total, fifty women receiving maternal care ($n = 50$), who met the inclusion criteria, took part in the in-depth interviews, which were conducted until data saturation was reached (Polit & Beck, 2017:877). Even though no new data emerging from the fourth hospital, the researcher continued to collect data in the fifth hospital as it had been selected.

Lastly, in Phase 2 a qualitative descriptive approach using semi-structured individual interviews explored and described the experiences of midwives regarding the provision of culturally competent care to women receiving maternal care (Objective 4). The midwives ($N = 104$, $n = 34$) were purposefully selected from five hospitals who had more than one year of experience in the wards. The midwives took part in semi-structured interviews conducted by the researcher, who was knowledgeable in qualitative data collection methods until data saturation was declared. A purposive sampling technique was applied in the selection of both population groups (Creswell & Poth, 2018). No payment was made to participants, but the researcher offered them a light snack and juice after the interviews as a token of appreciation.

The empirical study outlined above was conducted in the NWP, whereby a combination of large district, regional and tertiary hospitals was selected. The decision to select these hospitals was prompted by the fact that approximately 60–70% of all women who use government facilities require hospital services at some stage during their pregnancies (Department of Health, 2015).

Immediately after each interview, data were transferred to a password-protected laptop of the researcher, and confirmation of the recording was done before deleting the audio file. The participants were anonymous as the researcher used codes to identify each interview; thus, a folder was created with the relevant numbering of the interviews. Data analysis on the empirical data followed Creswell's generic qualitative analysis approach combined with Tesch's eight steps in the coding process (Creswell, 2014). An

independent co-coder followed the same analysis, with consensus meetings held to enhance credibility of the results.

Polit and Beck (2017) describe a framework (as depicted in Figure 6.1) as the conceptual underpinning of the study. The researcher was guided by the framework in a systematic development of the programme for cultural competence. Synthesis and integration of data were carried out based on the results of phases 1 and 2. The researcher then systematically followed the analysis, design, development, implementation and evaluation (ADDIE) model of curriculum development by Robinson and Dearmon (2013). It is important to note that only the first three steps of the ADDIE model (as depicted in Figure 6.1) were carried out; implementation and evaluation of the programme will be done in a separate study.

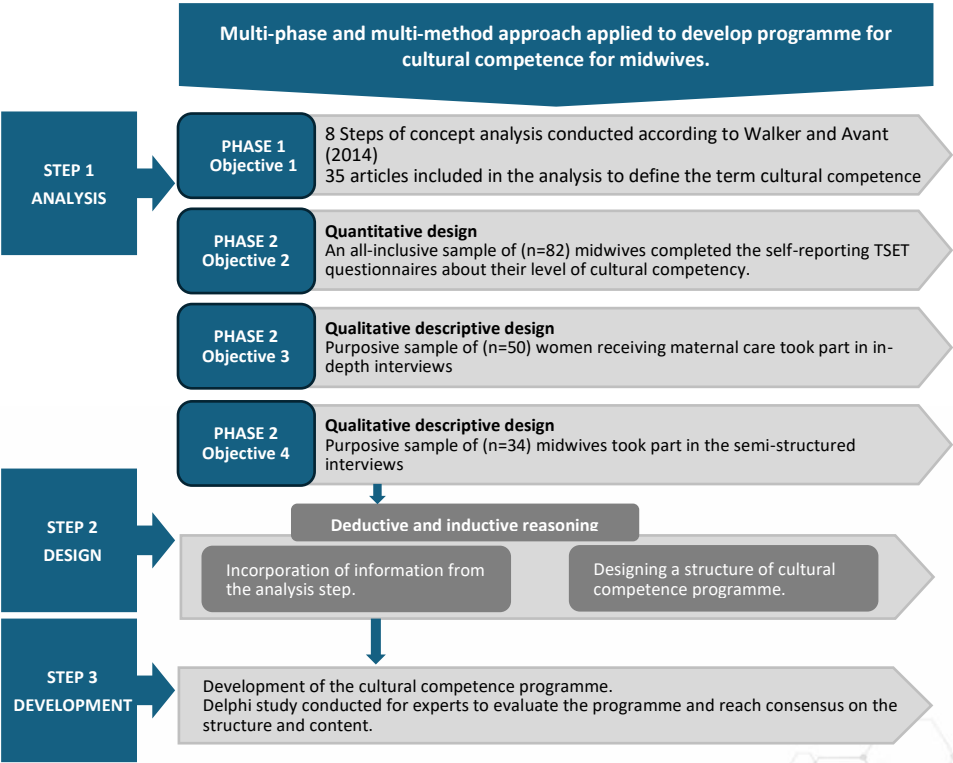


Figure 6.1: Incorporated phases for development of cultural competence programme

3.3 Step 2: Phase 3 (Design)

In Phase 3, the results from Phases 1 and 2 were synthesised to develop a cultural competence programme for midwives in the South African context (Objective 5). The process of development is outlined in the findings and discussion section as the main focus of this manuscript was development of the cultural competence programme. After development of the programme for midwives, the researcher carried out a consensus Delphi with criterion-purposively selected experts. Participants in a Delphi study are purposively recruited experts in the clinical nursing field, as well as researchers who are members of the Academy of Nursing South Africa (ANSA) and the Forum of University Nursing Deans of South Africa (FUNDISA), and who authored articles from the scientific research sites, such as ResearchGate. The researcher sent invitations to N = 15 experts via email using blind copy (BCC) to maintain anonymity after identifying them on the lists provided by FUNDISA and ANSA; however, only five (n = 5) experts consented to participate.

The experts received an email detailing the information on the study as well as the purpose of the Delphi and inviting them to be part of the process. After receiving the experts' responses to the invitation, the researcher then started preparing a questionnaire to send via email. The experts received no payment for participating; however, they received a token of appreciation, in the form of data sent to them electronically. The researcher kept confidential the names, locations and expertise of the participants involved in the process. The researcher continued observing the ethical principles of respect, autonomy, and confidentiality during the Delphi process.

The electronic Delphi (e-Delphi) could uniquely and effectively connect the opinions of expert health education researchers and practitioners from around the country and thus provided the researcher with information to systematically generate an agreed-upon direction for the cultural competence programme (Donohoe, Stellefson, & Tennant, 2012:40). The researcher ensured that the responses from the experts at each round were captured correctly and then circulated for evaluation without names of participants. Following the Delphi technique, the developed cultural

competence programme was agreed upon after two rounds as relevant to enhance the knowledge and skills of midwives. There were no disagreements from the experts on any aspects of the programme. Consensus was thus confirmed after the two rounds of the Delphi process.

4 Ethical aspects

The researcher obtained ethical clearance from the Health Research Ethics Committee of the North-West University (NWU-HREC), ethics number NWU-00067-18-S1. A presentation was made to participants, including the research study objectives, data collection methods and measures to ensure their confidentiality and anonymity. The participants exercised their right to self-determination by signing informed consent forms after getting information about the study. The ethical principles of respect for persons, beneficence and justice were applied in this study.

Lincoln and Guba's trustworthiness principles as cited by Polit and Beck (2018:982–983) were applied as they enhanced quality criteria, which are credibility (confidence in the truth-value of the findings was ensured by having a co-coder during data analysis), dependability (stability of the data over time was ensured by having one researcher collecting data across the five hospitals for both populations), confirmability (objectivity or neutrality of the data), transferability (this study is context-specific; however, the methodology is described in a manner that the study can be replicated in other settings or groups), and authenticity (the extent to which researchers fairly and faithfully show a range of different realities from the participants).

5 Findings and discussion

The previous sections focused on the methodology that was applied in the multi-method research, this section provides the findings of each section including the process of programme development.

The findings of the concept analysis identified key components: antecedents including cultural diversity and ongoing learning process; defining attributes comprising cultural knowledge, cultural awareness, cultural skills, cultural

encounters, and cultural desire; and the consequences which encompass development of culturally competent practitioners, improved quality of care, and improved health outcomes (Shopo et al., 2023a). These antecedents, attributes and consequences was significant in the development of a programme as they are necessary for cultural competence.

Furthermore, the self-reporting survey results (Objective 2, Phase 2) indicated that midwives have a moderate level of cultural competence, emphasising the need to develop the programme (Shopo et al., 2023c). The in-depth interviews with the women receiving maternal care provided rich data on the different cultural practices that exist within the province. The main themes that emerged were: self-care by a pregnant woman, important cultural practices for diverse women, cultural care of the newborn and perception about maternal care provided (Shopo et al., 2024). Lastly, Phase 2, Objective 4 data collection comprised semi-structured interviews with the midwives. The findings further confirmed that the programme for cultural competence is necessary for midwives in the NWP. Six themes that emerged were: communication is a key component of cultural competence; midwives lack knowledge and insight about patients' cultural practices; hospitals do not have a policy on culturally competent care; patients are secretive about cultural practices during labour; facility structure makes it impossible to accommodate different cultural practices; and midwives do not understand the concept of cultural competence (Shopo et al., 2023b). The following section discusses the programme development process based on the ADDIE model.

5.1 Step 3: Programme development

The ADDIE model of programme development was followed to develop the cultural competence programme for midwives in the NWP. According to Robinson and Dearmon (2013:204), the ADDIE model is a useful tool for curriculum building and for educational and practice performance improvement. The developed programme for cultural competence is envisaged to enhance the skills, knowledge and ability the midwives, thereby consequently bringing about an improvement in their practice.

Several researchers have applied the ADDIE model in developing educational programmes and learning instructions (Almomen, Kaufman, Alotaibi, Al-Rowais, Albeik & Albattal, 2016; Bopape, Mothiba & Bastiaens, 2019; Hadi, Kuntjoro, Sumarni, Anwar, Widyawati & Pujiastuti, 2017; Pretorius, Van Dyk, Small & Amukugo, 2016; Robinson & Dearmon, 2013; Widyastuti & Susiana, 2019).

The ADDIE model is also referred to as an instructional system design model representing a series of iterative steps that are applied to build effective education and training in five steps: analysis, design, development, implementation and evaluation (Almomen et al., 2016:539). The following section discusses how the first three steps were applied in this study.

5.2 Step 1: Analysis

The researcher conducted a literature review, which guided the concept analysis for this study. The analysis step occurred during the first two phases of this study, as depicted in Figure 6.1. The concept analysis, followed by self-reporting questionnaires on levels of cultural competence completed by midwives, the in-depth interviews with women receiving maternal care, and lastly, the semi-structured interviews with the midwives, form part of the first two phases. Furthermore, the researcher used inductive and deductive reasoning for analysis to develop the programme. The women receiving maternal care provided information regarding important cultural practices during the antenatal, intrapartum and postnatal phases of their pregnancies. The analysis provided the researcher with information on where the midwives rated themselves in terms of cultural competence levels, including their knowledge related to providing quality maternal care that is culturally appropriate.

5.3 Step 2: Design

The second step in the ADDIE model is design, which revolves around the programme objectives and outcomes (Robinson & Dearmon, 2013:205). The structure of the cultural competence programme was realised at the design phase. Hadi et al. (2017:150) emphasised that the design step is

where the outline and description of the module and storyboard are created. The objective of the cultural competence programme was to empower the midwives with cultural knowledge, skills, and attributes needed in the process of becoming culturally competent practitioners. Bopape et al. (2019:270) indicated that the design of the learning outcomes, content of the training programme, teaching and learning methods, and instructional strategies needs to be done at this stage.

In order to fulfil the intended objectives of a qualification within a learning programme, it is essential that the associated learning outcomes are acquired in a systematic and coherent manner (SAQA, 2000:15). The following learning outcomes were formulated to ensure that the objective of the programme is met. At the end of the programme, the midwife should:

- Understand and describe concepts such as culture, diversity, competence, cultural competence, cultural diplomacy, transcultural care and culturally congruent care.
- Discuss the different cultural competence models and their application.
- Demonstrate the ability to explain cultural diversity including important cultural practices for diverse women.
- Demonstrate cultural sensitivity by respecting the diverse cultural values and beliefs of women from antenatal to postpartum period.
- Be able to communicate effectively with the women receiving maternal care.
- Demonstrate ability to provide health education to women about safe cultural practices.
- Demonstrate ability to provide quality maternal healthcare using cultural competence skills.
- Contribute to the development of policies and or guidelines for cultural competency in their different environments (hospital, clinics or waiting homes).

The SAQA (2000:16) states that applied competence means that a qualification must address both the theoretical as well as practical needs of the learners. The design phase for the programme, therefore, included outlining the teaching and learning methods in which the midwives would engage during instruction, such as lectures, critical debates, role-playing, and case studies during the workshops. The mode of delivering the programme will be flexible enough to accommodate midwives, and would include a blend of online learning and lectures during the workshop. Workshops, which are well-planned and purposeful, are an effective method of educating (Muller & Bester, 2016:514). The researcher planned to make use of prepared workshops for the face-to-face and online lectures.

5.4 Step 3: Development

As the third step in the ADDIE model, the development depends on first and second steps being carried out correctly. Aldoobie (2015:70) suggested that this is where the instructional designer starts to develop and create a good-quality factual sample for the instructional design, and a runthrough the course content. Course content is the subject matter for completion in the course, including skills, knowledge and attitudes, as well as the planned activities that the midwives must cover in order to develop required competencies and reach the outcomes (Armstrong, 2017:237). Muller and Bester (2016:511) further explain learning content as the topics or themes included in the educational programme.

The researcher developed the content based on the learning outcomes so that there was sufficient time for presentation and interaction with midwives during instruction. The content is therefore based on three study units, 1) Introduction to cultural competence, 2) Utilising cultural competence skills, and 3) Application of cultural competence in midwifery practice. The following section outlines the related content of these study units.

Study unit 1 is theoretical content and covers cultural competence concepts; cultural competence models and the application; cultural diversity in maternal health; and different cultural practices in maternal health. Study

unit 2 also consists mainly of theoretical component covering cultural values and beliefs of women receiving maternal care; intercultural communication; effective and ineffective communication in maternal care. Lastly, study unit 3 focuses on the practical component with a focus on safe cultural practices in maternal health and incorporating cultural competence in maternal care.

The programme is envisaged to run for a period of two weeks, followed by assessment of competence. Assessment processes are important to ensure there is an alignment between the purpose of the learning programme and the way in which assessment of the learning outcomes occurs, and the way in which learners are credited (SAQA, 2000:15). The assessment will include written assignments as well as assessment of competence levels using the cultural competence questionnaires, for example the Transcultural Self-Efficacy Tool (Jeffreys, 2019). The assessment of the practical skills, which include communication and assessment, can be in the format of a Portfolio of Evidence submitted at the end of training whereby midwives are expected to apply knowledge obtained during instruction. Therefore, at the end of participating in the programme, the midwife must demonstrate an applied competence. SAQA (2000:16) differentiates applied competence as follows:

- Foundational competence, which is described as an understanding of what is done and why.
- Practical competence, which is described as a demonstrated ability to do a particular thing.
- Reflexive competence is described as the demonstrated ability to integrate or connect performance to learn from actions and adapt to change and unforeseen circumstances.

Integrated assessments, according to SAQA (2000:21), refer to a form of assessment that allows the learner (in this study, a midwife) to demonstrate applied competence, and use a range of formative and summative assessment methods. The researcher planned that the formative and summative assessments would be in the form of written assignments, as well as practical assessment. The development of the assessment processes

must be in such a way that it ensures alignment between the cultural competence programme's purpose and the way in which the learning outcomes are assessed. Table 6.1 below outlines the learning outcomes which are aligned to the assessment criteria.

Table 6.1: Specific learning outcomes of the Cultural Competence Programme

After completion of this cultural competence programme, the midwife will:	The midwife will prove that the outcomes have been realised by demonstrating the ability to:
<i>Theoretical component</i> 1. Understand and describe concepts such as culture, diversity, competence, cultural competence, transcultural care, cultural diplomacy and culturally congruent care. 2. Discuss the different cultural competence models and their application. 3. Demonstrate the ability to explain cultural diversity, including important cultural practices for diverse women. 4. Demonstrate cultural sensitivity by respecting the diverse cultural values and beliefs of women from the antenatal to the postpartum period. 5. Communicate effectively with women receiving maternal care reflecting the Ubuntu philosophy. <i>Practical component</i> 6. Demonstrate the ability to provide health education to women about safe cultural	<i>Theoretical component</i> 1. Discuss the concepts related to cultural competence and relate them to midwifery context. 2. Analyse the different cultural competence models. a. Discuss the assumptions of the following models: i. Leininger's Culture Care Model (2002) ii. Purnell Model of Cultural Competence (2002) iii. Campinha-Bacote Model (The process of Cultural Competence in the Delivery of Healthcare Services, 2002) b. Apply the different cultural competence models to the midwifery context. 3. Explain cultural diversity as a concept applicable to the healthcare environment. a. Identify different cultural practices in midwifery that are prevalent within the NWP. 4. Identify the cultural values and beliefs of women receiving maternal care in the NWP. a. Demonstrate cultural sensitivity when providing maternal care. 5. Discuss communication between people with different cultures (intercultural communication). a. Discuss effective communication in the midwifery context. b. Explain ineffective communication and its consequences in maternal care.

practices.	c. Describe Ubuntu philosophy within context of midwifery.
7. Demonstrate the ability to provide quality maternal healthcare using cultural competence skills. 8. Contribute to the development of policies and/or guidelines for cultural competency in their different environments (hospitals, clinics or waiting homes).	<i>Practical component</i> 6. Identify safe cultural practices prevalent in the NWP and provide health education to women receiving maternal care. 7. Design a care plan for diverse women incorporating the cultural knowledge, skills and attributes acquired during the programme. 8. Draft guidelines to incorporate culturally competent care in the different working environments (hospitals, clinics or waiting homes).

6 Limitations and recommendations

While the study made a significant contribution by means of a reliable programme for cultural competence, the researcher acknowledges that there are some limitations. The study was carried out in one province out of the nine provinces of SA; therefore, the findings cannot be generalised. The methodology is described in such a way that other researchers can replicate the study in other contexts.

The recommendations include that the programme be implemented and evaluated; this is currently being done in a post-doctoral project by the researcher. To ensure sustainability of the programme, there is a need to formally integrate the programme into an undergraduate midwifery curriculum. This will ensure that the programme is not a once-off training intervention. Furthermore, policy formulation and implementation by the NWP Department of Health in integrating the cultural competence component in the maternity guidelines are needed. The maternity guidelines used in the public hospitals must be updated to include the standards relating to the provision of culturally competent care. The

programme forms a basis for further research to be conducted in other contexts within SA.

7 Conclusion

The cultural competence programme for midwives was developed following a multi-phase, multi-method approach. The developed programme was validated using a Delphi technique, whereby consensus from a panel of experts was reached. The findings demonstrate that a well-structured, context-specific training can meaningfully enhance the awareness, confidence and skills of midwives when providing care to women from diverse backgrounds. This cultural competence programme is thus intended to enhance and strengthen the ability of midwives to provide quality, culturally appropriate midwifery services to culturally and linguistically diverse patients. Culturally competent midwives can contribute positively to a more respectful and person-centred maternal healthcare system.

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