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Author for correspondence: Marg Rogers, Email: mbaber@une.edu.au

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Harnessing the power of cultural health narratives when working with parents of young children

Marg Rogers

Lecturer Early Childhood Education, University of New England, Armidale, Australia

Abstract

Narratives are a powerful tool for transferring knowledge and culture. They have a profound effect on our psyche and our attitudes to messages and teachings. The transfer of information through traditional teaching and lectures is often less effective in changing a belief or understanding than using narrative. In this discussion paper, I explore this phenomenon and examine the persuasive effect of cultural narratives. The discussion also considers the impacts of cultural narrative as an educative tool on parental attitudes towards childhood immunisation. I explore the changing nature of the way parents with young children communicate and seek information and early childhood educators' roles in their lives within the Australian context. Understanding the way humans are drawn to narrative may be beneficial to health workers, early childhood educators, family workers and those who plan health education programmes. To effectively target their messages, it would be of benefit to public health officials to have knowledge about how parents with young children inform themselves and develop health beliefs, and the extent to which parents' ideas become fixed.

Introduction to narratives

Transference of knowledge and culture often occurs through narratives (Mallan, 2014) as elders, teachers and religious leaders have long realised their powerful effects (Gottschall, 2012). All cultures have narratives to record their experiences (Barthes & Duisit, 1975) and the extent of human engagement with narratives is profound and complex. Hardy (1968) explains 'we dream in narrative, day-dream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticize, construct, gossip, learn, hate, and love by narrative' (p. 5). We are drawn to novels, movies, social media, news stories, personal accounts, narrative-based computer games and virtual worlds. The meanings we create through narrative combine humans' behaviour and experiences and how we relate to other humans and living things (Polkinghorne, 1986). Embedded in our socio-cultural beliefs and traditions are our narratives (Moen, 2006), and cultural membership depends upon knowing the narratives and what they mean (Polkinghorne, 1986). Barthes and Duisit (1975) remind us that there has never been a group of people who do not tell stories because the human experience is always narrated (Moen, 2006).

We also use narratives to embellish history when the reality is not to our liking (Lake, 2010) and acculturate members of cultural sub-groups (Baber, Fussell, & Porter, 2015; Rogers, 2017; Rogers-Baber, 2017). Indeed, we even author our own lives to express who we are as individuals (Gleeson, 2012), voicing versions of events, downplaying parts we dislike while emphasising those that fit with the image we desire. We also use narrative to establish relationships within our family (Thomson, Hadfield, Kehily, & Sharpe, 2012), our social groups (Baber, 2016) and society, in general.

Why is narrative such an effective tool for education? When we hear a lecture or a lesson, we are more likely to be resistant to what is presented, even if it is persuasive and full of analytical facts appealing to our reason (Gottschall, 2012). Unlike lectures, narratives use characters, plot and settings to create interest to draw the listener or reader in, and to communicate an underlying lesson. Evolutionary psychologist Gottschall (2012) explains the effect of narrative on the human psyche, filtering the effects of logic and reason as we are drawn deeper into the story. Narratives achieve this by appealing to our ability and instincts to empathise with the characters in the stories (Gottschall, 2012). Even in a scientific field such as health, narrative exerts a degree of influence over a significant proportion of the population.

The influence of cultural narratives on immunisation behaviours

In countries with high levels of infant and childhood vaccination, there continue to be groups of parents who have alternative beliefs and attitudes towards childhood immunisation. These parents often gain their information from alternative sources, influenced by communities with alterative views, such as those of the anti-vaccine lobbyists. The level of influence of these sub-cultural narratives often baffles public health professionals, policy makers and health workers.

Mergler et al. (2013) found that parents who are vaccine refusers or vaccine hesitant have 'different vaccine knowledge, attitudes and beliefs' (p. 4592), while Sadaf, Richards, Glanz, Salmon, and Omer (2013) state that parental beliefs about safety and contraindications contribute to vaccine hesitancy. Further, Leask, Chapman, Hawe, and Burgess (2006) assert that anti-vaccine lobbyists use sophisticated narrative in the media, manipulating social anxieties and broader social problems. These social problems include: distrust of governments, dislike of public servants, self-interests of pharmaceutical companies and deception by health workers to protect colleagues (Leask et al., 2006). Contrary to this, public health authorities and governments tend to rely on appealing to the logic of parents through rational arguments using statistics to demonstrate that the benefits of vaccination outweigh the risks. Further, Leask et al. (2006) describe the tendency of governments to employ militaristic terms in health campaigns, such as 'fighting' and 'war' against disease in order to enlist support for a greater cause (p. 7238).

My views on immunisation

I believe in childhood immunisations and was immunised myself as a child through free immunisation programmes in health clinics and at school. Immunisations do carry real risks for some individuals, but for the general population, immunisations work extremely well in preventing disease. Similar to all medications, there are side effects and complications, some of which have not been firmly identified. Australia is now relatively free of immunisation-preventable diseases and has improved its rates of immunisation from 53% in the 1990s (Smith, 2006) to, more recently, 93% (Leask, Danchin, & Berry, 2017). This has been achieved through various effective health policies, funding, campaigns and the work of health professionals and researchers. When new immunisation data are released—and despite Australian media headlines—these rates are very good according to Leask et al. (2017), given it is a country that is geographically vast with particular populations at risk of not vaccinating their children at all. I believe more information should be given to parents about why the immunisation ages as outlined on the immunisation schedule (e.g. 3 months old, 6 months old) are chosen by the Department of Health and why Australia has a very rapid rate of childhood immunisation compared to some other countries which achieve and preserve high rates of immunisation with a more gentle rate of immunisation. I believe giving this extra information would assist parents to make a more informed choice, especially those who are influenced by anti-vaccination messages. Globally, there are researchers who are calling for a more varied approach for different cohorts within the population according to Tillermans, Henneman, Hirasing, and van der Wal (2005). It is thought that this might improve rates of immunisation. However, also providing more information may be of assistance.

Preserving rates of immunisation

Ensuring parents heed public health messages to preserve infant and childhood immunisation rates through herd immunity is of concern for individual governments worldwide (Brunson, 2013). Herd immunity occurs where enough of the population immunised to prevent a disease outbreak within the community. The World Health Organisation (WHO) states herd immunity requires a childhood immunisation rate of 80–90% for many of the vaccine-preventable diseases (Hak, Schonbeck, De Melker, Van Esen, & Sanders, 2005). While authorities aim for higher rates for herd immunity for certain diseases (e.g. 90–95% for whooping cough and measles) Australia does well overall.

Immunisation is believed to be one of the most efficient and cost-effective health interventions to reduce infant and childhood morbidity (Rainey, Watkins, Ryman, & Sandhu, 2011) and is one of the most effective public health achievements of the twentieth century (Mergler et al., 2013). According to Sadaf et al. (2013), 'the success of vaccines in reducing disease-associated mortality is second only to the introduction of safe drinking water' (p. 4293). Despite this, highly educated parents have been found to be more critical and more likely to scrutinise government public health messages, as described by Hak et al. (2005). Generally, there has been an increase in educational levels among parents in many countries that also have high levels of immunisation, thus potentially increasing the numbers of parents who might question these messages (Hak et al., 2005). Brunson (2013) suggests the ongoing success of vaccination is unstable without widespread parental and community support. Indeed, outbreaks of pertussis, commonly known as whooping cough (Kolos, Menzies, & McIntyre, 2006), and measles (Horne, Powell, Hummel, & Holyoak, 2015; Tillermans et al., 2005) in countries where successful immunisation programmes are present have been of concern. Australia has recently experienced an increase in measles outbreaks whereas five years ago, Australia had been declared measles free (Willis, 2019).

Messages for different cohorts

Hak et al. (2005) believe that the increase in the education levels of parents may intensify the need for health messages that specifically target highly educated parents and health workers who are very influential, although it is hard to imagine how these would be identified or targeted effectively. Government and public health messages are not convincing particular groups of parents, who are influenced by anthroposophical ideas (Tillermans et al., 2005) and anti-vaccine media. The anti-vaccination advocates are very effective in spreading ideas using the persuasiveness of cultural messages delivered through sophisticated narratives and personal accounts of perceived adverse vaccine effects. These messages are particularly compelling because they are operating in a vacuum, that is, they are operating in the absence of alternative, narrative-based views. There are few personal accounts or narratives of widespread vaccine-preventable diseases to equally appeal to parents' empathetic responses. In countries where there are high levels of vaccinations many parents, most community members and even health workers have not witnessed widespread diseases (Mergler et al., 2013) unless they have spent time in a majority world country (previously referred to as a developing country). Hence, the much lower risk of adverse effects and contraindications has become the focus of public attention, rather than the more serious diseases the vaccines are preventing (Tillermans et al., 2005). Conversely, governments harness the power of statistics to persuade the public of the efficacy of vaccines, but this may not always be an effective tactic with certain parent groups.

Narratives within the public discourse

Leask et al. (2006) believe that narratives about people with vaccine-preventable diseases need to re-emerge in the public discourse. In an Australian study, Leask et al. (2006) found narratives of personal experience of disease or adverse vaccine reactions were

of interest to participants in their study. In fact, they were a very powerful medium that participants held as sacrosanct during focus groups. Thus, relying on facts alone to convince parents to vaccinate does not take into consideration the broader beliefs and narratives that inform practice (Leask et al., 2006). Further understanding of the parental decision-making processes is needed, as stated by Brunson (2013).

Decision-making processes

In an in-depth Australian study involving 18 families, Brunson (2013) found there were a number of stages in decision-making for parents with infants. The first stage was an awareness that a decision needed to be made. The second stage was an assessment and in this stage parents within the sample seemed to exhibit one of three types of assessing behaviour. One group accepted the cultural norms of immunising their children with little or no questioning. A second group was active in their search for information and relied on advice they trusted, such as from family, friends, health workers, the internet, magazines and books. This group was fairly uncritical of the information gained. The third group actively sought out a variety of information, but was highly critical of the information they accessed and did not rely on the advice of others. They would consult with carefully chosen individuals, examining alternative ideas before they ultimately made their own decisions. All parents then entered the third stage of decision-making that resulted in accepting, delaying or rejecting immunisation for their child. Once the decisions were made, most parents entered a state of statis, that is they remained constant about their decision. At the same time they carried out ongoing assessment or reassessment but to a much lesser extent, generally to confirm their original decision. Reasons for reassessment were normally related to finding new information, changes in circumstances or conversations with others (Brunson, 2013). The latter reason reveals the effect of family narratives, personal experiences and rumour as effective sources of influence.

Understanding the way humans are drawn to narratives is beneficial because it may influence how vaccine information is used to influence parental decision-making. This is especially pertinent for the different stages and styles of decision-making. Leask et al. (2006) found that social networks, media, parents and spouses were reported as sources of influence within their research sample of parents. The mothers and siblings of these parents were strong influences and were used to validate their choices, reassure them of their stance and reinforced their resolve to maintain their stance. Medical literature suggests that technical rationality should reassure parents, however, facts alone may do more harm than good in relation to convincing parents to vaccinate (Leask et al., 2006). For example, if medical reports say there are less than 4% of children who show adverse reactions to a certain vaccination, certain parents will find this 4% to show that it is not safe, nor something they want to risk for their child. Moreover, 'parent attitudes are dynamic in terms of individual change over time and attitudinal shifts in new cohorts during controversies' as stated by Leask et al. (2006, p. 7273).

In a study involving a number of non-Western nations, Rainey et al. (2011) found that parental attitudes and knowledge were the main reasons parents resisted or refused to immunise their children. The four most common problems were parental lack of knowledge, fear of adverse vaccine events, belief that immunisations were ineffective or harmful and lack of motivation. Religious or strong social and cultural beliefs were reported from some nations and, additionally, girls were more likely to be unimmunised or under-immunised (Rainey et al., 2011). While there are some differences in parental attitudes across Western nations, some ethnic, cultural and religious groups may also be reluctant to immunise for these reasons within countries with relatively high levels of migrant populations, like Australia.

Australian context

Australia has a successful immunisation programme (Smith, 2006) and a national Australian Childhood Immunisation Register (ACIR) (Hull & McIntyre, 2006). At one stage, under-reporting was reported to be an issue with the ACIR, however, improvements seem to have occurred (Hull & McIntyre, 2006). Although childhood immunisations are not compulsory, the government has encouraged parents to fully immunise their child before school entry, providing the school with an immunisation status. Generally speaking, children are allowed to enrol in schools and early childhood services, whether they are fully immunised or not, although some states have taken a tougher approach. In Victoria, for instance, the legislation of 2016 states that children in kindergartens and childcare have to be up to date with vaccination, although medical exemptions are possible on the grounds of severe medical conditions, rather than conscientious objections. New South Wales also passed legislation in 2018 which was similar, although it does allow for a child to be enrolled if they were on an approved catch-up schedule with Medicare. The school or early childhood services that do not have to follow these rules reserve the right to exclude children who are not up to date with their immunisations for the duration of any outbreak of a vaccine-preventable disease (Smith, 2006). Although health workers partner with schools to administer school-aged immunisations, parents are expected to take their infants and young children to health clinics or their general practitioner for infant and childhood immunisations scheduled between birth and 5 years. As an added incentive, the Federal Government offers a financial bonus for parents who fully immunise their children. This was still available for those who had refused immunisations on religious or conscientious grounds, however, this policy has tightened since January 2016 with the introduction of 'No jab, no pay' to further entice parents to immunise (Department of Health, 2015). While health is funded by both State and Commonwealth Australian Governments (McCaffery et al., 2007), standard Australian infant and childhood immunisations are free for families under Medicare, the nationally funded health insurance scheme and the Immunise Australia Program.

Embracing diverse ways to engage with diverse families

We live in an information-dense society and some parents have become increasingly discerning in their acceptance of government and public health information. Additionally, parents have become more adept at accessing the array of alternative health information available from a variety of sources, many of which use narrative particularly well. Encouragingly, public health programmes attempt to address diverse population needs. Hull and McIntyre (2006) give the example of remote Indigenous communities' needs for timely vaccinations and there is also the need for extra vaccinations in high-risk communities as described by Lui et al. (2012). This is achieved through targeted delivery in isolated communities by nurses who travel to those communities and clinics. They also include vaccinations against Rota virus for Indigenous Australians

in their schedule due to the higher risks associated with that population. Such adaptations seem to be effective, but other measures are needed with different communities.

The next important step for health officials might be to diversify the range of message types employed and to use narrative as a powerful tool to sustain herd immunity. Indeed, Hinyard and Kreuter (2007) believe 'narrative approaches are emerging as a promising set of tools for motivating and supporting health-behavior change' (p. 777) in the expanding field of health promotion. Landry (2017) explains narratives are an adaptable tool that can be used by health care providers, patients and carers as prompts to positively impact health outcomes. Landry (2017) goes further, stating narratives 'facilitate processing thoughts and emotions related to healthcare experiences, identifying patterns affecting health or healthcare choices' (n.p.).

In addition to this, there appears to be a lag in the public health methods of delivery with the changes in modern families. Within many countries, there has been a large increase in the number of families in which both parents are working, increasing reliance on early childhood education and care services (Murray & Harrison, 2017). While economically, there are many advantages in these changes, time management has become a problem for an increasing number of families (Zimbardo, 2010). Accessing medical practitioner clinics is another time-consuming responsibility that erodes work and family time. There has also been a decrease in long-term permanent employment within countries like Australia which has resulted in a more mobile society. According to Doherty, Shield, Patton, and Mu (2015), this places further strain on the family as children and the other parent often have to compromise their own desires and start afresh in a new community. Fields (2016) describes the Australian population as one of the most mobile in the Western world, potentially reducing access to extended family and friendship support networks, and potentially increasing time between health care professional consultations.

Increasingly, parents are seeking guidance from early childhood educators on a range of child development and health issues. This is because they are in frequent contact with educators and it is the educators who generally demonstrate their interest in the wellbeing of their children and family. Wilson (2016) asserts the role of early childhood educators as an effective link between community services and families. Linking early childhood services to health clinics may be one preferable solution to be trialled. Such partnerships may alleviate some of the issues of timely vaccinations to address under vaccination that has been identified by WHO as problematic (Rainey et al., 2011).

As shown by the literature, utilising narratives to deliver immunisation messages, including personal experiences of disease, may be beneficial to maintenance and improvement in immunisation rates in Australia. Whilst it should not be the only method of educational information, it could complement a range of other health education initiatives currently in place and be targeted to specific communities where immunisation rates are low. Narratives featuring parents' reactions to immunisation and the decision-making process they went through may also be beneficial. Narratives from health practitioners who have experienced treating diseases that can be avoided through immunisation, either overseas or in previous generations, may be also beneficial.

Research gap

Indeed, Australians enjoy the benefits of having high levels of vaccination and therefore, very low risks of vaccine-preventable diseases. According to Leask et al. (2017), there are a small number of parents, probably about 3.5%, whose concerns about vaccines cause them to reject vaccination for their child, or select only some of the vaccines covering 16 diseases on the National Immunisation Program Schedule (Department of Health, 2015). The concern is that Australia has not yet reached the 95% target for childhood vaccination thought to be required for certain diseases such as measles (Leask et al., 2017). We do not know how to best influence parents who reject vaccinations and have not fully explored some of the influences on parents' decision-making, nor on the most effective way of engendering trust and a willingness to work with concerned parents to allay their fears about vaccination. We have not fully explored potential sources of information from trusted professionals, for example early childhood educators, with whom they are likely to be in contact frequently. Rainey et al. (2011) have called for more research into family characteristics and how they relate to vaccination, whereas Tillermans et al. (2005) state that more needs to be known about parents' concerns and attitudes towards vaccination to assist in designing more effective informational material. From these identified gaps, research questions have been formulated.

Potential future research

Exploratory research is used to examine areas where there are particular topics or parts of topics in which there has been little previous research (Nardi, 2006). In the Australian context we do not have enough information on the relationship between cultural and family narratives and their effects on parents' immunisation attitudes and decisions, thus exploratory research would be efficacious. This might include research questions such as:

- How much influence does cultural narrative and other sources of information have on parental decision-making about their child's immunisation?
- How fixed are parents' attitudes about immunisation?
- How do parents obtain information to inform their decisions about immunisation?
- What other methods are effective and feasible for at-risk communities, including home vaccination, as outlined by Bond, Nolan, and Lester (1998), or other targeted methods, as recommended by Lawrence, Hull, MacIntyre, and Mcintyre (2004)?
- How do families engage with and use narrative?
- How, and with whom, do families share these narratives?
- What is the relationship between a family's context, their employment of narratives and their immunisation decisions?

Conclusion

This discussion paper has found that narratives are a potent force in affecting parental attitudes and practices towards immunisation of their children (Leask et al., 2006) and are an effective education tool. Employing narratives may be an effective method to address different groups of parents within the community who may be fearful, anxious or resistant to vaccination. The literature review has also identified a gap in research about the effectiveness of health messages (Sadaf et al., 2013) and the diversity of families' decision-making practices has been identified (Rainey et al., 2011). Additionally, research is needed to determine the impacts of narratives on health behaviours and on the effectiveness of partnering health and early childhood education services to busy families. Overall, cultural narratives are powerful and health narratives

are often transformative (Landry, 2017). Health practitioners and government departments would benefit from learning more about their effects and how to use narrative effectively. As Pat Masters from the Patient Voice Institute states 'Let's just not tell people facts, but tell them why they matter. It's the stories that pull that together. That's how they learn. That's how they change' (Landry, 2017). Harnessing the power of cultural health narratives as an educative tool may be very effective when working with parents of young children.

Author ORCIDs. Marg Rogers 0000-0001-8407-7256

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