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Abstract

In this study, we attempted to explore the experiences and beliefs of Aboriginal families as they cared for their children in the first year of life. We collected family stories concerning child rearing, development, behavior, health, and well-being between each infant's birth and first birthday. We found significant differences in parenting behaviors and child-rearing practices between Aboriginal groups and mainstream Australians. Aboriginal parents perceived their children to be autonomous individuals with responsibilities toward a large family group. The children were active agents in determining their own needs, highly prized, and included in all aspects of community life. Concurrent with poverty, neocolonialism, and medical hegemony, child-led parenting styles hamper the effectiveness of health services. Hence, until the planners of Australia's health systems better understand Aboriginal knowledge systems and incorporate them into their planning, we can continue to expect the failure of government and health services among Aboriginal communities.

Keywords

Aboriginal people; Australia; children, growth and development; culture; infants; parenting

There is little dispute that the initial years of a child's life have life-long consequences (Center on the Developing Child, 2007; Shonkoff & Phillips, 2000). The research underpinning this knowledge has resulted in a significant increase in policies and interventions targeting parents with infants and small children in recent years (e.g., Safe Start, Sure Start, and Healthy for Life). No demographic group has a greater need of support than the remote Australian Aboriginal children, who are particularly disadvantaged and show much higher rates of low birth weight, respiratory illness, anemia, malnutrition, ear disease, skin disease, and tooth decay than their non-Aboriginal counterparts (Australian Institute of Health and Wellbeing, 2008). Child health outcomes have not substantially improved, despite a significant increase in the introduction of health and education programs targeting remote Aboriginal communities in recent years. Even though many of these programs are focused on promoting child development and parenting skills, their overall lack of impact could be attributed to the fact that they are based on Western conceptual models, without adequate reference to and understanding of Aboriginal cultural practices (Burchill, Higgins, Ramsamy, & Taylor, 2006).

In this study, we aimed to document the experiences of Aboriginal parents in their babies' first year of life. Some of the key child-rearing characteristics previously

documented contrast with Western understandings, such as the belief that children are autonomous decision makers from birth, free to make their own choices and decisions (Hamilton, 1981; Kearins, 1984; Malin, Campell, & Aguis, 1996; Priest, King, Nangala, Nungarrayi-Brown, & Nangala, 2008). Aboriginal families encourage children to be selfless and compassionate (Penman, 2006), thus encouraging them to keep each other safe, work together, and teach each other appropriate behaviors (Bromot, Maymuru, Munyarryun, & Yunupipu, 1989). Through these practices, children also acquire autonomy and early learning within a supportive and sharing environment based on traditional laws regarding the correct way to live and behave (Penman).

It is well established that Aboriginal peoples hold different worldviews than non-Aboriginal Australians (Devitt & McMasters, 1998), a fact that significantly

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influences the former's uptake of health and medical advice. Humphrey, Weeramanthri, and Fitz (2001) reported that most health care providers attributed "noncompliance" to three main factors: cultural differences between patients and providers, lack of patients' understanding, and communication gaps. At times, this is a form of "victim blaming," wherein health providers perceive Aboriginal culture as a barrier to good health outcomes. One nurse commented, "The way they bring their kids up is different to us. They don't force things like [taking medication] on them, where we do . . . and that's because it's a lack of education and a lack of understanding" (Humphrey et al., p. 62).

To be effective, health providers must engage with parents and families on the issue of child development in ways that respect and incorporate Aboriginal parenting frameworks and worldviews. Currently, there is little empirical information regarding these parenting paradigms. In this study, we explored the experiences and beliefs of Aboriginal families as they cared for a child during the first year of life. Our purpose was to better inform Western-educated health professionals working in remote communities on how to incorporate an Aboriginal-centered perspective in their work associated with infant development, parenting, and child-rearing practices. To do this, we collected Aboriginal families' stories about child rearing, development, behavior, health, and well-being.

Methods

We used a qualitative design employing ethnographic techniques to gather rich data from 15 family groups, and included multilingual Aboriginal researchers (authors three and four) in our team who had cultural credibility in their community and long histories of maternal and child health advocacy. We obtained ethics approval for this study from the Research and Ethics Committee at Charles Darwin University, which includes an Aboriginal subcommittee.

Our research design was a prospective study of a small number (15) of Aboriginal babies born in two remote communities in northern Australia. We observed and interviewed the selected families from each infant's birth to the first birthday. We started data collection in mid-2008 and completed it in late 2009, when the last infant turned 1 year old. The research team invested more than 125 days of field time in the project, observing and talking with the participating Aboriginal families. We observed the participants' family life and interviewed mothers, fathers, and family members every 4 to 6 weeks for an entire year. We collected photographs, audio recordings, and field notes of our observations and analyzed and interpreted the data using narrative analysis, through which we interpreted a story's embedded meaning, thereby

evaluating its speaker and context (Liamputtong, 2009; Wiles, Rosenberg, & Kearns, 2005). Researchers in the field use narrative analysis to understand the ways in which people learn about, explain, and organize their experiences through the telling of their own stories, through which the researchers can "concretize a body of knowledge in specific contexts" (Hall, 2011, p. 4).

The "plot" of each story, in essence, was the growing child and the family's view of the child's growth and development. The main character was the infant, and the supporting cast was the extended family. In addition, the parents and health centers gave us permission to access their infants' health records, which yielded important information about each infant's birth, visits to the health center, and general growth information.

Participation and Data Collection

We invited pregnant women from two Aboriginal communities to participate in the study. Both communities have populations of approximately 2,500 and experience 60 to 80 births per year. Of the 22 women that we approached, 19 agreed to participate. Over the course of the study, four mother-infant pairs left the study; of these, one woman did not respond to our attempts to visit her, and the remaining three moved out of the community.

Of the 15 women who remained in the study, all had singleton pregnancies, 6 were first-time mothers, and 9 had between two and four children each. The women were aged between 15 and 29 years, and all had male partners except one, who was a single mother. The interviews rarely involved only the mother and her infant, because the extended family members usually contributed to the discussions. Young mothers (under 20 years of age) and first-time mothers, in particular, were typically quiet during discussions, deferring to the older women in the group when asked questions about motherhood and child rearing. The children's grandmothers and aunts were the most vocal during the interviews, and the fathers, who were present at times, also contributed to the discussion.

We visited participants in hospitals and in their communities at locations of their choice, as negotiated through the Aboriginal researchers. We attempted to observe infants soon after their birth in the hospital, then in the community—either at their own homes or at a family member's home—and when they attended the local health center. Most interviews occurred under the shade of a tree near the family home or on the veranda. We conducted semistructured, informal interviews centered on the activities of the children and their siblings, as well as recent family events. We recorded interviews and observation data using audio tapes and handwritten field notes. The Aboriginal researchers played pivotal roles throughout the project because they assisted with participant recruitment, cultural brokerage, and data collection

and interpretation. Following each interview, we reviewed our data (by either listening to the recordings or reviewing the notes) and discussed the meanings of various stories. The Aboriginal research team members elaborated on many aspects of these discussions and stories to ensure that the meaning was fully understood by the non-Aboriginal members.

Analysis

We analyzed the short biographies of the 15 babies, on the basis of their caregivers' accounts as well as our own observations, for recurring experiences and beliefs that represented common parenting practices followed across the different family groups. Through our analysis, we were able to identify certain units of discourse (Liamputong, 2009) that captured the essence of the stories and their cultural meanings. We either took the stories at face value or further explored them when they contained complex or intriguing information. For example, nearly all the parents insisted that their child was healthy, even when the researchers could see that the child had skin sores or ear discharge, or knew that the child had recently been hospitalized or taken to the health center for acute sickness. This indicated that the children's biographies, as narrated by the caregiver, were not necessarily the "truth," but were coherent stories that the teller had selected to tell. The participating families and Aboriginal researchers often educated the non-Aboriginal researchers by explaining certain narrative aspects that were, to them, completely normal and commonly known. The parents' narratives across the two communities (situated more than 600 miles apart) were remarkably similar on many aspects of baby growth, care, and development.

Results

Through this study, we found that Aboriginal children were highly prized and valued members of a large family network. Our findings can be categorized into themes relating to the location of the child within the kinship system ("relationships," "one of many," "reading the baby's cues"), cultural practices ("behavior control," "making the baby strong"), and behaviors and beliefs regarding key health topics ("check ups," "cosleeping," "breastfeeding and other food," "developmental milestones," and "'healthy' babies"). In the following sections, we individually address these themes.

Relationships

From birth, babies were informed about their relationships with family members. These relationships were highly valued and fundamental to the child's development and place in the world. Babies were constantly told the

names and roles of people, and their faces were turned to encourage eye contact with the people being named and described. We often observed family members competing for recognition and making eye contact with the baby. They also used techniques such as nodding, making "oooo" noises, gesturing with their eyebrows, clapping, and touching the infant to attract his or her attention.

Members of the family constantly touched, handled, and held the babies. Each infant seemed very content with this activity and would happily go from one family member to another. Family members of all ages handled the babies competently, dexterously passing them to others through car windows and often hoisting them up by the armpit or an extended arm. Young men were very comfortable carrying and soothing babies. Despite the general lack of pavements or tarred roads, pushchairs were commonly used.

One of Many

Through all the observations, the infants were located in immediate proximity to their mothers. Although other family members frequently handled and attended to the infants, the mothers in this study were the infants' primary caregivers. When discussing the role of other family members, the respondents explained that the mother plays the most important role in a child's life at this young age, and that the father and other family members were responsible for ensuring that she was able to "do her job." As the child grew older, however, his or her relationships with other family members grew stronger, and other adult members of the broader family network soon undertook some of the responsibilities and became involved in child-rearing activities.

Infants, as accepted and valued members of the family, were involved in all community activities. Families did not exclude infants and young children from any event, whether it was a birth, death, illness, celebration, or ceremony (although it did exclude children from a particular age range or gender from certain ceremonies, such as the "young men's ceremony"). On one visit, a participant was unavailable to meet with the researchers because a sick family member had been evacuated to the regional hospital at 4:00 a.m. the previous night. A large number of family members, including the infant and other young children, had waited at the health center with the patient from 8:00 p.m. until the arrival of the evacuating airplane at 4:00 a.m. As a result, all the family members slept late, and the employed adults did not go to work; nor did the children go to school the following day. When the non-Aboriginal researcher later referred to this event, the respondents saw the inclusion of the infant and other children in this activity as normal and not requiring any justification or explanation.

Reading the Baby's Cues

During the interviews, the family members described how they identified and met their babies' needs, acknowledging the latter's capacity to communicate these needs. If an infant cried or even whimpered, the family members were obliged to respond. Letting a baby cry was unacceptable to all the respondents, with families often commenting that *balanda* (White people) were cruel to ignore crying babies. All the participating families clearly thought that an infant was capable of communicating his or her needs from birth. A first-time mother said, "We know what the babies want from their cries. We can tell the difference when they want milk or something else." Although the respondents reported that they could determine their infants' needs, our observations indicated that babies were invariably offered the breast when they appeared distressed in any manner.

Behavior Control

Although the children determined what they needed, older children and adults often influenced the children's behavior through stories and fear mongering; for example, by warning infants about dangerous things. As one woman explained, "We tell the kids to stay away. We say 'ah-ah,' keep away from dog, or rough one." One family reinforced such warning using nonverbal gestures such as making faces, or "pulling a monkey face":

The family all started trying to get the eight-month-old baby to pull his top lip over his top gum. They did this through demonstrations, so we had about eight people elevating their eyebrows and dropping their bottom lip in a scary and startled expression in front of this infant (who was totally unfazed). They say this is somehow related to "debil debil" [deriving from "devil," and suggesting a monster, using fear to control behavior]. The baby started doing it later, and they all roared with laughter and tried to get him to do it repeatedly. They said, "ooooorrrr," and laughed. "Oooooorrrr." They explained that it meant, "Don't look at me, or go away." (Field notes, July 2009)

The Aboriginal researcher later explained that these strategies have been designed to modify undesirable behavior by creating fear in children's mind or distracting them rather than by saying "No" or "Don't do this." The Aboriginal participants believed that merely forbidding an activity only deepens a child's desire to do it. However, they regarded instilling fear of the "debil" and other scary things in the child's mind as an effective method of managing infant and child behavior. This indirect approach to

behavior control reinforces the notion that children are autonomous individuals and active decision makers. Family members never spoke to children in a chastising tone. They also never judged children, although the respondents did describe some children as being "cheeky" or "silly" when they acted inappropriately.

While conducting this study, we observed Aboriginal children participating in activities that most non-Aboriginal families would consider them too young to undertake or simply too dangerous. We saw a 3-year-old son of one of the participants using a large knife to cut a rope. The family appeared to be casually watching the child, but nobody attempted to take the knife away from him. When we inquired whether the mother or the other family members were worried that he might hurt himself, the mother replied, "He's fine. He knows how to use a knife." We then asked her the age at which children learned how to use a knife, and she replied, "Depends [on who it is]. We know when they are ready to learn these things."

Making the Baby Strong

The participating mothers described a practice used by the old women: "Sometimes they hold the babies up to the full moon or new moon to help them grow up quick." In fact, several family groups mentioned this practice as a way to strengthen the child. Other cultural techniques used to make the babies strong included (gently) biting the infants on their knees to help them become ready to crawl.

Teaching the infants about their "Dreamings" was also important. The "Dreaming" is a reference to a sacred era wherein totemic spirit beings formed the Creation, and is often used to refer to an individual's or group's set of beliefs or spirituality (Kleinert & Neale, 2000). One mother explained about her son, "His Dreaming is magpie geese"; for further explanation, she bent the child's thumb backwards, dislocating it without causing any distress, and remarked, "We know he is like magpie geese because they can do like that." This meant that the baby could not eat magpie geese: "If he eats magpie geese, he might get sick." The family noted that the baby became "cranky" when his father went hunting for magpie geese. Every child in the two communities had their own Dreaming, with a maximum of three Dreamings per person. The Dreamings were not necessarily of birds or animals; they could be a "honey bag" (wild honey) or other objects. Knowledge about their relationship with their Dreaming and with all other living things—be it plants, the sky, or people—was one of the lessons families shared with infants in their first year of life.

Checkups

The families regularly visited the health center during the infants' first year of life, for health assessments or

“checkups” that consisted of a general physical examination and recording each infant’s weight. The mothers and grandmothers were very proud of their infants, wetting the babies’ hair and ensuring that the babies were dressed in fresh clothes before taking them to the health center. When we asked the mothers what the health staff did to their babies during the “checkups,” the mothers replied, “Just check up.” When we asked them what “checkup” meant, however, the respondents found it difficult to elaborate on, often saying, “weighing and check up.” Giving immunizations or “baby needles” to the infants was another common reason for visiting the health center, though this usually required a reminder from the health center. The families accepted immunizations as necessary practices to “keep the baby strong.”

One baby suffered from anemia, skin sores, chest infections, and diarrhea in the first year of life. His mother took him to the health center 19 times in the first 6 months, and 12 times over the following 6 months. The reasons for these visits, as recorded in the infant’s health record, included “checkup,” “hot” (fever), “crying,” and “coughing.” When we asked the mother if she took him to the health center, however, she replied, “Sometimes.” She said that her mother did not like her taking the baby to the clinic because she worried that he would be sent to the hospital, 350 miles away, and that she was able to heal him with local bush medicine, which was often combined with Western medicine to treat babies. We found consistently high presentation rates across the study cohort, with 25 to 47 visits to health centers for each infant during the first year of life.

Cosleeping

All the infants in the study slept in the same beds (usually consisting of a mattress spread on the floor) as their parents from birth. When non-Aboriginal health professionals advised the respondents to separate the mother and infant (based on the sudden infant death recommendations), they were met with incredulity. The majority of the participants knew that non-Aboriginal babies were put in cots in separate rooms, and they strongly criticized this practice; the Aboriginal families could not understand why White families did this. One mother of four children stated, “I know that balanda put their babies in a cot in another room, but we don’t do that. We keep our babies close to us so that we are there when they need feeding or whatever.”

The mothers appeared to have no set routines for their babies; their interventions and care were responsive to their babies’ needs, not prescriptive. They followed no fixed schedule as to when their children ate or slept or for how long. Hence, the children slept where and when they fell asleep, and ate or breastfed when they were hungry.

Breastfeeding and Other Food

Of the 15 infants involved in this study, 14 were breastfed throughout their first year of life. The babies had uninterrupted access to the breast and were offered it at the slightest sign of interest or distress. Babies were rarely offered food before 8 or 9 months of age, and only 2 mothers reported offering their infants food prior to this time, though infrequently. When we asked the mothers what was the best age to start giving solid food to babies, their responses included 4, 6, and 12 months, but we rarely saw these numbers reflected in practice in these families.

Although approximately half of the mothers could report their babies’ dates of birth, they attributed little significance to the infants’ ages. When we asked the mothers how old their babies were, most of them did not know or appeared to guess, offering an incorrect age. Similarly, when we asked family members to associate a particular age with developmental milestones or significant activities such as the introduction of food, their responses were varied and vague. For example, we asked one mother with a 2-month-old, fully breastfed baby when, in her opinion, he would be ready for solid food. She hesitated and replied, “Maybe at eight or nine months,” then paused and added, “Ten months, when he is older and crawling.”

Some families foresaw the introduction of solid food when the infant teethed, could sit up, or walk, but the responses were inconsistent across the participants. Most families said that the child would be weaned whenever he or she was ready. This supports our observation that the families responded to their infants’ specific needs and provided care on an individual, child-led basis. As one aunt explained, “If he turns his mouth away he doesn’t want food; you can’t make him have it.” Another experienced mother, the aunt of a study participant, explained: “Balanda are always worried about the right time. We eat [our babies eat] when we are hungry.”

The families knew that the health center staff attributed substantial importance to children’s food and growth. Hence, they would often furnish a long list of foods that they gave their young babies, including “bush tucker,” “baby food” (from the shop), and “pumpkin, banana, and potato.” However, we found little evidence that the babies did, in fact, receive this kind of diet. One of the Aboriginal researchers (author three) informed the non-Aboriginal researchers that

they are only saying this because they know that is what the nurses want them to do. They are not really giving their babies all that food. If you give them food too early, if you feed them [too much], they grow up greedy.

We explored this concept of “greedy babies” further with other families: all agreed that it was bad to have a greedy child. Family members employed cultural techniques to make the baby strong and minimize the undesirable characteristic of greed. As one grandmother stated, “The old people wipe their underarm sweat and put it on the baby; that stops them from being greedy.”

Developmental Milestones

All families showed pride in the achievements of their infants and would encourage the children to demonstrate these to us. These achievements did not appear to be age related or measured against those of other children: they were celebrated in the context of the individual child. The families valued the children’s development highly. As each baby grew up, the family members proudly reported the list of words he or she knew, including an extensive array of kinship terms such as *grandmother*, *grandfather*, *sister*, and *brother*. The families would promote infant development in many ways, such as providing constant verbal instruction, encouraging vocalization and language, encouraging infants to look for an airplane after first hearing its engines, and watching the water buffalo and other animals as they moved through the bushland.

The family members did not always encourage the infants’ physical development to the same extent. We observed that infants were usually carried around or placed in the laps of family members, who rarely allowed the infants to crawl. If an infant attempted to climb off a lap or crawl away, the mother or another family member would distract the infant or pass him or her to someone nearby. When we asked if the baby was allowed to crawl, we were informed, “No, there are too many bugs around; he might get bitten.”

“Healthy” Babies

We visited all the families between six and nine times during the infants’ first year of life, and always inquired about how the infants were faring. The family members invariably responded with a big smile and statements such as, “He [or she] is good/growing lots/eating a lot/a happy baby.” When we asked if the child had been sick since our last visit, most mothers replied, “No. He [or she] is healthy one/too fat now/happy/smiling all the time.” When reviewing the infants’ health records, however, we found that many of the infants had been taken to the health center with health concerns. For example, two infants had been hospitalized (one for pneumonia, the other for gastroenteritis) since our last visit, but their families made no mention of this. Another child had received four iron injections for anemia and had perforated eardrums. Neither the mothers nor the other family

members mentioned these visits to the health center without prompting from the research team. When we did prompt them—by saying, for example, “What about last week? We saw in the baby notes that this boy was sick”—they would agree that the baby had been sick but was “all better” now. One 5-month-old infant’s story demonstrates the community’s acceptance of the high rates of illness as normal:

He has extensive infected scabies¹ on his legs, a sore on his external ear, and pustules over his scalp. We offered to drive him and his mother to the health center but the mother thought it was not urgent and could wait. Her other children also have pustules on their legs and old scars. (Field notes, August 2009)

Holding other family members’ children responsible (in a nonaccusatory manner) was a common response to questions about illness or problems pertaining to the child. One 6-week-old baby had significant (though uninfected) scabies on his legs. When we asked his young mother what he was suffering from, she shrugged. We asked her if she thought it was a health problem, if the infant’s skin was itching, but she thought not. We then asked the mother what, according to her, was the source of the scabies; she replied that the infant had contracted it from her sister’s children. She then asked us if we would drive her to the clinic, but the health center was not open at the time.

The non-Aboriginal researchers and the study participants appeared to have different perceptions about what constituted poor health. None of the families in this study reported any health concerns associated with their infants, even though all 15 infants’ health records reported significant morbidities, including ear infections (in all 15 infants), respiratory illness (12 infants), anemia (14 infants), and poor growth (12 infants) during the first year of life. Some women spoke of the differences between their perception of their babies’ health and the clinical assessment at the health center. One mother claimed that although the center staff had informed her that her baby had “weak blood” (anemia), she did not believe this, saying that the clinic had the “wrong story.” She knew that her baby was given “good” (food) and that his blood was not weak; hence, she was not concerned. The baby had a recorded hemoglobin of 89 mmol/L, indicating marked anemia (normal levels are more than 110 mmol/L).

Discussion

In this study, it was revealed that the participating Aboriginal families had a very strong cultural identity and sets of beliefs about how their children should be raised to make them “strong.” These values are not in accordance with those of non-Aboriginal health

professionals. Smith, Bamundurruwuy, and Edmond (2003) found similar results in an East Arnhem community, which held distinctly different views on growth than those advocated by the local health staff. Lea (2005) acknowledged and skillfully articulated these differences, and the lack of a shared understanding, or even desired health outcome, between Aboriginal clients and non-Aboriginal health staff. Kowal and Paradies (2005) also discussed the difficulties faced by non-Aboriginal “helpers” who worked in the health sector in the Northern Territory, and their acute discomfort with notions of neocolonialism.

Despite the recognized heterogeneity of Aboriginal peoples across Australia, many researchers have reported the importance of kinship and the child’s relationship with others, including their connection to country (Hamilton, 1981; Kearins, 1984; Lowell, Gurimangu, Nyomba, & Yingi, 1996; Malin et al., 1996; Priest et al., 2008; Secretariat of National Aboriginal and Indigenous Child Care, 2005). We also clearly identified this relationship in this study. Each family member, of all ages, was engaged by and interested in the infant, and the family members were “introduced” to the infant as important members of that child’s kinship system. We observed that the infants in this study had primary relationships with their mothers in the first year of life, which extended to multiple connections with other family members once they were older. Relationships with multiple carers appear to conflict with attachment theory, which relies on the fundamental importance of a primary carer (Ainsworth, Blehar, Waters, & Wall, 1978). Some scholars have criticized the use of the attachment theory to inform assessments of Aboriginal children in child protection services as being based on ethnocentric views that fail to recognize the expression of secure attachment in Aboriginal families (Yeo, 2003). In our study, however, we found that all the children appeared to have a primary attachment to their mother and secondary attachments to many other family members.

An important finding in this study was the Aboriginal belief that each child is an independent, autonomous human being, capable of communicating his or her needs from birth. The child determines what his or her needs are, and the entire family group is responsible for responding to those needs. Failure to do is considered cruel and damaging to the infant’s well-being and autonomy. Researchers have found similar parenting characteristics, which situate the child as the active agent in determining his or her needs from birth, in other Aboriginal groups in Australia (Malin et al., 1996; Priest et al., 2008) and in non-Western families across the world (Rogoff, 2003).

This perceived “agency”—the child’s ability to influence “a relationship, a decision, or workings of a set of social assumptions or constraints” (Mayall, 2002, p. 21) is theoretically recognized in sociology literature (Qvortrup, Corsaro, & Honig, 2009). It receives little attention,

however, in the parenting literature, whose contributors typically support the theoretical categories identified by Baumrind (1971), namely, “authoritarian,” “authoritative,” and “permissive” parenting. Western experts largely promote authoritative parenting as the most effective type of parenting. The “firm but fair” approach is seen to produce the most self-reliant, self-controlled, content, friendly, cooperative, and successful children (Slee, 2002). In contrast, permissive parenting is a laissez-faire style of parenting, where parents are overindulgent, make few demands, and “permit the child to make many decisions before they are ready” (Berk, 2010, p. 388). These children are reportedly more likely to be undisciplined and poorly organized (Slee), lack self-control, and constitute the group with the lowest independence (Brooks, 2010).

The findings of our study do not support the allocation of this group to any of these categories. Although most closely aligned with the permissive style of parenting, the parents in this study used agency, autonomy, and respect to achieve social control and independence. This required the family members to be highly responsive to their infants. In line with the parenting resources in Western countries, parents are strongly advocated to follow parenting routines (Raising Children Network, 2010) and interventions such as “tummy time” [placing infants on the abdomen for short periods in the first 6 months of life to promote head control], reading to infants, and structured playing to stimulate development (Kidspot Australia, 2011). These activities, and parenting routines such as “bath time,” “quiet time,” “dinner time,” and “bed time” that dominate the life of many Western parents, were anathema to the families in this study. Nobody expected the Aboriginal children in these remote communities to adhere to such routines, and the children could eat when they were hungry and sleep when they were tired. Hamilton (1981), Kearins (1984), Lowell et al. (1996), Priest et al. (2008), and the Secretariat of National Aboriginal and Indigenous Child Care (2005) documented similar findings.

Lowell et al. (1996) reported that, although many East Arnhem families were not aware of their child’s age, they were aware of their child’s level of development in relation to that of his or her peers. In this study, Aboriginal parents did not value or rate as important concepts such as the age of their infants or of other family members. Age does not assume the same importance for these families as it does for mainstream Australian families. In fact, many non-Western cultures neither track a person’s age nor consider it important (Rogoff, 2003). This has significant implications for child health and education services, which attach high value to age-appropriate milestones and achievements. Woodhead (2009) highlighted this point: “Giving primacy to children’s age as a proxy for their developmental stage is not inevitable, nor natural” (p. 52). If Aboriginal families do not consider age an

important marker in a child's life, they will not base developmental achievement on chronological markers. Health services must consider this when promoting age-linked activities such as the introduction of solid foods, the identification of age-related developmental delays, and the initiation of schooling.

Aboriginal parents willingly provide whatever they believe is necessary for the child (Malin et al., 1996; Priest et al., 2008). Whenever possible, therefore, they give their children whatever the children want. To "want," "like," or "need" something are all regarded as part of the same concept: even families in strained financial circumstances will provide a child whatever he or she requests. According to Kearins (1984), who conducted research in Western Australia in the 1960s and 1970s, Aboriginal attitudes reflected no conception of the notion of "emotional spoiling." We obtained similar findings in this study. Family members appeared to find it impossible to deny children anything they wanted, including sweets and carbonated drinks, even when the parents knew the foods were unhealthy. Smith et al. (2003) found similar results.

Aboriginal families believe that children can make their own decisions, and thus, they act to support their children's autonomy (Malin et al., 1996; Priest et al., 2008). Other researchers documented similar notions of autonomy in Aboriginal groups in Canada (Pesco & Crago, 2008). Rogoff (2003) found that many non-Western groups consider it inappropriate to force anyone to do something against his or her will, even if failing to do so is detrimental to the other's well-being. This does not imply that the child is "spoiled" or "undisciplined," as some non-Aboriginal writers (Berndt & Berndt, 1983) have concluded in the past. As noted by Bromot et al., four senior Aboriginal (Yolngu) women in Eastern Arnhem Land,

It doesn't matter how old a person is; they could be very old or very young but they are still equal. A person is what they are, and they are all equal, and have equal rights. Nobody can make or force anybody to do what they want them to do. The other person has to agree before they will do it. A person is what he is and nobody else can change him not even a boss, unless he agrees to change for some reason. (1989, p. 32)

Family efforts to encourage skill development in infants are influenced by differences in the communities' values and expectations. The children in this study were not actively encouraged to crawl. Researchers have found similar discouragement in many other non-Western communities (for examples, see Rogoff, 2003). The family members of the Aboriginal infants in our study, however, actively encouraged the infants to develop other skills

from an earlier age than would be seen in mainstream Australian families; for example, the teaching of family relationships and other verbal and nonverbal communication skills. We found that the children themselves directed other skill development, including the handling of knives, climbing trees, and other activities commonly perceived as being dangerous for children by Western families. On the basis of these differences in exposure to skill development, we infer that remote Aboriginal children might achieve some developmental milestones at different ages than the mainstream Australian children, who have different levels of exposure to parental cues and encouragement.

The infants in our study showed high visitation rates to the local health clinics and had even been admitted to the hospital at times. In spite of this high health system use, they suffered from persisting conditions such as perforated eardrums, anemia, skin sores, and other morbidities, which suggests that primary health care services continue to be largely ineffective. The infants' families did not appear to be overly concerned about these high rates of illness, suggesting that they are desensitized to the abnormality and consequences of these conditions; these communities appear to have accepted and normalized poor health.

The failure of health services to significantly reduce the high rates of morbidity in Aboriginal children can also be related to the differences in parenting approaches highlighted in this study. Health and parenting interventions encourage parents to "do (something) to" their infants and children, which contrasts with the Aboriginal parents' inclination to "respond to" their infants and children. Thus, for example, an Aboriginal caregiver, even under instruction from a health provider, might not insist that an unwilling child take the bitter iron medicine (the treatment for anemia) or eat at a given time when the child does not display signs of hunger (sick children often lose their appetite). Health care providers generally perceive this lack of parental coercion as "poor compliance," and they subsequently experience and express frustration at their inability to achieve the desired health outcomes.

The corollary to this lack of understanding of Aboriginal parenting and child-rearing practices is that non-Aboriginal health providers continue to provide health advice and information from their own cultural perspective. According to McConnel (2003), for Aboriginal people to fully "comply" with such health advice would require them to fully convert to the health care providers' Western worldview—a conversion that would constitute a form of cultural violence and oppression. Instead, he proposed a fusion of the two worldviews as a way of contributing to improved health outcomes. This requires greater

understanding of and respect for Aboriginal values and beliefs pertaining to parenting and child rearing.

Differences in worldviews between indigenous and nonindigenous populations are not unique to Australia, and have been well documented in other countries with a history of European (particularly Anglo Saxon) colonization. In discussions on cultural competence, Lynne-Barone (2010) reported differences in health beliefs among Native American and Latino communities, particularly with regard to pregnancy and child health. Stairs and Bernhard (2002) drew particular attention to the impact of privileging Euro-North American child development views over Aboriginal visions and values. Following a summary of values and practices of child rearing among the First Nations peoples, they argued that the evaluation of progress makes sense only within the context of these values and practices (Stairs & Bernhard).

Current programs, such as Footprints in Time (Department of Families Housing Community Services and Indigenous Affairs, 2009), that aim to document the childhood experiences of Aboriginal and Torres Strait Islander children and their families across Australia have failed to capture the worldviews of the participants to date. This is most likely because of the large sample size (more than 1,600 children) and the limitations of survey methodology to meaningfully and accurately capture participants' values and beliefs (Krosnick, 1999). It is difficult to delineate the precise influence of different child-rearing practices on child development in infants in remote areas because of the high prevalence of illness among these children. Through our study, however, we clearly determined that Aboriginal children are raised in significantly different ways than their mainstream counterparts, and we have more to learn about these differences. Aboriginal culture is changing rapidly because, like all groups, it is dynamic and values change. These values, however, will change only in ways that fit the Aboriginal worldview and hierarchy of values (Folds, 2001).

Kowal and Paradies (2005) suggested that public health practitioners face difficulties in providing health-promotion activities against or in conflict with the notion of Aboriginal rights and self-determination. On the basis of our findings in this study, we argue that child health practitioners working with Aboriginal families will experience similar difficulties once the health service community becomes well acquainted with these differences in child-rearing practices. Although child health practitioners might not have been exposed to the differences in parenting beliefs outlined in this article, they are generally aware of the difficulties involved in exercising their expertise in an environment of conflicting worldviews (Lea, 2005)

On the basis of this study's results, we suggest that there are three conflicting influences inhibiting improvements

in Aboriginal child health in Australia: high rates of socioeconomic disadvantage associated with children currently living in remote areas, child development expectations that support middle-class non-Aboriginal beliefs at the expense of Aboriginal knowledge, and conflicts in clinical practice—where real measures intended to “close the gap” between Aboriginal and non-Aboriginal health outcomes conflict with cultural respect and scientifically informed solutions to poor health and well-being. We propose that systemic failure to address all three of these issues will only entail the continued failure of the health system to improve health outcomes for Aboriginal families and their infants.

Conclusion

In this study, we followed the lives of 15 Aboriginal infants from two remote communities in Northern Australia from birth to their first birthday. We found significant differences between the parenting discourses of these groups and those of mainstream Australians. Within the contexts of neocolonialism, poverty, and medical hegemony, the prevalence of current Aboriginal parenting styles, which rely on child-led development, will continue to create challenges for health service effectiveness. Until Aboriginal knowledge systems are better understood and respectfully incorporated into Australia's health systems, we can expect the continued failure of government and health services in Aboriginal communities.

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Note

1. Scabies is a common skin condition caused by infestation of the scabies mite, particularly found among people who live in overcrowded conditions.

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