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ABSTRACT

Cultural beliefs and values implicitly and explicitly shape every aspect of the way we parent our children and how we communicate about parenting. To support parents appropriately in this new and challenging role, child health services for parents in Australia need to do more than acknowledge a diverse range of cultural practices. While many health professionals believe they act in culturally sensitive ways, we need to closely examine this belief, question the cultural assumptions implicit in the information we give, and assess the extent to which our interactions are culturally appropriate. In this paper, we present a critical review of the literature on health care provision for migrant women and families. We then suggest a need to re-examine the values, beliefs and attitudes within cultural frameworks that inform how child health professionals communicate. Specifically, communication between child health professionals and migrant parents requires further analysis. We suggest that professionals need to reflect on the cultural self rather than solely on the culture of others.

Key Words

cultural competence; cultural safety; communication; child health professional; parenting

INTRODUCTION

Multiculturalism has influenced the formulation of Australian national and state government policies and programs for migrants since 1978 (DIMIA, 2004). Current multicultural policy incorporates a strategic direction for access and equity ensuring that 'government services are attuned to the realities of diversity in Australian society' (DIMIA, 2003: 8). The need for greater investment in vulnerable individuals and groups is highlighted. The South Australian Generational Health Review Committee identified both new arrivals and early childhood as areas requiring specific effort to promote health equity (DHS, 2003a). The review stresses the importance of the provision of culturally appropriate and safe parenting and child health services for migrant families. Research shows that culturally appropriate services are an important part of the effort to address the specific needs of these vulnerable groups (e.g., Long et al., 1999; Small et al., 2002). However while new policies in Australian health care shift the focus for service delivery for migrants from specialist providers to mainstream health care, there is little research on professional practice and cultural safety in relevant services such as child health.

'Women and children are particularly susceptible to inequalities, during the antenatal period and throughout the early years of the life of a child' (DHS, 2003b: 3). Women and children from migrant families face even greater challenges in having their health care needs met primarily due to communication and culture issues. Professional practice must be maintained and enhanced in this area to ensure that providers of child health services to migrant families are able to address issues of culturally appropriate communication. This will enable them to 'enhance the quality of early childhood for children who are disadvantaged as a result of their early childhood experiences' and to 'increase the equality of outcomes between groups of South Australian children' (DHS, 2003b: 4).

This paper emphasises the centrality of culturally safe communication in the provision of parenting and child health services to new parents in a new environment. Key strategies grounded in cultural theory are used to explore health care provision to migrant women and families through a critical review of the current literature.

CULTURAL FRAMEWORKS USED IN THE PROVISION OF SERVICES FOR PARENTS WHO ARE MIGRANTS

Parenting services for child and migrant health in South Australia are community-based and provided by a primary health care multidisciplinary workforce of nurses, social workers, psychologists, physiotherapists and medical practitioners. Professional groups, however, talk differently about their particular approach to providing culturally appropriate care. Terms such as cultural sensitivity, cultural awareness, cultural competence and cultural safety are used to describe approaches taken to meeting the needs of people from culturally and linguistically diverse communities. Eisenbruch et al. refer to an 'explosion of cultural competence theory in health' (2002: 127). They state that theories of cultural competence are applied across many health care disciplines and include clinical specialties and areas of primary health care and public health. Despite the seemingly wide application of theories of cultural competence in health, the lack of consistency in definitions and approaches is disconcerting. Terms are often used interchangeably and therefore remain poorly defined in their application. This suggests a fundamental difficulty in understanding culture, and the 'professional self' as a cultural being.

The problem of disparity in understanding culture and cultural competent practice led to the Intercultural Interaction Project commenced in 1992 in the School of Occupational Therapy at the University of Sydney (Fitzgerald et al., 1998).

A key finding showed that 'therapists and other health professionals appear to enter into interactions with clients with a limited understanding of the concept of culture and it's potential effects on the interaction' (1998: 61). Clinicians need to better understand how culture influences ideas about families and how they work with these ideas (Fitzgerald, 2004).

Bartol and Richardson define the term cultural competence as a 'dynamic process of framing assumptions, knowledge, and meanings from a culture different than our own' that could help health professionals in 'becoming self aware and understanding how meaning is assigned' (1998: 75). Their exploration of the concept returns to a focus of understanding the 'other' rather than understanding the professional's own self as a cultural being. While all models of culturally diverse care reviewed in nursing and allied health incorporate a process of self awareness (e.g., Fitzgerald, 1998; Smith, 1998; Campina-Bacote, 2003) until recently this process was not made explicit. Historically, culturally competent practice in medicine was a taken for granted assumption (Committee of Inquiry into Medical Education and Medical Workforce, 1988). Reporting on a recent workshop on cultural competence in Australian medical education Eisenbruch (2003) stated that attendees repeatedly returned to notions of self-reflection and self-awareness as distinguishing features of cultural competence. Recommendations from this workshop inform a national approach to the promotion of culturally competent care in Australian medical education and workforce development. The turn towards self-reflection is echoed in the USA where there is a call for greater research emphasis on the social-cognitive processes that influence 'patients' and providers' conscious and unconscious perceptions of each other' and how these 'affect the structure, processes, and outcomes of care' (Smedley et al., 2002). While all health disciplines are attending to the need for self-awareness in developing cultural competence it is questionable whether this is sufficiently robust on its own to support change in practice.

A particularly interesting model is 'Cultural Safety' because it prioritises the focus of self-awareness in the context of the cultural environment and history of the practitioner. According to Ramsden (1992) practitioners can become culturally safe by first developing self-awareness followed by cultural sensitivity. This is achieved through critical reflection and analysis of attitudes and values in the context of the historical, political and social processes that impact on health. Cultural safety is defined as 'the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurse's culture on own nursing practice' (1992: in NCNZ, 1996: 9). Cultural safety

therefore refers to the provision of health care by clinicians who recognise the self as a cultural being, the rights of others and the legitimacy of diversity and difference (NCNZ, 1996).

The theory of cultural safety is particularly useful in examining the cultural practices of child health professionals providing services to migrant families because it enables an analysis of communication practice that does not separate the communicator from the context of historical knowledges of social, cultural and political influences on parenting.

DEVELOPMENTS IN PARENTING PRACTICES

Exploring communication with migrant families in the specific area of child health requires an historical exploration of developments in parenting practices. These developments reflect changes and influences on practice from the broader social, cultural and political world. In tracing the social history of parenting in Western civilization, Dally (1982) describes how mothering moved from an activity based on intuition and experience to one based on mental activity directed by experts. She suggests that industrialisation brought many changes that acted to isolate mothers from family and community. These included the separation of the place of paid work from the home. In this context mothers increasingly turned to the advice of professionals and experts for both child-bearing and child rearing.

By the 1920s, the concept of motherhood had changed from 'an intuitive endeavour ... into a professionally taught activity' (Sanson & Wise, 2001: 36). The 1920s-1930s saw the inception of State-provided child health services, which employed infant welfare sisters, paediatricians and the soon to be ascendant psychologists. Practices emerged from European theories of childhood development, for example, behaviourism (Watson, 1924; Skinner, 1953) and attachment (Bowlby, 1953). The popularity of these theories combined with social changes emanating from the women's movement, developments in labour laws and women's increasing participation in the workforce led to changes in the social value of children. Parenting had become a both a scientific and moral practice taught to parents by experts.

Yet despite this increasingly professionalised focus on 'parenting', we still know very little about the best approaches to helping parents with this most challenging of 'roles'. Indeed 'there is now a growing body of research which shows that our familiar assumptions about bringing up children are not always correct' (Joughin & Law, 2005). There is an increasing need for health policy and service delivery to focus on developing evidenced based understandings of how health professionals and interventions can effectively support families, particularly those with diverse linguistic and cultural backgrounds (Vimpani et al., 2002).

CHALLENGES IN CHILD HEALTH PRACTICE

In Australian culture, professional support, guidance and advice about parenting remains problematic, lodged as it often is within discourses of health care that specify what are and are not 'acceptable' parenting behaviours. At times the approach to advice giving is straight forward with information explicably detailed in the literature such as in the example of shaken baby syndrome (Moran, 2002). However at other times it is challenging when health professionals need to navigate differing cultural practices, politics and histories in deciding how and what information to share with parents. Infant sleep presents as a prime example.

From wherever information is drawn the authority of child health professionals' to speak on parenting matters is privileged within health care discourses. As such the information communicated by them is often promoted as the preferred and most beneficial way of parenting. That is, a definitive way of becoming a 'good' parent is promoted against which all other approaches to parenting are measured. When this authority underpins child health practice it is referred to as the 'expert' model (Davis et al., 2002).

Of key interest to this paper is how and what child health professionals communicate in order to support first time migrant parents as they incorporate 'new' cultural knowledge with their preexisting cultural background in order to feel that they have made 'right' decisions about their parenting practices. Using the example of infant sleep, in many cultures co-sleeping is seen as a natural, nurturing and protective practice for newborns. How does the health professional support a parent accustomed to co-sleeping, when the preferred practice in industrialised western culture is to place a baby in a cot in a separate room from the mother where they experience sleep as an independent activity? Co-sleeping is known to enhance infant maternal attachment, support infant survival and promote breastfeeding (McKenna, 1995; 1996; McKenna et al., 1997). However, in South Australia independent sleeping has long been promoted as preferred practice (Leeson, 1990). In October 2004, Child and Youth Health posted a web based information sheet for parents on 'sharing beds with babies' (CYH, 2004). This site uses current literature to discuss the benefits and challenges of safe co-sleeping. While this site marks a shift in the content and style of information provided for parents, it does not necessarily mark a concurrent change in universal service delivery to parents.

In making decisions on how to support parents through the maze of parenting and child health information child health professionals are also challenged by the 'expert' model of communication that historically underpins a medically modeled health care system. This approach 'does not take account of the centrality and extent of the parents' role, particularly in relation to problems of a psychosocial nature or where one is attempting to meet aims with a broader remit than simply solving immediate problems' (Davis et al., 2002: 48). The broader remit in this context is the negotiation of culture and the cultural self.

Using a culturally safe approach, the child health professional becomes aware of their own cultural assumptions. Using the example of sleep, these may include how they were parented; how they parent their own children, the prejudices of their family and friends, the historical context of parenting within a Western health care system, the influence of health care professionals and power differentials between health professionals and vulnerable migrant parents. Within this matrix, child health professionals clearly need to be aware of their 'cultural self' in developing strategies to support migrant parents during the transitions of parenthood.

MANAGING CULTURAL AND PARENTING TRANSITIONS

While navigating the choices of first time parenting, new arrivals to Australia are also dealing with the chaos of moving from all things familiar, and often from an environment of violence and political unrest. They are redefining their identity and that of their family. For immigrant parents the birth of their first child in a new country is laden with additional meanings. It often joyfully symbolizes the parents' first real claim to citizenship in their new country. These parents often have to resolve alone the cultural, practical and ideological conflicts of childbearing, parenting and employment soon after their arrival in Australia. It is usually a time when their English is poor and their familiarity with the Australian health care system is minimal (Rice, 1999).

Foss (1996) proposed a conceptual model of determinants of healthy parenting in immigrant populations which builds on original work by Belsky (1984). This model comprises personal or parental, infant and contextual determinants. The social and economic environment is described as part of contextual determinants to parenting. Access to health care services is a key part of the social and economic environment. In reviewing the literature Foss (1996) found that health care providers often do not understand how migrants express health related problems; or what various migrant groups expect from a health care provider; nor do migrants understand the health care system, or know how to communicate with health care providers.

There are a number of key issues for health professionals who seek to provide care and services for new migrant parents and families. Existing research primarily refers to the beliefs, practices and experiences of the migrant women themselves in order to gain a greater understanding of differing cultural practices. There is a lack of research that investigates how health professionals, particularly child health professionals understand themselves as cultural

beings and how they practice in a culturally safe way.

The Victorian Mothers in a New Country (MINC) study addressed issues such as immigrant women's experiences of postnatal hospital stay (Yelland et al., 1998), cultural and language issues in immigrant women's experiences of maternity care (Small et al., 1999), and immigrant women's views about care during labour and birth (Small et al., 2002). A key issue for health practitioners identified by migrant women were the unhelpful attitudes and behaviours of staff. Yelland et al. (1998) described a lack of assistance, even unfriendliness and rudeness. Small et al. (1999: 66) cited examples of women being 'scolded', ignored or shouted at'. Both report women feeling intimidated and coerced into practices that contradicted cultural practices they wished to observe. Similarly, a phenomenological study of Muslim women's experiences during perinatal care described how they felt disliked, had problems with communication, felt distrusting and suspicious of nurses due to their attitudes and insensitive care, but were reluctant to complain due to a need to 'fit in' (Vose & Thurecht 1999).

Bayly researched medical staff experiences of working with women from different cultural backgrounds and concluded that communication was more difficult across cultural boundaries and that 'these difficulties may contribute to a less favourable experience of care by women from different cultural backgrounds' (2000: 106). She suggested that both communication difficulties and negotiating conflicting values causes distress for doctors as they continually strive to overcome these issues.

Health professionals often have difficulty in communicating appropriately with migrants who do not have English fluency (Markovic, 2001). They may not understand the terms women use; worry about giving culturally inappropriate or unacceptable advice and feel they do not know enough about particular cultural groups, beliefs and practices. Poor communication remains the commonest cause of dissatisfaction with health services experienced by immigrants (Schott & Henley, 2004). These researchers suggest that this can lead to inappropriate treatment, to clients rejecting beneficial advice, or to their not accessing services.

A review of recent Australian research on women's health noted 'discriminatory practices amongst health professionals towards women who were not Anglo-Australian' (Blackford & Street, 2002: 666). It could be assumed that these discriminatory practices may arise from unconscious or unexamined aspects of practitioners' everyday interactions.

Two elements are repeatedly identified throughout the literature. These are problems of communication and problems with the way care is provided. Small et al. (1999) suggest time on cultural awareness programs may be better spent addressing quality of care issues and addressing barriers to communication. It has been argued that the current focus on awareness of cultural difference through cultural awareness programs is inappropriate. Staff training needs to move away from the study of women and cultural diversity towards caregivers, and specifically to addressing staff attitudes and the culture of care (Small et al., 2002). Values and attitudes are made visible through communication and care.

Values and attitudes formed throughout life shape our prejudices. While prejudices can be helpful in enabling us to make sense of situations they can also 'constrain understandings and limit the capacity to come to new or different ways of understanding' (Spence, 2004: 163). In recommending communication strategies for working with people from cultures other than one's own, Schott and Henley (2004) describe a double barrier of culture. The first barrier is our own culture. A picture of one's own culture includes prejudices coexisting with a range of assumptions, values and beliefs. In accordance with the tenets of cultural safety Schott and Henley state that 'only when we become aware of what in ourselves is cultural can we step outside our cultural constraints and care for other people in terms of their own needs' (2004: 13).

Examination of self

A primary role of child health professionals is to support parents. In order to provide specific and appropriate care, cultural frameworks that inform the selection and delivery of information to migrants need to be questioned. Foss suggested that public health nursing standards came from the nurses' 'personal values, interpretations of how the dominant culture defines 'good parenting,' and professional experiences with other frequently encountered cultural groups in their caseloads' (1996: 86). Similarly, Polaschek suggests that a nurse always operates 'from her/his own cultural mindset which influences how she/he relates to those she/he cares for' (1998: 453). While this makes sense, the challenge for health care professionals is to develop reflexive strategies for examining how their culture and cultural self informs professional practices so that they grow their cultural competence and capacity to advocate for all clients (Ramsden, 1995). Research with such a focus is rare in Australia.

In exploring the many professional approaches to the provision of culturally competent practice, this review highlighted the use of cultural safety. McMurray states that 'research studies that protect cultural safety are designed to recognize the unique, power laden, and culturally dyadic nature of health care relationships' (2004: 17). In featuring the need to explore practice in the areas of communicating with migrant families about parenting, this review recommends cultural safety as a valuable framework.

Summary

Culture shapes the way we parent and therefore who our children become. Australian child health professionals play an influential role in the culture of parenting. New parents in a new country are vulnerable to the dual challenges of parenting and cultural transition and it is essential that we better understand how the cultural self influences practice, and particularly the fundamental practice of communication. The key findings of this review demonstrate a need to shift the focus from cultural awareness training to one that prioritises the examination of culture and the cultural self. Specifically to explore how values, attitudes, and beliefs formulated in a social political and professional context shape how child health professionals communicate with parents experiencing parenting for the first time in a new cultural environment.

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