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## Cultural Assessment: A Study of Midwives' Knowledge, Attitude and Self-reported Practice in Uganda

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### Abstract

**Background:** Cultural assessment is critical due to the increased movement and resettlement of people across the globe, and diverse cultural groups in Uganda. This is putting the health care delivery systems serving the communities under pressure to recognize the different attitudes of people towards health and to develop care systems that are effective in meeting diverse needs. However, despite the importance of cultural assessment in nursing literature, little is known about the cultural assessment competence of Ugandan midwives. This study assessed the knowledge, attitude, and practice of midwives in this assessment process.

**Methods:** A descriptive correlational design was used to generate data for the study from a convenience sample of midwives in three hospitals using a structured questionnaire. Data were analysed using SPSS version 20.

**Results:** Forty-nine midwives participated in the study. Over half of the respondents [57%, n = 28], demonstrated a positive attitude, however, their knowledge level was low. Almost all the midwives 90% (n = 44) had not been trained on transcultural or cross-cultural midwifery during

their basic midwifery programmes. The majority of the midwives cared for at least 1 – 5 mothers a month from a culture different from their own and occasionally (once a month) [65%, n = 32] experienced difficulties or problems attributed to cultural differences. Despite the diversity of the midwives' clients and their experiences, over half of the midwives [55%, n = 27] reported that they did not record cultural data during the assessment of mothers in labour. Where the data were recorded, it was limited to biographic information such as name, age, religion, tribe, and next of kin. These data were used to plan a client's care. The major barrier to cultural assessment practice cited by the respondents was lack of time.

**Conclusion:** Overall, the midwives knowledge level about cultural assessment was low. With a culturally diverse population living in Uganda, providing culturally congruent care to all women will continue to be a challenge and necessity. It is, therefore, recommended that a culture-based curriculum and in-service training on cultural assessment be developed for midwives.

**Key Words:** *cultural assessment, midwives, cultural competence, labouring mothers, Uganda*

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## **Background**

Uganda failed to meet the Millennium Development Goal (MDG) 5 of reducing maternal mortality by three quarters <sup>1</sup> and may face challenges in meeting the Sustainable Development Goals (SDGs). The Maternal Mortality Ratio (MMR) in Uganda is 336 per 100,000 live births with an infant mortality rate estimated at 27 per 1,000 live births.<sup>2</sup> Uganda signed the Sustainable Development Goals which include targets 1 and 2 of SDG 3: reducing the global maternal mortality ratio to less than 70 per 100,000 live births and ending preventable deaths of newborns and under five children respectively by 2030.<sup>3</sup>

Achieving these targets in Uganda has been challenging; barriers to accessing health care are reflected in the institutional delivery rate of 55% and antenatal care coverage for 4<sup>th</sup> visit of 38%.<sup>4</sup> In 2016, the recommendation was changed to eight visits.<sup>5</sup> Barriers to accessing maternal health care services in Uganda include but are not limited to: i) costs of care; ii) distance from health facilities and lack of transport; and iii) lack of decision making power among women.<sup>3</sup>

The reasons for under-utilization of health services are many and complex. Socio-cultural barriers need to be overcome if women are to access technical services and information that can prevent maternal mortality and morbidity.<sup>6</sup> As a result, it is important for health care delivery systems to recognize the differing attitudes of people towards health and develop care systems that are effective in meeting their needs.<sup>7</sup>

Midwives have been recognized as skilled health care professionals who can be part of the solution in the quest for a culturally sensitive and competent health care system. Lack of knowledge and respect for health-related cultural variations can result in the client's refusal of many recommendations for health promotion and disease prevention.<sup>8</sup> Furthermore, when cultural differences exist regarding beliefs about health and illness, health practices, and health-seeking behaviour, the progress of health-related interaction between midwife and patient becomes difficult and can negatively affect health outcomes.<sup>9</sup>

A cross-sectional study conducted in Ethiopia of 274 maternal health care providers revealed that nearly 10% of the health workers did not know the greeting style of women they were serving and had limited proficiency of key words and phrases of the women's native language that could facilitate health care delivery. Furthermore, 21.2% of the participants did not allow a woman in labour to pray, even when there was a request to do so, 33.9% restricted mothers from lying supine during delivery, 35% of respondents would only allow women to give birth on a bed, and 77% did not feel comfortable in asking a client's ethnic background. In addition, 69.3% of the participants never sought women's wishes around disposal of the placenta. Forty one percent of the participants did not agree with incorporating cultural considerations in their clinical service.<sup>10</sup>

Uganda is home to diverse cultural groups; over thirty different languages are spoken. This diversity is compounded by the increased movement and resettlement of people generally across the globe. Uganda has nationals from Southern Sudan, Kenya, Rwanda, Burundi, Democratic Republic of Congo and Somalia, among others.<sup>11</sup> This has created major changes in the mix of cultures and poses a significant challenge to midwives providing individualized and holistic care to their clients.

Ugandan women adhere to very traditional birthing practices and believe that pregnancy is a test of endurance and maternal death is merely a sad but normal event.<sup>12</sup> Culture is an important consideration in clinical care as it contributes to shaping patients' health-related values, beliefs, and behaviours. Despite an extensive literature review, no study was found about how Ugandan midwives elicit information about women's cultural beliefs and traditions. Therefore, this study aimed to assess midwives' knowledge, attitudes, and practice of cultural assessment of mothers in labour.

## **Methods**

### ***Design***

A descriptive correlational study was conducted among midwives in three hospitals. The design of the study and more specifically the framework of the qualitative data was guided by Leininger's theory of culture care diversity and universality theory.<sup>13</sup>

### ***Setting***

The study was conducted in two public and one private referral hospitals located in the central (Masaka and Kampala) and eastern (Mbale) part of Uganda. These facilities are known to serve large multicultural populations.

### ***Study participants***

The study included midwives employed as permanent staff in the three health facilities' labour wards who were recognized by the Uganda Nurses and Midwives Council as Midwives or Nurses with midwifery skills. Fifty-six (56) midwives were eligible to participate in the study and forty-nine (49) agreed to participate and were available during the data collection period.

### ***Data collection***

Data were gathered using a self-administered structured questionnaire authored by Hart (1999)<sup>14</sup> which was adapted for this study. Permission to use the questionnaire was sought and granted. The instrument contained 30 closed questions where participants selected responses from the provided options with eight open questions that encouraged the participants to write their individual responses. The questionnaire had three major components that included midwives' knowledge, attitude, and practice in addition to demographic information.

Midwives' knowledge was measured by items asking what constituted cultural assessment, how it was done, how cultural data were used, and its importance and impact on

midwifery care. Attitude was measured by asking about midwives' feelings towards conducting cultural assessment during labour and its importance while caring for a labouring woman. Midwives' practice was measured by self-report of the ability to conduct a cultural assessment, analyse the cultural data gathered during the assessment and use the data in planning and providing care.

### ***Data Analysis***

Thorough discussions with the research team were held and consensus was reached on how variables should be rated and categorized. Statistical advice was sought on the items to include for analysis of each response. The possible responses to each question could be negative (e.g. I have no time to assess) or positive. To analyse the total *attitude* score of the participants, five of the six questions in that section were analysed. One item was analysed separately because it allowed multiple responses and related to barriers. For the 5 items, every positive response was given a score of one while a score of zero was given to every negative response. The total sum was then divided by the total number of questions and then multiplied by 100. A participant with a score of 80% and above was considered to have a positive attitude while a score below 80% was considered to reflect a negative attitude to cultural assessment.

For the total knowledge level of the participants, four questions that assessed knowledge of cultural assessment were included. Each response was counted separately since the questions required more than one response. Every correct response was given a score of one while a score of zero was given to every wrong response. The total sum was then divided by the total number of response items and multiplied by 100. A participant with a score of above 80% was considered to have a high level of knowledge, a score of 60% to 80% was considered a moderate level of knowledge, while a score below 60% was considered a low level of knowledge.

### ***Ethical consideration***

The Uganda Christian University Research and Ethics Committee approved the study. Prior to commencement of data collection in each hospital, permission was sought from the hospital research and ethics committees. All participants in the study consented in writing upon acquisition of information about the study and their rights. Participants' information was kept strictly confidential and anonymous.

## Results

### *Socio-demographic characteristics*

Fifty-six midwives received the questionnaires, 49 midwives filled and returned the questionnaires yielding a response rate of 87.5%. The majority of the participants were working in public hospitals, with most midwives aged 30 years or younger (43%, n=21). Study participants were predominantly Diploma-level midwives [61%], had more than 15 years of experience as midwives [39%], had stayed in the area of their employment for 1 – 5 years [35%], and were from the Baganda ethnic group [41%] (Table 1).

**Table 1: Socio-demographic characteristics of midwives**

Socio-demographic characteristic	Number	Percentage
1. Gender	(n = 49)	
▪ Male	2	4
▪ Female	47	96
2. Age	(n = 49)	
▪ ≤ 30	21	43
▪ 31 – 40	9	18
▪ 41 – 50	10	20
▪ 51 – 60	9	18
3. Educational background	(n = 49)	
▪ Certificate	17	35
▪ Diploma	30	61
▪ Degree	2	4
4. Length of stay in years in the geographical area	(n = 48)	
▪ < 1	9	19
▪ 1 – 5	17	35
▪ 6 – 10	7	15
▪ 11 – 15	5	10
▪ >15	10	21
5. Ethnicity of the midwives	(n = 46)	
▪ Baganda	19	41
▪ Ateso	6	13
▪ Bagishu	6	13
▪ Basoga	7	15
▪ Others	8	17

### *First point of contact for midwives*

Midwives were asked to estimate how frequently their first contact with a labouring woman occurred in the latent, early active, active or second stage of labour. . A four-point Likert

scale was used with 1 meaning never at this stage of labour to 4 meaning always at this stage of labour (every mother). The highest frequency [46] was Early Active, 4 – 6cm (Table 2).

**Table 2: First point of contact for midwives**

	<b>N</b>	<b>Mean</b>	<b>Std. Deviation</b>
Latent	33	2.85	.755
Early Active (4-6cm)	46	3.22	.629
Active (7-10cm)	33	2.97	.637
Second stage	34	2.44	.786

**Cultural assessment practices**

Almost 42% (n = 20) of midwives stated that they cared for 1 – 5 mothers in a month from a culture different from their own. The majority [55%, n = 27] of the midwives stated that hospital labour admission forms did not include any cultural information. When it was included, most of the information was biographic such as name, religion, age, tribe, and next of kin. Of the 22 midwives who responded to this question, 12 thought it was limited and that current admission forms needed to be expanded; 14 indicated that the acquired cultural data were used to plan women’s care. All 49 respondents [100%] reported that no separate cultural assessment forms were available on any labour ward.

The midwives were asked how often they experienced problems related to cultural differences. Several cultural situations were considered as indicated in Table 3. A Likert scale was used where “1” was never, “2” was occasionally (once a month), “3” was frequently (once a week), and “4” was always (once a day). The majority [65%, n = 32] of the midwives experienced problems or difficulties that were attributed to cultural differences while taking care of labouring mothers and their families “occasionally (once a month)”.

**Table 3: Cultural situations faced by Midwives while taking care of labouring mothers**

<b>Situations</b>	<b>n</b>	<b>Min.</b>	<b>Max.</b>	<b>Mean</b>	<b>Std. Deviation</b>
Language barrier	49	1	4	2.27	.758
Family/caretaker involved in patient care	49	1	4	3.16	.800
Use of folk remedies	44	1	4	2.48	.628
Non-compliance with prescribed treatment and delivery options	45	1	4	2.02	.690



Performance of religious customs	46	1	4	2.39	.881
Role expectations between nurse – patient	43	1	4	2.23	.922
Desire for cultural health practitioner	45	1	4	1.91	.949
Others	1	1	1	1.00	.

### **Knowledge about cultural assessment**

Nearly 90 % [n = 44] of the midwives were not trained on transcultural or cross-cultural midwifery care during their basic midwifery programmes. When the total knowledge level of the midwives was calculated as a percentage score and categorized, 16% (n = 8) had a high level of knowledge, 29% (n = 14) had a moderate level of knowledge, and 55% (n = 27) fell below the agreed measure of 60%, which was low. Despite not receiving training, 48% [n = 23] of the midwives indicated that cultural assessment should be done during the initial antenatal assessment. The majority [61%, n = 30] of the midwives believed that cultural data positively influenced the quality of midwifery care and should be used in planning care for the mothers [69%, n = 34].

### **Attitude towards cultural assessment**

When the attitude of each midwife was scored as a percentage, 57% [n = 28] of the midwives were considered to have a positive attitude while 43% [n = 21] of the midwives were considered to have a negative attitude.

The majority [59%, n = 29] of the midwives were willing to spend 15 minutes or less carrying out a cultural assessment. An equal number (n = 29) indicated they would use the cultural assessment form once a day if it were readily available. The acquired cultural data were perceived as useful by just over one third of the respondents [39%, n = 19]. In addition, midwives cited lack of time [35%, n = 34] and language difficulties [33%, n = 32] as the biggest barriers to doing a cultural assessment of women in labour.

### **Relationship between total knowledge, total attitude, and various predictors**

A multiple regression analysis was conducted to examine the possible association between knowledge level, attitude level, and various independent variables. The knowledge level of diploma midwives when compared with certificate midwives increased by 0.191 while the total knowledge level of bachelor prepared midwives when compared with certificate

midwives increased by 0.326. Both differences were not statistically significant ( $p = 0.489$ ;  $p = 0.393$  respectively).

There were some observed differences in the attitude levels of midwives in the different age groups, but the differences were not statistically significant

## **Discussion**

This study around the knowledge and skills of midwives in performing a cultural assessment found that the skills were largely lacking. Although most of the midwives felt a cultural assessment was important, many felt they lacked the skills to conduct one as this had never been taught. This finding is in agreement with a study conducted by Reihani and colleagues<sup>15</sup> in Iran among 104 nurses and midwives on cultural safety that revealed the mean knowledge score for the participants being 4.32 out of 10 and thus considered undesirable. The high scores on attitude however provides hope that when cultural assessment practice is introduced, many midwives will be able to implement it routinely in their practice. This is motivation for future implementation.

The majority [48%] of the midwives preferred to have cultural assessments performed outside the labour ward, during the initial antenatal assessment. These findings do not concur with work by Hart<sup>14</sup> who highlighted that while conducting a careful cultural assessment may be impossible in labour, a quick assessment of patient's cultural needs should be done. This is especially relevant in this study as the first contact with women for the majority of midwives was during active labour. Furthermore, 61% of midwives in this study stated that cultural data positively influenced the quality of midwifery care suggesting that they are knowledgeable about the influence of cultural assessments on care, which increases the likelihood of implementing cultural assessment. These findings are supported by a study conducted by Murray and Huelsmann<sup>16</sup> that revealed midwives were culturally aware. The cultural awareness of midwives is further emphasized by our result [69%,  $n = 34$ ] that showed cultural assessment findings were used to plan care. The percentage, however, is too low to conclude that all midwives know when to use cultural assessment data and therefore is an area needing reinforcement through training.

Midwives were willing to spend 15 minutes or less to obtain cultural information in addition to the routine admission information and then use the cultural information only once a day. This portrays the midwives' willingness to perform cultural assessments but on condition

that the cultural assessment tool for use is short. This may be due to a shortage of providers resulting in heavy workloads. Midwives are realistically reflecting a known shortage and urgent need for recruitment in Uganda.<sup>17</sup> The addition of extra work may further worsen the maternal health indicators in Uganda; innovative strategies of incorporating cultural assessment into current practice are needed.

Midwives indicated in the month previous to the study that they cared for one to five mothers that were from a culture different from their own. This relatively small number may explain why midwives did not conduct a cultural assessment in labour. Since midwives experienced problems or difficulties believed to be caused by cultural differences occasionally, once a month, they may not feel it is important to address the cultural needs of women in their care. However, despite the relatively low numbers, some women may lack the cultural support and sensitivity needed at this vulnerable time.

Furthermore, the data analysis showed no significant difference among the hospitals regarding the cultural diversity of the women. This finding is noteworthy because when languages spoken by midwives were compared to the dominant languages of the hospitals' locations, the majority of midwives in the central public referral facility did not belong to the dominant culture. Women who seek health care in this facility may also originate from outside the area.

None of the hospitals where the midwives worked had a separate cultural assessment form. The hospital admission form had limited cultural data. This further shows the difficulty midwives had in acquiring knowledge about cultural assessment because it was not being practiced. Intuitively perhaps, the midwives considered that cultural assessment would influence midwifery care positively and wanted an expanded admission form to include more cultural data.

The study involved a limited number of midwives and health facilities that may have some impact on the generalizability of findings. The study also examined an unfamiliar but recognizable influencing factor of quality midwifery care, cultural assessment that may have limited participants' ability to respond.

## **Conclusion**

The overall knowledge level of the midwives around cultural assessment was unsatisfactory due to lack of theory and practice during their basic midwifery programmes and subsequent professional development. The midwives' attitudes toward cultural assessment was positive indicating that they considered it an important aspect of midwifery care but limited knowledge and skills in cultural assessment affected their ability to effectively integrate it into practice.

These results have national implications for maternal health and, therefore, call for continuing education of midwives and research in this area, and innovative strategies of offering culturally sensitive care as part of achieving holistic care. We recommend cultural assessment be part of the curriculum for midwives; that role models of cultural assessment be developed in practice sites and further research be done about cultural beliefs and practices exhibited by labouring women. Further research about the knowledge, attitudes, and the practice of cultural assessment by midwives could assess the impact of an increased emphasis on cultural competence.

## **Competing interests**

The authors declare that they have no conflict of interests

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## **References**

1. United Nations Development Programme. Millennium Development Goals Report for Uganda 2015. Kampala, Uganda: Ministry of Finance and Planning. 2015.
2. Uganda Bureau of Statistics and ICF. Uganda Demographic and Health Survey 2016: Key Indicators Report. Kampala, Uganda and Rockville, Maryland, USA: Uganda Bureau of Statistics and ICF. 2017
3. Kaducu MJ. Ministry of Health press statement on safe motherhood day. Kampala, Uganda: Ministry of Health. 2016.

4. Ministry of Health. Annual Health Sector Performance 2015/2016. Kampala, Uganda: Ministry of Health. 2016
5. World Health Organization WHO recommendation on antenatal care for a positive pregnancy experience. Geneva, Switzerland: World Health Organization. 2016
6. Damen H. Bridging the availability-utilization gap: the issue of quality in the provision of health care. *Ethiopian J Health Devel.* 2011;25(1), 1-99.
7. Stewart M. Cultural competence in undergraduate healthcare education: review of the issues. *Physiotherapy.* 2002;88(10), 620-629.
8. Doyle EL, Faucher MA. Pharmaceutical therapy in midwifery practice: a culturally competent approach. *J Midwifery Womens Health.* 2002;47, 122-129.
9. Zahr LK, Hattar-Pollara M. Nursing care of Arab children: consideration of cultural factors. *J Pediatr Nurs.* 1998; 13, 349 – 355.
10. Aragaw A, Yigzaw T, Tetemke D, G/Amlak W. Cultural competence among maternal health care providers in Bahir Dar City administration, Northwest Ethiopia. *BMC Pregnancy Childbirth.* 2015;15, 227.
11. International Organization for Migration. Migration in Uganda: a rapid country profile 2013. Kampala, Uganda: International Organization for Migration. 2015
12. Rutaremwa G, Wandera OS, Jhamba T, Akiror E, Kiconco A. Determinants of maternal health services utilization in Uganda. *BMC Health Serv Res.* 2015;15, 271.
13. Leininger MM. Leininger's theory of nursing: Cultural care diversity and universality. *Nurs Sci Quart.* 1988;1(4), 152-60.
14. Hart D. Assessing culture: pediatric nurses' beliefs and self-reported practices. *J Pediatr Nurs.* 1999;14(4), 255-262.
15. Reihani M, Keshavarz Z, Vedadhir A, Zaeri F. Cultural safety in motherhood: evidence from midwives and nurses in the multicultural context of Iran society. *Med Ethics J.* 2016;10(36), 55-64.
16. Murray M., Huelsmann G. Labor and delivery nurse: a guide to evidence-based practice. New York, USA: Springer Publishing Company. 2009.
17. Sekanjako H. Uganda needs 2,000 midwives. 2011. Available at: <http://www.newvision.co.ug>