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The perspectives of parents and healthcare professionals towards parental needs and support from healthcare professionals during the first two years of children's lives

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ABSTRACT

Purpose: The first two years of a child's life have been found to be crucial for optimal growth and development. Support from healthcare professionals is especially important during this period. This study explored the perspectives of parents with children aged 0–2 years and healthcare professionals concerning parental needs and support provided by healthcare professionals.

Methods: A qualitative research approach was adopted, which comprised semi-structured interviews with parents (N = 25) and focus group discussions with parents (N = 4) and healthcare professionals (N = 3). The data was analysed using the principles of inductive thematic analysis.

Results: Overall, we found that parents preferred support that was tailored to their personal needs and practices. Building a trusting relationship between healthcare professionals and parents was also found to be important. The healthcare professionals recognized many of the parents' experiences. Some expressed that they felt bound to adhere to professional guidelines, which hindered them to provide customized support.

Conclusions: Recommendation for establishing tailored support and trust are self-disclosure by professionals, addressing possible misconceptions openly, and showing interest in someone's considerations or family and cultural customs. Further research into how professional support for parents can be improved is recommended.

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Health promotion; early childhood; health information; qualitative research; support; parent; baby; health

Introduction

The first two years of a child's life have been found to be critical for optimal growth and development (Gicquel et al., 2008; Gillman et al., 2008; Koletzko et al., 2014). Indeed, this period is recognized as a critical window in which to promote good health, due to the manifold potential benefits on future health outcomes (Balbus et al., 2013; Hanson et al., 2012). More specifically, studies have shown that instilling healthy behaviours in young children during this period can help to prevent major health-related diseases, such as cardiovascular disease, type 2 diabetes and obesity (Agosti et al., 2017; Baidal et al., 2016; Balbus et al., 2013). Examples of such beneficial behaviours include breast feeding, healthy eating, sufficient sleep, relaxation and regular physical activity. It has also been shown that the health-related practices of parents during the first two years of their children's lives play an integral role in terms of influencing children's health (Anzman et al., 2010; Savage et al., 2007). However, several studies have demonstrated that many parents struggle to embed healthy practices within their children's daily routines during the initial stages of their lives (Bektas et al., 2020; Fuller et al., 2019). Of course, becoming a parent is a major life event that induces a whole host of uncertainties, which, in turn, leads to parents raising a whole series of concerns and questions regarding health-related practices (Bektas et al., 2020; Hjälmhult & Lomborg, 2012). Many parents benefit from the support of others in terms of fine-tuning their parenting skills and practices, such as, for example, through contact with their peers, family members, and the wider social community around them (Hanna et al., 2002).

Healthcare professionals constitute an important element of the social support network of parents during the first two years of their child's life. Research has shown that receiving professional support is a vital component of developing parental practices (Barlow et al., 2010; Holmberg Fagerlund et al., 2019; Marshall et al., 2014). The attitudes, knowledge, cultural sensitivity, and approach adopted by these healthcare professionals ultimately determines parents' perceptions of the professional support they receive (Burns & Schmied, 2017; Rossiter et al., 2019; Tavallali et al., 2017; Van Mourik et al., 2016). Studies in Sweden have shown that parents appreciated professionals with extensive experience and a relaxed attitude (Barimani et al., 2017), while parents

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from an ethnic-minority background valued professionals who were open-minded and sensitive towards other cultural practices (Tavallali et al., 2017).

The Netherlands has a comprehensive network of healthcare and professional support that is available to (future) parents with young children (Hilverdink et al., 2015). Healthcare professionals working at the municipal child healthcare centres are assigned to support parents. However, the best way to support parents remains unclear (Dera de Bie et al., 2012; .Golley et al., 2011). In 2018, the government introduced their "Solid Start the Action Programme" in order to guarantee the best possible start for every child in the first 1000 days of their lives (Rijksoverheid, 2018). This led to an increased focus from local municipalities on the importance of the first 1000 days for children's healthy growth and development. Similarly, in Amsterdam, the capital city of the Netherlands, various initiatives have been undertaken to improve the professional support network around (future) parents. A study in the Netherlands found that parents of young children, parents with low income levels and ethnic minority parents have frequently concerns about their children and parenting practices (Reijneveld et al., 2008). However, there is a relative dearth of information on how parents with young children experience the support they receive from healthcare professionals during the first two years of their children's lives, as well as what specific needs they require. Notwithstanding this lacunae in extant research, there is also scarce knowledge about how healthcare professionals themselves view the support they provide to new parents. Gaining insight into the experiences of both parents and healthcare professionals can contribute towards optimizing the support provision to parents during this critical developmental period, which, in turn, potentially benefits their children's health later in life.

Consequently, the aim of this study is to investigate the experiences of parents with regards to their needs and the support they receive from healthcare professionals in the first two years of their children's lives. In order to enrich our understanding further, we also included the perspectives of healthcare professionals on this issue. Our qualitative research was conducted in a multi ethnic and relatively low-income neighbourhood in Amsterdam, the Netherlands.

Method

Study aim and design

This study is part of the Food4Smiles research project in the Netherlands. Food4Smiles aims to promote a healthy growth and development of children in the first 1000 days of their lives, in cooperation with parents and other stakeholders. The research site was an ethnically diverse, relatively low-income neighbourhood in Amsterdam, the Netherlands. We chose this part of Amsterdam because this neighbourhood scores relatively low in terms of the health of its citizens, compared to the rest of Amsterdam. For example, in this neighbourhood, 1 out of 4 children has obesity, while in some other neighbourhoods this is 1 out of 10. (Steenkamer et al., 2021, p. 5). The research project began with a needs assessment, which involved carrying out a detailed exploration of the diverse experiences, needs, and practices of parents regarding the health of their children in the first two years of their lives. In order to achieve this, we adopted a qualitative research design that involved the use of semi-structured interviews and focus group discussions with parents and healthcare professionals of child healthcare centres (Bektas et al., 2020). The data presented in this article derived from this explorative study on the experiences and needs of parents with a child 0–2 years old.

Healthcare in the Netherlands

In the Netherlands, all residents have basic healthcare insurance, while the reimbursement standards are set by the Dutch government. This means that all parents who are expecting a baby have the right to free prenatal care (i.e., regular check-ups by a midwife); after the baby is born, maternity care is provided at home for a set period of time (typically several days) to all families, either for a reduced fee or for free depending on what type of insurance they have. Nurses from the municipal child healthcare centres also visit the homes of all parents with newborns in the first few weeks after birth, in order to check in and assess how things are going. Subsequent to this period, every parent then continues to visit these child healthcare centres, so that specialized nurses and doctors can provide regular developmental check-ups on their baby and provide advice. All babies and parents in the Netherlands are entitled to support from these centres, which are often the first port of call for parents (rather than a general practitioner or paediatrician) when they require professional support on their child's development or when they have parenting-related concerns and questions. If more (specialized) care or support is needed, then these child healthcare centres will refer parents to other professionals, such as dietitians or medical specialists. Besides providing support, the healthcare professionals are also sensitive to the situation within the family and how the parents are taking care of their child. If the healthcare professionals feel the child is at risk of are worried about how parents are taking care of their child, they are obligated to report this to the social services.

Data collection

Mothers and/or fathers with a child aged 0–2 years were recruited to take part in this study, during the period May 2018-July 2018. These parents were recruited by the researchers via child healthcare centres and pre-existing parental app-groups, as well as

at other relevant public places, such as parks and children's playgrounds. The parents were able to speak Dutch, English or Turkish during their interview, as these were the languages spoken by the two principal researchers (FB & GB). Overall, we conducted 25 semi-structured interviews with parents about their experiences, needs, and practices pertaining to the health-related behaviours of their children. The cultural backgrounds of the parents were mainly Turkish, Moroccan and Dutch, see also Appendix A, table AI.

Subsequent to the interviews, focus group discussions (N = 4) with parents (N = 21 in total) were also organized. We expected that this would provide additional information because this allows the participants to react on each other's ideas and experiences, which might lead to richer data. We discussed the findings emerging out of the interviews with the focus group participants and we also explored some topics that had not been discussed in-depth during the interviews. With regards to the findings about the support of professionals, the focus group discussions merely confirmed our earlier findings from the interviews. Eight of the mothers who took part in a focus group discussion had been interviewed previously by the principal researchers (FB & GB). The other parents who joined the focus group discussion were recruited via mothers who we had interviewed before.

Almost all participants in this study were mothers, two fathers participated in this study. One father was interviewed together with his spouse, and one was interviewed individually. We tried recruiting more fathers through our contacts with mothers and at public places, but fathers were hard to find at public places during the day, and most mothers indicated their spouses were working full-time and had no time to participate in our research. Most of the parents (N = 27) were born in the Netherlands, 3 were not born in the Netherlands and their years of residence in the Netherlands were 7, 10 and 21 years. Of 8 parents it is unknown what their country of birth or years of residence in the Netherlands are.

See appendix A, table AI for further details on the demographic information for each of the parents who participated in the study.

During our interviews with the parents, a topic list was used that encompassed a broad range of health-related topics associated with their children, including sleeping, (breast) feeding, physical activity, and the amount of screen time they were allowed. As well as these aforesaid topics, the topic list also included themes associated with daily family life, the parents' social networks, and the level of both formal and informal support (e.g., family, friends, healthcare professionals) they received, in order to gain insight into their unique needs and experiences as parents. During the focus group discussions, cards with questions and statements (about topics such as food, the role played by grandparents, health across different cultures, professional support) were used as guidelines to facilitate the group's conservations. See appendix B for an overview of the topics discussed during the interviews and focus group discussions with parents. For the purposes of this article, only the data pertaining to the parental experiences of the support they received from professionals at child healthcare centres was used, as the overall findings emerging out of the interviews with the parents have been described at length elsewhere (Bektas et al., 2020).

The interviews with the parents lasted 60–130 minutes, with some parents being interviewed twice if all of the topics were not discussed over the course of the first conversation. Almost all the interviews and focus group discussions were held in Dutch, but some interviews (N = 5) were partially conducted in Turkish and one interview was carried out completely in Turkish. One of the focus group discussions with parents was conducted in English, because most of the parents in attendance did not speak Dutch.

After analysing the data that emerged from our interviews with the parents, three focus group discussions were organized with healthcare professionals who worked at child healthcare centres in the research site in March 2019. There are three child healthcare centres in our research site, and we organized one focus group discussion per centre. The professionals were recruited by contacting the three team leaders of each of the three child healthcare centres, and the researchers introduced the project and themselves at each of the thee centres. After this general introduction, two professionals signed up for a focus group discussions from the first centre, and seven professionals signed up for a focus group discussion from the second centre. These two focus group discussion were then organized some weeks after the general introductions of the project. The focus group discussion with the healthcare professionals of the third centre was conducted right after the general presentation of the project, which 13 people attended. The professionals were remedial educationalist, nurses, or youth healthcare physicians. Most of the professionals who joined the focus group discussions were female, two males took part in the focus group discussion of the third centre. Due to time constraints, no further demographic information was collected from the healthcare professionals. During these meetings, we let the discussion by presenting the main findings from the interviews and focus group discussions with the parents to the healthcare professionals sequentially, and illustrated these by showing direct quotes from the parents. The three focus group discussions with healthcare professionals lasted 60, 90, and 35 minutes, respectively. Please see Appendix B for an overviews of the topics discusses with the healthcare professionals.

All the interviews and the first two focus group discussions were recorded subsequent to receiving consent from the participants, and were transcribed verbatim. As aforementioned, the third focus group discussion was

held immediately after the general introduction of the project, and all the attending professionals verbally agreed that we could write-up notes about our conversations, but no audio recording took place. The interviews that were conducted in Turkish were first transcribed in the original language before subsequently being translated into Dutch by the principal researcher (GB), who also conducted these particular interviews.

Quality procedures

All parents were sent a summary of their transcribed interview or focus group discussion, so that they could perform a member-check (Johnson, 1997). Similarly, a summary of the two recorded focus group discussions with healthcare professionals was sent to the healthcare professionals, for precisely the same purpose. Specifically, the participants were asked whether they felt the report accurately reflected the conversations they had with the researcher. Two researchers (FB & GB) analysed all the data to help reduce the effect of personal bias. Triangulation (Mays & Pope, 2000) was made possible by using both semi-structured interviews and focus group discussions. Moreover, the inclusion of both parents and healthcare professionals' perspectives ensured a more detailed and richer understanding and description of the topics being considered in the research.

Data analysis

First, the parents' data from the interviews and focus group discussions was analysed in accordance with the principles of inductive thematic analysis (Braun & Clarke, 2006), which is to say that the researchers independently identified and coded all of the data. Following this, inductive clusters and categories were formed, which were then compared and discussed by both researchers. Through a process of consultation, we subsequently established a consensus over the relevant categories and key findings. Next, the key findings emerging out of the parents' data were used to stimulate conversation in the focus group discussions with healthcare professionals. Finally, the aforesaid analytical process was repeated for the healthcare professionals' data.

Ethical considerations

All respondents were informed about the aims of the study, either verbally and/or through an information letter. The respondents signed an informed consent statement agreeing to be recorded and were informed that their data would be processed anonymously by removing any identifying characteristics from their individual data. The Medical Ethical Committee of Amsterdam UMC (VUmc location) decided that the study was not subject to the Medical Research Human Subjects Act (WMO) and thus approval was waived (approval number IRB0000 2991).

Results

Two main themes that were subdivided into different topics emerged out of our analyses of the data from both the parents and the healthcare professionals, namely that parents expressed a desire for customized support, alongside highlighting the importance of establishing a trusting relationship with healthcare professionals. These themes were again subdivided into different topics.

A desire for customized support

There were two further sub-topics associated with the analytical finding pertaining to customized support, namely the importance of practical and specific support and the importance of culturally-sensitive support.

Practical and specific support

Generally speaking, parents were appreciative of their child's development being monitored by healthcare professionals at child healthcare centres. Especially for first-time parents, information on the growth and development of their child was the primary means through which they were reassured that their child was healthy and doing well. As one mother said:

> I like the [child healthcare center, RED] actually. You get answers to all the questions you have, and they are very friendly. She is being measured and weighed regularly, and that is really good, as that way you can follow the development of your children, see it on the computer. And that is quite comforting. (I-R15)

However, some parents felt that the advice provided by the healthcare professionals was too general and not specific enough to their personal situation. Therefore, they wanted healthcare professionals to be cognizant of their personal needs and to give them information and concrete instructions on how to do things, rather than being given general advice. An example of general advice in this context would be as follows: "It is time to start introducing your baby to fruits and vegetables". According to the parents in this study, such general advice would leave them wondering what kinds of vegetables were most suitable, how much vegetables they should give their children, and how the vegetables should be prepared. As one father noted:

> The information you get is just not adequate. Often, it's: yes, my child needs to eat well. Yes, I know that she needs to eat well, and needs to be physically active. And that the child has certain behaviors. But how should you deal with those behaviors? They never tell you. (I-R6)

The fact that parents often desired more practical and specific support was acknowledged and recognized by the healthcare professionals. For example, two nurses explained that while child healthcare centres provided parents with a singular information guide in the form of a booklet, which contains all the information they need for the period of 0–4 years, from their experience, handing out this general information guide when a baby is born can leave parents feeling like they have too much information at once. Some healthcare professionals also reported that they themselves at times wanted to provide parents with additional written information during consultations, which is more tailored to their needs, such as leaflets, However, they explained that they are no longer allowed by the organization to do this. Indeed, two healthcare professionals opined that they missed the newsletters they used to send to parents at specific developmental points, which included practical information about how to feed children when they are seven months old, for example, as they felt these provided more practical information at the precise time it was needed.

Supporting the inner resources of parents

Some parents felt that the healthcare professionals mostly followed guidelines when checking whether their child's data corresponded to general statistics and normative scales. In this respect, the parents explained that they felt as if the professionals were simply working "by the book", and that this approach failed to consider the personal experiences, preferences, and practices of the parents. Some parents said to simply follow their own intuition as a parent, which formed the basis of their choices about what they thought their child needed but was not always in accordance with the general advice of healthcare professionals. One mother said in this regard that:

> I think every child is different, they use the system as a starting point and check the lists that lie before them. And then, I just do whatever suits me. I follow [the advice, RED] if I like it and I don't follow it if I think: 'Well, yes, that just does not make any sense.' (I-R13)

The healthcare professionals recognized that most parents usually followed professional advice only insofar as it accorded with their own personal situation and preferences. In this respect, one of the professionals stressed the importance of being reflective about one's own frame of reference, noting:

> We are rooted in a certain framework ourselves. And it is good to be aware of that. That we do not necessarily know what is right. (FG2-R1)

Indeed, some healthcare professionals stated that they encouraged parents to trust their own intuition at times, specifically when it came to opting for practices that best suited the needs of their child. One of the professionals explained this as follows:

> My own children were not sleeping very well either, so I sometimes would say [to parents, RED]: you know, since I have children myself, I know that there are a lot of guidelines. But you need to look for the things that suit you and your child, because what's written in books does not work for every child. And when you say that, parents sometimes go like, 'oh, yes.'. (FG2- R5)

Culturally-sensitive support

Some parents expressed their desire for customized support that factored in their cultural values, religious beliefs, and practices. Indeed, some parents indicated that they would prefer a healthcare professional who was from the same cultural background as themselves. From their experience, the guidelines that professionals followed did not always correspond with their distinct cultural practices and norms, while some parents with a non-Dutch background felt that professionals did not always understand the reasons for their practices, what their values meant to them, and why they wanted to sometimes do things a certain way. The following extract from one mother testifies to this:

> I have been breastfeeding for quite some time. With the first, and now also the second, which makes them not sleep very well. I just woke up every hour. And my Dutch colleagues and healthcare professionals would say quite simply: well, why don't you just quit? And that is for us … I read somewhere that breastfeeding 'til the age of two is beneficial for children, and that is also the case in our religion. So, I really want to continue until they are two. It is just really hard to explain this to people who do not have the same culture or religion. (I-R17)

Many of the healthcare professionals reported that they were cognizant of how cultural differences differentially impacted on parental practices, as well as how the practices of certain cultural groups differed from their official professional guidelines. For example, it was noted that in some cultures chubby babies are considered to be healthy babies, and that this makes it more difficult to raise issues like childhood obesity. Many of the professionals stressed that they made every effort to adopt a culturally-sensitive approach, noting that they tried to acquaint themselves with other cultural practices by, for example, asking parents about practices they observe that they are not familiar with. One example cited by healthcare professionals was that they sometimes heard that grandmothers stayed at their children's house for a period of time after their grandchild was born. The healthcare professionals found out that this was an Islamic practice, in which grandmothers support their

children to look after their babies in the first 40 days following the birth.

However, some healthcare professionals noted that it was also important not to generalize within cultures, but rather to be cognizant that cultures are heterogeneous and, hence, that people can have divergent ideas on how to do things and how to care for young children. There are also family traditions and practices that are passed on within families. As a youth psychologist stated:

> Do not ask: 'how are things in your culture?', but rather ask: 'how are things in your home?'. Because not all Dutch, Turkish, or Moroccan people are the same. One is not like the other. Everyone has their own family culture. Dutch people do not always do things my way either. (FG1-R3)

A desire to establish a trusting relationship with healthcare professionals

With regard to the communication between parents and healthcare professionals and the importance of establishing a trusting relationship, there were two topics that emerged out of the analysis: firstly, the way in which the parental experiences of healthcare professionals themselves led to a trusting relationship. Secondly, how a general feeling of distrust from parents towards the child healthcare centre as an institution seemed to inhibited the development of a trusting relationship with healthcare professionals.

The parental experiences of professionals can help to facilitate a trusting relationship

Many parents wanted to know if the healthcare professionals they were in contact with had children themselves. Indeed, some appeared to have more trust in professionals who also had experiential knowledge. For example, one mother said the following:

> Look, you have midwives, for example, who do not have children themselves. So how useful is that for me? Or, if they have not had gestational diabetes themselves, for example. (I-R18)

This point was confirmed by healthcare professionals, who said that parents often asked them if they had children themselves, while some healthcare professionals explained that being a parent and expressing this to some parents did indeed help to establish a trusting relationship. As one nurse said:

> I have learned to use that. Because I have noticed that you get more of a … I am not sure what to call it, a sort of connection. (FG3-R1)

Many of the healthcare professionals recounted how sharing a personal story based on their own children was helpful in terms of displaying empathy towards parents. Moreover, some healthcare professionals observed that sharing one's own parenting experience helped to establish a personal connection and a more equal peer-to-peer type of interaction with parents, as one nurse explained:

> Also, to show them: I know how difficult it can be; been there, done that. Just to make them feel that you are both parents, who are on the same level and both struggle sometimes. To get out of the Ivory tower. To make contact as a peer. (FG2-R2)

Some professionals articulated that it was sometimes difficult to maintain the balance between their personal and professional identities during their interactions with parents. For instance, one of the youth healthcare physicians said that during her education as a doctor she had learned to maintain a professional distance, but that during her work with parents she had to learn how to connect on a more personal level via sharing some of her own personal experiences. One of the professionals explained to parents which specific advice she were giving parents was based on her own personal experiences, rather than upon official protocol. She said in this regard:

> It seems that people are more inclined to take your word [if you are a parent yourself, RED]. I think it is important that they know that some of the information I give is not based on protocols or my profession, but rather is based on my personal experience. I make that clear to them. And that is also the reason I want to keep that separate sometimes. But I just can't, if I get that question once or twice a week: do you have children? Then at a certain point you think: 'well, apparently it is important for them to know.' And that is also the reason I have switched. Because people need it. Not all mothers, but quite a lot do. (FG3-R1)

Some of the healthcare professionals who did not have children themselves utilized another technique to incorporate experiential knowledge into their guidance to parents, which, as one doctor explained, involved drawing upon the experiences of other parents:

> I have also tried: 'My experience with other mothers is … ', or 'During consultations I see that … '. That is still an experience, not from myself, but it is something I experienced or heard from others. (FG2-R2)

Feelings of distrust from parents towards the child healthcare centre as an institution

Some parents felt distrust towards the child healthcare centres as an institution. These feelings typically stemmed from warnings they had had from other people or stories they had heard from others about cases in which a child healthcare centre had facilitated the outplacement of a child. One of the parents described how she was warned about the child healthcare centre by a friend:

> Before I went with [name daughter] to the child healthcare center, I got tips from others: always agree with the child healthcare center. Don't mention any problems, because that is asking for more problems. (I-R6)

Some parents expressed that they found it difficult to share issues or problems with healthcare professionals, because they were unsure about what the professionals would do with this information, or if the meeting with the professional was designed to help them or was in fact about checking up on them. As one mother said:

> Sometimes I am genuinely scared to tell them things, honestly. I say to myself: 'If I tell them this, what will they do with that information?' (I-R17)

The healthcare professionals recognized the distrust that some parents felt towards them and the organizations they represented, which added an additional layer of complexity to their conversations with parents. Circulating stories about rare instances in which information from a child healthcare centre had led to the out of house placement of a child by the youth protection institutions were not helpful in this regard. As one nurse said noted:

> They always think we want to take their children away from them. (FG3-R1)

Also, some parents were suspicious that healthcare professionals had ulterior motives when asking them certain questions. For example, one mother said that the nurse from the child healthcare centre had asked her whether her family had plans to go on a holiday. It was her belief that the nurse wanted to know this as a means through which to assess if the family had sufficient financial resources to care for their child. When sharing this story with the healthcare professionals, one nurse expressed her surprise and explained that healthcare professionals ask every parent this question to ascertain if additional vaccines were necessary for their holiday. A youth psychologist reflected on the above example in a different meeting and noted:

> For example, with vaccinations, you need to explain why you are asking certain questions. I have had positive experiences when I openly discuss why I am asking things, that makes them understand me better. A question of whether or not they are going on holiday is quite implicit. Implicit as in: why would you want to know that? What do you want from me? (FG1-R1)

One healthcare professional observed that people who have recently immigrated to the Netherlands do not always fully understand what the child healthcare centre is and, as such, are often more suspicious of what nurses want to know than parents who are familiar with the healthcare centre system. She explained that language barriers can exacerbate such misconceptions of harmless conversations and, in turn, can undermine the trust between parents and professionals. This professional reminisced about a first meeting with a parent who did not speak Dutch, noting:

> That first conversation [with a parent, RED] did not go well at all, through the help of a translator on the phone. I really had to stress: 'I am not the boss; this is your child. I am not from the police, it does not work like that in the Netherlands. You are good parents. Is this a case of child abuse? It is not. So don't worry.' One step at a time. (FG3-R1)

Discussion

Our qualitative study sheds light on the desires and experiences of parents with young children pertaining to the support they receive from healthcare professionals, based on the perspectives of both parents and healthcare professionals. We found that parents welcomed and were receptive to support from professionals, particularly if healthcare professionals were speaking based on their own personal experience. The research also gave voice to specific suggestions for improvement raised by parents, which concerned the fact that the information parents received from professionals was not always practical and specific enough, and did not always fit with parents' own personal intuition or cultural practices and beliefs. Some parents also expressed feelings of distrust towards professionals and the institutions they represented, which appeared to derive from disturbing stories about child healthcare centres that circulated. The healthcare professionals were cognizant of most of the views and experiences articulated by parents in the research, but indicated that at times they felt bound to follow professional guidelines in their interactions with parents, which impinged upon their ability to provide tailored support.

In accordance with other studies, we found that parents expressed a desire for more customized support and appreciated this form of support above others (Ames et al., 2017; Hennessy et al., 2020; Sobo et al., 2016). In this respect, some parents felt that healthcare professionals were overly focused on following professional guidelines and doing things "by the book"; that is, checking the child's development against general statistics (such as percentiles of growth curves). This is consistent with the findings of two Swedish studies that demonstrated how some parents experienced the support they received from child health centres as being "standardized", overly directive (Edvardsson et al., 2011b), and in contradistinction to their own family's daily practices (Holmberg Fagerlund et al., 2019). This focus on medical norms and "normal" developmental criteria can

put a lot of pressure on parents to conform to these "benchmarks" (Lévesque et al., 2020). Our research is also in line with other research that has highlighted how professionals can sometimes experience a discrepancy between what the guidelines prescribe and what they want to do based on their own judgment (Hallberg et al., 2001). Through recourse to Habermas's theory of systems and lifeworlds (Habermas, 1987), one could view the child healthcare centres as a social system that is regulated by organizational routines, structures, and bureaucracy, which can potentially dominate people's personal "lifeworld" and their underlying personal and cultural norms and values (Habermas, 1987). The tension between the system and lifeworld was tangible in some of the parents' experiences, who reported that health guidelines operated as health checklists that overshadowed their own personal lifeworld. Interestingly, most of the healthcare professionals in our study appeared to be cognizant of the discrepancy between the directive health goals and the personal needs and experiences of parents. By recognizing the struggles that parents faced and attempting to relate to them as a peer by sharing their own personal stories and showing empathy, healthcare professionals can endeavour to bridge this gap between the healthcare system and parents' lifeworlds. We discussed elsewhere (Bektas et al., 2020) that parents appeared to weigh-up different kinds of knowledge in their attempts to help instil their child with "good practices": experiential knowledge, intuitive knowledge, scientific and theoretical knowledge, and knowledge that derives from social and cultural norms and practices (Bektas et al., 2020). Another consideration that parents must make when raising their child pertains to the influence of social and cultural norms and practices, and their attempts to raise a child who will be accepted as a "member of the society" in which they live (Ruddick, 1995). If healthcare professionals are able to recognize and acknowledge these ongoing considerations of parents, then this can aid their attempts to provide customized support and attune their recommendations to the lifeworld of parents.

Differences in cultural, family and personal beliefs and practices can also potentially create a gap between the views and advice of healthcare professionals and the specific needs of parents. In this research, we found for instance, that healthcare guidelines were viewed by some parents as "Dutch" practices that simply did not align with their own (cultural) practices or identity. The concept of cultural sensitivity seems to be relevant here, which is defined by Ahluwalia et al. (1999) as "The extent to which ethnic/cultural characteristics, experiences, norms, values, behavioural patterns of a target population as well as relevant historical, environmental and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs." (Ahluwalia et al., 1999, p. 11). Our study indicated that some parents with a non-Dutch background felt a lack of cultural sensitivity with regards to the support from professionals. This is in accordance with other studies, which have shown that parents from ethnic-minority backgrounds can feel that healthcare professionals need to be more sensitive, respectful, and open-minded in their interactions with parents from different cultural backgrounds than their own (Tavallali et al., 2017; Wiebe & Young, 2011). After all, health-related behaviours, such as dietary habits, are intimately connected to the development of one's social and collective identity (Carrus et al., 2018; Cleveland et al., 2009), and, hence, recognizing and acknowledging this is a key element of being culturally sensitive. In this respect, this study found that healthcare professionals did in fact acknowledge potential differences between prevailing public health norms and practices and the cultural, family and personal beliefs of people from ethnic-minority backgrounds, which is in line with previous studies (Bradbury et al., 2018; Edvardsson et al., 2009). For example, healthcare professionals from Ireland noticed that people from Traveller communities sometimes seem to value religious iconography more than science based medical interventions (Beirne et al., 2020). Also, as one of the professionals in our study also mentioned: it is important to be aware that while some practices have strong cultural origins, all families are unique and different, and often have their own family and personal practices that are rooted in their family history or their social contacts with others. It is therefore important to not only focus on someone's cultural background when understanding the lifeworld of parents. One reason that some parents feel there is little consideration of their own practices may stem from the institutional arrangements of the child healthcare centres themselves, which perhaps lack sensitivity towards a diverse range of practices (Valizadeh et al., 2017). However, more research in the Netherlands on this subject is required.

Other findings emerging out of our study underscored the importance of creating a more personal, trusting relationship between parents and healthcare professionals. Edvardsson et al. (2009) found that a strong relationship between nurses and parents helped in terms of discussing the sensitive issue of children being overweight. Several studies examining vaccinations also found that good interpersonal communication between parents and healthcare professionals was of paramount importance to parents (Ames et al., 2017; Dubé et al., 2016; Sobo et al., 2016). It is also well-established that parents with young children are at times insecure about their parental practices (Bektas et al., 2020; Henshaw et al., 2018) and, consequently, benefit from reconfirmation and empathy from healthcare professionals (Hennessy et al., 2020). In this respect, our findings show that parents want to open up and share their parental struggles with healthcare professionals and, in return, want to be understood

and advised by someone who understands from their own personal experience precisely what the parents are going through. Similarly, the healthcare professionals in this study recounted that sharing a personal story or acknowledging that they themselves were parents strengthened their interactions with parents. This is in accordance with the findings of Burns and Schmied (2017), who also found that midwives and trained peer-counsellors routinely engaged in self-disclosure to connect with the mothers they visited. Hunter (2006) described similar situations, in which self-disclosure by midwives was "considered to be a valuable form of empathy" (Hunter, 2006, p. 318). Such mutual exchanges of personal experiences between parents and healthcare professionals can be regarded as a form of reciprocity, which contributes towards the development of more equal social relationships and collaborative partnerships with clients (Hunter, 2006). However, as we will argue further on in this discussion: there is inherently an uneven relationship between healthcare professionals and parents, and establishing a more personal connection might make it more easy for professionals to enact control over the practices of parents. Feelings of distrust can impinge upon the building of trusting relationships, and we found that sometimes there are misunderstandings in the contact between parents and healthcare professionals. Open and clear communication about why certain information is required would help to prevent these types of misunderstanding that can gestate and subsequently result in feelings of mistrust. Moreover, clear communication about what parents should realistically expect to get out of their interactions with child healthcare centres might also clarify for parents precisely what sort of support they can expect to receive, so that they have realistic expectations from the outset about how customized the support is likely to be. Of course, time is also an integral factor in this respect, and a study from the Netherlands found that parents expressed that there was too little time to ask questions during the consultation (Harmsen et al., 2015) Also others founds that there are time constraints on the consultations that healthcare professionals have with parents (Edvardsson et al., 2011a; Hennessy et al., 2020), which inevitably hinder their ability to attune their service to the specific needs of parents and establish a fruitful relationship. Also, healthcare professionals often experience language barriers in their contact with people from a different cultural background (Gerchow et al., 2020), which may cause misconceptions (Joo & Liu, 2020) and prohibits establishing a close relationship (Beykmirza et al., 2021).

This study also found that some parents were suspicious of the potential ulterior motives of healthcare professionals and their institutions. The fear of parents that healthcare professionals will report them to social services, is not unfounded as there is an unequal power relationship between parents and healthcare professionals: healthcare professionals in the Netherlands can intervene if they have concerns about the well-being of children (see also Knijn & Van Nijnatten, 2011; López et al., 2019). The Dutch child welfare system bears similarities with the Child Welfare Services in Norway and Sweden, and a studies from these countries also describe feelings of distrust by parents (Korzeniewska et al., 2019; Vassenden & Vedøy, 2019). Hallberg et al. (2001) describes how some parents experienced the check-ups by child healthcare services as a form of "surveillance", and immigrant families living in Norway expressed feeling controlled, watched and disempowered (Tembo et al., 2020). In general one could argue that through Child Welfare Services, the government sets the norms with regards to child welfare and child rearing practices, leaving little room for alternative beliefs and practices of parents.

Strengths and limitations

There are several strengths and limitations of the present study. One notable strength is that by including the perspectives of both parents and healthcare professionals, we enriched the extant understanding of how both parents and professionals experience their interactions with one another. By shedding light on parents' experiences of the support they receive from healthcare professionals, we were able to draw attention to underlying miscommunications and misconceptions, such as the reason behind why healthcare professionals ask parents about potential holiday plans. Another strength of our study was that one of the principal researchers was born and raised in the neighbourhood of this research and, hence, had a deep understanding of both the area and its inhabitants. This proved to be important insofar as it made respondents more willing to participate in an interview in the first place. The background of the principal researcher seemed to create a climate in which the respondents felt easily comfortable and secure. This had a positive influence on the level of openness of the respondents and provided us with a deeper understanding of the community. However, being perceived as an insider had the disadvantage that there was a sense of "quick understanding" between the respondents and the interviewer which led to the expectation of the respondents that the interviewer would readily understand them, which made them less inclined to elaborate on some issues. The language skills of the principal researchers also made it possible to interview some of the parents in either Turkish or English if this proved to be more convenient for them. The researchers could not speak Arabic, which might have affected the participation of parents with a Moroccan background. Because we excluded parents who were not able to speak Dutch, English or Turkish, we might have specifically excluded parents that recently immigrated to the Netherlands. One focus group discussion was held in English, to accommodate parents who did not speak Dutch. However, as

English was not the first language of these parents, this may have limited their ability to talk freely, and it may have affected the depth of the data that was collected.

With respect to the other limitations of the study, there was a underrepresentation of fathers in our sample, who we found to be more difficult to recruit in our research site. This could be explained by the fact that most fathers had full-time jobs and thus were less inclined to participate because of time constraints, according to their spouses who participated in our study. Another study in the Netherlands regarding parents with an ethnic minority background, also had an underrepresentation of fathers in their study (Van Mourik et al., 2016), which seems to be the case in most research regarding child health research (Davison et al., 2017; Reisz et al., 2019). As fathers might have different experiences, additional research is needed to understand the perspectives of fathers more in-depth. A further limitation was that the majority of the parents who took part in the study had studied at graduate schools or universities, which is not representative of the general educational level of the entire district, and, hence, the findings may not be generalizable to all people in the community. The next limitation concerns the amount of healthcare professionals we were able to recruit in the relatively short time period in which the study was conducted. As one would imagine, the healthcare professionals who work at the child healthcare centres have busy schedules and ordinarily do not have a lot of time to sit down for an extensive interview. Moreover, given the time constraints on the focus group discussions, the researchers were also not able to elaborate on all topics in the desired depth. Also, the data presented in this article was part of a larger exploration study on the experiences and needs of parents, and their perspectives on the support of professionals were not the only focus during the interviews. For a more in-depth understanding of the topics we raised in this article, more research is needed.

Conclusions

Overall, we found that parents with a child aged 0–2 years appreciated the support they received from healthcare professionals, but expressed a desire for this support to be more specific, practical, and suited to their needs, wishes, personal preferences, and cultural backgrounds. Although the healthcare professionals recognized the legitimacy of parents' needs, they stressed that they were bound to adhere to professionals guidelines and policies, which at times may be in contradistinction to the needs of parents. This study also demonstrated that the manner of communication between parents and professionals was of importance to how parents experienced the support they received from professionals. Establishing rapport and trust between professionals and parents was shown to be integral to fostering a beneficial relationship. The research identified several recommendations for how to establish this trust and rapport, namely that professionals could attempt to relate to parents as peers by drawing upon their own parental experiences and concerns, openly addressing and seeking to dispel any potential misconceptions or distrust, and embedding cultural sensitivity within their daily practices. Shifting demographics and the emergent cultural heterogeneity of the Netherlands is something that may needs to be factored into the educational training of healthcare professionals. Conducting further research into some of these aforesaid issues is essential, given that the provision of effective and customized support to parents with young children now can help to prevent manifold health-related disparities in the future.

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Appendix A

Table AI. Characteristics of the parents who participated in the study (total N = 38).

Female, n *(%)*	36 *(94.7)*
Male, n (%)	2 (5,3%)
Number pregnant at time of interview, n *(%)*	3 *(7.9)*
Age in years, mean *(range)*	31.2 *(22–41)*
Education level, n *(%)*	
Low	3 *(7.9)*
Middle	10 *(26.3)*
High	17 *(44.7)*
Missing data	8 *(21.1)*
Ethnic background, n *(%)*	12 *(31.6)*
Turkish	8 *(21.1)*
Moroccan	6 *(15.7)*
Dutch	12 *(31.6)*
Other ethnicities	
Country of birth	
The Netherlands	27 (71,1)
Other	11 (28,9)
Living with, n *(%)*	3 *(7.9)*
Extended family	35 *(92.1)*
Nuclear family	
Number of children, n *(%)*	21 *(55.3)*
1	12 *(31.5)*
2	3 *(7.9)*
3	2 *(5.3)*
4	
Age of infant in months, mean *(range)*	10.0 *(2–24)*
Age categories of infants, n (%)	3 *(7.9)*
0–3 months	10 *(26.3)*
3–6 months	7 *(18.4)*
6–12 months	18 *(47.4)*
12–24 months	

Appendix B: Interview guide with parents about lifestyle-related behaviours

Food

- How are you getting on with feeding your child?
- Are you breastfeeding or bottle feeding?
- What and how much does your child eat?
- Why did you decide to breastfeed or bottle feed your child?
- What was the transition from liquid to solid food like?
- When did you start giving your child solid food? What did you give them? What kind of problems did you experience? What kind of problems are you experiencing in relation to feeding?
- What influences the type of food and drink you give your child?

Sleep

- How are things going with your child's sleeping?
- How does your child sleep? Do you think your child is getting enough sleep?
- What do you do to get a better night's sleep?
- What kind of problems are you experiencing in relation to sleep?

Physical activity

- What kind of activities do you do with your child?
- Do you think your child is active enough?
- What kind of physical activities do you do with your child?

Screen use

- What do you think about young children using screens?
- Do you use a screen? When or why do you use a screen?
- How long should a child watch TV or use other electronic devices with a screen?
- Do you put any limitations on screen use?

Daily struggles

- What problems do you face when it comes to caring for your child?
- What type of information do you need about caring for your child?
- Do you receive support in caring for your child? Who from and what kind of support?
- How does your environment influence the healthy growth and development of your child? (barriers and facilitators)
- What do you need to stimulate the healthy growth and development of your child?

Perceived support

- Who gives you support in caring for your child?
- Who can you talk to if you want to discuss concerns about your child's health or behaviours? (other parents, family, professionals)

Health status

- How would you describe a healthy child?
- What role do food, sleep and physical activity play in the healthy growth of your child?
- How would you assess the health status of your child?

Health status (green cards)
S. If parents eat healthy food at home, a child will adopt the same behaviour.
S. It is not a matter for concern if an infant/toddler is chubby; he/she will grow out of it.
S. Watching TV is good for a child's development.
S. If children are overweight during infancy, they are usually overweight when they are older.

Motherhood (pink cards)
Q. How healthy do you feel? (How would you describe your own health?)
Q. As a mother, how do you know what your infant needs?
S. As a mother, you put the interests of your child first: your own health is less important.
Q. How would you describe your maternal instinct?

Fatherhood (blue cards)
Q. In what way is your husband involved in the care of your child(ren)?
Q. What is the role of a father during pregnancy?
Q. How would you describe the influence of your husband on your child(ren)?

Extended family (yellow cards)
S. If my mother/mother-in-law gives my child something unhealthy to eat, I don't say anything about it.
S. I accept my mother's advice on motherhood.
Q. What is the role of the extended family (grandmothers/grandfathers/uncles/aunts) in your children's health?

Cultural influences (purple cards)
Q. Does the advice you receive from Dutch healthcare providers fit in with your own culture?
Q. What cultural differences are there when it comes to how you care for or bring up your infant?

Statements or questions used during focus group discussions with parents.

S = Statement

Q = Question

Findings that derived from the data with parents and the questions used during focus group discussions with healthcare professionals

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(1) **Parents express a need for: information in the right moment, which is practical and specific and fits with their own personal ideas and intuition**

(2) Parents value support from people with experiential knowledge, and whom they trust

(3) Parents generally appreciate occasional health check-ups by healthcare professionals, especially from professional they know more personally.

(4) What parents find important in their contact with healthcare professionals is:
- **A non-judgemental and emphatic attitude**
- **Flexibility when it comes to national health guidelines**
- **Support that is tailored to their own child, not based on general statistics.**

(5) We heard some example of miscommunications in the contact between parents and professionals. For instance, about why health professionals would like to know if the family is going on a holiday.

Examples of questions:
- **Do you recognize these issues? What are your thoughts on this?**
- **What are your own experiences with regards to the issues we raised?**
- **What do you find important when providing support to parents?**
- **How do you attune to the needs of parents?**
