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Elements of cultural competence in an Australian Aboriginal maternity program

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ABSTRACT

Background: Pregnancy, labour and neonatal health outcomes for Australian Aboriginal women and their infants are frequently worse than those of the general population. Provision of culturally competent services may reduce these differences by improving access to timely and regular antenatal care. In an effort to address these issues, the Aboriginal Maternity Group Practice Program commenced in south metropolitan Perth, Western Australia, in 2011. The program employed Aboriginal Grandmothers, Aboriginal Health Officers and midwives working in a partnership model with pre-existing maternity services in the area.

Aim: To identify elements of the Aboriginal Maternity Group Practice Program that contributed to the provision of a culturally competent service.

Methods: The Organisational Cultural Competence Assessment Tool was used to analyse qualitative data obtained from surveys of 16 program clients and 22 individuals from partner organisations, and interviews with 15 staff.

Findings: The study found that the partnership model positively impacted on the level of culturally appropriate care provided by other health service staff, particularly in hospitals. Two-way learning was a feature. Providing transport, team home visits and employing Aboriginal staff improved access to care. Grandmothers successfully brought young pregnant women into the program through their community networks, and were able to positively influence healthy lifestyle behaviours for clients.

Conclusion: Many elements of the Aboriginal Maternity Group Practice Program contributed to the provision of a culturally competent service. These features could be considered for inclusion in antenatal care models under development in other regions with culturally diverse populations.

Statement of significance

Problem

Lack of access to antenatal care is a major reason for the differences in health outcomes that exist between Aboriginal women and their infants compared to the general population.

What is already known

Culturally competent antenatal care is one way to improve access and therefore health outcomes. Such care may include Aboriginal staff employment, transport and home visits.

What this paper adds

A culturally competent antenatal care model can positively influence practice among hospital maternity ward staff and community health service providers. Employing well-respected Aboriginal Grandmothers was an identified strength not previously reported in an urban Australian setting.

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1. Introduction

Insufficient or late antenatal care is a risk factor for numerous pregnancy, labour and neonatal complications, and is one explanation for the poorer health outcomes observed for Australian Aboriginal women and babies.[1] Aboriginal women are less likely to attend antenatal services for numerous reasons including lack of trust, long waiting times, poor communication, previous negative experiences, and duplication of services.[2,3]

Planning commenced for the Aboriginal Maternity Group Practice Program (AMGPP) in the South Metropolitan Health Service (SMHS) of Perth, Western Australia, in 2009. The need for the program was identified by local Aboriginal community members, who voiced concerns that many women were presenting late in pregnancy for antenatal care or not receiving antenatal care at all. Implementation of the program was made possible through funding from the federal government as part of the *Indigenous Early Childhood Development* initiative. The AMGPP was designed by local Aboriginal community members through planning and implementation steering groups initiated by the program contract manager, the South Metropolitan Population Health Unit (SMPHU), which has a well-established Aboriginal Health Team. Community members wanted the program to improve access to the pre-existing maternity services in the SMHS.

Perth is the fourth most populous city in Australia and is located on the west coast. The SMHS spans all of south metropolitan Perth, an area of almost 5000 km^2, and the traditional owners of the land are the Noongar people. Aboriginal people comprise 1.8% (n = 15,504) of the population[4] and 3% (n = 373) of births.[1] Although the boundaries of the SMHS have changed as of 1 July 2016, over the course of the study period the SMHS region was further divided into five health districts. Each district had a local hospital providing a mix of services, including maternity care. SMHS hospital policy mandated referral to the state tertiary maternity hospital, King Edward Memorial Hospital (KEMH), for all women with insufficient or late antenatal care. As a result, prior to commencement of the AMGPP, unnecessarily high proportions of Aboriginal women residing in the SMHS birthed at KEMH (between 52.4% and 59.6% before 2009), despite its location outside of the geographic boundaries of the health service region.[5]

Birthing on ancestral lands – the concept of *Birthing on Country* – is vital to the health and wellbeing of the mother, child and family, and is highly culturally and spiritually significant. Traditionally, Noongar society was and remains a collectivist culture, with the extended family including grandmothers and aunties playing a crucial role in maternity care. For example, grandmothers are pivotal to the birthing process. Traditionally, grandmothers often played the role of birth attendant and midwife, as well as carrying out practices that would support the spiritual, physical and emotional development of the child. Grandmothers play the role of parent and, dependent on the relationship and gender of the infant, they may become the lead in the child's development in certain areas, such as teaching and story-telling. In contemporary society, they bring the experience and knowledge that has been passed down from generation to generation.

The inclusion of the grandmother role within the AMGPP model was an attempt to recognise and incorporate aspects of this important relationship. One or more Aboriginal Grandmothers were employed in the program that operated within each district as part of a common core model that also employed Aboriginal Health Officers and midwives. The Grandmothers working in the AMGPP were respected local Elders whose role was to provide cultural support, pregnancy and parenting advice, advocacy, and transport. The Aboriginal Health Officer worked with the midwife to perform home visits, organise appointments, provide health promotion advice (including workshops), and refer to or liaise with other services. Although in some districts staff were occasionally able to attend births at the request of a client, due to resource constraints this was not a component of the common core model.

Clinical governance for the program was provided by the midwife either alone or in partnership with other antenatal care providers in the community or district hospitals. Practices adhered to local health service operational directives and protocols. Cultural governance was provided by the Grandmothers, Aboriginal Health Officers, and local community members who sat on AMGPP steering groups in each district. The steering groups met quarterly and guided the development and operation of the program, with six Aboriginal community members sitting on each steering group. An area wide forum was held six monthly where members of the steering groups could meet and share experiences. *Yarning* was used as a tool by the Grandmothers and Aboriginal Health Officers to provide health promotion advice for program clients. Yarning is a form of culturally appropriate conversation that is used by Noongar people to share stories and information.[6] All SMHS staff are now required to complete an Aboriginal online cultural learning package. Moreover, as none of the AMGPP midwives were Aboriginal, all of them underwent additional cultural awareness training to maximise their capacity to provide culturally competent services.

There were other common elements in each of the five district programs, including the provision of health promotion workshops, brief interventions for smoking and alcohol cessation, and transport to appointments. Partnerships were integral in all districts, with program partners including local community health service providers (such as general practitioners, obstetricians, child health services, imaging services and pathology services), and providers of social services (such as relevant government agencies, and organisations providing financial or housing assistance). Program staff assisted clients with accommodation, financial, or administrative issues through care coordination processes including referral to relevant partner organisations. There was a degree of autonomy in each district in order to account for the holistic needs of the local community and pre-existing differences in the delivery of maternity services. Consequently, there was some variation in services provided between districts, including the provision of hospital tours in the antenatal period (two districts), home visits (four districts), walk-in clinics (one district), outreach clinics (two districts; settings varied by district including women's refuges and Aboriginal community centres), providing ambulance cover (two districts), mothers' groups (three districts), and a playgroup (one district). Additionally, the program influenced other hospital activities in some districts, such as the refurbishment of a room on the maternity ward of one hospital to accommodate Aboriginal families, and the provision of hospital wide cultural awareness training by staff in one district.

There was a community view that access to the pre-existing antenatal services in the SMHS could be improved if the AMGPP staff could influence and improve the cultural appropriateness of the care provided. Culturally appropriate midwifery care is an ill-defined concept, and it is not always clear how it can be achieved, but there are two main approaches that have been identified in the literature.[7] The first focuses on the values, beliefs and traditions of a certain group of people, but has been criticised for its lack of acknowledgement of diversity within groups. The second approach takes a broader view of culture, focusing on the influence of the social determinants of health including the impacts of colonisation and its effects on social position.

The latter view is used in this study to describe elements of cultural competence of the AMGPP services. Cultural competence defines a set of consistent and culturally appropriate behaviours or policies existing in an organisation or other group of individuals

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