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Perceptions and strategies of healthcare professionals regarding cultural beliefs and practices in the management of paediatric chronic diseases in Kinshasa

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ABSTRACT

Introduction

In Kinshasa, the management of paediatric chronic diseases occurs within a context of strong cultural diversity. Traditional beliefs and practices influence healthcare decisions and present complex challenges for health professionals. This study explores their perceptions and the strategies developed to address these cultural realities.

Purpose

To understand healthcare professionals' perceptions of the impact of cultural beliefs and to identify the strategies implemented in managing paediatric chronic diseases.

Methods

A qualitative exploratory study was conducted at the Renaissance University Hospital Centre. Ten nurses participated in semi-structured interviews. None of them had received specialised training in intercultural communication. Data were analysed using Braun and Clarke's thematic approach, with reference to Leininger's transcultural theory.

Results

Three main challenges were identified: (1) persistent cultural misunderstandings, (2) partial or complete rejection of biomedical treatments, and (3) lack of training in cultural competence. The strategies adopted included partial adaptation of care, intercultural dialogue, and controlled tolerance of certain non-invasive family practices.

Conclusions

This is the first study in Kinshasa addressing healthcare professionals' strategies in relation to cultural beliefs. The findings highlight the need to strengthen cultural competence among healthcare staff. Institutionalising cultural mediator roles and integrating intercultural communication modules into continuing education should be prioritised to improve both care quality and the caregiver–patient relationship.

INTRODUCTION

International mobility and plural identities are reshaping health systems, where cultural diversity has become an essential component of healthcare practice. In Kinshasa, the capital of the Democratic Republic of the Congo, hospitals receive patients every day from a wide range of ethnic, religious, and social backgrounds (Konzo, 2022). This plurality influences not only perceptions of illness but also therapeutic expectations and interactions with healthcare providers.

In the field of paediatric chronic diseases, health professionals often face divergent representations of illness. These differences are reinforced by the frequent reliance on traditional and spiritual medicine (Shomba, 2022). Such practices generate misunderstandings and compromise continuity of care, exposing families to treatment disruptions and therapeutic abandonment (Ponzo, 2022).

Nurses, in particular, report situations involving care refusal or requests for specific rituals, sometimes expressed within hospital settings. Although these practices are culturally rooted, they compel healthcare providers to balance respect for beliefs with adherence to biomedical standards (Palakassi, 2025).

Beyond these relational challenges lies an institutional issue. The lack of intercultural protocols and the absence of specific training in cross-cultural communication significantly limit the adaptability of care teams (Mésenge, 2022). This gap generates a sense of powerlessness and professional frustration, especially in managing paediatric chronic illnesses where continuity of care is crucial.

Several scholars have nonetheless suggested potential solutions. Open dialogue with families has been identified as an important approach to improving care (Nguiagain-Launière, 2021). Moreover, transcultural competence has been underlined as a strategic tool to strengthen patient–provider relationships (Ondélé, 2024).

Similarly, research conducted in various sub-Saharan contexts has demonstrated the effectiveness of integrative approaches that combine respect for local beliefs with biomedical requirements (Kambale, 2021). These findings confirm the value of structured intercultural initiatives within hospital environments.

From a conceptual standpoint, Madeleine Leininger's transcultural nursing theory, introduced in the 1970s, underscores the need to understand patients' values, beliefs, and life practices in order to deliver culturally congruent care. More recently, this framework has been reinforced as a guide for nursing practice in contemporary multicultural contexts (Fraser et al., 2022).

Applied to Kinshasa, this approach opens the way for better adaptation of paediatric care to sociocultural realities. It enables the integration of religious, community, and socioeconomic dimensions that directly influence families' treatment adherence and the quality of long-term follow-up.

Against this backdrop, the present study, conducted at the Renaissance University Hospital Centre, pursues three objectives: (1) to analyse healthcare professionals' perceptions regarding cultural beliefs and practices; (2) to identify strategies developed to maintain therapeutic relationships; and (3) to propose concrete directions for strengthening both the humanisation and effectiveness of paediatric care in a multicultural setting.

METHODS

Study Type and Approach

This study adopts a qualitative approach with descriptive and interpretative aims. It seeks to understand, through the narratives and experiences of healthcare professionals, the concrete challenges they face in a multicultural hospital setting, as well as the strategies they employ to adapt their practice. This method is particularly relevant for capturing the subjective, symbolic, and relational dimensions of care in hospital environments (Muyumba, 2022).

Study Setting

The research was conducted at the Renaissance University Hospital Centre in Kinshasa, a reference hospital serving a population diverse in terms of ethnicity, religion, language, and socioeconomic status. This setting was chosen because of the wide variety of patients it receives and the frequent intercultural situations that healthcare professionals encounter.

Participants and Sampling

The study population consisted of nurses working in the paediatric units of the Renaissance University Hospital

Centre. A purposive sampling approach was used to include participants directly involved in the care of children with chronic illnesses. Inclusion criteria required that nurses have at least two years of hospital experience, be actively engaged in paediatric management of chronic conditions, and have encountered care situations involving significant cultural differences. Nurses in training or without sufficient clinical experience were excluded.

Recruitment occurred in two stages. First, authorisation was obtained from the nursing administration, which facilitated the identification of eligible nurses. Then, each nurse was individually approached by the researcher, informed about the study objectives, and invited to participate voluntarily.

A total of ten nurses agreed to participate after signing an informed consent form. This process ensured voluntary participation, confidentiality, and the option to withdraw at any time without professional consequences. The selection of participants aimed to capture a diversity of profiles in terms of seniority, professional background, and work context, reflecting the plurality of perceptions and strategies developed in response to families' cultural practices.

Sample Size

The study involved ten paediatric nurses. This small sample size is justified by the qualitative nature of the research, which prioritises depth and richness of data over statistical representativeness. A limited sample allowed for a detailed examination of professionals' perceptions, the challenges they faced, and the strategies implemented to reconcile families' cultural beliefs and practices with modern medical care.

Data Collection Methods

Data were collected through semi-structured interviews guided by a framework structured around four themes: experiences of cultural conflict or misunderstanding in care; perceptions of patients' cultural beliefs and practices; adaptation or mediation strategies used in the caregiver–patient relationship; and expressed needs regarding training or institutional organisation.

Each interview lasted approximately 40 to 60 minutes, was conducted in English in a confidential setting, and was audio-recorded with the participants' free and informed consent.

Data Collection Process

Data Recording

Data were collected from healthcare professionals (nurses) through semi-structured interviews. Each interview was recorded using an Android phone to ensure the accuracy of the information collected and to prevent data loss. Participants were informed about the recording process, and written consent was obtained in accordance with ethical research principles.

Data Transcription

The audio recordings were transcribed verbatim to produce a text faithful to the participants' statements. This transcription facilitated the identification of themes, perceptions, and strategies mentioned by healthcare professionals. Each transcript was numbered and coded to ensure participant anonymity and to facilitate thematic analysis.

Data Translation

Since the interviews were conducted in French, translation into English was performed during transcription. The transcripts were carefully reviewed to verify accuracy and fidelity to participants' original statements, thereby ensuring data quality and coherence prior to analysis.

Data Analysis

All interviews were transcribed verbatim to ensure fidelity to participants' statements. Data were analysed using an inductive thematic approach based on Braun and Clarke's (2006) framework. This method was applied in a structured and rigorous manner following the six steps defined by the authors. First, the transcripts were thoroughly read and reviewed to familiarise the researchers with the data and identify key ideas and emerging patterns. Subsequently, initial coding was performed manually, with each relevant segment labelled to retain proximity to the participants' experiences.

The generated codes were then grouped into broader patterns to identify recurring themes reflecting nurses' perceptions and strategies. This was followed by theme refinement and consolidation to ensure relevance, coherence, and alignment with the original data. Each

theme was then defined and clearly named and interpreted in relation to Madeleine Leininger's (1970) transcultural nursing theory. This step allowed the results to be situated within a solid conceptual framework and provided insights into professional practices in a multicultural healthcare context.

The analysis was conducted manually and supplemented by inter-coder validation to enhance rigour, reliability, and consistency in interpretation. Special attention was given to researcher reflexivity. The research team's professional backgrounds in paediatrics and nursing science were explicitly considered to acknowledge potential influences on data interpretation. Regular team discussions helped minimise bias and ensured that conclusions faithfully reflected participants' perceptions and strategies.

Scientific Rigour and Bias Reduction

The study ensured scientific rigour through multiple methodological mechanisms. Credibility was supported by source triangulation, cross-checking of data among researchers, and data saturation. Transferability was enhanced through a detailed description of the study context and participant profiles, allowing potential comparison with other similar settings. Reliability (internal consistency) was strengthened by rigorous traceability of the analytical process. Finally, confirmability was supported through continuous researcher reflexivity and the use of direct quotations to illustrate participants' statements.

Ethical Considerations

In accordance with ethical requirements for research involving human subjects, this study adhered to the principles of respect, beneficence, and justice. Each participant received a clear and understandable explanation of the study's objectives, their rights, and assurances of confidentiality and anonymity. Free, informed, and written consent was obtained prior to each interview. Official authorisation was requested and granted by the administration of the Renaissance University Hospital Centre. Anonymity was ensured through coding (PS1 to PS10), and data confidentiality was maintained throughout the process. The research protocol was approved by the institution's ethics committee. Special attention was given to respecting cultural sensitivities and the vulnerable situation of the families involved.

RESULTS

Results on Healthcare Professionals' Perceptions and Experiences in the Management of Chronic Diseases

Sociodemographic Characteristics of Study Participants

Eight sociodemographic characteristics were analysed to describe the study sample: sex, age, level of education, marital status, years of experience in paediatrics, experience in managing chronic diseases, specific training received in this field, and regular work with children with chronic illnesses.

Table 1:
Sociodemographic and Professional Profile of Healthcare Professionals

No.	Sex	Age	Education Level	Marital Status	Paediatric Experience	Chronic Disease Experience	Specific Training	Work with Children with Chronic Illness
PS1	F	40	A1	Married	10 years	10 years	No	Yes
PS2	M	30	A0	Single	5 years	5 years	No	Yes
PS3	F	41	A0	Divorced	10 years	10 years	No	Yes
PS4	F	30	A0	Single	5 years	5 years	No	Yes
PS5	M	50	A1	Married	<11 years	<11 years	No	Yes
PS6	F	30	A2	Single	1 year	1 year	No	Yes
PS7	F	40	A1	Married	6 years	6 years	No	Yes
PS8	M	50	A0	Widower	10 years	10 years	No	Yes
PS9	F	40	A0	Married	5 years	5 years	No	Yes
PS10	M	23	A2	Single	1 year	1 year	No	Yes

Legend: A0: Licensed nurse, A1: Graduate nurse, A2: State-certified nurse, PS = Participant (person), M = Male participant, F = Female participant

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The **Table** above shows that participants were aged between 23 and 50 years, with a predominance of single women. A large number held a bachelor's degree (A0), and most had more than five years of experience in paediatrics and chronic disease management. All participants reported working regularly with children suffering from chronic illnesses; however, none had received specialised training in this field.

Results on Healthcare Professionals' Perceptions and Experiences in the Management of Chronic Diseases

Thematic analysis of interviews conducted with healthcare professionals identified four major themes: families' reactions to diagnosis, interference of cultural beliefs in care, challenges in integrating these practices, and expressed needs for cultural support.

Table 2
Themes, Sub-Themes, Categories, and Verbatims

Theme	Sub-theme	Category	Verbatim
1. Reactions and perceptions regarding diagnosis	Families' attitudes at diagnosis	Shock / Denial	"Most often, when a chronic disease is announced, parents are in shock." (PS1) "Some parents directly say: No, it's not possible; you must be mistaken." (PS5)
		Sadness / Despair	"Parents show a lot of sadness, sometimes crying or prolonged silence." (PS2) "Once, a father shed tears in the room after the announcement." (PS4)
2. Interference of cultural beliefs and practices	Misunderstanding and perception of disease	Supernatural: witchcraft, divine punishment	"Some parents think it's a test sent by God." (PS1, PS3) "Parents talk about witchcraft or a curse." (PS5, PS7) "Someone would have cast a spell on the child." (PS2)
		Parallel care (mystical objects, rituals)	"I saw holy water and mysterious objects on the bed." (PS4) "Leaves and salt under the child's pillow." (PS3) "Parents want to combine medical care and traditional remedies." (PS8)
3. Difficulties in integrating cultural practices	Conflicts, refusal of care, and cooperation	Refusal or interruption of treatment	"Some parents refuse blood transfusions because of their faith." (PS1) "Some interrupt treatment to go to church." (PS2, PS3, PS6) "Sometimes they refuse medication to fast." (PS9)
		Dialogue and tolerance	"We try to dialogue without judging." (PS8) "We tolerate certain practices if they do not interfere." (PS10)
4. Needs, obstacles, and recommendations	Institutional organisation and training	Lack of training and resources	"We need a cultural mediator and psychologists." (PS1) "Staff must be trained on local cultures." (PS5, PS7, PS8)
		Currently implemented strategies	"We accept prayers if they do not disturb care." (PS5)
		Recommendations	"Establish a cultural dialogue framework upon admission to facilitate communication of families' beliefs and expectations." (PS1) "Organise an annual training session to strengthen staff's intercultural competencies." (PS6) "Create a cultural mediation service or appoint community liaisons to support dialogue between families and healthcare providers." (PS9)

The data reveal that healthcare professionals at the University Hospital Centre Renaissance in Kinshasa describe managing children with chronic illnesses as characterised by parental reactions of shock, denial, sadness, and confusion at diagnosis. These reactions are frequently linked to cultural and spiritual explanations, such as witchcraft, curses, divine punishment, or bad luck. Families often resort to religious and cultural practices (e.g., prayers, purification rituals, placing spiritual objects in the

child's bed, use of medicinal plants), sometimes abandoning biomedical treatments, which disrupts continuity of care.

Healthcare providers, therefore, adopt a stance of conditional tolerance, attempting to reconcile families' beliefs with biomedical requirements despite the absence of formal institutional frameworks, cultural mediators, or training in culturally adapted care. They emphasise the need for culturally appropriate educational materials, community partnerships with religious and traditional leaders, and improved intercultural communication strategies. The professionals recommend creating dialogue and prayer spaces, along with continuous training, to better integrate cultural dimensions into paediatric care.

DISCUSSION

Sociodemographic Characteristics of Healthcare Professionals

The findings show that most healthcare professionals are women aged 30–50 years, with 5–10 years of paediatric experience. While all regularly work with children with chronic conditions, none have received specialised training in this area. Their educational levels generally range from bachelor's degrees (A0) to graduate diplomas (A1). This mirrors staff demographics in public hospitals across Kinshasa, where nursing is predominantly female.

This highlights significant institutional gaps. Health 4 Africa (2013) reported that only 5% of Tanzanian nurses attained higher education, reflecting a structural deficit in specialised training. In the Congolese context, the absence of structured programmes in chronic disease management and culturally appropriate care limits both clinical and communication competencies. Amegonou (2023) stresses that continuous education, contextual understanding, and self-assessment are essential for developing cultural competence, yet these elements remain underdeveloped. Experience gained "on the job" fosters adaptability but underscores the urgent need for structured continuing professional development encompassing clinical, psychosocial, and intercultural aspects of paediatric chronic illness (Davoine & Salamin, 2022).

Perceptions and Experiences of Healthcare Professionals

Healthcare professionals report facing both cultural and institutional barriers, including family beliefs in witchcraft, curses, or divine punishment, as well as shortages of trained staff and educational tools. These factors create ethical dilemmas regarding how to respect family beliefs while maintaining patient safety and treatment efficacy. Borwick (2022) notes that clinicians must navigate multiple care logics without compromising quality or safety.

To address such challenges, nurses adopt conditional tolerance—allowing cultural practices that do not endanger patients. However, this approach remains informal and non-institutionalised, reflecting the absence of cultural mediation frameworks. Faye et al. (2023) recommend developing intercultural dialogue spaces to support clinical decision-making in diverse contexts.

Communication relies on strategies like using local languages or involving community and religious leaders. However, these are constrained by a lack of trained mediators, visual aids, and time for patient education. Chabot (2022) advocates for systemic cultural competence integrated at all organisational levels to ensure sustainability.

Critical Reflection and Institutional Recommendations

Institutional deficiencies—limited resources, unclear policies, and systemic neglect—undermine cultural mediation mechanisms. Ethical tensions between belief respect and medical safety further stress the need for structured guidance. Recommended interventions include intercultural communication training for paediatric staff, establishment of cultural mediators or community liaisons, development of culturally inclusive protocols, and clinical ethics frameworks to guide care decisions.

Implementing these measures would enhance care quality, promote family adherence, and ensure patient safety in Kinshasa's multicultural healthcare context.

CONCLUSION

This is the first study in Kinshasa examining nurses' strategies in response to cultural beliefs in paediatric chronic care. It reveals significant tension between biomedical models and family cultural realities, leading to misunderstandings, conflicts, and disengagement.

The strategies implemented remain largely informal, underscoring the lack of institutional preparedness for cultural diversity in hospitals, especially at the University Hospital Centre Renaissance. The study calls for targeted

cultural competence training, establishment of mediator roles, and structured intercultural care protocols.

Practically, it recommends continuous education on intercultural communication and ethical decision-making, institutionalisation of cultural mediators, and creation of hospital protocols that integrate cultural and spiritual aspects of care. Promoting an inclusive, culturally sensitive approach will improve care quality, strengthen treatment adherence, and affirm cultural diversity as a core value in clinical practice.

Recommendations:

- Train healthcare professionals in transcultural competence.
- Establish cultural mediation mechanisms within hospitals.
- Adapt care protocols to local cultural realities.
- Encourage local research on multicultural care.
- Raise awareness among hospital managers about cultural diversity.

Ethical Approval: The research protocol was approved by the Renaissance University Hospital Centre's ethics committee.

Conflicts of Interest: None declared.

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