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Experiences of midwives regarding provision of culturally competent care to women receiving maternal care in South Africa

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ABSTRACT

Due to the cultural diversity in South Africa, midwives are challenged to provide culturally competent, congruent, and sensitive maternal care. Using a qualitative descriptive design, this study aimed to explore and describe the experiences of midwives providing culturally competent care to women receiving maternal care within overburdened public hospitals. Purposive sampling of thirty-four ($n = 34$) midwives employed to provide maternal care (antenatal, intrapartum, and postpartum) at five public hospitals in the North West Province of South Africa was done. Semi-structured interviews were conducted in English and transcribed verbatim. Data was analysed thematically with the assistance of an independent co-coder. Data revealed that midwives viewed communication as a key component of cultural competence. Midwives do not necessarily understand the concept "cultural competence." It is recommended that a policy of culturally competent maternal care be developed and implemented by midwives in practice.

Original research

Introduction

Midwives' cultural competency can potentially improve patients' satisfaction levels and maternal health outcomes (Henderson et al., 2018). However, globally there is still concern regarding the unacceptably high maternal mortality ratio, which is the number of maternal deaths per 100,000 live births, especially in sub-Saharan African countries such as South Africa. The World Health Organization (2019) reported a global maternal mortality ratio of 542 in sub-Saharan Africa. It is therefore pivotal that healthcare professionals, especially midwives – the primary care providers, provide culturally competent care to diverse populations. Culture, in general, influences patients' interpretation of and response to healthcare (Purnell, 2005) and health professionals who lack cultural competence may contribute to delays in patients' treatment or non-compliance thereof and inappropriate diagnoses (De Beer and Chipps, 2014).

According to Campinha-Bacote (2002), cultural competence is the "ongoing process in which the healthcare provider continually strives to achieve the ability to effectively work within the cultural context of the patient." This process involves the integration of five constructs, cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Both the midwife and the patient hold their own cultural beliefs and practices, and these might be different. Cultural differences between the midwife and patient requires cultural competence from the midwife, using cultural-based knowledge and skills for the benefit of the patient and baby.

South Africa, coined the "rainbow nation" by Archbishop Desmond Tutu (South Africa Online, 2022), is a culturally diverse country. This diversity is not limited to culture and language only, but also to spiritual practices, age, race, gender, ethnicity, class, and sexual orientation. The population consists of four main ethnic groups, namely African (44.23 million), Coloureds (4.83 million), White (4,53 million), and Indian/Asian (1.36 million) (Statistics South Africa, 2015). The country has nine provinces and 11 official languages (Government Communications and Information Systems (GCIS), 2016), which demonstrates the diverse population. Additionally, South Africa and Africa are known for migration, with people migrating between provinces and neighbouring countries, such as Lesotho, Botswana, Democratic Republic of

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Congo, Zimbabwe, Nigeria, Mozambique, Swaziland, Malawi, and Somalia, in search for work and livelihood. The estimated provincial migration statistics of the North West Province, the setting of the study, had a positive net migration of 89 317 people from other provinces from 2011 to 2016 (Statistics South Africa, 2015).

The International Confederation of Midwives (2019) outlined the minimum competencies for midwives that are specific to antenatal, labour, birth, and postnatal, including an emphasis on cultural norms, beliefs, and practices of childbearing women. In South Africa, it is important to note that the national strategies for maternal care include quality of care with a focus on healthcare providers' demonstrating respect and genuine interest towards their patients without being judgmental regarding perceived unsafe practices (Department of Health, 2015). Concerning maternal health, midwives must be culturally sensitive when rendering care to pregnant women to provide quality care. However, a gap still exists within the health facilities, for trained and permanently employed interpreters to bridge the gap of diverse languages. Currently, midwives used foreign doctors to translate for them because they do not have interpreters, while others used family members if they accompanied patients.

In 2001, there was a policy formulated on the quality of healthcare aimed to improve the quality of care in both private and public sectors (Department of Health, 2007). Following the implementation of the quality policy, the Office of Standards Compliance developed and piloted the National Core Standards, which devised the expected level of performance to measure the quality of care provided by these health sectors (Whittaker et al., 2011). The six quality priorities of the core standards promote professionalism: 1) improving cleanliness of the facilities; 2) patient safety; 3) reducing waiting times; 4) preventing health facility acquired infections; 5) ensuring availability of medicines through improved supply chain management; 6) achieving more positive attitudes and values of nurses and managers in the healthcare sector. All these initiatives are aimed at improving quality for the general population, at the same time encouraging public-private partnerships in healthcare, and not focusing on cultural competency aspects. Therefore, the objective of this study was to explore and describe the experiences of midwives regarding the provision of culturally competent care to women receiving maternal care.

Methods

Study design

The study used a qualitative descriptive design, which assisted the authors to acquire an in-depth understanding of the research topic (Gray et al., 2017).

Setting and population

The setting was a combination of the district, regional and tertiary public hospitals in North West Province. The population included both these public hospitals, and the midwives employed in the antenatal, intrapartum, and postpartum wards of these hospitals.

Sample size and selection of sample

Once ethical approval was obtained, a mediator recruited participants. Purposive sampling (Bradshaw et al., 2017) was used for both populations, which included hospitals and midwives. Five hospitals ($N = 19$; $n = 5$) agreed to be included and were a combination of district, regional and tertiary public hospitals. These hospitals were distributed throughout the province and granted the researchers access to participants from diverse cultural groups.

Table 1
. Interview schedule.

• Introductory question: Share with me your experience of providing care to patients with diverse cultural backgrounds.....
What have you learned about the patients' cultural practices in maternal care (antenatal, intrapartum, and postpartum)?Which factors, according to you, prevent you from providing culturally congruent maternal care in the midwifery units?What do you identify as facilitating factors for providing culturally congruent maternal care to pregnant women?What do you understand by culturally competent care in midwifery?How do you view the cultural competence of the midwives in this maternity unit?

In total, 34 ($N = 104$; $n = 34$) midwives participated in semi-structured interviews until data saturation was confirmed.

Inclusion criteria were permanently employed midwives working in one of the selected public hospital's maternity units (antenatal, intrapartum, and postpartum), had at least one or more years' experience as a midwife, English-speaking, and willing to give informed consent. The exclusion criterion was any midwife working at a selected public hospital but not in the maternity unit as these midwives had no direct involvement in maternity care.

Data collection

Data collection began in November 2018 and lasted until June 2019. Semi-structured interviews were based on an interview schedule (see Table 1) which continued until data saturation was established. Interviews lasted between 30 min to one hour and were digitally recorded.

Data analysis

Immediately after each interview, an independent transcriptionist transcribed the audio recordings verbatim. All participants remained anonymous and codes were used to identify them. Data analysis followed Creswell's generic qualitative analysis approach combined with Tesch's eight steps in the coding process (Creswell, 2014). These included organisation and preparation of data for analysis; developing a general sense of the data; coding of the data; identifying and describing the themes and sub-themes; data representation; and lastly, interpretation. After concluding the data analysis, a consensus discussion was held with a co-coder to verify that the themes and sub-themes that emerged were a true reflection.

Ethical consideration

The Health Research Ethics Committee of University X granted ethical approval. Thereafter applicable authorities granted approval to continue with data collection. Participation was voluntary and before data collection commenced, the participants gave written consent. The interview venues were in the hospitals, assigned by the unit managers of each hospital. Disturbances were minimal as access was controlled. To ensure confidentiality and privacy interviews were in private and no participant identity disclosed throughout the research process. Confidentiality was ensured by replacing names with codes and by ensuring that no identifiable information could be traced back to any hospital or participant.

Table 2
Themes and sub-themes arising from the Midwives data.

Themes	Sub-themes
1. Communication is a key component of cultural competence	1.1 Diverse languages amongst patients and staff 1.2 Ineffective support is given to patient 1.3 Utilisation of interpreters or sign language 1.4 Insufficient incorporation of cultural preferences
2. Midwives lack knowledge and insight about patients' cultural practices	2.1 It is difficult to incorporate culture without knowledge 2.2 Midwives are willing to learn different cultural practices 2.3 Different indigenous practices
3. Hospitals do not have culturally competent policies on culturally competent care	3.1 Hospital policy is Eurocentric 3.2 Midwives feel unprotected due to a lack of policies
4. Patients are secretive about cultural practices during labour	4.1 Grandmothers' role in patients being secretive about cultural practices 4.2 Elders' decisions can be against hospital policy
5. Facility structure makes it difficult to accommodate different cultural practices	5.1 Preferred birthing positions, such as squatting, are not always possible 5.2 Companions in the labour room are usually not allowed due to policy, space, and communication issues 5.3 Performing midwifery procedures with a companion in the labour room
6. Midwives do not understand the concept of cultural competence	

Study limitations

Public hospitals and maternity wards are overburdened and understaffed and it was an intensive process to enter this practice and obtain a suitable date and time to interview midwives. Because only midwives that were employed in maternity wards with at least one year experience were recruited, the perspectives of less experienced midwives were excluded. English is the official mode of instruction in the public hospitals; therefore, interviews were in English. Considering the cultural diversity in South Africa, some midwives might have been more proficient to express themselves in their mother tongue.

Results

Demographic characteristics

The majority of the participants ($n = 31$; 91%) were females and 9% ($n = 3$) were males. Participants ages ranged between 50 and 59 ($n = 13$; 38.2%), followed by the 40 to 49 age group ($n = 12$; 35.3%), the 30 to 39 age group ($n = 5$; 14.7%), and the youngest age group 20 to 29 years ($n = 4$; 11.8%). Most participants ($n = 20$; 59%) had between 1 and 5 years' experience, while 41% ($n = 14$) had more than 5 years' experience.

Themes and sub-themes

Six main themes and 14 sub-themes emerged. Table 2 presents the six main themes and sub-themes, and a discussion follows.

Communication is a key component of cultural competence

Diverse languages amongst patients and staff

According to the midwives, they provide care to women who speak diverse languages. The provision of maternal care becomes strained when there is ineffective communication. There is an inaccurate understanding of the specific needs of patients when patients do not know or understand the language spoken by the midwives.

> *… Sometimes patients who you don't even know their culture, they can't even speak the same language that you are speaking. And it is very hard to be able to engage culturally…* [Participant 1, 30 years old, 5 years' experience in midwifery]

> *… We've got difficulty in communicating, it's difficult because others don't even know English. Because at least if they know English, we could have had a better communication…* [Participant 3, 43 years old, 4 years' experience in midwifery]

Ineffective support is given to patient

The midwives described how they are unable to explain procedures to the patients well when they do not understand their language. They also reported that the patients might have fears regarding labour, which they cannot address due to languages barriers.

> *… You just take her to the bed, you understand that she sees the bed, but she doesn't understand what am I going to do… you are not really getting consent. At the end of the day the cardiotocography is done, the vitals are done, the PV (*vaginal examination*) is done, but you are not communicating with your patient…your patient is scared, she is vulnerable, they don't know what's happening…* [Participant 1, 30 years old, 5 years' experience in midwifery]

> *… Patients are not free enough that they can be judged for being diverse in their lifestyle that will make our lives easier so that we could provide care based on what the problem is…* [Participant 2, 35 years old, 5 years' experience in midwifery]

Utilisation of interpreters or sign language

When patients do not understand English, midwives tend to use sign language. However, when patients cannot 'read' the midwives' sign language it becomes less effective communication when sign language was inaccurate and misunderstood. As hearing-disabled people traditionally use sign language, there could be incorrect information conveyed if one does not have training.

> *… We have to resort to asking another patient to interpret because none of the staff can speak the language…* [Participant 1, 30 years old, 5 years' experience in midwifery]

> *…You use…the sign language, it is not all of us who are trained on sign language…* [Participant 4, 56 years old, 3 years' experience in midwifery]

Insufficient incorporation of cultural preferences

Some midwives acknowledged that they lack an understanding of the patients' preferences, which could lead to assumptions regarding preferences. Patients might have fears regarding labour, which they cannot address due to different languages and not understanding each other In return, patients may also have a false assumption that midwives will not understand their cultural practice and therefore choose to remain silent.

> *… So here in the maternity they don't practice it, they don't include the cultural things here. So, that is why they are hiding it.* [Participant 5, 57 years old, 5 years' experience in midwifery]

> *… They don't understand English properly, so you'll find that maybe she wants something and you don't understand properly, so you end up maybe not doing exactly what the patient needs…* [Participant 14, 48 years old, 18 years' experience in midwifery]

Midwives lack knowledge and insight about patients' cultural practices

It is difficult to incorporate culture without knowledge

Some midwives voiced that because they found it difficult to incorporate patients' culture into maternal care without the required cultural knowledge, they would rather exclude culture in the labour process. The midwives further acknowledged they have limited knowledge of different cultures, which in turn limits their ability to provide culturally competent maternal care.

> *…Sometimes you don't know other people's cultures, you don't have any insight about it…* [Participant 3, 43 years old, 4 years' experience in midwifery]

> *…Maybe we need to be trained…training…this culture because apart from being healthcare professionals, we've been taught culture when we were still doing Sociology…* [Participant 16, 53 years old, 5 years' experience in midwifery]

Midwives are willing to learn different cultural practices

Midwives indicated they are willing and interested to learn about the different cultural practices of the women to whom they provide maternal care.

> *… We should know about cultural diversity and prepare to care for patients…* [Participant 14, 48 years old, 18 years' experience in midwifery]

> *… I think maybe if we can learn about other people's cultures or have knowledge about other people's cultures, we can manage them better. …* [Participant 3, 43 years old, 4 years' experience in midwifery]

Different indigenous practices

The midwives acknowledged the women receiving maternal care are from diverse cultural groups with different indigenous practices. Examples provided ranged from Indian women who did not want to be touched or attended to by male nurses (Accoucher), to some Hindu women not wanting to be undressed fully for initial assessment as they must be always covered.

> *… Maternity has got women of different cultures and then most of the time those people of different cultures…cultures are not the same and then people also don't react the same and practices also are not the same for different cultures…* [Participant 14, 48 years old, 18 years' experience in midwifery]

> *… And sometimes when we admit them (Hindus), some of them they'll be hiding themselves, they don't want to put out that…the clothing. They don't want to wear the hospital attire* [routinely offered to patients in the hospital if they are interested]*, we just leave them like that, we respect that's their culture…* [Participant 15, 48 years old, 1 years' experience in midwifery]

> *… Yeah, some of the Xhosas and the Zulus, they don't…they don't go for lithotomy, they squat…* [Participant 11. 54 years old, 8 years' experience in midwifery]

Hospitals do not have culturally competent policies on culturally competent care

Hospital policy is Eurocentric

Most of the midwives explained there is a lack of cultural competence policy in their hospitals. These midwives further described that the hospitals function on a Western-centric culture that is exclusive to others, especially Afrocentric.

> *… … most of the hospitals' policy are in line with Whites'* (Western) *culture…some of them* (patients) *when they tell you that I can't do this in hospital, it will be termed as 'refusal of hospital treatment'…* [Participant 8, 35yrs old, 4yrs experience in midwifery]

Midwives feel unprotected due to lack of policies

Midwives are trained to function according to specific protocols and guidelines, but providing culturally competent maternity care in the absence of clear policy causes midwives to feel unprotected in the public health system. For example, some midwives felt unprotected in instances where they cannot allow patients to practice their rituals, such as allowing traditional healers to assist in labour if there is prolonged labour. The midwives indicated that a policy on the provision of culturally competent maternal care would provide legal protection as they would be guided by a legal document endorsed by management.

> *… They must come up with something. With a policy so that me, as a Nurse, I must be covered…* [Participant 15, 48 years old, 10 years' experience in midwifery]

> *… They must give a policy for us as Midwives to allow whatever the pregnant woman is coming with, concerning the culture…* [Participant 22, 42 years old, 5years' experience in midwifery]

Patients are secretive about cultural practices during labour

Grandmothers' role in patients being secretive about cultural practices

During the interviews, the midwives described how the patients' grandmothers play a pivotal role in directing women to be secretive about their cultural practices specifically during labour. At times the grandmothers instructed the patients not to tell midwives anything regarding cultural practices. For example, some patients drank traditional medicines before coming to the hospital, however they will deny that they drank traditional medicines. They usually only tell the midwives the truth once they hear the news their baby's life is in danger.

> *… People prefer to practice their culture in secret and therefore you would not understand it.* [Participant 30, 59 years old, 15 years' experience in midwifery]

> *… No, they will forever hide it as if all of them know that we don't like it. But then they do it and it's as if somebody who gave it to them said they mustn't tell the sisters at the hospital what they took and they will forever deny it…* [Participant 7, 53 years old, 5 years' experience in midwifery]

Elders' decisions can be against hospital policy

Some of the midwives indicated that the decisions of elders within the patients' social community can place them in a dilemma regarding hospital policy. For example, when the patient

consented to the incineration of a foetus, elders will come to the hospital and tell midwives that incineration is against their cultural beliefs, they must '*bury their bones.*' According to hospital policy, any foetus born before 26 weeks (miscarried or by choice of termination) is classified as medical waste and disposed of using incineration.

> … *You would tell them* (patient), *ok this is the policy, this is what it* (policy) *says, do you want to keep the foetus? Or do you want to have it incinerated with the hospital things? They* (patients) *will just take the option of saying 'No sister I don't have money for the burial' and they sign the consent …. Tomorrow the family, the elders, they come and they say 'no, in our culture we don't do that* (incineration). *We don't do that; we bury our bones'…. you are in a dilemma, the woman has signed but now the elders are here, she can't really take a decision now*… [Participant 1, 30 years old, 5 years' experience in midwifery]

> … *Sister, I know you taught me but then when I arrive at home there's a different story and it's like now, I'm disrespecting the elders. I have no choice, but I just have to listen to them* (elders)… [Participant 23, 40 years old, 6 years' experience in midwifery]

Facility structure makes it difficult to accommodate different cultural practices

Preferred birthing positions, such as squatting, are not always possible

Midwives reported that the women preferred different birthing positions, such as squatting, but this is not always possible. The midwives attribute the failure to allow women to be liberal and give birth in whatever position they want to the structures of their labour rooms. According to midwives, labour rooms are too small, and don't have correct equipment to allow squatting or other birthing position.

> … *You cannot allow a woman to squat in the hospital…like in the hospital set-up, a delivery room now that there is a delivery bed…the risk that you…that I've been talking about, of the baby being delivered on the floor…* [Participant 10, 50 years old, 11 years' experience in midwifery]

> … *There is no room for being liberal, you want maybe to give birth in a certain type of position like we were educated that we have to let the woman be liberal, but in practice, in this facility, it's really kind of hard….* [Participant 1, 30 years old, 5 years' experience in midwifery]

Companions in the labour room are usually not allowed due to policy, space, and communication issues

Due to the policy and structure of some facilities, companions are not always allowed in labour rooms. Some smaller hospitals' labour rooms only have two beds, which accommodate only two patients, thus, it would be inappropriate at times to have companions during labour. Some midwives, however, reported they did allow companions one at a time, for example, partners or husbands.

> … *So due to our hospital set-up plus the policy, it doesn't give…husband space or…to come and witness the delivery…* [Participant 10, 50 years old, 11 years' experience in midwifery]

> … *Our facility is not built in such a way that we allow the companions, because of the structure of our…the facilities…* [Participant 16, 53 years old, 5 years' experience in midwifery]

> … *I allow them, let me just say I allow them. But I also explain that I allow one person per patient …* [Participant 7, 53 years old, 5 years' experience in midwifery]

Performing midwifery procedures with a companion in the labour room

Midwives revealed it was difficult for them to do procedures when the relative or companion was in the labour room. They added that sometimes they (midwives) spend more time explaining procedures to both the patient and the companion, and this delays them. This could be due to staff shortages which is a long-standing problem in the public health sector.

> … Sometimes it's difficult we have challenges… it is difficult for us to stop them, to say we need to do 123, every time you want to do a procedure to the *patient…one member wants to be with them.* [Participant 9, 48 years old, 18 years' experience in midwifery]

> … *But we'll be keeping on trying to explain to the relatives to say 'we know you're…traditionally you can use it but, on this stage, please…can you please give us space so that we can treat your patient'…* [Participant 15, 48 years old, 1 years' experience in midwifery]

Midwives do not understand the concept of cultural competence

The majority of the midwives revealed they do not understand the concept of 'culturally competent care.' In most events, midwives' comprehensive culturally competent care was about how they treat patients from different cultural backgrounds.

> … *I don't think I understand cultural competency…* [Participant 16, 53 years old, 5 years' experience in midwifery]

> … *Culturally competent care? .... I'm not sure about that one…* [Participant 2, 35 years old, 5 years' experience in midwifery]

> … *Culturally competent care in Midwifery according to me is how to service each and every client that you come across with culturally and… culturally, spiritually…everything…* [Participant 11, 54 years old, 8 years' experience in midwifery]

> … *Somebody who'll be culturally competent is somebody who'll be cultural-conscious, not cultural-knowing but cultural-conscious…* [Participant 30, 59 years old, 15 years' experience in midwifery]

Discussion

Midwives view communication as a key component of cultural competence. The midwives must acquire effective communication skills amidst a diverse population to provide quality maternal healthcare. According to Mohale et al. (2016), women in Australia had communication difficulties and cultural misunderstandings, which also disempowered them in labour. Maputle and Hiss (2010) asserted that ineffective communication, such as inadequate listening skills and the existence of language barriers between midwives and patients, would often result in limited participation by women. Effective and good communication skills are therefore necessary as they provide a foundation for the woman to be involved in the birthing experience.

Another finding was that midwives reported they were unable to provide support to women due to the diverse languages spoken and the lack of interpreters at hospitals. Most of the time husbands/partners or other patients without medical training had to assist midwives with interpretation, however, this was of concern to midwives because there could be incorrect information communicated unintentionally. For midwives to be supportive and provide culturally sensitive and appropriate maternal care, they must also respect the autonomy of their patients. However, there can be no respect for autonomy without midwives and patients fully engaging and understanding each other within an environment where

language diversity is not supported by effective communication, including interpreting services offered by trained personnel, and lack of enough midwives with diverse language skills.

A unique finding was that the midwives found it difficult to incorporate cultural preferences due to diverse languages. The diversity within the health system requires the midwives to be culturally sensitive to patients' values, beliefs, and behaviours, which might be different from theirs. However, being culturally sensitive does not mean that the midwife is culturally competent. The main attributes of cultural competence include cultural awareness, cultural knowledge, cultural encounters, cultural skills, and cultural desire (Campinha-Bacote, 2002). The nurse practitioner (for this study the midwife) must be able to sensitively and competently incorporate cultural care into contextual routines, clinical ways, and approaches to maternal care through role modelling, policy-making, procedural performance, and performance evaluation, and the use of advanced practice nursing process (McFarland and Eipperle, 2008).

Midwives lack cultural knowledge and insight into the patients' cultural practices. Cultural knowledge refers to the process of seeking and obtaining a sound educational foundation for diverse cultural and ethnic groups (Campinha-Bacote, 2002). Although midwives lacked cultural knowledge it was clear they were willing to learn the cultures and indigenous practices of diverse patients to whom they provide care. This indicates that the midwives acknowledged their weaknesses and were motivated to learn; the attribute of cultural desire was therefore evident.

Some midwives reported that the hospitals have no policy on culturally competent care; they also highlighted an element of hospital policy favouring Western medical culture. Moeta et al. (2019) emphasised that the co-existence of both Western and African traditional health systems should be equally supported and strengthened to ensure that the health needs of patients are not only addressed from one viewpoint. The authors suggested that policy in healthcare organisations must support both Western and traditional cultures' healthcare viewpoints. The midwives further reported that the lack of policy leaves them vulnerable and unprotected, as patients blame them if anything goes wrong during labour. Grant and Perry (2013) supported the notion that culturally competent care within health services is an important factor to improve health outcomes for families from marginalised communities. Furthermore, the authors believed the policy must provide clear definitions and instructions on what constitutes cultural competency to assist healthcare organisations to provide culturally competent care.

The midwives revealed that patients are secretive about their cultural practices during labour, specifically regarding traditional healers and advice given by elders. No other study confirmed that elders influence women receiving maternal care and are secretive about the use of traditional medication, which is another unique finding in this study. Callister (2001) emphasised cultural conflicts may arise when traditional beliefs conflict with the standard nursing protocols. Decision-making by elders revealed a contradiction between culture and Western practice, which further creates a dilemma for midwives. Therefore, there is a need for midwives and elders to have open communication to develop an understanding of cultural practices and their influence on maternal healthcare. This would ensure both parties understand and clarify practices that midwives could allow, which are beneficial and safe for the mother and baby without belittling the cultural practices and beliefs of others.

Midwives revealed that the facility structure in their hospitals makes it impossible to accommodate different cultural practices, such as birthing positions. Traditionally in the South African context, lithotomy is the birthing position used in health facilities, and many midwives support this position because they fear the risks of third-degree tears on the women. Esienumoh et al. (2016) supported this and mentioned midwives in Nigeria subtly displayed ethnocentrism by imposing the culture of bed birth on women instead of adapting to that which the women prefer. The midwives in this current study might fear perceived complications that could arise from the squatting position preferred by women. Another finding was that some midwives did not allow a companion in the labour room, but others allowed one person.

Not allowing a companion with the patient during birth is concerning because the women delivering a baby feels comfortable and safe in the presence of familiar faces of people they trust (Ngomane and Mulaudzi, 2012). Furthermore, Aannestad et al. (2020) concurred that continuous support provides the midwife with the opportunity to build a trusting relationship with the woman in labour. Consequently, a woman who experiences a trustful relationship with the midwife feels in control of the labour based on her self-confidence. Some midwives cited time wasted by explaining procedures to both the patient and companion; this could be due to the shortage of staff in maternity units. Literature confirms the staff shortages and the overworking of midwives in the studied country (Malesela, 2020; Spencer et al., 2018).

Lastly, it was clear that midwives do not understand the concept of cultural competence. Globally, cultural diversity is prevalent within various countries and healthcare professionals, especially midwives, need to be culturally competent to manage patients from different cultures effectively. Matthews and Van Wyk (2018) recommended that specific learning objectives related to cultural competence must be included in the clinical training of health practitioners. Mhlongo (2016) stated that as nurses do not inherently practice the principles of transcultural nursing, they need teaching. Furthermore, Ngomane and Mulaudzi (2012) recommended that transcultural midwifery and nursing modules should be compulsory in the training of nurses, from the lowest level of training, to strengthen cultural tolerance. However, the authors contend that nurses and midwives must receive training to develop cultural competency rather than tolerance.

Ethical statement

The Health Research Ethics Committee at North-West University in South Africa granted ethical approval for this study, Ethical approval number: (NWU-00067-18-S1).

Data availability statement

All analysed data supporting the findings of this research are included in the article.

Disclaimer

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the institution or any affiliated agency of the authors.

Authors' note

The submitted manuscript is approved by all authors. KDS, TR, ADP, PB conceived and planned the study. KDS collected the data. KDS analysed the data. KDS, TR, ADP interpreted the data. KDS, TR, ADP, PB drafted and revised the manuscript. KDS, TR took the lead in writing the manuscript. All authors provided critical feedback and helped shape the research, analysis, and manuscript.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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