Grandmothers and fathers of young children in a multicultural society.
Scientific, social and ethical issues for health and citizenship education.

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Abstract
The developments in the health sciences provide that for all stages of life, young and old, an enhanced range of value loaded decisions have to be made about one’s own health, starting from predictive genetic counseling up to decisions about one owns death. These decisions are more and more complex and the need for consultation by citizens is growing. Young children (0-4 years old) depend on the decisions of their parents and other relatives about their lives. Health authorities play a consultancy role. In ethnically coloured regions of Amsterdam the mother is the real decision maker for their children’s health, independent of the ethnical setting. Next to them, grandmothers, fathers and house doctors play a role too. The municipal health authorities play a role in the margin, according to the mothers (Brinkman, 2006). In this paper we describe an inventory into the role of grandmothers and fathers of young children in ethnic minorities in Dutch cities by interviewing them about their values in life, their health and their (grand) children. The outcomes will focus discussions about how health authorities can integrate the way of thinking of these ‘partners in education’ in a more effective communication strategy about health education for young children.

Introduction
Holland is a country of migrants, also in the perspective of health care. Non Western migrants form ten percent of the Dutch population. In some regions in the Netherlands the number of migrant inhabitants surpasses the number of autochthones. Some parts of Amsterdam are almost exclusively inhabited by migrants. There are marked differences in language, mores and looking’s between ethnic groups. And also in lifestyle and health.
Research about the access of migrants to health care institutions in the Netherlands has been started only recently. One of the problems is the generation of valid research data and the validation of quantitative research instruments. (Mackenbach et al., 2004). Qualitative research, in general, generates valid data and so seems to be a more appropriate method for these fields of research.
In two ethnically coloured regions of Amsterdam, the municipal health bureau (GGD) observed less frequent consultancy visits to the regional health offices of mothers of children in the age range of 0 – 4 years. The question came forward if the communication between consultancy bureaus and the target groups was appropriate and what could be undertaken to make communication more effective.
The recognition of the existence of personal conceptions of receivers of information prior to communication and their influence upon the effects of communication has led to a reconceptualization of communication as conceptual change (Driver, 1978). In communication about health not only technical issues are on the table, but even more, issues of life and death. In a dialogue between medical doctors and nurses and their patients the sender- and receiver-roles should change repeatedly, thus giving room to an exchange of conceptions about the issues at hand. (Waarlo, 2005). Such a medical communication process gives citizens the opportunity to participate into the making of decisions about their own health. (Marteau, 2005).

There is a third actor in this communication process: the public. Families, friends, peer groups, other mothers, journals and media all contribute in homes, waiting rooms and school gardens via the life – of – every- day talks to a public debate about the topic and thus influence the conceptions of citizens. This public debate is not a formal debate and is most of the time a ‘hidden debate’ as in place as well as in style of exchange. Nevertheless, these hidden debates govern ideas of public responsibility and construct conceptions of social and cultural identities (Hermes, 2005).

The developments in the health sciences provide that for all stages of life, young and old, an enhanced range of value loaded decisions have to be made about one’s own health, starting from predictive genetic counselling up to decisions about one owns death. These decisions are more and more complex and the need for consultation by citizens is growing.

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In this paper we describe an inventory into the role of grandmothers and fathers of young children in ethnic minorities in Dutch cities by interviewing them about their values in life, their health and their (grand) children.

The outcomes will focus discussions about how health authorities can integrate the way of thinking of these ‘partners in education’ in a more effective communication strategy about health education for young children

**Methods**

13 grandmothers of 0 – 4 year old grandchildren from Surinam minorities and 14 Maroc fathers with children in the same age-range have been interviewed about their ideas about health in a hierarchical concept mapping test and in a drawing test. (Brinkman et al., 1988; Kievits et al, 1998)

The respondents were asked for their co-operation in shops, crèches, churches, mosques and schools in Amsterdam. The interviews took place at their homes.

The concept maps were registered on paper, writing down in two minutes words associated with the stimulus word ‘your life’, thereafter in two minutes grouping those words in coherent groups and in another two minutes writing a statement for each group that describes what that group of words has to do with your life. After this a drawing of your life has been made.

Statements have been categorized into themes and elements in the statements have been recognized and their distribution over the themes tabularised. (Brinkman, 1990)

The drawings have been analyzed into components that are placed into the same themes as
from the word tests.

**Results**

The elements found in the word tests and in the drawings of the grandmothers and fathers are summarized in table 1.

Table 1:
Relative distribution (%) of elements in statements and in drawings from ten Surinam grandmothers and from 14 Maroccian fathers.
Total statement elements = 100%; total drawing elements = 100%.

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<td>Work and prosperity</td>
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<td>Land of origin</td>
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The relative distributions of statements and drawings about ‘your life’ give the possibility to compare the categories between the two groups. The results here suggest a global correspondence between the profiles of grandmothers and fathers where the statements in majority can be categorized as ideas about family and friends, about work and prosperity and about health.

A less prominent correspondence can be found in the drawings: nature, beliefs & values and symbols of emotions are roughly parallel in abundance (although nature is almost three times more abundant in grandmothers). However some remarkable differences can be seen here too. Fathers draw more family and work drawings, that are almost absent in the drawings of grandmothers. Grandmothers draw exclusively aspects of emancipation and personal development.
When the elements of statements are seen as the rational part of thinking and the drawings are seen as emotional views, a characterization of views of life between Surinam grandmothers and Maroccian fathers can be made.

Surinam grandmothers and Maroccian fathers seem to think rationally in the same way about their life: families, including (grand)children, friends, work, health and beliefs dominate in the ideas, the land of origin, and personal development play a less dominant role.

Emotionally there are striking differences with the rational statements character and between fathers and grandmothers.

Fathers show emotionally the most correspondence with their rational thoughts, although nature and emotional symbols like hearts and death symbols are new. Development and emancipation seem to be absent in the

Grandmothers seem to be emotionally bound to nature (56% of the drawing elements). Symbols of emotion are here new to their ratio too, as in the fathers’ drawings. Beliefs and emancipation correspond with their rational thoughts about life. Far behind and in contrast with their ratio are emotions about families and work.

Drawings about health aspects are (almost) lacking in both respondent groups making this aspect a more rational than emotional issue.

It has to be noted that municipal health institutes like the GGD Amsterdam never have been mentioned, neither by Surinam grandmothers, nor by Maroccian fathers.

Discussion

If medical agencies want to play a role in the education of citizens in a multicultural society and want to participate in an effective communication process with families of young children about their child’s health, they should be aware of the categorical shift that has taken place in the relation between individual and society.

Beck (1992) describes how in the Western industrial world especially the situation of woman has changed. Woman have been cut loose from marital support which was the material cornerstone of the traditional housewife’s existence. The entire structure of familial ties and support comes under pressure by this individualization process. The type of the negotiated provisional family emerges. Individuals in- and outside the family become the agents of woman’s livelihood, mediated by the market.

In the same time in society a high degree of standardization takes place, not only for money dependent mass consumption but also in other areas. The change from an individual health insurance system in the Netherlands into a standardized health insurance that is the same for every citizen is a recent example. The standardized calls from the health consultancy bureaus to mothers with young children for control, is another one.

These individualization and standardization processes build up a tension between the separate areas of the private sphere and the various areas of the public sphere. Individual situations have the contradictory double face of institutionally dependent individual situations. The liberated individuals become dependent of the labour market and because of that dependent on education, state regulations and support and medical and pedagogical counselling and care.

What do these developments mean for the communication between medical consultancy bureaus and families of young children? Not the standardized monologue letter to the mothers will be effective, as it does not take into account the individual concerns of the family members. In the ‘crossroad’ of communication possibilities (Ruler, 1998) the most influential communication occurs when both sender and receivers engage themselves in a negotiation process of mutual acceptance of each others concerns and needs. Both parties should adapt to, or to say it in educational terms, learn from each other.

Research is important for this negotiation, to discover which concerns are on the table.
This inventory gives, we hope, a contribution by giving some insight into the concerns of Surinam and Maroccian families of young children. A Surinam marital tradition of the broad family that takes its responsibility as a whole for the child is found here too in Maroccian families, stressing the role of families. That means that in the consultancy communication with Surinam and Maroccian families of young children, the medical bureau has to negotiate itself into the private sphere by investigating individual concerns about the child’s and the family’s life. The role of grandmothers and fathers should be investigated and brought into the dialogue too. However, the similarities in ‘your life’ conceptions of Surinam and Maroccian family members are greater than the differences. Although the differences can be used in the starting up of the communication, for realizing a long term, stable and mutually profitable relation, the whole range of conceptions should be taken into account, in investigation as well as in the building up of the dialogue. In-service training of consultants can be helpful in this respect, as we found in teacher training experiences elsewhere (Brinkman, 2001). The absence of the municipal health bureau (GGD) in the conceptions of the family members means at least that in Surinam and Maroccian concerns this institution does not play a dominant role in their life. If any reason for a less frequent consultancy is sought, indifference or mistrust to the profits that is expected from the consult could be a consideration of the families that should be investigated further.

References