



The Characteristics of
Culturally Competent Maternity Care
for
Aboriginal and Torres Strait Islander women

Culturally Competent Care for Aboriginal and Torres Strait Women Report 2012

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Executive summary

A culturally competent workforce is recognised as a priority reform area in Closing the gap in Indigenous life outcomes (COAG, 2010). The development of organisational, systemic and individual cultural competence is essential to ensure all Aboriginal and Torres Strait Islander people using a health service are treated in a respectful and safe manner that secures their trust in the capacity of the service to meet their needs (Reibel & Walker, 2010).

This document aims to identify the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people as required under Action 2.2 in the National Maternity Services Plan (NMSP) (AHMAC 2011).

Following a review of the literature and selected stakeholder consultations, the characteristics of effective culturally competent care in maternity care were identified under the following headings:

- Physical environment and infrastructure
- Specific Aboriginal and/or Torres Strait Islander program
- Aboriginal and Torres Strait Islander workforce
- Continuity of care and carer
- Collaborating with Aboriginal Community Controlled Health Organisations and other agencies
- Communication, information sharing and transfer of care
- Staff attitudes and respect
- Cultural education programs
- Relationships
- Informed choice and right of refusal
- Tools to measure cultural competence
- Culture specific guidelines
- Culturally appropriate and effective health promotion and behaviour change activities
- Engaging consumers and clinical governance.

It is emphasised that the indicators provided in this report are preliminary in nature and require future development and testing in line with 'middle year' activities provided in the NMSP. There is also current work on measuring cultural competence being progressed by other sub-committees of AHMAC that align with the indicators outlined in this report. Further development of the indicators should include partnerships with key stakeholders including: the Office of Aboriginal and Torres Strait Islander Health (OATSIH); the National Aboriginal Community Controlled Health Organisation (NACCHO); The National Aboriginal and Torres Strait Islander Health Officials' Network (NATSIHON); The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID); and leading individual Aboriginal and/or Torres Strait Islander academics and experts.

Introduction

Aboriginal and Torres Strait Islander women and babies continue to experience higher rates of mortality and morbidity compared to non-Indigenous women and babies. Australian governments are committed to reducing this difference through a range of initiatives. The Australian Health Ministers' Advisory Council (AHMAC) has identified a number of activities in its National Maternity Services Plan (NMSP) (2011b). The NMSP outlines a range of initiatives, including Action 2.2 to *develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people*. This will be achieved across the next five years through the following actions.

The initial year	The middle years	The later years	Signs of success
2.2.1 AHMAC identifies the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people.	AHMAC undertakes a stocktake of access to culturally competent maternity care for Aboriginal and Torres Strait Islander people. Australian governments expand programs providing culturally competent maternity care for Aboriginal and Torres Strait Islander people. AHMAC identifies mechanisms for evaluating cultural competence in all maternity care settings.	AHMAC evaluates culturally competent maternity care for Aboriginal and Torres Strait Islander people. AHMAC evaluates cultural competence in all maternity care settings.	Increased numbers of Aboriginal and Torres Strait Islander people have access to culturally competent maternity care. Increased numbers of maternity services demonstrate culturally competent maternity care.

AHMAC 2011 p. 39

The purpose of this report is to address the activities of the initial year as outlined above: *to identify the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people*. It is important that this document is able to inform the activities of the middle and later years. To achieve this, considerations on characteristics that are achievable and measurable have been included.

Background

The best primary maternity services demonstrate 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)

Many Aboriginal and Torres Strait Islander women currently do not have access to many of the above components of quality primary maternity care. 'Evidence' is driven by fear of litigation and biomedical risk (Dahlen, 2011). 'Risk' is determined by those most powerful within the health system, and denies the 'risks' that are identified by, and important to, the women themselves (Kildea, 2006). Care is currently coordinated based on health service availability often prioritising service needs over the needs of the woman. Aboriginal and Torres Strait Islander women in rural and remote areas in particular are being denied access to high quality care from the full range of health expertise (Hirst, 2005; Kildea, Kruske, Barclay, & Tracy, 2010) and have care that is

fragmented and does not meet their cultural needs (Hancock, 2006). Improving Aboriginal and Torres Strait Islander health outcomes within the maternity services community is a high priority. A culturally competent workforce is recognised as a priority reform area in Closing the Gap in Indigenous life outcomes (COAG, 2010). The development of individual and organisational cultural competence is essential to ensure all Aboriginal and Torres Strait Islander people using a health service are treated in a respectful and safe manner that secures their trust in the capacity of the service to meet their needs (Reibel & Walker, 2010).

In 2005, Ana Herceg undertook an extensive literature review on improving health in Aboriginal and Torres Strait Islander mothers, babies and young children. She reported a lack of rigorous research results published in the area. However, she identified the following key factors in successful programs

- Community based and/or community controlled services
- Providing continuity of care and a broad spectrum of services
- Integration with other services (e.g. hospital liaison, shared care)
- Outreach activities
- Home visiting
- A welcoming and safe service environment
- Flexibility in service delivery and appointment times
- A focus on communication, relationship building and development of trust
- Respect for Aboriginal and Torres Strait Islander people and their culture
- Respect for family involvement in health issues and child care
- Having an appropriately trained workforce
- Valuing Aboriginal and Torres Strait Islander staff and female staff
- Provision of transport
- Provision of childcare or playgroups.

(Herceg, 2005, p. 3)

Herceg's factors have been cited widely across academic and policy documents since the release of this report in 2005. Yet few improvements have been made in health service delivery to Aboriginal and Torres Strait Islander women. Health services in general, and the large majority of individuals within those systems, fail to work appropriately with Aboriginal people (Dudgeon, Wright, & Coffin, 2010; Dunbar, Bengler, & Lowell, 2008).

In a rigorous audit of antenatal care in Western Australia, Reibel and Walker (2010) found that 75% of services fail to provide culturally competent care to Aboriginal women. They state that

...despite the existence of policies and guidelines to highlight cultural competence as a core feature of improving, [maternal health] service delivery, there are currently no mechanisms to facilitate changes and improvements to embed cultural competence in health services and increase the capacity of individual health professionals to provide appropriate care to Aboriginal women

(Reibel & Walker, 2010, p. 72)

Mainstream services are often resistant to proposals that Aboriginal and Torres Strait Islander people need to be offered care in a different way or in a different location or by Aboriginal health workers (Larson & Bradley, 2010). This report aims to provide a proposed framework for policy makers and maternity care services to move beyond motherhood statements of culturally competent care and provide concrete strategies, measurable where possible, to assist health services to provide culturally appropriate and effective care for Aboriginal and Torres Strait Islander women and their families.

This requires supporting health professionals to provide services to Aboriginal and Torres Strait Islander women that is meaningful and respectful, meets their needs, supports their view of the world and improves their capacity to improve their health and wellbeing.

Methods

A desktop review of published and grey literature was used to inform this report. Journal publications, reports, policies and other relevant documentation on the topic of cultural competence and health services for Aboriginal and Torres Strait Islander and other Indigenous peoples were reviewed. Sources of information were taken from many different disciplines including midwifery, nursing, medicine, anthropology, health systems, health policy and human rights.

Main search terms included: cultural competence; cultural safety; cultural*; Aboriginal and Torres Strait Islander; Australian Aboriginal; maternity care; disrespectful care; discrimination; racism; barriers to maternal health care; and women's perceptions of maternity care.

A purposive sample of Aboriginal and/or Torres Strait Islander leaders, senior maternal health policy makers, program planners and other stakeholders was approached and invited to review the document. Feedback was incorporated into the document where relevant and possible (see Appendix A for a list of individuals and groups who reviewed the document).

Assumptions

A number of assumptions underpin this report and reflect the core philosophies of contemporary maternity services.

- Pregnancy and birth, for most women, is a normal physiological event.
- Services should provide a social model of service delivery recognising that pregnancy, birth and parenting exist within the woman's social, emotional, cultural, spiritual and environmental world.
- Woman centred care must include working in partnership with women in a way that respects their right to informed consent and informed refusal of care.
- Pregnancy, childbirth and early parenting is a time of vulnerability for all women, but particularly for many Aboriginal and Torres Strait Islander women who experience inequity in health care as well as injustice and disadvantage more broadly.
- All women require midwifery care, some women require obstetric care.
- There is wide diversity in Aboriginal and/or Torres Strait Islander cultures.

From the United States, Purnell (2000) lists some useful principles, in cultural competence including the following.

- To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and worldviews of diverse populations and individual acculturation patterns.
- Prejudices and biases can be minimized with cultural understanding.
- All cultures change.
- There are differences within, between, and among cultures.
- No culture is better than another, only different.
- Individuals and groups belong to several cultural groups.
- Professions, organisations and associations have their own cultures.

(Purnell, 2000 p. 43)

Nomenclature around effective cross-cultural health care

A raft of names has been used to describe care to Aboriginal and Torres Strait Islander women and their families including: cultural awareness; cultural safety; cultural responsiveness; cultural capacity; cultural competence; cultural capability; cultural security; cultural respect; and cross-cultural efficacy. 'Transcultural nursing' is also used in literature originating in, and pertaining to, the United States of America. This term, however, is not routinely used by Australian authors. Similarly the 'cultural safety' literature is firmly identified within New Zealand and the Maori

populations. Despite the transferability, usefulness and applicability of many of these concepts to the Australian context, a universal term has yet to be adopted across the Australian Aboriginal or Torres Strait Islander communities/services.

For the purposes of this report, the term 'cultural competence' will be used in line with the National Maternity Services Plan (AHMAC, 2011) and other key national policy documents (NHMRC, 2004, 2006). The term is widely used across international health care literature and refers to both migrant and Indigenous populations. The concept evolved from the work of Cross and colleagues (1989) and is supported by Aboriginal academics in Australia as follows:

Cultural competence requires that organisations have a defined set of values and principles, and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally... Cultural competence is a developmental process that evolves over an extended period. Both individuals and organisations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

(Dudgeon, et al., 2010, p. 34)

To become more culturally competent, a system needs to:

- value diversity
- have the capacity for cultural self-assessment
- be conscious of the dynamics that occur when cultures interact
- institutionalise cultural knowledge; and
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures.

(NHMRC, 2006, p. 7)

The above definition fits within the key principles of maternity services that should provide woman-centred care that is coordinated according to her needs, including her cultural, emotional, psychosocial and clinical needs (AHMAC, 2011b). If all of these aspects of care were provided to Aboriginal and Torres Strait Islander women, care would be 'culturally competent'. The challenge of operationalising this definition is the misunderstanding and poor communication that occurs when people provide care to individuals and groups whose values, beliefs and practices differ from those of the mainstream group. This, along with the unique effects that colonisation has had on Australia's original inhabitants, supports the need for particular attention to culturally competent care for Aboriginal and Torres Strait Islander people.

A Core Competency Model and Educational Framework has been developed in Australia to ensure that maternity services can achieve the best outcomes for women, their babies and families. It includes the needs and preferences of women, the promotion of greater access to continuity of care and the fostering of collaborative working relationships between providers of care (Homer et al., 2010).

Cultural competence should encompass the principles of basic human rights. This includes the right to respect (respectful interpersonal care), the right to equality and non-discrimination, the right to information (informed consent), the right to redress (accountability) and the right to privacy (confidentiality), among others (AHMAC, 2008).

The term 'cultural competence' implies both action and accountability (Stewart, 2006). Cultural competence must focus on the capacity of the health system to be culturally responsive—that is to integrate cultural recognition and respect into service delivery, organisation structure and workforce to improve the health and wellbeing of Aboriginal people (Walker & Reibel 2009). It also focuses on all aspects of the health care system – organisationally, systemically and individually (Noh, Kaspar, & Wickrama, 2007).

In a review of antenatal services across Western Australia, Reibel and Walker (2010) reported on services that: (i) were close to home; (ii) offered unbooked or walk-in antenatal clinics; and (iii) provided transport, as key elements of access suitability. However, even with all of those three

factors present, it did not ensure acceptability as indicated by utilisation. They concluded that the perception of cultural security experienced by individual service users is indicated by their frequency of visits (Reibel & Walker, 2010). Therefore services must have the capacity to record and report on data that represents both the perceptions of care and service utilisation by Aboriginal and Torres Strait Islander women.

The quality of care is also paramount with reporting mechanisms developed that reflect the Five Year Vision of the National Maternity Services Plan:

Maternity Care will be woman centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women

(AHMAC, 2011b, p. iii)

Key characteristics of culturally competent care

Following the literature review and selected stakeholder consultation, the characteristics of effective culturally competent care in maternity care were identified under the following headings:

- Physical environment and infrastructure
- Specific Aboriginal and/or Torres Strait Islander program
- Aboriginal and Torres Strait Islander workforce
- Continuity of care and carer
- Collaborating with Aboriginal Community Controlled Health Organisations and other agencies
- Communication, information sharing and transfer of care
- Staff attitudes and respect
- Cultural education programs
- Relationships
- Informed choice and right of refusal
- Tools to measure cultural competence
- Culture specific guidelines
- Culturally appropriate and effective health promotion and behaviour change activities
- Engaging consumers and clinical governance.

Each of these categories will now be expanded on individually.

1. Physical environment and infrastructure

Specialised health care requires suitable physical infrastructure (Aboriginal Health Council of Western Australia, 2010). Successful maternity programs need a designated area where women and their families are accommodated in a welcoming, culturally secure environment. This space must also be suitable for the male partners of the women and be considerate of particularly vulnerable subgroups such as teenage women (Larson & Bradley, 2010).

A number of infrastructure strategies are recommended to increase utilisation by women. These include: the provision of outreach services; transport; drop in (not appointment based) clinics; ensuring confidentiality and privacy (Aboriginal Health Council of Western Australia, 2010; Larson & Bradley, 2010; Reibel & Walker, 2009).

The physical space provides powerful first impressions for the service user and signifies how and if the institution values Aboriginal and Torres Strait Islander people. Visual acknowledgement of Aboriginal and/or Torres Strait Islander flags demonstrate inclusiveness and respect. A written display of recognition of the traditional country on which the health service is situated also sends

a clear and powerful message to the community. Artwork from local and national Aboriginal and Torres Strait Islander artists, signs in traditional languages and other visual representations of Aboriginal and Torres Strait Islander culture all contribute to a welcoming and respectful environment (Dunbar et al., 2008). Elders and community members could also be invited into maternity care settings to assist with ensuring appropriate physical and safe environments.

Suggested Indicator for further development

All health services demonstrate a physical and visible acknowledgement of Aboriginal and/or Torres Strait Islander people and culture.

2. Specific Aboriginal and/or Torres Strait Islander programs

Aboriginal women are more likely to utilise a maternity service that is used by significant numbers of other Aboriginal women (Nel & Pashen, 2003; NSW Health, 2005; Reibel & Walker, 2010). Antenatal care attendance is higher in care settings which are specifically for Aboriginal women (Rumbold & Cunningham, 2008) and have been showed to improve perinatal health outcomes (Panaretto et al., 2005 ; Panaretto, Mitchell, Anderson, Larkins, & Manassis, 2007). Mainstream services therefore should be encouraged to offer Indigenous specific programs for their Aboriginal and Torres Strait Islander clientele. Ideally these programs should be offered within a community setting (NSW Health, 2005; Reibel & Walker, 2009), advertised well and offered to women as early in the pregnancy as possible.

There is a number of models in mainstream services that are designated specifically for Aboriginal and Torres Strait Islander women. These include:

The Aboriginal Maternal Infant Health Strategy (NSW)

This program is a community based maternity service, with a midwife and Aboriginal Health Worker or Aboriginal Education Officer working in partnership with Aboriginal families to provide culturally appropriate care to Aboriginal women and babies. A three year evaluation concluded in 2005 with positive findings including a reduction in preterm births, improved breastfeeding rates and access to antenatal care in early pregnancy (NSW Health, 2005). The strategy is assisted by a dedicated support unit and ongoing education for the teams.

Aboriginal Maternal Infant Care Program (South Australia)

This program originated in 2004 in Whyalla and Port Augusta but is currently being rolled out across rural South Australia as well as metropolitan Adelaide. The program aims to improve primary health and hospital care by providing culturally appropriate support to women by Aboriginal Maternal and Infant Care (AMIC) workers who work in partnership with midwives (Stamp et al., 2008). These teams are allocated a caseload and provide continuity of carer (including labour and birth) from the time of the woman's acceptance into the program until six to eight weeks after birth when care is transferred to Child and Youth Health services.

The Malabar Community Midwifery Link Service (NSW)

This community-based program offers midwifery and child and family health services in Eastern Sydney. It specifically targets Aboriginal and Torres Strait Islander and culturally diverse women, families and children. Midwives are supported by an Aboriginal Health Worker and Aboriginal Educational Officers to provide antenatal and postnatal care and early parenting and health information. A review in 2011 found that for the women who used the service the Aboriginal Health Worker is extremely important for the development of trust and availability of support (Homer et al., 2011). It was acknowledged that the role of the Aboriginal Health Worker was complex and time consuming and that this needed ongoing recognition.

Murri Antenatal Clinic (Mater Hospital, Brisbane)

A team of Aboriginal Liaison Officers and an Aboriginal midwife is supported by an obstetrician and allied health professionals to provide antenatal care to Aboriginal and Torres Strait Islander women accessing maternity care at the Mater Hospital in southern Brisbane. An evaluation of this program has recently been completed (Stapleton, Murphy, Gibbon, & Kildea, 2011).

Midwifery Group Practices for Aboriginal women (NT)

Continuity of midwifery care is now available to some remote dwelling Aboriginal women planning to give birth at Alice Springs or Darwin hospital. Whilst receiving care at a remote primary health centre by remote based midwives, Aboriginal women are allocated a town based midwife. When the woman relocates to town during her pregnancy for birthing or other maternity care needs, her care is transferred to the town based midwife. This midwife remains the lead care provider until the women returns to her place of residence, often in the early postnatal period. This is available for women of all risk.

In Darwin the midwives work alongside two Aboriginal Health Workers who are also student midwives as well as Strong Women Workers and a senior Aboriginal woman from one of the large remote communities. This senior woman provides support to women from the same community during pregnancy, birthing and the postnatal period. An evaluation of this program is currently underway.

In Alice Springs the midwives work alongside a senior Aboriginal Liaison Officer, who provides cultural brokerage including language skills.

Congress Alukura, the Community Controlled Aboriginal Health Organisation in Alice Springs, has a midwifery group practice with two direct entry Aboriginal student midwives attached to the program and a cultural advisory council made up of traditional grandmothers who provide cultural guidance, support and oversight. This practice provides care to Aboriginal women living in Alice Springs and surrounds. There is a Memorandum of Understanding (MOU) between Alukura and the Alice Springs hospital that enables Alukura staff to provide continuity of care antenatally, during birth and postnatally. A specialist obstetrician from Alice Springs hospital visits Alukura every week to provide care in the culturally appropriate primary care setting.

The Alukura service also includes a non-clinical intensive home visitation program called the Australian Nurse Family Partnership Program. Nurses and Aboriginal Cultural Workers visit women during pregnancy until the child is two years old.

It is evident that any specific Aboriginal and Torres Strait Islander maternity program should include care from Aboriginal and Torres Strait Islander health professionals and vocational workers in a continuity of carer model across the child bearing period of pregnancy, birth and the post natal period (see sections 3 and 4 below).

Services should also have the capacity to record and report on data that represents service utilisation by Aboriginal Torres Strait Islander women (Reibel and Walker 2010).

Health care programs and institutions providing services to significant numbers of Aboriginal and Torres Strait Islander peoples should have cultural interpreters and Aboriginal health advocates on staff (Smylie, 2001). Communication and language barriers significantly contribute to ineffective health service delivery and adverse health outcomes (Dunbar et al., 2008).

Information must be communicated to Aboriginal and Torres Strait Islander people to effectively engage with this client group (Wild & Anderson, 2007). The risk of miscommunication is also significant even for Aboriginal and/or Torres Strait Islander clients fluent in English, when staff do not share the same cultural background or knowledge (Eckermann et al., 2006).

Interpreter services are generally poorly utilised with Aboriginal and Torres Strait Islander clients, even when available (Dunbar et al., 2008). Effective use of interpreter services are reported to:

- help Aboriginal and Torres Strait Islander clients feel more at ease and communicate more effectively
- increase Aboriginal and Torres Strait Islander people's access to appropriate medical care
- ensure fully informed consent to medical procedures
- assist patients to understand the nature of their illness and to discuss all issues related to it effectively
- enable health staff to obtain much more information from their Aboriginal and Torres Strait Islander patients and therefore make better clinical decisions
- help protect health agencies from medico-legal liability

(Wilczynski, Wallace, Nicholson, & Rintoul, 2004).

Where women speak English as a second, third or fourth language, care should be provided in their own languages whenever possible and interpreters offered if not possible.

Suggested Indicator(s) for further development

All maternity services with significant numbers of Aboriginal and/or Torres Strait Islander women provide designated Aboriginal and/or Torres Strait Islander programs.

Services report percentage of Aboriginal and/or Torres Strait Islander women who access continuity of midwifery care across the pregnancy, birth and postnatal period.

Interpreter service utilisation in the languages spoken by Aboriginal and/or Torres Strait Islander women accessing the services is reported.

Mainstream services report percentage of women who access care provided by Aboriginal and/or Torres Strait Islander health professionals.

3. Aboriginal and Torres Strait Islander workforce

The inclusion of Aboriginal and/or Torres Strait Islander workers as members of a multidisciplinary care teams is essential for the provision of culturally competent care (Aboriginal Health Council of Western Australia, 2010; Reibel & Walker, 2010). Aboriginal and/or Torres Strait Islander workers have the unique capacity to act as a bridge between cultures, a translator of information, and someone who can ease relationships between the health staff and the woman (Wilson, 2009).

The development and support of an Aboriginal and Torres Strait Islander maternity workforce is also a key Action area within the National Maternity Services Plan (AHMAC, 2011b). Latest figures report that 1.2% of the Aboriginal and Torres Strait Islander population was employed in health-related occupations. This is below the proportion of the non-Indigenous population (approximately 3%) (AHMAC, 2011a).

The existing Aboriginal and Torres Strait Islander health workforce is currently poorly utilised and this influences the attraction of Aboriginal and Torres Strait Islander people to work in mainstream facilities (Dunbar et al., 2011). In addition to mainstream professional or vocational roles, there is a number of Aboriginal or Torres Strait Islander specific roles that could enhance maternity care effectiveness. These include the Aboriginal and/or Torres Strait Islander Health Worker, Aboriginal Education Officer, Strong Women Worker, Community Child Health Worker, Indigenous Liaison Officer. These positions should be considered essential in any mainstream maternity service that provides care for Aboriginal and Torres Strait Islander women and their families.

An evaluation of the NSW Aboriginal Maternal Infant Health Strategy found significant improvements in key outcomes for women and babies (NSW Health, 2005). This program relies on a partnership between a midwife and an Aboriginal Health Worker or Aboriginal Education Officer to support women through pregnancy. Additional factors identified that contributed to

program success included community based services, the availability of transport, and education pathways for the Aboriginal workers.

The success of the Aboriginal Maternal and Infant Care (AMIC) program in South Australia has also been reported (Stamp et al., 2008). Aboriginal workers on the AMIC program identify important components of their work to include their ability to take a lead cultural role and participation in all aspects of perinatal care. A crucial part of their role is to advocate for Aboriginal women in the hospital setting. Of interest, the AMIC workers noted significant resistance from some of the hospital midwives, with reluctance to accept and provide support for the new program or the AMIC workers. Much of this resistance diminished as the hospital staff developed a rapport with the AMIC workers and an understanding of their role and capability. However, AMIC workers report that some midwives remain resistant and some midwives will never be able to provide culturally competent care due to persisting poor attitudes (Stuart-Butler, McKenzie, & Clarke, 2011).

Most mainstream services often fail to acknowledge the importance of cultural practices in their services, nor do they integrate traditional teachers or elders and their wisdom and experience into the health care system both in Australia (Dunbar et al., 2008) and overseas (Health Council of Canada, 2011). This has led to health care services that are often not culturally relevant or sensitive and do not meet local community's health needs.

The Strong Women Strong Babies Strong Culture program was first developed in the Northern Territory and has been adopted in other states and territories including Western Australia and Queensland. This program employs senior Aboriginal women in the community to work in partnership with health service professionals to support young women in pregnancy and parenting. The senior women encourage attendance at antenatal care clinics, support traditional knowledge and provide advice on nutrition. Connections and support for involvement in cultural events are an important part of the program. This particular program is one that has a strong community development focus and potentially major health benefits to Aboriginal people. Initially, positive improvements in birth weight including decrease in low birth weight were reported (Mackerras, 1998). These benefits, however, do not appear to have been replicated in other communities (d'Espaignet, Measey, Carnegie, & Mackerras, 2003) though there have been no published reports on measureable health outcomes since 2003.

An 'agenda creep' was identified by Lowell and colleagues in a 2008 qualitative evaluation where the Aboriginal cultural dimension of the program was losing emphasis as the knowledge and practice of the Western domain took precedence. The lack of cultural competence of some staff involved with the program, combined with a high turnover, was also reported to have weakened the partnership component of the program that promoted two way learning and strong Aboriginal control (Lowell, Kildea, & Esden, 2008).

It is therefore essential for Aboriginal and Torres Strait Islander workers to not only be included in the multidisciplinary maternity services team, but for health services to ensure they have meaningful opportunities to contribute to service delivery in an equitable and sustainable way.

Workforce opportunities for Aboriginal and Torres Strait Islander women must include mainstream professional educational opportunities. The training of Indigenous Inuit midwives in remote parts of northern Canada has contributed to significant improvements in health care utilisation and maternal and infant health outcomes (Van Wagner, Epoo, Nastapoka, & Harney, 2007). Midwifery training should be an integral part of changes in maternity care for rural and remote Aboriginal communities (Couchie & Sanderson, 2007). The support of Aboriginal women to participate in education programs such as Bachelor of Midwifery should be included in all services capable of supporting student midwifery positions. Increasingly this should not be only occurring in large tertiary settings, but can occur in any service that provides maternity care to women including non birthing units.

Suggested Indicator(s) for further development

Services report on:

- ***the number (in what roles) of Aboriginal and/or Torres Strait Islander workers within the maternity service team***
- ***the number of training positions supporting Aboriginal and/or Torres Strait Islander education (e.g. Bachelor of Midwifery students, Certificate III & IV in Maternal Infant Health).***
- ***the number of Aboriginal and/or Torres Strait Islander students completing (which) supported programs including medical, midwifery, Aboriginal Health Worker programs***

4. Continuity of care and carer

Increased access to midwifery models of care is also a priority identified in the National Maternity Services Plan (AHMAC, 2011b). The most recent Cochrane meta-analysis reviewed 11 trials, involving 12,276 women and found women who have midwife-led models of care were less likely to experience antenatal hospitalisation, regional analgesia, episiotomy and instrumental delivery, and were more likely to experience no intrapartum analgesia/anaesthesia, spontaneous vaginal birth, feel more in control and have higher rates of satisfaction (Hatem, Sandall, Devane, Soltani, & Gates, 2009).

Aboriginal and Torres Strait Islander women value care from a person they know and trust (Dunbar et al., 2008; Homer et al., 2011; Wilson, 2009). In 'continuity of midwifery care' or 'caseload practice' each woman has a primary midwife who is her first point of reference and who takes responsibility for her individualised care through pregnancy, birth and the early weeks of motherhood (Homer, Brodie, & Leap, 2008). Continuity of midwifery care is particularly useful for disadvantaged women who may feel marginalised from mainstream services (Homer et al., 2011). Therefore continuity of midwifery care should be offered to all Aboriginal and Torres Strait Islander women.

Currently most Aboriginal and Torres Strait Islander women who live in rural and remote areas are automatically excluded from receiving care from a known midwife due to lack of local birthing services that necessitate the transfer of care at 36-38 weeks gestation. However, local services should be arranged to provide care from a primary carer for both the antenatal and postnatal care. Once the woman is transferred to the regional service, care should be provided from an identified and named carer in the last weeks of pregnancy, labour and birth. This carer ideally will be identified by the outlying health service when the woman is first engaged in the service. Midwives from both settings should communicate with each other as well as other members of the multidisciplinary team as required. Flexible models could include outreach visits by the regional midwife to the rural or remote area, midwifery exchange, the provision of photographs of the regional carer/s (midwife and Aboriginal co-worker) shown to the woman upon booking etc. Some aspects of this model have been successfully implemented in some parts of the Northern Territory with evaluation results pending.

For rural and remote women requiring transfer to a larger centre for birth, case conferencing between the local and regional team should be routine practice as part of the antenatal program of care. These meetings should discuss all women who had booked in that week, who were 36 weeks that week and any other women of concern.

Another aspect of care that disadvantages Aboriginal and Torres Strait Islander women is an exclusion criteria applied to women based on their ethnicity. Many midwifery care models currently only provide care for low risk women, though this is changing in some jurisdictions to include women with all risk factors. For Aboriginal and Torres Strait Islander women to have access to the benefits of midwifery models of care, an 'all risk' program needs to be offered. As noted earlier, this has been successfully implemented in some areas of the Northern Territory.

Suggested Indicator(s) for further development

All maternity services should prioritise continuity of carer models for all Aboriginal and Torres Strait Islander women (of all risk).

Flexible models that maximise continuity of care and integrated health services should be available to all women in rural and remote communities.

Ideally the known carer is an Aboriginal or Torres Strait Islander midwife. However where this is not possible non-Indigenous midwives should partner with an Aboriginal and/or Torres Strait Islander Worker who also provides continuity.

5. Collaborating with Aboriginal Community Controlled Health Organisations and other agencies

Lack of quality partnerships with other service providers creates the greatest threat in ensuring Aboriginal women are able to access the services they need (Larson & Bradley, 2010). A sustained improvement in health outcomes for Aboriginal families requires a culture of collaboration involving all stakeholders working closely across professional disciplines and fully involving service users.

Some jurisdictions are undertaking initiatives for cultural learning and reconciliation. The WA Health's Aboriginal Cultural Learning Framework (2012), broadly identifies opportunities for individuals and work units to respond to Aboriginal communities through strategic partnerships and planning.

There is a range of Aboriginal specific health service agencies available for Aboriginal women to access maternity care. These services are often preferred by Aboriginal women (Doherty et al., 2009). In their review of 42 Western Australian antenatal services (not including private GPs) Reibel and Walker (2009) found that Aboriginal women use Aboriginal services more regularly than they use mainstream services.

In a review of Aboriginal Community Controlled Health Organisations (ACCHOs) in Western Australia, approximately 50% had only basic referral systems and a few visiting specialists (Larson & Bradley, 2010). This low degree of collaboration minimises opportunities for seamless care and for sharing resources to achieve a common goal. Women bear the consequences and can either be over-served by the various agencies or underserved, failing to receive quality care from any agency (Kruske & Jones, 2010). Effective collaboration between ACCHOs and regional area health services can lead to reduced antenatal admissions, improved perinatal outcomes and a reduction of costs (Doherty et al., 2009).

It is recommended that all services establish a Memorandum of Understanding (MOU) or service agreement to clarify roles and provide a record of intention which can survive frequent changes of workers and managers (Larson & Bradley, 2010). Policy documents that promote partnership and collaboration between professionals and agencies should include details around the shared involvement in clinical governance, procedures for case conference, joint planning, exchange of health information, local cultural protocols, sharing of human and physical resources and dispute resolution (Larson & Bradley, 2010).

Collaboration and exchange of information between ACCHOs and government services should also include maintenance of current community profiles, the provision of contact details of Aboriginal and/or Torres Strait Islander and non-Indigenous people, times for cultural ceremonies and information regarding other important community protocols (Dunbar et al., 2008).

Members of the maternity services team must be supported to actively engage in and promote inter-agency regional initiatives (Aboriginal Health Council of Western Australia, 2010). Improved networking between agencies can be promoted through the establishment of regular case conferencing, outreach services and combined health events. Health service staff can provide

outreach care to the ACCHOs, and ACCHO staff can visit the local hospital to identify and connect with inpatient women or provide support for antenatal care (Kruske, 2010).

Insurance restrictions limit the opportunities for ACCHOs to currently provide birthing services. This significantly restricts the possibility of Aboriginal women accessing care through ACCHOs to receive care by a known midwife during labour and birth. Collaborative models between government health services and ACCHOs that facilitate ACCHO staff to accompany their women to the local hospital to care for them in labour and birth should be encouraged. This has been successfully achieved in Alice Springs (see section 2 above). These arrangements not only promote continuity of carer for the women but offer a workforce model that is responsive to staff and workload demands. It also addresses the Actions within the National Maternity Services Plan (AHMAC, 2011b).

Suggested Indicator(s) for further development

All public maternity services demonstrate arrangements/agreements with ACCHOs if locally appropriate.

Arrangements/agreements should include access for ACCHO midwives to provide care for ACCHO clients in labour and birth.

Health services provide evidence of regular case conferencing with annual chart audits demonstrating effective care.

Health services provide evidence of joint education and sharing of resources with ACCHOs.

6. Communication, information technology and transfer of care

Effective communication between health services, other agencies and women is essential if women are to receive high quality care. Communicating effectively with someone from another culture requires the practitioner to have both an understanding of the manner of communication and the practical ability to enact that understanding (Dudgeon et al., 2010). Poor communication within and across agencies and organisations will compromise patient safety and quality of care (Lowell, 2001). Effective communication must also consider the importance that many Aboriginal and Torres Strait Islander people place on the need to spend time to develop a rapport with a stranger before the 'business' of the health visit takes place.

Aboriginal and Torres Strait Islander women value not having to tell their story over and over again and report having to do this at mainstream services (Doherty et al., 2009; Homer et al., 2011). Ideally electronic and/or paper recordkeeping systems should exist that all health professionals can contribute to (Larson & Bradley, 2010). Handheld records for women and infants are also important. These systems must have the ability to generate recall lists and reminders (Larson & Bradley, 2010) so that women are not missed or forgotten and to ensure duplication of services and tests does not occur.

Discharge from maternity care and the transition to community based care and child and family health services is an area that requires particular attention (Bar-Zeev, Barclay, Farrington, & Kildea, in press; Homer et al., 2009) and is an identified Action in the National Maternity Services Plan (AHMAC, 2011b). Information sharing should be encouraged (with the woman's permission and subject to privacy laws) and priority given to the timely provision of discharge information to the woman and other relevant services. Improvement in the quality of information included in the discharge summary can be achieved through the development of guidelines or a template. Midwives could coordinate the discharge process to limit delays in summaries being sent due to unavailability of medical staff. Copies of pathology and other test results should be sent to all health professionals involved in the woman's care.

Feedback from consultations resulting from referrals should also be promoted both within and across agencies.

Suggested Indicator(s) for further development

Guidelines are developed that maximise sharing of information whilst respecting privacy and confidentiality.

Discharge summaries are provided to all relevant stakeholders (including the woman) on the day of discharge from maternity services.

Regular audits are undertaken on the use of hand held records and referral feedback to ensure high quality is maintained.

7. Staff attitudes and respect

It is not uncommon for non-Indigenous health practitioners to show discrimination or ignorance of Aboriginal cultures, realities and challenges (Dunbar, et al., 2008). Aboriginal and Torres Strait Islander consumers have reported feeling marginalised, disrespected and judged by mainstream health service providers (AHMAC, 2011a). Disrespect and abuse may sometimes act as more powerful deterrents to maternity service utilisation than other more commonly recognised deterrents such as geographic and financial obstacles (Bowser & Hill, 2010). Paradies and colleagues (2008) report on the benefits of racial socialisation (i.e. learning about the nature and ubiquity of racism in society) to find effective ways to combat interpersonal racism in Australia and New Zealand.

Although respect is a universal concept, some of the behaviours which generate or manifest respect are culturally specific (Smylie, 2001). Therefore it is more likely for a person from a minority group to feel disrespected when receiving care from a mainstream service. This is because of differences in values, beliefs and worldviews, all influencing behaviour and attitudes around what constitutes respectful behaviours. Some examples that may apply to Aboriginal and/or Torres Strait Islander women include the use of excessive eye contact, sitting too close, or actual physical contact, standing over (versus sitting next to) and the preference for female caregivers (Dunbar et al, 2008). Failure to be responsive to these cultural behaviours by non-Indigenous staff can lead to Aboriginal and/or Torres Strait Islander clients feeling disrespected and devalued.

Disrespectful behaviour can range from minor misunderstandings of culturally informed behaviours outlined above through to covert and overt racism. Racism and race-based discrimination is the most important issue in the application of cultural competence (Trenerry, Franklin, & Paradies, 2010). Racism constitutes a 'double burden' for Indigenous Australians, known to negatively impact both their physical and emotional health status, and their access to effective and timely health care services (Awofeso, 2011). Racism, often unintentional, discreet and covert is much more influential when determining the suitability of health services for Aboriginal and Torres Strait Islander women than many other aspects of care (Bradby, 2010).

Blatant or overt racism is now less acceptable in Australia than in previous years. This has resulted in a change in the way racism is expressed to a more underhand or covert expression (Dunbar & Murakami-Gold, 2010). Some argue that covert forms of race-based discrimination may have a more detrimental effect on health than blatant race-based discrimination (Noh et al., 2007).

Examples of more covert racism could include not involving Aboriginal or Torres Strait Islander male partners based on the stereotype that birthing is women's business. Whilst this is appropriate in some communities, it may be inappropriate in others. Similarly, withholding written or complex information from women based on the assumption of low education and health literacy is similarly inappropriate to many Aboriginal and Torres Strait Islander service users.

Learning about the nature and ubiquity of racism in society is known as 'racial socialisation' and has three main components: (i) learning to identify racism; (ii) learning appropriate responses to racism; and (iii) understanding that the experience of racism may be fraught with feelings of rejection, confusion and doubt (Paradies, 2008). It is important for non-Indigenous health care

providers to understand and appreciate the diversity of Aboriginal and Torres Strait Islander people in culture, education, socio-economic circumstances, professional status, community standing and location.

Regardless of the education programs provided (see below), there will be variations on the impact on individuals across the health system. Callister (2005, p. 385) identified a continuum from 'resistant to impassioned', supporting the idea that some health practitioners will resist the reflective process and continue to practise the way they have always done. Therefore additional processes must be implemented to identify and further support staff who remain resistant.

Health staff are rarely held accountable for their culturally unsafe and ignorant behaviour (Dunbar et al, 2008). Unacknowledged racism in our health system is a significant problem that the health care system and the health professions have a stringent responsibility to address (Johnstone & Kanitsaki, 2005). Guidelines that address situations and staff who break cultural protocols or demonstrate covert or overt racist practices would assist in the promotion of culturally competent health services. These guidelines could include processes that provide individual support for staff reported to be providing unacceptable care, or systemic processes when issues are identified that warrant a service-wide response. Useful components for increasing cultural competence may include establishing processes for self reflection, gaining feedback on performance and implementing a mentoring system (Dudgeon et al., 2010).

Inclusion of key selection criteria that addresses cultural competence in recruitment activities and ongoing performance reviews will also assist in changing workplace culture and emphasise management's commitment to culturally competent care.

Key factors that promote inclusion of minority groups and protect against race-based discrimination at an organisational level include:

- organisations that have policies, practices and procedures to reduce discrimination and ensure fair and equitable outcomes for clients and staff from varied backgrounds;
- have strong mechanisms for responding to discrimination when it occurs;
- are accessible, safe and supportive for clients and staff from varied backgrounds;
- have strong internal leadership in the reduction of discrimination and support of diversity and model this to other organisations and the wider community;
- model, promote and facilitate equitable and respectful inter-group relationships and interactions;
- respect and value diversity as a resource

(Paradies et al., 2009)

Suggested Indicator(s) for further development

A cultural competence policy exists in each jurisdiction/service that promotes a lack of acceptance of racism and discrimination.

Key selection criteria regarding culturally safe care to include in all job descriptions and performance reviews of all staff are identified.

8. Cultural education programs

Cultural competence is an important component of all health professional training and service delivery and should be supported by policies, guidelines, and a range of methods for delivering care in a culturally safe manner (Paradies et al., 2009). Various forms of cultural competence training have been provided to health providers in Australia for over 20 years, yet there is limited evidence that it is effective in improving access, equity, client satisfaction or health outcomes (Lie, Lee-Rey, Gomez, Berekenyei, & Braddock III, 2010; Thomson, 2005).

Cultural education must go beyond the provision of information about Aboriginal and Torres Strait Islander people (Pedersen, Walker, Paradies, & Guerin, 2011). This traditional model of

education focuses on the culture of the 'other' and has been widely criticised for stigmatising and stereotyping people as well as ignoring the historical and political influences of Aboriginal society (Browne & Varcoe, 2006; Dudgeon et al., 2010; Kruske & Kildea, 2006). Cross-cultural programs must consider the experience of the person who is accessing the health service as well as increasing awareness of the participant's own prejudices and discriminatory beliefs (Trener et al., 2010).

The long history of paternalistic treatment and racism, coupled with a continued lack of understanding of the challenges faced by Australia's original inhabitants have created a sense of wariness among many Aboriginal and Torres Strait Islander people and is a significant barrier to good health (Dunbar & Murakami-Gold, 2010). Awareness of 'black disadvantage' as well as the 'white privilege' afforded to Australia's non-Indigenous members is an important principle of cultural competence (Dudgeon et al., 2010, p. 38).

In New Zealand, health services have always considered the unique interaction between the carer and the consumer as an important aspect of cultural safety:

[Cultural safety is] the understanding of self as a cultural bearer; the historical, social and political influences on health; and the development of relationships that engender trust and respect.

(NZCoN, 2011, p. 5)

This model further recognises that:

Cultural safety is underpinned by communication, recognition of the diversity in worldviews (both within and between cultural groups), and the impact of colonisation processes on minority groups.

(NZCoN, 2011, p. 8)

To be effective, health systems and the individuals working within them, must acknowledge that differences between cultures exist, that these require respect and that our unquestioned, familiar or usual ways of relating to people of a different culture can cause them to feel uncertain, unsafe or offended (Walker, 2011b). To achieve this, a significant level of critical reflexivity must be possible whereby practitioners are able to interrogate the political, social and cultural positioning of Indigenous people in temporal terms (historical and contemporary) and geographic contexts (including community contexts), to affirm and validate Indigenous identity and difference (Walker & Sonn, 2010). Pedersen and colleagues (2011) stress that to be effective in reducing prejudice, multiple mechanisms are required.

Clinicians, administrators, and funding agencies (both government and non-government) should have access to cultural education programs to ensure they are well informed about the health needs of Aboriginal and Torres Strait Islander peoples and the broader determinants of health. Sensitising or increasing awareness of aspects of Aboriginal and/or Torres Strait Islander cultural practices and traditions is insufficient to ensure equity is achieved in both access to health services and in health outcomes. Similarly, concentrating on Aboriginal and/or Torres Strait Islander 'culture' alone will not improve the suitability and accessibility of maternity care by these women. Cultural education programs must include the impacts colonisation, racism, and policy (e.g. stolen generation) have on the continuing health and wellbeing of Aboriginal and Torres Strait Islander peoples and their utilisation of mainstream services.

In most contemporary cultural education programs, limited attention is given to individual, professional and institutional racism or how the attitudes of health professionals will influence health service effectiveness. Individual, professional (particularly the acceptability and support of Aboriginal workforce) and institutional racism are the most important aspects of maternity care that should be addressed.

Cultural education must be continuous and monitored to ensure required behaviour change occurs and is sustained.

Suggested Indicator(s) for further development

All staff attend mandatory Cultural Practice education that are led or delivered in partnership with Aboriginal and/or Torres Strait Islander people.

These programs should be provided on commencement of employment with annual updates.

9. Relationships

Supportive relationships are the ‘keystone’ to working effectively across cultures (Dudgeon et al., 2010, p. 37) and must occur with Aboriginal and Torres Strait Islander people individually (as clients) and professionally (as co-workers) and with the community (as partners with services).

Any effective health program must recognise, respect, support and promote the importance of family and country to many Aboriginal and Torres Strait Islander people (Stamp et al., 2008). Aboriginal family and kinship relationships are the primary structures that provide cultural and social and emotional cohesion and support for many Aboriginal people (Walker, 2011b). This kinship network includes large extended family members, often biological and non-biological. These relationships can challenge non-Indigenous health staff’s notions of what is suitable support, and conflicts with many maternity policies such as the allowance of only ‘the partner and one other’ in the birth suite or ‘two visitors only’ in postnatal wards.

For Aboriginal and Torres Strait Islander women to be effectively supported, health services must modify protocols and allow individual women to identify who is most suitable to support them in childbirth. Family-centred care is a term commonly applied in health service literature but has specific application to Aboriginal and Torres Strait Islander people. This locates the woman in the centre of an important family network where different family members will have obligations and responsibilities to the woman and her newborn (Kruske, Belton, Wadaguga, & Narjic, in press). It is important for health service providers to understand the important role of family members and older women, particularly when caring for young pregnant and birthing women (Kildea, 1999). It is also important to remember that decisions that need to be made about the treatment of wellbeing of a mother or her infant may require significant consultation across various family members that may take time.

It is also important to facilitate relationships to occur between the Aboriginal and/or Torres Strait Islander client and the health professional. The relationship between the worker and the client is critical, and unless respect and humility toward cultural differences is demonstrated in those providing services to clients, little progress will be made at an organisational level (Dudgeon et al., 2010). Many Aboriginal and Torres Strait Islander families require a relationship and trust to be established before health advice will be accepted (Dunbar et al., 2008; Wilson, 2009).

For many Aboriginal and Torres Strait Islander people, their spirituality and identity is determined by their sense of connection to country. Aboriginal and Torres Strait Islander people will often refer to themselves by the region where their ancestors originated or by their language and tribal group. It is important for health systems and professionals to acknowledge this connection to tribal groups and regions and to acknowledge the importance they hold to a person’s identity and wellbeing (Walker, 2011b).

This understanding should be applied to both Aboriginal and Torres Strait Islander service users and workers within the service. Additional and specific cultural leave and support should be able to be negotiated.

Suggested Indicator(s) for further development

Cultural competence policy includes guidelines that outline recognition, support and promotion of Aboriginal and Torres Strait Islander people’s cultural identity and connection to family and country.

10. Informed choice and right of refusal

Choice in health care is highly valued by all consumers including Aboriginal and Torres Strait Islander women who are more likely to have less choices available to them (Hancock, 2006). In a consultation of Aboriginal women in Central Australia, choice includes 'who and how members of their family participated in the care; the kind of service they attended; the profession, Aboriginality, sex and skills of midwives and Aboriginal Health Workers; the continuity of carer; and confidentiality and privacy' (Wilson, 2009, p. 3).

The National Maternity Services Plan (AHMAC, 2011b) defines woman-centred care as:

Care that is responsive to women's needs and preferences, and enables them to access objective, evidence-based information that supports informed choices about their maternity care.

(AHMAC, 2011b, p. 25)

It is essential that clinicians and health services recognise and respect the right Aboriginal women have to make decisions about their care (AHMAC, 2011b; Hunt, 2006). Women must be fully informed of the risks and benefits so they can make an informed choice about where to give birth. A woman's right to choose should be respected (SOGC, 2010).

Currently in maternity care 'risk' is considered within a bio-medical context that excludes the social, emotional and cultural risks that have equal or greater importance for Aboriginal and Torres Strait Islander women (Kildea, 2006). For some Aboriginal and Torres Strait Islander women, being separated from their land, language, culture and families during the birth of their children can represent an unacceptable risk (Ireland, 2008; Roberts, 2001).

Supporting women's right to informed choice must also include supporting their right of informed refusal. Many professionals and health services place the risk of the foetus over the risk for the mother (Lancet editorial, 2010). When faced with the potentially competing interests of the safest possible birth for the child versus the safest birth for the mother, the mother's right to bodily autonomy and self-determination are legally and ethically recognised (Kingma, 2011). Health professionals therefore are legally and ethically obligated to respect this right and ensure women are not denied care when those choices are at variance with professional advice.

Guidelines currently exist including: the Consultation and Referral Guidelines, (ACM, 2008); ANMC National Competency Standards for the Midwife (ANMC, 2006); Code of Professional Conduct for Midwives (ANMC, 2008) that outline the appropriate course of action midwives should take when faced with the situation where a woman chooses care outside health service guidelines. When followed, these guidelines uphold ethical and legal principles of the woman's autonomy as well as ensuring the health professional is protected and the woman is still supported.

Suggested Indicator(s) for further development

Cultural competence policy includes reference to appropriate guidelines that protect and support both health professionals and women when women's choices are at variance with professional advice and may place the mother or foetus at increased risk (e.g. place of birth).

11. Tools to measure cultural competence

Large institutions such as government health services require tools to assist and assess local services if cultural competence is going to be achieved. Operationalising what constitutes culturally competent services into a set of mechanistic indicators has been criticised for diminishing community ownership. However, these criticisms can be addressed by incorporating community partnership into the organisational assessment process and accessing Aboriginal and/or Torres Strait Islander leadership through community controlled health organisations into systems level change (Walker 2010).

There is a range of frameworks already in existence to support cultural competence across the health sector (see below). Mechanisms are required to operationalise these frameworks within systems and organisations to embed cultural competence in professional and individual practice. It also needs education and training to occur simultaneously (Reibel & Walker 2009).

Alongside cross cultural education, organisational accountability has been argued to be the most important factor in reducing racial discrimination (Trenerry et al., 2010). Organisational auditing and accountability promotes resource development and role-modelling and facilitates positive intergroup contact. Auditing and assessment approaches are a means to achieve organisational accountability. Organisational audits should involve assessment of workplace practices, policies and procedures that support cultural diversity and reduce discrimination (Trenerry et al., 2010).

Walker (2011a) identified nine elements in an audit tool to assess cultural competence. These are:

1. leading and managing change: Organisational Cultural Competence requires leaders with the capacity, commitment and continuous quality improvement mechanisms to develop and maintain culturally responsive services
2. creating a welcoming environment: a welcoming, friendly and culturally safe and inclusive environment increases access by Aboriginal families
3. developing cultural competence of new and existing staff
4. providing culturally responsive care: access, transport, specific Aboriginal programs, drop in capacity etc are shown to enhance Aboriginal family access to services
5. facilitating culturally inclusive/secure policies and practices
6. communicating effectively with Aboriginal people: miscommunication is one of the greatest barriers to Aboriginal people receiving quality care
7. building relationships: collaborative partnerships with Aboriginal communities and organisations promote culturally secure care
8. improving service delivery: evidence confirms that organisational and practitioner cultural competence improves health outcomes
9. monitoring and evaluating effectiveness of strategies.

(Walker, 2011a p 4)

There is a considerable number of cultural competence tools now available (see Trenerry Franklin et al 2010 for a comprehensive overview). Most, however, pertain to individual assessment, rather than organisations. They also tend to focus on knowledge, rather than attitudes or behaviours, and fail to address race-based discrimination (Kumas-Tan, Beagan, Loppie, MacLeod, & Blye, 2007). The majority of organisational cultural competency assessment tools have also been developed within the frameworks and theoretical contexts of the United States and do not necessarily apply to the Australian environment (Trenerry et al., 2010).

Tools developed for the Australian health context that specifically address the improvement of services for Aboriginal and Torres Strait Islander people include:

1. Cultural Competence Assessment Tool Kit: developed for and tested in both maternal and paediatric health settings (Walker, 2011a)
2. The Cultural Competency Self-Assessment Instrument: designed for South Australian health care agencies working with Aboriginal children, families and communities (South Australian Department of Premier and Cabinet, 2006)
3. The Making Two Worlds Work Health and Community Services Audit: developed in Victoria by the Mungabareena Aboriginal Corporation and Women's Health Goulburn North East health service. Assesses domains including: the physical environment; engaging Aboriginal clients and communities; communication and relationships; developing cultural competence; staff training; and working collaboratively and respectfully with Aboriginal organisations and services (Mungabareena Aboriginal Corporation, 2008).

4. The Aboriginal and Torres Strait Islander Health Performance Framework, provides a reporting framework to monitor progress of the health system and broader determinant of health in improving Aboriginal and Torres Strait Islander Health (Department of Health and Aging 2008)
5. The Koori Practice Checklist: designed for the alcohol and drug service sector, but is applicable to a range of organisations (Ngwala Willumbong Co-Operative, 2007).

While some of the available tools have been positively evaluated (Walker, 2010), more research is required to determine if these processes lead to an improvement in the experience and participation of Aboriginal and Torres Strait Islander people in health service delivery or in health outcomes.

Suggested Indicator(s) for further development

A (suitably tested) cultural competence tool be applied to all maternity services.

12. Culture specific guidelines

Non-Indigenous professionals don't necessarily understand the importance of honouring Indigenous practices and integrating them with modern health care or other services (Health Council of Canada, 2011). Understanding of the unique needs of Aboriginal and Torres Strait Islander families specific to the area of childbirth is an important component of effective and culturally competent care. Aboriginal families in the Northern Territory highlighted constant breaching of cultural protocols by non-Aboriginal health professionals and requested that health systems, and workers within those systems, know 'more about us' (Dunbar et al., 2008, p. 67).

Guidelines such as those developed by Walker (2011b), entitled: 'Improving Communications with Aboriginal Families around critical care issues' provide practical considerations when providing care to Aboriginal and Torres Strait Islander families when their newborn is unwell or requiring palliative care. This tool would be useful for health professionals with limited experience in providing care to Aboriginal and Torres Strait Islander clients and their families. This would be particularly relevant in large city referral hospitals who may receive infrequent referrals from rural and remote areas.

Care must be taken, however, not to develop 'recipes' or a 'check list' approach to the provision of care. While some principles, such as the importance of family and collectivist notions of communication and decision making (Hofstede, Hofstede, & Minkov, 2009) may provide useful background information, 'recipe' approaches run the risk of perpetuating cultural stereotypes and do not allow for inter- or intra-cultural diversity among Aboriginal peoples (Smylie, 2001).

Therefore any documents that outline practices specific to Aboriginal and/or Torres Strait Islander women and families must be developed in a sensitive and respectful way that acknowledges the heterogeneity of Aboriginal and Torres Strait Islander peoples and avoids the promotion of stereotypes.

Suggested Indicator(s) for further development

Maternity health care staff in all jurisdictions have access to guidelines that promote culturally specific care.

Cultural competency policy emphasises the importance of individualised care for all women.

13. Culturally appropriate and effective health promotion and behaviour change activities

One-on-one education is the most common form of health education done by health professionals and also the least effective, even in the receptive setting of maternal health care (Michie, Jochelson et al. 2009). Health education sessions should involve patient-centred and patient-led goal setting and problem solving rather than simply a health education talk

Brief intervention and motivational interviewing are effective techniques when working with clients to achieve behaviour change. These are difficult skills for health professionals who are used to providing services within a biomedical paradigm. This 'expert' approach will never be effective for social behaviours that require client-led responses to change (Davis, Day, & Bidmead, 2002).

Factors in designing effective health promotion interventions for Aboriginal and Torres Strait Islander communities include: involving local Aboriginal and Torres Strait Islander people in the design and implementation of programs; acknowledging different drivers that motivate individuals; building effective partnerships between community members and the organisations involved; cultural understanding and mechanisms for effective feedback to individuals and families; and developing trusting relationships, community ownership and support for interventions (Black, 2007).

Gender issues should be considered in some communities (Dunbar et al, 2008). Wall posters about illnesses, depression and other diseases should not be placed on the walls. Discreet information and education can be offered in the form of flip charts or 'yarning' with trusted health professionals. Similarly screening activities around sexually transmitted infections, depression and other sensitive ailments need to be sensitively discussed and introduced slowly, ideally within trusted known relationships between client and care provider (Dunbar et al, 2008).

Suggested Indicator(s) for further development

Annual audits of health promotion activities and strategies are undertaken to address smoking in pregnancy and other health behaviours

14. Engaging consumers and clinical governance

It is the perspective of the recipient of services that should be the litmus test as to whether a service is culturally secure and/or culturally safe to engage with.

(Dunbar & Murakami-Gold, 2010, p. 8)

Genuine community engagement in service planning and evaluation is a critical factor in achieving equity of access to safe and quality care for Aboriginal and Torres Strait Islander people (Dunbar et al., 2008). Representation on, and cross-cultural input into, governance structures and processes will assist health services achieve cultural competence (AHMAC, 2004). Competent governance must address the cultural responsiveness of mainstream service delivery for Aboriginal and Torres Strait Islander clients and effective participation of Aboriginal and Torres Strait Islander people on decision-making boards, management committees and other bodies, as relevant (AHMAC, 2011a).

When local Aboriginal people are involved in the planning and delivery of community based services that incorporates their cultural values, individual and community wellbeing is promoted (Dunbar et al 2008). This was successfully demonstrated through a community model of renal services documented by Riverland (2006).

Recognition and respect of the important role of Aboriginal elders in Aboriginal society is considered essential for cultural competence to be achieved. Elders are the professors and lawyers of Aboriginal culture, language, history and law, and deserve to be treated with respect and authority (Dunbar et al 2008). Elders and senior women can be invited to work in partnership with maternity services to develop local strategies that reintroduce and value

traditional birthing practices and ceremony (Kildea, Wardaguga, Dawumal, & Maningrida Women, 2004). Seeking feedback from community groups and elders on services will assist in maximising culturally competent care.

Regular (monthly) meetings with ACCHOs and senior government maternity services representatives should occur to discuss priorities, issues and ideas to continually improve coordinated care and service delivery (Dunbar et al., 2008). Additional community members and agency representatives should also be invited to attend and processes should be established that facilitate resolution to issues that impede service effectiveness and cultural competence.

Incorporating and learning from client feedback on the maternity care experience is an important component of clinical governance (Aboriginal Health Council of Western Australia, 2010). Satisfied consumers may be more likely to cooperate with treatment, continue using services, maintain a relationship with a specific provider, and actively participate in their own treatment (AHMAC 2011a). However, mechanisms for obtaining consumer feedback from the Aboriginal and Torres Strait Islander community are not well established and need to be better researched (AHMAC, 2011a). A confidential service is required for Aboriginal and Torres Strait Islander consumers to be heard, and assisted to provide formal feedback and complaints (if required) (Dunbar et al, 2008).

Suggested Indicator(s) for further development

Clear policies and processes exist that facilitate consumer participation.

Services report on level of participation of Aboriginal and Torres Strait Islander people on decision-making boards, management committees and other bodies.

Culturally safe processes are established to facilitate consumer feedback and complaints in a supportive, responsive and transparent way.

Conclusion

This document aims to assist health services to maximise their effectiveness in providing services to Aboriginal and Torres Strait Islander women, babies and their families. Specifically, it addresses aspects of the National Maternity Services Plan (AHMAC, 2011b) including: Action 2.2 to develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people.

The information in this report should provide a baseline for the further refinement of indicators to enable AHMAC to undertake the activities outlined in the National Maternity Services Plan in upcoming years of the Plan. These activities include the following.

Middle years:

- AHMAC undertakes a stocktake of access to culturally competent maternity care for Aboriginal and Torres Strait Islander people.
- Australian governments expand programs providing culturally competent maternity care for Aboriginal and Torres Strait Islander people.
- AHMAC identifies mechanisms for evaluating cultural competence in all maternity care settings.

Later years:

- AHMAC evaluates culturally competent maternity care for Aboriginal and Torres Strait Islander people.
- AHMAC evaluates cultural competence in all maternity care settings.

(AHMAC, 2011b, p. 39)

It is emphasised that the indicators provided in this report are preliminary in nature and require future development and testing in line with 'middle year' activities provided in the Plan. There is also current work on measuring cultural competence being progressed by other sub-committees of AHMAC that aligns with the indicators outlined in this report. Further development of the indicators should include partnerships with key stakeholders including: the Office of Aboriginal and Torres Strait Islander Health (OATSIH); the National Aboriginal Community Controlled Health Organisation (NACCHO); The National Aboriginal and Torres Strait Islander Health Officials' Network (NATSIHON); The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID); and leading individual Aboriginal and/or Torres Strait Islander academics and experts.

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Appendix 1: Document reviewers

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Ms Bronia Rowe	A/Director, Maternity Services Policy Section	Primary and Ambulatory Care Division, Department of Health and Ageing
Ms Deborah Schaler	Manager Women, Youth & Child Health Policy Unit	Policy & Government Relations Health Directorate ACT Government
Ms Tracy Martin	Principal Midwifery Advisor	Nursing and Midwifery Office, WA Department of Health
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Renee Heath	Principal Policy Officer, Maternity Unit, Primary Community and Extended Care Branch	Qld Health
Member of NATSIHON with responses endorsed by Jacqui AhKit	Chair	National Aboriginal and Torres Strait Islander Health Officials' Network
Assoc Prof Juli Coffin	Associate Professor, Aboriginal Health	
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Ms Ann Kinnear	Executive Officer,	Australian College of Midwives