European Journal of Public Health Studies
ISSN: 2668 - 1056
ISSN-L:2668 - 1056
Available on-line at: www.oapub.org/hlt

DOI: 10.46827/ejphs.v8i2.218 Volume 8 | Issue 2 | 2025

CULTURAL COMPETENCE AMONG MIDWIVES AND NURSES PROVIDING MIDWIFERY CARE IN MPIKA DISTRICT, ZAMBIA

Joyce Namalongo[1i],
Conceptor Kwaleyela[2],
Brenda Siachampa[3],
Jean Ngala[3]
[1]University of Zambia,
School of Nursing Sciences,
Department of Midwifery, Women and Child Health,
P.O. Box, RW 50110,
Lusaka, Zambia
[2]University of Zambia,
School of Nursing Sciences,
Department of Midwifery, Women and Child Health,
P.O. Box, RW 50110,
Lusaka, Zambia
[3]University of Zambia,
School of Nursing Sciences,
Department of Basic and Clinical Nursing,
P.O. Box, RW 50110,
Lusaka, Zambia
[4]Mulungushi University,
School of Nursing and Midwifery,
P.O. Box, 80415, Town campus,
Kabwe, Zambia

Abstract:
Background: Cultural competence is an essential component of quality midwifery care that enhances respectful and individualized care regardless of the woman's cultural background (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Consequently, it assists midwives and nurses to know their clients' needs, beliefs, and values, and to establish an appropriate relationship with them. This enhances accessibility and utilization of midwifery care provided by skilled personnel (Bastami *et al.*, 2016). In the Mpika district, most women are reported to respect their cultural practices during antenatal, labour and postnatal. The district in 2020 recorded 218 home deliveries with 11 (20%) maternal deaths, which were increasing and maintaining consistent from 2018. According to the Mpika Health Information Management System report, the deaths related to home deliveries were a result of cultural beliefs. The indicator

[i]Correspondence: email bwalyajoyce93@gmail.com

was recorded despite measures to train and recruit adequate midwives and nurses to provide midwifery care, especially in the most rural areas of the district (Mpika HMIS, 2020). **Main objective**: To determine cultural competence among nurses and midwives providing midwifery care in the Mpika district. **Methods and Materials**: A descriptive cross-sectional study involving 58 conveniently selected midwives and nurses was conducted in the Mpika district. Data was collected using a self-administered questionnaire and analyzed using IBM Statistical Package for Social Sciences (SPSS) version 23.0. Chi-square test was used to test associations between dependent and independent variables, while linear regression was used to determine the degree to which the independent variables influenced the dependent variable. The level of significance was a p-value of <0.05. **Results**: Study results revealed that of the 58 participants (36), 62% were not culturally competent. The attitudes of the nurses and midwives towards the provision of culturally competent midwifery care were negative, with a p-value of <0.008. The nurses and midwives were offended and denied care to clients who insisted on upholding their cultural beliefs during antenatal, labour and postnatal. Further outcome indicated that the younger nurses and midwives (19 to 25 years) were providing culturally competent care with a p-value of 0.023. This can be attributed to the society's culture of respecting elderly women. All 5 of the 58 participants respected women's culture during midwifery care. Professional qualifications showed that Registered Nurses (13 of 22) provided culturally competent care, with a p-value of 0.007. The cultural beliefs of the nurse and midwife had a positive influence on the provision of culturally competent care, with a p-value of 0.008. The nurses' and midwives' cultural differences with the women under their care led to demeaning and rejecting women's needs during antenatal, labour and postnatal. Despite the nursing and midwifery curriculum's inclusion of cultural competence, there was no statistical significance between having knowledge on cultural competence and respecting women's culture when providing midwifery care p-value 0.603. The professional duration of providing midwifery care did not show a strong influence on the provision of culturally competent midwifery care, with a p-value of 0.05. Participants with ten years or more (12 of 16) providing midwifery care were not respecting women's culture. **Conclusion**: Cultural competence among midwives and nurses providing midwifery care is vital because it enables them to provide acceptable and valued midwifery care, which is effective for clients of diverse cultural backgrounds. This can contribute to the reduction of morbidity and mortality among women during antenatal, labour and postnatal. The findings signify the need for more rigorous mentorship, supervision and regular in-service training on cultural competence. **Recommendation**: To enhance the program on induction, in-service training and technical support on cultural competence for nurses and midwives providing midwifery care to mothers during the antenatal, labour and postnatal periods.

Keywords: cultural competence, midwifery care, antenatal, labour, postnatal, nurses and midwives

1. Introduction

Cultural competence is an essential component of quality midwifery care. It is the ability to provide midwifery care to any woman regardless of her cultural background. It comprises knowledge, skills, and values that promote the ability of midwives and nurses to care for women from diverse cultural backgrounds. The nurses and midwives who attain cultural competence are capable of communicating and understanding women under their care with different cultural values, beliefs and health functions (Coast *et al.*, 2015).

Midwives and nurses are expected to provide culturally competent midwifery care in order to enhance women's accessibility and utilization of midwifery services. Respecting women's culture during midwifery care is a significant approach in being culturally competent and enhancing the quality of midwifery care. However, the attitude of nurses and midwives towards culturally safe midwifery care compromises respective and individualized maternal care, thereby increasing home deliveries, which result in maternal morbidity and mortality rates (WHO, 2013). Worldwide, cultural competence is now a requirement for every midwife and nurse providing midwifery care because the majority of societies have become multicultural (Filby *et al.*, 2016)

According to Govender *et al.* (2017) and Adaptive and Foster Family Coalition [AFFC] (2016), levels to achieving cultural competence include;

- **Cultural Destructiveness:** This is the initial step where an individual comes in contact with other cultures, develops a negative attitude towards other cultures, and dehumanises them. The individual feels that their culture is superior to others and does not value cultural diversity. They do not desire to learn about other cultures and resist changing their behaviour to meet the needs of others. **Cultural**
- **Incapacity:** This stage is when the individual starts to demonstrate some understanding of their own prejudices towards cultural diversity. The individual interprets cultural information about others as they perceive them, whether correctly or wrongly, but they still do not fully understand cultural diversity.
- **Cultural Blindness:** This is when the individual begins to value cultural diversity. The individual finds pleasure in learning about other cultures and considers cultural differences as preferences, not uniqueness, because they still lack the hidden aspect of culture. They still desire to learn more about other cultures, although they resist changing behaviour.
- **Cultural Pre-competence:** At this stage, the individual develops a deeper and stronger value of cultural diversity and appreciates other unique cultures. The individual views them as important and not mere preferences, although they do not know how to change and meet the needs of others.
- **Cultural competence:** At this level, the individual is capable of managing individuals from any cultural background. He or she fully values cultural diversity and understands that cultural beliefs are deep and intense.

2. Methodology

This part of the study presents the methodology which was used, which includes the research design, research setting, study population, sample selection, inclusion and exclusion criteria, sample size, data collection tools, data collection technique, validity and reliability, pre-test and ethical considerations. The aim of the study was to determine cultural competence among nurses and midwives providing midwifery care in the Mpika district.

2.1 Research Design

The study adopted a descriptive cross-sectional quantitative design, meaning that data were collected from the respondents at one point in time. The design was found suitable for the study because it facilitated a systematic collection and interpretation of information. The design was also cost-effective as respondents were not required to move from their normal environment.

2.2 Research Setting

Mpika is among the 8 Districts in Muchinga province of the Republic of Zambia, and one of the largest Districts in Zambia with a land size of 41,000 square kilometers. Most of the district is rural. The research was conducted at 16 health centers in Mpika district: Chikwanda, Nabwalya, ZNS (Zambia National Service), Mpika Urban, ZCA (Zambia College of Agriculture), Chikakala, Mpepo, Kasenga, Chilonga HAHC, Mufubushi, Chitulika, Lufira, Mukungule, Kamwanya, St. Odilia and Kazembe, as well as two general hospitals: Chilonga and Michael Chilufya Sata. The health centers provide primary health care, antenatal, labour, postnatal, and family planning services. Chilonga and Michael Chilufya Sata General Hospitals were second-level health facilities where complicated antenatal, labour, and postnatal cases from the 16 health centers were referred to. The hospitals provide comprehensive health care services.

2.3 Study Population

The study population consisted of all nurses and midwives providing antenatal, labour and postnatal services in the Mpika district. However, the target population consisted of nurses and midwives providing midwifery care in the 16 health centers of Mpika district, as well as Chilonga and Michael Chilufya Sata General Hospitals. The accessible population included nurses and midwives on duty during the period of data collection.

2.4 Sampling Method

The study setting encountered a limited number of nurses and midwives providing maternity care in the Mpika district, and convenience sampling was used to select the respondents. This means that all the midwives and nurses who were found on duty during the time of data collection and were willing to participate in the study were

recruited. The convenience method also facilitated the selection of participants who had characteristics suitable for the study.

2.4.1 Inclusion Criteria

Nurses and midwives providing midwifery care in the study settings during the time of data collection, and those who had more than one year of providing midwifery care.

2.4.2 Exclusion Criteria

Nurses and midwives providing midwifery care in the study setting who did not consent, and those who were on leave.

2.5 Sample Size

The study involved 58 nurses and midwives who were conveniently selected. This implies that only nurses and midwives who were providing midwifery care and present during the study in the 16 clinics and 2 general hospitals were involved.

2.6 Data Collection

Data was collected over a period of four weeks.

2.6.1 Data Collection Tool

A pre-tested semi-structured self-administered questionnaire was used to collect information because all the respondents were literate. The questionnaire consisted both closed and open ended questions, and comprised five sections; section A consisted questions on the respondents' demographic information; section B comprised questions on cultural competence; section C was on respondents' knowledge on cultural competence; section D comprised questions on socio-cultural background of the respondents; and section E was on attitudes of respondents towards cultural competence.

2.6.2 Data Collection Technique

On each material day of data collection, the researcher initially introduced herself to the departmental in-charges, got permission and requested a private room where data was collected. The researcher then introduced herself to the prospective respondents, and the purpose of the study was explained in detail. Nurses and midwives who were willing to participate in the study were each given a Participant Information Sheet to read, so that they could understand the study in depth. A written consent was obtained from each participant. The respondents were allowed to read instructions on the questionnaire and were given the chance to seek clarification if needed. Each respondent was reassured that the filled-in questionnaires were secured by the researcher in sealed envelopes that were kept in a lockable cupboard, and the keys to the cupboard were under the custody of the researcher. Each respondent was encouraged to answer questions truthfully and was given enough time, about 15- 20 minutes, to answer the questions. After filling in the questionnaire, the respondents were given time to ask questions, which were answered

accordingly. The researcher then thanked the respondent for the participation and collected the filled-in questionnaires.

2.7 Validity

2.7.1 Internal Validity

This was ensured through the appropriate selection of the study design, an extensive literature review, in order to use a standardized data collection tool that enabled participants to answer the same questions. The questions were constructed in a simple, clear and precise manner in order to remove inconsistencies in the understanding of the required information.

2.7.2 External Validity

This was achieved by the supervisors checking the data collection tool and conducting a pilot study before embarking on the final study.

2.8 Reliability

To ensure reliability, a variety of open-ended questions were included in the questionnaire to allow for triangulation of some answers. The data collection tool was tested through a pilot study, which was done at TAZARA and Chibansa Rural Health Centers. Respondents were provided with enough time to answer the questions, and convenience sampling was utilized to select respondents to facilitate the collection of suitable data and enhance diversity.

2.9 Pilot Study

A pilot study was conducted at TAZARA and Chibansa health centers. The number of participants was 10% of the total participants in the main study. Clarification was made on all the questions raised by participants. The pilot study settings were chosen because of similarities in the environmental settings and respondents in the main study. There were no significant adjustments made to the data collection tool.

2.10 Ethical Consideration

Ethics approval was obtained from Excellence in Research Ethics and Science (ERES) Converge and the National Health Research Authority (NHRA) at the Ministry of Health (MoH) headquarters before conducting the study. Written permission to conduct the study was obtained from the Provincial and District Directors of the health facilities of the study sites. Permission was also sought from the sisters, the in-charge health facilities where the data was collected. Written Informed consent was obtained from the study participants after providing detailed explanations before involving them in the study.

3. Data Analysis and Presentation of Findings

The study answered the hypothesis, which stated that "there is no relationship between being culturally competent and the following variables: knowledge of nurses and midwives on cultural competence, attitude of nurses and midwives towards cultural competence, social and cultural background of the nurse and midwife."

3.1 Data Processing and Analysis

Processing and analysis of the collected data involved checking for completeness of each questionnaire, coding the responses and grouping them into categories. Statistical analysis was done by utilizing SPSS statistical software version 23.0. The relationship between categorical (dependent and independent variables) was ascertained using the Chi-square test. Linear Logistic Regression tests (univariate and multivariate analyses) were used to determine the factors associated with the dependent variable (cultural competence). Multivariate Logistic Regression was used to control for confounding variables and to identify independent contributing factors to cultural competence. A significant level was set at 0.05% with a 95% confidence interval**.**

3.2 Presentation of Findings

Table 1: Respondents' Socio-Demographic Data (n=58)

Age (years)	**Frequency**	**Percent (%)**
19-25	5	9
26-32	22	38
32-38	9	15
39 and above	22	38
Total	**58**	**100.0**
Professional Qualification	**Frequency**	**Percent (%)**
Enrolled Nurse (EN)	2	3
Enrolled Midwife (EM)	12	21
Registered Nurse (RN)	18	31
Registered Midwife (RM)	22	38
Registered Nurse Midwife (RNM)	4	7
Total	**58**	**100.0**
Number of years of providing midwifery care	**Frequency**	**Percent (%)**
Less than 2 years	15	26
2-5 years	17	29
6-9 years	10	17
10 years and above	16	28
Total	**58**	**100.0**

Table 1 shows that 38% (22) of the respondents were aged between 22 and 32 years, 38% (22) were above 39 years, while 9% (5) were aged between 19 and 25 years. The Table also provides information that 38% (22) were RMs, 31% (18) were RNs,21% (12)were EMs, 7%

(4) were RNMs, and 3% (2) were EMs. Regarding length of work, 29% (17) of the respondents had provided midwifery care for 2-5 years, 26% (15) had provided midwifery care for less than 2 years, and 17% (10) had provided midwifery care for 6-9 years.

Section A: Cultural Competence Among Nurses and Midwives Providing Midwifery Care

Figure 1: Respondent Is Able to Describe Cultural Beliefs of Women in the Community (n=58)

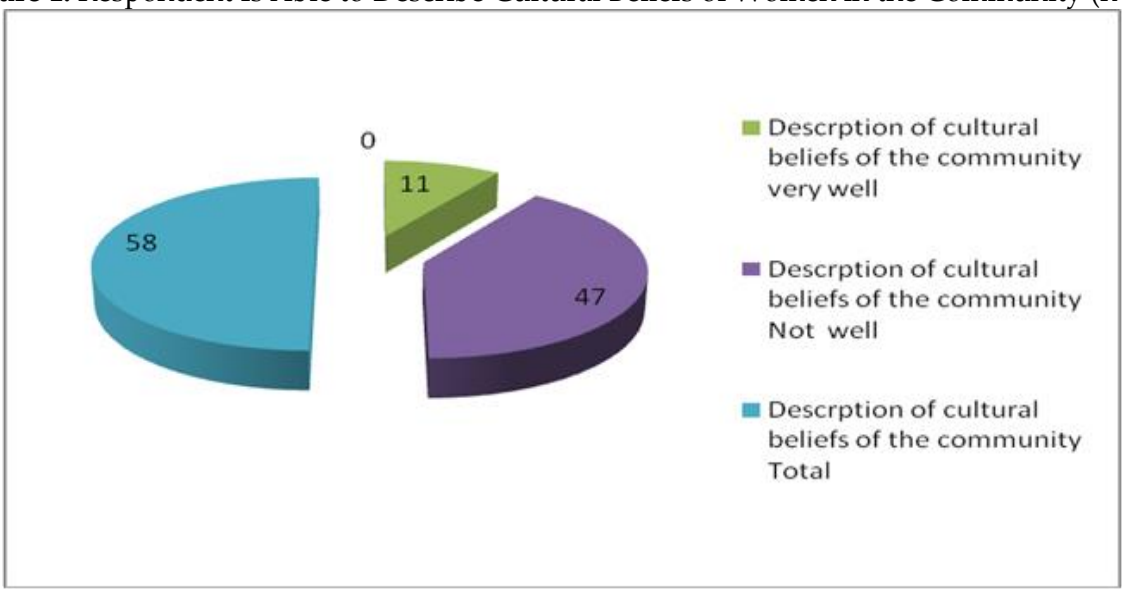
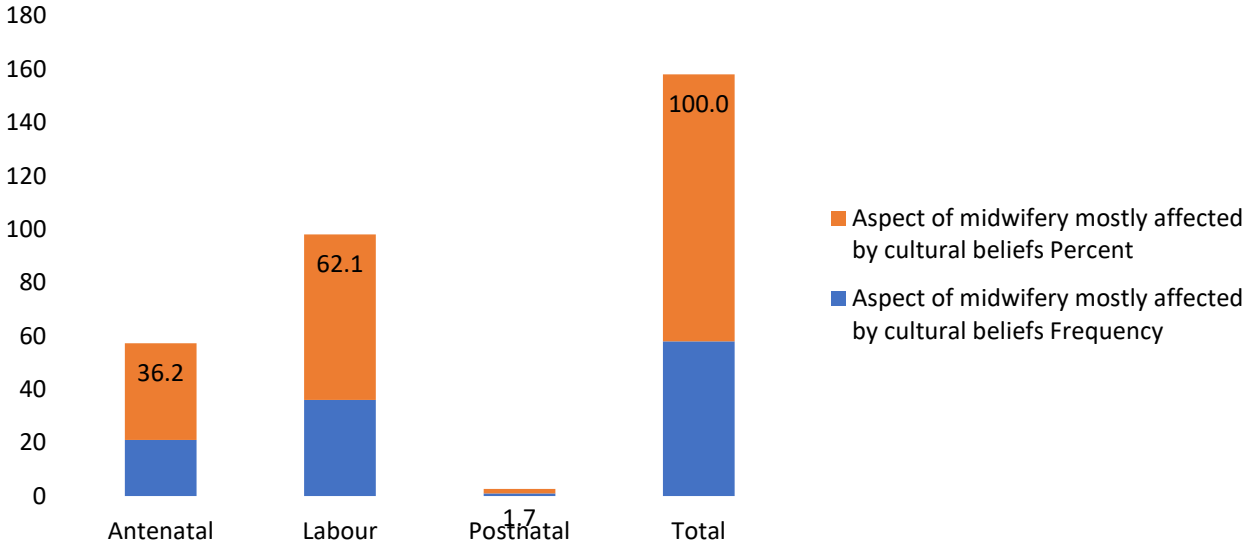


Figure 1 shows that most of the respondents, 81% (47), could not describe the cultural beliefs of the women in the community well, while 19% (11) could describe the cultural beliefs well.

Figure 2: Aspect of Midwifery Care Mostly Affected by Cultural Beliefs (n=58)



When asked about the aspect of midwifery care mostly influenced by cultural beliefs practiced by women, most of the respondents, 62% (36) indicated that it was labour, 36% (21) stated that it was antenatal and 2% (1) stated that it was postnatal.

Table 2: List of Common Cultural Beliefs among Women (n=58)

Cultural Belief	Frequency	Percent
Infidelity causes obstructed labour, FSB, PPH and maternal death	46	79
Taking herbs to treat obstructed labour and accelerate labour	49	84
Eating eggs in pregnancy causes obstructed labour and baby with bold head	29	50
Early antenatal booking and reporting early for delivery lead to IUFD	22	38
Having sex in late pregnancy causes IUFD and a dirty baby at birth	13	22
Having sex during breastfeeding lead to malnutrition	6	10
Caesarian section is a sign of laziness	13	22
Delivering in the presence of a husband can cause FSB	3	5
Eating in labour can lead to obstructed labour	5	9

Table 2 shows that 84% (49) mentioned taking herbs to treat obstructed labour and accelerate labour, 79% (46) mentioned infidelity being the cause of obstructed labour, fresh still births, postpartum haemorrhage (PPH) and maternal death.

Figure 3: Respondents' Categorisation of the
Effects of the Cultural Beliefs on Women's Health (n=58)

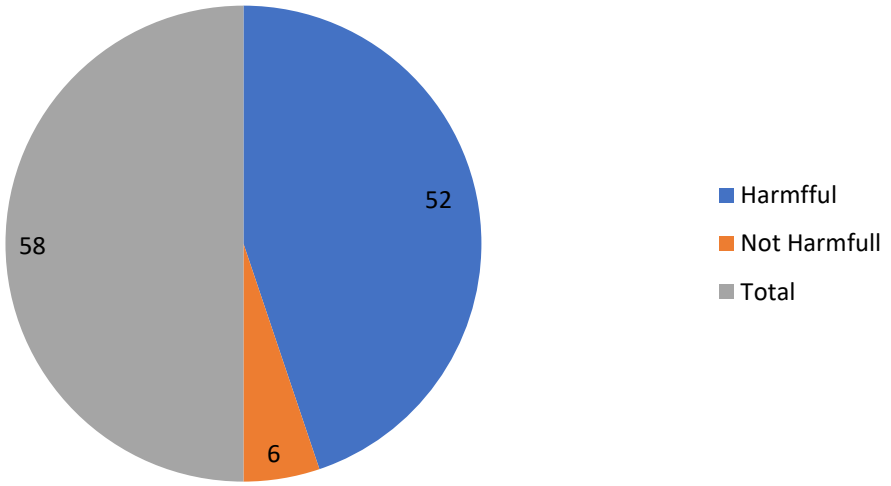


Figure 3 show that the majority, 90% (52) of the respondents stated that cultural beliefs were harmful to women's health, and 10% (6) indicated that they were not harmful.

Figure 4: Respondents Respecting Women's Culture When Providing Midwifery Care (Cultural Competence) (n=58)

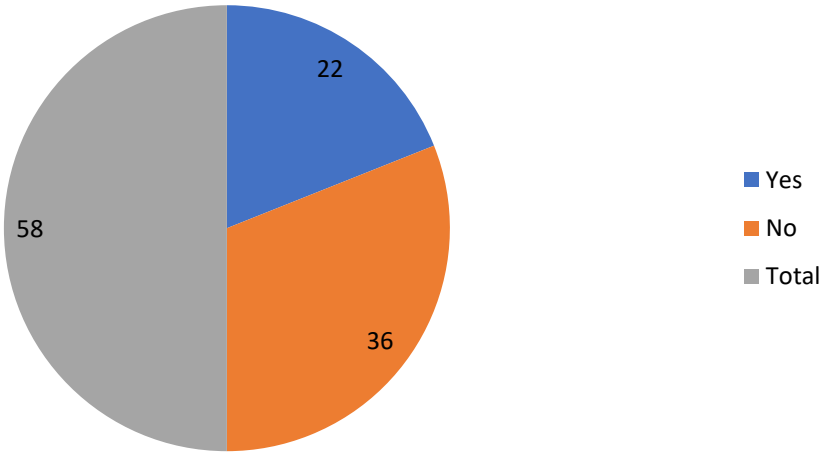


Figure 4 shows that when respondents were asked whether they considered women's culture when providing care, most, 62% (36), indicated that they did not, while 38% (22) stated they did.

Section C: Nurses and Midwives' Knowledge of Cultural Competence

Table 3: Respondents' Reading Literature, Learning During Professional Training or Attending a Workshop on Cultural Competence(n=58)

Whether the respondent read any literature on cultural competence	**Frequency**	**Percent (%)**
Yes	8	14
No	50	86
Total	**58**	**100.0**
Whether the respondent learnt about cultural competence during professional training (n=58)	**Frequency**	**Percent (%)**
Yes	46	79
No	12	21
Total	**58**	**100.0**
Whether the respondent has ever attended a workshop on cultural competence (n=58)	**Frequency**	**Percent (%)**
Yes	2	3
No	56	97
Total	**58**	**100.0**

Table 3 shows that the majority, 86% (50) of the respondents, had never read literature on cultural competence, 90% (52) had never learnt about cultural competence, and 97% (56) had never attended a workshop on cultural competence.

Section D: Nurses and Midwives' Attitudes Towards Cultural Competence

Table 4: Respondents' Denying Midwifery Care to a Woman Because of Refusing to Follow Hospital Policy(s) and How the Respondent Feels When a Woman Insists on Following Cultural Beliefs (n=58)

Whether the respondent denied midwifery care to a woman because of refusing to follow hospital policies	**Frequency**	**Percent (%)**
Yes	12	21
No	46	79
Total	58	100
How the respondent felt when the woman insisted on following her cultural beliefs	**Frequency**	**Percent (%)**
Bad	54	93
Good	4	7
Total	**58**	**100.0**

Table 4 shows that most, 79% (46) of the respondents, had never denied any woman midwifery care when they refused to follow hospital policies, while 21% (12) stated denying women services. The majority, 93% (54), responded that they feel bad when a woman insists on following their cultural beliefs despite them being against hospital policy.

Section E: Nurses' and Midwives' Social-Cultural Backgrounds

Table 5: Respondent Failed to Provide Midwifery Care Due to Cultural Background Differences with a Woman under Their Care (n=58)

Whether the respondent has ever denied providing midwifery services to a woman because of cultural differences	**Frequency**	**Percent (%)**
Yes	35	60
No	23	40
Total	**58**	**100.0**

Table 5 shows that most, 60% (35) of the respondents stated that they had denied midwifery care to women due to cultural background differences with the women, and 40% (23) never denied midwifery services to women with cultural background differences.

Figure 5: Respondent Failing to Provide Care Due to Language Differences (n=58)

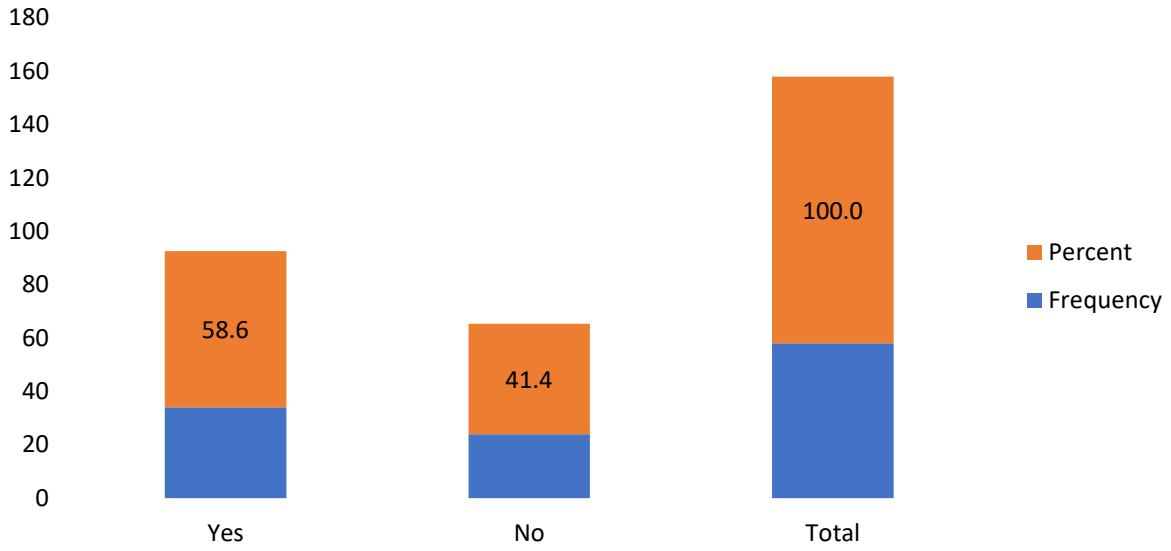


Figure 5 indicates that most, 59% (34) of the respondents, have failed to provide midwifery care due to language differences with the woman before, while 41% (24) have provided care despite language differences.

3.3 Associations Between Variables

Section A: Demographic Data

Table 6: Relationship between a Respondent's Age in Years and Respecting a Woman's Cultural Beliefs When Providing Midwifery Care

		Whether respondents respect women's cultural beliefs when providing midwifery care (Cultural Competence).		**Total**	**P-value**
		Yes	**No**		
Age in years	19-25	5 (100%)	0 (0%)	5 (100%)	0.023
	26-32	8 (36%)	14 (64%)	22 (100%)	
	32-38	2 (22%)	7 (78%)	9 (100%)	
	39 and above	7 (32%)	15 (68%)	22 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square Test analysis showed that there was statistical significance in the relationship between a respondent's age and respecting a woman's cultural beliefs when providing midwifery care, with a p-value of 0.023. Therefore, the null hypothesis was rejected.

Table 7: Relationship between a Respondent's Professional Qualification and Respecting a Woman's Cultural Beliefs When Providing Midwifery Care

		Whether respondent respect women's cultural beliefs when providing midwifery care (Cultural Competence).		**Total**	**P-value**
		Yes	**No**		
Professional Qualification	Enrolled Nurse	2 (100%)	0 (0%)	2 (100%)	0.007
	Enrolled Midwife	3 (17%)	15 (83%)	18 (100%	
	Registered Nurse	13 (59%)	9 (41%)	22 (100%)	
	Registered Nurse Midwife	4 (25%)	12 (75%)	16 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square Test analysis showed that there was statistical significance in the relationship between a respondent's professional qualification and respect for a woman's cultural beliefs, with a p-value of 0.007. Therefore, the null hypothesis was rejected.

Table 8: Relationship Between a Respondent's Duration of Providing Midwifery Care and Respecting a Woman's Culture When Providing Midwifery Care

		Whether respondents respect women's culture when providing midwifery care(Cultural Competence).		**Total**	**P-value**
		Yes	**No**		
Number of years in providing midwifery care	Less than 2 years	5 (33%)	10 (67%)	15 (100%)	0.050
	2-5 years	11 (65%)	6 (35%)	17 (100%)	
	6-9 years	2 (20%)	8 (80%)	10 (100%)	
	10 years and above	4 (25%)	12 (75%)	16 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square Test analysis showed that the relationship between a respondent's duration of providing midwifery care and respecting a woman's culture when providing midwifery care was statistically significant with a p-value of 0.050. The variable failed to reject the null hypothesis.

Section B: Cultural Competence among Nurses and Midwives Providing Midwifery Care

Table 9: Relationship between a Respondent's Ability to Describe the Community's Cultural Beliefs Well and Respecting a Woman's Culture When Providing Care

		Whether the respondent respects women's cultural beliefs when providing midwifery care (Cultural Competence)		Total	P-value
		Yes	No		
Describing cultural beliefs of the community	Very well	3 (27%)	8 (73%)	11 (100%)	0.418
	Not well	19 (40%)	28 (60%)	47 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square test analysis indicates that the relationship between a respondent's ability to describe a community's cultural beliefs well and respecting women's cultural beliefs was not statistically significant, with a p-value of 0.418. Therefore, the hypothesis was accepted.

Section C: Knowledge of Nurses and Midwives on Cultural Competence

Table 10: Relationship between a Respondent Reading Literature on Cultural Competence and Respecting Women's Culture When Providing Care

		Whether respondents respect the women's cultural beliefs when providing midwifery care (Cultural Competence)		Total	P-value
		Yes	No		
Whether respondent read any literature on cultural competence	Yes	11 (39%)	17 (61%)	28 (100%)	0.837
	No	11 (37%)	19 (63%)	30 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square test analysis indicates that the relationship between a respondent reading literature on cultural competence and respecting a woman's cultural beliefs when providing midwifery care was not statistically significant, with a p-value of 0.837. Therefore, the null hypothesis was accepted.

Table 11: Relationship between a Respondent Learning About Cultural Competence during Professional Training and Respecting Women's Cultural Beliefs When Providing Midwifery Care

		Whether respondents respect women's cultural beliefs when providing midwifery care (Cultural Competence)		**Total**	**P-value**
		Yes	**No**		
Whether the respondent learnt about cultural competence during professional training	Yes	17 (37%)	29 (63%)	46 (100%)	0.603
	No	5 (42%)	7 (58%)	12 (100%)	
Total		**22 (38%)**	**35 (62%)**	**57 (100%)**	

The Pearson Chi-square test analysis indicates that the relationship between a respondent learning about cultural competence during professional training and respecting women's cultural beliefs when providing midwifery care was not statistically significant, with a p-value of 0.603. Therefore, the null hypothesis was accepted.

Section D: Attitudes of Nurses and Midwives Towards Cultural Competence

Table 12: Relationship between a Respondent's Feelings Towards a Woman Insisting on Their Cultural Beliefs When Seeking Midwifery Care and Respecting the Woman's Cultural Beliefs When Providing Midwifery Care

		Whether respondents respect women's cultural beliefs when providing midwifery care (Cultural Competence)		**Total**	**P-value**
		Yes	**No**		
How the respondent felt when the woman insisted on her cultural beliefs, which affect the delivery of midwifery care	Bad	18 (33%)	36 (67%)	54 (100%)	0.008
	Good	4 (100%)	0 (0%)	4 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square test analysis indicates that the relationship between a respondent's feelings towards a woman insisting on their cultural beliefs when seeking midwifery care and respecting the woman's cultural beliefs when providing midwifery care was statistically significant with a p-value of 0.008. Therefore, the null hypothesis was rejected.

Section E: Socio-cultural Factors Influencing Cultural Competence among Nurses and Midwives

Table 13: Relationship between Differences in Respondent and a Woman's Cultural Beliefs and Respecting the Woman's Cultural Beliefs When Providing Midwifery Care

		Whether respondents respect women's cultural beliefs when providing midwifery care (Cultural Competence)		**Total**	**P-value**
		Yes	**No**		
Whether the differences in cultural beliefs between the respondent and the woman influence midwifery care	Yes	16 (46%)	19 (54%)	35 (100%)	0.132
	No	6 (26%)	17 (74%)	23 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square test analysis indicates that the relationship between differences in respondents and a woman's cultural beliefs and respecting the woman's cultural beliefs when providing midwifery care was not statistically significant, with a p-value of 0.132. Therefore, the null hypothesis was accepted.

Table 14: Relationship between Difference in Language of Respondent and Woman Seeking Midwifery Care and Respecting the Woman's Cultural Beliefs When Providing Midwifery Care

		Respondent respects the woman's cultural beliefs when providing midwifery care (Cultural Competence)		**Total**	**P-value**
		Yes	**No**		
Difference in language of the respondent and the woman seeking midwifery care	Yes	15 (44%)	19 (56%)	34 (100%)	0.248
	No	7 (29%)	17 (71%)	24 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square test analysis indicates that the relationship between the difference in language of the respondent and the woman seeking midwifery care, and the respect of the woman's cultural beliefs when providing midwifery care was not significant, with a p-value of 0.248. Therefore, the null hypothesis was accepted.

Table 15: Relationship between a Respondent Caring for a Woman with Age Preference and Respecting the Woman's Belief When Providing Care

		Whether respondents respect women's cultural beliefs when providing midwifery care (Cultural Competence)		Total	P-value
		Yes	No		
Whether the respondent ever failed to provide midwifery care to a woman due to their age preference	Yes	3 (50%)	3 (50%)	6 (100%)	0.520
	No	19 (37%)	33 (63%)	52 (100%)	
Total		**22 (38%)**	**36 (62%)**	**58 (100%)**	

The Pearson Chi-square test analysis indicates that the relationship between a respondent caring for a woman with age preference and respecting the woman's belief when providing care was not statistically significant, with a p-value of 0.520. Therefore, the null hypothesis was accepted.

Section F: Linear Regression Analysis

Table 16: Linear Regression Analysis

Dependent Variable	Independent Variable	Unstandardized Coefficient	Coefficient (Better)	T-Statistics	P-value
Cultural competence	Age in years	.205	.438	2.640	.011
	Professional qualification	.095	.243	1.476	.147
	Learning about cultural competence	.015	.012	.092	.927
	Attitude towards culturally competent care	.005	.007	.053	.958
	Cultural beliefs of the respondent	.417	.417	2.760	.008
	Language differences	.128	.130	.887	.380
	Religious belief differences	.059	.027	.151	.881
	Marital status of the respondent	.267	.122	.726	.471

The linear regression analysis outcome indicates that cultural beliefs of the nurse and midwife have a higher ability to influence the nurses and midwives to be culturally competent, with a p-value of 0.008, <0.05.

4. Discussion of Findings

4.1 Socio-demographic Characteristics of Study Respondents

The socio-demographic characteristics which were necessary for the study and vital for the interpretation of findings were age, professional qualifications and duration of providing midwifery care. The demographic characteristics revealed a statistical significance with a p-value of < 0.023 (Table 6), implying that it has an influence on the nurse and midwife's ability to be culturally competent in the provision of midwifery care. These are individualized and indigenous characteristics of the nurse and midwife. The

respondents were nurses and midwives aged between 19 and 55 years. Of these, 38% (22) were aged between 26 and 32 years, similar to those aged 39 years and above. This was an appropriate age for the delivery of midwifery care to society. However, 9% (5) were aged between 19 and 25 years, indicating the involvement of young midwives in the delivery of midwifery care. In the study, respondents aged between the ages of 19 and 25 were found to respect women's cultural beliefs when providing midwifery care, p-value. The younger the nurse, the more culturally competent they are when providing midwifery care. This could be attributed to the cultural upbringing of respecting elders, being non-judgmental due to ignorance. In respect to professional qualifications, 45% (26) were Registered Midwives, while 21% (12) were Enrolled Midwives and 31% (18) Registered Nurses, providing an impression that midwifery care was provided by trained and specialized nurses and midwives. There was a statistical significance p-value < 0.007 (Table 7), the nurses with diploma qualifications respected women's culture compared to other professionals. The years in service of providing midwifery care were between less than two years and more than ten years. Among the respondents, 26% (15) had less than two years, 29% (17) had provided care between 2 and 5 years, and 28% (16) had more than ten years of experience. There were nurses and midwives who had fewer and more years of serving the community and being in contact with women, which is a factor in attaining cultural competence (Table 1), p-value 0.05. This was related to Bastami *et al.* (2016) that the age of a nurse or midwife, professional qualifications and duration of providing midwifery services influence one's potential to attain cultural competence.

4.2 Cultural Competence Among Midwives and Nurses

The results revealed that 62% (36) of the respondents (n=58) were not respecting women's culture when providing midwifery care, and only 38% (22) were able to do so (Figure 4) with statistical significance of p-value <0.023 (Table:6). Among the respondents, 81% (47) (Figure 1) were not able to describe the common cultural beliefs of the women in the community despite 90% (52) stating that they were harmful as most of the women were stated to have been taking herbs during labour (Figure 3). The ability to understand and interpret the cultural beliefs of women under care is an important factor in the provision of individualised and respectful midwifery care. Respecting women's cultural beliefs regardless of their background is an indication of being culturally competent. Aragaw *et al.* (2015) had similar findings in a study conducted in Ethiopia, which stated that the cultural competence of midwives and nurses was at 57% due to nurses and midwives' ability to respect women's cultural beliefs during the provision of midwifery care. However, findings by Bastami *et al* (2016) in Iran revealed that the score of nurses' cultural competence was at 51%. The overall impression of cultural competence among nurses and midwives is contrary to the WHO (2018) perspective that cultural competency among nurses and midwives is vital and a legal obligation because it promotes quality midwifery care and women's rights in midwifery practice. However, Ngoma and Mayimbo's (2017) indicated in an earlier study that cultural competence was not

mandatory in Zambia, a concept that can have an influence on the ability of nurses and midwives to attain cultural competence.

Cultural beliefs included taking herbs to induce and augument labour, Cephalo-Pelvic Disproportion (CPD) being caused by infidelity, and not seeing the baby after delivery if a woman had sexual intercourse with any other man apart from the husband. These findings are similar to those by Silubanje *et al.* (2016) in a study conducted in Mpika district on cultural practices among women during pregnancy, labour and pueperium, which revealed the taking of herbs during labour and stated that cultural practices had both negative and positive impacts on women's health.

4.3 Knowledge of Midwives and Nurses on Cultural Competence

The results showed that the nurses and midwives providing midwifery care in the Mpika district had knowledge of cultural competence. This is due to the fact that 46 (79%) of the respondents (n=58) learnt about cultural competence during professional training, and 14% (8) read literature on cultural competence. There were only 3% (2) respondents who had gained knowledge through a workshop (Table 3). However, 63% (29) of 46 nurses and midwives with formal knowledge on cultural competence were not culturally competent. The result can be compared to Hart and Mareno's (2016) perspective, which stated that nurses and midwives can be culturally competent through interactions with women and knowing women's cultural practices. This implies that formal knowledge requires reinforcement through interaction with the women. However, Cruzen *et al.* (2017) and Hart and Mareno (2016) study findings indicated that nurses and midwives' cultural competence can be enhanced if education is introduced at an earlier stage in the professional training. The studies by Repo *et al.* (2017) and Mlongo's (2016) conducted in South Africa, similarly supported the perspective that if nurses and midwives acquire knowledge through education during their training, it has great influence on their ability to be culturally competent. This is because the nurses and midwives would have valued cultural competence in their provision of midwifery services at an earlier stage in the profession.

The respondents' knowledge acquired during professional training was unable to facilitate midwifery care, which was not culturally safe. This could be attributed to the fact that in the curricula for nurses and midwives in Zambia (GNCZ, 2014), cultural competence is integrated as a unit and not a course. The knowledge acquired is not comprehensive enough to enhance the provision of culturally safe care. This training approach is contrary to Cruzen *et al.*'s (2017) study findings, which stated that education on cultural competence during professional training should include international cultures because there are a lot of immigrants worldwide. Zambia is not spared from the international and intra-national migration phenomenon; hence, the situation in the country requires nurses and midwives who are culturally competent.

4.4 Midwives and Nurses' Attitudes Towards Cultural Competence

The results revealed that 54 (93%) (n=58) of the nurses and midwives stated that they felt bad when a woman under their care insisted on upholding her cultural beliefs. This outcome was supported by the statistical significance of p-value <0.008 (Table 12). This further resulted in 21% (12) denying midwifery care to the women, thereby compromising quality care and risking the women's health (Table 4). This is similar to the outcome of Bastami *et al.* (2016) study, which indicated that cultural competence was low (50%) among nurses due to their negative attitudes. Bastami *et al.* (2016) also indicated that 93% of nurses and midwives felt bad when a woman seeking midwifery care insisted on having her cultural beliefs respected during the care. Suk's (2018) study results also revealed that more than 50% of nurses and midwives were not culturally competent in their provision of care due to negative attitudes of nurses and midwives towards cultural competence. Cruz *et al.* (2017) stated that negative attitudes of nurses and midwives towards cultural competence influenced their ability to attain cultural competence. The perspective stated in the study by Ngoma and Mayimbo (2017), that a non-judgmental attitude is vital in the provision of care in a multicultural nation, supports the study results. It is necessary to acknowledge that personal negative feelings of the nurses and midwives revealed in the study had less negative impact on the women, although it is a threat to the delivery of quality midwifery care. This is due to the fact that a feeling can easily be converted into an action which is in harmony with the feeling. The negative feelings of the nurses and midwives towards cultural competence could be attributed to delayed sensitization, inadequate education and delayed training on cultural competence during professional training. This is in support of the study conducted by the Midwifery Council of New Zealand (2014), which stated that cultural competence should be introduced at an earlier stage of nursing profession training in order to mould the nurses and midwives' affective domain towards cultural competence.

4.5 Socio-cultural Background of the Nurses and Midwives

The study results revealed that the difference in cultural background between the women and respondents has an influence on the ability of the nurses and midwives to be culturally competent in the provision of midwifery care. This is due to the fact that 60% (35) of respondents (n=58) nurses and midwives failed to provide care to women with different cultural backgrounds from their own, which they failed to appreciate and did not respect women's culture when providing care (Table 5). The providers were imposing their beliefs on the women under their care. This finding is similar to Kang's (2014) study findings, which revealed that all (100%) of the nurses and midwives in their study were unable to provide culturally safe care due to their cultural backgrounds, which were different from the cultures of the women they were providing care to. Sienuwoh *et al.* (2016) also stated that nurses and midwives' differences in their indigenous birth practices and cultural beliefs influenced their ability to achieve cultural competence during the provision of care. However, the study showed that despite the disparities in cultural beliefs, women were still provided with midwifery care. The respondents

indicated that they provided explanations aimed at discouraging women from practicing harmful cultural beliefs.

The study findings also showed that social background, which encompassed the aspects of language, age, gender, marital status and religious beliefs of the respondents, influenced the ability to be culturally competent. 34 (59%) of the respondents who had language differences with the women failed to provide culturally competent midwifery care (Figure 5). The results are similar to those of Tobin and Lawless (2014) as well as Kang's (2014), which revealed that all (100%) of the midwives had challenges to culturally competent when providing midwifery because of differences in language with the Asylum women. The women felt safe and free with the care provider who was able to understand their language. However, gender preferences by the women about the nurse and midwife to provide them with midwifery care influenced the nurses and midwives not to be culturally competent, with 13% (8) failing to provide culturally safe care due to gender differences with the women. This finding is similar to Osborne's (2017) study, which stated that all (100%) of the nurses and midwives that encountered women with gender preferences failed to provide care in a culturally competent manner and women further indicated that they preferred to deliver at home rather than at the hospital where there were male midwives because their culture prohibited any man to see a naked woman they were not married to. The result could be attributed to inadequate community sensitization on professional trends. However, since 86% of respondents in the study did not encounter women with gender preferences, it could mean that there was some awareness among community members about gender trends in the midwifery profession. The outcome on women's preference on the age of the caregiver did not reveal a significant influence, as 3 (50%) of the 6 respondents (n=58) who encountered such women, 3 (50%) were not culturally competent. Those respondents (n=58) who cared for women with marital status preferences 3 (5%), 2 (67%) were not culturally competent. Furthermore, respondents (n=58) who had religious differences with women seeking midwifery care, 3 (5%), only 1 (33%) were not culturally competent. It is conclusive from the social background outcomes that the variable has less influence on the nurse and midwife to be culturally competent.

5. Implications on Nursing and Midwifery Practice

5.1 Midwifery Practice

The study findings showed that nurses and midwives are capable of providing culturally safe midwifery care, which uplifts women's rights despite challenges such as inadequate knowledge on cultural competence. However, some nurses and midwives were not respecting women's cultural beliefs during delivery of care, implying that there is a need to enhance cultural competence to promote individualised and respectful midwifery care. Despite being able to describe cultural beliefs of women, some nurses and midwives in the study had negative attitudes towards women's beliefs when providing care. Initially, they were offended when a woman insisted on their cultural beliefs. They were

chasing women who were insisting on observing their cultural beliefs, such as taking herbs to accelerate labour, and maintaining culturally acceptable delivery positions.

Good attitudes towards women's cultural beliefs during delivery of care are vital because, among numerous benefits, they ensure that women value and appreciate midwifery services. Culture is what gives an individual identity and value; thus, to make women undo their harmful cultural beliefs without being viewed as being offensive, a nurse or midwife providing health services requires being culturally competent. A woman's psychological aspect is influenced by such factors as denying them the right to respect their culture. It is therefore imperative that nurse managers, educators and mentors are oriented to cultural competence through in-service workshops so that they can, in turn, reinforce orientation and supervision of subordinates at operational levels and the profession at large in order to promote culturally competent attitudes during the delivery of midwifery care. They should also establish strategies aimed at integrating cultural competence in the nurses and midwives curricula in order to empower nurses and midwives with scientific and evidence-based reasoning when providing midwifery care rather than chasing the women. In addition, service training on cultural competence among nurses and midwives should be conducted periodically in order to sustain and expand knowledge, because culture is dynamic, and society has become multicultural. Nurses and midwives should also understand that negative attitudes create apprehension and stress in women when seeking midwifery care. Physiologically, apprehension and stress have a negative impact on labour and delivery, predisposing a woman to avoidable complications of prolonged labour and maternal/foetal distress, and above all,depriving the woman of her rights.

5.2 Nursing Administration

The study results revealed that there were no scheduled programmes in place aimed at enhancing cultural competence among nurses and midwives; thereby compromising the delivery of quality maternity care that values women's rights. This also implies that there is a need for nurse/midwife managers to be highly equipped with knowledge and skills on cultural competence in order for them to provide comprehensive technical support. Duration in providing midwifery care does not warrant a nurse or midwife to be culturally competent. There is a great need for technical support and evaluation. Most nurses and midwives had provided midwifery care for more than ten years, but they were not culturally competent. The non-availability of a tool to assess cultural competence creates a gap, which has the potential to compromise the provision of culturally safe maternity care in culturally diverse societies and communities. The nurses and midwives in the study had scant scientific information on the significance of respecting women's culture when providing care. This brings about the need to have an assessment tool because it can assist practitioners to carry out self-evaluations of their care. Language differences have been cited as a barrier in the provision of quality midwifery care. In this regard, newly recruited nurses and midwives who may have differences in characteristics, such as language, can be provided close supervision that

ensures that appropriate communication is hastened and facilitated during the delivery of care. Nurse Managers can initiate sessions during induction to orient new nurses on the culture of the community.

5.3 Nursing Education

Foundational knowledge on cultural competence, which is significant in enhancing cultural competence among nurses and midwives, was found not to be adequate among study participants. This has the potential to create a gap in the attainment of cultural competence among qualified nurses and midwives, as the knowledge can be eroded as nurses and midwives qualify. Cultural competence is a vital tool in the enhancement of respective midwifery care; therefore, initiating it as a separate course, not just a topic in the curriculum, can facilitate broader knowledge. Broad knowledge of cultural competence during training can facilitate appropriate self or peer assessment during the delivery of maternity care services. Through such assessments, nurse/midwife managers can easily identify areas needing capacity building and technical support. It is therefore necessary that nurse educators review nursing and midwifery curricula often in order to encompass emerging factors such as cultural competence that are vital elements to the provision of respective maternity care. This can enhance adequate accessibility and utilisation of maternity services, thereby reducing home deliveries and deaths among women.

5.4 Nursing Research

The study revealed that there is scant literature on cultural competence, and 86% of the respondents had not read any literature. This is an indicator that there is a great need for more nursing research on cultural competence, which is vital in the provision of individualised, respectful and quality midwifery care amidst a culturally diverse society.

6. Conclusion

The study attempted to establish the relationship between being culturally competent and the following variables: respect towards women's cultural beliefs, knowledge on cultural competence, attitude towards cultural competence and social and cultural background of the nurse and midwife. This was based on nurses and midwives providing midwifery care in the Mpika district. A cross-sectional study involving 58 nurses and midwives providing midwifery care in 18 selected health facilities was conducted in the Mpika district. The study outcome revealed that the nurses and midwives in Mpika district were not culturally competent, as 36 (62%) of 58 nurses and midwives included in the study did not respect women's culture when providing care p-value (0.023). It was established that most of the nurses and midwives had knowledge about cultural competence through professional training, although they were not providing culturally safe care. There was no relationship between being culturally competent and having knowledge of cultural competence (p-value> 0.0603). However, significance in the

relationship of attitude towards cultural competence and cultural competence was evident (p-value 0.008), implying that the nurses and midwives' attitude towards cultural competence reduces their ability to be culturally competent. There is a great need for nurse managers to provide mentorship and technical support to in-service nurses to monitor and evaluate nurses' and midwives' attitudes towards cultural competence. Cultural competence comprises skills and techniques which facilitate the provision of care to women from any cultural background, hence uplifting their rights and promoting their health. The findings further showed that the social and cultural background of the nurses and midwives had no significant relationship with being culturally competent. It was noted that despite some women having preferences for age (p-value=0.520), gender (p-value=0.945) and marital status (p-value=0.866) of the nurse and midwives to provide midwifery care to them, the nurses and midwives were still able to provide culturally safe care. Cultural competence among nurses and midwives providing midwifery care can help to motivate women to access reproductive health services because they will feel cared for as their individual needs are met. Women's culture does not just involve women's traditional beliefs, but encompasses beliefs, customs and values which give them identity.

6.1 Recommendations

Based on the research findings, the following recommendations are made:

6.1.2 Nurses and Midwives

1) Nurses and midwives holding management positions should establish close supervision measures, provide technical support and in-service training to nurses and midwives on the importance of providing culturally safe midwifery care.
2) A protocol on cultural competence should be established in order to enhance positive attitudes among nurses and midwives.
3) Research on cultural competence should be promoted.

6.1.2 Nurse Educators

1) Review of nurses and midwives' curricula should be undertaken on a regular basis to ensure that new trends, such as cultural competence, are included.
2) Cultural competence should be a significant component in the nurses and midwives' curricula, and it should be introduced at an early stage in their training until competence examinations are administered.
3) Enhancement of the importance of cultural competence through simulations or drills during training should be strengthened in order to inculcate a good attitude towards cultural competence.

6.1.3 Provincial and District Medical Officers

1) PHOs and DHOs should ensure that logistics that enable nurse and midwifery managers to provide technical support and in-service training on cultural competence to nurses and midwives are available.
2) Cultural competence should be integrated into the PHO and DHO quarterly assessment tools for health facilities.
3) Cultural competence should be included in the protocols on quality improvement/quality assurance so that nurses and midwives get to understand that being culturally competent is an obligation.

6.2 Study Strengths

1) The study was timely as the district was experiencing home deliveries, which were resulting in maternal deaths due to cultural practices among women.
2) The study managed to prove that the research hypothesis and objectives were achieved.

6.3 Study Limitations

The study was done on the nurses and midwives providing midwifery care in the Mpika district only. Therefore, generalisation of the study outcome should be done with caution due to contextual differences.

6.4 Dissemination and Utilization of Findings

Bound copies of the study will be submitted to the UNZA School of Nursing Sciences, library and ERES Converge. Summaries of the results will be presented to the managements of Muchinga PHO, Mpika DHO, Michael Chilufya Sata General Hospital, and Chilonga hospitals. A manuscript will be submitted to a peer-reviewed journal for publication. The researcher will also utilize clinical meetings at any available forum to sensitize nurses, midwives, managers and other health care providers in the Mpika district on the findings of the study.

Acknowledgements

The authors would like to acknowledge all the respondents for participating in the study, the Muchinga Province Health Director and the Mpika District Health Director for permission to conduct the study.

Author's Contribution

JN conceptualized the study, collected and analyzed data and drafted the manuscript. CK and BS supervised proposal development and the research process, and participated in drafting and proofreading the manuscript. JN proofread and sponsored the publication of the manuscript. All authors read and approved the final manuscript.

Conflict of Interest Statement

The authors declare that they have no competing financial or personal interests that influenced the study.

About the Author(s)

Joyce Namalongo (MSWCH, BScN) is a HoD in Nursing/ Researcher at Kalulushi College of Nursing. Her research interests include Midwifery, Adolescent Women's Health, Reproductive Health and Nursing.

Conceptor Kwaleyela (PHD, MSn, BScN) is an associate professor at Mulungushi University Department of Nursing and Midwifery. Her research interest includes Midwifery, Adolescent, Women's Health, Reproductive Health and Nursing.

Brenda Sianchapa (PHD, MSn, BScN) is a lecturer at The University of Zambia School of Nursing Sciences. Her research interest includes Midwifery, Adolescent, Women's Health, Reproductive Health and Nursing.

Jean Ngala (MsN, BScN) is a lecturer/ Researcher at Mulungushi University. Her research interests include Midwifery, Adolescent Women's Health, Reproductive Health and Nursing.

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