Cultural Competency in South Africa: A nursing education perspective

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Abstract

One of the biggest issues facing nursing education in recent times is the effort to develop more culturally sensitive graduates (Salminen, et al. 2010), against a view that cultural competency pedagogy is particularly inadequate in nursing, and this is the discourse that is primarily addressed in this paper. This paper argues incorporating cultural competency content into South African nursing education programmes. In support of this position, this paper thus discusses the significance of cultural competency to South African nursing education; expounds the existing cultural disparities in the country's nursing education programmes; presents models of cultural competency which could be used in nursing education; proposes ways how cultural competency nursing education could be achieved; and points out the implications of this information for South African nursing.

Keywords: Nursing education, cultural competence, transcultural nursing, South Africa.

Introduction

This paper addresses the increasing need for programmes that produce culturally competent nurses in South African. The argument that nurse educators need to consider cultural competency theoretical models, in order to promote effective and safe nursing care, is presented. Further, the paper discusses how cultural competency content can be incorporated into South African nursing education programmes.

Statement of the Problem

Garity (2000) defined cultural competence as having sensitivity towards different cultural groups – suggesting the necessity to produce nursing professionals that are cultural competent – and are sensitive to cultural diversity. The South African Constitution (1996) enshrines multiculturalism as a national resource to be protected and promoted in all spheres of public life, including education. Yet, there is a view that cultural competency pedagogy is particularly inadequate in nursing, and this is the discourse that is primarily addressed in this paper. It is argued that the South African nursing programmes have, for the most part, assumed a '*one-size fits all*' approach in the education and training they provide. This largely ignores the historical and cultural experiences and the world views of indigenous peoples, which tend to differ significantly from the mainstream Western cultural framework. In South Africa, cultural competence remains a challenge for 'conventional science' nurses who are not necessarily aligned with the various indigenous knowledge systems (Corsiglia & Snively, 2001; Odora-Hoppers, 2002; Ogunniyi, 2004). Thus, the overall aim of this paper is to present an argument in support of the development of nursing education that is culturally appropriate to the South African context.

Given the complexity of the topic and the limited time here, this paper focuses only on the following aspects of cultural competency:

•	The paper begins with a brief discussion of the concepts of cultural competence and the related concepts.

•	It then moves to discuss the significance of cultural competency to South African nursing education.

•	Some of the cultural disparities that can be generalized for the South African society – and within nursing in particular are outlined.

•	Five major cultural competency models and theories are discussed in relation to the current nursing literature. These are Leininger (1991), Purnell and Paulanka (1998), Papadopoulos et al (1998), Giger and Davidhizar (2004), and Campinha-Bacote (2007).

•	Drawing on the literature, the paper explores the principles associated with cultural competency. More specifically, the paper uses Campinha-Bacote's model to discuss how cultural competence can be taught to nursing students.

- The article concludes with discussion of the implications of this information for South African nursing. Recommendations were made for provision of professional development, in particular, education and training to promote cultural competency and research.

Basic Concepts

Understanding the theory and principles of cultural competence and incorporating these principles into nursing education is the focus of this paper. However, before pursuing the application of cultural competency to nursing education, it is important to reflect on the meanings of a few concepts germane to this paper.

Put simply, *culture* can be defined as 'how we do and view things in our group' (Henley and Schott, 1999). Thus, within the health care context, *cultural competency* is seen as "the process in which the health care provider continuously strives to achieve the ability to work effectively within the cultural context of a client, individual, family, or community (Kardong-Edgren & Campinha-Bacote, 2008). In concurrence, Betancourt et al., 2003) define cultural competency, within healthcare, as "the ability of systems to provide care to patients with diverse values, beliefs, and behaviours, including tailoring delivery of care to meet patients' social, cultural and linguistic needs". Likewise, Murray, Zenter, Pangman, & Pangman, (2006) see cultural competency as "*the ability of a health care provider, agency, or system to respond to the unique trends of the populations whose cultures are different from that of the mainstream or dominant society*". To Garity (2000) cultural competency is, simply, having sensitivity towards different cultural groups. It is a dynamic, fluid, continuous process whereby an individual, system, or health care agency finds meaningful and useful care-delivery strategies based on knowledge of the cultural heritage, attitudes, and behaviours of those to whom they deliver care (Giger & Davidhizar, 2002, 2004). Accordingly, cultural competency implies that the healthcare provider has basic knowledge and specific attitudes towards health care beliefs and traditions (Spector 2004).

There are also other terms which are used to refer to the notion of cultural competency. For instance, transcultural competence is a term used by some scholars to refer to the ability to interact with clientele who come from a range of different cultural backgrounds (Gerrish & Papadopoulos, 1999; Trentham, Cockburn, Cameron, & Iwama, 2007). This is a relatively new term which has grown out of the older concept of transcultural nursing. However, one can deduce from the definitions of both cultural competency and transcultural competency that there is a degree of interchangeability between terms, and how these constructs, within each definition, relate to each other. Both concepts have the same theoretical underpinning about the ability to function effectively in the context of cultural differences or diversities. Therefore, in this paper, these concepts are used interchangeable. The need to adopt the principles of cultural competent nursing and its importance to nursing education and care of patients is discussed in the following section.

Thus, from the point of view of nursing education, we may then define this concept as the teaching and learning of cultural competency. Of course, in this paper, we argue that nurse educators need to be culturally competent. The author believes that nurse educators should play a prominent role in promoting transcultural care education.

The significance of cultural competency to nursing education

In this section the author relates the need for cultural competency to the context of major aspects of nursing education. These major aspects include socio-cultural, ethical, professional, research, and educational aspects.

Socio-cultural significance
The broader South African society is composed of a mosaic of cultural groups existing within the context of their values and identities. There are eleven official languages in South Africa, namely English, Afrikaans, isiNdebele, Sepedi, isiXhosa, Tshivenda, Setswana, Sesotho, isiZulu, siSwati and Xitsonga. Personal background, heritage, and language have a direct impact on both the way patients or clients reach and respond to health care services and the way health care providers practice within the system (Lowe & Archibald, 2009). The majority of people [and this includes South Africans] require health care that is cognizant of their diverse cultural needs (Cortis, 2003; Duffy, 2001; Holland and Hogg, 2001; Price and Cortis, 2000; Fletcher, 1997).

Ethical Significance

As it is the case everywhere, nursing in South African is embedded in a specific culture that pervades all aspects of care and practice. In this context, nursing is not culturally free but culturally determined and if this is not acknowledged or understood then nurses are in danger of being guilty of gross ethnocentrism (Stokes, 1991). It has been claimed that nurses have a moral obligation to provide quality care, which includes culturally appropriate care (Button et al. 2005:315). The ethical and legal bases of the aforementioned comment has been ascribed to by professional bodies such as the International Council of Nurses (2007) and the International Confederation of Midwives (2005), as well as South African Nursing Council (2005). Therefore, nurses are obligated to respect patients' rights. As stated by Leininger (1978), *one such right is for patients to have specific cultural beliefs, values, and practices.*

Educational significance

There is an urgent need to develop cultural competency amongst nurses and other care workers if they are to meet the needs of the diverse populations they serve. We need to prepare professionals to become more skillful in dealing with multicultural issues (Falvo & Parker, 2000; Remy, 1998; Steiner, 1997). All nurses need to address this issue, especially nurse educators in schools of nursing in which professional attitudes and behaviours are formed. According to Halloran (2009), all nursing schools require a specific course that focuses on transcultural nursing, cultural concepts in health, health and culture, or more recently, health disparities. The principles of transcultural nursing are not inherently practiced by nurses—they really do need to be taught—just as other principles need to be taught. They also need to be taught by people who are committed to the philosophy underpinning it and who have knowledge and understanding of the particular group being focused upon (Goold, 2001).

Professional Significance

Within the nursing literature, cultural diversity, changes, and the need to have culturally congruent nursing care was repeatedly reported in various countries (Davidhizar, Giger & Hannenpluf, 2006; Jeffreys, 2006). According to Parfitt (1998, p. 52): ''Nurses who hold ethnocentric views will be unable to interpret their patients' behaviour appropriately as they will judge it according to norms of their own behaviour''. Culturally competent nurses have knowledge of other cultural ways and are skilled in identifying particular cultural patterns so that an individualized care plan is formulated that will help meet the established healthcare goals for that patient (Gustafson, 2005). In support of the above observation, Giger & Davidhizar (2004) declare that a nurse who is entrusted with the care of patients and their families must recognize the value and importance of providing culturally appropriate care. According to Yuen and Yau (1999), understanding influences on health beliefs and behaviours of particular cultural groups leads to a better understanding of how clients perceive and take action around their illness, and improves clinical judgment.

From the above discussion, one can deduce that it is clearly necessary to produce nursing professionals that are cultural competent – and are sensitive to cultural diversity. This paper argues that there are difficulties with the transcultural response to the challenge of [South African] ethnic diversity. The following section is concerned with disparities in nursing.

Cultural disparities in South African nursing education

This section looks at the historical, social and political climate [disparities] in which the need to educate more culturally competent service providers [should, hopefully] became evident.

Socio-political Disparities

Atrash and Hunter (2006) define the factors contributing to health disparities, including uneven levels of education, salaries and incomes, environmental and economic conditions, specific health attitudes and lifestyles, access to care, and quality of service provided. It is also important to understand that South African indigenous peoples have suffered distress for many years as a result of the social, cultural, political and economic strain of Apartheid. The Apartheid legacy has continued to seriously marginalize each successive generation. While it is beyond the scope of this paper to explicate the complexities of these issues, it is fair to say that the health care, social, justice and other service orientated systems have failed to adapt to the needs of South African indigenous peoples (Carpenter, Field, & Barnes, 2002; Nash, Meiklejohn, & Sacre, 2006; Nolan, 2008; Ranzijn, McConnochie, Day, Nolan, & Wharton, 2008; Ranzijn, McConnochie, & Nolan, 2007; Wepa, 2005b). Providing culturally competent care to health care clients provides a very unique challenge to a South African nurse (Mulaudzi, 2005; Mhlongo, 1999).

Socio-Educational disparities

Cultural competency pedagogy is particularly inadequate in nursing, and this is the discourse that is primarily addressed in this paper. One of the biggest issues facing nursing education in recent times is the effort to develop more culturally sensitive graduates (Salminen, et al. 2010). In South Africa, cultural competence remains a challenge for 'conventional science' nurses who are not necessarily akin with the various indigenous knowledge systems (Corsiglia & Snively, 2001; Odora Hoppers, 2002; Ogunniyi, 2004). It therefore argued that the South African Nursing programs which prepare nurses have for the most part assumed a '*one-size fits all*' approach in the education and training they provide nursing students, largely ignoring the historical and cultural experiences and the world views of Indigenous peoples which differ significantly from the mainstream Western cultural framework.

Professional disparities

Inherent in discussions of an ethnocentric approach to care are issues concerning race, racism and the superiority of one race over another (Price & Cortis 2000). Moreover, deficiency of language and communication skills [mother-tongue instruction] has raised concern about the real and potential risks to patient safety and quality of care because effective communication is critical to safe and competent care (Aiken, 2007; Aiken & Cheung, 2008; Brush, Sochalski, & Berger, 2004; Buerhaus et al., 2009; Xu, 2007; Xu et al., 2008) – communication is inherently and "intimately" linked to culture and contexts (Shen et al., 2010; Xu et al., 2010). Currently, languages other than English are spoken by 10 tribal groups – yet English is the only official language in South Africa. However, as inspired as culturally relevant competence may be, healthcare professionals are often ill-prepared educationally and clinically to provide safe and effective care for diverse populations (Hsueh-Fen et al., 2004). According to Iwama (2003), Western-trained health professionals lack critical reflection on the universality of core tenets of health care/therapy and thus health care professions appear to be ethnocentric constructs that particularly favour Western and European sociocultural contexts and modes of experience' (p. 587). Similarly, Darnell (2002) accuses Western-trained professionals of taking for granted an established set of values that are often not shared by their clients – and this, she observes, can lead to frustration, miscommunication and even marginalization. Thus questions are raised as to the expectations that a nurse trained within the [Eurocentric] framework can provide unbiased care for their [South African] clients.

It can be deduced from the abovementioned disparities that there is a dire need to educate more culturally competent service providers. This calls for reconceptualization of nursing education system. However, before we can suggest a cultural competent nursing education strategy, we need to know the theoretical models of cultural competency. The models are discussed in the following section.

<center>**Models of cultural competency which could be used in nursing education**</center>

In this section the author explores the five major models/theories developed on cultural competency: specifically, those of Leininger (1991), Purnell and Paulanka (1998), Giger and Davidhizar (2004), Papadopoulos et al (1998), and Campinha-Bacote (2007). These transcultural models are explored and critiqued for their efficiency in relation to the current discussion.

Leininger Model (1991)

The aim of Leininger's theory, "***Cultural Care, Diversity, and Universality***," is to expand transcultural nursing knowledge and practice to achieve culturally congruent nursing care whether the patients are culturally diverse or similar. The major theoretical premise (or "givens") of the model is that culture care concepts, meanings, expressions, patterns, processes, and structural forms vary transculturally, with diversities (differences) and some universalities (commonalties) (Leininger, 1991, 1997). Leininger's transcultural nursing model highlights the need to consider both *emic* and *etic* perceptions about cultural practices (Leininger, 1976/1993), i.e., the need to understand from the perspectives of the community members themselves as well as from (expert) outsiders. The '***Sunrise Model***' or '***Culture Care Model***' (Leininger, 2002, p. 190) for health care includes seven dimensions which must be considered in order to gain a holistic understanding of the client. These include factors associated with the following: cultural values, beliefs and life-ways; politics and law; kinship and society; economics; religious and philosophy; education; and technology (Leininger, 2002; Leininger & McFarland, 2002).

Papadopoulos et al Model (1998)

Papadopoulos et al (2004) advocated that ***cultural awareness*** begins with an examination of ones personal values and beliefs. This comprises self-awareness, cultural identity, heritage and awareness of the potential for ethnocentricity. ***Cultural knowledge*** can be used to understand similarities and differences of cultural groups, as well as related inequalities that may be the result of structural forces within society, such as unequal power

relationships between health care professionals and clients (Papadopoulos et al, 2004). *Cultural sensitivity* is concerned with having empathy, cross-cultural interpersonal communication skills, facilitation advocacy and negotiation achieved with the foundation of mutual trust, knowing what is appropriate, mutual acceptance and respect (Papadopoulos et al, 2004).

Giger and Davidhizar Model (2004)

Davihizar and Giger's alternative cultural assessment model for the delivery of health care identifies six factors for the practitioner to consider: communication (verbal and non-verbal systems); space (culturally appropriate distance between people); social organization (how cultural groups organize themselves around families, social roles and spiritual beliefs); orientation with respect to time; environmental control (beliefs about people's relationship to their environment); and biological variation (genetic biological predisposition and diversity within groups) (Davidhizar, Bechtel, & Giger, 1998; Giger & Davidhizar, 2002). Giger and Davidhizar state that, although all cultures are different, there are several organizational factors that are common to all. However, this model does not presume that every person within an ethnic or cultural group will behave or act in the same manner; therefore, according to this model it is essential to view each individual as culturally unique and that they be assessed according to the six identified phenomena in this model (Dayer-Berenson, 2010). The model also explores the variables affecting the caregiver's response and the recipients' perspective in relation to cultural diversity (Davidhizar, Giger & Hannenpluf, 2006).

Purnell and Paulanka Model (1998)

Davidhizar and Giger's model could be related Purnell's (2002). The first five items in Purnell's list below are akin to those appearing in Davidhizar and Giger's model above, though the remainder is unique to. According to Purnell & Paulanka (2003), the Purnell Model for Cultural Competence "provides a comprehensive, systematic, and concise framework for learning and understanding culture." The Purnell and Paulanka model has an organizing framework of twelve domains that are common to all cultures. There are twelve domains of information categorized by Purnell. These are: 1) Overview, inhabited localities, and topography, 2) Communication, 3) Family roles and organization, 4) Workforce issues, 5) Bio-cultural ecology, 6) High-risk behaviours, 7) Nutrition, 8) Pregnancy and childbearing practices, 9) Death rituals, 10) Spirituality, 11) Health care practices, and 12) Healthcare practitioners.

Campinha-Bacote Model (2007)

Campinha-Bacote first developed this model in 1991, and by 1998 it was revised to become known as the process of "Cultural Competency in the Delivery of Healthcare Services". This process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Campinha-Bacote (1999) maintains, moreover, that in order for practitioners to truly understand a particular cultural group and the diversity within it, learner practitioners must actively look for opportunities to participate in cultural encounters with members. Finally, in order to deliver culturally appropriate services, practitioners must have an inherent curiosity or drive to '*want* to, rather than *have* to' (Campinha-Bacote, 1999, p. 182) undertake the processes that enhance cultural (self) awareness, knowledge and skills and be interested in actively seeking opportunities to engage in encounters with those from other cultures.

Having reviewed the cultural competence models – with theoretical framework on how transcultural care is planned, delivered and implemented – this paper offers its own suggestions on how cultural competent nursing education can be taught. Accordingly, the following section discusses how the cultural competency can be utilized by nurse educators in their cultural competent nursing education process.

Introducing cultural competency nursing education

This paper uses Campinha-Bacote Model for Cultural Competence and applies it to the South African nursing [education] context. Derived from this model, a systematic way to consider nursing education interventions is suggested. The choice of this model was motivated by the fact that the model requires health care providers [in this case, nursing students] to see themselves as becoming culturally competent rather than already being culturally competent. The aim of this model is to look at cultural competence as a process rather than an end result, where the nursing student is required to strive to achieve effective and optimum care with individuals (Dayer-Berenson, 2010). Proponents of cultural competency education agree that the introduction of cultural competency components to existing education programs and institutions should be done in increments (Campinha-Bacote et al., 2005; Gilbert, 2003). According to Campinha-Bacote Model, in order to develop

culturally sensitive graduates, the curriculum should include five components, which are cultural *awareness, knowledge, desire, encounter, and skills.*

Cultural Awareness
Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Without being aware of the influence of one's own cultural or professional values, there is risk that the health care provider may engage in cultural imposition. Cultural imposition is the tendency of an individual to impose their beliefs, values, and patterns of behavior on another culture (Leininger, 1978). As cultural awareness exercise, students could be encouraged to write their own cultural autobiography, they should be prompted to explore the cultural construction of their values and normal behaviours and to reflect on how others' values and normal behaviours developed similarly.

Cultural Knowledge
Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. In obtaining this knowledge base, the health care provider must focus on the integration of three specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Lavizzo-Mourey, 1996). Obtaining cultural knowledge about the client's health-related beliefs and values involves understanding their worldview. The client's worldview will explain how he/she interprets his/her illness and how it guides his thinking, doing, and being. Disease incidence and prevalence among ethnic groups is the second issue the health care provider must address when obtaining cultural knowledge. Nursing students could be assigned to obtaining knowledge concerning the field of bio-cultural ecology. Disease incidence varies among ethnic populations, and nursing students should gather as much epidemiological data as possible to guide decisions about treatment, health education, screening, and treatment programs – so as to positively impact on health care outcomes. Treatment efficacy is the third issue to address in the process of obtaining cultural knowledge. This involves obtaining knowledge in such areas as ethnic pharmacology. Ethnic pharmacology is the study of variations in drug metabolism among ethnic groups. In addition the students should also have basic knowledge or general knowledge of the traditional medicinal substances that ethnic clients are likely to take and their possible effect [or side effects]. Students should be asked to pay close attention to the various approaches to cultural assessment in the readings and then to design their own cultural assessment tool [for example: the Mental Status Examination, traditional healer's assessment tools, etc.]. In obtaining cultural knowledge, it is critical to remember that no individual is a stereotype of one's culture of origin but rather a unique blend of the diversity found within each culture, a unique accumulation of life experiences, and the process of acculturation to other cultures. Therefore, the nursing student should be training and be given a chance to conduct a cultural assessment with each client.

Cultural Skill
Cultural skill is the ability to collect relevant cultural data regarding the client's presenting problem as well as accurately performing a culturally based physical assessment. Students should be taught how to conduct cultural assessments and culturally based physical assessments. Leininger (1978) defined a cultural assessment as a "systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served" (pp. 85-86). Cultural skill is also required when performing a physical assessment on ethnically diverse clients. Students should know how a client's physical, biological, and physiological variations influence her ability to conduct an accurate and appropriate physical evaluation.

Cultural Encounters
Cultural encounter is the process that can encourages students to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds. Directly interacting with clients from diverse cultural groups will refine or modify one's existing beliefs about a cultural group and will prevent possible stereotyping that may have occurred. However, students must be aware that interacting with just three or four members of a specific ethnic group will not make them an expert on this cultural group. It is possible that these three or four individuals may or may not represent the stated beliefs, values, or practices of the specific cultural group encountered by the health care provider. This is due to intra-ethnic variation, which means that there is more variation within a cultural group than across cultural groups. Cultural encounters also involve an assessment of the client's linguistic needs. Using a formally trained interpreter may be necessary to facilitate communication during the interview process. Students should be encouraged as much as possible to learn the client's language. This lack of knowledge can lead to faulty and inaccurate data collection.

Cultural Desire

Cultural desire is the motivation of the nursing students to *want to*, rather than *have to*, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters. Cultural desire involves the concept of caring. It has been said that people don't care how much you know, until they first know how much you care (Campinha-Bacote, 1999). It is not enough for the nursing students to merely say they respect a client's values, beliefs, and practices or to go through the motions of providing a culturally specific intervention that the literature reports is effective with a particular ethnic group. What is of grave importance is the student's real motivation or desire to provide care that is culturally responsive. Cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants. This type of learning is a lifelong process that has been referred to as "cultural humility" (Tervalon & Murray-Garcia, 1998).

This author has described how, in his own view, the teaching of cultural competency can be taught. The overarching aim is for nurse educators to facilitate the development of awareness, knowledge and skills required to enable students to begin the process of becoming culturally competent service providers. This strategy, like any others, has implications for nursing education and research – and these implications are discussed in the following section.

Implications for nursing education

As aforementioned, this section highlights implication of above discussed culturally competent information. The discussion and suggested cultural competent model has both research and educational implications.

Implication for Nursing Education

• Nursing education curricula need to focus on providing students with the opportunity (theoretical and practical) to work in a multi-disciplinary health environment. This environment should not only comprise partners from medicine, nursing, and other Western trained health professions but also include traditional healers. The principles underlying this approach: openness, mutual respect, inclusiveness, responsiveness and understanding one's roles should be fundamental to the delivery of culturally competent health care to all South African ethnic communities.

• Nurse educators need to appreciate the fact that they, themselves, are cultural beings. Developing good diversity and anti-discriminatory practices would mean that nurse educators themselves apply the theory and principles of cultural competency themselves before teaching to their students. In other words, education and training is also about achieving a greater sensitivity to, and acceptance of, racial and cultural differences.

• Nursing educators should ensure that they receive ongoing education and training in culturally and linguistically appropriate service delivery.

• Nurse educators must assure the competence of language assistance provided to limited English proficient consumers by interpreters and bilingual staff. The feasibility of mother-tongue instructions should be explored.

Implication for Nursing Research

• There is considerable scope for inquiry into ethnic cultural beliefs as they impact on a variety of physical and psycho-social diseases that affect the ethnic patient population. In particular, qualitative nursing studies that incorporate anthropological research methods such as interviews and participant observation would be very helpful in bringing out the *emic*, or insider, point of view.

• With eleven cultural groups, the population of South Africa is one of the most complex and diverse in the world. It is important that health care providers attempt to understand the different distinct South African

tribes and nations. To this end it would be important to conduct studies to gather baseline data on the beliefs and practices of South African cultural groups.

- In addition to describing South African cultural beliefs and practices, nurse researchers need to investigate, define and describe the meaning of quality nursing care from different cultural perspectives. In addition to expanding the knowledge base of culturally competent nursing care, this could help South African nurses in determining effective nursing interventions that advocate and provide culturally competent care to patients in a meaningful and acceptable way.

- Consensus is lacking on definition of cultural competence and on the sequence of when the components should be acquired, some terms being used interchangeably. It is unclear how cultural competence in nursing education can be delivered. No attempts have been adequately evaluated, particularly by service users (Bhui et al, 2007). More innovative research is needed to develop a consensual definition of cultural competence and to facilitate the delivery and evaluation of such, in ways acceptable to service users and service providers.

Conclusion

The significance of cultural competent nursing education was discussed in relation to the South African nursing context. The argument that South African nurse educators need to consider the principles of cultural competent was presented in this paper. The author believes that this paper provided knowledge that may sensitise nurse educators and encourage them to apply the theories and principles of cultural competency to nursing education. Hopefully, this paper would help promote cultural competent nursing education, research and practice. By developing curriculum and pedagogical frameworks to educate and train students to begin their journey of becoming culturally competent service providers, the model aims to prepare a future workforce that can begin to address the disparities in the access to services. Finally the author believes that this paper makes a significant contribution to the new South Africa, in respect that nurse educators can apply the information obtained in this paper to improve nursing education outcomes for South African students. However, it is argued that while these principles may be specific to the South African context, they inform a pedagogical approach to service teaching that enhances the capability of students as future services providers to work with all clientele. Many of the issues raised are generic and likely to occur whenever students and patients' health practices and beliefs differ from conventional Western care. This, therefore, gives this work universal relevance and appeal.

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