Doesn’t everyone have poison in the kitchen cupboard?

Investigating socio-cultural differences in child unintentional poisoning.

Final Report to DHS Public Health Research Grants Scheme

Prepared by the School of Health and Social Development, Deakin University
PROJECT DETAILS

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Summary of ethics clearance:
Ethics approval was obtained from the Deakin University Human Research Ethics Committee in May 2005. The ethics application number is EC 62-2005.

Key words:
child unintentional poisoning; ethnography; protective factors; risk factors; socio-cultural differences; culturally and linguistically diverse communities
EXECUTIVE SUMMARY

Background
Child unintentional poisoning is an important public health issue in Victoria. Unintentional poisoning is the second most common cause for child injury hospitalisations for children under five years of age after falls. This DHS-funded project aimed to identify the protective and/or risk factors for child unintentional poisoning in the home environment of culturally and linguistically diverse (CALD) communities identified as being under-represented in emergency department presentations for poisoning. This project arose from a DHS Commissioned study which aimed to identify the motivators and barriers to compliance with child poisoning safety practices.

Methodology
Statistical analyses included the comparison of the rate and pattern of emergency department presentations for child unintentional poisoning in children with Chinese, Somali, Filipino, Turkish and Vietnamese backgrounds, the most frequent CALD consumers of the Royal Children’s Hospital (RCH) emergency department. It was confirmed that these CALD groups were over-represented for child injuries but under-represented for child unintentional poisoning in hospitals in Victoria. Three of the five CALD communities were identified as the most appropriate population sub-groups to answer the research questions: Somali, Turkish and Vietnamese. Due to time restrictions, the Chinese and Filipino groups could not be included in the study.

Ethnography is a qualitative research method used to study the beliefs and practices of cultural groups. Integral to the ethnographic approach are interviews and participant observation, both of which were used to collect data from the primary care-givers of children under five from the Somali, Turkish and Vietnamese communities. Interviews were conducted in the homes of participants to allow observation of safety practices. Overall, primary care-givers from 23 families participated: 8 Somali, 7 Turkish and 8 Vietnamese, representing the home environment for 45 parents and grandparents and 61 children.

Summary of Expenditure*

<table>
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<tr>
<th>Category</th>
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<th>Actual</th>
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<tr>
<td>Personnel</td>
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<tr>
<td>Equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Administrative</td>
<td>$16,500</td>
<td>$12,660</td>
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<tr>
<td>Total</td>
<td>$74,280</td>
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</tr>
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* See Appendix 1 for full report on expenditure

Results
A number of issues emerged from the interviews and observation. A range of toxic products (cleaning and medication) were observed in the home, with some participants possessing an extensive range whilst others only had a few products. The use of natural remedies for cleaning or medication was not common, but incense use was observed in Vietnamese Buddhist and Somali homes. Parental knowledge of toxic products in the home was limited. Most participants indicated they read product labels for instructions on
appropriate use and storage, side effects and consequences of incorrect use. Most participants were not aware of the Victorian Poisons Information Centre.

Poisoning experience, direct or indirect, was not common. One participant from each community indicated their child had been unintentionally poisoned. The response for each incident varied: one participant called her GP for advice, another participant called the ambulance and the child was hospitalised overnight, and the other child was given yoghurt in the belief that it would minimise the potency of the product consumed. All children were symptom-free afterwards. There were no apparent barriers to accessing health services for poisoning; many participants had previous experience accessing emergency services for other child-related health issues. Participants with no poisoning experience reported that the most likely anticipated response would be to call for an ambulance or take the affected child to hospital. Only two participants indicated they would call the Victorian Poisons Information Centre. Another anticipated response across the three groups was inducing vomiting. Vietnamese participants indicated they would manually induce vomiting by sticking their finger down their child’s throat. Somali participants indicated that prior to vomiting, milk would be given to the affected child whilst Turkish participants stated yoghurt would be given. Younger Vietnamese and Turkish participants were not familiar with inducing vomiting as a response to poisoning. The most commonly reported safety measure that would be undertaken after a poisoning incident was a change in storage procedures, with products stored in a higher location.

A number of safety practices were used to protect children from toxic products. Storage of toxic products away from children was commonly used although Somali participants living in high-rise flats did not have a laundry, so laundry-related products were stored in the bathroom. The use of child-resistant containers was evident across the three groups as these containers are used for child and adult medications. Few participants were currently using child safety products such as locks or latches, specially-designed or home-made, but others had used them previously until their children reached three or four years of age. Safety products were primarily used to prevent child injury from access to cutlery, glassware and crockery rather than toxic products.

Parenting practices were found to have a possible protective influence on child safety. Participants engaged in active supervision of their children whereby children were in close proximity and usually within sight of an adult or an older child. In Somali homes the presence of many adults and older siblings ensured younger children were well-supervised. Many participants reported using fear-based messages with their children. These messages described the consequences of consuming toxic products. However, other participants used household activities such as cleaning dishes or washing clothes to explain to their children the proper use of cleaning products. Harm minimisation techniques such reading product labels, care in purchasing, and using products when younger children were absent were also used.

Few participants had received structured education about child unintentional poisoning. Two participants (one Turkish and one Somali) were child care workers and had received formal training as part of their work. Two Somali participants had participated in child safety education sessions. Most others did not see the need for education because of their belief that poisoning would never happen to their children. However, if information was required, they reported they would ask their GP.
**Conclusion**

This study highlights the complexity of socio-cultural differences in parenting and home-based practices that impact on child safety, and poisoning in particular. Interacting protective factors identified in the study included small homes in the Somali communities, community networks which are supportive of parents, active supervision practices, and cultural values that emphasise the importance of family and respect for authority. It is unclear why these factors would have had a differential effect on poisoning as compared to injury generally. Parents’ confidence that their child was not at risk of unintentional poisoning was based on faith in their parenting strategies to protect their child from that risk rather than a disregard for the dangers of toxic products. There was a clear reliance on supervision and child ability to understand instructions and show respect for authority by adhering to those instructions, even at an early age.

There was evidence of possible risk factors for certain CALD communities that may have contributed to under-representation for child unintentional poisoning. Lack of storage options in public housing made it difficult for parents to store toxic products out of children’s reach. The existence and role of the Victorian Poisons Information Centre was not known in these communities and is a clear contributor to potential risk in management of poisoning incidents. The majority of participants reported that they anticipated using a GP or hospital if a child unintentional poisoning incident occurred, but it is possible this reflected response bias rather than an indication of actual behaviour. There were also indications of language barriers impacting on ability to read and understand product labels, and home-based remedies of uncertain treatment effectiveness being used in response to a poisoning incident. These factors could lead to parents being unaware that a product/amount consumed was dangerous for a child. It could also result in inappropriate strategies being used to manage poisoning incidents.

It was difficult to achieve theoretical saturation in this study given the huge diversity that exists within and across cultural groups. Ideally, ethnographic research involves immersion in a given culture over an extended period of time to enable true understanding of the cultural issues to develop. Nonetheless, this study has highlighted a number of important cultural features which could be used to inform policy decision-makers regarding appropriate directions for poisoning prevention policy decisions.

**Recommendations**

The protective factors identified in this study show the importance of parent support and the potential for promoting discipline and active supervision in parenting for all community groups. There is also evidence to suggest that encouraging the development of supportive community networks for all parents of young children will have a positive impact on effective adult supervision of children.

The potential risk factors identified in the study show the importance of ensuring all residents of high rise public housing have access to appropriate storage options for toxic products. Child poison safety is also likely to be enhanced by educating CALD communities about the risks of child unintentional poisoning, poison safety strategies, and appropriate management of child unintentional poisoning incidents. Building on the traditional focus on family and respect for authority is likely to be a useful strategy when developing poison safety programs targeting CALD communities. Increasing the accessibility of the Victorian Poison Information Centre for people from CALD communities will also support poison safety.
Development of further understanding of socio-cultural differences in child unintentional poisoning is recommended through research assessing self-reported parent understanding of product/medication labels versus actual understanding, and exploring differences in parent understanding of active supervision.
ACKNOWLEDGEMENTS

There are many people we would like to thank for their assistance with this project in no particular order. Thank you to the members of the project advisory group: Jeff Robinson from the Victorian Poisons Information Centre and the representatives from each community: Amina Elmi, Chu Tran and Neval Ilbahar. Their advice on culturally-appropriate research methodology and participant recruitment opportunities, as well as their insight into the findings, was invaluable and allowed the project to progress as well as it did. Thank you also to Barbara Minuzzo and Helen Rowan from the Safety Centre at the Royal Children’s Hospital for their assistance in setting up the project advisory group, providing staff support and literature resources, and for their support of the project. Thank you to Erin Cassell from the Monash University Accident Research Centre for providing access to the Victorian Emergency Minimum Dataset.

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ACRONYMS

CALD  Culturally and linguistically diverse
DHS  Department of Human Services
GP  General Practitioner
MUARC  Monash University Accident and Research Centre
NAATI  National Accreditation Authority for Translators and Interpreters
NESB  Non-English speaking background
RCH  Royal Children’s Hospital
VEMD  Victorian Emergency Minimum Dataset
CHAPTER 1: INTRODUCTION

This research project was funded by the Department of Human Services (DHS) as part of the Public Health Research Projects 2003-2004. The project aimed to identify the protective and/or risk factors for child unintentional poisoning in the home environment of culturally and linguistically diverse (CALD) communities identified as being under-represented in emergency department presentations. This project arose from a DHS Commissioned study which aimed to identify the motivators and barriers to compliance with child poisoning safety practices. The project was called *Child Unintentional Poisoning Interventions: Improving the uptake of safety practices.*

Child unintentional poisoning is an important public health problem in Victoria. Unintentional poisoning is the second most common cause for child injury hospitalisations for children under five years of age after falls. In Victoria, the child poisoning rate has steadily increased from 196 per 100,000 in 1987-88 to 248 per 100,000 in 1998-99 and remained steady at 249 per 100,000 in 2001. Of children who are exposed to poisons, the most vulnerable are those aged between one and three years. The home environment is also the most common site for unintentional poisoning in children. National statistics demonstrate that 76% of poisonings occur at home and 20% in an unspecified location. In Victoria, 95% of childhood pharmaceutical incidents presenting to Victorian emergency departments during 1987-98 occurred in homes. Despite efforts over the last decade at prevention, child poisoning rates have not declined in Victoria. Both national and state governments have identified childhood poisoning as a priority issue for intervention.

1.1 Project rationale

There is little research available on social and cultural protective factors for the prevention of unintentional poisoning in children in CALD communities. Previous research indicates that certain CALD communities are over-represented as users of the emergency department at the Royal Children’s Hospital (RCH) due to the cultural pattern for these groups to access the emergency department instead of a general practitioner for primary care. However, qualitative research indicates that these CALD communities are under-represented in terms of emergency department presentations involving childhood unintentional poisoning. It is unclear whether this under-representation is due to a lower incidence of child unintentional poisoning in these communities, perhaps arising from:

- Socio-cultural differences in the agents used for cleaning in the home;
- Socio-cultural differences in medication use;
- Socio-cultural differences in nature/level of carer supervision;
- Language/literacy/cost barriers affecting access to toxic products.

Alternatively, the under-representation may reflect an increase in risk factors, such as parents’ decreased awareness of the dangers of ingestion of toxic products, or socio-cultural differences in response to unintentional poisoning (home remedies, concern regarding the response of authorities to the incident).
Perhaps parents are seeking assistance from health care providers other than the hospital although this is unlikely given their apparent reliance on the emergency department as a primary health care provider.

This research project aimed to quantify CALD hospital presentations for child unintentional poisoning and identify cultural practices that may act as protective factors for child unintentional poisoning in CALD communities identified as being under-represented in emergency department presentations. Identification of protective factors that are consistent across these communities has the potential to lead to the development of targeted environmental, educational and/or behavioural interventions. However, if it is identified that risk factors are responsible for the under-representation of CALD communities in emergency presentations for child poisoning, it will highlight the need to engage these communities and the relevant health care services to identify the barriers and circumstances leading to adverse risks.

1.2 Project aims and objectives

The overall aim of this research project was to gain an understanding of the factors influencing the apparent socio-cultural differences in the patterns of incidence and health care use related to child unintentional poisoning.

The project objectives were to:

1. Review the published and unpublished literature on socio-cultural factors for the prevention of unintentional poisoning in children AND health service utilisation among CALD communities for child unintentional poisoning;
2. Examine the rate and pattern of CALD presentations for child unintentional poisoning to emergency departments in Victorian hospitals;
3. Identify the protective and/or risk factors for child unintentional poisoning in the home environment of CALD communities identified as being under-represented in emergency department presentations;
4. Identify similarities in protective and/or risk factors across the communities;
5. Identify the socio-cultural differences in child unintentional poisoning.

Participants from the Somali, Turkish and Vietnamese communities were invited to participate in this study. The rationale for this decision is described in Chapter 3: Methodology and Chapter 4: Analysis of Hospital Data.

Information collected will be used to inform the development of appropriate public health intervention strategies.
CHAPTER 2: LITERATURE REVIEW

A literature review was undertaken to review the evidence relating to potential social and cultural protective and risk factors for the prevention of unintentional poisoning in children from CALD communities. This review also provides background information on the participating CALD communities.

2.1 Method

Search Strategy

The following electronic databases were searched from 1990 to 2005: Medline, Pub Med, CINAHL, InfoTRAC, EBSCOHost, Cochrane Library, BMJ Journals, Expanded Academic ASAP, Ovid Journals, and PsycINFO. Key words used for the search included: emergency, health care, CALD, culturally and linguistically diverse, Vietnamese, Somali, Turkish, risk factors, protective factors, culture, immigrants, unintentional poisoning, injury, children, ethnicity, newly arrived, ethno-medicine and parenting. The reference lists of the original articles were also reviewed for further articles of relevance.

Other information sources were accessed in response to the emerging themes in the data collection and analysis. These were the Centre for Culture, Ethnicity and Health library, child development reference material held by the child health research team, the SBS World Guide 12th Edition 2004, and the following Australian Government websites: Department of Human Services, Australian Bureau of Statistics, and the Victorian Government website. These additional sources were searched for research relating to parenting practices in culturally and linguistically diverse communities, in particular the CALD countries of interest (Somalia, Vietnam, Turkey), geographical, historical and migratory information about the target CALD communities, and child development in terms of the capacity of children at different ages to follow instructions.

Study selection criteria and procedures

Criteria for selection of studies for review were: poisoning and injury prevention, involving children, in non-English speaking communities. Studies addressing parenting practices in non-English speaking communities were also included. Articles relating to food poisoning, intentional poisoning, specific injury issues other than child unintentional poisoning, adult injury, and articles written in languages other than English were excluded from the study.

Study quality assessment

Given the limited research available, and the heterogenous approach to study design, a meta-analytic approach to the literature review was not possible. Therefore, a narrative approach was adopted to review the results.
2.2 Background to the participating communities

Somali, Vietnamese and Turkish participants were selected to be the focus of the research project. The selection process is described in Chapter 3: Methodology and Chapter 4: Analysis of Hospital Data. Geographical, historical and migratory facts about each community have been outlined below to provide a context for the study findings.

Somali community

Somalia, a former protectorate of Great Britain and Italy, is one of the four nations comprising the Horn of Africa in the north-east of the African continent. The other three nations are Ethiopia, Djibouti and Eritrea. Ethiopia is located to the west of Somalia, while Djibouti and Eritrea are located to the north-west. Kenya is another neighbouring country located south-west of Somalia. To the east is the Indian Ocean. Figure 1 demonstrates Somalia’s location in the Horn of Africa. Figure 4 demonstrates Somalia’s location on a global scale.

Somalia’s population is 8 million, of which 1.2 million live in the nation’s capital Mogadishu. Thirty six percent of the population live in urban areas. The majority (95%) of Somalis are Sunni Muslims. The official language is Somali, but Italian, English and Arabic are also spoken. Association with their clan and a nomadic existence are key features of Somali life. Over two-thirds of the population are nomads, with survival dependent on the raising of livestock.

In 1991, civil war broke out in Somalia, resulting in the mass movement of Somalis into refugee camps in Kenya and Ethiopia. Approximately 1% of Somalis based in these camps were accepted by Australia as part of its humanitarian program. Of the Somalis now based in Australia, 65% live in Melbourne. The Somali community is one of the fastest-growing in Melbourne, with the population of Somali-born residents increasing 65.4% from 1996 (pop. 1,397) to 2001 (pop. 2,311). Somali is also the seventh fastest growing languages, with 3,068 speakers in 2001, an increase of 91.6% from 1996 (1,601 speakers).
**Turkish community**

*Figure 2: Map of Turkey*

Turkey is a unique nation in that it is part of Europe, but also part of Asia. Its neighbouring countries include Syria, Iraq, Iran, Armenia, Georgia, Bulgaria, and Greece. Figure 2 demonstrates Turkey’s location in Europe and Asia, while Figure 4 shows where Turkey is placed on a global scale.

The population of Turkey is 68 million of which two thirds live in metropolitan areas. Istanbul (formerly Constantinople) is Turkey’s largest city and home to 9.6 million. Ankara, the capital, is home to 3.5 million. Although Turkey is a secular state, the majority of Turks are Sunni Muslim. Turkish is the official language, but Kurdish, Greek, Arabic and Armenian are also spoken.

A labour shortage in Australia during the 1960s resulted in the development of the Australia-Turkey agreement in 1967 which facilitated the migration of skilled Turks to Australia. Now, nearly 40 years since the signing of the agreement, the Turkish community is one of the most well-established CALD communities in Victoria, coming in as the 21st largest non-English speaking community, with 13,996 Turkish-born residents in metropolitan Melbourne in 2001. Excluding English, the Turkish language is the eighth most commonly spoken in Victoria with 28,496 speakers.

**Vietnamese community**

*Figure 3: Map of Vietnam*

Vietnam is located on the eastern most side of Southeast Asia. To the north of Vietnam is China and to the west is Laos and Cambodia. The South China Sea is to its west. Figure 3 highlights Vietnam’s location in Asia, while Figure 4 shows where Vietnam is placed on a global scale.
Vietnam’s population is 81.6 million of which 22% live in urban areas. In the south, Saigon (now referred to as Ho Chi Minh City) is home to 3.9 million while in the north, Hanoi, the capital, is home to 3 million. The majority of Vietnamese are Buddhist although 10% of the population is Christian (predominantly Catholic). The languages spoken include Vietnamese (official), English, French, Khmer and Chinese.

Along with Laos and Cambodia, Vietnam was a part of French Indochina until 1945 when it declared independence from its colonial ruler. In the 1960s civil war erupted between the Communist north and the US-supported south. On April 30, 1975 Saigon fell to the Communists, resulting in an exodus of refugees from southern Vietnam. Soon after the end of the war, the Vietnamese entered Australia on humanitarian grounds and were accepted as refugees. Since the 1990s, Vietnamese have primarily migrated to Australia under the Family Reunion Scheme.

Of the three targeted CALD communities, the Vietnamese is the largest in Victoria. The Vietnamese community is the third largest non-English speaking community, with 55,859 Vietnamese-born residents in metropolitan Melbourne. Excluding English, Vietnamese is the third most commonly spoken language in metropolitan Melbourne, with 63,033 residents communicating in this language.

The settlement trends in metropolitan Melbourne of each community are represented in Table 1.

**Table 1: Predominant settlement trends in metropolitan Melbourne of the Somali, Turkish and Vietnamese communities (2001)**

<table>
<thead>
<tr>
<th>Local Area</th>
<th>Government Area</th>
<th>Number of overseas-born residents</th>
<th>Number of language speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Somali</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Moonee Valley</td>
<td>471</td>
<td>610</td>
<td></td>
</tr>
<tr>
<td>2. Banyule</td>
<td>401</td>
<td>530</td>
<td></td>
</tr>
<tr>
<td>3. Melbourne</td>
<td>281</td>
<td>402</td>
<td></td>
</tr>
<tr>
<td>4. Maribyrnong</td>
<td>153</td>
<td>202</td>
<td></td>
</tr>
<tr>
<td><strong>Turkish</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Hume</td>
<td>5,254</td>
<td>10,181</td>
<td></td>
</tr>
<tr>
<td>2. Moreland</td>
<td>1,872</td>
<td>3,002</td>
<td></td>
</tr>
<tr>
<td><strong>Vietnamese</strong></td>
<td></td>
<td></td>
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<tr>
<td>1. Brimbank</td>
<td>13,483</td>
<td>17,044</td>
<td></td>
</tr>
<tr>
<td>2. Greater Dandenong</td>
<td>10,420</td>
<td>11,758</td>
<td></td>
</tr>
<tr>
<td>3. Maribyrnong</td>
<td>6,792</td>
<td>7,703</td>
<td></td>
</tr>
<tr>
<td>4. Yarra</td>
<td>3,183</td>
<td>3,702</td>
<td></td>
</tr>
</tbody>
</table>
Figure 4: The location of Somalia, Turkey and Vietnam on a global scale
2.3 Socio-cultural factors and child unintentional poisoning: a review of the literature

The literature review identified a limited number of studies in Australia and internationally addressing socio-cultural issues relating to child safety and parenting practices, and to a lesser extent addressing protective and risk factors for child unintentional poisoning.

**Potential protective factors**

Parental ethno-theories focus on the ideas and attitudes parents possess about children, families and their own parental roles and responsibilities. More specifically, these ethno-theories suggest the correct way of rearing children. These ideas, attitudes and practices related to parenting may be a key factor in the protection of children from unintentional poisoning. Whilst there is no literature about parental ethno-theories focusing on child safety, other studies highlight parenting practices that may contribute to poisoning prevention. Such practices, which revolve around an understanding of the importance of family, include supervision by older children and/or extended families, teaching children respect for elders and authority, strict discipline and rules.

The importance of family underpins beliefs about parenting in many CALD communities. In Somalia, family unity is paramount as it contributes to the preservation of Somali language and culture. In Vietnam and Turkey, the extended family is integral; elders in particular are consulted for advice on numerous issues including child rearing. The emphasis on family may therefore equate with greater supervision of children, which is considered a protective factor. Consequently, studies about parenting practices in CALD communities have demonstrated that supervision is the primary safety measure used by parents to protect their children from accidents in and outside of the home. However, of the attributes of supervision (visual, auditory and physical proximity), physical proximity is associated with reduced incidence of child injury and so is the only aspect of supervision which can be considered protective. This may be because parents who remain close to their children are in a better position to react quickly to prevent or minimise injury events as they occur.

Supervision of younger children in CALD communities is a family responsibility also involving older children and extended family. Research has shown that in some cultures the whole family was involved in the supervision of younger children, with older siblings expected to assume this care-giving responsibility. Nonetheless, older children enjoyed this role, contributing to enhanced family interaction. Furthermore, younger children were valued and indulged as a result of their young age. The extended family may also be available for additional supervision and could therefore reduce the incidence of unintentional poisoning amongst certain CALD communities.

Respect for elders and authority is another entrenched parenting concept across CALD communities that may act as a protective factor in child unintentional poisoning. As Islam is the predominant religion in
Somalia and Turkey, children from these nations are expected to demonstrate respect for authority as dictated by the Qur'an. Meanwhile, Confucianism, an ethical philosophy originating in China, has exerted significant influence in Vietnamese society. One of the basic tenets of Confucianism is respect for elders, with the parent-child relationship considered the most important within the family unit. Confucianism suggests that a harmonious society is achieved through harmonious family relationships. However, the onus is on children to maintain harmonious relationships within the family unit through filial piety, or respect for parents and obligation to the family. Filial piety has even been attributed to the delayed uptake of smoking in Vietnamese youth living in Australia. Respect for authority and filial piety may explain the low incidence of unintentional poisoning in children from the targeted CALD communities as children are expected to respect parental orders to stay away from toxic products in the home. However, it is unclear how this would differentiate between protection from poisoning and protection from injury generally.

Another aspect of Asian culture that may also be a protective factor in child unintentional poisoning is the use of strict discipline and the imposition of rules. A major Australian study of parenting in Anglo, Vietnamese and Torres Strait Islander communities found that 98% of Vietnamese parents participating in the study favoured the use of rules. Rules were also considered a contributing factor in delayed uptake of smoking in Vietnamese youth in Australia. This is supported by child development research which shows that authoritative parenting styles that are also supportive and responsive to the child, have been shown to be positively associated with emotional and social skills among preschoolers.

The use of fear in delivering safety messages is yet another potential protective factor in child unintentional poisoning in CALD communities. One study found that Chinese mothers used anxiety induction as a means of controlling their children, and ensuring they followed rules and parental expectations. Different parenting approaches such as restricting access, using products when child was absent, and using consequence explanations (education) were reported in a study of parental uptake of safety strategies. Mexican-American mothers were also found to use consequence explanations successfully with younger children as a safety mechanism. Explanations needed to outline harmful consequences to children to be successful.

The success of consequence explanations also appears to be linked to the level of acculturation. Acculturation is the change or acclimatisation to a new host culture’s way of thinking and behaving. One study of the risk of injuries in low-income parents found that children of Hispanic parents with a higher level of acculturation were more likely to comply with orders or consequence explanations than children from homes where the level of acculturation was lower.

Potential risk factors
Under-representation of the target CALD communities in presentations for child unintentional poisoning does not necessarily mean that there are less incidents occurring. There is evidence in the literature that cultural and linguistic diversity can increase risk of child unintentional poisoning.
Studies about safety practices in immigrant, minority or racially disadvantaged parents found that knowledge and utilisation of appropriate child safety mechanisms was limited when compared to parents who were locally-born.\textsuperscript{18-19, 32-33} Specifically, parents were not aware of safety products that could be used in the home,\textsuperscript{18-19} or the correct use of toxic products not normally found in their country of origin,\textsuperscript{18} or the local poisons information centre,\textsuperscript{32} or that iron supplements could be dangerous for children.\textsuperscript{18} Instead of using safety products, parents used home-made devices such as elastic bands to keep cabinet doors closed.\textsuperscript{18} Lack of knowledge could be attributed to a lack of education about child safety\textsuperscript{32} or socio-economic status.\textsuperscript{18, 33}

The level of acculturation can also affect the risk of child injuries in the home.\textsuperscript{31} The children of less-acculturated parents have been found to be at an increased risk of being injured in the home environment as they are more likely to disregard parental orders in dangerous situations compared to the children of more-acculturated parents.\textsuperscript{31} Different parenting practices and goals in less- versus more-acculturated parents, as well as differences in parental adaptation to risk, are the explanations for this finding.

A Victorian study that included both Australian born participants and participants from CALD communities found that parental uptake of safety measures in the home to prevent child unintentional poisoning was incomplete.\textsuperscript{1} This was attributed to parent lack of awareness of the personal reality of the risk of child unintentional poisoning, an attitude which changed after a poisoning incident.

These potential risk factors for child unintentional poisoning highlight the possibility that the under-representation of CALD communities may be due to risk factors impacting on appropriate management of incidents rather than reduced incidence. This was explored in this study to contribute to the understanding of socio-cultural differences and to inform future child safety interventions.\textsuperscript{34}

As Australia is a culturally diverse nation, such diversity can result in difficulty in effectively meeting the health needs of each CALD community and ensuring they are integrated into the health care system.\textsuperscript{35} This is partly due to the ever-changing demographics and assimilation patterns of patients.\textsuperscript{36} Consequently, ethnicity, race and acculturation influence the level of awareness and understanding of health services and access to these services.\textsuperscript{37} Furthermore, language and communication barriers also affect access\textsuperscript{36} as can shyness.\textsuperscript{37}

Negative parental expectations of health services can also be a barrier to access. Participating mothers in a non-CALD study did not view themselves as potentially negligent parents, believing that unintentional poisoning of their children would be due to the active and curious nature of their children. However, they were afraid of accusations of neglect if presenting to health services after a poisoning incident, possibly due to low self-efficacy.\textsuperscript{37} Self-efficacy is the level of confidence or belief in one’s ability to execute a specific behaviour. This study found that mothers exhibited low self-efficacy, doubting their ability to carry out instructions or recommendations from poisons centres. Furthermore, these mothers also feared impersonal treatment at the hands of health professionals.
Culture can have a significant impact on patient satisfaction with level of care, so expectations of negative outcomes may also act as a health service access barrier for CALD communities. A study of culturally appropriate hospital care in Australia, Britain, Indonesia and Thailand found that cultural differences increased the chance of negative interactions or outcomes unless all parties were aware of these differences and adapted accordingly. Specific negative outcomes include inadequate understanding of diagnosis and treatment, lower quality of care, preventable morbidity and mortality, and miscommunication.

One factor that may be associated with child unintentional poisoning is socio-economic status. Issues such as illiteracy may affect the care-giver or parent’s ability to read warning labels or directions for use. In America, in a group of illiterate adults with reading levels up to third grade, 30% were unable to interpret caution statements and directions of three separate products, thereby potentially increasing the susceptibility of their children to poisoning. With almost half of Australians aged 15-74 with poor or very poor literacy skills the issue of reading product labels becomes important in addressing child poisoning prevention strategies. This is an even greater issue among CALD communities due to the strong relationship between first language spoken and English literacy skills.

Other potential risk factors of relevance include a parental belief that no danger could come to children; the type of housing in which members of CALD communities are likely to first settle in upon arrival in Australia; and parental expectations of children to comply with rules. Child development research in relation to child developmental stages for understanding instructions and exercising self control is inconclusive. However there are indications that it develops gradually between the ages of 18 months to 30 months and is closely linked to language development.

Conclusion
This literature review has sought to investigate potential protective and risk factors relating to child unintentional poisoning amongst CALD communities. Culturally-based parenting styles, respect for elders, and extended family involvement in child care were identified as possible CALD protective factors although it was unclear why these factors would not have the same effect on injury presentations overall. A range of CALD-specific injury risk factors, particularly negative expectations of health services, low knowledge of poison safety strategies, and low literacy, were also identified as potentially influencing management of child unintentional poisoning incidents. As the literature on child unintentional poisoning and CALD communities, particularly those which were targeted in the study, is limited, it is difficult to draw conclusions based on the review alone. However, the literature review sensitised the Research Officer to possible issues during data collection and analysis.
CHAPTER 3: METHODOLOGY

The quantitative and qualitative research methods utilised during this research project included a literature review, statistical analysis, and ethnography using semi-structured interviews.

3.1 Analysis of emergency department presentation data

The rate and pattern of hospital presentations for child unintentional poisoning in CALD communities were compared with non-CALD communities using emergency department presentation data to confirm the under-representation of CALD children.

The Monash University Accident Research Centre (MUARC) provided data on emergency department presentations from 28 Victorian hospitals, all of which collect data in accordance with the Victorian Emergency Minimum Dataset (VEMD). This dataset represents approximately 80% of state wide emergency department presentations. This analysis focused on emergency department presentations for children aged 0-5 years for poisoning and/or other injuries over a five year period from July 1999 to June 2004. The statistical software package SPSS was used to devise frequency and contingency tables that were used to identify comparative rates and patterns of service.

Children from Chinese, Somali, Filipino, Turkish and Vietnamese backgrounds are most likely to present to emergency at the Royal Children’s Hospital. Therefore, comparison of presentation data for these five CALD groups were combined and compared with the English-speaking group and with all other CALD communities collapsed into a third group. Further reduction in categories would have resulted in cell sizes that were too small for valid statistical analysis. The findings from this exercise, which can be found in Chapter 4, were used to identify the communities to be targeted in the research.

Unfortunately, whilst the Victorian Poisons Information Centre collects output data on the nature of callers to their helpline, currently they do not record information about callers’ country of origin. Therefore, it was not possible to include calls to the Poison Information Line as part of the analysis.

3.2 Ethnographic qualitative study

As an aim of the project was to ascertain the protective and/or risk factors for child unintentional poisoning in the home environment of CALD communities, an ethnographic approach was considered most appropriate for an exploration of socio-cultural differences in the home context. This is because of its strength in developing a culturally-based description of practices and interactions impacting upon health status. Common to anthropological studies and qualitative in nature, ethnography is an exploratory exercise used to study the beliefs and practices of cultural groups. Integral to ethnography is fieldwork, using interviews and participant observation, where the research occurs in the natural setting of participants to facilitate the uncovering of meaning behind culturally-specific or embedded norms which
encourage beliefs and behaviours in that culture.\textsuperscript{44-45} The success of the ethnographic exercise is dependent on a number of conditions: gaining the trust of participants, researchers feeling comfortable in the participant's environment, researcher familiarity with the culture before the research begins, and researcher credibility.\textsuperscript{45} In this study, the Research Officer, a female, was responsible for undertaking interviews. The characteristics of the Research Officer which contributed to the success of this ethnographic exercise included a significant level of cross-cultural awareness and understanding developed through extensive travel, basic communication skills in Vietnamese, and a great level of respect for other cultures. It is also likely that the predominantly female participants were more comfortable being interviewed in their homes by a researcher who was female.

**Selection of the target communities**

Only three of the five CALD groups were selected for inclusion in the study. Whilst limited time was one factor, the three chosen each represented a different global region: Somalia (Africa), Turkey (Europe/Middle East/Central Asia) and Vietnam (Southeast Asia). This could allow analysis of the similarities and differences across each group of the socio-cultural protective and risk factors. Furthermore, access to these groups was considered to be easier due to the number of culturally-specific support services and organisations available for these groups. Whilst there are a number of services for the Chinese community, the community features a number of ethnic sub-groups, featuring those who speak Mandarin, Cantonese, Hakka, Teo-chew amongst others. There was insufficient time to cover all these sub-groups.

**Project advisory group**

A project advisory group was established to be a focal point for discussion about the project. The advisory group consisted of the project’s principal investigator and co-investigators (including the Research Officer) as well as representatives from the Victorian Poisons Information Centre and the Somali, Turkish and Vietnamese communities. The community representatives were invited from the pool of casual bilingual peer educators employed at the Royal Children’s Hospital Safety Centre. The primary aims of the advisory group were to provide advice to the researchers about culturally-appropriate research methods, to assist researchers with collaboration with community leaders and with the promotion of the research project to the communities, and to assist with interpretation of the study findings.

The involvement of the community representatives was an integral factor in the project. Their insider knowledge of community contacts and potential avenues for recruitment allowed easier access to these CALD communities. Furthermore, their intricate knowledge of their own culture allowed them to provide insight into and interpretation of the study findings that would not have otherwise been possible.

**Recruitment**

Primary care-givers of children under five from the Somali, Turkish and Vietnamese communities were sought as participants in this study. Actual experience of child unintentional poisoning was not a criterion for participation. Prior to recruitment, the Research Officer met or communicated with leaders from the
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Somali community and bilingual community development workers working with Somali, Turkish and Vietnamese parents and grandparents. The purpose of these meetings and discussions was to provide information about the project, to gain an understanding of culturally-appropriate research methodology, to learn about possible avenues for recruitment, and most importantly to establish rapport and gain the trust and support of these community representatives. Contact was also made with staff from the City of Greater Dandenong in Melbourne’s southeast for their advice on possible recruitment options given the council’s previous work in child safety and high Vietnamese population. Permission was also obtained from the City of Hume in Melbourne’s north to recruit Turkish participants from council premises as the municipality is home to the largest Turkish community in metropolitan Melbourne. The entire process of making contact with relevant community representatives and professionals engaging with targeted CALD communities was yet another integral component of the project. The process was largely responsible for the project progressing as well as it did because of the willingness of these representatives to be involved and to assist with the project.

A number of avenues were used to recruit participants. Where possible, the Research Officer personally presented information with the assistance of an interpreter to potential participants at women’s groups and kindergartens. Somali and Vietnamese participants were primarily recruited from women’s groups whilst all the Turkish participants were recruited through a kindergarten with a high number of Turkish preschoolers. In addition, contacts at the City of Greater Dandenong with experience in child safety, or who were involved with the Vietnamese community, recruited three Vietnamese participants through their networks.

The personal approach to recruitment was a factor contributing to the success of the project. Primary care-givers seemed more willing to participate in the research project after meeting with the Research Officer and learning first hand of what participation involved. Furthermore, the personal approach allowed the primary care-givers to ask any questions and become familiar with the Research Officer and interpreter, establishing trust and rapport in the process. The power of the personal approach to recruitment was further confirmed when the distribution of information flyers by child care workers to care-givers of children attending a Turkish child care centre did not generate any response.

Professional translators accredited with the National Accreditation Authority for Translators and Interpreters (NAATI) translated the participant information sheet. This was provided to all participants immediately before their interviews with the consent form, into Somali, Turkish and Vietnamese. Community representatives from the project advisory group and bilingual community development workers who had also been consulted about the project’s methodology read through the information sheet in their respective language to ensure it used culturally-appropriate language to convey the key messages about the project. Once approved, the translated versions of the information sheet were finalised. The consent form was not translated, but interpreted before each interview began. Each participant signed the consent form after being fully informed about the interview process. The interpreter, where present and the Research Officer also signed the consent form before the interview began.
Overall, primary care-givers from 23 families participated: 8 Somali, 7 Turkish and 8 Vietnamese, representing the home environment for 45 parents and grandparents and 61 children. Of the 23 family participants, 21 were mothers, but there was one father and one grandmother, both of whom were Turkish. Other relevant demographic information about the participants is presented in Table 2.

**Table 2: Participant demographic information**

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Religion</th>
<th>Housing</th>
<th>Residence in metropolitan Melbourne</th>
</tr>
</thead>
<tbody>
<tr>
<td>8: Somali</td>
<td>All Muslim</td>
<td>5: High-rise Housing Commission flats&lt;br&gt;3: Housing Commission homes</td>
<td>5: Inner&lt;br&gt;3: North-east</td>
</tr>
<tr>
<td>7: Turkish</td>
<td>All Muslim</td>
<td>6: Houses&lt;br&gt;1: Townhouse</td>
<td>7: North</td>
</tr>
<tr>
<td>8: Vietnamese</td>
<td>4: Christian&lt;br&gt;3: Buddhist</td>
<td>6: Houses&lt;br&gt;2: Units</td>
<td>5: West&lt;br&gt;3: South-east</td>
</tr>
</tbody>
</table>

**Interviews and participant observation**

The semi-structured interview, a qualitative research method which uses a combination of open- and closed-ended questions, was used to collect data from participants to fully explore the cultural practices and interactions in relation to cleaning, medication and supervision. As the home environment is known to contribute to child safety, home visits were also undertaken to allow observation of the cultural practices and home circumstances discussed during the interviews.

Female NAATI-accredited interpreters were enlisted to interpret during the interviews. One interpreter was used for each community to ensure consistency in the manner the questions were asked of participants. Prior to the commencement of the interviews, the Research Officer made contact with all three interpreters to provide them with an overview of the project and to familiarise them with the participant information sheet, but particularly the consent form which required interpretation before each interview began. Furthermore, the initial contact was an opportunity for the Research Officer to establish a working relationship with each interpreter that ultimately resulted in positive open-ended communication with the participants during the interviews, yet another factor contributing to the project’s success. Subsequently, the interpreters came to be viewed as ‘co-researchers’ because of the interpretation or confirmation each provided about the issues emerging during the interviews, insights that could only have been provided by those familiar with the culture.

Of the 23 interviews conducted, 22 were conducted in the home. One participant was not comfortable with a home visit, so the interview was conducted in a community centre. A potential participant who had expressed interest in participating, withdrew from the study when the Research Officer and interpreter arrived and explained the time commitment involved. Interpreters were used for nineteen interviews.
Somali, 4 Turkish and 8 Vietnamese). Participant consent was obtained before each interview and basic demographic information was also collected (place of residence, number of children and their age and gender, time spent living in Australia, which region/part in country of origin they came from and if it was metropolitan or rural, religion, and employment status). The following themes were discussed in the interviews:

- Common toxic products present in the home;
- Awareness of the toxicity of various products in all parts of the home environment;
- Experience of child unintentional poisoning, direct or indirect, and the factors contributing to this incident;
- Response to the incident including changes in safety behaviours after incident;
- Knowledge of safety measures to reduce the risk of child unintentional poisoning including knowledge of Victorian Poisons Information Centre;
- Safety measures in place in all parts of the home environment (including outdoor and work areas) in relation to common household toxic products;
- Influences on choices in relation to uptake of safety measures;
- Storage options and perceptions of safety products;
- Perceptions and behaviours in relation to child resistant containers;
- Supervision of children in the home;
- Help-seeking behaviour with regards to child unintentional poisoning (including sources of help, barriers).

During the course of interviews conducted in the home, participants were asked to demonstrate storage of toxic products, but only if they were comfortable with this and participants were assured they were free to decline if they were not comfortable. This allowed the Research Officer to observe storage practices. Participants all consented and appeared comfortable showing the Research Officer where toxic products were located.

**Analysis**

Seventeen interviews were recorded and notes taken during the other six interviews because the participants were not comfortable being recorded. The seventeen recorded interviews were transcribed and a thematic analysis was conducted on the transcriptions and interview notes to analyse the data. The software package QSR NVivo Version 2, which is designed to assist with the management and analysis of qualitative data, was used to categorise and code the emerging themes in the data, allowing for a description of cultural practices and interactions within the communities to emerge. Analysis of the interacting influences in the home environment then allowed development of an understanding of links between particular cultural practices and child unintentional poisoning protective and/or risk factors.

**Limitations**

Traditionally, ethnography is meant to be a time-consuming process involving observation over a long period of time. However, the time constraints of this project meant that observation of safety practices in
the home environment and interaction between primary care-givers and children was limited to one visit, the length of which varied across the interviews from as little as 25 minutes to as long as 90 minutes. Time restrictions also meant that a maximum of eight interviews was scheduled for each community. However, some community representatives explained that eight interviews were insufficient to fully capture the socio-cultural differences within each community. Therefore, the project did not reach saturation level and could have yielded additional results.

Whilst the Research Officer made every effort to establish rapport with participants before their respective interview, the degree to which this succeeded varied. The success in recruiting participants suggested that a degree of rapport had been established; however, the amount of information provided during the interviews varied. Perhaps participants had little to say, or were not completely familiar with the dynamics of research. It was also possible that a distrust of authorities resulted in participant reticence to reveal a great deal, believing the information would be relayed to government departments. Despite assurances of confidentiality to participants, some interviews lacked detail.
CHAPTER 4: ANALYSIS OF HOSPITAL DATA

Analysis of emergency department presentation data was undertaken to determine the rate and pattern of presentations at VEMD hospitals for child unintentional poisoning in CALD communities. This chapter focuses on the findings of this quantitative analysis.

4.1 Total emergency department presentations

Analysis of VEMD data shows that from July 1999 to June 2004, 115,566 children aged 0-5 years presented to emergency departments with poisoning and/or other injuries. The presentations are categorised in Table 3.

Table 3: Total number of emergency department presentations for poisoning and/or other injuries in children aged 0-5 years from July 1999 to June 2004

<table>
<thead>
<tr>
<th>Type of injury</th>
<th>N</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other injuries</td>
<td>108,586</td>
<td>94</td>
</tr>
<tr>
<td>Poisoning – medications</td>
<td>3,513</td>
<td>3</td>
</tr>
<tr>
<td>Poisoning – other*</td>
<td>3,467</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>115,566</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* Includes food poisoning

These percentages can be viewed as expected percentages and so used as normative data when analysing injury distributions in sub-samples, such as language groups.

4.2 English-speaking and non English-speaking presentations

In the first analysis, the sample was divided into two categories: those self-identifying as English-speaking, and those self-identifying as being of non-English speaking background (NESB). The latter group represented 72 languages (see Appendix 1). Of the total number of emergency department presentations, the English-speaking group comprised 104,706 presentations or 90.6% of total sample AND the NESB group comprised 3,558 presentations or 3.08% of the total sample.

For the remaining 7,178 presentations, or just over six percent (6.21%), the language questions were either inaccurately or inadequately answered, or not answered at all. These presentations could not be categorised as English-speaking or NESB and so were excluded from further analysis. Table 4 shows the total number of emergency department presentations for poisoning and/or other injuries by language (English-speaking and NESB).
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Table 4: Total number of emergency department presentations for poisoning and/or other injuries by language (English-speaking and NESB)

<table>
<thead>
<tr>
<th></th>
<th>Other injuries N (%)</th>
<th>Poisoning – medications N (%)</th>
<th>Poisoning - other N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>98,358 (93.9)</td>
<td>3,261 (3.1)</td>
<td>3,087 (2.9)</td>
</tr>
<tr>
<td>NESB</td>
<td>3,413 (95.9)</td>
<td>90 (2.5)</td>
<td>55 (1.5)</td>
</tr>
<tr>
<td>Normative percentage</td>
<td>94</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

NESB children are more likely to present with other injuries and less likely to present with poisoning cases than children from an English-speaking background. The difference between the two groups was statistically significant (p < .001).

4.3 Main CALD consumers of emergency services

Previous research indicates Chinese, Vietnamese, Turkish, Filipinos and Somalis as the most frequent consumers of RCH emergency services. These top five CALD consumers of hospital emergency services were collapsed into one group for the purpose of analysis as it was not possible to conduct chi-square analysis using each CALD group due to small cell sizes. The rates of presentation for the collapsed group were compared to both English-speaking presentations and presentations representing all other language groups. Results showed that:

- The Chinese, Vietnamese, Turkish, Filipino, and Somalis group represented 1,778 presentations (1.6%);
- The English group represented 104,706 presentations (96.7%) and
- All other language groups were represented in 1,780 presentations (1.6%).

Table 5: Total number of emergency department presentations for poisoning and/or other injuries for the top five CALD consumers of emergency services (collapsed) and consumers from English-speaking and other CALD groups

<table>
<thead>
<tr>
<th></th>
<th>Other injuries N (%)</th>
<th>Poisoning – medications N (%)</th>
<th>Poisoning - other N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top five CALD consumers</td>
<td>1,737 (97.7)</td>
<td>28 (1.6)</td>
<td>13 (0.7)</td>
</tr>
<tr>
<td>English</td>
<td>98,358 (93.9)</td>
<td>3,261 (3.1)</td>
<td>3,087 (2.9)</td>
</tr>
<tr>
<td>All other cultures</td>
<td>1,676 (94.2)</td>
<td>62 (3.5)</td>
<td>42 (2.4)</td>
</tr>
<tr>
<td>Normative percentage</td>
<td>94</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 5 shows the rate of emergency department presentations for poisoning and/or other injuries for the top five CALD consumers of emergency services as a collapsed group and for the English-speaking and other CALD groups. Individuals from the top five CALD consumers of emergency services are more likely than English-speaking and all other cultures to present for other injuries and less likely to present for poisoning. The difference between the groups was statistically significant (p < .001).

This analysis confirms previous qualitative findings\(^1\) that the main CALD consumers of RCH emergency services for injuries were least likely to present for child unintentional poisoning. Three of the five CALD communities were identified as targets for this research project: Somali, Turkish and Vietnamese.
CHAPTER 5: FINDINGS FROM ETHNOGRAPHIC STUDY

This chapter outlines the qualitative findings from the interviews conducted with the primary care-givers of children under five from the Somali, Turkish and Vietnamese communities. The themes covered include toxic products in the home, parental knowledge of toxic products, experience of poisoning, parent approach to safety, and information and education about child unintentional poisoning.

5.1 Toxic products in the home environment

A range of toxic products (cleaning products and medications) were observed in the home across the three groups. Some participants possessed an extensive range whilst a few only used basic products like one Somali participant who only had one cleaning product in each of the following rooms: the kitchen, laundry and bathroom. Cleaning products seen in the homes included dishwashing detergents, laundry detergents, washing powders, laundry liquids, toilet cleaners, air fresheners, oven cleaners, and cosmetics. However, specific toilet cleaners such as Domestos were not observed in any of the Somali homes. Instead, Jiff was used for cleaning toilets. Jiff was a popular cleaning product, with Somali participants immediately mentioning Jiff when questioned about products in the home. Products for the car or garden were rarely observed in homes, with most participants either not using these products or storing them outside the home (such as in the boot of the car or outside shed).

The most commonly observed medications were for children including Panadol and Dimetapp and prescribed medication for asthma and eczema; however, adult medication was also observed (such as Panamax). Very few participants were on prescribed medication; only one Turkish participant indicated he was using potent medication.

The use of natural remedies specific to each culture for cleaning or medication purposes was not common. One Somali participant indicated the use of cumin with honey for colds while a Turkish participant reported sniffing an onion for the same purpose. Specific to Vietnamese Buddhist and Somali homes was the use of incense. Vietnamese Buddhist homes featured a shrine or temple with offerings and incense was used as a means of paying respects to ancestors. Meanwhile, Somalis burnt sugary-smelling incense in a specially-designed container to create a welcoming atmosphere for guests. Other natural products observed in Somali homes were natural-based cosmetics such as avocado oil and snake oil hair mask and Arabian essential oils and perfumes.

5.2 Parental knowledge of toxic products

As a means of understanding the level of parental knowledge of toxic products, participants were asked about the use of such products in their country of origin. Many products were not used outside metropolitan areas of Somalia. One Somali participant from Mogadishu, the capital of Somalia, indicated cleaning products and medication were available in the city. Consequently, this participant was the most
aware of the danger of toxic products, indicating that Somali parents and elders had warned her about the
danger of these products:

‘Before I came to Australia, our mothers educated us as to the dangers of these products. They used to say this is very dangerous and they used to put very high you know [so] any child cannot reach. So that’s why we only put up there and when we come here we read the label and it’s the same. I was educated as before for the dangers of these products.’

S8 – Somali participant

However, this participant was also a registered family day care provider and had received formal education on child safety. On the contrary, a Somali participant whose range of cleaning products was limited indicated that in rural areas of her homeland sand was used to clean dishes. This lack of familiarity with chemical-based cleaning products in Australia may explain why her home featured few cleaning products.

Turkish and Vietnamese participants also indicated that the range of cleaning products and medication was similar in their country of origin.

Overall, parental knowledge of toxic products in the home was limited, with the majority of participants aware that these products could be harmful to children, with particular reference being made to the potency of oven cleaner by many participants. A couple of Somali participants suggested that these products were dangerous for adults as well as children. Only a few participants also stated that these products required proper storage away from children.

Parental knowledge about toxic products was acquired through child safety education and reading product labels. The most knowledgeable participant was a Turkish mother and qualified child care worker who had gained her knowledge through child safety training received as part of her job. She was the only participant who specifically read the content information on the labels to facilitate making decisions about purchases. Her intention was to purchase the least poisonous products. Consequently, she ranked products from most to least dangerous, citing Domestos and window cleaners as the most potent of cleaning products. She did not purchase Domestos as she considered it the most dangerous product.

The majority of participants indicated they were proactive in reading the product labels, but only to read instructions for appropriate use and storage, or side effects and consequences of incorrect use. Participants whose children had asthma or eczema, the most commonly reported health conditions in the children of participants, were also more wary of the products, careful of what products were used in a bid to prevent any asthmatic or eczema attacks. The English skills of participants appeared sufficient in most cases to allow them to read product labels; however, a couple of participants had such limited knowledge of English that they were not in a position to read the labels, but reported that common sense and a sense of smell alerted them to the danger of cleaning products. One Somali participant who was illiterate requested her son read the label instructions for her prior to use.
Another participant, a Turkish mother who had arrived in Australia as a child, recalled how she was required to read product labels for her mother and advise her about which products were the least and the most dangerous to use. Perhaps as a consequence of her childhood responsibility, this participant appeared to be very diligent about the use of toxic products, also highlighting the importance of conscious consumption of products and the minimisation of waste:

‘I think the more you have in the house, the more you waste.’

T2 – Turkish participant

5.3 Experience of child unintentional poisoning

The majority of participants had no experience, direct or indirect, of child unintentional poisoning. Consequently, this lack of experience made it difficult for participants to contemplate the factors that would contribute to such an experience occurring, or even how they would respond. This was most pertinent for Vietnamese participants who were convinced such an experience would never occur as their children would never touch toxic products. Nonetheless, a couple of indirect experiences in participants’ extended family were reported, and three participants, one from each community, reported that their child had been involved in an incident of child unintentional poisoning.

The Vietnamese participant indicated her son had consumed a small amount of adult liquid medication meant for her immediate consumption but which she was distracted from taking immediately; the Turkish participant indicated his young daughter had consumed acetone or nail polish remover; and the Somali participant suspected her daughter had consumed her husband’s medication as the child was light-headed. Lapsed supervision and easy access to the toxic agent appeared to be the contributing factors for all. However, the response differed for each incident. The Vietnamese participant called her general practitioner (GP) for advice, perhaps a reflection of the respect for authority that is a feature of Vietnamese culture. Respect for authority was also a feature of the Turkish response. As the child was in her uncle’s house, her father did as his older brother suggested out of respect for him rather than doing what he felt was right for his child. He followed his brother’s advice and gave the child yoghurt to minimise the potency of the product consumed. Had the incident occurred in his own home, he suggested the response would have been different: the child would have been taken to the hospital immediately. The Somali participant called the ambulance and the child was hospitalised overnight before her health returned.

Contributing factors

Lapsed supervision and easy access to toxic products appeared to be the common contributing factors in the reported poisoning experiences. A couple of the participants also suggested that the liquid consumed may have looked like a drink to the child. The liquid medication was clear and looked like water while the nail polish remover was bright pink, perhaps appearing as a soft drink.
Other participants also suggested poor storage of products and lack of supervision could lead to poisoning incidents. Children’s lack of awareness of the dangers of toxic products was also mentioned as a possible risk.

**Anticipated response to a poisoning incident**

Across the three groups, the most commonly anticipated response to a child consuming a toxic product was accessing emergency services immediately either by calling the ambulance, or taking the child to hospital. Only two participants, one Vietnamese and one Turkish, reported they would call the Victorian Poisons Information Centre. Very few participants were even aware of the Centre. There was certainly no reluctance on the part of participants to access hospital services in the event of poisoning; many had previous experience in accessing the emergency services for other child health-related issues such as asthma, eczema, respiratory conditions and injuries. It is acknowledged that participants’ responses may have been influenced by a desire to provide the perceived ‘correct’ answer.

Residence appeared to influence where participants would take their children for unintentional poisoning. As all the Turkish participants lived in Melbourne’s northern suburbs, Epping Hospital was the hospital of choice for the majority. The Vietnamese participants lived in the western and south-eastern suburbs, so Sunshine Hospital and Monash Medical Centre in Clayton were the hospitals of choice respectively. The Somali participants in inner Melbourne and the eastern suburbs nominated RCH and Austin Hospital respectively. A few participants also nominated RCH as it was perceived to provide better quality of care for children.

Other anticipated responses included shock (Somali participants), increasing supervision until ambulance arrived, and giving water to the affected child to minimise the potency of the product consumed and to hydrate the body in anticipation of vomiting.

Inducing vomiting was another anticipated response that many participants across the three groups considered if a child was unintentionally poisoned. Inducing vomiting appeared to be a means of parents or care-givers maintaining power over the wellbeing of children, but also reducing any sense of helplessness in the situation:

‘Yes, at least I would do something. Because the ambulance maybe could come late so I have to do something; I would try to help her any way I could.’

S8 – Somali participant

Vietnamese participants indicated they would manually induce vomiting by sticking their finger down their child’s throat. Somali and Turkish participants indicated that prior to vomiting, milk and yoghurt would be given after a child had been poisoned, primarily as a way of minimising the potency of the product consumed. However, in some cases it was a way of inducing vomiting. The Somali participants had never needed to use this method but it was noted that it would be unlikely anyway because camel’s milk, the milk of choice for this purpose, is not readily available in Australia.
The majority of Turkish participants indicated that Turkish yoghurt, which was preservative-free, was recommended after unintentional poisoning. Participants reported hearing this from elders and parents:

‘The elderly people usually mention yoghurt...we were told yoghurt cleans everything.’

T5 – Turkish participant

However, only one participant had reason to use this remedy when his child had consumed acetone. The remedy appeared to work and no harm came to the child. Other Turkish participants considered this remedy, but a couple were against this advice from elders due to a belief that such an act was not good for the child, or out of concern that vomiting would not be possible. Other culturally-specific measures used to induce vomiting included lemon in water or squeezed straight, or lemon with crushed garlic (Somali participants).

Interestingly, younger Vietnamese and Turkish participants aged in their twenties or early thirties did not know about inducing vomiting; the concept of inducing vomiting was foreign to these participants:

‘I’ve heard yoghurt like they put it on burns, but nothing like eating it after poisoning.’

T7 – Turkish participant

Perhaps, the younger generation of parents had not been exposed to the traditions of ancestors, or had a more modern approach to parenting, challenging the more conservative approach of their parents or grandparents:

‘That’s more the older people...I’m more new tradition.’

T7 – Turkish participant

**Safety measures subsequent to a poisoning incident**

Direct experience of child unintentional poisoning made the affected participants vigilant in protecting their children from subsequent occurrences. In particular, the Vietnamese participant whose son had consumed adult medication indicated she now immediately consumed any necessary medication. The Somali participant changed storage procedures for medication after informing her husband of the need to take his medication immediately and store the medication away from children.

Change in storage procedures was also the measure most participants reported they would undertake as a follow up if their child was poisoned. Products would be stored in a higher location than before and some Somali participants indicated doors would be locked as well. Somali participants also indicated they would improve supervision and reinforce safety messages to their children. One Vietnamese participant indicated lids on products would be tightened.
5.4 Parental approach to safety

There were a number of aspects of parenting in the Somali, Turkish and Vietnamese cultures which may influence child safety.

**Storage (including safety products and child-resistant containers)**

The storage of toxic products in the majority of participant homes consisted mainly of placing them out of reach of children. The only observed difference in product storage was in the homes of Somali participants living in the high-rise flats in inner Melbourne. These flats did not have a laundry; a communal laundry on each level was used instead. Laundry-related products such as washing powder and bleach were stored on ledges in the bathrooms. This limitation in public housing was also identified in a previous study of parent poisons safety strategies.

Overall, other observed storage practices were as follows:

- In kitchens, the cupboard under the sink, and top cupboards were used to store kitchen-related products, although dishwashing detergent was left on the sink in many homes. Children’s medication was stored in the butter container in the fridge. One Turkish participant even had a refrigerator, recently purchased, that had a lockable butter container, so children could not reach medicines;
- In bathrooms, products such as hand wash, toothpaste, mouthwash were stored on main bathroom bench. Wall cabinets and under the sink were also common storage places as were bathroom ledges. In showers, shampoos, conditioners and showering products were either stored in shower baskets hung from shower heads or placed on the shower floor;
- In laundries, under the sink was a common storage location, although products were also stored in ordinary cupboards;
- In toilets, toilet cleaners and air fresheners were more likely to be stored on the window ledge;
- Other storage locations included the bedroom (for prescribed adult medication) and lounge room (Vietnamese Buddhist shrines featuring incense); however, shrines were usually located high up and close to the ceiling, requiring a ladder or chair to reach.

**Safety products and child-resistant containers**

The use of child-resistant containers (CRCs) across all groups was common. The use of CRCs has become standard for medication, so it was not uncommon to observe medications in these containers. Some participants also reported only purchasing cleaning products that were child-proof.

Very few participants were currently using child safety products such as locks or latches, specially-designed or home-made. Other participants had used them previously until their children reached three to four years of age, when they were considered to be sufficiently aware of the dangers of toxic products. Some participants who had infant children were considering the use of safety products when
these children were aged between one and three years of age. Participants considered children of this age to be inquisitive and incapable of understanding safety messages. All the groups were represented in those who used safety products, but more so the Vietnamese participants, one of whom had an interesting means of protecting her twin boys. A specially-built safety barrier or fence on one side of the lounge room, a blocked archway on the other side of the room and a closed door was used to keep her sons in the lounge room at all times to improve her ability to supervise them. The boys knew that they were to stay in the room.

Those participants currently using safety products were primarily using them to prevent child injury due to easy access to cutlery, glassware and crockery rather than toxic products. The kitchen was the only place where safety products were used although one Somali participant used a home-made safety device on the bottom cupboard in the bathroom to protect her youngest child from the contents. A Somali participant who had participated in a structured child safety education program previously used a specially designed box/container with locks to store medications, but ceased use of the box when her youngest child had turned three. Two participants, one Turkish and the other Somali, both with a background in child care were most diligent in the use of child safety products courtesy of training received as part of their jobs. The Turkish participant even encouraged her parents to use the products in their home and was proactive in discussing child safety with her husband. Both followed the same child safety routines in the home.

**Supervision**

‘I grew up with the thing that if you keep an eye on your kids enough that the rest of it is not really a problem.’

T2 – Turkish participant

The majority of participants did not work or worked during times when another adult was able to supervise young children. The supervisory techniques observed or reported included children only allowed in one part of the house and parents using their auditory abilities to listen to where their children were at all times.

All Somali and Vietnamese participants were mothers and were the primary care-givers of children. Father’s involvement in child care in these communities was limited to short periods after work or study commitments. The situation differed with Turkish participants. Supervision remained a key responsibility of women (mothers and grandmothers) but fathers appeared to be more involved than their Somali and Vietnamese counterparts, including showing a more active involvement in the interviews for this study. In one case the primary care-giver was the Turkish father as he was the main disciplinarian of the children.

In addition to parents providing supervision, older siblings were also expected to assume responsibility for the care of young children if parents were not present. This was most pertinent for Somali participants, all
of whom had at least three children. Large families are the norm in Somali culture and in this study the number of children ranged from three to seven.

Other observed aspects of Somali culture which may contribute to increased supervision of children was the constant presence of other adults in the home and the living arrangement for Somalis living in high-rise Housing Commission flats. The Somali community is close, tight-knit and altruistic, with adults visiting each other possibly as a means of providing and gaining support from others in the community. Living in close proximity to each other in the same Housing Commission estate and/or same suburb could facilitate this closeness. Another supervision issue specific to Somali participants living in the high-rise Housing Commission flats was the limited space in these flats allowing adults and care-givers to better supervise children.

Very few participants indicated that members of the extended family were involved in the supervision of their children partly due to the lack of family in Melbourne. Even if there was access to extended family in Australia, many of these participants did not seek their assistance with supervision, apart from one Somali participant who indicated that her teenage nieces supervised her children on occasion. It was Turkish participants who were more likely to utilise members of their extended family, particularly grandparents, for supervision:

> Most of the Turkish people live with their grandparents as well [and] they’re very over-protective. They’re all around the children; they don’t leave them alone. If the mother isn’t there then the father, if the father isn’t there then the grandparents will be involved.’

T3 – Turkish participant

In fact, one Turkish participant was a grandmother raising her grandson in conjunction with her daughter. Another participant lived with her husband, child and father. Interestingly, a couple of Turkish participants were not enthusiastic about grandparents being involved in the supervision of their children:

> ‘I mean she’s a fantastic mother and grandmother but yes I wanted to bring my children myself and my husband because I really believe that’s very important for me. I want them to have only one discipline, one sort of mind.’

T7 – Turkish participant

These participants preferred to be the main supervisors, believing their parents spoiled their children. Interestingly, these participants were Australian-born or came to Australia at a young age suggesting they have achieved a higher degree of acculturation.

One apparent reason for the prominence of supervision in these cultures was the importance of children. This was most evident in the Somali community where large families are the norm and where children are considered vital for the perpetuation of Somali culture. Thus much attention was given to child-rearing:
‘As a mother in Somalia, we are always here for our kids.’

S6 – Somali participant

**Education of children**

‘We sort of try put some fear into her...that she will get very sick and ill and that she'll end up going to the hospital and that would be very bad...so information like this is given to her.’

T4 – Turkish participant

The education of children about toxic agents was primarily fear-based, with participants across the three groups using consequence explanations (going to hospital, disfigurement) to keep children away from these products. Many participants indicated there was a need to reinforce these messages particularly with young children. Older children were considered aware of the dangers of toxic products.

In some cases, participants took advantage of household activities, using them as teaching opportunities to educate children about the correct use for cleaning products and medications. Children were taught about the right purpose of toxic products and the need to stay away from such products when they were not being used.

**Harm minimisation**

One aspect of the parent approach to child safety included harm minimisation. Participants indicated care in purchasing products for use in their house or actual utilisation in the home; or reading product labels to learn of the correct use of products or the possible side effects if consumed.

Harm minimisation included care in purchasing products for use in the home. One Turkish participant ranked products from least to most dangerous and was careful not to purchase any product such as Domestos that she considered too dangerous for use around children. One Vietnamese participant had changed her cleaning practices after the birth of her child:

‘Before I had this child, I used to use a lot of chemical stuff, cleaning products like Windex. But ever since I had him, I often use just a wet towel or paper to clean the TV and windows. Because my child often touches the screen and I don’t want that to get on his fingers...so I’ve used less chemical product than before I had him.’

V7 – Vietnamese participant
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Another Turkish participant was also wary of cleaning products such as Domestos and Morning Fresh and refused to be seduced by advertising for new cleaning products, which she believed to be replicas of existing products on the market.

Discussion about household activities demonstrated that care was taken to prevent child exposure to toxic products as outlined below:

- In most cases, younger children were not allowed into the laundry or kitchen whilst activities such as clothes washing, dish washing, and oven cleaning were being carried out. For those participants that did allow children into these rooms whilst cleaning, children were not allowed to touch the products being used, but in some cases children were taught the correct use of the product in question. Some participants indicated that clothes washing or oven cleaning were carried out when children were asleep or at school, or during a particular time of the week when they knew children would not be present;
- Children were supervised during bathing or showering, with participants either in the bathroom with their child/ren or in the immediate surrounds using their auditory abilities to supervise. Children were not allowed to touch products whilst bathing. Participants whose children showered indicated they always applied the shampoo to their child’s hair for them. Somali participants with older children indicated these children may also be involved in the bathing of younger children;
- Medications were administered according to GP, pharmacist or label instructions. However, participants may have reported what they felt the Research Office wanted to hear. Alternatively, participants with poor English skills may believe they are following label instructions correctly but be unaware of their error due to language barriers.

Of all the household activities, participants were the most meticulous with the administration of medication for children. The majority of participants were able to read the instructions on product labels, dose for weight or age, but some used doctors’ or pharmacists’ instructions as a back up. One Somali participant in particular was most vigilant in administering children’s medication. This participant, who was a single mother, had three checks in place to make sure her children were medicated properly. The checks were following her doctor’s instructions, and then the pharmacist’s instructions and then her eldest son read the instructions for her to verify she understood how to medicate her children properly. Perhaps being a single mother responsible for four children made her more vigilant. Other safety mechanisms used by participants included preparing the medicine away from children so they could not see where the medicine was stored, and hiding medicines in the main bedroom. Conversely, other participants allowed children to handle medication under supervision during preparation, as a means of learning about their proper use.

Self-administration of medication by participants was also used as an educational opportunity for their children. Some participants indicated that their children quizzed them about the medication they were taking. The most common response to children’s questions was that it was adult medication and they were not allowed to touch it.
Behaviour management

‘And again we [are] so strict so we don’t need to tell them many times. We only need to tell them once and I think it’s more than enough.’

V1 – Vietnamese participant

Discipline appeared to be an important part of child-rearing in these cultures, but more so in Vietnamese and Turkish groups:

‘I mean I’ve really brought up my children in a very disciplined and very particular way and I mean their attitude and the way they’re brought up it’s very disciplined.’

T7 – Turkish participant

Turkish participants in particular mentioned that children were disciplined to ask for consent or permission before putting themselves in a situation where they could be at risk of unintentional poisoning such as opening the fridge and finding child medication:

‘They know not to touch it. I’m very cautious about that. I know that they wouldn’t touch it without my consent.’

T7 – Turkish participant

One Turkish participant used a rather unique approach to controlling her child’s exposure to toxic products. Her daughter was given her own spray bottle with water to use to minimise her curiosity for toxic products. She was taught to only play with this bottle to reduce the likelihood of her playing with these products.

5.5 Parent education and information about child unintentional poisoning

The majority of participants had not received any structured education about child unintentional poisoning. Two Somali participants had taken part in a structured child safety education program offered to Somalis on the Housing Commission estate. The two participants (Somali and Turkish) with a background in child care also received structured education on child safety as a requirement of their position.

The four participants who had received structured child safety education knew of the Victorian Poisons Information Centre. One of these participants indicated she would call the Centre in the event of a poisoning. On the contrary, most other participants were not aware of the Poisons Information Centre, or only had vague recollections of hearing about the Centre. One Turkish participant indicated she would call information hotlines listed on the labels of toxic products for information about poisoning. One Vietnamese participant indicated that she would call the Poisons Information Centre if her child was poisoned. She had learnt about the Centre through the local Vietnamese media and kept the number close to her telephone.
The media appeared to be an informal source of information for Turkish participants who had learnt about poisoning in children and generally from Turkish media via satellite from Turkey.

Another culturally-specific source of information for Turkish and Somali participants in particular was elders, perhaps an indication of the respect for authority paramount in these cultures. As mentioned previously, elders either provided warnings on the danger of toxic products, or recommended treating many ailments with yoghurt:

‘No formal education or information, but it’s through the elderly in our family. The parents and whatever, we learnt through them.’

T5 – Turkish participant

Very few participants were proactive in seeking out information; they felt there was no need as they strongly believed that poisoning would never occur to their children. However, other sources of general information about children either actively sought or received included pamphlets and child-related magazines. Playgroups, bilingual community development workers, and maternal and child health nurses were also cited as information sources about child-related issues.

All the participants indicated having a regular GP, but few actually sought information from their GP. Only one Vietnamese participant contacted her GP about poisoning when her child was unintentionally poisoned. Other participants indicated that GPs did not provide information to them about child poisoning prevention. However, GPs and to a lesser extent pharmacists were cited as sources of information for the proper administration of medication in children. In addition, participants indicated that if information about poisoning was needed, GPs would be the key source of information.

Whilst there are barriers for members of CALD communities to accessing health services, many participants did not feel disempowered in accessing health services. Several participants had children with chronic conditions such as asthma or eczema and thus had previous experience accessing health services. Nonetheless, some participants did highlight potential barriers to accessing assistance about child unintentional poisoning, with language the most commonly reported. Other barriers included transport, lack of knowledge of available services, insufficient information in other languages, low literacy levels (cannot read English), waiting time at GP surgeries, GP lack of time, and parental responsibilities.
CHAPTER 6: DISCUSSION

Parental ethno-theories are ideas and attitudes that CALD communities possess about families, children and parenting. Findings from this study contribute to an understanding about parenting practices which may act as protective and risk factors in child unintentional poisoning in the Somali, Vietnamese and Turkish communities.

6.1 Protective factors

An important emerging theme from the study was the parental perception that their children would never touch toxic products or experience unintentional poisoning. Participants, particularly the Vietnamese, were absolutely resolute in their conviction that the risk of poisoning was minimal if non-existent; some even found it difficult to contemplate contributing factors and their response to a poisoning incident. This conviction could be an indication of their faith in their parenting practices which would ensure poisoning would never occur in their children. Alternatively, it could simply demonstrate lack of awareness of the reality of personal risk as found in the previous study of parental uptake of safety strategies.

The importance of family, and children as part of the family unit, was one emerging protective factor from this study. Family is an important element of the Somali, Turkish and Vietnamese cultures. In Vietnam, the family is a source of social identity, but is also a source of assistance in times of crisis. Consequently, children are viewed as an integral component of the family unit as it is through them that language and culture are preserved. It is acknowledged that the role of children and family are also likely to be considered as central issues in families of other backgrounds, including Australian-born. However, it was a particularly strong theme in this study and was not an emergent theme in the previous study of parental safety strategies. This supports the finding that values relating to the importance of children and families were a culturally-specific protective factor in the Somali, Vietnamese and Turkish communities involved in the study.

Studies demonstrate that children who are not properly supervised are at an increased risk of poisoning. This study found that an important aspect of parenting in CALD communities which protected children from unintentional poisoning was active visual and auditory supervision whereby children were in close proximity and usually within sight of an adult or an older child. This supports previous findings that supervision was the most common safety measure CALD parents used to prevent child accidents, poisoning included, in and out of the home. The majority of participants from this study did not work and could actively supervise their children. Somali participants living in the high-rise Housing Commission flats were better able to actively supervise their children as the flats were small with fewer places children could go within the home environment. In some homes a strong adult presence also ensured that children were closely supervised. This was most pertinent for the Somali community which was observed to be a close and tight-knit community where members provided assistance and support to each other and visited...
each other’s homes on a regular basis. Living in close proximity to each other either on the same housing estate or suburb further enabled the provision of support in this manner and this subsequently had indirect benefits for child supervision. Additional supervision also came from older children, particularly those in Somali families, who were expected to assume this care-giving responsibility. Supervision appeared to be the domain of women, perhaps a reflection of traditional cultural attitudes that women’s primary role is raising children. This strong emphasis on active visual supervision emerged as a protective factor in the targeted communities.

Parental expectation that children demonstrate respect for authority was yet another protective factor found in this study. Children had been educated to comply with parental orders not to touch toxic products. This is supported by child development research which shows that a caring but strong disciplinary approach to parenting is associated with child competence. Whilst respect for authority was expected of children across the three communities, it was the Vietnamese participants who most demanded their children comply with expectation. The Confucian philosophy, a significant influence on Vietnamese culture, highlights the importance of social order, a contributing factor of which are harmonious family relationships. The relationship between parent and child is the most important family relationship, with children expected to demonstrate respect for elders as a means of maintaining harmony within the family.

Fear-based messages highlighting the consequences to children from touching or consuming toxic products have been shown to have a protective effect on young children. This study supported this finding as many participants indicated they also used fear when educating their children about toxic products. The use of fear appeared to be a key feature of parenting Vietnamese-style, supporting previous research which highlights how Asian mothers of Chinese origin use anxiety induction to ensure children follow rules and parental expectations. The use of fear to ensure children follow parental expectations highlights a need to educate parents about children’s capacity to understand child safety measures and rules. This is most pertinent for parents expecting young children to adhere to rules and orders that they are not old enough to comprehend. Child development research indicates that children’s ability to follow instructions and exercise self-control develops gradually between the ages of 18 months to 30 months and is closely linked to language development.

An expected protective factor that did not manifest was that participants would have a limited range of toxic products in their homes. It was expected that the availability of toxic products in participants’ country of origin was limited thereby affecting their use of such products in Australia. On the contrary, the reverse was more likely with the majority of participants utilising a wide range of products in the home. Many participants, particularly Turkish and Vietnamese, indicated that a similar range of products was available in their country of origin. The use of natural remedies to clean and medicate was limited.

Extended families have been found to be involved in the supervision of children in CALD communities, but this did not emerge as a protective factor during the study. Whilst the Somali culture is family-oriented, many Somali participants indicated their extended family was not present in Australia. This may
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be due to the traumatic circumstances under which many Somalis have migrated to Australia. War in their homeland and time in refugee camps may have torn families apart. Other participants had migrated to Australia without extended families, but Turkish participants who were born in Australia or came to Australia as young children did not want their parents to supervise their children. This was primarily out of concern that their parents would spoil their children, perhaps affecting the ability of children to respond to disciplinary measures.

6.2 Risk factors

It was expected that this study would confirm previous research which demonstrates that members of CALD communities experience barriers to health service access, possibly explaining the under-representation of certain CALD communities in emergency department presentations for child unintentional poisoning. However, this was not the case. All participants indicated having a regular GP and several participants indicated previous experience with access to emergency departments for child-related issues, injury included. Despite access to a GP, the majority of participants did not see the need to discuss or obtain information about child safety from their GP, primarily because of their firm belief that their child would never experience poisoning.

Language and cultural barriers to reading and understanding content information on product labels was more of an underlying theme emerging from the study rather than appearing overtly. Most participants reported possessing sufficient English skills to read and comprehend information on product labels about correct use. While this may be the case, there are a number of potential confounding issues to consider; they may not be aware that their understanding of labels and instructions is incomplete or incorrect; they may have been reluctant or embarrassed to reveal any difficulties and instead answered in a way to satisfy or even impress the Research Officer and the interpreter; many participants seemed unfamiliar with the dynamics of research and were concerned the Research Officer would report any findings to government authorities, so may have been worried about the impression of their parenting style.

Lack of knowledge is a potential risk factor in child unintentional poisoning.\textsuperscript{18-19, 32-33} This study found that the majority of participants had limited knowledge about toxic products and the Victorian Poisons Information Centre. Knowledge was limited to what participants could read on labels. Language and cultural understanding can clearly limit access to this source of information. Only one participant with a background in child care demonstrated knowledge beyond the other participants, indicating she used her knowledge to rank products from least to most dangerous. Only a few participants indicated they were aware of the Victorian Poisons Information Centre, with only two of these indicating they would call the Centre in the event of their child being poisoned. This is in stark contrast to the previous poisoning prevention study where many participants were aware of the Centre and had access to the Centre’s number.\textsuperscript{1} This finding indicates that parent education on child unintentional poisoning needs to increase and reinforce awareness of the Centre and its role in child unintentional poisoning. It is important that such education also be made available in other languages and distributed through appropriate avenues such as maternal and child health centres, child care centres and kindergartens. Many participants
indicated they would either call an ambulance or take their child to a hospital emergency department in the event of their child being poisoned. Others referred to home-based remedies of uncertain effectiveness as a likely response to a child unintentional poisoning incident. The most common of these remedies across each of the communities was inducing vomiting. This has the potential to cause greater injury if a caustic substance has been ingested.

The conviction with which many participants insisted that child unintentional poisoning was unlikely in their home environment could place them at risk if they are not employing safety strategies as a result but it appeared to be more a function of their belief in the efficacy of their parenting practices. Parent lack of awareness of the personal reality of risk was shown in the previous study to change when an actual incident of poisoning took place, encouraging the uptake of safety practices in the home environment. In the current study, participants believed that poisoning was unlikely because in most cases it had not occurred previously. Storage of toxic products away from children in the home environment was the most common safety strategy, which is consistent with the previous study. However, in contrast, safety products, specially designed or home-made, were not commonly used in the target communities of this study. Education for parents from CALD communities on child unintentional poisoning needs to address the perception of risk, highlighting that any child can experience poisoning. Such education could explain the developmental stages in childhood, including ability of children to comply with parental safety rules and orders. Education also needs to highlight the importance of safety measures such as correct storage and the use of safety products.

The expectation that children show respect for authority appeared to be a protective factor. Children were expected to adhere to parental orders to keep away from toxic products. However, respect for authority can also influence parents’ response to a child unintentional poisoning incident and therefore can operate as a risk factor. One participant reported giving his daughter yoghurt, a cultural remedy as suggested by a senior member of the family, after she ingested acetone or nail polish remover, despite the fact that he felt it would be more appropriate to seek assistance from a health professional. Research demonstrates that parents from CALD communities trust the advice of health care providers on child health matters, strongly believing that medical practitioners act in the best interests of their children. Therefore, child safety education for CALD communities needs to reinforce parental trust for medical practitioners, but also capitalise on the concept of respect for authority. Parents and care-givers still need to be encouraged to shift their attitudes on appropriate sources of advice on child health matters, especially in emergency situations. Medical practitioners and other health professionals could be promoted or reinforced as ‘authorities’ or ‘elders’ who should be consulted immediately in the event of child unintentional poisoning.
CHAPTER 7: CONCLUSION

This study contributes to the evidence-base by confirming early indications that CALD communities are over-represented in presentations to emergency departments for child injuries and under-represented for child unintentional poisoning. In addition, themes emerging from the qualitative study provide an increased understanding of the combination of socio-cultural protective and risk factors contributing to the discrepancy.

The study results highlight the complexity of socio-cultural differences in parenting and home-based practices that impact on child safety and poisoning in particular. The interaction between home environment, parent support, supervision practices, and cultural values about family and respect for authority seems to have resulted in a protective effect for children in relation to child unintentional poisoning. It is unclear why this would have differentiated between risk of poisoning and risk of injury generally. Parents’ confidence that their child was not at risk of unintentional poisoning was based on faith in their parenting strategies to protect their child from that risk rather than a disregard for the dangers of toxic products. There was a clear reliance on supervision and child ability to understand instructions and show respect for authority by adhering to those instructions, even at an early age. A reliance on storage of toxic products away from children, rather than use of safety products to restrict access, was evident in these communities.

There was evidence of possible risk factors for Somali, Turkish and Vietnamese communities that may have contributed to under-representation for child unintentional poisoning. Lack of storage options in public housing made it difficult for parents to store toxic products out of children’s reach. The existence and role of the Victorian Poisons Information Centre was not generally known which is a clear contributor to potential risk in management of poisoning incidents. The majority of participants reported that they anticipated using a GP or hospital if a child unintentional poisoning incident occurred, but it is possible this reflected response bias rather than an indication of actual behaviour. There were also indications of language barriers impacting on ability to read and understand product labels, and home-based remedies of uncertain treatment effectiveness being used in response to a poisoning incident. These factors could lead to parents being unaware that a product/amount consumed was dangerous for a child. It could also result in inappropriate strategies being used to manage poisoning incidents.

It was difficult to achieve theoretical saturation in this study given the huge diversity that exists within and across cultural groups. Ideally, ethnographic research involves immersion in a given culture over an extended period of time to enable true understanding of the cultural issues to develop. However, a number of important cultural features have been highlighted which can be used to inform policy decision-makers regarding appropriate directions for poisoning prevention policy decisions.
Recommendations

The protective factors identified in this study provide an opportunity to develop child unintentional poisoning prevention programs cross-culturally. In particular, the following strategies are recommended:

- Develop regulations requiring the inclusion of lockable, overhead cupboards in public housing
  - In the interim, provide lockable storage containers for residents in high rise public housing.
- Promote the use of authoritative but responsive parenting styles through parent education and training.
- Promote active supervision of children in the home through parent education and training.
- Encourage and assist in the development of supportive community networks for parents of young children.

The potential risk factors identified in the study show the importance of undertaking the following child unintentional poisoning prevention strategies targeting the CALD communities:

- Educating the CALD communities about the risks of child unintentional poisoning, poison safety strategies, and appropriate management of child unintentional poisoning incidents.
- Build on the traditional focus on family and parents’ respect for authority to promote poison safety and appropriate management of child unintentional poisoning incidents.
- Develop the capacity of the Victorian Poison Information Centre to meet the needs of people from CALD communities.
  - In the interim, provide clear information to CALD communities about what strategies they need to use to access the expertise of the Victorian Poison Information Centre (eg place call via the Telephone Interpreter Service, enlist the help of an English-speaking family member/friend/neighbour).

The findings of this study also highlight the need for further research in the following areas:

- Assessing self-reported parent understanding of product/medication labels versus actual understanding.
- Exploring differences in parent understanding of active supervision.
REFERENCES


3. Victorian Admitted Episodes Dataset data


7. Victorian Emergency Department Minimum Dataset data.


40. Mrvos R, Dean BS, Krenzelok EP. Illiteracy: a contributing factor to poisoning. *Veterinary & Human Toxicology* 1993; 35: 466-468

42. Totikidis V. An overview of data related to cultural and linguistic diversity in Victoria and the acute hospital system. 2002. Richmond: Centre for Culture, Ethnicity and Health.


APPENDIX 1: Report on Expenditure
### APPENDIX 2: Languages represented in the VEMD data set

<table>
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<th>Language</th>
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**Missing**                        | 124                     | **Inaccurately coded**            | 1575                    |
**Inadequately described**         | 136                     | **Not stated**                    | 5449                    |
**Nonverbal (Auslan)**             | 18                      |                                 |                         |