Journal of Transcultural Nursing
2014, Vol. 25(4) 325–333

DOI: 10.1177/1043659614523468
tcn.sagepub.com
SAGE

Applying Ecological Modeling to Parenting for Australian Refugee Families

Julian Grant, PhD[1], and Pauline B. Guerin, PhD[1,2]

Abstract

Children in families with parents from refugee backgrounds are often viewed as a vulnerable group with increased risks of developing physical or psychological problems. However, there is very little research regarding the strategies that parents might use to parent their children in a new country while they also manage the interrelated challenges of poverty, social isolation, maternal stress, and mental ill health that often go along with resettlement. We explore the application of ecological modeling, specifically at individual, institutional, and policy levels, within an Australian context to critique the factors that shape the development of parenting capacity within refugee families settling in a new Western country. Ecological modeling enables examination of how public policy at local state and national levels influences the individual and family directly and through the organizations that are given the task of implementing many of the policy recommendations. Recommendations for health practice and research are made.

Keywords

ecological modeling, Bronfenbrenner's model, Australia, parenting, refugees

Parents are the first people through whom children experience the world. What happens during the early years of life greatly affects a child's long-term health outcomes and their ability to achieve educationally and economically (Belsky, 2008; Shonkoff & Phillips, 2000; Waldfogel, 2004). A child's experience is explicitly shaped by their parents' socioemotional, physical, and economic situation. Indeed, disadvantage that begins before birth and follows into infancy and early childhood is known to accumulate throughout life (Global Health Inequity Group, 2010). Compared with the general population, we know that parents who are also refugees or asylum seekers have significantly poorer psychosocial, health, and economic circumstances (Zwi et al., 2007). This means that children of parents who are refugees are at risk of having poorer health experiences and outcomes than those of the general population.

Accordingly, children in families with parents from refugee backgrounds are often viewed as a vulnerable group with increased risks of developing physical or psychological problems (Sims, Guilfoyle, Kulisa, Targowska, & Teather, 2008). Given this vulnerability, there is very little research regarding the strategies that parents might use to parent their children in a new country while they also manage the interrelated challenges of poverty, social isolation, maternal stress, and mental ill health that often go along with resettlement. The strategies that are used to parent are shaped by a complex interweaving of internal and external societal factors. The discussion that follows is a prelude to research aimed at exploring with refugee parents how they manage parenting in a new country. Considering parents who have settled in South Australia as a case study, we review literature and policy documents to contextualize the pathways to settlement and the more general refugee context in Australia. We then describe the use of ecological modeling to make sense of the intersecting and competing factors identified in the literature that shape the parenting experience. Following this, we draw on international literature to explore, through ecological modeling, the individual, social, and cultural factors that shape child health and parenting for refugee families and parenting in a new country. At a societal level, we focus specifically on the South Australian context and compare broader national policies with international literature. We then argue how this critique provides a framework for both research and practice to find ways to enable this group of vulnerable children and parents to thrive.

Background to Refugees in Australia

The United Nations High Commissioner for Refugees (UNHCR; 1967) defines a refugee as someone who is

[1]Flinders University, School of Nursing and Midwifery, Adelaide, South Australia, Australia
[2]The Pennsylvania State University, Brandywine Campus, Media, PA, USA

Corresponding Author:
Pauline Guerin, Pennsylvania State University, 25 Yearsley Mill Road, Media, PA, 19063 USA
Email: pbg12@psu.edu

outside of their home country and cannot return because of a "well-founded fear" of persecution due to race, religion, nationality, or a member of a particular social group or because of their political opinions. Australia is a signatory to the Refugee Convention and provides a few different options for people with a refugee background to settle in Australia through the Humanitarian program (see Australian Human Rights Commission, 2008; Department of Immigration and Citizenship, 2011). The Offshore resettlement program grants visas either through the UNHCR refugee program or there are Special Humanitarian visas that are accessed through a "proposer." Proposers must support an application for entry and are required to be an Australian citizen, permanent resident, or eligible New Zealand citizen, or an organization that is based in Australia. Persons who submit their applications onshore are often referred to as "asylum seekers," whereas those who apply "offshore" are often referred to as refugees, though the "refugee" label is often inclusive of anyone who has gained access to residence in Australia via Humanitarian pathways. "Onshore" applicants apply for protection when they are already in Australia and can either obtain a Protection Visa or a Permanent Protection visa (Australian Human Rights Commission, 2008; Department of Immigration and Citizenship, 2011).

Importantly, with a total Australian population of around 22 million, around 13,000 refugees are accepted in Australia's Humanitarian Program each year. Although this may seem high, considering the relative wealth of Australia, Australia was ranked 77th in 2009, behind Canada, the United States, and the United Kingdom for refugees relative to the GDP (PPP) per capita (UNHCR, 2010). The vast majority of refugees in Australia have Special Humanitarian or Refugee visas via the UNHCR. Roughly 15% to 20% of visas are through onshore protection programs. The majority of refugees in Australia come from the Middle East and South West Asia, Asia, and Africa, with much smaller numbers from Europe and the Americas. In 2008-2009, one third of the Humanitarian entrants were from the Middle East, South and West Asia, one third from Asia, and one third from Africa (Department of Immigration and Citizenship, 2011). The top 10 countries of birth for Humanitarian offshore entrants in 2008-2009 were Iraq, Burma/Myanmar, Afghanistan, Sudan, Bhutan, Ethiopia, Congo (DRC), Somalia, Liberia, and Sierra Leone.

Making Sense of Refugee Experiences of Settlement: Ecological Modeling

Refugees resettling in a Western country have a wide range of experiences that often differ markedly from those who are not refugees or migrants. These experiences and their sequelae are not well accommodated in Western, individualistic models of understanding human behavior. Ecological theories take into consideration the wide range of environments that influence people and their families and offer many advantages to understanding the complexities of refugee resettlement, particularly, the resettlement of refugee parents with small children in a new, Western country.

Perhaps the most well-known ecological model, particularly in relation to human development, is that of Urie Bronfenbrenner (2004). Bronfenbrenner's bioecological model considers five systems—the microsystem, the mesosystem, exosystem, macrosystem, and chronosystem—that influence human development (see Figure 1).

Adopted by the Australian Institute of Family Studies for the Longitudinal Study of Australian Children (Commonwealth of Australia, 2012), this model shows the developing child in the center, with her or his individual biological capacities. He or she is surrounded first by the *microsystem* of home, family, and immediate bidirectional contacts. It is here that the physical and mental health of the refugee parent has greatest impact on the life course of the child. Furthermore, it is at this level that the parent has the potential to develop their own social capital in their new home. This social capital is an essential determinant of how children will engage with their newly adopted home. The process of parenting is core to the development of capital: social, financial, and human in infants and children. Coleman (1994) argues that without social capital parents will be unable to transfer other forms of capital such as financial capital (the capacity to purchase resources) or human capital (the capacity to provide an environment conducive to educational success). As children develop and grow within society, they develop their own frameworks and networks influenced by their own internal working models and their experiences of being parented. This is how children develop their own social capital (Felton & Carlson, 2001; Furstenberg, 2005; Parcel, Dufur, & Zito, 2010).

Bronfenbrenner's widening systems, such as the *exosystem* of government agencies, educational systems, and transport networks, further shape how the families develop capital and thus support their growing child. The furthest reaching of Bronfenbrenner's systems is the *macrosystem*. This system incorporates the economic and political system and the dominant beliefs and ideologies of the living environment. All these systems are underpinned by the *chronosystem*, which is the dimension of time and change over the life course. For refugee parents this chronosystem encompasses all presettlement experiences and the traumas associated with forced migration, living in refugee camps, arrival in a new land, and the challenges of settlement. The chronosystem, therefore, has a substantial effect on parental well-being and capacity to raise healthy children in a new and different country.

An ecological model provides an interactive, dynamic system that enables us to consider how the behavior of any individual is affected by their environment and, in turn, how they affect their environment (McLeroy et al., 1988). It enables us to understand that there are always intersections between and within the individual and their community,

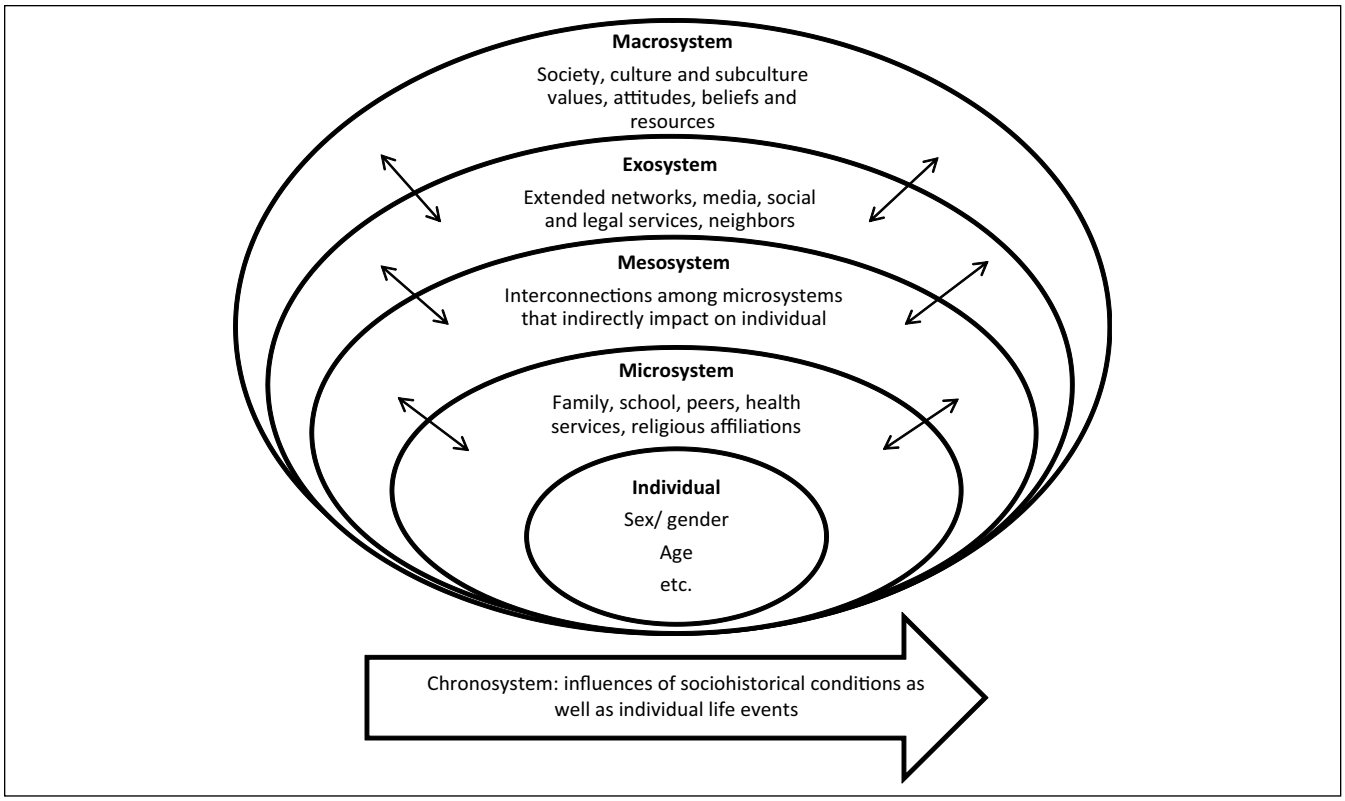

Figure 1. Depiction of Bronfenbrenner's bioecological model (1979, 2004).

institution and public policy (following McLeroy et al., 1988). Through an ecological model we are able to recognize that the individual's capacity to parent is shaped not only by their own intrapersonal factors such as knowledge, beliefs, and attitudes but also interpersonal factors such as formal and social networks. Furthermore, the rules and regulations of the institutions and organizations that they deal with to access support also influence this capacity alongside the relationships between and within these organizations and the community. Ecological modeling therefore enables examination of how public policy at local state and national levels influences the individual directly and through the organizations that are given the task of implementing many of the policy recommendations. Finally, and of great importance for groups identified as vulnerable, contemporary ecological framing enables exploration of relations of power, within and between individuals and institutions.

In this analysis, we explore the individual level through the international literature on the individual health and well-being of children as a result of their settlement experiences. We also explore, in this section, the health and well-being of parents at the level of the microsystem as we know that parental well-being can affect child health outcomes. In the exosystem, we focus on exploring parental experiences of engaging with health care services as they are required to do to access support for their children. In our exploration of the macrosystem, we look at national and international policy directions on child growth and development and national policies that shape migration in the Australian context.

The Individual and Family: Microsystem

We begin at the individual and family levels, exploring the literature on infants, children, and parents who are refugees or who have arrived in Australia via humanitarian pathways. We note that not all children are cared for by their biological parents and we use the term *parent* to refer to those adults who take on the parenting role for refugee children. Of note, most, if not all, of the literature in this area has focused on the health burdens on individuals who have gained entry into Australia using humanitarian pathways and on society. We, however, are considering the family context within and as part of multiple contexts in an ecological model.

Research shows that infants and children in families with parents who have come from refugee backgrounds are vulnerable, with an increased risk of developing physical or psychological problems (McKelvy, Sang, & Baldassar, 2002; Rees, 2004; Sims et al., 2008). Factors that particularly affect children of parents who are refugees include poverty (P. B. Guerin & Guerin, 2002) and social isolation (Wilkinson & Marmot, 2003). There is an emerging body of research in South Australia exploring the emotional and behavioral

problems experienced by refugee children as well as their protective factors and help-seeking behaviors (DeAnstiss et al., 2009; Warland et al., 2007). More specifically, refugee children who have also experienced traumas such as physical and mental deprivation, violence, and displacement at critical developmental stages are likely to have a higher burden of mental health problems (Fazel & Stein, 2002).

Using historic examples of trauma, research has shown that third- and fourth-generation survivors of the holocaust continue to experience severe trauma (Sigal, 1998; Sigal, DiNicola, & Buonvino, 1988). We do not know how individuals, who experienced the trauma of the holocaust or lived through other humanitarian crises, parented their children in a new country through subsequent generations, or what, if any, parenting strategies resulted in better outcomes (but see Robertson & Duckett, 2007). Exploring and understanding the factors that shape parenting capacity in a new country (e.g., Lewig, Arney, & Salveron, 2010) can contribute to the development of programs and services aimed at reducing the effects of the traumas related to refugee status on subsequent generations of Australian children.

The majority of research published to date regarding parents who are refugees or seeking asylum in new countries has focused on identifying the problems associated with resettlement. These include health problems (Davidson et al., 2004; Fazel & Stein, 2002; Zwi et al., 2007), the challenges of birthing in a new country (Small, Yelland, Lumley, Brown, & Liamputtong Rice, 2002), and the differences between Western and other cultural parenting behaviors (Sims & Omaji, 1999). Although this research has been timely and essential, it could also be argued as being derived from a deficit model of care that may not incorporate the strengths of the individual parents and families (Feeley & Gottlieb, 2000).

Infants and children who are raised in conditions of poverty and social isolation and who are raised by mothers who experience maternal stress and mental ill health have increased health risks across the life course (Australian Institute of Health and Welfare, 2005; Gray & Sims, 2007; Halgunseth, Ispa, Csizmadia, & Thornburg, 2005). Mothers and fathers of infants and young children who are refugees in Australia are known to experience high levels of all the factors within this cluster (Sims et al., 2008).

Additionally, parents who are refugees in Australia experience higher levels of welfare dependency, housing problems, and challenges to entering the workforce than those entering under the migration program (Holmes, Hughes, & Julian, 2003). These challenges affect refugee arrivals that are on temporary protection visas more deeply, particularly, women and children (Rees, 2004).

Single mothers are among those who are likely to be most underresourced. This is compounded when these mothers are fleeing war-torn countries, have experienced trauma or torture, or are from culturally distant societies, that is, are visible minorities in their host country (Ryan, Dooley, & Benson, 2008). This not only poses psychological health problems for new arrival single mothers but also for their children. "Young children of colour are more likely to experience factors that put them at risk for poor social, emotional, and behavioural development" (Cooper, Masi, & Vick, 2009, p. 5). We have little evidence the relationship between social and cultural resources of mothers who are single and with a refugee background.

Despite these challenges, the Refugee Council of Australia (2010) reports above average rates of success in education and employment for children of refugees. This is variously attributed to cognitive advantage due to proficiency in languages other than English and high levels of motivation as part of the "ethnic success ethic" or "ethnic advantage" (Refugee Council of Australia, 2010, p. 3). The report also highlights the need for research into the "experiences and outcomes of children of refugees and humanitarian migrants, to determine the role of the refugee experience, settlement support, parental motivation and educational opportunities in their educational and social development" (Refugee Council of Australia, 2010, p. 5).

Implementing Care Through Structures and Organizations: Exosystem

At a structural level, or that of the exosystem, we consider how health care organizations have taken up the challenge of providing services to support parenting for those who are refugees or of humanitarian background. Parents who are migrants or refugees have poorer health care experiences than the general population due to issues of culture and communication. For example, the "Mothers in a New Country" study undertaken in Melbourne identified problems of unprofessional communication and lack of cross-cultural understandings culture for migrant women experiencing birth in a new country (Small et al., 1999; Yelland et al., 1998). Yelland et al. (1998) describe a lack of assistance, unfriendliness, and rudeness. Small et al. (1999) cite examples of women being "scolded," ignored, or shouted at. Both publications cite women feeling intimidated and coerced into practices that contradicted cultural practices they wished to observe (Small et al., 1999; Yelland et al., 1998). Ten years later, despite the development of cultural competency tools for practice and the best intentions of workers, health care professionals, particularly nurses, continue to use unexamined approaches of White Western parenting when working with parents who were culturally different to themselves (Grant & Luxford, 2008, 2011). At times, this has unintended effects of paternalism and assimilation into White cultural practices (Grant & Luxford, 2008, 2011).

In attempting to address health inequities, the Australian Institute of Health and Welfare, (AIHW; 2005, p. 94) suggest that "access to affordable socially and culturally appropriate services and support systems that strengthen families and community capacity to look after children is important for

improving outcomes for children." In 2012, there remain no clear definitions around how to provide this culturally appropriate care. Sims et al. (2008) identified that cultural competency and partnership are important factors in the provision of culturally appropriate care. Apart from specific "show case" examples there is no evidence regarding how cultural competency and partnership "work" in practice (Taylor & Guerin, 2010). Although this broad usage may hopefully enable organizations to develop local and regional strategies for developing cultural competency and working in partnership it does not help organizations to know what is meant by these terms nor how to implement them at organizational and individual levels. Despite common usage there remains a lack of consistency in how both cultural competency and partnership are defined, understood, and implemented in practice (Grant & Luxford, 2008; Grant, Luxford, & Darbyshire, 2005). This makes it difficult for health and welfare workers to implement care using these frameworks.

In 2005, the AIHW stated that as a nation we "lack specific indicators to monitor the performance of systems and services that are available to children and families" (p. 94). Although the 2009 report argues that many indicators are now available on a range of performance measures around health and well-being, there remain no measures to indicate whether service provision is culturally safe, culturally competent, or that service delivery demonstrates working in partnership (AIHW, 2009, p. 171). Performance of systems and services aimed at supporting children and their families becomes even more imperative when the families we are working with have experienced the multiple traumas of forced migration and are at risk of experiencing continued trauma through institutional racism (B. Guerin & Guerin, 2007). Unless we are able to comprehensively define effective strategies such as cultural competency and partnership we cannot begin to develop indicators to monitor systems and services used by the vulnerable group of children and families who are refugees.

National and State Policies and Frameworks for Care: Macrosystem

As part of the macrosystem, growth and development of Australian children is supported by a range of policy initiatives. These include the National Quality Framework, which regulates early childhood education and care (Australian Children's Education and Care Quality Authority, 2012). Core to this framework is a National Early Childhood Development Strategy (Commonwealth of Australia, 2009). Using an ecological framework to position the development of an effective early childhood development system, the strategy has a core vision to ensure that "by 2020 all children have the best start in life to create a better future for themselves and for the nation" (Commonwealth of Australia, 2009, p. 13). Of particular importance to children from refugee backgrounds, the strategy cites "a focus on respect for diversity and difference as a strength, and helping children develop a positive sense of self and culture" as one of the six underlying principles (Commonwealth of Australia, 2009, p. 4). Seven core outcomes are articulated including that "children's environments are nurturing, culturally appropriate and safe and that children benefit from better social inclusion and reduced disadvantage . . . " (Commonwealth of Australia, 2009, p. 22). Some children from cultural and linguistic backgrounds are identified within the population of vulnerable children for whom improved service responses and outcomes are recommended (Commonwealth of Australia, 2009). The strategy is a broad population-based tool to improve health and education outcomes for all children in Australia. Specific population groups are identified as in need of particular support due to vulnerability. Although some children of cultural and linguistic backgrounds are identified as part of this group, children of refugee or humanitarian entrance are not included.

In describing the demographics of Australia's children, the 2009 *Picture of Australia's Children* (AIHW, 2009, p. 7) includes both cultural and linguistic diversity and refugee children in their descriptors. This is a welcome improvement from the previous *Picture* (AIHW, 2005). Even though children of refugee status are named in the introductory chapter, this attention is not continued throughout the document. In all descriptors throughout the report, children of refugee background are not identified. They appear to be subsumed into the population descriptors of "low socioeconomic status."

The AIHW (2005) report noted that parents of children who come from a language background other than English were less able to demonstrate access to family and social networks required for the development of social capital. This is an important finding as we know that strong family and social networks protect children against the adverse effects of socioeconomic disadvantage (see, e.g., Attree, 2004, cited in Zwi & Henry, 2005), and the development of social capital is required for parents to transfer other forms of capital to their children (see, e.g., Parcel et al., 2010). Although the report also identifies the increased physical, psychological, and socioeconomic risks for children where parents have a mental illness, it does not attend to the needs of the specific subgroup of refugee children where parents commonly experience mental ill health as a result of their premigration experiences.

On the other hand, in the section on literacy and numeracy, the report notes that "the proportion of children with a language background other than English who have met the minimum standards was similar to that for all students for reading and numeracy" (AIHW, 2009, p. 7). This positive finding may well suggest that it is not necessary to explicitly isolate refugee children for particular attention. Additionally, the recognition that in 2008 refugee children accounted for less than 1% of the Australian population of children (AIHW,

2009) may reduce the statistical relevance of including this subgroup.

Australia also has a comprehensive measure of "Headline" indicators for child health (AIHW, 2011). Although these include a range of factors that are likely to be present for infants of parents who are refugees, again, they do not specifically identify forced migration or migration as a unique health indicator, nor are they representative of a cluster of indicators. Again, this population subgroup appears to be subsumed into the areas of low socioeconomic background for health data and children with a Language Background Other Than English in the education data. This could be interpreted in a number of ways. First, this omission could simply be due to a lack of available population specific data. Forced migration and refugee status may not be recognized as significantly affecting the health of children, or forced migration may not affect *enough* of Australia's children to be worthy of inclusion in data collection. Additionally, this group of vulnerable children may not be included in the report because, at least for some, their residency status is tenuous.

In Europe, the Child Health Indicators of Life and Development project (Kohler & Rigby, 2003; Rigby & Kohler, 2002; Rigby, Kohler, Blair, & Metchler, 2003) takes a different approach. Under *demographic and socioeconomic determinants of health* the report to the European Commission (Rigby & Kohler, 2002) specifically includes asylum seekers as one of five indicators. Furthermore, it includes a broad category called "issues in the health of children" (Rigby et al., 2003, p. 39), which makes space for the inclusion of "migration" as a category that affects the health of children. This recognizes the impact of migration in and of itself rather than isolating the effects of migration as secondary outcome factors as used in Australia's Headline Indicators. For example, homogenized outcome factors include "social and emotional well-being" under the health priority area and "family economic situation" is an outcome under a family and community priority area. The current Australian data prevent the intersecting issues relating to migration from being examined as a unique collection of indicators. The collective impacts of factors such as forced migration, poverty, trauma, and racism on children and their families could be more understood and, therefore, attended to at policy level if a specific population group of children arriving under refugee or humanitarian status was considered.

The current policy *Multicultural Australia: United in Diversity* incorporates a strategic direction for access and equity, highlighting the need for greater investment for vulnerable individuals and groups, including refugees living as permanent or temporary residents in Australia (Department of Immigration and Multicultural and Indigenous Affairs, 2003). It does not however identify the unique vulnerabilities of children as a group.

In response to the Generational Health Review, the South Australian policy, *Better Choices Better Health*, identifies both new arrivals and individuals in the early childhood years as at-risk populations requiring specific effort for equity strategies within health (Department of Human Services, 2003a). Furthermore, women and children are identified in the *Framework for Early Childhood Services in South Australia* as particularly susceptible to inequalities in health and welfare, mainly during the antenatal period and throughout the early childhood years (Department of Human Services, 2003b). Despite these policy commitments there is little research evidence as to how this might be enacted in the health and welfare practices in services for families who are refugees. As discussed previously, refugees continue to experience health care inequities. In reviewing policy responses to health inequities, Newman, Baum, and Harris (2006) confirm that refugee health is not mentioned in strategies to close the vulnerability gap. A compounding problem is that terms such as "disadvantage" and "health inequities" are not obviously defined and not clearly addressed in government targets (Newman et al., 2006).

Summary and Recommendations

Because parenting is influenced by individual, community, institutional, and public policy factors, an ecological approach is an ideal framework from which to critique current knowledge and to develop research questions. A parent's capacity to raise children directly affects the lifelong outcomes of their children. More research exploring how parents manage this first stage of supporting their children while settling into a new country is essential. In particular, the perspective of the parent appears to be missing from much of the literature at all ecological levels. We need to explore with parents who are refugees, how they raise their children in a new country, and identify the challenges, supports, and strengths they bring to the role. This knowledge will help future generations of newly arrived and settling Australian citizens.

Several recommendations arise from this ecological exploration into the factors that shape capacity for refugees to parent in a new country (see Table 1). First, this review suggests a need for investigation of parental perspectives on the factors that influence parenting in a new country and the strategies and strengths that they bring to their role. This would contribute to a more contextual understanding particularly of how the individual and microsystem function, in Bronfenbrenner's model, while also illuminating the complexities of the interconnections of microsystems in the mesosystem (see Table 1). Such data from a recently completed study in South Australia of single refugee mothers with young children are currently being analyzed (Grant, Guerin, & Cole, 2012). A comprehensive examination of how health and welfare professionals implement approaches to care would enable a contribution to health care performance and strategies for care. Finally, an analysis of how the terms *cultural competency* and *partnership* are represented by organizations that provide parenting services to

Table 1. Extrapolation of Bronfenbrenner's (2004) Ecological Model to Recommendations Relating to the Needs of Refugee Children in Australia.

Components of the model	Significance	Recommendations
Individual and microsystem: Family, school, peers, health services, religious affiliations	Where the physical and mental health of the parent has greatest impact on the life course of the child	Explore how parents experience and negotiate their microsystems to raise children while experiencing settlement as a refugee in a new country. Single mothers and mothers who are from visible minority groups are particularly vulnerable and should therefore be prioritized.
Mesosystem: Interconnections among microsystems that indirectly affect the individual	Where parents develop social capital to support their children	Explore how microsystems are connected and how parents connect to microsystems to develop social capital.
Exosystem: Extended networks, media, social and legal services, neighbors	Where policies and services can support development of social capital	Examine terms such as cultural competency and partnership in policies and how they are defined and used. Monitor performance of systems in relation to culturally safe and competent care for children and their families.
Macrosystem: Society, culture and subculture values, attitudes, beliefs, and resources	Australia is a signatory to the Refugee Convention and to the Convention on the International Rights of the Child	Include children from refugee or humanitarian backgrounds as a specific population group when collecting and reporting national data on children's well-being.
Chronosystem: Influences of sociohistorical conditions as well as individual life events	Recognition of presettlement experiences of the child and their family including experiences of being a visible minority in a new country	Develop programs of culturally safe and competent practice across all professions to ensure that service providers consider the child in context of their lifetime experiences.

families who are refugees would shed light on the structural foundations that inform practice. Indeed, a recent review of such policies in South Australia has found a lack of clear definitions of concepts such as "culture" and "partnership" in policy documents, as well as ambiguity in recommendations for appropriate practice (Grant, Parry, & Guerin, 2013).

Of greatest importance is the need to explore refugee family experiences of developing capacity to parent in a new country. Analysis of these experiences can then potentially contribute to enhancing the experience of new arrivals and improve the health care outcomes for infants and children. In particular, exploration needs to focus on the multiple factors that shape capacity to parent, how these factors shape capacity to parent, and how parents who are refugees manage these factors while raising a child in a new country.

Exploration of this nature would benefit all health and welfare professionals who work with parents who are refugees by providing specific information around the factors that shape parenting capacity and the strengths that parents use to manage these factors. It would also be beneficial for service planning and policy development in addition to informing work at individual practice levels. Parents are the first adults with whom children develop a relationship. Unless we examine how the effects of forced migration and settlement affect this relationship, we will not have evidence to support parents to halt the subsequent generational effects of trauma on this group of Australian children.

Acknowledgment

This article was accepted under the editorship of Marty Douglas, PhD, RN, FAAN.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received financial support for the research, authorship, and/or publication of this article from a seeding grant from the Faculty of Medicine, Nursing, and Health Sciences, "Parenting in a new country: Exploring the complexity for single refugee mothers" $19,950 from 2010-2012 .

References

Australian Children's Education & Care Quality Authority. (2012). National Quality Framework. Retrieved from http://www.acecqa.gov.au/national-quality-framework

Australian Human Rights Commission. (2008). *Face the facts: Questions and answers about asylum seekers and refugees*. Retrieved from http://www.hreoc.gov.au/racial_discrimination/face_facts/index.html

Australian Institute of Health and Welfare. (2005). A picture of Australia's children 2005 (Cat. No. PHE 58). Canberra, ACT: Author.

Australian Institute of Health and Welfare. (2009). *A picture of Australia's children 2009* (Cat. No. PHE 112). Canberra, ACT: Author.

Australian Institute of Health and Welfare. (2011). *Headline indicators for children's health, development, and wellbeing 2011* (Cat. No. PHE 144). Canberra, ACT: Author.

Belsky, J. (2008). War, trauma and children's development: Observations from a modern evolutionary perspective. *International Journal of Behavioral Development*, *32*, 260-271.

Bronfenbrenner, U. (1979). The ecology of human development. Harvard University Press, Cambridge isbn 9780674224575

Bronfenbrenner, U. (2004). *Making human beings human*. Thousand Oaks, CA: Sage.

Coleman, J. (1994). Social capital, human capital & investment in youth. In A. Petersen & J. Mortimer (Eds.), *Youth unemployment & society* (pp. 34-50). Cambridge, England: Cambridge University Press.

Commonwealth of Australia. (2009). *Investing in the early years—A national early childhood development strategy: An initiative of the Council of Australian Governments (COAG)*. Canberra, ACT: Author.

Commonwealth of Australia. (2012). *Longitudinal study of Australian children: Key research questions*. Retrieved from http://www.aifs.gov.au/growingup/pubs/reports/krq2009/keyresearchquestions.html

Cooper, J. L., Masi, R., & Vick, J. (2009). *Social and emotional development in early childhood: What every policy maker should know*. Retrieved from http://www.nccp.org/publications/pub_882.html

Davidson, N., Skull, S., Chaney, G., Frydenberg, A., Issacs, D., Kelly, P., . . .Burgner, D. (2004). Comprehensive health assessment for newly arrived refugee children in Australia. *Journal of Paediatrics and Child Health*, *40*, 562-568.

DeAnstiss, H., Ziaian, T., Procter, N., Warland, J., & Baghurst, P. (2009). Help-seeking for mental health problems in young refugees: A review of the literature with implications for policy, practice, and research. *Transcultural Psychiatry, 46*, 584-607.

Department of Human Services. (2003a, April). *Better choices better health. Final report of the South Australian Generational Health Review: Summary*. Adelaide, South Australia: Author.

Department of Human Services. (2003b). *Every chance for every child-making the early years count. A framework for early childhood services in South Australia*. Adelaide, South Australia: Author.

Department of Immigration and Citizenship. (2011). *Fact sheet 60: Australia's Refugee and Humanitarian Program*. Retrieved from http://www.immi.gov.au/media/fact-sheets/60refugee.htm

Department of Immigration and Multicultural and Indigenous Affairs. (2003). *Multicultural Australia: United in diversity. Updating the 1999 new agenda for multicultural Australia: Strategic directions for 2003-2006*. Canberra, ACT: Author.

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Diseases in Childhood*, *87*, 366-370.

Feeley, N., & Gottlieb, L. N. (2000). Nursing approaches for working with family strengths and resources. *Journal of Family Nursing*, *6*, 9-22.

Felton, E., & Carlson, M. (2001). The social ecology of child health and well-being. *Annual Review of Public Health*, *22*, 143-166.

Furstenberg, F. F. (2005). Banking on families: How families generate and distribute social capital. *Journal of Marriage and Family*, *67*, 809-821.

Global Health Inequity Group. (2010). *Fair society, healthy lives: The Marmot Review Executive Summary*. London, England: Department of Epidemiology & Public Health, University College London.

Grant, J., Guerin, P., & Cole, C. (2012). *Developing social capital as a single refugee mother in a new country: Narratives of creating life*. Retrieved from https://www.dunstan.org.au/events/Grant_Developing_social_capital_refugee_single_mums_DDF_2012.pdf

Grant, J., & Luxford, Y. (2008). Intercultural communication in child and family health. *Nursing Inquiry*, *15*, 309-319.

Grant, J., & Luxford, Y. (2011). Culture, it's a big term isn't it? An analysis of child and family health nurses' understandings of culture and inter-cultural communication. *Health Sociology Review*, *20*(1), 16-27.

Grant, J., Luxford, Y., & Darbyshire, P. (2005). Culture, communication and child health, *Contemporary Nurse*, *20*, 134-142.

Grant, J., Parry, Y., & Guerin, P. (2013). *An investigation of culturally competent terminology in health care policy finds ambiguity and lack of definition*. Australian and New Zealand Journal of Public Health, 37, 250-256.

Gray, C., & Sims, M. (2007). Parental stress and child rearing decisions. *New Zealand Research in Early Childhood Education*, *10*, 119-130.

Guerin, B., & Guerin, P. (2007). Lessons learned from participatory discrimination research: Long-term observations and local interventions. *Australian Community Psychologist*, *19*, 137-149.

Guerin, P. B., & Guerin, B. (2002). Relocating refugees in developed countries: The poverty experiences of Somali resettling in New Zealand. In K. Lyon & C. Voight-Graf (Eds.), *Fifth International APMRN Conference, Fiji 2002: Selected papers* (pp. 64-70). Wollongong, New South Wales, Australia: University of Wollongong.

Halgunseth, L. C., Ispa, J. M., Csizmadia, A., & Thornburg, K. R. (2005). Relations among maternal racial identity, maternal parenting behaviour, and child outcomes in low-income, urban, black families. *Journal of Black Psychology*, *31*, 418-440.

Holmes, D., Hughes, K., & Julian, R. (2003). *Australian sociology: A changing society*. French's Forest, New South Wales, Australia: Pearson Longman.

Kohler, L., & Rigby, M. (2003). Indicators of children's development: Considerations when constructing a set of national Child Health Indicators for the European Union. *Child: Care, Health and Development*, *29*, 551-558.

Lewig, K., Arney, F., & Salveron, M. (2010). Challenges to parenting in a new culture: Implications for child and family welfare. *Evaluation and Program Planning*, *33*, 324-332.

McKelvy, R. S., Sang, D. L., & Baldassar, L. (2002). The prevalence of psychiatric disorder among Vietnamese children. *Medical Journal of Australia*, *177*, 413-417.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). Ecological perspective on health promotion programs. *Health Education Quarterly*, *15*, 351-377.

Newman, L., Baum, F., & Harris, E. (2006). Federal, state and territory government responses to health inequities and the social

determinants of health in Australia. *Health Promotion Journal of Australia*, *17*, 217-225.

Parcel, T. L., Dufur, M. J., & Zito, R. C. (2010). Capital at home and at school: A review and synthesis. *Journal of Marriage and Family*, *72*, 828-846.

Rees, S. (2004). East Timorese women asylum seekers in Australia: Extrapolating a case for resettlement services. *Australian Social Work*, *57*, 259-272.

Refugee Council of Australia. (2010, February). *Economic, civic, and social contributions of refugee and humanitarian entrants: A literature review*. Retrieved from http://www.refugeecouncil.org.au/docs/resources/Contributions_of_refugees.pdf

Rigby, M., & Kohler, L. (Eds.) (2002). Child Health Indicators of Life and Development (CHILD): report to the European Commission. Keele, UK: Centre for Health Planning and Management and Health and Consumer Protection Directorate, European Commission.

Rigby, M. J., Kohler, L. I., Blair, M. E., & Metchler, R. (2003). Child health indicators for Europe: A priority for a caring society. *European Journal of Public Health*, *13*(3), 38-46.

Robertson, C. L., & Duckett, L. (2007). Mothering during war and postwar in Bosnia. *Journal of Family Nursing*, *13*, 461-483.

Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical perspectives on post migration adaptation and psychological well-being among refugees: Towards a resource- based model. *Journal of Refugee Studies*, *21*(1), 1-18.

Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). *From neurons to neighbourhoods: The science of early childhood development*. Washington, DC: National Academies Press.

Sigal, J. (1998). Long-term effects of the Holocaust: Empirical evidence for resilience in the first, second, and third generation. *Psychoanalytic Review*, *85*, 579-585.

Sigal, J., DiNicola, V., & Buonvino, M. (1988). Grandchildren of survivors: Can negative effects of prolonged stress be observed two generations later? *Canadian Journal of Psychiatry*, *33*, 207-212.

Sims, M., Guilfoyle, A., Kulisa, J., Targowska, A., & Teather, S. (2008). *Achieving outcomes for children and families from culturally and linguistically diverse backgrounds*. Canberra, ACT: Australian Research Alliance for Children and Youth.

Sims, M., & Omaji, A. (1999). Migration & parenting. *Journal of Family Studies*, *5*, 84-96.

Small, R., Liamputtong Rice, P., Yelland, J., & Lumley, J. (1999). Mothers in a New Country: The role of culture and communication in Vietnamese, Turkish and Filipino Women's experiences of giving birth in Australia. Women & Health, *22*, 77-101.

Small, R., Yelland, J., Lumley, J., Brown, S., & Liamputtong Rice, P. (2002). Immigrant women's views about care during labour and birth: An Australian study of Vietnamese, Turkish and Filipino women. *Birth*, *29*, 266-277.

Taylor, K., & Guerin, P. (2010). *Health care and indigenous Australians: Cultural safety in practice*. South Yarra, Victoria, Australia: Palgrave MacMillan.

United Nations High Commissioner for Refugees. (1967). *Convention and protocol relating to the status of refugees*. Geneva, Switzerland: United Nations.

United Nations High Commissioner for Refugees. (2010). *2009 Global trends: Refugees, asylum-seekers, returnees, internally displaced and stateless persons*. Retrieved from http://www.unhcr.org/4c11f0be9.html

Warland, J., Ziaian, T., Stewart, H., Sawyer, M., Procter, N., & Baghurst, P. (2007). Challenges faced when conducting research with young Australians with refugee experiences. *The Australian Community Psychologist*, *19*, 53-62.

Waldfogel, J. (2004). *Social mobility, life chances, and the early years* (CASE Paper 88). London, England: London School of Economics.

Wilkinson, R., & Marmot, M. (Eds.). (2003). *Social determinants of health: The solid facts*. Geneva, Switzerland: World Health Organization.

Yelland, J., Small, R., Lumley, J., Cotronei, V., Warren, R., & Rice, P.L. (1998). Support, sensitivity, satisfaction: Filipino, Turkish and Vietnamese women's experiences of postnatal hospital stay. Midwifery, *14*, 144-154.

Zwi, K., & Henry, R. L. (2005). Children in Australian society. *Medical Journal of Australia*, *183*, 154-160.

Zwi, K., Raman, S., Burgner, D., Faniran, S., Voss, L., Blick, B., . . .Smith, M. (2007). Towards better health for refugee children and young people in Australia and New Zealand: The Royal Australasian College of Physicians perspective. *Journal of Paediatrics and Child Health*, *43*, 522-526. doi:10.1111/j.1440-1754.2007.01152.x