Carbal Institute of Aboriginal and Torres Strait Islander Health Research

Culturally Appropriate Maternal Health Care

Introduction

It is a well-known fact that poor quality of maternal health care, especially around the time of childbirth, continues to contribute significantly to morbidity and mortality of mothers and newborns around the globe. According to the World Health Organisation (2016), 7300 women experience a stillbirth, and 800 women and 7700 newborns die every day from complications during pregnancy, childbirth, and in the early postnatal period. In 2015 alone, this equated to an estimated 303,000 women dying from pregnancy-related causes, 2.7 million babies dying within the first 28 days of life and 2.6 million babies being stillborn (WHO, 2020).

Further, statistics show that poor women in remote areas are least likely to receive adequate health care – in 2015 the mortality rate was 239 per 100,000 live births in developing countries versus 12 per 100,000 live births in developed countries (WHO, 2020).

Reducing child mortality and improving maternal health are two of the eight Millennium Development Goals for 2015, that were developed during the United Nations Millennium Summit in 2000.

In Australia, despite being a developed country, statistics show significant disparities between indigenous and non-indigenous women in terms of health outcomes for mothers and newborns. Of crucial importance to improving these outcomes are both an increase in coverage and accessibility and a much-enhanced quality of care provided to women through health facilities, birth attendants or otherwise during pregnancy, childbirth and post-partum. Research shows that to safeguard pregnancy and childbirth, all pregnant women and newborns need to have access to skilled care consisting of evidence-based practices delivered in a humane, respectful, safe and supportive environment (Tunçalp et al., 2015). But the utilisation of skilled care, even when available, is heavily dependent on how safe and culturally appropriate it is deemed by the recipient. Thus, it is paramount to ensure that a woman's cultural background and setting are not only taken into consideration but form an intrinsic part of the care being provided.

Quality of Care

Quality of care during childbirth in health facilities is reflected in the available physical infrastructure, supplies, management, and human resources with the knowledge, skills and capacity to deal with pregnancy and childbirth under normal physiological, social and cultural processes (Tunçalp et al., 2015). However, the World Health Organisation (WHO) envisages a world 'every pregnant woman and newborn receives quality care throughout pregnancy, childbirth and the postnatal period.'

In general, the utilisation of skilled care is influenced by a range of factors such as urban residence, maternal age and education, household economic wealth, perceived benefit, need and physical accessibility (Gabrysch & Campbell, 2008). Quality of care is also considered crucial to uptake of care but might be challenging to establish in some contexts. Closing the quality gap through provision of effective health care for all women and neonates could prevent a significant percentage of maternal and infant mortality. The WHO vision for the quality of maternal and child health care is illustrated in the below diagram. Factors contributing to quality of care are divided into the provision of care and the experience of it. And it is this experience that can form a significant barrier to the uptake of skilled health care, even where it is available and accessible.

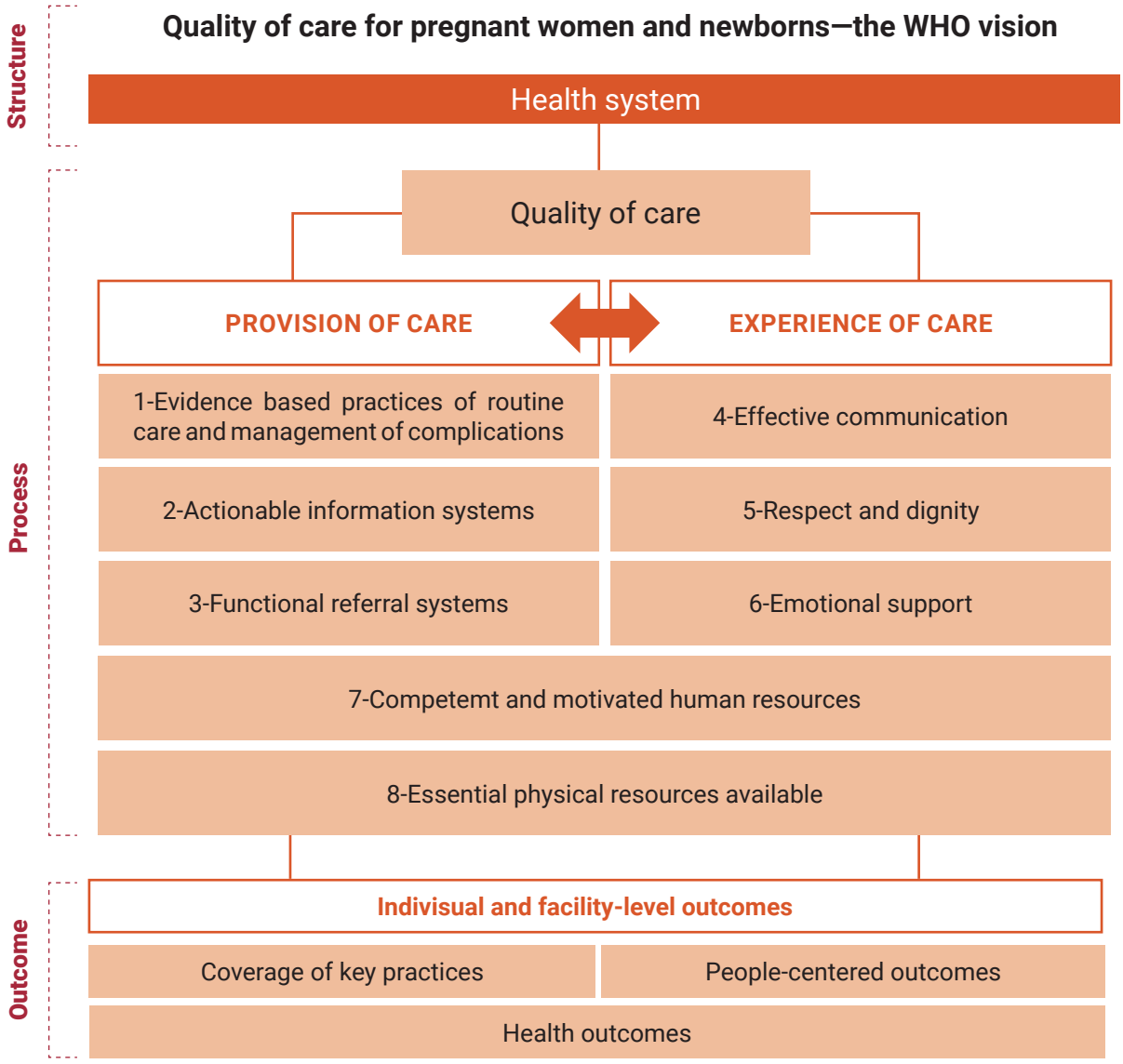
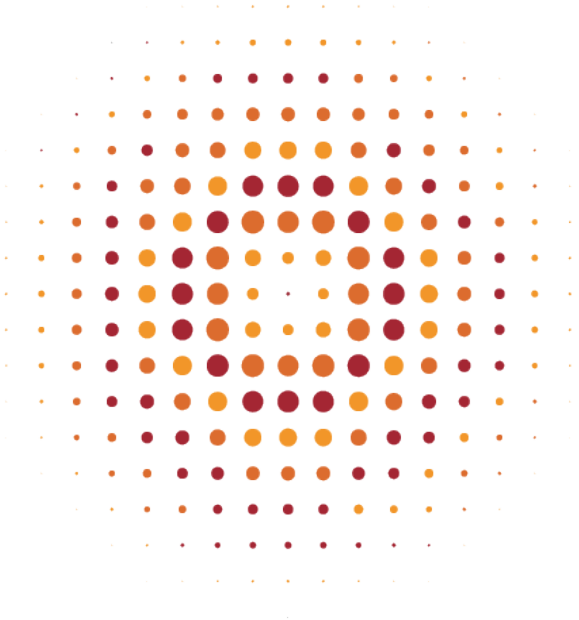


Figure 1 BJOG: An International Journal of Obstetrics & Gynaecology, Volume: 122, Issue: 8, Pages: 1045-1049, First published: 01 May 2015, DOI: (10.1111/1471-0528.13451)



The WHO further defined six strategic areas to provide guidance for improving quality of maternal and newborn care: clinical guidelines, standards of care, effective interventions, measures of quality of care, relevant research and capacity-building (WHO, 2016).

Scientific analysis of symptoms and treatment based on measurable, scientific evidence are the foundation of modern medical care in the western world. This, though effective in situations of life-threatening injuries, for instance, is not a holistic approach to viewing the patient as a whole person in context of their community and interacting with their environment. The Australian Commission on Safety and Quality in Health Care in a paper on patient-centred care formulated that a patient-centred approach 'provides demonstrable personal, clinical and organisational benefits' and is simply 'the right thing to do' (ACSQHC, 2011). It is thus important, that every woman is treated as a whole and an individual and antenatal visits are used to establish rapport and trust, to ensure a positive experience of the care given for each woman.

In 2010, the Australian Health Ministers endorsed the National Maternity Services Plan. Action 2.2 of this Plan was to 'Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people'. According to this Plan, the best primary maternity services demonstrate all of the following features:

1. High quality care enabled by evidence-based practice.
2. Care is coordinated according to the woman's clinical need.
3. Health professionals work together in a collaborative multidisciplinary approach.
4. Continuity of care through pregnancy, birth and the early postnatal period.
5. Enable woman-centred care which gives women a sense of control of their birthing experience.
6. Care is culturally appropriate and reduces health inequalities.
7. Enable continued access to best practice care at the local level. (AHMAC, 2008)

Following on from the NMSP, a National Framework for Maternity Services was drafted, which includes being 'culturally safe' as the second guiding principle to underpin all future planning and development, i.e., maternity services should reflect an understanding of the diversity between and within cultures, supporting a woman's wellbeing, and meet the needs of the woman, her partner and/or support network including her community'.

Aboriginal and Torres Strait Islanders in Australia

There are large disparities in maternal and neonate survival around the world. Minority groups, like refugee women in foreign countries or indigenous populations like Aboriginal and Torres Strait Islanders in Australia fare significantly worse in terms of health outcomes than the general population; this includes outcomes for mothers and babies. It has been shown that, for instance, in Europe minority groups are far less likely to access skilled health care and experience poorer outcomes (Boerleider et al., 2013). In Australia it was found that indigenous women also access care differently from non-indigenous women, i.e., they usually seek help later in their pregnancy (less than %50 see a professional in their first trimester) and attend antenatal clinics less frequently overall (Rumboldt, 2011).

In addition to a disproportionate burden of disease amongst Aboriginal and Torres Strait Islanders, indigenous women in Australia also suffer from a disproportionate burden of adverse perinatal outcomes, including an increased rate of maternal mortality (4 times that of non-indigenous women), pre-term births, low birth weight babies and perinatal deaths (Clarke & Boyle, 2014). These differences can to a large extent be explained by low socioeconomic status and smoking during pregnancy (almost half of all indigenous women smoke during pregnancy) (Titmuss et al., 2008). Marmot (2011) referred to this as the social gradient in health: the lower the social position the worse the health.

In %6 ,2011 of all births registered in Australia were to either one or two parents who identified as Aboriginal and Torres Strait Islander.
The maternal mortality rate between 2012 and 2018 was 20.2 per 100,000 women giving birth for Aboriginal and Torres Strait Islander women, and 5.5 per 100,000 for non-Indigenous women (AIHW, 2020).
Women who lived in remote and very remote areas had the highest MMR, followed by women who lived in inner regional areas (12.3 and 8.9 per 100,000 women giving birth), while those in major cities had an MMR of 5.7 per 100,000 women giving birth (AIHW, 2020).

Most Aboriginal and Torres Strait Islander people live in urban or inner regional areas and receive healthcare through mainstream services – health professionals in these settings need to be aware of the disparities to aid in 'closing the gap' and to ensure that mainstream services are equipped to be able to provide culturally appropriate health care, as this is prerequisite for indigenous women accessing services more readily. All the attempts at developing policies and guidelines for health professionals will otherwise have little hope in improving outcomes.

Maternal and neonatal health care needs to encompass the entire time frame from before conception until a year after birth, and as such requires different kinds of support and interventions over time to guarantee maternal and neonatal survival and thriving.

Actively engaging women in antenatal care has the greatest chance of impacting health outcomes positively for mother and baby, as it allows for:

1. An early and ongoing risk assessment,
2. The chance at health promotion, including smoking cessation advice (smoking in the first 20 weeks of pregnancy has been linked to a higher rate in maternal deaths (AIHW 2020)) and facilitating informed choice,
3. Medical and psychosocial intervention and follow-up where needed (Boerleider et al., 2013).

Special Considerations

As a general rule, Aboriginal and Torres Strait Islander women require the same antenatal care as other women. However, there are some particular concerns in Aboriginal and Torres Strait Islander communities that warrant special consideration by health care professionals. These include:

- psychosocial factors – higher rates of teenage pregnancies (higher maternal mortality rate for women under 20 (AIHW 2020)), anxiety and depression and higher rates of domestic violence,
- chronic/long term illnesses – diabetes, ischaemic heart disease, renal disease,
- infections – screening for sexually transmitted diseases should form part of antenatal care,
- nutrition – lower rates of folate supplementation and limited access to fresh fruit and vegetables in many communities, many women are underweight or overweight during pregnancy,
- physical activity – healthy exercise should be discussed,
- alcohol – especially drinking at levels above the NHMRC 2001 guidelines, and
- smoking – almost half of all pregnant indigenous women are reported to smoke, and smoking cessation is the one simple (Clarke & Boyle, 2014).

The Role of Culture in Maternal and Child Health

Across the globe the time around childbirth is a social and cultural event always governed by societal norms. In practice it is often difficult to separate 'culture' from social, economic or geographic considerations and aspects. Culture can be both explicit and implicit. It encompasses a variety of aspects, such as shared beliefs, expectations, norms and rules, behavioural customs, and a spoken language. A society will often have more than one culture within them, distinguished by ethnicity, religion, social class or rank, with sub-cultures differentiated through distinctive attributes (Coast et al., 2014).

In Australia, it must be acknowledged that Aboriginal and Torres Strait Islanders are a diverse rather than homogenous group, with wide variations in beliefs and practices. They cannot easily be addressed with one standard set of health care policies and regulations, but rather each clinician will need to learn about the particularities of their patient communities, if they are to secure their trust.

- Health care professionals need to acknowledge that no woman and her baby exist separate from the woman's social and emotional wellbeing or her cultural and societal context. Mothers are embedded in a family system of supervision and caring where, depending on the culture in question, a particular group of individuals, such as the grandmothers, will have a strong influence on maternal and child health care and nutrition practices. It is often the older women (aunties in the Aboriginal context) and grandmothers or 'Elders' who function as the repository of traditional knowledge, values, customs and rituals in a community. Both male and female Elders are pivotal to family life in Aboriginal communities. For any attempt at implementing a systemic change in maternal health care services to achieve an improvement in quality of care, the Elders of the community and their traditional knowledge, leadership and decision-making responsibilities (Lohoar et al., 2014) need to logically be consulted and where possible incorporated and should never be discounted or ignored.

One common theme in terms of indigenous births in Australia is the importance of birthing on country. This is considered to support the best possible start in life and believed to improve maternal and neonate outcomes due to the connection between birthing, country (as in ancestral land) and place of belonging, establishing a life-long spiritual connection (Dragon, 2019). This was highlighted in the National Maternity Services Plan 2015-2010. Other common themes include a collective community approach to raising children, child autonomy and independence, the role of Elders in the community and family life and the role spirituality in family functioning (Lohoar et al., 2014). It is important to note and understand that 'family' in an Aboriginal sense is not limited to physical connections alone.

Culturally Appropriate and Safe Health Care in Australia

Common to both traditional customs around the world with regards to pregnancy and birth and conventional western medicine is of course the aim to keep mother and baby safe. Cultural beliefs and practices can, however, form a significant barrier to the uptake of skilled maternity services; thus, the WHO stipulates that taking into consideration the preferences and aspirations of individuals and the culture of their community is fundamental to quality of care. This is especially important where conventional academic wisdom seems to be incompatible with traditional indigenous knowledge. Differences in the cultures of health care service providers and service users can quickly lead to a perception of poor quality of care and discrimination against some users. Whether perceived or actual, cultural insensitivity or a lack of cultural competence of professionals will without doubt be equated with poor quality of care.

To guide the process of evolving the health system into one where every patient feels safe, a number of policies, frameworks and plans have been developed and put into action to not only paint a vision but define cultural safety and respect and give more specific guidelines on what is required to ensure that the entire Australian health system is accessible, responsive and culturally safe for all indigenous Australians. These include the National Aboriginal and Torres Strait Islander Health Plan 23–2013, the Cultural Safety in Health Care for Indigenous Australians: Monitoring Framework and the Cultural Respect Framework 26–2016, National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2023 - 2016), National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families and the National Framework for Maternity Services which incorporates an evaluation of the National Maternity Services Plan 2015-2010.

In order to ensure a positive experience of care, health practitioners need sufficient cultural competence that allows for effective communication with patients and provides a sense of cultural safety of Aboriginal and Torres Strait Islander women in particular. This in turn requires a deeper understanding of the historical and political events that have through centuries of alienation and marginalisation shaped and continue to shape the disparities in health outcomes for indigenous people and their resulting strained relationship with 'the system' (Oxfam Australia). Having a deeper understanding will lead to a more empathetic approach by the clinician which can in turn positively impact the health and wellbeing outcomes for mother and baby. In Australia, several tools and training programs for cultural awareness and cultural safety have been developed and can be accessed by clinicians to further their education and understanding and support the process of minimising disparities, e.g., the online 'Cultural awareness module for PIP Indigenous Health Incentive' provided by ACRRM or the 'Cultural awareness and cultural safety training' provided by the RACGP.

The following points might enable health care practitioners to more readily gain every patient's trust:

1.Become culturally competent.

2.Treat every woman as an individual.

3.Involve every woman in the decisions made about her health.

4.Involve Aboriginal Health Workers to bridge gaps.

5.For every individual treated, to bear in mind the special considerations, where indigenous patients might differ from the general population.

As laid out in a literature review on **'Birthing on Country'** by Kildea and Van Wagner (2012), for maternal health care to become more culturally appropriate and safe the aspects of governance, philosophy, training and education, service characteristics and training and evaluation need to be considered and addressed in Australian health policies, guidelines and most importantly practice:

Birthing on Country

Maternity services designed and delivered for Indigenous women

Governance

Indigenous control, community development approach, shared vision, cultural guidance and oversight

Philosophy

Respect for Indigenous knowledge and incorporation Of traditional practice / Respect for family involvement /
Partnership approach / Women›s Business / Continuity Of carer / Capacity building approach -- particularly with training & education / Holistic definition of health

Training & Education

Partnership approach / -2way learning; Appropriately trained and supported; Competency based; Delivered on-site; Career pathway from maternity workers to midwifery

Service Characteristics

Culturally competent service and staff; Community based; Specific location; Designated ongoing funding; Welcoming flexible service focusing on relationships and trust; Outreach, transport, child friendly and group sessions; Social, cultural, biomedical and community risk assessment criteria; Interdisciplinary perinatal committee; Effective IT; Integrated with tertiary services

Monitoring & Evaluation

Designated funding for monitoring and evaluation; Continuous quality assurance; audit activities and recall register

Results

Community healing as evidenced by: Reduced family separation at critical times, restoration Of skills and pride; Capacity building in the community; Supporting community and family relationships; Reduced family violence; Increased communication and liaison with Other health professionals and service providers; Comprehensive, holistic, tailored care.
Improved Maternal and Infant Health Outcomes

Fig 2: Components of maternity service delivery models for Indigenous mothers and babies (Kildea & Van Wagner, 2012)

If future mainstream health care is community-based and indigenous controlled, incorporates traditional practice, enables a connection with land and country, incorporates a holistic approach to health, values both indigenous and non-indigenous ways of knowing and learning, includes risk assessment, and is developed by, or with, the indigenous people of Australia, a giant step towards becoming culturally safe and thus closing the gap will have been achieved. Clear guidelines on how barriers and challenges to this can be overcome, evaluation of successes and failures as well as developing a skilled indigenous health workforce will necessarily constitute part of a successful process of change.

Conclusion

In order to help 'close the gap' in disparate health outcomes for Aboriginal and Torres Strait Islanders in Australia in general, and for their mothers and babies in particular, mainstream medical care being the most frequently accessed kind of care, needs to urgently become more individualised and culturally appropriate, moving away from the historically provided western medicine oriented routine care. Cultural safety needs to be a guaranteed part of all maternal and newborn healthcare, as an increase in the availability of skilled care alone cannot guarantee an improvement in maternal care and neonatal survival. In the interim, tackling the underlying social and economic determinants of health outcomes and ensuring the continuity between general/standard health care and culturally appropriate care must be addressed to safeguard access and utilisation of skilled health care by all mothers and their newborns.

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