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## **Supporting Pakistani and Chinese families with young children: perspectives of mothers and health visitors**

### **Abstract**

**Background:** In the UK, public health nurses (health visitors) provide support and advice to families with young children, including those from minority ethnic communities. While the need for cultural sensitivity is being increasingly recognised, the factors which contribute to this sensitivity are poorly understood. The Pakistani and Chinese communities constitute the two largest minority ethnic groups in Scotland. This study explored Pakistani and Chinese women's experience of motherhood and of the health visiting service and public health nurses' experiences of working with Chinese and Pakistani mothers.

**Methods:** Semi-structured individual interviews were carried out with 16 Pakistani and 15 Chinese mothers. Eight health visitors took part in two focus groups. The study was undertaken in an urban area of Scotland. Data were analysed thematically.

**Findings:** Chinese and Pakistani mothers negotiate complex processes in order to ensure that their children maintain their own ethnic identity while fitting in with their peers in their adopted country. Health visitors were seen as supportive, although sometimes advice and information given was culturally inappropriate, and their role was often poorly understood. Health visitors were anxious to be sensitive to families' religious and cultural beliefs.

**Conclusions:** Cultural sensitivity is an important factor in providing appropriate advice and help to Pakistani and Chinese families, and involves health visitors in considering views and practices on parenting which may differ across cultures, including their own. Family characteristics need to be understood on an individual basis, rather than making assumptions

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about clients' cultural norms and lifestyles. This is best achieved by exploring with mothers if they understand the advice and information they are being offered and also if it is appropriate to their cultural and religious beliefs.

**Key words:** cultural sensitivity, parenting, health visiting, mothers, Pakistani, Chinese, public health

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## **Supporting Pakistani and Chinese families with young children: perspectives of mothers and health visitors**

### **Introduction**

Increasing globalisation and ethnic diversification emphasise the need for 'culturally sensitive' health services. However, the factors which contribute to such sensitivity are poorly understood (Netto *et al.* 2010), with much of the literature on cultural sensitivity assuming that specific cultural groups have consistent values (Liamputtong and Naksook 2003). In the UK, health visitors support families with young children, including those in minority ethnic communities. This is challenging work given that beliefs and attitudes about parenting are likely to be culturally constructed as well as influenced by individual experiences (Li *et al.* 2010). Parenting practices change as minority ethnic families from undergo the process of acculturation, depending on many factors including family structure, socio-economic status and English proficiency (Portes and Rumbaut 2006). Parents are often seeking ways to maintain important aspects of their own culture while relinquishing some to help their children assimilate into the host society (Londhe 2009).

Resnicow *et al.* (1999) have distinguished between interventions adapted at 'surface structure' and those adapted at 'deep structure.' The former match interventions to observable characteristics, such as diet and language, while the latter interventions engage with cultural, social, historical, environmental and psychological forces that influence health behaviour. Resnicow *et al.* (1999) argue that while the former will increase the 'receptivity' of health-related messages, it is only the latter which will impact on behavioural change. These distinctions are important in providing a culturally sensitive health visiting service, given its role in promoting parenting behaviours.

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While user perspectives are being increasingly recognised in the development of health services (Department of Health 2012, Scottish Government 2008), little is known about minority ethnic families' experience of the health visiting service. This paper explores Pakistani and Chinese women's experience of parenthood and the health visiting service and also health visitors' experience of working with Pakistani and Chinese families.

### ***Health and social context of the Pakistani and Chinese communities***

The Pakistani and Chinese communities comprise respectively 23% and 10% of Scotland's non-white minority ethnic population, who constitute only 3% of the total Scottish population (Scottish Government 2012); . The Pakistani community have the poorest health of all ethnic groups in the United Kingdom (Equality and Human Rights Commission 2010). while the socio-economic and health status of the Chinese population in Scotland compares overall, favourably with that of the white population, (Scottish Government 2012 but some studies suggest that mental health problems may be relatively common amongst Chinese women (Chan, 2000, Guo & Wright, 2005).

The aims of the study were to explore Pakistani and Chinese mothers' experiences of being the parent of a young child and of the health visiting service and health visitors' experiences of working with Pakistani and Chinese families with young children.

## **Methods**

### ***Setting***

The study was carried out in one health board in an urban area of Scotland. Ethical approval was obtained from the local NHS ethics committee prior to undertaking the study.

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### ***Participants***

Participants comprised 16 Pakistani and 15 Chinese mothers and eight health visitors.

The mothers (16 Pakistani and 15 Chinese) were purposively recruited, mainly via health visitors, to represent a range in terms of age, number of children, fluency in English, number of years lived in the UK, geographical location and professional or educational background. (see Table 1). Half of the participants from each ethnic group had fluent English and the remainder little or no English. Chinese mothers were generally older than Pakistani mothers, and had fewer children.

Bilingual research assistants assisted in the recruitment of mothers who were not fluent in English. -. Written consent was obtained from all participants prior to taking part in the study. Eight health visitors ( seven white and one African), all of whom had experience of working with Pakistani and Chinese families, were also recruited to take part in the study.

### ***Research approach***

Author 2 carried out individual semi-structured interviews with mothers with fluent English, in their own homes, to obtain rich, in-depth qualitative data (Britten 2006). Interviews with mothers with limited or no English were carried out by research assistants whose first language was that of the mother and who also spoke fluent English, or in some cases by Author 1 and an interpreter.

Health visitors took part in one of two focus groups, facilitated by Authors 1 and 2. Table 2 provides examples of topics covered during interviews with mothers and focus groups with health visitors.

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The data were audio-taped and transcribed verbatim. The interviews with mothers with no or limited English were translated and transcribed by the research assistants who had undertaken the interviews

The data were organised using NVivo software. Units of meaning were given codes, which were condensed into categories and then themes (Graneheim & Lundman 2004). Themes from individual transcripts were compared to signify higher order themes that reflected the larger data corpus.

## **Findings**

The findings are presented thematically, with quotations from interviews with Pakistani (P) and Chinese (C) mothers and health visitor focus groups (HVFG). The main themes which appeared particularly relevant to providing culturally sensitive support to parents involve the juxtaposition of traditional values, beliefs and lifestyles and the western environment in which families were living.

### ***Family structures and relationships***

Some women, particularly Pakistani women, were living or had lived with extended family, which in some situations was a source of support:

*"I was very young when I had my first one, we lived with my in-laws, so it was like a joint family system. I had lots of help from my mother-in-law." (P1)*

However, others found they were expected to look after their parents-in-law as well as children:

*"The husband has to look after his mum, so the wife is expected to stay in the house and look after the parents-in-law while the husband goes off to work." (P4)*

One Chinese mother described a positive aspect of living in the same household as her sister:

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*"But I'm really fortunate because my sister helps me when I'm down. When she's really naughty my sister will share the burden." (C 5)*

The complexities of the structure and role of the extended family in Pakistani and Chinese households could also prove a challenge for health visitors:

*"But it's the extended family that you've got to take into consideration....., you're not just dealing with the immediate family, it's a much bigger picture." (HVFG1)*

This meant that health visitors had to recognise the power dynamics within an extended family situation, with various family members having a significant influence on how children were brought up.

In contrast, other women who did not live with or near extended family appeared very isolated, especially when they were not fluent in English:

*"I just go out for shopping. My health visitor is like a light for me in a dark world. Nobody's here, I much appreciate it. I talk in Pakistan, I say don't worry, mum, I have a friend here." (P16)*

In these instances, mothers tended to be more reliant on health visitor advice and guidance. Moreover, they could come to see the health visitor as a friend as well as a supportive professional, and thus as to some extent, substituting family and peer support.

### ***Parenting in gendered, cultural and religious contexts***

Whether living in extended families or not, Pakistani and Chinese parents in our study appeared to adopt specific gender roles. Several mothers said that children were their responsibility, and working outside the home to earn money was the father's responsibility. Many Pakistani and Chinese fathers worked long hours in restaurants and small businesses, and therefore had limited time available to spend with their families. The participants in the study appeared to accept this. For instance, one mother explained:



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*"So when he is in work I look after my children, my home and when he comes back I cook for him. So these are my duties and I like it, this is my responsibility because my husband works for us." (P7)*

Linked to the gendered nature of parenting, motherhood appeared to be particularly central to Chinese and Pakistani women's identity, as illustrated by two mothers:

*"I feel very proud to be a mother, I feel valued, I've got a purpose." (P8)*

*"I feel happy, I don't mind. I don't need to go out to see any people." (C 11)*

Some Pakistani mothers said that they felt that as well as generally becoming mothers younger than white women, they were generally more likely to have several children at a much earlier age than white women because this was the norm in Pakistani families. This was not evident for Chinese participants who were generally older than the Pakistani mothers.

Some Pakistani mothers described their Islamic faith as being an important influence on their lives and their approach to childrearing, and they were concerned about children adopting British norms in terms of dress, and consuming alcohol and drugs, when they were older. One mother described why she felt she needed to ensure that her children understood their religious background and the bearing this had on their expected behaviour:

*"There are lots of boundaries and rules. If they're not understanding their own religion, they're obviously going to be on the boundaries." (P4)*

Some Pakistani mothers believed that their Muslim faith helped them to accept the difficulties they encountered caring for a large number of children, sometimes in difficult circumstances. One mother, who lived with her depressed husband and six children in a small flat, explained why she felt able to cope with her situation:

*"We are Muslims, we do it. My mother had eight children so why wouldn't I manage." (P9)*

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Religion did not seem to hold such a strong influence on childrearing for Chinese mothers as it did for Pakistani mothers. However, the underlying philosophy of some faiths, while not influencing specific childcare practices, did underpin the behaviour of some Chinese mothers, as one mother explained:

*“With Buddhism, if I do good things, when I go to another life I can get good things. But in this life, if I've done something wrong, then next life is no good.” (C5)*

Some Chinese mothers also had culturally related beliefs, for example, that washing hair within 21 days of delivery could cause prolonged headaches in later life. Such views illustrate that what may be viewed as appropriate post-natal care for mothers could also vary significantly within and between communities. Health visitors have to consider the extent to which they should challenge beliefs that are not consistent with Western medical science, support women in upholding their cultural norms or adopt a neutral stance.

Both Chinese and Pakistani women considered themselves to be more protective of their children than white mothers and worried about them being hurt in playgrounds or in the street. This resulted in mothers believing that Chinese and Pakistani families spend more time within the home than white families. Pakistani and Chinese mothers also seemed reluctant to allow their children to be cared for by others, whether family, friends or professionals. Indeed, some Pakistani mothers did not see any advantages in sending their children to nursery and preferred to care for them at home until they started primary school.

### ***Balancing traditional beliefs and values with need to fit in with western lifestyle***

Many mothers appeared to be continually critically appraising the differences between their traditional culture and that of their adopted country. Significantly, while some childrearing ideologies appeared to be specific to either or both of the two minority ethnic groups, such as

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protectiveness towards children and assuming traditional gendered roles, many mothers showed an openness to adopting some of the British approaches to childcare. For instance, some Chinese mothers said that consistent with some Chinese customs, children are brought up very harshly and there is an overemphasis on formal education. This point was re-iterated by health visitors:

*"but ideas about things like discipline you just have to be very aware of their ideas."*

*(HVFG1)*

While still placing considerable importance on education, some mothers wanted their children to have a more liberal education including music and art.

Some families who were in Scotland temporarily, usually because the father was undertaking a university course with the intention of returning to their home country, were often not interested in adapting to British ways. This indicated the significance of not only length of residence in the country but also of whether the move to Scotland was short-term or expected to be on a long-term or permanent basis.

Many participating Pakistani and Chinese mothers seemed to try to ensure that their children retained traditional norms and values, while fitting into their peer group in the majority population. As one Chinese mother explained:

*"If she's a typical Chinese person she won't cope with the situation here. She has to be a western person and be a Chinese person."* (C6)

This involved considerable effort:

*"Maybe we do have to work twice as hard to explain to them the Scottish side of it and the Pakistan side of it."* (P1)

Many mothers said that they tried to inculcate traditional values in their children when they were very young and more easily influenced by their parents than was likely to be the case as

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they grew up. Similarly, teaching children the language associated with their ethnic group was considered important so that they could communicate with extended family, both older relatives staying locally who could not speak English and those who remained in Pakistan or China.

The conflicting aims of mothers to fit in with local approaches to childrearing while retaining traditional values were mirrored in the way mothers dealt with advice and information given to them; they seemed adept at modifying advice to suit their own situation and values, and to varying degrees, were willing to consider using western approaches to childrearing.

Health visitors noted that sometimes couples who appeared to have very westernised lifestyles, and who were working for large institutions such as insurance companies rather than traditional family businesses, were often under pressure from extended family to adopt traditional ways when they had children, as one health visitor noted:

*“They feel that they should adhere to western culture..... until they get married and have a baby, then it's almost expected that they revert back to very traditional roles.” (HV FG1)*

This return to a traditional way of life was sometimes because of the arrival of family from their home country to help care for the new baby or because of increased involvement of extended family living locally. However, it may also stem from the conscious decision of mothers to teach their children the cultural and religious values of their own ethnic group as described above.

Health visitors observed the tendency of Pakistani and Chinese parents to try to instil religious and cultural values in young children before fitting in with peers became important:

*“And women with younger children were very purist, whereas the ones with teenagers had come to terms with having to give them that freedom.” (HVFG2)*

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This observation reflects the likelihood that parental views of what is considered appropriate among their children are likely to change over time, demonstrating both the nature of the acculturation process and the influence of experiences gained in the rearing of older children.

This suggests that mothers try to balance their own cultural expectations with integrating their children safely into westernised society.

### ***Culturally sensitive health visiting***

Mothers reported that health visitors generally acknowledged cultural and religious factors. Sometimes however, routine advice and information was difficult to understand and use in a traditional Pakistani or Chinese household. Some mothers said that they would benefit from more culturally appropriate nutritional advice, as one mother demonstrated:

*“They don't have Chinese style recipes. So it's difficult because we are not familiar with British ingredients, like custard? That's why I just bought the readymade baby food.” (C2)*

One health visitor described how she had in the past given Chinese families inappropriate advice:

*“They don't like to give children cold foods, I'd been stressing things like yoghurt that is completely inappropriate.” (HVFG1)*

This suggests that health visitors need to familiarise themselves with the traditional diets of these families and consider with mothers how these can be adapted.

Health visitors were anxious not to offend mothers, especially in the early stages when they were trying to build up a relationship. However, once a rapport had been established it was felt that it was often better to check with mothers the appropriateness of questions and advice rather than trying to learn the religious and cultural beliefs of all families:

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*"I often say, 'Is this okay to ask you this in this way?' So that you check out with them, you're being sensitive in saying, 'Is it alright, it's not offending you if I ask you this?'" (HV FG2)*

Mothers in this study said that they particularly appreciated health visitors asking them directly if advice and information was appropriate for them.

From health visitors' perspectives, families' length of residence in the country emerged as a significant determinant in terms of establishing relationships with Chinese and Pakistani mothers. Mothers whose babies were born in Britain understood that professional help was offered to all families with young children, with the routine post-natal visits providing an opportunity to establish a relationship. In contrast, for families arriving in Britain from Pakistan and China, the idea of having professional support with childrearing was an alien concept to them.

Pakistani and Chinese mothers both described their ethnic groups as reticent, which could hamper communication with health visitors.

### ***Communication between health visitors and mothers without fluent English***

Half of our sample spoke little or no English. While some mothers reported that health visitors made good use of interpreters when nobody in the family speaks any English, some mothers with limited English felt that they were unable to communicate effectively with their health visitor as described by one mother:

*"Some I could understand some I couldn't. Maybe because they said that they could understand me they think I could understand them." (C4)*

The assumption that a mother could understand English was often perpetuated because the mother wanted to avoid embarrassment. Mothers and health visitors gave illustrations of

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situations where dialogue was inhibited because a family member was interpreting. Often the family member answered for the mother rather than translating, and sensitive issues such as domestic abuse could not be raised. Even when professional interpreters were used, there was some doubt about whether the answers to questions were always an accurate reflection of the mother's account as one health visitor reflected:

*"I've found sometimes using interpreters, .....they'll put a little fling on it themselves depending on their experience of parenting." (HVFG2)*

Some Pakistani and Chinese mothers suggested that it would be useful to have health workers from their own ethnic group, trained to provide support and information to families, working with health visitors. Health visitors too, believed that there could be benefits in having Pakistani and Chinese bilingual health workers working with health visitors, but that it might be difficult to provide such a service to families from smaller minority ethnic groups.

## **Discussion**

There were commonalities and differences between mothers and health visitors in their understanding of cultural sensitivity. Both mothers and health visitors emphasised the need to recognise the often multi-generational nature of Pakistani and Chinese families, who do not differentiate between the terms 'nuclear family' and 'extended family' (Ochieng (2003). Services therefore need to embrace these family dynamics and their influences on child-rearing. Interestingly, although the two minority ethnic groups studied contrast in terms of socio-economic position and health status, these factors did not emerge as clearly influencing experiences and perceptions of the health visiting service.

Rather than health visitors trying to learn about cultural differences about specific topics, such as diet, the more pragmatic approach of checking with mothers about the suitability of

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advice seems a more effective way of providing culturally sensitive care. This is important given the acknowledgement by both mothers and health visitors, and by previous studies (Portes and Rumbaut 2006, Londhe 2009), that families often adopt aspects of a western lifestyle to varying degrees. This is likely to hold particularly in relation to aspects of childcare which relate to what Resnicow *et al.* (1999) refer to as 'surface structure', such as diet, where it may be easy to adapt the health visitor advice that is provided to the majority population. However, other aspects of childcare, usually relating to more deeply held norms and beliefs such as in the area of discipline, may be contrary to what is considered acceptable or indeed legal in the adopted country (Scottish Executive 2003).

It is also important for health visitors to take account of peoples' lives and the norms they adopt (Netto *et al.* 2010), for example, the long hours worked by many fathers in our study and the sequelae for mothers and children.

Overcoming language barriers in both minority ethnic groups, with or without the help of professional interpreters, also clearly poses a challenge, concurring with Gerrish *et al.* (2004), who have shown that communication problems between patients and healthcare professionals lead to insufficient information exchange and poor health care.

More positively, this study demonstrates that health visitors are aware of the diverse contextual factors which affect parents' approach to childrearing, including cultural, environmental, social and psychological factors, associated with Resnicow *et al.*'s (1999) 'deep level of cultural sensitivity' and viewed as salient in impacting on health-related behavioural change. In particular there was no evidence of the crude stereotyping which was encountered in earlier studies (Bowler 1993; Stubbs 1993). Further, health visitors also appeared to be sensitive to differences within ethnic groups that related to length of stay in the UK, nature and extent of informal support available, likelihood of continuing to live in



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the country and varying degrees of cultural identification. Taking into account levels of acculturation is important; Netto *et al.* (2010) found that this affects the impact of health promotion interventions.

## **Conclusions**

The study findings highlight the need for a health visiting service which can confidently and competently work across diverse ethnic groups. Family structures and relationships, religion, culture and beliefs need to be understood on an individual basis rather than being based on stereotyped notions. All individuals and families have unique characteristics, whether obvious or less easily identified, which need consideration when providing care and support. This is an essential part of user-focused care for all health service users and encourages partnership working to ensure that health needs are assessed and addressed effectively.

The scope and boundaries of the health visiting service need to be made clear to parents.

## **Key messages**

- Pakistani and Chinese mothers value the support they receive from the health visiting service.
- Pakistani and Chinese mothers want to teach children traditional cultural and religious values while ensuring children fit in with their peers.
- Cultural sensitivity in supporting parents involves health visitors in considering practices and views on parenting which may be culturally influenced and involves checking with mothers, that advice and information is appropriate for their cultural and religious beliefs.

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## **Table 2: EXAMPLES OF QUESTIONS USED TO GUIDE INTERVIEWS WITH MOTHERS AND FOCUS GROUPS WITH HEALTH VISITORS**

### **A) Interviews with Mothers**

1. What's it like being the parent of a young child? What do you enjoy and what do you find difficult?
2. What role does your husband play in caring for your child/ children? And others such as extended family, friends etc.?
3. Do you think your own upbringing has affected the way you are bringing up your own children? If so, how?
4. Do religious and cultural factors affect the way you are bringing up your child/ children? If so, how?
5. Can you tell me about any sources of advice and support you use as a parent? How useful are these?
6. What has been your experience of the health visiting service – e.g. understanding of role, good and poor aspects, accessibility, and cultural sensitivity?

### **B) Focus Groups with Health Visitors**

1. How do you think Chinese, Pakistani and white parents are similar and different in their terms of bringing up children?
2. What are the similarities and differences between white, Pakistani and Chinese families in terms of working with them?
3. Do you think there is a need to develop services to support Pakistani and Chinese families? If so, how?