

Cultural influence on angolan maternal care of newborns and health strategies: health professionals' perspective

Influência cultural nos cuidados das mães angolanas aos recém-nascidos e estratégias em saúde: perspectiva dos profissionais de saúde

Influencia cultural del cuidado de las madres angoleñas al recién nacido y estrategias de salud: perspectiva de los profesionales de la salud

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Abstract

Child mortality is a key indicator not only for child health and wellbeing, but also for the general progress towards the Sustainable Development Goals (SDGs). Health professionals are bestowed a prominent position and must be provided with skills for fostering quality and culturally consistent healthcare. Health education practice acts as a means for optimising self-care. This is a descriptive, exploratory and transversal study with qualitative methodology, the sample of which is non probabilistic as a matter of convenience, composed of Angolan health professionals. We analysed cultural influence on Angolan maternal care of newborns and strategies for health intervention from the perspective of Angolan health professionals, as well as the performance of said professionals. Health professionals mention that cultural influence on care fosters practices which are not recommended by the WHO, with a detrimental effect on health, as happens for example in umbilical cord stump care by using products which cause omphalitis and increase the risk of sepsis and neonatal death. Said professionals defend that in view of this finding, it is fundamental to invest in strategies which will improve the quality of healthcare, in order to reduce neonatal mortality in Angola. These results support what has been described in scientific literature and studies within the same framework, reinforcing the need to pay attention to this reality.

Keywords: Newborn; Angolan mothers; Health professionals; Cultural influence; Culturally competent healthcare.

Resumo

A mortalidade infantil é um indicador-chave não apenas para a saúde e o bem-estar infantil, mas também para o progresso geral em direção aos Objetivos de Desenvolvimento Sustentável (ODS). O profissional de saúde assume uma posição de relevo, e deve estar munido de competências que promovam a excelência do cuidar, culturalmente congruente e de qualidade. Atuando as práticas educativas em saúde como um potencializador do auto-cuidado. Trata-se de um estudo descritivo, exploratório e transversal com metodologia qualitativa, cuja amostra é não probabilística por conveniência, composta por profissionais de saúde angolanos. Analisou-se a influência cultural dos cuidados das mães angolanas aos recém nascidos e estratégias de intervenção em saúde na perspectiva de profissionais de saúde angolanos, bem como o desempenho desses mesmos profissionais. Os profissionais de saúde referem que a influência cultural nos cuidados é promotora de práticas não recomendadas pela OMS, com consequências nocivas para a saúde, como é exemplo, os cuidados realizados ao coto umbilical, com utilização de produtos que causam onfalite e aumentam o risco de sépsis e morte neonatal. Os mesmos defendem que perante tal constatação, é primordial, investir em estratégias que permitam melhorar a qualidade dos cuidados de saúde, de modo a reduzir a mortalidade neonatal em Angola. Estes resultados corroboram o descrito na literatura e em estudos no mesmo contexto, o que valoriza a merecedora atenção perante a atual realidade.

Palavras-chave: Recém-nascido; Mães angolanas; Profissionais de saúde; Influência cultural; Cuidados culturalmente competentes.

Resumen

La mortalidad infantil es un indicador clave no solo para la salud y el bienestar infantil, sino también para el progreso general hacia los Objetivos de Desarrollo Sostenible (ODS). El profesional de la salud asume una posición destacada,

y debe estar dotado de habilidades que favorezcan la excelencia en la atención, culturalmente congruente y de calidad. Prácticas educativas actorales en salud como potenciador del autocuidado. Se trata de un estudio descriptivo, exploratorio y transversal con metodología cualitativa, cuya muestra es no probabilística por conveniencia, compuesta por profesionales angoleños de la salud. Analizamos la influencia cultural del cuidado de las madres angoleñas al recién nacido y las estrategias de intervención en salud desde la perspectiva de los profesionales de la salud angoleños, así como la actuación de estos mismos profesionales. Profesionales de la salud relatan que la influencia cultural en el cuidado promueve prácticas no recomendadas por la OMS, con consecuencias nocivas para la salud, como el cuidado del muñón umbilical, con el uso de productos que provocan onfalitis y aumentan el riesgo de sepsis y muerte neonatal. Argumentan que, ante este hallazgo, es fundamental invertir en estrategias para mejorar la calidad de la atención a la salud, con el fin de reducir la mortalidad neonatal en Angola. Estos resultados corroboran lo descrito en la literatura y en estudios del mismo contexto, que valora la atención merecedora ante la realidad actual.

Palabras clave: Recién nacido; Madres angoleñas; Profesionales de la salud; Influencia cultural; Atención culturalmente competente.

1. Introduction

The high concentration of migrants in cities makes them multicultural settings, where cultural features, lifestyles and identities are expressed. Angola, particularly Luanda, concentrates a high number of migrants and has become a meeting place for cultures. This explains the multiculturalism of this city and the huge challenge as regards health issues. Culture is a set of beliefs, values and assumptions about life shared within a group of people and passed down from generation to generation. It is developed over time and is resistant to change (Leininger 2002, cited in Stanhope & Lancaster, 2011).

Social determinants are the social conditions in which people live and work and to which great weight is given in health status, and migration is an important social factor (Loureiro & Miranda, 2010). Social determinants play an important role in the health of women and newborns (WHO, 2014; WHO & UNICEF, 2015). Practices for the care of the newborn's umbilical cord stump vary according to cultural traditions within communities (Pires, 2016). The actions of each lay caregiver and also their beliefs may significantly contribute to the occurrence of neonatal infections, which increase morbimortality rates (Ribeiro & Brandão, 2011; Linhares, et al., 2019).

Migration has a potential impact on how Angolan mothers take care of newborns and influences their health. Maternal care of newborns is not immutable or independent of the context in which the mothers are involved (Ramos, 2004 a,b, 2012 a,b,c). In the process of acculturation, mothers find it difficult to select which aspects of their culture of origin should be maintained and which ones should be abandoned when taking care of their newborns (Ramos, 2004, 2008 a,b,c, 2012 a,b, 2016). This situation leads to a complementarity in healthcare, revealed by the use that puerperal women make of the several care systems at their disposal. In these situations, the therapeutic relationship established with health professionals is decisive in the healthcare options adopted (Ramos 2004 a,b, 2007, 2012 a,b,c; Sopa, 2009).

Child mortality reflects the limited access of children and communities to basic health interventions, such as vaccination, access to medicines, prevention consultations, maternal and child health treatment and follow-up, adequate nutrition, drinking water and sanitation (Pinto, 2005; UNIGME, 2018; Santos, et.al 2022). In 2015, according to Wateraid (2015), cited in Ramos & Tavares (2020 b), Angola was considered the most dangerous place in the world to have a baby, with infections accounting for almost 30% of all neonatal deaths. According to WHO (2016), about 50% of neonatal deaths in the world occur in the first days after birth and 75% during the first week of life. A child born in sub-Saharan Africa or South Asia is nine times more likely to die in the first month than a child in a developed country. According to the current trends, an estimated 56 million children under the age of five will die between 2018 and 2030 (80% of these deaths are expected to occur in South Asia and sub-Saharan Africa). Of those 56 million children, 28 million are newborns (UNIGME, 2018).

The United Nations 2030 agenda addresses several dimensions of sustainable development and consists of 17 Sustainable Development Goals (SDGs). SDG 3: quality health aims at “ensuring healthy lives and promoting well-being for all at all ages” by 2030 (UNRIC, 2017). The SDG target for child mortality represents a renewed commitment to the children of our

world, namely to end, by 2030, preventable deaths of newborns and children under five years of age. It is therefore aimed, in all countries, to reduce neonatal mortality to at least as low as 12 deaths per 1,000 live births (UNIGME, 2018).

To achieve the SDG target by 2030, efforts need to be increased in 51 countries, two thirds of which are located in sub-Saharan Africa, with Angola being one of the countries included (UNIGME, 2018). According to WHO (2017), Angola is at the bottom of the table in terms of global child mortality. Therefore, the Angolan National Health Development Plan (2012-2025) (NHDP), in the programme for disease prevention and control, includes in project 18: “the provision of healthcare for maternal, neonatal and child survival”, one of the goals being to reduce maternal and child mortality rates by 50% (MINSa, 2012).

It is thus a priority to provide healthcare to mothers and train health professionals, so that their assistance to mothers and newborns is effective and with quality, in order to improve health and reduce neonatal mortality rates in Angola (Ramos & Tavares, 2020a; Albuquerque, et. al.2022). Therefore, specific newborn health programmes and policies aim at promoting the quality of life of children, their development and their health. Healthcare includes actions for health promotion, prevention, early diagnosis and recovery from health problems (Andrade et al., 2015). A high coverage of interventions before, during and after pregnancy is a possibility for preventing health problems in approximately three million women and newborns (WHO,2014; WHO & UNICEF, 2015).

Luanda has been committed to fulfilling the strategies for reducing maternal and child mortality, complying with the policies and strategies previously established by the Angolan Ministry of Health in the implementation of essential maternal, newborn and child health programmes (WHO, 2018a). In the long-term strategies, Health Policy Angola 2025 presents, as one of its goals, the substantial reduction of child mortality and under-five mortality (Republic of Angola, 2018). This policy is also coincident with the goals of the African Union's Agenda 2063, with two priority areas for intervention: “poverty, inequality and hunger” and “health and nutrition” (MINSa, 2012; Republic of Angola, 2018).

In view of the reality of the data presented above, we felt that it was necessary to “give a voice” to the health professionals who work daily with mothers and newborns in Angola and are aware of the cultural and health context of the population, as well of as their needs. Therefore, our aim is to analyse the influence of culture on the care provided by Angolan mothers to their newborns and health intervention strategies from the perspective of Angolan health professionals. We wish to raise awareness and stimulate reflection on this topic and encourage action by the officials of the Ministry of Health to implement measures for supporting the training of health professionals in the country in the provision of culturally competent care, given that good quality healthcare is reflected in the improvement of the population’s health indicators.

This article is structured by the introduction, where the subject and objectives of the article are contextualised, followed by the presentation and development of the theoretical foundation and literature review, and by the methodology, analysis and discussion of the results of the empirical research. Subsequently, the final considerations are presented and, finally, we indicate the bibliographical references that served as support and foundation for the research work carried out.

Theoretical Contextualisation

Overview of neonatal and child health

The most critical period in the life of an individual is the neonatal period.

In Africa, there are 23 out of 24 countries with child mortality above 100 per 1000 live births. World health statistics show that about two thirds of infant deaths occur during the first month of life. Of those who die in the first month of life, about two thirds die in the first week of life and of those babies who die in the first week of life, about two thirds die in the first 24 hours (Beck et al., 2004).

To achieve sustainable and equitable progress towards 2030, disparities in child survival across countries must be addressed (UNIGME, 2018).

Two thirds of newborn deaths are preventable through simple, low-cost measures that can be taken by health professionals, mothers and families (WHO, 2016; WHO, 2018; UNICEF, 2018).

The main causes of death of African newborns are related to infections, prematurity and perinatal asphyxia (Setumba, 2018). Infections in the neonatal period remain one of the leading causes of neonatal morbimortality worldwide and are often caused by infections from the umbilical cord stump (WHO, 2016, cited in Pires 2016).

According to WHO (1998, cited in Branco 2003; Luís, 2014), newborns only begin to develop their own protective flora after 24 hours of life. Moreover, their immune system in the first days of life is not yet fully developed, which makes it highly susceptible to infection (Beck, Ganges, Goldman, & Long, 2004). Therefore, umbilical cord stump care is relevant for the prevention of neonatal omphalitis and sepsis (Pires, 2016).

Despite the improvement in the country's main overall health indicators and the economic development in recent years, Angola still has one of the highest infant and child mortality rates in the world and one of the worst records in the African continent for primary health services (World Bank, 2013; UNICEF, 2017).

Sociocultural, economic, demographic conditions and factors and use of health services are considered as determinants in neonatal and child mortality in Angola (Toni, 2010).

Cultural influence on healthcare: empirical versus scientific knowledge

Pregnancy and puerperium are most likely the periods in which women feel the greatest need to mobilise their resources, seeking the assistance of family members for the provision of care. Parental migration may have an impact on the health of newborns, related to the allocation of resources and the adoption of risk behaviours (Ramos, 2004, 2012 a, c, 2016). The neonatal period, which corresponds to the first 28 days of life, is a critical period, which involves a high degree of vulnerability and risk of death.

A newborn child is totally dependent on a person responsible for the satisfaction of its needs. The way in which these needs are met is intimately related to cultural and individual factors which, among other things, will be decisive to the physical and psychological development of the child (Lowdermilk & Perry, 2009).

Culture influences the value and meaning of health and illness, as well as the need for care. Wong (1999) states that the greatest influence on child-rearing practices and consequences is probably the social class of the family into which a child is born.

According to Ramos (2004 a: p159) “the development, health, behaviours, theories and conceptions related to a child correspond to a complex, interactive and dynamic process, understanding the individual as a whole, his/her relationships with the different contexts in which he/she is inserted, in individual and collective representations”.

Health models and theories contribute to the understanding of the health behaviours adopted. Nola Pender's Health Promotion Model defends that each person has unique individual characteristics and experiences, which will affect his/her behaviour, thus the fostering of healthy behaviours is sought. The personal factors which influence behaviour fall into three categories: biological, psychological and sociocultural (Pender et al., 2006).

Meleis' Middle-Range Theory (2007) emphasises the importance of care taking life transitions into account. Life transition periods correspond to periods of greatest vulnerability and health risk. How each person experiences the transition, his/her representations and meanings about the factors inherent to change are influenced by the surrounding environment. In the puerperium period, the transition is experienced not only through the changes inherent to the new role of mother, but also in the perception in relation to the umbilical cord stump, given that the stump itself is in transition.

Madeleine Leininger's Theory of Culture Care Diversity and Universality is based on the universality and diversity of care coated with the cultural influences of the surrounding environment and interpreted in accordance with the different cultural

meanings of human care (Leininger & McFarland, 2006). Caring is a universal phenomenon, but its expressions, processes and patterns vary across cultures (Ramos 2003, 2004 a,b, 2016; Ribeiro et al., 2009). Therefore, some of the assumptions of transcultural nursing are: care is seen as essential for health; all cultures have knowledge and care practices which vary transculturally; values, beliefs and practices of cultural care are influenced by the religious, family, political, educational, economic, technological, historical and environmental context of a specific culture (Tomey & Alligood, 2004). This model relates cultural care to health determinants and their multiple influences from a multicultural perspective (Ribeiro et al., 2009). The aim is culturally competent care and through this model, a health professional obtains the guidelines for care planning, so as to work effectively in the cultural context of the person, family and community (Martins, 2010).

In traditional African societies, health is seen as a balance between the social, natural and supernatural environments. The method of care is directed towards the relationship with society and the supernatural, generally making use of emotionally and affectively charged symbols. In Western society and medicine, explanations centred on the patient and the natural world are predominant. In both societies, there is an increasing existence of medical pluralism, based on principles originating from different cultures, where traditional and modern scientific explanations coexist and there is an official medical system in addition to other alternative systems (Ramos, 2004 a, p.104).

Kleinman (1980), cited by Ramos (2004 a, p. 104-105), developed the concept of “healthcare system”, with three sectors of healthcare that can be used by individuals. The popular sector refers to the lay, non-specialist and informal field. It includes self-treatment, self-medication and treatments recommended by family and friends based on a set of beliefs about health preservation. The family is the main support of assistance, in particular women, who are more experienced in life events. It consists of specific rules for each cultural group on preventive and healing behaviour, sometimes using protective objects or magical-religious practices. The folk sector is most present in non-Western societies (African, indigenous, Asian...). In this context, healers are individuals specialising in healing methods and generally share the same cultural values and beliefs, with greater proximity, affection and inclusion of the family in the therapeutic relationship. Its approach is generally holistic and includes events and life aspects of individuals. The professional sector corresponds to Western scientific medicine, with health professionals who are professionally regulated and protected by law.

Cultural care is multidimensional and considers the different social contexts in which the subjects are inserted and the intergenerational influences, which makes it possible for caregiving to include meanings, expressions, patterns, processes and forms of cultural care with diversities and similarities (Ramos, 2004 a,b; Leininger & McFarland, 2006).

Health and disease cannot be understood without giving voice to the population and without seeing the world from the point of view of those who experience it every day. Therefore, knowing the manifestations and beliefs of common sense enables us to understand the logic of their actions in everyday life, particularly in health.

It is fundamental to know the cultural context in which the newborn and its family are inserted, so that the care to be provided will not cause conflicts between the parties (health professional and caregiver), but rather will occur based on a reality which considers the individual and cultural differences between those who are involved (Ramos 2004 a,b, 2012 a,c, 2016).

Common sense interprets reality, the lived experience, and negotiates according to the group's meanings, opposing itself to scientific knowledge. Science is objective and neutral and reduces phenomena to controllable dimensions, separating its analytical field from the cultural contexts and meanings. Popular knowledge integrates the culture of a group, practices and behaviours lived in a given context and knowledge from various fields, in which religion, morality and magic are included (Ramos 2004 a; Alves, 2015). Thus, there are two explanatory models of illness, the scientific and lay models, in which individuals build plural itineraries and mobilise the resources which enable them to access healthcare more swiftly and effectively.

In Angola, family care is based on the experiences of each family member, deriving from health professionals and

popular and cultural knowledge (Leininger & McFarland, 2006). Inside the family, when providing care, grandmothers convey myths, beliefs, values and practices across generations (Ramos 2005).

In the mother-grandmother-caregivers relationship, there is a subordinate position on the part of some puerperal women who, motivated by fear, insecurity and lack of knowledge, accept and subject themselves to the knowledge of elders, making it impossible for the puerperal woman to deliver care to her children, even when this care needs to be readapted or modified. The independence of the grandmother-caregiver actually constitutes a form of "power" with decisive characteristics of control over her family members, especially when it comes to taking care of a newborn. Sometimes, the knowledge conveyed by grandmothers culminates in traditional practices which are not recommended by the scientific community. Culture, myths and beliefs are revealed in a body of traditional knowledge which often prevails over scientific knowledge, leading to care practices with negative consequences for health, as is the case of omphalitis (infection of the umbilical cord stump), due to the application of non-recommended products in umbilical cord stump care (MINSa, 2012). This care provided at home is not always delivered by mothers, who are the focus of attention in hospitals (Rosa, 2009).

Therefore, it is fundamental to include grandmothers in the care guidance and encourage puerperal mothers, young mothers to participate in the care process and acquire responsibilities and power in decision-making, delivering care with safety and pleasure.

In newborn umbilical cord stump care, several traditional practices originating from lay knowledge are adopted, mentioned by various authors. In Luanda, some of the practices mentioned by Ribeiro & Brandão (2011) are the bandaging of the stump, placing coins, using chicken lard, burnt leaves, ash, salt, burnt cockroach, palm oil, olive oil, breast milk, coffee powder, faeces, spiders.

Umbilical cord stumps require the use of scientifically recommended products to avoid infections (Luís, Costa, Casteleiro, 2014; Luís, 2014; Pires, 2016).

Currently, there are several methods for umbilical cord stump care, such as the application of topical antiseptics, the use of topical antibiotics, and the dry care method (which means keeping the cord clean and dry after bathing or cleaning the site, without applying solutes as a routine) (Gutiérrez, 2015, cited in Correia, Pires, 2016; Cardão et al., 2019).

According to WHO (2018), this practice is recommended for births in places with low neonatal mortality, where the risk of omphalitis is low and access to healthcare is easy and swift. However, WHO's guidance is the use of antiseptics on the umbilical cord stump in developing countries, where there are poor hygiene habits, home births and a high incidence rate of neonatal infection or mortality (30 or more neonatal deaths per 1000 live births); in this context, chlorhexidine 4% is the agent of choice (WHO, 2018). However, chlorhexidine is expensive, which makes it difficult to acquire. Therefore, as a substitute for chlorhexidine, ethyl alcohol 70% is recommended, with application between 7 to 10 days, keeping the stump exposed until the substance evaporates (WHO, 1998).

The migratory trends in Angola and the low socioeconomic status of the majority of its inhabitants give rise to situations of vulnerability in the care of newborns, leading to a collateral effect on their health condition. From this perspective, parental migration can be an undoubted disruptor of traditional family structures and potentially cause damages to the health of a newborn, in conjunction with other influential factors (Carvalho, 2013).

Women who come from the provinces to live in the capital are separated from their family and support environment and subject to different cultural habits. They often feel uprooted and isolated, which makes them feel more vulnerable and insecure as mothers in relation to the care provided to their newborns (Ramos, 2004 a, 2008 a). As mentioned by this author, these factors and the fact that immigrant women make less use of health services for prenatal and postnatal monitoring lead to an increase in risk situations during pregnancy (obstetric pathologies), during childbirth (prematurity) and in the postnatal period (maternal depression and psychosis) and functional disorders in the baby (such as sleep and feeding disorders). These situations

are due not only to issues of accessibility, but also to the lack of knowledge, health monitoring habits and feelings of misunderstanding of their customs by health professionals.

Some childcare practices are somewhat frequently modified and abandoned due to the demands imposed by living conditions, the desire to do the same as the host culture and the fear of being judged or criticised. Furthermore, the characteristics of the family dynamics also influence maternal behaviours related to motherly care (Ramos, 2004 a, 2008 a,b, 2012 a, b, c; Machado et al., 2006).

As mentioned by Ramos (2004 a,b), in a migratory context, when the cohesion of the family group is fragile due to rupture with the cultural aspects of the region or country of origin, references to traditional practices of education and childcare disappear. The experience of maternity in migration circumstances shows that acculturation happens in three ways: successful acculturation, when there is a balance between traditional practices and those acquired in the place of arrival. It is more common in families which maintain close ties with their place of origin. Semi-acculturation, which occurs when mothers choose, mainly for the care of their children, the practices of the host society, with a tendency for the care derived from their place of origin to diminish or disappear. It is most frequent among young mothers, with a rupture in intergenerational relationships. Semi-acculturation is prone to contradictions, indecision and conflicts between the knowledge learned in the culture of origin and the knowledge conveyed by health professionals in the host culture. Deculturation occurs when cultural uprooting is very high and the mother is unable to adapt to the new environment when taking care of her child. It corresponds to situations of greatest vulnerability, which may be accompanied by isolation, depression and psychopathology (Ramos, 2004 a).

Culturally competent healthcare

Cultural and social dimensions may constitute important barriers to healthcare and should deserve the attention of health professionals in culturally congruent and adapted care (Ramos, 2007).

Communication is a basic tool for healthcare, which influences behaviour through a multidimensional flow of information and is a good indicator of the quality of healthcare and health systems. Communication in a therapeutic relationship contributes to the success of healthcare practice and makes the patient an active and responsible agent in his/her health-disease process (Ramos, 2004 a, 2007, 2012 a). Investing in a helping relationship, the humanisation of care and communication skills by health professionals fosters health gains for mothers and children and gives confidence to professionals. It is fundamental that health professionals respect cultural differences in their professional practice and understand the motivations for the health practices adopted by patients in the environment where they live. According to Ramos (2008 c), in order to develop competence in intercultural communication and relationships, it is necessary for health professionals to be aware of the degree of cultural determinism of their own behaviours, i.e. to develop cultural awareness.

For Leininger and McFarland (2006), providing care should consider three forms of action. Care preservation, by supporting people in selecting the aspects of culture which foster healthy behaviours. Care accommodation, by recognising that a particular practice, even if it has no scientific efficacy or health basis, may have meaning from a cultural point of view and helps to integrate practice into care. Care repatterning, which corresponds to the action of health professionals in the modification of behaviours of cultural origin which are harmful or incompatible with well-being and health.

Care accommodation implies a bilateral education, in which the professional learns the way of caring adopted by the family and teaches them his/her way, and this is the starting point for a process of negotiating a way of caring acceptable to both. Negotiation is an interactive and dynamic process between the mother/family/caregiver and the health team, and requires that everyone share knowledge, decisions and powers (Ramos, 2004 a,b, 2016; Leininger & McFarland, 2006).

Leininger's Transcultural Nursing Model (2006) suggests two processes that health professionals may use to communicate with clients of different cultures: the initial cultural assessment, which refers to the assessment of beliefs and

behaviours, where information is used to determine the appropriate interventions, and the initial cultural negotiation, which refers to the process of negotiating care with the client, taking into account the differences between beliefs and behaviours (Leininger & McFarland, 2006).

If there is no knowledge about the client's culture and no training in interculturality, coming across cultural differences in healthcare may cause emotional reactions or attitudes of rejection on the part of health professionals and on the part of clients (Ramos, 2004 a, 2007, 2008 a).

Prior knowledge of cultural beliefs and habits, which may guide women during their adaptation to motherhood, provides early identification by the health professional of behaviours that are harmful to the health of the mother and the newborn and may facilitate the communication process.

Cultural competence is the combination of culturally congruent behaviours for working efficiently in cross-cultural situations. It implies a holistic view of people, respect for different cultures and individuality of values. Culturally competent nursing care is guided by four principles: to be designed for a specific patient, to be based on his/her cultural uniqueness, include self-empowerment strategies and be provided with sensitivity (Stanhope & Lancaster, 2011).

Campinha (2003, cited in Stanhope & Lancaster, 2011) proposes five constructs of the theoretical model of cultural development: cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounter. Cultural desire refers to the intrinsic motivation to guarantee culturally competent care. Cultural awareness involves self-assessment and in-depth exploration of one's own beliefs and values and how they influence behaviour. Cultural knowledge consists of learning to see the world through the patient's eyes from a sociocultural perspective. Cultural encounter is the process which makes it possible to develop relationships and activities in transcultural situations. It can be direct, when the professional learns directly from patients, or indirect, when he/she shares experiences with other professionals.

In culturally competent care, the health professional is responsible for cultural mediation, which consists of advocating, negotiating and intervening on behalf of the client so as to reconcile his/her culture with healthcare (Stanhope & Lancaster, 2011). In the view of these authors, failure in culturally competent care may result from a lack of opportunity to learn, pressure from superiors to increase productivity or peer pressure. This may result in stereotyping, prejudice, racism, ethnocentrism, cultural imposition, cultural conflict and cultural clash.

Leininger and McFarland (2006) mention generic care based on traditional knowledge and professional care based on scientific knowledge. Generic care includes what can be found in any culture in the world in natural or popular forms and professional care is that performed by health system professionals. Popular, traditional or lay knowledge must be taken into account when health professionals mobilise their professional knowledge and seek transculturality in care. It is necessary to know which practices are being used, so that their association can be made with full knowledge of the facts. Health professionals should have knowledge of the cultural elements and respect cultural diversity, and the individualisation of care should always be considered, because just as cultures are not similar, individuals within the same culture are not all identical (Stanhope & Lancaster, 2011).

When caring for an immigrant person, the health professional has to assess certain influential factors, such as the reason for migration and the quality of adaptation to the host country. He/she must also take into account the maintenance in the host country of the family structure, ethno-religious values and access to traditional health practices (Ramos, 2008 a,b). The health professional should consider what is important for the person and family, establish priorities in respect of needs, assign objectives, determine the reason and the area of intervention of the elements involved (mother, family, non-formal healthcare agents), where each one contributes with his/her knowledge, experiences and attitudes to the promotion of the child's health, so as to respond to the needs in a progressive and continuous way (Collière, 2003; Zanatta & Motta, 2007).

With the birth of a child, individuals and families find themselves in a phase of transition and family change, in which

profound changes in family roles and dynamics may occur, which may have consequences, meaning that it is essential to support and foster families' health in this life phase. It is necessary to consider the individuality of each family and the specificity of their experiences, which will influence the care provided by mothers (Collière, 2003; Albuquerque 2022).

The permanent attention of professionals to the mother-child binomial, in the puerperium, in both the hospital environment and the home environment, within the scope of primary healthcare, is fundamental to reduce maternal and child morbimortality (Andrade et al., 2015). Negotiation is a strategy which formally involves the family in the care process and jointly establishes the roles of both family members and health professionals. An increase in the family's control implies an increase in their responsibility. The health professional, particularly the nursing professional, develops the care plan in his/her intervention, which includes three fundamental components: the management of actual or potential health problems; education and anticipatory guidance; and case management and care coordination (Stanhope & Lancaster, 2011).

The health professional has a major responsibility in health promotion and education. The theoretical model of health promotion by Nola J. Pender (2011) provides a simple and clear structure in which the health professional can provide care individually or in groups, which allows for the planning, intervention and assessment of the actions leading to health promotion, and also relates three main points: individual characteristics and experiences, feelings and knowledge about the behaviour to be achieved and a desirable health-promoting behaviour (Pender, 2011; Paiva 2021).

The right and duty of populations to participate individually and collectively in the planning and provision of healthcare achieved particular importance after the Alma-Ata Conference. Therefore, health citizenship is promoted, which is capable of exerting, in an informed and responsible manner, power/influence upon health status and the development of the health system/services, based on the assertion of the individual's independence and freedom of choice (Gonçalves, & Ramos, 2010; Simão & Gallo, 2013). Since the person is the centre of attention of care, humanisation is a core aspect of citizenship.

By providing health education instead of making decisions for the family, the health professional supports the family in decision-making and enhances their self-esteem by recognising and using the family's strengths and support networks (Stanhope & Lancaster, 2011). Empowerment is thus the process of acquiring knowledge and developing skills that leads to an increased power and control by citizens in decision-making, thus increasing their capacitation, participation and responsibility in their health and quality of life process (Loureiro & Miranda, 2010; Leite et al., 2015; Albuquerque 2022). The construction of transdisciplinary knowledge is a collective process in which each person creates his/her own knowledge and contributes to the construction of the knowledge of others.

2. Methodology

This is a descriptive, exploratory and cross-sectional study based on a mainly qualitative methodology.

The qualitative approach is an appropriate approach for intercultural research, as it allows seeing the world through the eyes of the participants, finding answers that are most relevant to them and working in the natural environment, that is, in the social, economic and cultural context where care takes place, bringing the researcher closer to the context of his investigation. Qualitative research within the social sciences seeks to understand reality through inferential and inductive processes and works with meanings, beliefs, values and attitudes, relationships, perceptions, behavior and intergenerational influences, in the case of this study, in newborn care. This approach resorts to a multiplicity of research designs, with common aspects such as: holistic approach to the issues to be analyzed, focus on human experience, high researcher involvement and flexibility (Bardin, 2011; Amado, 2017; Creswell, 2018).

As a matter of convenience, we opted for a non-probabilistic sample, composed of Angolan health professionals who work with mothers and newborns in the public health sector in the city of Luanda.

The purpose of this study is to analyse cultural influence on Angolan maternal care of newborns and health strategies

from the perspective of Angolan health professionals.

We requested the participation of health professionals to provide their expert contribution on the topic under study through a semi-structured interview, which was applied personally in the workplace of each participant. The results were analysed in the light of the scientific evidence of the current literature on the topic and context. Ethical principles and codes were guaranteed, so as to maintain the privacy and integrity of all those involved in this study.

3. Results and Discussion

Characterisation of the health professionals

Health professionals, due to the position they occupy, the functions they perform or the knowledge they have about the topic to be researched, have proved to be fundamental sources of information.

Five health professionals participated in this study. They were an administrator, a clinical director, a nursing supervisor, a specialist midwife currently working at the Samba Health Centre and the head of the Public Health Section of the Urban District of Luanda. The participants have higher education qualifications in Nursing, Medicine and Hospital Management. All of them are Angolan nationals and have over 20 years of experience in the Angolan Ministry of Health.

Three participants are female and two are male. The average age is 52 years old, four are between 53 and 55 years old and one is 47 years old. Two of them were born in Uíge, two in Cuanza Sul and one in Huambo.

The questions focused on topics such as: cultural influence in the care provided by mothers to newborns; the performance of health professionals; intervention strategies.

Cultural influence in the care provided by mothers to their newborns

All five health professionals in this study are unanimous in stating that currently cultural and traditional practices prevail in the care provided by Angolan mothers to their newborns.

1: they end up giving more value to culture (...) in some regions and cultures some people still persist in doing what is the opposite of scientific knowledge.

3: I believe that culture has a great influence.

5: (...) particularly in the Angolan population, myths and cultures have a great influence on baby care... we convey this information, however sometimes the environment where this mother lives... is an environment that uses a certain practice... this population, this province has its own culture. In fact, you are really influenced by the environment to which you belong.

The reports support Ramos (2004) and Linhares et al. (2012), who state that practices are constructed based on the knowledge acquired in the social, family and cultural environment of belonging.

In newborn umbilical cord stump care, the use of popular substances, based on the knowledge and customs acquired in the social and family context of the caregivers, is deemed beneficial to health (Linhares et al., 2012). This situation is evidenced in the assertions of the health professionals when they mention that many of the traditional practices present in Angola are related to newborn umbilical cord stump care.

1: Some people treat the umbilical cord, for example, with a root that has a sap... like milk. Others burn a mat, the mat cane, they do that powder thing to also apply it to the spot.

2: The umbilical cord, you tell them that they have to put alcohol on it, but when they get home they put other things.

3: *The care provided to newborns here, in Angola, by many mothers is not very adequate, because some materials, like ash... burnt cockroach, and even some others... According to them, the cord falls off earlier.*

4: *In the past, they treated the navel with "luando" dirt, now they use palm oil, they use Pepsodent, they use a method that they call glue on the baby's navel.*

5: *Many people still believe that putting on products like ash, lizard droppings... that these are products that can really heal the baby's navel.*

The information conveyed by health professionals is in line with that described by Ribeiro & Brandão (2011), when they mention as frequent practices in newborn umbilical cord stump care the use of products such as leaves, ash, salt, burnt cockroach, oil, olive oil, coffee powder and droppings.

These findings are also present in the research of Tavares (2022), which was conducted among Angolan mothers, whose testimonies showed the use of non-scientifically recommended products in newborn umbilical cord stump care. This study also reported that in the practice of this care, mothers who were born in various provinces of Angola most frequently mentioned the use of ampicillin, spit, leaves and powder, whereas the mothers from Luanda mentioned most frequently the use of ash, semen, oil, toothpaste, powder and salt.

Four of these five professionals mention the risks that traditional practices performed on the umbilical cord stump involve to a newborn, such as omphalitis, infections, or even death.

1: *Sometimes this causes an umbilical infection in the newborn.*

2: *Neonatal sepsis is high.*

4: *(...) Many babies show up in Paediatrics with a large umbilical infection. Some even end up dying in the paediatric ward.*

5: *Practices that can often hinder the progress of umbilical healing.*

Practices based on empirical knowledge are adopted even when scientific evidence shows that incorrect practices in umbilical cord stump care result in infection (omphalitis) (Ribeiro & Brandão, 2011) which, when it spreads in the bloodstream, causes sepsis, this being one of the causes of neonatal death in Angola.

According to WHO (2016), should this trend continue, approximately half of the estimated 69 million child deaths between 2016 and 2030 will occur in the neonatal period, the majority of them being related to preterm births, anoxia in labour and infections. It is estimated that about 15% of all neonatal deaths globally occur due to infections (WHO, 2016). Omphalitis is responsible for the mortality of over 520,000 newborns worldwide (Correia & Pires, 2016).

The influence of the family, especially of older women, with their traditional knowledge in newborn care is cited by health professionals.

1: *But many of them, what happens is that they hear the information given by professionals and when they get home, they are also influenced by other relatives (...) We treat the navel of the newborn only with 70% alcohol, and sometimes they don't even follow this procedure.*

4: *We, during the lecture, talk so, so much with them, the puerperal women, but at home, the grandmother, the mother says no!... we treated you like this. How is it that now your baby can't be treated in the same way?*

5: *The family carries weight..., because the family orders that the baby has to use that product.*

In Angolan culture, the transmission of intergenerational and cultural popular knowledge is striking, accompanied by a bond of affection and safety in the care of the newborn (Ramos, 2004, 2016; Melo et al., 2015). In this context, grandmothers emerge, who are respected and valued in the family structure and make their contribution to the continuity of future generations (Linhares et al., 2012).

This situation was also confirmed by Tavares (2022), who mentions the strong influence of support people in the care provided to newborns. In the transmission of traditional knowledge, the family is the most frequent presence and, within the family, the newborn's grandmothers stand out. Outside the family, friends and neighbours are the most commonly mentioned help and reference in care.

The cultural component and social determinants influence the care options that Angolan mothers adopt. In the opinion of some of the health professionals, mothers do not value the guidance provided by health professionals.

2: You are a health technician... you teach them one thing, they get home and do something else.

4: The nurse is talking, talking, that mother is sleeping, she didn't hear a thing.

The health professionals report that mothers do not follow the indications provided by health professionals.

4: They do the opposite, but the baby is the one who suffers. We tell them that you can't use powder, you can't use soap, all of that, but yes, they use them.

One of the professionals is of the opinion that mothers do not believe in health professionals.

5: Many of them don't believe [what the professionals say], because that is really a family matter.

In the view of another health professional, the fact that mothers do not care for newborns in accordance with the scientific recommendations is mainly related to economic difficulties and poverty.

4: I think this is a poverty problem, because we advise them to use alcohol, they don't use it... some say they don't have money to buy alcohol, we advise them to buy sterilised compresses, but they don't buy them either, due to lack of money. So, I think that the mothers' problem is poverty.

The various representations and specificities of care according to cultures have in common the adult's concern to provide the best conditions to the child, in addition to having a psychological function for the mother/caregiver (Ramos, 2004, 2014). Therefore, it is frequent for mothers, even when assisted by a health unit, to adopt the application of homemade solutions to the umbilical cord stump (Ribeiro & Brandão, 2011). Fear and lack of security make puerperal women submissive to the will and experience of others, thus they provide care to newborns based on empirical knowledge (Miranda et al., 2015). Corroborating the results of Tavares (2022), there are puerperal women who, while stating that they are aware of the scientific indications in respect of newborn umbilical cord stump care, choose to maintain traditional care using non-recommended products, thus there is a dissonance between the information conveyed by the health professionals and the options made when caring for their newborns.

For Miranda et al. (2015), although they receive guidance from health professionals regarding how to care for their newborns, women continue to receive and convey information passed down from previous generations, often without knowing

why and its real importance in care. Therefore, the influence of various cultural and social determinants on the representations and practices of childcare, in general, is confirmed.

Performance of health professionals

Regarding the influence of culture on the performance of professionals, a qualified informant mentioned that culture does not influence the performance of professionals because scientific knowledge overrides myths and traditions.

5: No, no. There, you, as a professional..., a professional is unlikely to be influenced.

From the point of view of two professionals, in some cases there is an influence of culture on the performance of health professionals.

2: On some of them, yes.

3: I believe it has an influence because many of them, even though they are professionals, still have that culture in their consciousness. And sometimes they are not able to pass on information as firmly as they should.

According to the vision of two health professionals, cultural influence must be set aside and the professional must be guided by scientific knowledge.

1: A health professional must not be led astray by popular culture. He should rather banish this kind of behaviour. Each health professional must feel like an agent of change in some behaviours, conveying what benefits the population.

4: (...) we should no longer follow culture, because we have already been trained.

“Cultural awareness” includes the ability to analyse the world by recognising differences and plurality from the perspective of another culture, respecting it and understanding the motivations for the health practices adopted, with health professionals fostering negotiation based on an intercultural dialogue and promoting health gains (Ramos, 2012). Therefore, the traditional practices related to the care of newborns can be changed or eradicated, if mothers understand that this will bring advantages (Ramos, 2004).

For the provision of culturally competent healthcare, it is crucial to develop culturally competent strategies and interventions and to invest in the training and development of individual, ethical, professional, communicational, intercultural, relational and citizenship skills (Ramos, 2006, 2010 b, 2017)

As regards the guidance given by health professionals to mothers, the health professionals point out some existing vulnerabilities.

4: The information is not yet adequate...the technician who is going to give this information has to give correct information, with no misgivings whatsoever.

5: In general terms, professionals pass on what they learned from the knowledge they acquired during their training. Now, what is sometimes missing is the follow-up.

Communication implies continuous exchange of information with reciprocal dimensions and influences, leading to feedbacks which condition behaviour (Ramos, 2001).

Therefore, in order to provide quality care, a health professional must establish communication channels which embrace cultural diversity, value plurality, provide authentic and reciprocal exchanges of experiences with patients, which facilitate the delivery of care (Wong, 1999; Leininger & McFarland, 2006). A health professional must thus understand and use the patient's language in cultural care and be aware of the power that the person exerts over the situations and events which affect him/her (Pontes, 2002; Jenko & Moffitt, 2006; Sopa, 2009).

One participant defends that the guidelines for health professionals respond to the needs of the population; however, they often counteract the view of the family members.

2: *They meet their needs, but even mothers do not put them into practice.*

3: (...) *but when they get home, the mother-in-law or the mother contradicts her... The family overrides her.*

However, from the point of view of some professionals, there has been progress with the guidelines for health professionals.

1: *I mean to say that the population is aware, that some taboos are really being left behind (...) This is a sign that it's having some effect...The message of the professional is really reaching people.*

According to Tavares (2022), as regards the practices performed in newborn umbilical cord stump care there are reports of puerperal women who mention the use of alcohol, as recommended by WHO. In said study, mothers born in Luanda and primiparous mothers are the ones who most use alcohol in isolation as a practice in umbilical cord stump care. The same study mentions the existence of mothers who, despite having information transmitted by their relatives, choose to adopt the recommended scientific practices conveyed by health professionals and some of them refer that their own grandmothers adhere to scientific care. Therefore, in addition to the fusion of traditional and scientific knowledge, it can be seen that a transition is underway from traditional practices to scientific practices, where the traditional reference model, the newborn's grandmother, adheres to the scientific recommendations in umbilical cord stump care.

For Ribeiro and Brandão (2011), if it does not conflict with the present culture, culturally competent care makes it possible to acquire knowledge and adopt correct practices when caring for a newborn, thus contributing to a decrease in neonatal morbimortality.

Professional care should be congruent with popular care, respecting the individuality of patients and families. In this way, accommodation should be taken into account by the health professional, because not all beliefs are wrong, and it should not be totally repatterned only because the professional has other beliefs.

Regarding the motivation of health professionals, the majority of the participants explain that they are motivated, but with reservations or limitations. One of these limitations is the lack of continued training.

3: *Yes [they are motivated and willing to change], but I believe that professionals also have to have continued training, because their training took place long ago and they may feel outdated.*

The lack of incentives, in the opinion of the health professionals, is another limitation.

2: *First of all, they are poorly paid, they have no incentive... They may even have the will, but we don't have sufficient medicines. We lack more conditions, yes.*

According to one of the professionals, despite their motivation, overwork is an obstacle.

4: We are motivated and do our job properly. Something may be missing, but this is due to overwork... there is no time to stay and talk with the mother for a little longer, to give more information.

Regarding the implementation of continued training for health professionals, four of the health professionals interviewed stated that this is very important.

2: It is important, very important, because in health, especially here in Angola, we always need to receive updating.

5: Many of us sometimes have knowledge that is already five years old.

According to one of the health professionals, there should be more incentive for training.

3: I think that there has to be more incentive for them to attend the training courses, because few people are interested... the majority of them don't show up. Hence the need for an incentive, to explain the reasons for the training (...). To make the importance [of the training] better known.

For one of these health professionals, the flaw in training is related to the lack of instructional materials.

5: Sometimes what is missing is actually material support... we must have instructional material.

Scientific knowledge must focus on investing in the training of health professionals and in actions which involve the community and contribute to exercising citizenship.

Professionals should be concerned about the provision of care in accordance with the WHO recommendations and understand the cultural and social practices of families. In healthcare, the encounter with cultural differences may compromise the success of interventions and the quality of care when a health professional has not been trained in communication and interculturality (Ramos, 2006).

Therefore, it is fundamental for health professionals to know the culture of Angolan mothers and families and take into consideration the family context in which they are included, which will make it possible to provide culturally congruent and quality care based on a continuous partnership relationship (Ramos, 2008; Ribeiro, et al., 2009).

Investing in the helping relationship and humanisation of care and in the communication skills of health professionals promotes health gains for children and their mothers, who start to trust professionals. At the same time as the attention paid to the cultural and social background of a patient, empathy is a part of the communicational and relational paradigm of care, including emotional attention and congruence (Ramos, 2004, 2016).

There is no doubt about the relevance of solid training for health professionals in the fields of communication, psychology and intercultural relationships, so that they can develop strategies for intervention in view of individual and cultural diversities (Ramos, 2004 a, 2007, 2012 a).

Intervention strategies

The health professionals in this study mentioned some intervention strategies to improve the quality of care. The professionals' opinion is consensual regarding the relevance of health education.

1: *We, health professionals, our mission is to educate the population for changing wrong behaviours, what is harmful to health. We cannot get tired of talking to the population, because umbilical infections have taken many newborn lives. You must speak, raise awareness among people, more and more. Prevention and health promotion must prevail.*

2: *It is important that we give lectures, many lectures.*

3: *Greater emphasis on information.*

5: *Education of these mothers, to see if we are able to correct some habits and customs that sometimes our population has when taking care of a newborn and of the umbilical cord. It is worthwhile acting more on causes than on effect, because the effect is more expensive in terms of money... In causes, yes, prevention is more effective.*

According to some participants, health education sessions should start precisely at the time of the medical appointments.

1: *At antenatal appointments, they should always give their talks, so that when the mother arrives at the delivery room, she already has some information.*

3: *Guidance should begin at the antenatal appointments and continue up to the delivery time. They would already have in mind what they can or cannot do with a newborn.*

It is essential to invest in mothers' health education, adapting the teachings to their level of knowledge and sociocultural context, empowering them for care and fostering their adherence to the therapeutic programme. According to Loureiro & Miranda (2010), health literacy represents a set of cognitive and social skills and the ability to assimilate information in order to foster health. Health literacy fosters equity and is built on quality education and lifelong learning. Literacy should be an integral part of the skills developed during the process of development of the individual, within the family and through equitable access to health services. Therefore, investment at health facility level is important.

Health professionals are required to pay attention to the community's popular experiences, valuing what is scientifically proven but understanding the meaning of beliefs and practices practised over generations (Melo et al., 2015). These authors defend that health professionals, when dealing with popular knowledge, should combine common sense knowledge with scientific principles, an opinion also supported by Linhares et al. (2012), who defend that this is a necessary condition, given that it makes relationships meaningful and fosters the reworking of knowledge and actions. Multiculturalism requires cultural and communication skills from health professionals to effectively respond to the needs of individuals and groups (Ramos, 2004, 2016).

The testimonies of the health professionals mention the importance of involvement and participation of the family when providing information.

3: *I believe that if besides the mother... someone was called... the father... If this information were shared by two or three more people, I think this would have a great influence on that care.*

4: *It could also help with the behaviour of mothers who are at home... that mother who heard will say no. Besides the mother, I also received this information.*

4: *As is done in Brazil... the family is there as from the birth, they watch all the information, the birth, the period following birth, all the care done inside the hospital.*

Considering that the learning process of mothers happens with the help that they receive when caring for their newborns, WHO (1998), cited in Sopa (2009), defends that health professionals should involve the partner, other family members or caregivers in the care of mothers and newborns.

From the perspective of the health professionals, some policies should be implemented at the level of the Angolan Ministry of Health, in order to improve the information and empowerment of mothers, namely how to provide the material for the care of the umbilical cord stump.

2: (...) *Providing a kit... so that she is not bound by traditional practices.*

4: *The material, for example... compresses for umbilical cord stump dressing, inside an appropriate kit, with 70% alcohol.*

Extending hospitalisation after childbirth.

2: *The Ministry of Health should organise a place where mothers could stay on for at least 72 hours, at least until the fall of the umbilical cord.*

4: *Staying six hours in the delivery room and then going home... the length of the stay should be increased. She would stay longer, but with her family members.*

Developing more health education actions in the community.

3: *Intensifying lectures in the community... future mothers would already have in mind how to care for newborns.*

5: *Organising lectures in the communities to advise mothers how to take care of the umbilical part, it needs special care, because many mothers, sometimes, are really unknowledgeable about this care.*

Increasing support for the implementation of public health programmes in the community.

5: *They already exist, they already have programmes, there are programmes at the public health level. They exist, only the implementation is poor. Because of support issues.*

According to a qualified informant, one of the strategies developed by the government is the implementation of community agents.

1: *We are in the phase of training some "Adecos", agents for community development (...) we will have this privilege and will introduce the knowledge to this group, because they deal directly with the community, they are actual residents of the community, they deal with the people, they know them.*

A strategic priority involves reinforcing the health system, so that it is better structured, more efficient and equitable, with an expanded network of care and essential services that is functional and structured into levels of reference. For this purpose, WHO concentrates its interventions in the following areas: organisation and management of health systems, human resources development, reinforcing the health system and health research, medicines, medical equipment and the health laboratory network. The implementation of Community Development Agents (ADECOS) is a strategy for supporting the promotion of health and

community programmes (Republic of Angola, 2018). The development of multisectoral partnerships for health in Angola also continues to be a key strategy, as it facilitates and promotes critical interventions aimed at improving the health status of the Angolan population (WHO, 2017).

Healthcare must interpret and understand the cultural diversity, the meanings of health/illness and the experiences of mothers. Healthcare professionals must carry out a self-reflection and critical reflection, recognising their own values as well as the values and practices of the patients with whom they establish care relationships (Ramos 2006, 2008, 2012).

4. Final Considerations

As in other countries, Angola has a set of beliefs, attitudes and health practices inherent to its cultural context.

The reflections of health professionals about the cultural influence on Angolan maternal care of newborns corroborate the results obtained in studies conducted within the Angolan context, as well as the scientific evidence in this field.

From the perspective of the participants in this study, the care provided by Angolan mothers to their newborns during the puerperium period has a cultural influence and multifactorial determinants, revealing itself as a sensitive and complex period.

According to the health professionals, the knowledge of Angolan mothers is based on traditional knowledge, transmitted intergenerationally. In the transmission of this knowledge, the family is the most important presence and within this family, the grandmothers of the newborn child stand out.

The traditional knowledge present within each culture and family is important in the health behaviours adopted and must be known, in order to understand health practices and for scientific development.

The health professionals mentioned that the scientific aspect is also present in the origin of the knowledge of newborn care, yet there are mothers who, even though they state that they are aware of the practices recommended by the World Health Organisation (WHO), opt to maintain traditional care. Therefore, the statements of the health professionals show that non-recommended practices with harmful consequences for the newborn, such as in newborn umbilical cord stump care, are deeply rooted. They derive from the application of a variety of harmful traditional and homemade products, which can cause omphalitis and septicaemia in the newborn and are one of the main causes of neonatal death in Angola. This is a public health problem with harmful and irreversible consequences, but which can be prevented.

The results show that the behaviour of caregivers, as well as the functioning of health services and healthcare are related to the high number of omphalitis cases occurring in the country, which calls for an adequate response from institutions and health policies and requires the implementation of appropriate public health measures. They also show that there are mothers who choose to adopt the recommended scientific practices, thus there seems to be some transition in terms of knowledge and practices in care.

In view of these findings, the health professionals recommend some strategies for improvement, being unanimous in stating the importance of investment in the training of health professionals. Health professionals should work together with mothers who arrive at health units, cooperating towards the empowerment and awareness of the implication of their practices on the health of the newborn, in order to reduce the high rates of neonatal morbimortality in Angola. It is fundamental to empower them to promote, when necessary, the repatterning of behaviours through relational, educational and communicational strategies.

Health education is an intervention strategy, which should occur both in the health unit and within the scope of the community, focusing on family involvement and participation. Therefore, the health professionals stress the importance of investment at the level of health units, particularly with the implementation of: childbirth preparation courses; postnatal check-ups at home to assess the needs of mothers and families in their context and increase patient-health professional proximity and intervention at the community level; support groups within the community and community agents to collaborate in the implementation of health education initiatives and contribute to community training. The construction of intervention models

intended for puerperal women at primary healthcare level will help systematise the care provided to newborns.

It would be important to complement the existing programmes of the Angolan Ministry of Health at the level of child health. In cases of mothers with risk behaviour, it may be necessary to mobilise the intervention of adequate health professionals from the multidisciplinary team, in addition to parents, family members and other significant persons, to assist in providing appropriate and effective newborn care and responsible parenting. Intervention should be early and start during pregnancy, to be continued throughout the puerperium.

Individuals are inseparable from their cultural roots and the social environment in which they live, thus for the intervention of health professionals to be effective, they must be aware of and understand the values, rules and beliefs which guide and direct their clients and their life contexts.

We verified that from the perspective of these professionals, cultural influence on Angolan mothers when caring for their newborns derives from the strong influence of the people who help them, namely their relatives, with particular prominence of the newborn's grandmothers.

A dissonance is frequent between the information conveyed by health professionals and newborn care options adopted by mothers, namely related to the umbilical cord stump, traditional culture carrying a large weight in the provision of care as compared to scientific knowledge. In this respect, the efforts made by health professionals may be a source of stress which, depending on the capacity of resilience and adaptation of each professional, may affect the provision of care.

In the practice of culturally congruent care, health professionals should have communicational and cultural knowledge and skills regarding the care to be provided, so as to be able to substantiate the advantages of practices based on scientific evidence, as opposed to certain practices based on tradition, which may be harmful to children's health. It is evidently necessary for these professionals to take into account the cultural and social context of their intervention, rethink their professional approach in order to gain the trust and acceptance of the community and family, involve everyone's participation, and promote the empowerment and adoption of healthy care practices.

The multiculturalism present in Angola requires efforts to reformulate adequate strategies and public policies for the purpose of improving health and quality of life. Appropriate and decentralised neonatal and child health measures must be taken in the city of Luanda and extended to the whole of the country, in order to respond to the need for improved healthcare provision services. Strategies should be developed for establishing mechanisms to guarantee involvement and cooperation between qualified professionals, family caregivers and informal caregivers. These informal caregivers are familiar with the social contexts and cultural barriers, thus they can be used to improve integration and the acceptance of public health services.

They defend that the skills of health professionals should be strongly developed for the purpose of providing culturally competent healthcare.

In addition to investment in continued training for the whole team of health professionals and increased incentives for training, the health professionals point out the following strategies: implementation of community intervention programmes, supply of kits with material for umbilical cord stump care, increase in the length of hospitalisation after childbirth (which is currently around 24 hours) and follow-up at the health unit by reference persons.

In addition to family, it is likewise deemed pertinent to "give voice" to health professionals working in the field, encouraging the reflection and experience of health professionals on this topic and intervention strategies.

Scientific knowledge and production at the level of neonatal health in Angola is fundamental, and conducting more studies in this field should be encouraged.

It is hoped that these results will contribute to raising awareness among those responsible for investing in the training of health professionals and developing strategies and policies at country level, contributing to gains in neonatal health by reducing

neonatal mortality and morbidity and improving the country's health indicators, in order to achieve the Sustainable Development Goals recommended by the UN in the field of neonatal and child, maternal, family and community health.

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