Achieving Cultural Safety in Australian Indigenous Maternity Care

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Abstract

Background: Indigenous populations suffer poorer maternal and infant health across the Australian nation, also affecting populations of SE Australia. Representing less than 2 % of the population in southern Victoria, Indigenous mothers and babies demonstrate disproportionately high healthcare problems, compared with mainstream communities. These worse outcomes provide evidence that midwives and health systems who care for Indigenous mothers and babies are failing them. **Aim:** The project sought to examine what practices healthcare workers in a maternity service employ to support Indigenous women though maternity care. The aim was to examine where barriers and complexities challenge their practice. Revealing the successful and positive strategies used will be pertinent to how current maternity care provision, can facilitate greater access and quality within services. **Method**: an ethnographic form of qualitative enquiry was employed to gather data form 9 participants. **Findings:** This study reinforced the importance of culture, respect, and therapeutic relations for productive communication strategies in an Indigenous maternity service. **Conclusion:** Improvements in Indigenous maternal healthcare may be found in approaches which utilise cultural safety and support health carer's working within organisations to address cultural needs of every client.

Keywords: Maternity care, Cultural sensitivity, Indigenous Health carers, Cultural safety, respect, Indigenous Australians

1. Introduction

Providing cultural appropriate services in maternity care is becoming more and more of a concern. This is because if the service is not deemed culturally appropriate to women they will fail to attend.

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Often these are women from minority groups who are at increased risk of childbearing complications and therefore more crucial that they regularly attend such service (Pairman, Tracy, Thorogood and Pincombe 2010). This is particularly the case for the Aboriginal and Torres Strait Islander or Indigenous populations in Australia. Culturally appropriate maternity services are therefore crucial in order to enhance personal empowerment and as a result, provide more attractive and effective maternity services for Indigenous people.

The statistics, which are supported by Kildea, Kruske, Barclay & Tracy (2010), suggest that significant issues in service provision are resulting in inadequate and ineffective support for these Indigenous women and infants in rural Victoria. Currently the mainstream westernised health system (Kruske, Kildea & Barclay, 2006) provides care to the majority of the ethnic and Anglo-Australian population. The diverse cultural groups of the population are often inappropriately cared for (Johnstone & Kanitsaki, 2007) and many health professionals fail to recognise the dominant healthcare systems failures in responding or accommodating minority population values and beliefs (Adams, 2010) or the damage inflicted during these encounters (Blackmann, 2011).There is a need to find better ways forward through collaboration with Indigenous people (Kelly, 2006) and respecting cultural diversity in health practices (Blackman, 2011).

Being culturally appropriate, however, is more than being culturally sensitive or having a cultural awareness. Both of these terms refer to having an understanding that there are cultural similarities and differences between groups, and about people being open and flexible. According to Bin-Sallik (2003) cultural safety is developing cultural sensitivity and awareness further. This can be appreciated from the definition of cultural safety, which is "An environment that is spiritually, socially and emotionally safe, as well as physically safe for people … it is about shared respect, shared meaning, shared knowledge and experience of learning together" (Williams, 1999, p 213). Cultural safety is than about empowering people and facilitating the achievement of positive outcomes by recognising cultural identity and the impact of personal culture on professional practice (Bin-Sallik, 2003).Health practitioners are encouraged to understand and remain unbiased in their care. Cultural safety cannot be provided in a context of treating all clients the same way (Eckermann, et al, 2009) as this denied cultural differences and the ethnic, gender and many cultural beliefs they hold. Being culturally safe is recognised as the way forward to closing the Indigenous health gap (Australian Government, 2009).

2. Health Disadvantage Background

National and local indicators demonstrate Indigenous women and babies have not experienced equal health and welfare status compared to the rest of Australian society. Across Australia Indigenous women receive fewer antenatal health visits, less access to maternity services and, too often, culturally inappropriate care (Reibel& Walker, Henderson & Kendall, 2010). The differences in expectations of care by the Indigenous women, (Graham, Pulver, Wang, Kelly, Laws et al., 2007; Willis, Dwyer, Owada, Couzner, King et al., 2011), poorer perinatal outcomes (Sayers & Boyle, 2010; Hancock, 2007; Mohsin, Bauman, Jalaludin, 2006), challenges in health practices, and failures in service provision for Indigenous women within mainstream Australia are well documented (Smith, Edwards, Martens, & Varcoe, 2007; Burns, Mailing & Thomson, 2010; Pyett, Waples-Crowe & van der Sterren, 2008; Rumbold, Baille, Si, Dowden, Kennedy et al., 2011). In addition, Australian Indigenous females are much younger overall than the general population. Almost half the Indigenous female population was below 20 years by ABS predications at the end of 2011 compared with total female population of 25% (Burns, Maling & Thompson, 2010).

The local shire statistics for the area understudy identified 369 Indigenous persons, representing 1.9% of the total population, which was higher than the general Victorian percentage of less than 1.0% (Department of Education and Early Childhood Development, 2010a). The Local Shire Indigenous Community Profile (Department of Education and Early Childhood Development, 2010a) presented comparable data to the State for childbearing Indigenous women. The median age for Indigenous mothers was 24 years compared with 30-34 in the general female population. Higher fertility rates existed in all age groups, but particularly fertility rates for teenage Indigenous women was 4 times above the general female teenage population. Figures for the Southwest of Victoria reveal Indigenous women have babies at a younger age and are 5 times more likely to have a low birth weight baby (below 2500g) than non-Indigenous women. Low birth weight infants suffered a 2.6 times increased mortality rate, and higher morbidity rate, including greater likelihood of hospitalisation for infectious condition, respiratory, circulatory, ear, dental and parasitic disease(Burns, Maling & Thompson, 2010).

These figures provide evidence that midwives and health systems who care for Indigenous mothers and babies are failing them.

Local reports have revealed cases of culturally inappropriate care within regional health and welfare services (Local Community VACCHO, 2011). Reasons for Indigenous mothers failing to access or participate in regular antenatal visits, maternal and child health reviews have not been fully explained or investigated (Department of Education & Early Childhood Development, 2010b,) and continue to be problematic. There remains a need to find better ways forward through collaboration with Indigenous people (Kelly, 2006) and respecting cultural diversity in health practices (Blackman, 2011).

The project sought to examine where barriers and complexities challenge midwives and health carers in their practice. Revealing the successful and positive strategies used will be pertinent to current maternity care provision, potentially facilitating greater access and quality within services.

3. Methodology

This study employed an ethnographic form of qualitative inquiry to explore the practices of healthcare workers providing maternity care within an Indigenous community. This study was based at a rural site in Victoria. It aimed to explore the issues Indigenous healthcare providers face in addressing the multiple factors which contribute to Indigenous women's childbearing support and outcomes. Ethics approval from Human Research Ethics Committee at RMIT University was received for the project. Recruitment of participants for study was achieved through convenience sampling as described by Burns and Groves (2007). This included those who agreed to participate, primarily the midwife and Indigenous Health Worker employed at the selected research site. Sampling continued until all available participants had been selected and data saturation reached, which was 9. The participants' inclusion criteria were that they were employed for at least one year as healthcare professionals or trained staff involved with maternity or newborn care of Indigenous women. These participants's role in maternity care was either administrative or clinical capacities. Identifiable data was carefully removed from the final report to ensure confidentiality and anonymity of every participant and their position.

4. Data analysis and Interpretation

The ethnographer uses description to report the interaction and events within a cultural group (Holloway & Wheeler, 2010). Interviews were transcribed verbatim. Lengthy analysis of the data required a process of ordering data into manageable and meaningful sections or categories to make sense of what was going on. The researcher compared and contrasted these categories in search of relationships to further order the subcategories together into well-structured themes.

The analysis and interpretation was not a systematic progression through each stage of inquiry and each phase was revisited multiple times occurring simultaneously with the interviewing process. Ultimately themes and explanations supported by the data were presented as the findings. The interpretation and critical discussion of findings was then compared with the literature (Streubert & Carpenter, 2011) to share what was learnt by the researcher

A number of themes were identified and explored in the project. This paper will discuss only the theme surrounding cultural safety.

4.1 Respect Needed

Participants reported the importance of developing therapeutic relationships with Indigenous women in order to make the service work. Empathy toward culturally marginalised peoples and deep understanding of cultural safety was consciously developed and promoted over time. Most spoke of the privilege to work within the Indigenous community, displaying a tangible concern for Indigenous health.

People working here have a Deep Interest in Indigenous Health. (Participant G)

In addition the need to acknowledge cultural etiquette and practices as part of caring for Indigenous clients was stated by the participants. The health workers also had a particular awareness of the importance of appropriate communication and remaining non-judgmental, open and honest throughout the consultation process.

Verbal communication was acknowledged to be a complex process by most participants.

Specifically, respectful communication was frequently repeated as important when dealing with Indigenous populations. An awareness of cultural issues and being sensitive to these was needed, whilst being prepared to learn about cultural rituals or beliefs for non-Indigenous staff was essential.

> *It's not necessarily understanding but it's an attitude, I don't know how else to describe it, it's being respectful for what they wish and you ask the question "is there anything I should be doing for you"…"I'm willing to learn and I want to help you but if I'm doing something wrong please tell me; because I don't want offend you."* (Participant C

One important example of awareness of cultural issues was remaining sensitive during health assessments. Health providers had to be able to assess some illnesses as being a part of the client's cultural views and be careful not to assert a diagnosis as a simple biomedical judgement. For instance;

> *It's like asking an Indigenous person about their mental health, "Do you hear people speaking to you?" That's part of their culture that the spirits speak to them. So do you diagnose them with schizophrenia because they're hearing voices…?* (Participant B)

In addition the inclusion of culturally thoughtful approaches within carer-client communications was noted by participants. For instance health workers discussed the manner used to deliver their message to the Indigenous women. Some described communication as having a "chinwag"; taking care not to push advice but offer supportive information and being realistic about the consultation outcomes. In addition, the participants at times were entrusted with personal information from the client who understood it would not be taken further without the client's decision to do so. Indigenous women were reported as sometimes shy or wishing to remain distanced from medical professionals who they could not identify with. That situation was managed by advocating for the woman's needs.

> *There's that trust because I've worked on it but I mean the openness, the things that comes out blows my mind.*
>
> *The things I do is refer to the right people because I'm just a support worker, to me I'm a support worker to advocate and to lead down the right paths and be there for them, you know, practice primary health care but, um, I can't go no further. That's my, that's as far as I can go…* (Participant E)

To build further knowledge and maintain the respectful healthcare environment, a reciprocal relationship between staff and the Indigenous community had developed. Whilst caring for families the staff demanded in return a level of respect and behaviour within the facility. Occasionally situations had led some clients being temporarily refused entry to the premises whilst restraining orders were in place. This was not used however to disadvantage the client from healthcare or supports, but ensured the safety of other clients and staff. In other words;

We treat people with respect and we expect them to treat us the same. (Participant G)

Another essential aspect of working in appropriate ways with the Indigenous women meant ensuring those clients were received in a compassionate manner within the service encouraging them to keep using the health system. This included a number of strategies as identified in the following;

it's around having plenty of Indigenous staff and non-Indigenous staff to work with these people, that they feel happy about coming through the front door, that they're welcomed, they're embraced, they're listened to, they're respected, people communicate with them, (Participant G)

4.2 Understanding the Issues

All participants reported promoting a relaxed and flexible service as conducive to cultural safety. Knowledge of culturally appropriate practice that embraced the client and a deep compassion for Indigenous people's plight was clearly communicated. It was important therefore to;

…develop an intimate understanding of the issues that have brought indigenous people to where they are now in terms of their health status and how they got there and therefore the things that you need to be really sensitive to when, you're in a consultation with an Indigenous person. (Participant F)

Taking all of the issues into consideration there was a need therefore to develop strategies which could effectively assist Indigenous childbearing clients. For instance, healthcare staff demonstrated a commitment to engage the woman and her family through supportive partnerships which monitored and protected them from missing appointments or follow up.

Staff would accommodate the woman by offering different personnel if she preferred or reassurance of the importance to have maternity care. The following are some of the examples of what participants did.

So definitely, I always ring a lot and a lot of reminders and a lot of cards and stuff like that but it's working. If it's working you're going to keep doing it. (Participant E)

We'll send somebody else who can try again and see who we can get in the door because we want the care for the children and we don't want them to have a DHS referral because they haven't linked with services. (Participant C)

Another way staff would accommodate the women was by setting realistic goals between the client / family unit and the health provider. This process meant no-one was superior or in charge of the direction of care thus avoiding issues of cultural dominance or patient compliance.

You need to have collaboration with your patient it is about working out mutual goals that are achievable for both. (Participant F)

4.3 Non-Verbal Cues

One of the important aspects that participants related was that communication between client and carer contained a non-verbal element in which the demeanour of the Indigenous woman needed to be observed to assess her comfort within the situation. For instance, the health professional may consciously assume a non-authoritarian position to enhance a consultative process. One participant stated as an example of this that they were aware of their client's body language and used it as an indication of the therapeutic interaction and response by the woman.

It depends how the client is feeling and we go on their cues whether we do to the invasive stuff or not. So, um, it's really up to the client and putting them back in control of their bodies and their health. (Participant C)

In addition there may be instances in which the consultation dynamics suddenly change due to underlying past events or assaults suffered by the client. One participant discussed their conduct in these particular situations as accepting without judgment of the woman's defensive behaviours and responding in a reassuring manner.

…that really needs to be taken into account and it cannot show it cannot rear its head, and then all of a sudden just be there in your face, and the person's demeanor changes and everything changes because, you know, there's something historical that's had an effect on why they're making a particular decision. (Participant F)

Participants commented that another strategy they used was adopting a neutral position in relation to the Indigenous woman. They felt that this may assist the health professional in calming a client and encourage equality and mutual respect within the carer-client relationship.

> *And, and it's body language too, you know, I quite often kneel down on the floor if somebody's, sitting on a chair, I might kneel on the floor just so I'm not that dominant or, depends how nervous they are. Other times I'm fine, I can stand face to face or, depends how they're responding to me.* (Participant C)

4.4 Coming from Another's Perspective

In order to achieve a therapeutic relationship, participants commented that they practised individualised care for each client situation using a consultative and thoughtful approach. This involved two way communications demonstrating an understanding of each other's values and differences between cultures. For instance some non-Indigenous health carers would seek feedback on the appropriateness of care in order to ensure a positive rapport was gained.

> *First six months of my job, probably eight months you could say and that was because the community needed to know who I was and that's when I started networking then with other agencies and getting them to know who I was because first I had to get to know the community.* (Participant E)

Further instances of understanding Indigenous cultural beliefs and values required the health professional to acknowledge different parenting styles and cultural practices in rearing children. The participants acknowledged the strong bonds that people who are Indigenous had between family members and kinship beliefs toward mothering and children. Indigenous people were very family orientated and valued each other's children as their own. Kinship to Indigenous peoples means in their society everyone has a place and relationship with all other members of their group. The family is not a traditional western nuclear family but a broader extended family structure of various arrangements that nurtures the young and respects the elders. This connectedness and relationships ensure that everyone is looked after. Terms such as Aunt and Uncle or Brother and Sister acknowledge this acceptance of a place within the family. There is a tendency toward communal participation in parenting and childrearing. The following quote is an example of how this happens.

They just have someone watch the kids. Yeah a lot of the time it's the community helping each other. (Participant A)

Another differing perspective outlined by the participants was to do with entry to homes for visits. Indigenous peoples treated their home as a safe place and health care staff had to be aware of the privilege and be invited into this private area to support antenatal or postnatal care. The Indigenous women would reveal as much of their home situation as they felt comfortable and in return the staff would support and protect this choice. This included health providers being denied access if the woman was distrustful.

I had doors shut in my face and that because they didn't like the fact of whatever happened here with this health service in the past, there was a bad thing there but yeah. Their home is a safe place and not anyone can come in. (Participant E)

However past injustices brought about by the Australian Government policies aimed at dismantling the Indigenous society and culture were evident in young mothers lacking support or connectedness within their Indigenous family. For many years compulsory relocation of Indigenous families to missions or reserves, dispossessed them of their land, and also traditional culture and language.

The stolen Generation where children were forcibly taken from their mothers and placed in institutions or used in some states as cheap labour continued from the 1890's to recently 1970's. These children in many cases never saw their parents again and lost all connection to kinship and family (Human Rights & Equal Opportunity Commission, 1997). Missed generations of parents and role models have damaged Indigenous society. The participants communicated how they worked with clients affected by these issues and acknowledged this as the cause of current social problems suffered by Indigenous families.

…for those indigenous people who've never really experienced parenting, you know, that, that is going to be damage that I'm not sure we're ever going to really completely be able to make up, not in the next few generations but hopefully in generations to come. (Participant F)

5. Discussion

The findings of the study indicated the importance of cultural safety. Thus the elements of communication and cultural safety were reported by the healthcare staff caring for Indigenous women and their families.

Being sensitive meant showing a cultural respect between the carer and client. In this context the differences in cultural beliefs were acknowledged at the service.

To further develop cultural safety, many equally trusting relationships were created, maintained and actively protected by the health service staff. This trust was built on honesty, mutual agreements, and nonjudgmental approaches in care, and was evident throughout the study. Participants acknowledged the damage incurred by historical events and found it was important to understand this as an explanation of the fear which persisted for Indigenous peoples when relating to authorities or institutions. This concept has been widely presented in the literature as long standing mistrust by Indigenous peoples in dealing with authority (Watson, Hodson, Johnson, Kemp & May, 2002a; Departments of Human Services, 2008). Within health situations it was suggested by some authors (Hupcey, Penrod, Morse, & Mitcham, 2001) that trust could be limited to the area of need by minority groups. Thus the only reason for trusting the healthcare provider was because the individual client's needs would only be met by the assistance of another.

An element of risk, therefore, was involved for the Indigenous client as they placed some dependence on another's action (Hupcey et al., 2001). The health care staff were very aware of the vulnerability Indigenous women felt and the fear of shame, recurrent abuse or oppression of the client by the dominant position holder. This knowledge was in turn used by health providers as the basis for forming solid rewarding relationships with their clients and empathy as to why mistrust developed. Instead the successful positive relationships formed between the healthcare service and clients, existed in agreements of trust and respect. The service focused significant energy toward preservation of trust where creating culturally safe relationships was foundational in their approach to care.

However, cultural safety and effective communication was not always present in healthcare practices across the region. The study found that energy invested by the health providers was influenced by their beliefs and capacity to offer cultural safety to clients. Similarly, Australian multicultural environments researched by Watson et al. (2002a), found health providers held wide ranging views on relationships and communication with Indigenous mothers from frustrating to rewarding, and reported ' like any human being Indigenous women can tell when people care and sympathise' (Watson et al, 2002a, p. 165).

It was evident from this study that the healthcare service staff understood the value of culturally respectful communication in interactions with women to be of such importance it was a corner stone in effective healthcare. The participants found the Indigenous women responded to this genuine compassionate care. In contrast the local institutions which did not provide a cultural responsive approach to Indigenous women were unsuccessful in achieving favourable outcomes (Local Community VACCHO, 2009;Durey, 2010).

Consequently the recognition of cultural safety in certain organisations raised issues of prejudice as well as the level of confidence in service provision. A particular area of concern to the healthcare service was their dilemma in encouraging clients to use the maternity services within the mainstream service institutions. Whilst mainstream services offered medical and obstetrical care, the local unit was also a facility that had very recently rejected cultural training resources for its staff. Consequently the Indigenous service staff were placed in a predicament where they acknowledged the need for medical and midwifery care but had reservations for their clients because the mainstream service facility could be viewed as culturally unsafe. Thus a dilemma of ensuring cultural safety in facilities beyond the scope of the Indigenous service was apparent from this study.

This concept of culture-specific health (Garrett et al., 2010) and Indigenous specific views of childbirth had an impact on risk management within organisations. The research findings suggested that obstetric and medical risk had to be balanced with social and spiritual risk in Indigenous maternity care. Whilst the mainstream western medicine (Wallis et al., 2011) and biomedical approach (Garrett et al., 2010) to maternity care acted in the best medical and scientific interest of the mother and baby, it frequently denied traditional practices and spiritual or psychological ownership of the Indigenous mothers journey. In contrast the studied Indigenous service achieved suitable maternity and baby outcomes through acknowledgement and deep understanding of the issues impacting on their clients.

The service collaborated closely with the client to determine suitable solutions. These women were protected, therefore, by addressing the range of social, financial, physical, psychosocial and cultural beliefs of each women and family.

Evidence from this study also identified miscommunication and negative events as a contributing factor to refusal to use social or health services again by Indigenous families in the area. Families would refuse appointments or contact with agencies if they felt threatened.

Systematic failure to collaborate or consult with clients, therefore, could be counterproductive and destroy any attempts within organisations to improve wellbeing. This finding was supported in the literature where ample evidence of miscommunication leading to sentinel events, such as maternal or infant mortality and morbidity, or adverse consequences due to failures of communication between health providers and Indigenous women (Johnstone & Kanitsaki, 2007; Watson et al, 2002a). Further to this the Australian healthcare system was labelled as racist by Henry, Houston, and Mooney (2004) who claimed it perpetuated the lack of trust in the healthcare system by Indigenous peoples. Whilst the health carers were careful in declaring any negativity toward mainstream service systems, there were elements within this study, which did suggest a lack of regard to some cultural minorities. Some local services remained lethargic and reticent towards addressing barriers to healthcare utilisation by Indigenous populations. Confirming this result was literature stating there has been widely accepted and reproduced indifference to Indigenous health in Australia as described by Derose, Gresenz and Ringel (2011). The service was endeavouring to address the continued failures by some organisations to offer culturally safe care. It viewed this fault as impacting and creating a sustained lack of Indigenous self-confidence or assertion of their culture.

Inequity in Anglo Australian driven healthcare was labelled unacceptable (Durey, 2010) and hence discriminatory towards the cultural differences within Australia's multicultural populations.

6. Recommendations

1. Promote *cultural safety* by continued cultural awareness public education strategies which can encourage reflection of individual beliefs and build interactions with other cultures. Identify barriers to interactions and resolve them were the potential exists.
2. Undertake further research which asks the Indigenous women what they value and believe is required for good maternity healthcare.

7. Conclusions

In order to improve Indigenous maternity care, Australian health providers and health systems must accommodate Indigenous cultural beliefs and values (Reibel & Walker, 2010) such as found within this Indigenous maternity care service. This research into culturally inclusive healthcare focused on maternity health service within rural Victoria.

The specific culturally safe practice the health carers provided within a local Indigenous community, the barriers and successes they encountered in maternity care for local Indigenous women and babies was investigated and the findings presented.

One of the major themes identified from this study was the importance of cultural safety and the inherent aspects of achieving therapeutic relationships. The project found this Indigenous service to be working effectively because respect and trust were the integral structure within therapeutic relationships between clients and carers. The health professionals and associated staff treated the Indigenous women's beliefs and values as paramount, ensuring culturally appropriate care could be provided. This study clearly identified the presence of trust by Indigenous women was critical to health care services and client engagement throughout maternity and postnatal care. Trust and effective communication, therefore, directly impacted Indigenous maternity outcomes.

Whilst Indigenous staff could be viewed as culturally safe, the requirement of the right staff was more relevant.

Differences in gender and family rivalry or sensitivities to health situations made it imperative that only certain people where involved in care. The study highlighted the usefulness of employing Indigenous staff from outside the local clan or community as an independent practitioner who became a trusted individual in delicate affairs or private business. Any organisation, therefore, must be mindful of making assumptions about appropriate staff for Indigenous clients and always offer women a choice of contacts.

Rural and regional health policy which offers a 'one size fits all' or dominant society held view of services and program implementation should be reconsidered. Whilst current indigenous statistics indicate the need for health providers and systems to improve their responsiveness, there are successful services that are making considerable improvements in maternity and general health care. The role out of similar services such as the Indigenous service site studied would contribute culturally safe care within other facilities. As recognised by this service, the Australian workforce has the capacity to train a culturally competent workforce. Cultural competence toolkits and cultural safety within institutions and mainstream health care is overdue.

This Indigenous maternity service has delivered a positive model of care. This was demonstrated by the increasing number of Indigenous clients visiting the centre and the return of women in subsequent pregnancies.

The service is playing a key role in closing the gap in Indigenous health and wellbeing. This centres health carers working with Indigenous clients are making a valuable contribution to culturally safe care for the women and their families entitling them to physical, spiritual, social, and emotional safety. To attain greater improvements in Indigenous welfare it is important that appropriate maternity care be provided to Indigenous women, and supports are put in place to allow health professionals working in any environment, to achieve exactly that.

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