

Culture, Health and Parenting in Everyday Life

Dr Sharon Chalmers



SOUTH EASTERN SYDNEY
ILLAWARRA
NSW HEALTH



Culture, Health and Parenting in Everyday Life

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A UWS partnership project with:

**Sydney Children's Hospital (Randwick)
and
Multicultural Health Service, South Eastern Sydney &
Illawarra Area Health Service**

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2. Executive Summary

2.1 Culture, health and parenting in everyday life

This project was a partnership between Sydney Children's Hospital (SCH), Randwick, the Centre for Cultural Research (CCR), University of Western Sydney and The Multicultural Health Service (MHS), South East Sydney and Illawarra Area Health Service. The major aim of this research was to investigate the relationship between cultural diversity, parenting practices and the provision of health care services, in particular community-based health services.

The research is the second component of a previous collaboration with the same partners that culminated in the report *We All Come from Somewhere: Cultural Diversity at Sydney Children's Hospital* (2002). One of the major recurring themes in this initial project was how different family structures and ways of parenting can influence the relationships between health workers and parent/carers from culturally and linguistically diverse (CALD) backgrounds.

We invited parents/carers from the Arabic, Vietnamese and Chinese-speaking communities to participate in focus groups and individual interviews. According to the most recent information, these communities are three of the largest culturally diverse groups that access Sydney Children's Hospital. Child & Family Nurses that worked in Early Childhood Community Health Centres (SESIAHS) were also interviewed.

2.2 Summary of findings

2.2.1 *The cultural complexity of culture, health and parenting practices*

- i. Mainstream communities are multicultural. However, mainstream parenting practices are premised on Anglo-Australian values and ideals.
- ii. Length of time spent in Australia does not always equate with increased economic, social and cultural capital, particularly for women migrants.
- iii. The physical and mental health of all parents and children are inextricably linked to what is considered culturally familiar or 'common sense' understandings of what constitutes 'good' parenting.
- iv. Social, cultural and economic isolation is often experienced by new mothers who do not have access to familial or community support systems.
- v. Primary parents/carers often feel conflicted between the health care advice they receive from health professionals and advice from their own parents in relation to appropriate parenting practices.

- vi. Parenting practices change and are reinvented over time and place. This applies as much to Anglo-Australian customs as to any other cultural practices. While this seems rather obvious, there remains a propensity to categorise certain groups according to simplistic over-determined stereotypes.
- vii. The role of discipline and parental authority were closely connected. The majority of parents had adapted and accepted Australian disciplinary practices. However, there were also obvious misunderstandings about why and under what conditions mandatory reporting was required.
- viii. There is a tendency for women with children to stay within unhappy marriages because of the social stigma still attached to divorce.
- ix. Domestic violence and sexual abuse occur in all communities. Significant issues that impact on family well-being include religious beliefs, family hierarchies, disciplinary practices as well as the pressures resulting from dislocation and resettlement. Research also suggests that erroneous assumptions are made about certain ethno-specific communities that impact on institutional authorities' responses to calls for assistance by women from minority CALD communities (Adelman, Erez, & Shalhoub-Kevorkian, 2003). This claim may hold some validity as participants in this research reported that they were more likely to approach trusted friends than access professional advice for assistance when domestic violence or child abuse occurs. This is partly due to issues such as embarrassment and shame. When domestic violence was reported anecdotal evidence suggested that there was a lack of culturally competent follow-up procedures and few cross-cultural staff available.

2.2.2 Feelings of cultural and national 'belonging' impact on parents' sense of entitlement to health care services

- i. Some parents expressed concern about the differences between the values and practices with which they were raised and the apparent extreme freedoms that their children are growing up with in Australia.
- ii. All parents/carers felt their children should learn their parents' language before learning English.
- iii. There was some unease by parents as to how their children would be accepted into Anglo-Australian society and whether they could straddle the private-public cultural divide with minimal or no conflict. While they wanted their children to feel as though they 'belonged' in Australian society, they were also anxious that their children retain some of their parents' cultural values and practices for example to foster communication between grandchildren and grandparents.

- iv. Self-confidence for parents (and subsequently children) is to a large extent related to feelings of social inclusion and an affirmation of diverse parenting styles and values.

2.2.3 Health, social well-being and informal networks

- i. Religion, for many parents, played a significant and often inseparable role in their children's physical, social and moral well-being.
- ii. It was common for parents to turn to informal networks for health advice for their children.
- iii. Informal networking is vital for women and their children. This is particularly the case for those women who are not working and who spend most of their time at home with their children.
- iv. Ethno-specific early childhood playgroups and mothers' groups play a critical role in creating an opportunity for women and children to interact and socialise. Some mothers continue these friendships through more informal networks.

2.2.4 Where health care services and parenting converge

- i. Cultural competency is more than just a factor of language. An understanding of broader cultural values and practices is a significant component of effective health care interactions.
- ii. GPs were the preferred health care service provider for the majority of these parents. The main reason for this appears to be that all parents/carers and their children were able to access a GP who spoke their first language. Access to a health care service that was based on cultural and/or linguistic commonalities was a priority for most parents/carers.
- iii. Traditional Chinese and Vietnamese Medicines are commonly used in combination with Western Medicine. Parents/carers do not always reveal their use, or their children's use, of Traditional Chinese Medicines due to negative responses from Western-trained health practitioners. This results in a lack of trust and potential conflict in the provision of medical care.
- iv. Access and use of professional interpreters remains an ongoing issue for staff and parents/carers alike. For example, there are many accounts of staff 'making do' because of the inconvenience of arranging appointments.
- v. Children interpreting for adults, even in simple interactions, can place undue responsibility and pressure on the child who is in an inequitable and vulnerable position. There were also several accounts of husbands interpreting for their wives in the Early Childhood Community Health

Centres. While this was not encouraged by staff, it raises serious implications for the health and welfare of the women and children accessing these services.

- vi. Greater flexibility by Child & Family Nurses allows for better communication with parents. Compared to hospital-based nursing, Child & Family Nurses in the community have:
 - greater autonomy
 - less institutional support
 - fewer infrastructural resources
 - a more educative role

2.2.5 Parenting concerns about visiting hospitals

- i. Some participants were critical of the standard of care their children received at local hospitals in particular, and preferred access to children's hospitals where possible. Major criticisms of accessing hospitals included:
 - lengthy waiting times,
 - conflicting professional advice,
 - disparaging behaviour by hospital staff,
 - lack of private transport, and
 - inadequate interpreter services.
- ii. Parents/carers are hesitant to voice their concerns about the former issues for fear of less than optimal health care being provided for their children.
- iii. English language is a major barrier for parents/carers, particularly women, in their access to hospital and community health services.

2.2.6 Issues specific to Early Childhood Community Health Centres and Child & Family Nurses

- i. The majority of Child & Family Nurses were extremely good communicators, although this does not necessarily translate into adequate cross-cultural competency skills.
- ii. There was a perception by a number of Child & Family Nurses that the physical health of the child and mother were separate from the social and cultural well-being of the family. They considered issues of religion, cultural background, migration and settlement experiences, diverse parenting practices and values outside of their professional expertise are peripheral to the health encounter.
- iii. Outreach to parents from CALD backgrounds who do not access the community health clinics is minimal. It was reported that many women from both high and low socioeconomic groups often suffer from extreme isolation and there is a need to engage with these families.

- iv. There is minimal and often difficult access to training and education about diverse parenting and health practices for community-based health staff. The lack of training, for instance, can impede on community nurses' skills to implement culturally competent health care practices. In addition, the lack of adequate technology in community centres also impacts on the provision of relevant health care information for both clients and staff.

2.3 Recommendations

1. Diverse post-natal cultural practices are not encouraged by hospital staff. Hospital policies need to account for diverse post-natal parenting practices, with support from management in helping staff develop their openness and flexibility toward allowing, but also encouraging, diverse practices to be maintained. For example, an alternative to staff telling Chinese and Vietnamese women to bring in their own thermoses is for hospitals to provide free access to them and to provide hot water as an alternative to ice water.
2. A curiosity and interest in diverse cultural practices is not equivalent to an invasion of privacy. A parent from a CALD background is more likely to appreciate the attention given to them. At the same time, clients are under no obligation to respond. The emphasis needs to be placed on the style that is employed to gain information. This includes an understanding by both staff and parents/carers about why cultural issues may be pertinent to the health encounter.
3. The concept of 'family' is still generally conceptualised as a child and two parents (mother and father). However, there is a significant increase in the number of grandparents, relatives, single parents and divorced people who are becoming primary carers. These carers require additional assistance and informal and formal support mechanisms to maintain the health and social well-being of the 'family' concerned. Finding out the structure of a family and its primary caregivers needs to be established in order for relevant and appropriate family support to be offered. Part of this support rests on health professionals' ability to have access to government and non-government networks and the resources available to coordinate across a range of services.
4. Children often take on multiple roles to assist their parents who are unfamiliar with bureaucracies, such as the health and education systems. This can destabilise family structures and place children under due stress. For example, the use of children as interpreters for their parents is poor practice and health staff need to understand the ramifications for the family and the child. This can only be achieved with the full support of management providing resources to health staff so that they are not

dependent on children to act as health service resources. The same applies to friends and family who interpret on behalf of parents either in hospitals or community health settings.

5. There is a great need for increased communication about the context under which guidelines and laws that cover the level of discipline appropriate for children and young people have emerged. This involves *two* strategies:
 - i. Telling parents who are used to handing out discipline according to their own, rather than state guiding, principles that they are 'wrong' is likely to be counterproductive. Parents/carers are more likely to respond positively if they understand why it is better for them and the child if they change what are considered to be harsh practices, rather than inciting feelings of individual or collective demonisation. To achieve sustainability, this guidance needs to take place in a non-threatening environment and should not be reduced to broad assumptions about any particular ethnicities. This can occur through both formal networks (for example, ethno-specific triple-P parenting classes) as well as the dissemination of parenting information throughout informal networks such as migrant resource centres, shopping centres, as well as places of employment.
 - ii. Health staff need to be aware that different parenting practices especially in relation to children's discipline cannot be reduced to 'bad' parenting. Therefore, staff require cross-cultural training in order to acquire the skills needed for engagement with parents/carers and to direct them towards culturally sensitive advice and training. At the same time, health staff also need to be able to distinguish between what are 'harmful' and simply different parenting practices.

Both the above strategies involve proactive outreach measures by Sydney Children's Hospital in concert with Early Childhood Community Health Centres.

6. Given that all parents clearly preferred to access GPs that spoke their first language, there seems to be a solid case for a stronger alliance between specific hospitals and GPs in their local area. The dissemination of information that can link isolated parents and children to both formal and informal networks that increase their capacity to access healthy outcomes can make a positive contribution to sustaining children's long term health and social well-being.
7. There is a need for more cross-cultural domestic violence workers/counsellors to match the fact that domestic violence is now subject to mandatory reporting. There are two major issues involved. The first is the ability of health professionals to reach those women from CALD backgrounds who are subjected to domestic violence. The second is to make sure women and children are safe and subsequently engage with the

family to develop a future plan in which family members do not live in a state of fear. Outreach services need to be extended within ethno-specific communities and culturally appropriate strategies implemented to educate all communities on the unacceptability of domestic violence and child abuse.

8. GPs and health staff in hospitals and community centres need more information and training around the efficacy and use of Traditional Chinese/Vietnamese Medicines (TCMs) among parents/carers and their children. The usage of TCMs is significant with parents/carers of Chinese and Vietnamese backgrounds and so it is incumbent on health professionals to find out the degree of usage and whether there are contraindications to their use. Health professionals, like others in the community, hold differing opinions regarding the usage of TCMs, however their personal views need to be peripheral to the health encounter in order for clients to trust their health professional and to therefore disclose all relevant information. This is an important safety issue.
9. The continuation of bad practices in the use of interpreter services needs to be addressed. Suggestions to improve interpreter usage include:
 - increased networking with local GPs to advise them on the advantages of using, and encourage them to use, professional phone interpreters rather than relying on family members or friends because of convenience, and.
 - to introduce a regular team of interpreters located within Sydney Children's Hospital to work with the major language groups, that is, the training and coordination of industry-specific interpreters who are highly skilled in several areas of paediatric interpreting. These workers can also play a significant role as 'cross-cultural brokers' who can work between the hospital and community organisations in facilitating culturally appropriate after-hospital care when necessary.
10. Child & Family Nurses in community health centres need increased support and opportunities to further develop their skills in cross-cultural competency. At present, there are structural limitations on them attending training sessions that need to be addressed.
11. Most Early Childhood Community Health Centres in this region do not have computers. The lack of what today is considered a basic communication system impacts severely on the ability of staff to collect and disseminate up-to-date information and statistics as well as being extremely time-consuming. It also affects staff's access to on-the-spot cross-cultural and ethno-specific information that can link both themselves and their clients to relevant resources existing within and outside of the health sector.

12. All the above recommendations (in combination with those from the previous research project *We All Come from Somewhere: Cultural Diversity at Sydney Children's Hospital*) point towards the integral role that Sydney Children's Hospital could play as a leader in developing an overall Diversity Health Care strategy in paediatric care. This would involve a long-term commitment to the development of a comprehensive plan that could include but not necessarily be limited to:

- increased outreach services that link informal and formal services. This might be achieved by researching existing potential community-based entry points and integrating community resources that health services have not necessarily used in the past. This can assist in creating a level of trust within communities so that women and children feel less isolated and more secure in coming forward when they need particular services,
- the initiation of cross-cultural competency skills for both hospital and community-based children's health service staff. This training must be tailored to different staff needs,
- in-hospital based interpreter/cross-cultural brokers,
- up-to-date resources and institutional support for Early Childhood Community Health Centres,
- providing women, in particular, with access to English classes so that they can increase their capacity to respond to their children's needs as parents/carers rather than being dependent on their children to navigate them through complex systems,
- as Australia increases its intake of refugees, particularly of women and children, there will be a greater need for health professionals to understand the complexity of refugee and migrant experiences. Health staff need to be trained and competent in meeting these challenges on a practical level in their daily encounters with 'difference'. What we do know is that our understandings of 'culture', 'health' and 'parenting' all impact on the way parents access the health care system today and will inevitably affect how their children respond to their health care, and their own children's health care, in the future.

3. Overview and background of study

3.1 Aims of study

The major objectives of this research are:

1. To identify the mismatches between service provision and culturally diverse parenting practices at Early Childhood Community Health Centres operating in conjunction with Sydney Children's Hospital.
2. To produce original Australian evidence-based research on culturally diverse parenting practices that will inform both clinical practice and guide the development of diversity education programs.
3. To increase the paediatric health sector's understanding of how diverse parenting practices impact on every day health care and social well-being.

3.2 Overview of current research

The proposed project is a continuation of the research undertaken in partnership with the Multicultural Health Service (MHS, South East Sydney and Illawarra Area Health Service), Sydney Children's Hospital (SCH) Randwick, and the Centre for Cultural Research (CCR) University of Western Sydney (UWS) in 2001–02. In the previous study, *We All Come from Somewhere: Cultural Diversity at Sydney Children's Hospital* (Chalmers & Allon, 2002), a qualitative and quantitative research project was undertaken to identify and examine a range of issues that were important to parents and carers of children from culturally and linguistically diverse (CALD) backgrounds. The ways in which hospital staff responded to other cultural dimensions of their work lives and how these affected their engagement with a heterogeneous population within a large and complex hospital system were also explored.

Based on this initial work, it was recognised that one area which has the significant potential to create conflict or to present 'cultural mismatches' is that of culturally diverse parenting practices. Issues surrounding who is deemed to be the culturally appropriate adult(s) in the family to look after a child, how specific religious and cultural practices influence the intersection of parenting and health practices as well as potential and actual resistance to Western medical models were recurring themes. Other issues that emerged from this initial study included misinformation, inappropriate or incorrect assumptions about the quality of parenting and instances of miscommunication based on linguistic, and cultural and religious differences, which potentially cause stress and friction among staff, parents and children alike. In the long term, these mismatches negatively impact on access and equity to quality health care, a situation in which parents, children and staff are all disadvantaged.

4. Multidimensional approach to health care

As a result of the initial project, we continue to throw the research spotlight on children/young people and their families from culturally and linguistically diverse (CALD) backgrounds. However, in this report we shift the focus slightly to investigate the broader cultural context in which parenting occurs and its relationship to health care and social well-being. This means that the current research not only centres on the interactions between hospitals and parents/carers but also places an emphasis on early childhood community health care work and the ways different cultural contexts affect the daily parenting/health 'habitus' (Bourdieu, 1995: 6), or 'the minutiae of every-day life' (Sims & Omaji, 1999: 87). Through an understanding of the physical and mental needs of parents/carers within the context of their local communities (which includes their access and usage of health services), their capacity to nurture, protect and communicate with their children increases. This maximises their children's ability to participate within a healthy social environment.

A range of qualitative modes of inquiry were employed. These included:

1. placing research subjects (parents/carers and health staff) into real world contexts, ie exploring how their daily experiences impact on their respective understandings and representations of parenting and health care encounters for both themselves and their children,
2. collecting and analysing empirical information in order to interpret the complex interactions of research subjects against the backdrop of differing cultures,
3. juxtaposing the empirical local material with an international literature review in order to understand both the general and specific dimensions of the collected data,
4. incorporating a multi-method approach which adds a 'richness and depth' to the collected material (Denzin & Lincoln, 2000: 6).

4.1 'Ethnicity' as a strategic social marker

The use of the term 'ethnicity' as a shorthand for 'culture' has become common practice in Australian political parlance in recent years (Omeri, 2004: 184). However, the term 'ethnicity' within this research needs to be understood as a strategic marker rather than as a one-dimensional, fixed or stable identity (McEvoy et al., 2005). Yet what is generally overlooked is that issues of ethnicity are not the sole domain of non-Anglo-Australians, nor are they the sole concern of people from non-English speaking backgrounds. The fact that most Anglo-Australians do not list ethnicity as an identifier through which they mediate their social, economic, cultural and political subjectivity does not mean it is not central to their place in the world (Weston, 1996: 3). Consequently, how one uses the often interrelated concepts of culture and ethnicity presents a particular difficulty, especially — as Morrissey (1997) argues — where the implementation of health service provisions are concerned. Morrissey asserts that presuming an implicit

causal relationship between ethnicity and culture leads to several erroneous assumptions including that:

1. migration and settlement experiences do not impact on the new status of recently arrived migrants,
2. the culture in one's country of origin is static and unchanging, and
3. references to ethno-specific practices tend to emphasise the traditional rather than the natural dynamism of cultural forms (Barclay & Kent, 1998; Morrissey, 1997).

4.2 Intercultural interactions

The three foci of this study — 'culture', 'health' and 'parenting' — are all complex and highly contested concepts that are open for debate. The aim of this work is to question these seemingly self-evidentiary concepts. On the one hand, the goal is to increase the awareness of health professionals to the inherent intercultural dialogues that they enter on a daily basis. On the other hand, intercultural dialogues (in whatever context) need to legitimise the differences, contradictions and conflicts that emerge for parents who, like health professionals, are drawing on cultural rules to guide them in the shaping of their children's health, development and well-being. Cultural mismatches can arise over different understandings of what are deemed 'good', 'normal' or 'common sense' behaviours and attitudes, given that the concept of a 'good child' or 'good parent' is not a universal known but a culturally and historically specific notion (Airhihenbuwa, 1995). How these factors manifest is the focus of this study.

What is not in dispute is that all stakeholders — health professionals and parents alike — have the well-being of their children as the utmost priority. How to define children's well-being is central to this report, and we adopt the Australian Institute of Health & Welfare's (2004: 2) definition that not only refers to the present health care experiences of children and young people but just as importantly how their access and use of health services today will affect their future well-being. We expand our analysis of 'children's health care' to include — but not rely solely — on the experiences of their specific health encounters. That is, we take a longer term and more complex approach that includes the significant role that family environment, social interaction and education plays on children's long-term health outcomes (ibid).

4.3 The complexity of intercultural dialogues

At the core of any health encounter is the issue of finding a common language in which to communicate as those outside of the health profession often struggle with the terminology, and the subsequent assumptions, that underpin Western health care norms (L. Barnes, Plotnikoff, Fox, & Pendleton, 2000; Ulrey & Amason, 2001). However, while there has been an increasing amount of literature drawing attention to the cultural construction of both social and

professional practices, there still remains an overwhelming tendency to dismiss the effect that different forms of cultural knowledge have on the way health staff present, and consumers receive and use, health care information and services.

One of the major barriers in the access and use of health care for people from CALD backgrounds is the general issue pertaining to 'perceptions of illness, health-care seeking behaviour, and response to treatment' (Cartledge, Rea, & Simmons-Reed, 2002: 117; Hernandez & Charney, 1998: 9). Specifically in relation to children's health care, research suggests that diverse parenting styles and their underlying values are considered less valid than Anglo-Australian parenting approaches (National Initiative for Children's Healthcare Quality, 2005). Indeed, the rules surrounding Anglo-Australian parenting practices are invisible or assumed as 'known' and 'knowable'. The result is that, when miscommunication occurs and the trust factor central to any positive health encounter breaks down (Vose & Thurecht, 1999: 43-4), both staff and parents tend to fall back into their respective, and oftentimes defensive, familiar terrains.

5. Methodology

5.1 Location of research

The location of the research can be mapped on two major sites. The project was located in a broad sense within an Australian context. While there has been some overseas research undertaken on the relationship of culture, health and parenting, there is a dearth of information relating specifically to the Australian context. Different issues arising within the Australian situation are not necessarily interchangeable with international experiences. Factors such as immigration policies (historical and contemporary), settlement practices, and domestic social, economic and political policies — including the structure of the Australian health care system — all impact on how we have come to understand multicultural Australia. In light of these historical specificities, this project aims to extend our knowledge and contribute to our understanding of the everyday issues that parents/carers, children and young people from CALD backgrounds face when accessing and using health services within the urban Australian environment.

The second location is the particular geographical area in which the research was undertaken, that is South Eastern Sydney & Illawarra Area Health Service, incorporating Botany, Hurstville, Kogarah, Randwick, Rockdale, Sutherland, Waverley, Woollahra, South Sydney (part), Sydney (part) and Lord Howe Island, Botany and Rockdale local government areas (LGAs).¹ The focus groups were held in various locations including churches, a mosque, migrant resource centres and Early Childhood Community Health Centres (ECCHC). Individual interviews took place in private homes, community meeting rooms and coffee shops: the place of interview being chosen by the participant. Two interviews were undertaken by phone, one using an interpreter.

The research did not incorporate Sydney Children's Hospital as an isolated health care site as previous research had been specifically located at the hospital (Chalmers & Allon, 2002). Rather, the staff component of the research shifted to the Early Childhood Community Health Centres (ECCHCs), which are under the jurisdiction of the Sydney Children's Hospital. The ECCHCs were all located within SESIAHS and included a range of socioeconomic areas from the more affluent Eastern suburbs to the housing commission areas in various southern sections.

5.2 Demographic information for SESIAHS

According to the 2001 National Census, nearly 30 per cent of Sydney's population are first generation migrants while another 28 per cent are second generation migrants (Australian Bureau of Statistics, 2001). The former SESAHS

¹ On January 1, 2005 the Illawarra Area Health Service and South Eastern Sydney Area Health Service were amalgamated into a single entity, the South Eastern Sydney and Illawarra Area Health Service (SESAHS). This report will generally use the new amalgamated regional category SESIAHS with the understanding that the Illawarra area was not included in the collection of data.

LGAs have the highest proportions of non-English speaking populations, at about 35 per cent. Historically, young children have been one of the major users of health services in this area, the other being older persons. South East Health has a slightly higher number of people born overseas (30.96 per cent) than the NSW average (23.27 per cent) and 25.62 per cent of the South East Health population spoke a language other than English (LOTE) at home (Australian Bureau of Statistics, 2001).² Manderson and Allotey (2003) assert that the uptake of screening and preventative health care services among Australia's non-English speaking populations is lower than the general Australian population.

There have also been substantial population, linguistic and economic shifts throughout this region over the past 20 years and it is important that these changes be reflected in the health policies within these areas. One Child & Family Nurse (CFN) working in the southern section observed that there were only a handful of Chinese families 20 years ago while they now constitute the major non-English speaking background (NESB) language group. Furthermore, within this broad language group identified as 'Chinese-speaking', there are several subgroups which speak a variety of Chinese languages/dialects and who come from wide ranging countries and regions.

In addition, the CFN also pointed to the increasing number of women accessing her clinic who are of an Arabic-language background and whose children's children are becoming proficient in English. Intergenerational demographic changes impact on the local area's need for health services for both children and adults. Mention was also made of the changing socioeconomic face of various areas, for example, Western Sydney which has long held the reputation of being a 'working class' region with large pockets of high unemployment. While this portrayal has always been exaggerated, pockets of known 'poorer' suburbs are themselves seeing what one nurse referred to as the emergence of upper, young, Eastern suburbs professionals into these areas, having been squeezed out of the inner-city housing market due to inflated house prices.

5.3 Timing of research

The majority of the interviews were undertaken from March through to December 2004. The research was divided into three sections: parent focus groups, individual parent interviews and individual³ staff interviews. While parent focus groups were undertaken prior to the individual interviews, staff interviews were carried out as the opportunities presented themselves throughout the period of the project.

² Cantonese (1.3 per cent), Arabic (1.2 per cent) and Vietnamese (1 per cent) are the 3rd, 4th and 5th largest language groups in Australia respectively.

<http://www.abs.gov.au/Ausstats/abs@.nsf/0/DFD8C90C1A541EFECA256F720083300A?Open>.

³ In one case the researcher interviewed two Child & Family Health nurses together.

5.4 The participants

The study focused on the Chinese, Vietnamese and Arabic-speaking populations as they constitute the three major non-English speaking language groups that access Sydney Children's Hospital at Randwick.

Research participants varied in age, ethnic identification, gender, sexuality, modes of migration, settlement experiences, family structures, socioeconomic status, pre- and post-migration education and employment experience, caregiving situation, English ability, country of origin, religious identification and affiliations, place of residence, and country and region of origin. In the past, little attention had been given to the different historical circumstances existing in relation to different waves of migration (Lillie-Blanton & Hoffman, 1995: 2; O'Callaghan, 2000: 324-25), for example, the Vietnamese migratory experience into Australia. Up until the early 1990s, the majority of Vietnamese migrants entered Australia via refugee camps while later arrivals migrated under different circumstances. In every health encounter, it may be more or less significant to place children and their families within a cultural context that gives legitimacy to the diversity of their histories, and consequently how they respond to the health care system (Kolar & Soriano, 2000: 12-17).

Ethics approval was sought and approved from the University of Western Sydney (UWS) and South East Sydney Area Health Service. Consent forms and information sheets were translated in the three languages in addition to an English language version. Interpreters were used within all the focus groups as well as several individual interviews. Interpreters were made available through the NSW Health Interpreter Service.

1. *Parent/carer focus groups*

Several parent focus groups were undertaken within each of the language groups. A total of eight focus groups were carried out with approximately 60 people participating. The focus groups preceded the individual interviews as we recruited participants from the focus groups to take part in the in-depth individual interviews. The focus groups were also an opportunity to develop further themes for the later in-depth interviews. The focus groups were carried out in several locations within SESIAHS.

Table 1: Focus groups

Language group	Subgroup	Location
Arabic-speaking	Muslim	Lakemba (1)
	Coptic Christian	Bexley (2)
		Arncliffe (1)
Chinese-speaking	Mandarin	Pagewood (1)
	Cantonese	Hurstville (1)
Vietnamese-speaking		Canley Vale (2)

The aim of the focus groups was to take a momentary glance at a small group of linguistic-specific populations that may not be so easily accessible in the attempt to find out about general sociocultural understandings of norms and practices. Focus groups also add another dimension to individual interviews and complement our understanding of everyday social life (Prior et al. 2000:819).

Individual parent interviews

The number of people who participated in the individual interviews totalled 15: five Arabic-speaking, five Vietnamese-speaking and five Chinese-speaking participants. Professional interpreters assisted in five of the interviews.

Table 2: Individual interviews

Name	Country of birth	Age	Gender	No. of children	Length of time in Australia	Visa status on entry
Margaret	PRC	20-30	Female	2	9 years	Skilled migrant
Amal	Egypt	30-40	Female	3	12 years	Spousal visa
Shun-Hing	Hong Kong	20-30	Female	2	n.d.*	Tourist
Wedad	Egypt	40-50	Female	4	14	Family reunion
Kit-Ling	PRC	20-30	Female	2	12 years	n.d.
Violet	PRC	20-30	Female	1	10 years	Family reunion
Yen Ha	Vietnam	40-50	Female	4	24 years	Refugee
Frances	PRC	20-30	Female	1	9 years	Skilled migrant
Najla	Lebanon	40-50	Female	3	30 years	Spousal visa
Cuong	Vietnam	30-40	Male	1	13 years	Refugee
Nguyen	Vietnam	40-50	Female	1	25 years	Refugee
Nhu	Vietnam	40-50	Female	3	24 years	Refugee
Amina	Lebanon	40-50	Female	4	26 years	Spousal visa
Sara	Egypt	30-40	Female	3	10 years	Spousal visa
Kim Anh	Vietnam	40-50	Female	2	20 years	Refugee

*n.d. = not disclosed

2. Child & Family Nurse interviews

All interviews with community health staff were undertaken at their workplaces. With the exception of one interview with two staff members, all interviews occurred individually. In total, 12 staff members (11 Child & Family Nurses and one primary school-based nurse) were interviewed. Staff also came from a

diversity of cultural and religious backgrounds covering three continents. Given the small number of staff involved, care has been taken not to attach individual statements to any one specific health worker or clinic.

The recruitment methods and locations of the parent/carer focus groups (and the subsequent individual interviews) as well as the staff interviews reveal the interests and particular biases of the various groups accessed. That is, meeting in a mosque or church signified that religion tended to be a significant influence within those parents' social lives. Similarly, those attending ethno-specific mothers' groups were obviously aware of, and partook of, these services. And finally, the interviews conducted with Child & Family Nurses likewise centred on the very early health needs of babies and their parents, particularly mothers. While not diminishing from the depth of the information collected, it is important to highlight that, given the interview recruitment methods, certain issues such as the role of religion in health care decisions and social well-being may be more significant than in other interview contexts.

Research Findings

6. The cultural complexity of culture, health and parenting

6.1 The early days of parenting

Across the three language groups, several commonalities arose when discussing the difficulties experienced in the first couple of years of taking care of a newborn baby. They included:

- lack of assistance by male partners, who are often working extremely long hours,
- communication issues: linguistic and cultural,
- acceptance of a strict gender division of labour,
- cost and cultural relevance of child care ,
- limited transport options — most women did not have access to their own cars and travelling on public transport is time-consuming and difficult especially when they are caring for more than one young child,
- visa applications are not always confirmed and there is uncertainty about future residency status,
- exhaustion,
- cessation of employment which had largely defined their sense of worth,
- all of the above, which can lead to new mothers feeling extremely isolated.

Within the following narratives, it becomes apparent that the above factors rarely, if ever, express themselves as mutually exclusive but rather are experienced as multidimensional. Women who had been associated with or experienced giving birth in their country of origin noted that there were significant differences between the Australian maternal and child care system and the cultural practices with which they had grown up. Within the Vietnamese focus groups, for example, there was substantial discussion about the customs that came into play after a child was born. These covered practices dealing with how to take care of the baby, the mother's health and her ablutions during the first month as well as appropriate food for both the mother and baby.

Outside of basic caring for the baby, for both mothers and community nurses there was a strong concern about the social and economic factors that produced feelings of extreme isolation. For some mothers and most nurses, this was described as 'post-natal depression', while for other mothers this term had no meaning or was rejected as being too simplistic.

Frances did express her feelings as post-natal depression. Her husband was working six days a week, 12 hours a day, and two months after giving birth he had to return to China to organise his permanent visa. This took a process of seven months. Frances felt particularly isolated and alone during this period without her partner or other close family members:

Yes, I was really very angry ... especially when you are suffering from post-natal depression and I was desperate, grieving that no-one is here to look after me. ... My husband only took one day off after the labour. I had to feed the baby every two to three hours. ... From day one, since the labour, since I gave birth, I have had to manage everything by myself. (Frances – Chinese background)

Frances was faced with the prospect of bringing up her child alone during this period. She attempted to contact a social worker but explained that because of her exhaustion she didn't follow up with the information provided. Despite her husband's relatives living on the other side of the city, without her own transport it felt too far to travel. Her husband's relatives were also working extremely long hours and had little time to assist her except for phoning occasionally.

In contrast, some women did not understand or relate to having their feelings pathologised. Rather, the very connection between depression and mental illness was both alien and potentially harmful (Barclay & Kent, 1998). In some cases, a medicalised language or the construction of collective feelings that create a broad sociocultural concept does not necessarily translate or evoke the same connotations across diverse cultural contexts (Cohen, Moran-Ellis, & Smaje, 1999; Kolar & Soriano, 2000: 17).

One woman from an Arabic-speaking background felt very isolated because her mother was not around to support her after giving birth. While her husband's family lived close by, her mother-in-law was constantly telling her what to do. On visiting an ECCHC she was told she had 'post-natal depression'. She balked at the term 'depression' and argued that her feelings were based on the fact that she couldn't live up to her mother-in-law's definition of what it meant to be a 'good mother'. While it is often thought by having extended family support that less stress is placed on new mothers, the opposite can also apply. By pathologising her feelings within medicalised terminology, she felt undermined by both the nurses and her family.

Parenting practices and values about who should be involved in the upbringing of children are fluid and there is significant diversity within as well as across CALD populations (Kolar & Soriano, 2000: 6). These include differences in social class, education, gender roles and employment opportunities — all of which can influence parenting behaviours.

Sara was previously a high school teacher in Cairo (Egypt) but her qualifications were not recognised in Australia. After having her first baby she felt quite depressed. For Sara, her isolation was initially caused by her loss of employment but was then compounded by the birth of her children and staying at home to care for them:

It was really difficult for me to stay at home with baby — no friends, no work, because I used to work every day in Cairo. (Sara – Egyptian background)

Sara was advised to spend one month in hospital before the birth of her first child because her doctor wanted to monitor her. Her husband was employed in shift work and she didn't have any other support:

I felt so bad, my husband was working and I have no family and no friends. I'd been reading books until I settled, because it was my first child and you don't know what's going on. You haven't got parents and sometimes they [staff] say, 'you may lose it' ... and every time I asked when I would have the baby, they'd say maybe I have it today, maybe I have it tomorrow, maybe I have it after three weeks. (Sara – Egyptian background)

She proceeded to explain that she was given access to interpreters but only when a medical decision had to be made and then for only ten minutes at a time which she says was inadequate. Moreover, most of the interpreters she encountered were Lebanese and not Egyptian, thus finding their accents difficult to understand. The issue of loss of employment was particularly noticeable among the Egyptian women interviewed:

I have three boys. I am from Egypt. And when I came 11 years ago I felt like I could do many things, some work or even study at university, but I didn't have a chance. As soon as I came here, I was pregnant. Taking care of my boys is not a waste of time but sometimes I feel like I'm tied at home. Doing everything, but nothing for myself. (Focus group participant – Egyptian background)

This woman was studying for a Masters degree prior to coming to Australia but had to leave Egypt before completion because their departure was based on her husband's needs. Overwhelmingly it is men who make the decision to migrate, leaving women to pick up their lives and follow. The consequence for these women is that they usually do not have the support of extended family, they tend to be more isolated because of their new roles as primary caregivers and, by default, become the conveyors of cultural values and practices (Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002: 753). This often results in women having less interaction with mainstream communities by way of employment or education opportunities, including access to improving their English language proficiency.

Competing advice from parents, health professionals and friends can also place stress on new mothers. Violet explained that she receives a lot of advice from her parents and parents-in-law in relation to what to eat and do after giving birth:

Actually they've told me everything. When I was pregnant, they told me what sort of food to eat. They asked me not to eat too much outside quick-service food, like fast food and stuff. ... And don't eat too much hot chilli and sour things. And don't drink too much cold things. A lot of things I can't eat. And we always listen to what they say, and we try to be good girls. (Violet – Chinese background)

However, in contrast to the above apparent respect for her elders' advice, Violet went on to say that if she disagrees with something she has been told to do, she will listen and then does what she thinks is right. Yet when she does disagree, she is surreptitious so as not to hurt her parents' feelings or to show disrespect towards their experience and expertise. For example, it is usual in China not to shower for one month after giving birth. Violet, while seemingly acquiescing to this practice, in fact waits for a time when she is alone and then proceeds to shower.

In contrast, a few mothers from Vietnamese and Chinese backgrounds commented that, despite their better judgement, they were strongly encouraged to have a shower after giving birth. Shun-Hing explains the differences between post-natal care in hospitals in Hong Kong and Australia:

I know that for a woman who's just had a baby, the diet would be quite different and in Hong Kong you're not supposed to have a shower immediately after the birth. You are not supposed to have an electric fan, no wind whatsoever. You are not allowed to drink icy water and you're not allowed to wash your hair either. But here they do something completely different. ... Here in the hospital when I just had my baby, they asked me to go and have a shower and I said, 'okay', but I didn't go to have a shower. I just patted with a wet cloth to clean myself and I didn't wash my hair, but as for the electric fan, there's not much I can do. ... But as for the icy water, of course I didn't drink it, I asked my family to bring me a thermos with hot water, and they also brought me some Chinese food. (Shun-Hing – Chinese background)

A (Chinese) Child & Family Nurse explained that women should be prepared for the nurses to offer them cold drinks and food. She advises them:

Whenever I give classes I say, 'now when you go to a labour ward, the first thing they give you is an iced jug of cold water'. And they [the women] say, 'oh no!' and everybody shrinks at the idea. So I say, 'if you want warm water, you just bring your own flask and ask them to top up your jug with hot water'. (Child & Family Nurse)

It was also very common across the three language groups to find that, where possible, relatives would bring in food that fitted in with their ethno-specific tastes, or religious and/or cultural post-natal dietary customs. This practice is consistent with previous studies undertaken in Australia and overseas (Barclay & Kent, 1998: 5; Chalmers & Batool, 2006; Morrissey, 1997).

These differences in post-natal care were further elaborated on by a Chinese grandfather whose daughter had recently given birth at the Royal Hospital for Women. He noticed that the temperature in the delivery room and wards was quite cool and showed some concern:

You see, people like me were born in the 1930s. In our time, when you were giving birth to a baby you had to be really careful — never get a cold. In China we are more careful with post-natal care. We think you should not catch cold or get any illness. I saw a woman having a shower, there's some mothers even barefoot on the floor,

they're walking about and doing everything. And I think they should be careful that they don't catch a cold. It's quite different from Chinese culture. We are very cautious and careful. (Focus group participant – Chinese background)

A grandmother continued the explanation:

After giving birth to a baby, of course the body is very weak so it's important to take care not to catch a cold. Of course hygiene is important ... if you open the windows you've got to be careful not to directly face the wind. (Focus group participant – Chinese background)

Some Vietnamese parents related that they have been taught that there are various rubs that can be used on their babies to keep them warm or to cleanse their skin. These, however, are not always condoned by the doctors. This apparently does not discourage their use, but rather prevents parents/carers from admitting to the practice, which can lead to tension between the health professional, the parents and the grandparents. For the parent who is trying to do the right thing for their child, they are caught between two competing systems, although — interestingly — both the grandparents and the doctors call on respect, experience and skill to convince (sometimes browbeat) new mothers (particularly first-time mothers) to follow their respective health regimes.

Yen Ha's family arrived in Australia as refugees from Vietnam via Malaysia and she has been here for over 20 years. Her first two children are 26 and 22 years of age while the latter two are eight and six years old. The reason for the gaps in ages is that, once they arrived in Australia, Yen Ha and her partner had to work seven days a week to establish their new lives. Her first son was born in Vietnam and she describes the differences:

When we've just had a baby in Vietnam then we have to rest. We can't get off the bed because the thinking is that it's not good for our health when we get older. Also, after seven days in the hospital, when I got home, when I stepped on the floor I fell down because I'd just been lying down on the bed and not doing any walking, so I felt weak. Also in Vietnam, after a baby we can't have a shower. We can't wash our hair, we only get a towel to clean — that's all. Because in Vietnam it's hot weather, I had head lice as I didn't wash my hair. (Yen Ha – Vietnamese background)

After having her first baby in Australia, Yen Ha did not want to shower afterwards but she followed the nurses' instructions: 'I preferred not to, but I feel like I have to follow them. I don't want to make them cranky, even though I don't like it'.

Amal was three months pregnant when she arrived in Australia and she has had all three of her children in local hospitals. Amal was hesitant in explaining the feelings she experienced when having her children:

I feel like most of the midwives, when they see an Arab, they're not happy. They like the Aussie people. I shared a room with four ladies, they were all Australian. She [the midwife] was happy with them, she wasn't happy with me. Maybe it's not general,

maybe it's just one nurse, one midwife, but I want people to understand that the Arab people, we're not all the same. When I go anywhere, I don't like anyone to deal with me as an Arab, I am a Christian Coptic Orthodox person. In hospital they looked at my visitors as though they wanted to them to go away quickly and not to talk in loud voices and there shouldn't be children in the room. (Amal – Egyptian background)

Amal makes the distinction between herself and other 'Arabs' and it becomes clear that when she is referring to 'bad' Arabs she is in fact talking about Muslim-Arabs. Her antipathy is somewhat explained by her experience as a Coptic Christian in Egypt as she went on to describe widespread discrimination against Christians and its impact on education, employment and religious freedom. Amal has held on to this antagonism towards Muslims and constantly distinguishes herself as separate from 'them'. Her discomfort at being seen as the same as Muslim-Egyptians is obviously even more important to her since the events of 9/11 and the subsequent barrage of negative representations and harassment of people from Middle Eastern backgrounds (Dreher, 2005).

Thus, from the very beginning of parenting, factors such as one's past and present cultural experiences, ideas around what constitutes 'traditional practices', changing gender and familial roles as well as the level of formal and informal supports all affect the ability of a parent to care for their new child.

6.2 The role of parental values in children's health and social well-being

A number of parents from an Egyptian background explained the contradictions they face raising their children in Australia. They want their children to retain the values that they grew up with while, at the same time, they are aware that they are also raising children within a different cultural context. Several mothers also expressed the view that it was important for them to be at home to take care of their children even if it didn't necessarily fit in with their own needs as expressed in previous comments about missing education, language and employment opportunities.

6.3 The role of grandparents

Among Chinese, Vietnamese and Arab-speaking participants, the role of grandparents from the outset is an important one. It was reported that, for many Chinese women, it is common for the grandparents to begin parenting immediately after a woman gives birth, allowing the mother time to recuperate for up to six weeks.

From the hospital after the birth, we are in charge. Every night, all the time, day and night. (Focus group participant (grandparent) – Chinese background)

In fact, this was the sole reason for this grandmother's arrival in Australia — to take care of her new grandchild. Similar stories were told of grandparents coming out to Australia for a few months to help out the new parents. One participant explained how important it was for her to have her parents with her in Australia in order to keep the family together. Several women from Chinese backgrounds

explained the financial need to return to work after giving birth, and so the grandparents in many ways take over the day-to-day child care requirements. Indeed, they are the adults who spend the majority of the time with the newborn and, with that, have the associated responsibility of the health of the child (and the child's siblings).

In situations where it was not possible for grandparents to leave China or Hong Kong, it was not unusual for young babies to be sent to their grandparents to be taken care of for the first few months of their lives. This was particularly the case where the parents were both working and when there was a strong belief that children should only be left with family members. The shortage of child care places (including ethno-specific child care) and associated costs also make this decision more acceptable and can suit both parents and grandparents. The time that the young child is away can range from six months to three or four years although, by most accounts, the usual time frame was approximately 6–18 months. One Child & Family Nurse recounted that in the past year she knew of six or seven babies that had gone back to China with their grandparents.

Frances has considered sending her child back to China as she was feeling isolated due to little family support. However, when she did take her baby to visit, she ultimately decided against leaving her baby with her parents as her observations of direct parent-child bonding in Australia appealed to her more:

The advantage in Australia is that because most mothers look after children by themselves, the relationship between the mothers and the baby is very close. Personally I think it is the mother's duty to look after the baby. ... Earlier this year I took my daughter back to China to visit her grandparents and my husband said 'Grandmother would like her to stay so she can look after her'. But I didn't like the idea because I thought I would miss out on the opportunity to bring up my own child, and I feel that the ideas between the old generation and my generation may be different in terms of education. (Frances – Chinese background)

The difference Frances is alluding to incorporates issues of discipline and the child's ability to learn new things on its own. These include the level of education expected from the children and the extent to which particularly older relatives would spoil the child to the point that Frances felt it would impede on her child's physical skills. For example, women in China tend to carry small children on their back while they are working or doing housework. Frances prefers her child to be crawling on the ground in order to stimulate her child's physical and mental development, however this contrasted markedly during her visit to China as her relatives constantly carried her child, encouraging minimal crawling skills.

Frances also wanted to develop eating, sleeping and toilet training schedules and, in the latter case, Frances took an extra potty with her to China. However, the grandmother thought the potty was too cold to sit on, therefore holding the baby so she didn't get cold.

Cultural practices are constantly changing and are being hybridised. While some women prefer interactions with an ethno-specific nurse because they feel a connection on both a linguistic and sociocultural level, others find these interactions limiting. Some women believe that by simply being given appointments with an ethno-specific nurse, they will be stereotyped in line with traditional practices with which they have little or no connection.

Among the Vietnamese groups, there were several grandparents present who were the main caregivers to at least some of their grandchildren. This was not always a matter of choice but sometimes due to other factors such as the death of parents, mental illness or child abuse. Some of these older carers explained that they parented grandchildren who required special health needs that they had to manage. This is in addition to monitoring their own health care as well as finding appropriate housing and schools to cater for the family. For those grandparents who are the sole carers of children, they are also often perplexed and at a loss to understand the different parenting styles and Australian laws relating to acceptable levels of discipline (Fitzpatrick & Reeve, 2003).

6.4 Parent-child communication: language and values

There was a general feeling among the Egyptian women that, when you come to Australia, it is extremely important to maintain good communication with one's children. This seems to be particularly important for those parents who feel isolated from friends and family upon arrival. They also alluded to the fact that, because children have access to education and are able to pick up English much faster than their parents (particularly their mothers) they become reliant on their children's English skills. Mothers tend to rely on their children for interpreting and so keeping a good relationship with their children can be significant in order for them to can carry out their daily routines. Butcher's work on youth from Middle Eastern and Asian backgrounds in western Sydney (2006) found:

... understanding [English] is more than just speaking the same language. Proficiency in English gave them [young people] a degree of control in their domestic situations, as they were frequently called upon to translate for older relatives, not only language but issues, organisations and structures in wider Australian society.

In other words, children acquire increased social capital in light of their ability to learn language more easily than their parents and become very savvy about when to use which language. There was also discussion about changing values and the tendency for children to talk back to their parents, something that would never have been tolerated in their youth. Other mothers talked about the importance of maintaining close family relationships and the difficulties they had in sustaining family ties.

Kit-Ling wants her children to retain some of the values that she was brought up with in China. She wants them to understand the importance of interpersonal relationships, particularly showing respect to elders, not answering back and not interrupting when others are speaking. She thinks Chinese families tend to be

more family-oriented and the relationships between brothers, sister and parents are closer. For instance, if she knows someone is visiting the area she is from in China, she asks them to take presents back to her family. She remembers being brought up to help out other family members and support them without hesitation. In contrast, her impression of Anglo-Australians is that they are more self-centred with less importance being placed on interpersonal relationships.

While many parents indicated that they found the issue of instilling 'cultural values' one of the most important issues in relation to their children's social well-being, some also acknowledged the universal nature of intergenerational change.

It's not just for Egypt but for everywhere, because there is a big difference in the generations. Even here, 10 years ago it was different ... so all the parents in every country, every place, there are different points of view in every generation. (Focus group participant – Egyptian background)

This was reiterated by participants in other focus groups:

The child is different now, everywhere. Even in Eastern country or Western country. Like I've seen my nieces, they're different than the way I used to be before. They are more educated. They are more open which is good but they are still keeping the culture, the one we grew up with, which is very good, I like that. (Focus group participant – Lebanese background)

The general consensus throughout all the interviews was that children should learn their parents' language first and then English. This is important, they argue, because, firstly, they want to be able to understand their children. Secondly, they believe it will help their children to maintain their cultural heritage. Finally, they believe that being bilingual will assist in future employment prospects. As a result, children tend to speak their first language and English interchangeably in different contexts.

Wedad speaks Arabic at home with her husband but recently they have begun to mix English and Arabic when talking with their children. The first two children understand and speak Arabic quite well while the younger two use English all the time. All the parents from Egypt said they speak Arabic at home with their children and that the majority of children are bilingual. However, there is a tendency for children to respond in English to their parents as they become older.

Generally there didn't seem to be much resistance to the idea that very young children learn their parents' language first. However, there were two exceptions to this. The first was Violet, a parent from China, who felt it was more important for her son to learn English since he was born in Australia. Even so, she conceded that, given that her parents' and her husband only speak Chinese, it is more likely that her son will learn more Chinese than English prior to starting school. The second and more powerful objection was expressed by a community nurse, who was herself from a non-English speaking background.

I just get very angry when I hear my friend say that children should know their own language first, their parents' language. I totally disagree ... I expect English first. Everyone should speak English. Once we arrive in this country, first of all, we should all speak English and obey this country's rules and culture. It means that if I come to your house I'm here to deliver a health service, dress your wound, give you medicine, injections, whatever it is. I'm not here to know what background you are from. I came to this country in the early 1970s when being a foreigner, and not speaking English, you were dumb. Now we've gone to the other extreme where I, as a health professional, have to know everybody's culture. How is that reasonable? (Child & Family Nurse)

Whether parents are able to speak English but more specifically communicate in contexts outside the family (for example, in a health encounter) to some degree reflected their feelings of 'belonging' to Australian society.

Overall, there is a perception that second generation children will find it more difficult to straddle the home-community divide. Research on first and second generational change among Asian migrants in Britain suggests that first generation immigrants who have large informal networks can fit in with minimal change to their original values. In contrast, second generation youths tend to face the brunt of cultural conflict between 'the differing values of home and school' (Ghuman, 1997: 23). Similar findings are found in this study and are articulated by the parents in a variety of ways. Margaret describes how her children will be living and learning across at least two ethnic cultures and is concerned how this will affect their upbringing and sense of self within Australian society.

Actually, nearly all my friends are Chinese and most of my husband's friends. And our relatives are Chinese, so my daughter is growing up in a Chinese environment. But once she starts education and goes to school, she will find another side. It depends on how she handles it. I mean, she might have more stress than me. She might have more problems, because I made the choice to come to Australia. During her life, she has lots of things to handle and face. In those cases, I can't help her much ... I hope the government or society can give them some more help, especially the second generation ... born here, because they are growing up different. (Margaret – Chinese background)

In the above quote, Margaret alludes to the role that government plays in her children's social development, particularly in terms of how national identity and the extent to which 'national belonging' may be defined in terms of citizenship rights. For others, 'belonging' is defined through language. Najla defines 'Australian culture' as Anglo-Australian culture:

I only describe this because of the language. The most important thing in this country is the language, and who dominates this language? The Anglo-Saxons. There's no other culture — I mean the Greek, the Indian, Macedonian — all of them, they need to speak the English language. (Najla – Lebanese background)

Yet, Najla continues to emphasise how important it is for her and her family to hold onto their language, strongly stating this as her priority. Her children always spoke Arabic at home ('no English at home!'), and while her grandchildren tend to speak English, she constantly reminds them of the advantages of being bilingual. Her first grandchild commenced schooling in an Islamic institution but now goes to a mainstream public school while undertaking Arabic and religious studies after hours.

In contrast, Nhu frames 'belonging' in terms of a duty to raise her children as 'good citizens'

I believe that the day I came to Australia and I became a new Australian citizen, I became a full citizen then — all my dedicated work to getting employment and things like this to pay back what I owe Australians. My benefits, my life and everything, that's why I try hard and work hard, in a way to return the favours. And also to raise my kids and let the kids know it's their responsibility towards this country. (Nhu – Vietnamese background)

Among many of the parents with whom we spoke there was, as Nhu articulates, a strong sense of 'owing' Australian society for accepting them as migrants. For many migrants from less developed countries, the health services received in Australia are far safer and cleaner with most people eligible to access the public health system. However, several parents also indicated that they feared that if they were unhappy with care, and complained or asked for special requirements, either the quality of their health care might be compromised and/or they would be seen as not fitting into 'mainstream' Australian culture (Vose & Thurecht, 1999: 51). When this was related to their children, they were even more unlikely to express themselves or openly criticise the system (Chalmers & Allon, 2002: 162; MacIntyre, 1994: 162).

In all of the above narratives and across all the focus groups and interviews, without exception, there was a strong desire by parents for their children to understand and take up at least some of their cultural values and practices as Kit-Ling explains:

Well, they are sort of second generation Australian. Of course, their English will be better than their Chinese, although I'd still like them to learn about some Chinese culture. At the same time, I also like them to take the Chinese values and have some, well, Chinese manners as well. I don't want them to become too Westernised. (Kit-Ling – Chinese background)

Often the cultural values that were discussed as important to the family were intertwined with religious values and practices, and this was particularly the case among those parents from Egypt and Lebanon, whether they identified as Christian Coptic or Muslim.

6.5 Religion, parenting and health care

Religious observance played a highly significant role for the Lebanese-Muslim and Egyptian-Coptic participants when explaining the relationship between parenting and healthy child rearing. However, it should be remembered that the initial focus groups were undertaken at a mosque and two churches. In contrast, while some parents/carers from Vietnam and China also expressed a spiritual side, it was not as overt and tended to be more subtle and intertwined with children understanding their cultural background and participating in Chinese or Vietnamese festivities and ceremonies on special/auspicious days of the year.

Despite these more obvious differences, spiritual growth is considered a very important part of children's health and social well-being as it is through their parents' understanding of religious doctrine that they can pass on their morals and values that will teach their children the 'right way' to live a happy and successful life. Fadia (Egyptian background) explained that keeping her traditions and culture in Australia is important and that this should be part of their daily lives. An essential part of these 'traditions', she explains, is religion: 'And God has to be at home so the children will be good. They have to know to fear God'.

Wedad considers her children's health extremely important and part of their 'normal' development includes taking care of their spiritual side. Going to church and Sunday school, Bible study classes and knowing about God is, she says, an important part of her children's health needs:

To be honest with you, we feel we're grown up and no one will take our faith from us. But we're worried about our children. So we go to Mass very early, and that's why we try to push ourselves to make sure they learn right and wrong. We're very cautious about that. (Wedad – Egyptian background)

Wedad believes that parents play a primary role in a child's education and that the home is the place where children learn their values and principles. Parents should be role models for their children. Wedad's faith also applies to how she deals with her children's health care. She believes that if her children are ill and need medical attention, her faith in God will see her through. On asking Wedad what would happen if there were potential negative consequences that hadn't been explained to her, she responded that her children's fate would be in the hands of God and that God would guide the doctor's hands through the operation. She continues in her explanation that she is only interested in the immediate health issues and does not want to know about the long-term side-effects, risks or specifics of how things are done.

One issue that repeatedly surfaced was that of appropriate morals and values and how they travelled across generations, that is, the healthy 'maintenance' of religious and cultural practices. For several of the Chinese and Vietnamese parents, marrying within a particular ethnic group is still important despite the growing figures of inter-ethnic marriages, particularly among second generation migrants in Australia (Ang, Noble, Brand, & Wilding, 2002: 25-6). The reason for

parents wanting their children to marry within a similar ethnic group was language oriented, in order for younger generations to communicate culturally with their parents and grandparents:

It's more the parents who would rather their son to marry a Chinese wife so that, in the future, when they've got grandchildren, they can still communicate with their grandchildren in their own language. They sort of assume that if their son marries an Australian wife then the children usually speak English. (Shun-Hing – Chinese background)

In contrast, parents from Lebanese and Egyptian backgrounds indicated that religion was a more important factor than ethno-specific grouping regarding their children and marriage. Wedad explained that if your daughter married outside of the family religion, she would probably be cut off — this being a message passed down from parents to children as parents communicate the importance of a strong religious doctrine to their children. Najla expresses her objection to inter-religious marriage in slightly stronger terms:

I will kill myself ... I mean this is an expression, but I would be dead. Maybe I would be alive but I would dead. (Najla – Lebanese background)

Furthermore, these mothers expressed great concern about the morality that their children were exposed to in their daily interactions with Australian youths in a broader sense. Najla, for example, is highly critical of young Australian people who she claims have 'excessive freedoms' and, despite the fact that she is now studying community work, she holds relatively narrow ideas about the heterogeneous views held across the wider Australian population. However, while Najla holds strict ideals about what is permissible for her children and family, at the same time she also espouses a strong sense of social justice ('I believe in freedom and people without freedom, they don't have dignity. They can't be creative without freedom'). Yet, in the same sentence she valorises her religious and moral values by indiscriminately collapsing several cultural, social and health phenomena into the one category, which she terms 'excessive freedoms':

When someone proposes [marriage] in my culture, or in my belief, Islamic belief, the parents ask for the boy. But the last word has to be from the girl but everything is fixed through the parents. She can see him and everything, sit down with him and talk to him, but she doesn't see him in the street, like make an appointment with him. But these days, what happens — the sexual instinct, it's natural and every person deserves to use this desire. They can use it in a good way, not in an excessive, unorganised way, like have illegitimate children, they can have AIDS, they can have problems in the family, like you don't have a father or you don't have a mother. ... What kind of negative consequences in the society will we have? This is what I mean by excessive freedom. (Najla – Lebanese background)

Interestingly, Najla's son planned to return to Lebanon to 'find a virgin' to marry and bring back to Australia. He told his mother that he did not trust Australian

women, whether they had a Lebanese background or not. At the time of this interview, he had just returned to Australia with his new wife.

Many of the parents surveyed use their religious affiliations as a way of keeping an eye on their children as well as connecting their family with other people of similar cultural and religious beliefs. Amal's main form of social interaction for both herself and her children takes place through her church:

When I go there, I feel like I'm in Egypt, like I'm having the same religious feelings. I can't go to the church and attend Mass and then go. I can't. The Mass finishes at 12pm and we'll be there until at least 3.30pm ... it's a full experience. (Amal – Egyptian background)

Amal believes that the more the children are exposed to their church, the better people they will become with minimal problems in their lives – children take part in Holy Communion and children's clubs while she is able to participate in the women's club and social activities. Amal says church provides a good example for the children, allowing them social interaction after Mass as they always stay and eat with their friends. Similarly, Wedad believes that the most difficult issue for parents from a Middle Eastern background is getting used to their children mixing with people from different backgrounds. Sara's eldest son, who is 10 years old, belongs to a soccer club and sometimes asks for permission to attend birthday parties of friends from his club. However, Sara does not feel comfortable sending him to a family she does not know. On the other hand, his enrolment at a Coptic school, where he is able to mix with other children from an Egyptian background, allows Sara to be a part of his cultural upbringing and affirms for her that her son remains within a set of 'known' values and practices.

There is a general wariness that the different values their children are exposed to may lead not only to a rejection of their cultural heritage but also an undermining of parental authority that parents feel is integral to their sense of self-worth. This is particularly the case for women who often rely on their children to link them with their informal networks and who are often judged through their children's adherence to following their moral and religious teachings. For example, Najla considers it to be of paramount importance, especially for men, to go to the mosque. Women who can't leave the home meet together for study and prayer (Bouma & Brace-Govan, 2000), including listening to the Islamic radio station. Indeed, one study of Muslim women in Australia suggests that some women in fact 'become more devout in order to care properly for their children' (Bouma & Brace-Govan, 2000: 167). The range of social, cultural and religious values and practices is described by most parents to overtly impact on the social and moral well-being of children (D. Barnes, 2003: 139) which consciously structures their lives in order to give them every opportunity of success in Australian society.

In our culture, the family has to be very close. And they have to come to church, and stick to religion. We left our country because there is some prejudice religiously. We feel much more comfortable here. But to bring up children, the father cannot really

say a lot of things to the children. If you say something or hit or something the children will call the police. ... We do really take care of our children more than the police, we try to teach them to be good kids. A good generation for Australian society.
(Focus group participant – Egyptian background)

Thus, according to this, a healthy lifestyle for children is based on a good education and the retention of ethno-specific cultural and religious values, even if these practices are different from their own experiences, sometimes due to religious persecution in their country of origin (Bouma and Brace-Govan 2000: 167).

6.6 Discipline and healthy parent-child relationships

A 'good education' was repeatedly cited to include issues of discipline. However, it became obvious that the control of what constituted physical punishment and when it could be used evoked very strong responses from the various groups interviewed. The two major issues that emerged were a) the removal of parental controls by the state over corporal discipline which many parents felt undermined their authority, and b) as Kolar and Soriano also found, a sense of disbelief that physical punishment, even when used sparingly, was unacceptable with the implication that parents 'were mistreating their children' and with the associated assumption that children should therefore resent their parents (2000: 54). While corporal punishment is now banned and the physical disciplining of children is frowned upon, the demonising of parents who are unaware of the cultural and historical developments concerning the shift in children's discipline needs to be understood, and alternative approaches negotiated with more sensitivity to diverse parenting practices.

At the same time, many surveyed parents were also aware that knowledge from their own parents about child rearing and parenting may not be appropriate within an Australian cultural context and/or the way they want to discipline their children. What appeared to be lacking, however, was an explanation or rationale behind these laws that made sense to them. Having said this, the vast majority of parents interviewed were of the opinion that discipline was best undertaken by attempting to communicate with their children verbally.

The way I discipline her [my daughter] is a bit different from what I would do in China, because in China, it would be maybe a more forceful way. Sort of force the kids to do things according to what I want them to do. But here I treat her more like a friend, and a lot of the time she will tell me things that she wouldn't even mention to her father.
(Shun-Hing – Chinese background)

Similarly, Anglo-Australian parents in mainstream society have not always rested easily with the significant changes to appropriate disciplining techniques that have emerged in the last 30 years. In a parenting study with parents of African backgrounds, Sims and Omaji (1999) found that the major concern for parents was that their children would grow up without proper respect for their elders (McEvoy et al., 2005). Our research similarly displayed a certain scepticism by

some parents to the ‘freedoms’ shown to children and young people, somehow equating this to a lack of care or love by Anglo-Australian parents for their children (Sims & Omaji, 1999). Indeed, there was significant confusion by some parents over the cultural construction of displaying concern and love for children in relation to an acceptable system of discipline, including the fear they feel about losing the respect of and control over their children:

In my community, we love our children. We love them to death. We would like them to have very high qualifications and to be bright, and this country doesn't help us to do that. They help the children to not listen, and if my voice loud they say, 'I'll call the police!' or something like that. And the police don't differentiate between the mother who doesn't care about her children or drinks or gambles or hurts her children — the system doesn't differentiate between this mother and the mother who works and looks after her children. They see abuse, abuse. ... I might hit my children because I'm worried about them, but I'm not hitting them to harm them or make a mark. (Child & Family Nurse)

In Lebanon, it was suggested that you could bring children up the way parents wanted and without so much interference from the state. One woman commented that, in Australia, children are protected by the police. Boys in particular, she said, go their own way once they start growing up and that even girls tend to do what they want despite their parents' disapproval:

I think environment plays a big role as well. Most people who live in Lebanon, you wouldn't ever hear a child dare say to the parent, 'I'm sixteen now' or 'I'm eighteen, I can do this'. It doesn't happen over there. (Focus group participant – Lebanese background)

Within the Vietnamese focus groups there was a great deal of discussion about what was appropriate discipline. One grandfather explained that in Vietnam it was up to the parents to teach politeness and respect for elders prior to children entering formal education. These values were then reinforced throughout their school years. Another grandmother went further to say that there was no strict discipline in Australian schools.

When I was small, I respected my parents very much. I was even afraid of them! But here it looks like the kids do what they want. No restrictions. My own experience with my grandkids here, they always say that they have their own freedom and grandparents and parents should not interfere with what they're doing. I know that kids here are very intelligent, maybe because the environment is good, but it look to me that they're a lot more stubborn and difficult to teach. (Focus group participant – Vietnamese background)

Amal described her experience growing up in Egypt, where children were supposed to be quiet — no noise, no grabbing or touching things (not so far removed from Anglo-Australian parenting practices!). Amal acknowledges that the world is a different place today, making the crucial point that the advent of computers, Play-Stations and the huge flow of information and ideas render it

much more difficult to guide children. She says that children aren't as innocent as they used to be due to their constant exposure to new technology and the global media.

Cuong, the only male primary carer interviewed, explained that it was more usual in Vietnam for parents to use a cane to scold their children but that in Australia this is not the done thing. He and his parents have different ideas about discipline which they often discuss, believing his parents' attitudes have changed due to a shift in control from grandparents to parents. He states that the decision about how his child will be disciplined, and by who, will rest with him, and that this includes not hitting his child.

6.7 Safety, security and family well-being

Other family dynamics affecting children's social well-being that were discussed included the very difficult subjects of divorce, domestic violence and child abuse. Given the extreme sensitivity of these issues and the fact that there was only one individual interview with each parent, it was not surprising that minimal information was disclosed. Nevertheless, domestic violence and child abuse occur within these communities as they do in all parts of society. However, a combination of issues including religious beliefs, economic dependency, patriarchal family structures, saving 'face' and small community networks were all cited as reasons for the tendency towards keeping silent about domestic violence.

A community worker who runs health and parenting classes for women from Arabic-speaking backgrounds explained that most women simply do not talk about domestic violence and child abuse. Even for those who do, these women might talk to other female friends but not to doctors, co-workers or any officials as they believe it will come back to haunt them in the long run. According to this community worker, women are more prepared to stay in a violent relationship as long as the violence is directed towards them and not their children. In contrast, if physical and sexual child abuse is occurring, some women may leave but even then the reasons proffered for leaving are often set within a hierarchy of abusive behaviour. That is, it is better for community members to think that domestic violence has occurred rather than knowing that child abuse has taken place.

The woman will take her children out of this relationship but not give the real reason. She will give another excuse, like 'he didn't give me money', or domestic violence. It's good that the community blames her more than giving that to her children. And then in the future, because normally Arabic women and men are very concerned about their children's marriage and this is more important than her. One woman she said to me, 'whatever he does to me, I don't care, but my children, I don't want him to touch my children!' (Child & Family Nurse)

Accessing services or requesting assistance is often read as impacting negatively on the family and ultimately the children (Neufeld et al., 2002: 763), so that beliefs about what can be divulged becomes a matter of protecting the

family's reputation, thereby inhibiting the use of health services (Gutiérrez, 1992: 324). This is further complicated when the usual mechanisms in place to deal with family disputes (that is, the extended family) are absent (Thomas, 1998: 95). Even when extended families are in the same city or suburb, they are usually located across several households, creating a situation in which the public/private familial dichotomy becomes re-established (Kolar & Soriano, 2000: 13). For women who come from countries where formal dispute mechanisms do not exist, their lack of knowledge of and access to these mechanisms — but just as importantly their sense of self-worth — often cuts them off from outside assistance. It is also a misnomer to assume that it is simply geographical and social dislocation of either the migration and/or settlement process that precipitates domestic violence. Rather, it is a combination of these and other factors including issues around sexual violence, power and control. Thus, domestic violence does not simply stop because 'successful settlement' has been achieved, nor because one has moved to a country that does not necessarily condone sexual violence. Indeed, in Australia, the overall incidence of domestic violence and sexual assault has increased by 6 per cent between 2001–2002, with 65 per cent of assaults occurring within residential locations (Australian Institute of Criminology, 2004).

Disclosure of physical and sexual violence within the home continues to be difficult for all women and divorce is not always an obvious option. An Arabic community worker explained that while divorce and separation are not unusual within the communities, there is still significant stigma attached to divorce with the onus of 'fault' still firmly placed on women (Cheung, 2003). For women, there is also the associated connotation that they have somehow 'failed' as both a wife but perhaps more importantly for them as a mother. Thus, often women will stay in an unhappy marriage rather than leave. Community moral condemnation is very difficult to live with and there is the perception that, if at least one stays in a marriage, no one questions where one goes — a better situation than feeling ostracised and alone. There is also the other fear for women that if a woman is known to be alone, it is assumed she is fair game for other men. This 'kind of woman' is referred to colloquially as 'an easy piece of cake' according to one woman from an Egyptian background.

It is unacceptable within the Coptic Church to live with another person outside of marriage, yet remarriage is not allowed within the church. The exception is that men may divorce their wives if they find out she was not a virgin. Rosa explains, depending on where your family comes from in Egypt, it is not uncommon for pre-marriage checks to occur to confirm whether the woman's hymen was broken or not. This is seen as a reflection of the honour of her parents as a way of judging whether their daughter was brought up with the appropriate moral sexual values.

The sexual mores of what it is to be 'a good wife and mother' are not limited to any culture but rather express themselves in different forms within diverse

cultural contexts. The effect on children and their attitudes towards developing healthy relationships in relation to their family, parenting and women in general cannot be underestimated.

With obvious relief in being able to speak about her experiences, Kim Anh revealed the history of her sexual and physical abuse by her ex-husband. Kim Anh had left Vietnam in the early 1980s and spent several years in a refugee camp in Indonesia. Here, she found out that unless she was married she had little chance of being resettled and so married another refugee in the camp. There began her long history of marital rape and domestic violence. She gave birth to her first son in the camp and her second son some years later in Australia. Her sons saw her husband hitting her, although he did not hit the children. In fact, he doted on the children, proud that he had fathered two sons. She finally got her husband to leave although he regularly reappears despite now being separated for several years. For all intents and purposes, she is now a single mother although the people she mixes with, according to Kim Anh, do not know about her separation. Again, the status of single parenting and her views about a woman living alone have been strongly influenced by her negative experiences of abuse and is now fearful of letting any men into her house:

When my friend, a single mum, come to visit me when I live with my husband, my husband always said, 'see you always copy her'. He doesn't like single mums. And that's why I was worried. If I'm a single mum and go to my friend's house, maybe their husbands don't like me. Maybe one day the wife runs away and maybe they'll say, 'it's your fault, you always came to visit!'. I feel safer if they think there's a man in the house. (Kim Anh – Vietnamese background)

By the time I spoke to Kim Anh, it became apparent that she had become quite terrified and mistrustful of anybody finding out about her separation. She also believed that being a single mother, for those in her close-knit community, meant that she had failed or was a bad parent.

I haven't let people know that I'm separated. I haven't allowed my son's friends to come here. I say, 'you want to go out, go out'. I ask my son, 'don't bring anyone here, and don't tell them you have no daddy'. ... I'm so scared that they'd know I'm alone. Because my son's friends, they're mature, already men. (Kim Anh – Vietnamese background)

Parenting skills have not come easily to Kim Anh who does not have close family or friends to support her. Rather, she explained, she picked up tips from her work as a volunteer at a Christian charity which runs play groups. She would listen and observe the interactions within these groups and then tried to apply these practices to her own situation. When she had a question, she would talk to the carers as though a friend had the problem. I asked her whether she thought the workers believed her or not:

Yes. They think I've got a perfect family. When I'm not going to work, I work here [as a volunteer] three times a week. They think maybe my husband works at night, [they

think] we've got enough money so I've got spare time for them. (Kim Anh – Vietnamese background)

When people begin to talk to her about her home life, she just says she doesn't want to talk about it and changes the subject.

A women's health worker confirmed the hesitancy of women among Arabic communities to deal with their own health issues, including domestic violence. Advertising 'health issues' among the women elicits little response, but if she talks to women under the guise of 'parenting' she has little trouble in drawing an audience:

This is how we get around it, because if we say 'stress management', no one will come. If we say 'domestic violence', no one will come. What we found was the best way to deal with the Arabic community is talking about parenting ... children are very important in the Arabic community. (Child & Family Nurse)

Similarly, very few of the nurses raised the issue of domestic violence in relation to cultural diversity. The one salient comment that was made by staff members was that, while there is now mandatory domestic violence screening and reporting, follow-up procedures remain somewhat lacking. The nurses' criticisms are based on the fact that there is no support for these women if they are found to be victims/survivors of domestic violence — indeed, one nurse reported that there is only one domestic violence counsellor in her area. With little or no follow-up support the result can be equally, if not more, devastating for the women and children involved. Moreover, concerns were raised that little, if any, training is given to domestic violence workers who are unfamiliar with migrant settlement issues, let alone the more complex problems faced by an increasing number of often traumatised refugees.

In some cases where domestic violence occurs or where mothers are at high risk, there is a tendency to not want the aid of interpreters or cross-cultural workers. Among the Chinese communities, a nurse explained that it has a lot to do with keeping 'face' among local networks.

They don't want any other people to know their business, especially from their own kind. That is the worst thing. And I can identify with that, because Chinese have the same problem, they only want you to know how great they are, what a great job they have done. I think it's human nature too. So that's why those people who are at risk, they are the ones who really resist using the interpreter or the cross-cultural worker, because they really worry that things may go back to the community. (Child & Family Nurse)

It is difficult enough to admit to a stranger that domestic violence is occurring, but when an interpreter needs to be involved issues of confidentiality and domestic violence interpreter training must be further considered to avoid informal interpreting, particularly by husbands/partners.

7. Where health care services and parenting meet

7.1 Parent experiences of using GP and hospital services

With the exception of one or two people, all the parents/carers interviewed, including those in focus groups, accessed general practitioners (GPs) who spoke their first language and/or who came from a similar cultural background either in terms of religion or birth place. The majority of primary carers, mothers and grandparents also took their children to these local GPs, claiming that communicating in a common language was far more effective (Cohen et al., 1999: 163-64). Women also tended to access female GPs or FPA (NSW) for specific gynaecological needs, but this was usually separate from their local GP to whom they presented their children. Interestingly, some parents/carers had tried Anglo-Australian doctors for the provision of their children's health care but found communication in terms of language, diverse treatment regimes, and cultural understanding placed them at a disadvantage or unconsciously blocked access to the information parents/carers from CALD backgrounds required.

Margaret gave birth to both her children in the local hospital. She sometimes sees an Anglo-Australian GP but more often than not she takes her children to a Chinese-speaking GP. It's not just language, she says, but broader cultural practices that make for the effective interaction:

The food, how we raise children ... even though we speak English, the Chinese doctor can more easily understand what we're saying ... you know, China has a long history of a medicine system. Once I mentioned my child had a dry cough, the doctor will straight away understand me ... the Chinese, we talk about how our body has two sides. One is hot. When you get a hot fever, you get dry eyes. When we say you get cold, you cough during the night, not the daytime. (Margaret – Chinese background)

She compares this to her experiences visiting an Anglo-Australian GP who regularly tells her that what is wrong with her children is 'common'. She finds this is also similar among the midwives with whom she speaks. Margaret describes the midwives' views as rather 'old-fashioned' and again emphasises her anger when they respond to her concerns as common or 'everyday problems'.

Of course, I feel uncomfortable because I feel that it's a serious problem. They always say it's very common. They might see this everyday ... but the reason I'm there is to make sure the problem is okay. I still want some advice. Don't tell me it's common. It's common for you, it's common for some experienced mothers but it's not common for me! (Margaret – Chinese background)

Margaret emphasises that her local Chinese GP asks more questions and that this is the critical issue. It is also, she explains, about knowing what to ask and finding out the appropriate information. As a new migrant, a Chinese doctor would understand this and would be aware the parent may not have access to the information needed. While second generation Chinese may already have knowledge about how to access all the information, for recent arrivals, she adds,

there is no prior knowledge, especially when there are few or no family members to rely on for support. Other parents/carers held similar views:

If I see a Western doctor I have nothing to say. I don't know what they're thinking and that doctor doesn't know what I'm thinking. But if I see a Chinese doctor, then I can talk a lot. One example is the flu. A Chinese doctor knows that some foods are no good but for a Western doctor, they say you can eat everything. (Focus group participant – Chinese background)

Margaret turns to friends and family for informal advice before she approaches health professionals. Informal networks play a very large role linking people into the more formal networks, and their role in helping parents find appropriate health care services for themselves and their children cannot be overstated. However, when these informal networks are not available (and this is often the case with recent migrants and new and emerging communities), it is even more important that health professionals and official systems of information are widely known and are culturally relevant.

In contrast to Margaret's negative experience with midwives, Sara's experience of accessing the Early Childhood Community Health Centres has been very positive. While she also regularly uses an Egyptian-born GP who is open until 9pm, she has found that the nurses are incredibly knowledgeable:

I feel they (Child & Family Nurses) know more than the doctors. They've got good experience ... even my brother [a doctor] says, 'ask at the clinic, they've got more experience than us'. (Sara – Egyptian background)

The exceptions to going straight to one's GP were when accessing large medical clinics and hospitals at night or on the weekends when their regular doctors were unavailable. The other obvious occasion when cultural background was not an issue in deciding where to go was in emergency situations, when complex medical technology was required and the Emergency Department in a public hospital system was the only option.⁴ Initial evidence collected⁵ from this and other studies (Chalmers, Dover, & Lissing, 2005) suggest that parents do not access hospitals, particularly tertiary children's hospitals, unless they feel it is an emergency or when their children have been referred for specialist care.

Well, it [the hospital] is okay but usually if it's not something major I won't go to the hospital because of the long waiting times. Like my daughter, sometimes she has some really serious asthma attacks but when we go to the hospital it's still hard to get

⁴ While a small number of participants took out private health insurance when emergencies occurred they went directly to their local public hospital's Emergency Department.

⁵ We are, at present, undertaking a large 3-year Australian Research Council Linkage Grant examining the long-term health outcomes of children from culturally and linguistically diverse backgrounds. One component of this study 'Accounting for culture within children's health services in Sydney: A survey of parents and carers' will be collecting quantitative data to give a more detailed picture of decision-making by parents in relation to accessing health care services for their children.

the immediate attention of a doctor. They only give you a mask for relief. ... With the asthma program, I really got very detailed information from my GP. The reason we go to the hospital is that you feel a bit safer if something serious happens. The hospital has the equipment and resources to help. So you know what is there, it's not much else. (Kit-Ling – Chinese background)

Another initial point of contact for some parents is their local church. Wedad goes to consult her priest when she is worried about her children's health and this is not an uncommon practice for those who believe in the power of prayer to cure (L. Barnes et al., 2000). She asks him to pray for the child and then proceeds to her GP who decides on the next course of action for the child. In emergencies, Wedad goes to either her local hospital or takes her child to Sydney Children's Hospital, the decision on where to go having more to do with her level of stress despite believing that a 'children's hospital' has better facilities and specialists available. She stated that if she's feeling very anxious she will tend to go to the closer, local hospital so that she doesn't have to drive very far.

In fact, there were a litany of reasons given as to why the majority of these parents/carers prefer to access their GPs or their local community-based child health centre rather than going directly to a hospital. These included:

- long waiting times at hospitals,
- conflicting advice by doctors,
- pejorative language and behaviour by hospital staff,
- lack of child care for other children,
- transport to hospitals outside their local area, especially at night,
- communication issues, and
- lack of trust in the number of medical tests undertaken and long waiting times for results.

The issues listed above were often cited as arising in combination rather than as mutually exclusive issues, and often resulted in a high degree of stress within the health encounter interaction. One of the reported effects was the exaggerated responses of parents/carers, described as either remaining silent or demanding action, the former more common than the latter. More stressful situations for those parents accessing health care outside of GP hours were exacerbated by not being able to speak English adequately to explain the illness or accident narrative. This can begin prior to arriving at the hospital when attempting to contact an ambulance:

I have a child who had an epileptic fit and I had to ask a friend to ring the ambulance because I couldn't speak English well. I even asked that person to go with me to the hospital because my husband was not available at the time. So I feel a language barrier is quite a big problem. (Thi Mihn – Vietnamese background)

Delays in ringing an ambulance can obviously be critical and Thi Mihn's ability to access the ambulance relies heavily on her friends being home when a crisis

occurs. In the situation described above, in realising her daughter needed help, the first thing Thi Mihn did was to drop down on her knees and pray. She then became aware that she needed to get her child to hospital — fortunately her friends were available and called the ambulance on her behalf. In this instance one of her children was having convulsions, but by the time the ambulance arrived the convulsions had stopped. Thi Mihn says that the paramedics did not believe her account and it was only when the child started to fit again that they acknowledged the gravity of the circumstances. Naturally her response was one of extreme anger but this parent felt she was not in an equitable position to express her frustrations (O'Callaghan, 2000: 830; Pugliese, 1995). All she could do was to try and hide her feelings, walking to and fro with the baby crying in her arms. Her friend stayed with her and assisted with interpreting until the child was admitted, and then returned to inform Thi Mihn's husband who was caring for the other children at home:

When I was alone I was very anxious because ... I didn't know what was going on. In my mind I was concentrating on my child more than the environment. The hospital staff did come to check on the child but did not talk to me. (Thi Mihn – Vietnamese background)

Her daughter remained in hospital for two nights and during this period Thi Mihn felt confused, lonely and helpless. She also felt she did not receive much emotional support from either the staff nor from her husband.

The first point of contact — either with paramedics or hospital Admissions — is particularly important, and when there is a child involved parents/carers are extremely stressed. For those parents/carers who are not yet fluent in English, this situation is compounded by not being able to communicate clearly and concisely. Participants explained that sometimes the way English is communicated under pressure is often understood as being rude or demanding, particularly when one is literally translating from one language into another. In other situations, everyday English is simply forgotten. When this occurs, the Admissions clerk could either make one feel safe and relieved or they could demonstrate their intolerance through obvious displays of impatience and annoyance, 'mak[ing] you feel that you're not a person that we should care for'.

Because of my limited English, usually with hospital Admissions there's lots of forms for you to fill in and sometimes when there's something I don't understand I have to ask. And some of the Australians are pretty nice, they'll help you, but others give you a long face! (laughs) ... Because my younger daughter is always sick and a lot of times I've had to take her to hospital, and then my English is not adequate. Most of the time, it's a really unhappy experience. But sometimes I get the social worker to go with me, but I feel that ... sometimes I feel that they don't like Chinese. (Shun-Hing – Chinese background)

Vietnamese parents/carers also referred to the way they were treated by Admissions personnel on arrival at a hospital. One grandmother recounted her

experiences of going to hospital with children in her care without other adult family members present. She is generally ignored by staff because she does not speak English and does not know how to ask for assistance. Her only option is to, she says, sit down and wait to be approached. If she can call on one of the children to help she does. She explains that it is easier if she has a referral letter because then she can pass it across and the clerk can respond without her having to say anything.

Curt answers and dismissive behaviour by hospital workers in response to low level English skills is by no means the exclusive domain of any one profession. Yen Ha has had a number of negative encounters with doctors at her local hospital and she now travels directly to Sydney Children's Hospital as her daughter requires regular hospital care:

My daughter, she had a temperature and when I took her to the hospital the doctor said, 'when you see your daughter has a temperature, give her medicine to take the temperature down. Don't wait until your daughter is very ill'. And then another time when this happened I gave my daughter Panadol, and I took her to the hospital. This doctor said, 'you are not the doctor. You give a baby like this medicine, it's not good'. But I followed the other doctor's advice, and then when I bring her in and he asks me how many times I gave her the medicine he says, 'why did you give her this? You can't touch her head and know why she has a temperature!' I said 'I don't know but the other doctor told me'. 'But I am your doctor!' he was screaming. Made me think I'm rubbish. That's why sometimes I feel like the people, they have high education so they feel like they can treat people very low. (Yen Ha – Vietnamese background)

Yen Ha explains that she is happier with the personal treatment she receives at Sydney Children's Hospital, but she also claimed that she is not offered an interpreter and she does not ask for one. Instead Yen Ha asks staff to talk in simple English so she can understand.

While the majority of parents/carers were generally satisfied with health care services, there were concerns over communication processes. For example, several parents indicated that they felt their health needs were being overlooked or not taken seriously because staff could not be bothered listening to them. Wedad also went to her local hospital's Emergency Department late at night. She waited two hours for her daughter to be seen and was then 'told off' by the doctor for not knowing what was wrong with her. By this time, Wedad had become angry as she had tried to explain what she knew as best as she could:

She's (the doctor) not happy with my answers and she treats me like a stupid idiot, and then she asks the nurse to put on the medication, and got the nurse to explain it to me and I'm not happy about it ... she caught me at the wrong time (laughs). I don't usually react that way. (Wedad – Egyptian background)

Wedad feels lucky to be living in Australia but has felt discrimination particularly when people judge a person's intelligence or capability by their English fluency:

Some people, if you don't speak the language they treat you as an idiot. I feel that, and I'm educated enough to know how the person in front of me is treating me.
(Wedad – Egyptian background)

This experience of being made to feel stupid not only impacts on the self-confidence of parents (more often mothers) but also undermines parental authority in front of their children. Moreover, the 'expert' status of health professionals can be seen as a validation for verbal abuse or for expressing annoyance at parents' lack of knowledge so that parents feel unable to claim an authoritative position in the encounter. Whether the children are young or adolescent, watching an interaction in which their parent is belittled cannot help but affect the way the family as a whole may respond to future health interactions, for example, the motivation needed to access preventative health care.

This links back to the previously discussed fear of inconveniencing staff. For some new mothers, language is cited as the major issue that they face within the hospital, followed by a lack of knowledge about diverse cultural practices. According to a (Chinese) Child & Family Nurse, women from Chinese backgrounds often tell her that they do not want to impose on hospital staff, so they will try to 'fit in'. Nevertheless, she explains that while they may not articulate their needs this does not mean that they feel comfortable adhering to all the hospital's Eurocentric protocols. One mother explained that keeping quiet and 'going with the flow' is an easier option than trying to assert one's cultural needs:

You come from a different place so you always choose the easy way, the easy way is to keep quiet. If you mention something you might get a hard time so you don't mention it. But most migrants will do these things. Not only in a mothers' group or a playgroup. That's the way migrants choose, the easy way, follow the main group, even though you've got a different opinion. (Focus group participant – Chinese background)

This withholding or denial of difference, while not always a critical factor in every health encounter, normalises the organisational and professional cultures operating in the hospital. Thus the notion of 'diversity' is reinforced as problematic for consumers and staff alike (Pinderhughes, 1989: 58). Moreover, the sentiments expressed above were not confined to any one group and fears of compromising their children's health care placed additional pressure on parents/carers not to express dissatisfaction with the hospital care system:

If I bother them too much they'll get angry and they won't look after my child ... and maybe it's not an Arabic thing, but I know lots of people who feel that way, where they'd rather not ask too much, just in case. People are worried that the nurse is going to get frustrated, get angry with me and that's a scare, or major concern.
(Focus group participant – Lebanese background)

The lack of English proficiency is only one of many communication problems that occur. Bodily representations that indicate difference can also affect the health

interaction, effectively setting up negative responses by both parents/carers and hospital staff:

I mean, being scarved, it's obvious that we're Muslims. In the hype of what's been happening in the media over the last few years, sometimes people show anger, the media plays a very big role. I covered only recently, about four years ago, and the difference I felt was immense. People come up to me and talk to me a little bit slower. People say to me, 'oh, you speak really good English' — I was born here! Or, people are rude to you. Why aren't they doing courses for the receptionists to do better public relations? Like the lady just said, the person with a sick child comes to the hospital very anxious, stressed and you don't want to find the person in front of you being more aggressive. They don't yell or scream but the way they talk to you, it's more aggressive than the way you're talking to them. This is the first moment you're receiving care and you don't need it at that time. (Focus group participant – Lebanese Muslim background)

As this woman states, the media has played a large role in constructing negative images of Muslim women, the hijab often being used as a metaphor or metonym for antisocial, un-Australian values, militancy and, in the extreme, terrorism. This was reflected in the fact that several Muslim women openly acknowledged that they often expect to be discriminated against or treated differently because of their appearance. Indeed, they admitted that they tend to be defensive even before an interaction had occurred because they have become so used to indiscriminate slurs on their cultural background and religious affiliations (Bouma & Brace-Govan, 2000). In extreme moments such as post-9/11 or most recently in the wake of the Cronulla riots (December 2005), Muslim women had repeatedly expressed that they felt as though they were under siege, and this fear had resulted in numerous reports of them feeling confused and physically frightened to be seen within the public sphere (Bouma & Brace-Govan, 2000: 163; Dreher, 2005; Poynting & Noble, 2004).

7.2 Views around Western Medicine and Traditional Chinese Medicine

The issue of how Western-trained doctors and nurses reacted to parents' use of traditional Chinese and Vietnamese medical practices was also extremely contentious. The majority of Chinese- and Vietnamese-speaking parents/carers explained that they use a combination of Western and Traditional Chinese/Vietnamese Medicines for both themselves and their children and this is mirrored in other health studies (Chan-Yip & Kirmayer, 1998; Immigrant Women's Health Service, 2003; Roy, Torrez, & Conkin Dale, 2004). There is also evidence to suggest that age and gender also play a more significant role than 'ethnicity' per se (Nakar, Vinker, Kitai, Wertman, & Weingarten, 2001; Prior, Pang, & See, 2000). This assertion was also born out in this research where the usual primary caregiver is female, a first generation migrant (mother or grandmother) or second generation parents who are closely connected with older family/community members.

However, parents/carers differentiated their own use from their children's in that they were aware of the potential conflict between using Western and Traditional Chinese Medicines together. The parents' use of TCM also impacts on which GP they choose to supervise their children's health care as several reported that they had either experienced or heard of negative and disparaging responses from Western-trained practitioners. For example, Vietnamese participants, particularly the grandparents, used herbal medicines regularly but were aware that non-Asian doctors objected to them because, as one grandfather stated, they were 'smelly'. The result is that there is a dearth of information about the current use of TCM, primarily due to under-reporting to Western (although not necessarily Anglo-Australian) health professionals (Immigrant Women's Health Service, 2003; Nakar et al., 2001; Roy et al., 2004: 28).

For instance, if I tell a Western-trained GP that my baby's having a cold or hot sweat they will laugh at me and say there's no difference in the Western medical concept, while the Chinese (TCM) doctor will distinguish what is cold or hot sweat and decide the condition of the baby. (Frances – Chinese background)

Parents and carers have also raised concern about reporting TCM use among their children due to the potential threat of child protection issues being raised. They were also aware of Western medical opposition to practices such as 'coin-rubbing', and accusations that the bruising is harmful to the child. For some parents/carers, such negative responses are enough to make them cease these practices, while for others a compromise is seemingly reached:

When my child's got a temperature, I use medicated ointment, rub it first on the back, just on the back, and then use a coin to rub it in. (Focus group participant – Vietnamese background)

What is known, however, is that non- or partial disclosure of alternative/complementary medical treatment immediately sets up a health encounter which is based on mistrust, misinformation and intolerance (Omeri, 2004: 185). Rather, as Fugh-Berman's work (2000) suggests, disclosure will only occur if health professionals at least appear to be non-judgemental and attempt to keep open communication. This is particularly important when ascertaining information from the more vulnerable cohorts in the CALD population — children and the elderly. On a more general level, less information is known about parents' use of 'home remedies' on their children (Roy et al., 2004: 28) with the exception of work by Hornyak et al. (McEvoy et al., 2005). Their research suggested that parents from CALD backgrounds, while prepared to continue taking home remedies, are much more hesitant about using them on their children.

7.3 Formal and informal interpreter use

The use of interpreters within Sydney Children's Hospital has been outlined in detail in our initial report, *We All Come from Somewhere* (Chalmers & Allon, 2002) — suffice to say that interpreter usage is an ongoing issue for

parents/carers and children from CALD backgrounds and this was further evidenced in the data collected in this study. There were many accounts of interpreters not being available when needed, not offered, or merely used as 'voice boxes' where both staff and interpreter see the interpreter's role as passing on information verbatim. However, this dismisses the importance of conveying the context in which language is communicated, that is, the translation of meaning.

Requesting friends or relatives to assist with interpreting is common and there is a wealth of literature on issues relating to the pros and cons of informal interpreting (see, for example, (Heaney & Moreham, 2002)). There are obvious negative repercussions with informal interpreting which include: withholding information, breaking confidentiality, misinformation due to unfamiliarity with medical terms and processes, protecting 'private' family issues, embarrassment in translating and talking about intimate issues. These concerns are further compounded in the case of a child interpreting for their parents/carers, especially when the subject of the health encounter is the child themselves, or their siblings. While some parents/carers who are members of very small communities may be concerned about confidentiality (Cohen et al., 1999: 170), the alternative, as Shun-Hing succinctly points out, places an unreasonable burden of responsibility onto children. She stresses that a young child interpreting for their parents is obviously at a disadvantage because of their age and maturity, as well as their lack of language ability in understanding and hence translating medical terminology.

As we did not talk to GPs in this study, we are unable to report on the usage of professional interpreters among this group. Anecdotal evidence from other studies (Chalmers et al., 2005), however, does suggest that many GPs are unaware that they do have access to the Telephone Interpreter Service (TIS) while it is the case that they are unable to use the NSW Interpreter Service. In contrast, the majority of community-based Child & Family Nurses are aware of and have access to both the NSW Interpreter Service as well as TIS. These nurses generally used the face-to-face interpreter service as necessary although there were some reports of informal interpreting by family members. In the following section (7.5), there is further discussion about the obstacles faced in the usage of TIS services.

Both the benefits and the ethical use of interpreter services have been widely documented in Australia and internationally. Indeed, according to our research most health professionals are aware of their formal requirements to access interpreters for all health encounters with non-English speaking clients (see *NSW Community Relations Commission and Principles of Multiculturalism Act 2000*). Despite this knowledge, because of various institutional, budgetary and time constraints, it is equally acknowledged that informal interpreters are still used across a wide range of health services. Yet there has been very little qualitative

data produced to demonstrate how the Australian situation compares to the international context (Heaney & Moreham, 2002: 40).

7.4 Community-based health care: Child & Family Nurses

As outlined in the introduction, the staff component of this report focuses on the attitudes and educational role of Child & Family Nurses working across several Early Childhood Community Health Centres within the SESIAHS. In-depth interviews were held with 12 nurses. The issues discussed ranged from their professional work practices, including differences between hospital and community-based health care, differing ideas about the role of cultural diversity and parenting practices, to specific descriptions of different cultural practices that they have come across in their work lives.

Professional work practices

Upon entering the Early Childhood Community Health Centres (ECCHC), there was often a sense of controlled chaos in that mothers, babies and young children were playing, talking loudly, and coming and going out of consultations with the nurses. In other words, there was a generally relaxed atmosphere where a safe and comfortable space was created for parents and children. Thus, the obvious starting point for many of these interviews was the different conditions under which Child & Family Nurses worked in contrast to their experiences in hospital nursing. The first major difference expressed was the increased autonomy that came with working in a community setting.

Community? You're much more able to run your own race. I have a space that I can actually call my own. I can work from there, and if someone comes to me and says 'you're doing it wrong,' I can actually say, 'hmm, give me a minute'. I can then close the door and actually reflect on it before it's in my face again. And I think that's the big difference between hospital work and community. (Child & Family Nurse)

This autonomy also means that staff have to be much more self-sufficient — therefore team work plays an important role in the running of the centres. In contrast, one nurse suggested that in the hospital you are supported by a large established hierarchical system with the associated high level of technology to assist staff. Community work, she asserted, by its very nature, means that you are an autonomous practitioner and it was generally recognised that community health staff need to think through and deal with situations as they occur:

How do you deal with each situation? You have to be thinking on your feet all the time, whereas in the hospital system there's always some back-up, there's always somebody, there's always a doctor, there's always another colleague. Here, you're very much on your own. ... Yeah, okay, maybe it's not so much life and death situations but, nevertheless, you know the need is real. So I think that's the difference. (Child & Family Nurse)

There was some concern particularly by the Child & Family Nurses from CALD backgrounds that those employed in community nursing do not necessarily

reflect the diversity of the constituencies they serve. There were also recommendations by these nurses that there was a large need in some areas for more designated cross-cultural health workers. This, they explained, was in response to calling on nurses who speak more than one language to use their language skills as impromptu interpreters and educators. The result is a high incidence of burnout of these nurses who often undertake transfers because they cannot meet the demands of the communities. At the same time, one nurse suggested that, just because large numbers of women from Chinese backgrounds access clinics in south-eastern Sydney, this does not mean that the overall need has been met. Rather, she argues that:

Because it's a big population, of course you're going to see a lot of them (women from a Chinese background) coming to the clinic, but there's a whole lot more that don't come. And what do you do about them? ... I definitely feel we should have somebody. We did have a Chinese-speaking nurse but she was burnt out, same as me. I try and do it but because my language skills are not that good, I find that I'm constantly very frustrated that I'm not giving quite as good a service as I'd like to. (Child & Family Nurse)

Another nurse from a CALD background, who worked extensively as a community nurse in the UK, reflected on the fact that there is much greater outreach into the community in the UK, rather than expecting the community to come to established traditional health services. She hopes that in some way, the *Families First* home visiting program may address some of these concerns and goes on to say that this should be part of the Child & Family Nurse's role rather than remaining relatively isolated in their respective community centres. To shift this mindset, she argues that there needs to be increased public education and outreach work to access more families whose children are likely to be at risk:

I feel very frustrated. People don't know about me. People know about a doctor, people know about teachers, social workers, but they don't know about the Child & Family Health Nurse. So we've got to do something about that, and until we do we're not going to be able to have people accessing the service properly. (Child & Family Nurse)

On the same issue, a Child & Family Nurse adamantly declared that if there are parents who don't think they will be supported, they just won't come to the clinic and they fall off their radar:

We're talking about keeping an engagement with people who might be at risk and if you say, 'you've got to do this', well, the first thing they're going to say is 'well, piss off!' ... Why do you think I get Aboriginal people coming here who won't tell me they're Aboriginal? They don't want to be identified as Aboriginal. That says to me a lot about the way we pigeonhole people and the way they're subsequently treated. (Child & Family Nurse)

The differences between community and hospital nursing are significant, one nurse explained. The most marked difference is that they are generally dealing

with prevention and social well-being rather than acute illness or injury. Nevertheless, when she first came into community nursing, she was very task-oriented and relied heavily on what the textbooks told her, not on her 'gut feelings' which she said was, in fact, based on her professional knowledge and experience. Nor did she trust the mothers' gut feelings about their own children. She also criticised the constant bombardment of advice that mothers receive that it is enough to make any mother not trust themselves. She described her attitude in her first few years as quite prescriptive but has come a long way since then, now seeing her role in terms of being a health educator.

Another nurse cast her mind back to when she began working in community health and commented that not only has there been a significant change in the demographics of Sydney but also a change in community nursing which emphasises collaboration with the whole family over a more hospital-based approach.

Things have changed in the way we work. When I first started [20 years ago] it was just checking the baby. Now it's more the whole family, what's happening to the family. So I suppose with that change in our role from Baby Health to Early Childhood to Child & Family Health you're seeing things a bit differently. (Child & Family Nurse)

This has involved a shift in power relations. Instead of lecturing or dictating what the medical 'experts' see as appropriate care, the majority of the nurses interviewed expressed their role as a health mediator. The shift is about finding out what the concerns and practices of the individual mother are and then providing them with the relevant information:

We're not the parent. So, [it's about] leaving them to decide what to do. We can only guide, we can't enforce anything. We're not the police. But you kind of ask them what they're doing and what their practices were and things like that. (Child & Family Nurse)

Many mothers who come to community health centres, Kim suggests, are just looking for reassurance but she warns that it is very easy to turn them off by seemingly criticising the way they do things — and once that happens they don't come back.

7.5 Cultural diversity and parenting practices: community health responses

It was clear that many of the nurses we spoke with were very good communicators and listeners. This is essential because, as was stated above, reassurance when facing parenting (and often for the first time) is central to both the child and parents' health and well-being. When childbirth and parenting occur within a new and unknown cultural and social environment, without familiar family and community support, the ECCHC becomes a critical safety valve for women and their children. Indeed, it was reported that women will come to the centre because they have had a bad experience or feel unable to cope and need to find a sympathetic and knowledgeable sounding board for their fears.

A further factor, according to several nurses, that differentiated their work practices from those in the hospital was a greater opportunity to be flexible. This increased flexibility, it was suggested, comes from a combination of diverse personal and professional interactions that are gained over one's working life. It is also closely related to the issue of greater autonomy. According to one nurse who has worked across several countries, 'cultural competence' in health care is premised on some basic principles that stay relatively the same. It's just, she says, a matter of adjusting these principles to the particular cultural practice or value system to make it acceptable:

So we'd always look if it was beneficial, you'd reinforce it. If it made no difference, you'd just accept it happily, and if it was something really negative, you'd try and find out an acceptable way of bringing about the change in that practice. For example, here Jewish people have the red cotton, it's something to protect their babies. And all cultures have something like that. Christians will have St Christopher, or Arabic mums will often have that blue eye to protect their babies. So you would see the same belief, but manifested in a different way. And I think it enriches your life, to be honest, to know what traditional practices are there, and what they mean and so on. (Child & Family Nurse)

Similarly, another nurse asserts that the most important thing for her is to keep an open mind when trying to understand and work with other cultural values and practices:

For example, the Central Europeans have a piece of yellow, it looks like yellow stone. It's like really hard barley sugar that they boil and give their babies with colic. And you think, well, I mean they've been doing it for generations. It must be okay. (Child & Family Nurse)

In contrast to the above comments, there was a minority of nurses who — possibly because of minimal contact with clients from CALD backgrounds — did not feel diversity issues were relevant to their nursing practice. On the one hand, whether these attitudes impact on who accesses these clinics is not known. However, it is evident from the literature and previous comments from nurses that 'engagement' and a sense of 'curiosity' around cultural diversity encourages feelings of safety and belonging. On the other hand, it is also significant that education or training around cultural competency skills was non-existent. Indeed, one nurse stated that she had never heard of the term 'cultural competency':

Basically, we're dealing with the well-being — primarily really — of the baby, and then with the mother. So, in a way, because you're focused on the health, on the guidelines — because you're operating within such strict guidelines — of course you approach things as best as you can under the circumstances. So regardless of everything else, their health is paramount. So any other issues we have, really, I don't regard that as being my expertise. (Child & Family Nurse)

We all learn the same thing and that's the knowledge we impart. Now, their cultural differences may well be very different but they are the Department of Health guidelines that we have to follow, whether that fits into their cultural background or not. (Child & Family Nurse)

The guidelines referred to above are those of the World Health Organisation and the NSW Department of Health guidelines. There are certain directives that need to be followed, including recommending immunisation and domestic violence and psychosocial screenings (the latter two being fairly recent additions). However, according to a widely used social model of health care circulated by the World Health Organisation:

Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity. (Jirojwong & Manderson, 2001)

While these nurses acknowledge that the information they give may not be followed when the parent leaves, they feel that they have fulfilled their responsibility as professionals. One nurse also expressed the opinion that 'best practice' equates with following the needs of the status quo or the majority.

I think that a lot of people like to do what's done here [in Australia], don't you think? What's accepted ... they like to know what's medically correct and not what's culturally correct. (Child & Family Nurse)

Consequently, other than asking questions about the physical health of the child and by extension the mother, she feels any other questions are not part of her professional sphere. She went on to assert that asking someone about their religious affiliations was an invasion of privacy and that they are prohibited from asking such questions. In fact, on further examination of this issue, it was found that while Child & Family Nurses are not 'prohibited' from asking this question, it was described as being 'unnecessary', 'of no benefit' and 'time consuming'.⁶ Yet another community nurse made the point that often the cultural practices that one sees are in fact closely intertwined with religious expression that manifest in daily values, attitudes and behaviours.

She continued to say that she is sometimes at a loss to counter what is and isn't good health practice. She explained that all she can do is to present the information she has learned and let the parents make the final decision:

I mean, how do we know that all these things, practices that we're doing in the Western way is the best way? ... In some cultures, for thousands of years these civilisations have managed. ... So yes, I'd like to see more research going into what is the best practice. ... I mean, it's very hard because I've had people challenging me. 'Oh, but my mum's been doing this with us, and look at us! There's nothing wrong with us!' Sometimes we're stumped you know. ... So I give them all the advice of

⁶ Information gained through contacts made by Sydney Children's Hospital's Diversity Health Coordinator.

what I know best now, and then again it's up to you to make well-informed choices. If you choose not to do those things, that's your right. (Child & Family Nurse)

Cultural practices, particularly around the birth of a child, are often significant for parents and can symbolise the future health outcomes of a child (Liamputtong Rice & Watson, 2002: 823-24). One senior Nurse commented that sometimes when a staff member feels that cultural issues are outside the scope of their basic nursing skills, she tries to explain the relevance for the parents involved:

You know, when that (umbilical) cord came off and while you examined it and then tossed it in the bin, did it occur to you that you might say, 'oh, the cord — is there anything special about the cord that you want it kept?' The nurse replied, 'who would want to keep a cord?' And I said, 'well, that's not actually the point. You might be horrified, but it might be something very significant to her because it's part of her body'. So you point things out like that. (Child & Family Nurse)

While training in relation to mandatory screening is compulsory for Child & Family Nurses, education around cultural competency skills is minimal at best and non-existent for most of the nurses with whom we spoke.

In addition, nominal centre resources and staff training support also impacted on nurses' abilities to offer more inclusive and equitable services. For example, numerous nurses commented that they were strongly discouraged from using telephone interpreters because, firstly, they were too expensive and, secondly, the equipment in the centres were so basic that no one had access to speaker phones that would enable a more open conversation with the client. Rather, phones needed to be passed around, proving to be a clumsy and awkward feat which did not allow for good quality communication. The issue of telephone interpreting becomes further complicated because several centres had only one phone line that was also used for their fax machine. Given that it is not unusual to wait up to 30 minutes on the phone to get through to make a booking, the phone line and staff member are tied up for long periods of time. Furthermore, despite several centres visited, there were no computers available at any of these places. Unavailability of computers also means that the monthly collection of data, storage and dissemination of information is extremely time-consuming and cumbersome.

Everything is very much handwritten and ... we're working in a very obsolete structure here, and I think that we need to move on. We're in the 21st century but we're still working on hardcopies — and we've got no support here. (Child & Family Nurse)

Thus, for staff to access multicultural health material such as translated fact sheets or access to information about optional training sessions, they relied on word-of-mouth or regular mail. It was reported that, often when training sessions are available, staff often cannot attend because either they have not received the information or the training is over before the information has arrived. However, the main obstacle for those nurses who run local small clinics by themselves was

about making a choice between closing their clinic and attending a training session, the latter option often losing out.

7.6 Informal networks, parenting and health care

Women unable to communicate effectively in English are less likely to be able to access services, including health care (MacIntyre, 1994: 160) and this results in an increase in social isolation and a decrease in emotional health. This also affects their entry into employment which subsequently blocks their access to paid child care. As previously stated, several of the women with whom we spoke also found that their qualifications were not recognised in Australia and they were unable to find neither the time nor the money to gain equivalent qualifications or retraining (Castles, 2000: 36-7).

Language was constantly mentioned as a major barrier to accessing both formal and informal networks in Australian society. Whether residing in Australia for a few or many years, lack of access to English classes for women — after finding housing, schooling and employment for their children and male partner (Pittaway, 1991) — was often identified as the main marker of difference:

Really, I regret, and I told myself I should have done this [learn English] from the beginning when I came here to Australia, because language was the barrier between me and Australian society. And I mean, you think these people are different from us, but really when I have contact with them, I think lots of barriers went [away]. (Najla – Lebanese background)

One of the barriers Najla refers to is, again, the derisive manner in which Anglo-Australians responded to her, explaining that they would neither listen nor give her an opportunity to speak. Najla says that, at times, people would laugh at her because she couldn't communicate well in English and this undermined her confidence to the point that she no longer wanted to participate in broader Australian society. As a result, for many years she stayed within a closed social and economic network where she could communicate without feeling censured.

The isolation that many women feel cannot be underestimated. Several women in each of the three groups described the extreme feelings of social isolation they felt when they first arrived in Australia and once again when they were left at home with young children while their partners worked extremely long hours (Raphael, 2001: 12). This is further exacerbated by a lack of social networks and limited familial support:

I'll tell you the truth. I was so sad in the beginning, because the feelings of leaving the family — I didn't expect it to be that hard. I was crying for about one and a half years. I was by myself, no one was here. All my family was in Egypt. All my husband's side are here ... and it was very hard to deal with them, because I didn't know them very well and the relationship was very tense then. To go all the time to them and not see my family and not to see anyone, I got jealous sometimes. And I was so sad, so scared, so unprepared. (Amal – Egyptian background)

Kit-Ling explained that, in Taiwan, after giving birth one's mother would normally do most of the work in the house including washing, cleaning and making the meals. She also had brothers and sisters in Taiwan that she used to rely on for help and advice. Kit-Ling raised the problem of not knowing how to access child-related information and it was due to this lack of information that her first son spent his first two years not interacting with other children. This absence of relatives and friends may mean more support is needed from professional services to compensate for this, and to thus fill an integral role in the communication of health information for parents.

To a small degree there has been some response to this situation from SESIAHS, having employed a nurse to work with Chinese mothers in order to assist them in their post-natal care. This nurse not only runs groups at one of the ECCH centres but also undertakes home visits for Chinese women who choose not to leave the house for the first 30 days. She has found that the hospital midwives tend to promote breastfeeding as the only way to 'correctly' feed a baby, even when women are having difficulties doing so. Some mothers, she says, resent this inflexibility and so upon returning home stop breastfeeding. This worker had also found that these women tend to give up on breastfeeding very easily when they do not have support. The home visits are not part of the Area Health Service's official policy but was initiated by this particular Child & Family Nurse to deal with the gap in services.

Frances was introduced to a Chinese-speaking mothers' group at the Early Childhood Centre by a midwife at the hospital after she gave birth. This centre had a very experienced Chinese-speaking (Mandarin) Child & Family Nurse and the mothers' groups were extremely well-attended. Interestingly, she explained that while she received a lot of useful practical information, emotionally she still felt very isolated. Consequently, she relied on phone calls to friends to relieve her emotional stress.

For the health worker, her job is to give me some guidelines to manage my daily life. For emotion, I feel this is my personal problem. (Frances – Chinese background)

The use of Early Childhood Community Health Centres is a new concept for many mothers from China because in China it is more the case that parents, relatives and social networks are firmly in place. Instead of attending a clinic, new parents usually rely on the experience and knowledge of their own personal networks to take care of any problems as they surface.

There are a number of ethno-specific playgroups and mothers' groups for women and children from a Chinese background within the SESIAHS region and they have proven to be extremely popular. While these groups are advertised as a way of offering information and early childhood health education, one Child & Family Nurse explained that the main aim is to assist Chinese mothers to meet up with other families in the area. Another nurse concurred that the isolation

these women feel could be overwhelming and can significantly affect their own as well as their children's health outcomes.

Yet there was a tendency among this group of women to neither acknowledge the term 'depression' nor to recognise their feelings within a Western medical paradigm. Health care workers reported that they have noticed — particularly among Chinese mothers — that their ability to express loneliness, sadness and grief (Yick & Gupta, 2002) can reach an all-time low before they can externalise their feelings:

If it's a Chinese lady that's depressed – if I know she's depressed because she's told me or she's burst into tears I know things are really bad because they won't cry. They hide it. So if she tells me that she is sad, I take it very seriously. (Child & Family Nurse)

The point was also made that 'post-natal depression' exists among both rich and poor families. However, the way different socioeconomic groups respond take on many forms:

The first time I said to a mother she needs to go for brisk exercise, it would help her depression each day, I was thinking like a walk around the park with the pram, you know, 30 minutes will get you going. And she said, 'have you got a list of personal trainers?' Well, that was day two here. (Child & Family Nurse)

This same nurse noted that, working in a high socioeconomic area, issues around depression and 'mental illness' in general tended to be swept under the carpet. This is in contradiction to the commonly held belief that rich people are, by definition, healthy.

I suppose if they're more upper class they do come in and seek out, they access services more. They know what to look for to get advice and look out for things. Whereas those in a lower economic bracket may not access services at all. They stay home and do what their mothers, neighbours and friends tell them to do, or do what they think. (Child & Family Nurse)

However, as mentioned previously, what one expects from a health service, knowing how to access it and understanding the culture of the system needs to be contextualised within a broader framework of where one comes from, what one is used to, community, friends and relatives' expectations, education levels, employment status, what one looks like and how well one can articulate one's needs. There is no doubt that those parents who have greater access to economic and social capital (Allen & Mitchell, 1996: 17) are in a better position to deal with, in particular, their physical health needs. However, many women internalise fears about their apparent inability to raise children especially when they are inundated by media advice and representations of 'motherhood' and parenting as though it were a universal, 'natural' phenomenon.

Self-confidence is often connected to the cultural appropriateness of parenting practices and feelings of social inclusion for both parents and children. Wise and Sanson (2000: 12) have argued that when children have a smooth transition between home and child care, cultural conflict is minimal. This research supports this finding but extends the importance of encountering minimal cultural conflict to the parents as well.

Several women felt strongly about participating in the mothers' and children's Chinese playgroups:

I want my child to understand Chinese, at least understand it even if she can't read or write. But at least she can speak because they still have grandparents and relatives who only speak Chinese. But if they only hear the language from their parents like me, that's not enough. They need to get friends who speak the same language and be happy. When we come here, at least she can see someone like herself. I also send my daughter to the long day care. She's the only Chinese child there and I feel she's not very happy because the others don't understand her language. I think for her it's quite easy to pick up English later, so I let her be. Here, she will feel something equal and friendly that can balance her if you know what I mean. So I think it's very important. No matter how busy, I bring her here every week. (Focus group participant – Chinese background)

Another participant from a Chinese background continued to explain the discomfort she feels when attending a predominantly Anglo-Australian playgroup. Sometimes, she says, it is not that the parents in these groups are unfriendly but often the difference in the level of English makes it difficult to have involved conversations, and therefore communication remains at a basic level. However, it can also be due to subtle and not-so-subtle disapprovals about different ways of providing for their children:

Yes, I've been to playgroups where I'm the only Asian, not just the only Chinese. And when I talk about how I feed my baby, all the ladies come up to me and say 'no, no, no! You shouldn't follow the tin! That's why your baby's crying, it's not enough. How much are you feeding him?' The can says 120ml but they say to feed him 180ml. I mean, in Asia that's our size. I mean, they can suggest it to me, but when the whole group comes to you and they are standing opposite and you are alone, you say, 'hang on, I'm not one of them. I don't belong here'. (Focus group participant – Chinese background)

Interestingly, a number of mothers from Chinese backgrounds — even those who have been in Australia for 10 years or more — indicated that they still felt like 'migrants' when they attend Anglo-Australian child care groups. However, this does not stop them attending but rather ensures that their children experience both worlds.

Many participants in the Vietnamese focus groups indicated that they use their informal networks to initially gain health advice for their children. For example, Cuong's parents-in-law worked in the health care system in Vietnam where they

were both nurses. Thus, Cuong initially calls on their expertise when his child is ill. This access to informal health networks was similarly articulated by other participants who also had connections with people among the older generation who had previous experience with other health care systems. For those who lived in rural areas in Vietnam, health care was often limited to the use of local plants that were easily accessible and affordable (Lee & Mathews, 1982: 4), and this form of traditional medicine (Marr, 1987) continues to be used when the ingredients are available.

Similarly, Nguyen relayed stories of people within the Vietnamese community who access ex-nurses or pharmacists, ie people whose qualifications were unrecognised in Australia, for minor ailments. In some cases, they may suggest particular kinds of medication or may have connections with local pharmacies, and people may act on their advice having known that person and having trusted in their previous medical experience. However, it should be noted that this was not common and only acted upon by a minority of people.

One mother of Egyptian background found the waiting times at the hospital Emergency Department so long that if one of her children became ill at night, she would sometimes call friends for advice and administer medication that she already had at home. She knew this wasn't right but, like comparable accounts, she was not able to leave her other children alone at night, often relying on her husband to drive her to the hospital.

Many of the accounts in this report have demonstrated the importance of social networks and this supports other research undertaken in Australia (Kolar & Soriano, 2000; Neufeld et al., 2002). Further to the AHMACs findings, the *Non-English Speaking Background Women's Health Strategy* (Alcorso & Schofield, 1991) also found that social networks were equally, if not more, important than formal English classes. Due to employment and child care commitments and/or financial constraints, many women are unable to access formal English tuition. It is assumed that the majority of Australian families are 'naturally' tied into several networks including familial, friendship, school, employment, sports, political and/or religious associations. However, for many people from a range of CALD backgrounds this is not necessarily the case. It is therefore incumbent on health professionals to actively assist in developing both informal and formal links which will enable parents to provide both culturally relevant and good quality health care in order to encourage and sustain their children's long-term health and social well-being.

8. Appendix

8.1 Individual staff interview questions

1. Can you describe your cultural background? And, what does it mean to you?
2. Can you describe some positive experiences you have seen or encountered when working with CALD families? How do you think this situation impacted on the child, parent(s) and your ability to offer best quality care?
3. Can you describe any negative experiences that you have encountered when working with CALD families? How do you think this situation impacted on the child, parent(s) and your ability to offer best quality care?
4. Have you ever encountered a situation where there was tension between parents/carers and their children?
5. What is your definition of 'good parenting'?
6. Do you think parenting and caring for children is influenced by different cultural practices? If you think so, can you describe in what ways some of these practices differ?
7. How involved do you think parents should be in the health care of their child?
8. Do you think your workplace practices are linked to any one culture? If so, can you describe this culture(s)? If not, how would you describe your workplace environment?
9. To what extent do you think parents/carers and children from CALD backgrounds should fit into mainstream health services? Can you explain your response?
10. What expectations do you have of parents/carers when you are taking care of their child(ren)? Do you expect, for example, punctuality, adherence to medication regimes, conforming to dietary requirements or English language competency?

8.2 Parents/carers focus group questions:

1. What does it mean to you to be a 'good' parent in your country/culture of origin?
2. Do you think your way of parenting has changed since coming to Australia? If so, how?
3. How does the way you bring up your children differ from the way you were brought up by your parents?
4. What do you think it means to be a 'good' parent in Australia? Is this different from your previous answer? If so, in what ways?
5. How does your idea of parenting differ a) between raising a boy or girl and b) in terms of age, from what you see when observing Anglo-European parenting practices?
6. When your child is unwell what do you do, where do you go?
7. Do you face any difficulties when accessing health care facilities for your child? If so, can you talk about what the problems are?
8. Have you ever encountered disapproval or antagonism (verbal or non-verbal) by a) health or community workers b) by others in the general community toward how you parent? If so, what forms did they take?
9. Do you use other forms of healing other than the western model of health care? If so, can you describe these?
10. What roles do other members of your family/social network play in supporting you when your child is unwell? Do you have other social networks that you access when you need help with your children?

8.3 Individual parents/carers interview questions:

1. What is your cultural and religious background and what language do you speak at home with your respective family members?
2. How long have you and your family lived in Australia and under what circumstances did you come to Australia?
3. In your country of origin was your child(ren) ever admitted to hospital? Can you tell us about that experience(s)?
4. Has your child(ren) ever been to a hospital or child health clinic in Australia? Can you tell us about that experience(s)?
5. Do you have a regular doctor in your local area that you go to when you or your family are sick? How long have you been seeing her/him?
6. In your contact with any health workers do you feel confident and in control of the situation? For example, are you able to communicate in terms of understanding language, medical jargon or when asking questions?
7. How do you know when your child is sick or not feeling well? Are there certain signs that you look for?
8. If you had to make an important decision about your child's health, who or where would you look for guidance and could you explain why?
9. As a parent, what do you think your main responsibilities are toward your child(ren)? How does this role differ from other family members' roles?
10. What religious or cultural activities do you consider important for your families' well-being, health and happiness?

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