IpAC Unit
interprofessional ambulatory care unit

AUSTRALIA ECU EDITH COWAN UNIVERSITY

# Interprofessional learning through simulation

## Creating cultural empathy: *ensuring client centred care*

THIS CLINICAL TRAINING INITIATIVE IS SUPPORTED BY FUNDING FROM THE AUSTRALIAN GOVERNMENT UNDER THE INCREASED CLINICAL TRAINING CAPACITY (ICTC) PROGRAM

Health Simulation Centre

AUSTRALIA ECU EDITH COWAN UNIVERSITY

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## Acknowledgements

This resource was developed by the Interprofessional Ambulatory Care Program (IpAC) at Edith Cowan University (ECU) in collaboration with the ECU Health Simulation Centre with funding provided by the Australian Government under the Increased Clinical Training Capacity (ICTC) Program.

## Foreword

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Australia's health workforce is facing unprecedented challenges. Supply won't meet demand, and the safety and quality of care remain key issues. The national health workforce agency, Health Workforce Australia (HWA), an initiative of the Council of Australian Governments (COAG), has been established to address the challenges of providing a workforce that meets the needs of our community – now and in the future.

Accordingly, ECU has set a priority on meeting these challenges, with a focus on the national health workforce reform agenda set out in the 2008 National Partnership Agreement (NPA) on Hospital and Health Workforce Reform.

In June 2010, ECU was awarded $4.6M from the Australian Government through a nationally competitive process under the ICTC Program, an initiative which aims to develop interprofessional learning and practice capabilities in the Australian health workforce.

The IpAC Program aims to complement traditional clinical placement activities with high quality interprofessional learning competency development and assessment, so that at the earliest point students gain exposure to best work practices within multidisciplinary teams that have the patient's individual needs as the focus.

Additionally, the IpAC Program has developed interprofessional learning resources and interprofessional health simulation challenges in collaboration with the ECU Health Simulation Centre. The ECU Health Simulation Centre is recognised internationally as a



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specialist centre in providing human factors based sequential simulation programs using professional actors. Most simulated learning interactions revolve around a single moment, such as a patient's admission to the emergency department. What we provide at the ECU Health Simulation Centre is a sequential simulated learning event that follows the patient and carer's journey through the healthcare system, for example, from the accident site following a motor vehicle accident, to the emergency department, to a hospital ward, to their home and into the community for GP and allied health follow-up.

Human factors in health care are the non-technical factors that impact on patient care, including communication, teamwork and leadership. Awareness of and attention to the negative aspects of clinical human factors improves patient care.

ECU's involvement in national health workforce reform is all about playing a role that enables the health workforce to better respond to the evolving care needs of the Australian community in accordance with the NPA's agenda. The IpAC Program is an example of how we can work across sectors, nationally and internationally, to determine better ways of addressing the pressing issue of how best to prepare students for the workplace and thus assuring that health systems have safe, high quality health services.

## Interprofessional Ambulatory Care Program

ECU's IpAC Program was established with support from the Australian Federal Government through funding from the ICTC Program. The IpAC Program aims to deliver a world-class interprofessional learning environment and community clinic that develops collaborative practice among health professionals and optimises chronic disease self-management for clients.

This is achieved through the provision of clinical placements within the multidisciplinary team at the IpAC Unit, a community clinic that develops communication and collaboration among health professionals and optimises chronic disease self-management for clients. Additionally, a range of clinical placements are offered at existing health facilities, where trained IpAC Program clinical supervisors provide clinical support and ensure the integration of interprofessional learning into each clinical placement.



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The IpAC Unit, in collaboration with the ECU Health Simulation Centre, has developed a range of interprofessional learning through simulation resources. These learning resources are packages consisting of an audiovisual resource and a facilitator's manual, and aim to facilitate interprofessional learning and to support the participants in the development of interprofessional skills.

The interprofessional learning through simulation resources developed by the IpAC Program aim to provide health students and health professionals with the opportunity to learn with, from and about one another by engaging them in interactive live simulation events. These simulations encourage students and professionals to challenge themselves and each other in a safe learning environment.

## ECU Health Simulation Centre

ECU houses the only fully functioning Health Simulation Centre of its kind in Western Australia, specifically designed and equipped to address the interprofessional learning needs of the health workforce and implementation of both state and national safety and quality frameworks.

The ECU Health Simulation Centre offers health workforce training and development specialising in clinical skills, human factors, and patient safety training for multidisciplinary health teams. Using a variety of educational techniques, including a broad range of simulation mannequins, professional actors and task trainers, ECU specialises in immersive simulation and observational learning. Supporting the ECU Health Simulation Centre are nursing, medical, paramedic and psychology academic and technical staff whose aim is to cultivate the development of competent and confident health professionals centred on enhancing patient safety.

## Interprofessional learning

Interprofessional education occurs when two or more professions learn with, from and about each other in order to improve collaboration and quality of care (Centre for the Advancement of Interprofessional Education, 2002).



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Interprofessional learning is the learning arising from interaction between students or members of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings (Freeth, Hammick, Reeves, Barr, & Koppel, 2005). It has been found that interprofessional education can improve collaborative practice, enhance delivery of services and have a positive impact on patient care (Canadian Interprofessional Health Collaborative, 2008).

The World Health Organization (WHO) has recognised the importance of interprofessional education and collaborative practice in developing a health workforce that is able to meet the complex health challenges facing the world and assist in the achievement of the health-related Millennium Development Goals (World Health Organization, 2010). In developing its framework for action, the WHO have recognised that models of interprofessional collaboration are most effective when they consider the regional issues and priority areas (including areas of unmet need) in the local population (World Health Organization, 2010). In doing so, interprofessional education and collaborative practice can best maximise local health resources, reduce service duplication, advance coordinated and integrated patient care, ensure patient safety and increase health professional's job satisfaction (World Health Organization, 2010).

The end goal of interprofessional education is to create a health workforce with improved levels of teamwork, collaboration, knowledge-sharing and problem-solving, eventually leading to better patient and client outcomes in health settings (Braithwaite et al., 2007).

## Interprofessional learning through simulation

Simulation in education refers to the re-creation of an event that is as closely linked to reality as possible. Gaba (2004) defined simulation as a technique, rather than a technology, to replace or amplify real life experiences with guided experiences often immersive in nature to evoke or replicate aspects of the real world, in a fully interactive pattern. Simulation provides a safe learning environment for students to practice, where they are free to make mistakes, correct them and improve the processes of care (Kenaszchuk, MacMillan, van Soeren, & Reeves, 2011). Simulation is the bridge between classroom learning and the real life clinical experience, allowing students to put theory into practice.



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Interprofessional learning through simulation combines the principles of interprofessional learning and the use of simulation as an educational methodology. Interprofessional learning through simulation provides students with the opportunity to practice working with other health professionals and allows participants to explore collaborative ways of improving communication aspects of clinical care (Kenaszchuk, et al., 2011).

Many of the interdisciplinary team core competencies, such as problem solving, respect, communication, shared knowledge and skills, patient-centred practice, and the ability to work collaboratively (Canadian Interprofessional Health Collaborative, 2010) can all be developed by interprofessional learning through simulation.

Teamwork and interprofessional practice and learning are being recognised as central to improving client care and outcomes and enhancing client safety (Sargent, 2008). Promoting patient safety through team efforts is one of the five core competencies identified by the Institute of Medicine (2003).

In today's healthcare setting, no one health professional can meet all of the client's needs and therefore a healthcare team approach is required. Interprofessional learning through simulation provides learning opportunities to prepare future healthcare professionals for the collaborative models of healthcare being developed internationally (Baker et al., 2008).

## How to use this resource package

This interprofessional learning through simulation resource package has been designed to support the facilitation of interprofessional learning among students and practitioners with an interest in developing their skills and knowledge of interprofessional practice.

The package consists of two components: an audiovisual resource and a supporting manual. In order to optimise the learning opportunities from this package, it is recommended that participants are firstly introduced to the concepts of interprofessional learning and human factors in health care.

The audiovisual resource consists of two scenarios, the first demonstrating sub-optimal performance of the healthcare team, with the second demonstrating more effective performance, improving the patient experience. The package has been created in a format



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to enable flexibility in its application, depending of the educational setting. We recommend the following format:

1. Facilitator guided discussion around the concepts of interprofessional learning, human factors in health care and cultural empathy (samples given within manual).
2. View the first segment of the audiovisual resource, 'Interview with midwife 1'.
3. Facilitator guided discussion around the scenario specific learning competency areas (samples given within manual)
4. View the last two segments of the audiovisual resource, 'Debrief' and 'Interview with midwife 2'.
5. Facilitator guided discussion, identifying and discussing the changes witnessed and how this resulted in an alternative outcome. In particular, discussion relating to the behaviours and attitudes of each person involved and how the causes of these changes to personal (future) practice is essential in improving interprofessional and client centred practice.

Opportunities for further reading and exploration of the scenario are provided in the *Further Information* and *References* sections of this resource manual.



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## Scenario brief

Kaylene Matthews is a young Aboriginal woman who had a previous negative experience during her third pregnancy, when she was expecting twins, in which she repeatedly attended an emergency department for pain in her abdomen. Accompanied by her mother, Coreen Matthews, Kaylene's behavior and symptoms were assumed to be associated with her being drunk and Coreen being abusive. However, Kaylene had in fact experienced an ectopic pregnancy. Whilst the ectopic pregnancy was eventually diagnosed, Kaylene lost both babies, one at diagnosis and the other being stillborn at birth. Now in her fourth pregnancy, Kaylene is attending her first antenatal appointment. She is defensive and distrustful and expects to be treated badly because of her previous negative experience with health services.

List of characters

- Aboriginal Health Worker
- Midwife
- Patient
- Patient's mother

## Key learning competencies

The key learning competencies for this scenario are based on the IpAC Program learning objectives as well as the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework (Canadian Interprofessional Health Collaborative, 2010). The specific competency areas for this scenario are:

- Perceptions and attitudes influencing practice;
- Client and family centred care;
- Interprofessional communication;
- Role clarification; and
- Team functioning.

### Perceptions and attitudes influencing practice

- Recognise the role that cultural values, beliefs and practices can have upon healthcare provision and health outcomes for Aboriginal and Torres Strait Islander people.



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- Knowledge of the how the actions, attitudes and behaviours of health care professionals' can impact on the delivery of the health care they provide to Aboriginal and Torres Strait Islander people.
- Awareness of how one's attitudes, beliefs and assumptions can impact upon how one approaches a client or colleague.
- Develop an understanding of Aboriginal and Torres Strait Islander people and their community's past experiences and how this can influence their involvement with mainstream services.

## Client and family centred care

The interaction between team members and the patient (and family) demonstrates:

- The sharing of information with clients (and family) in a respectful manner.
- Communicating with the client (and family) in a way that is clear, understandable and free of jargon.
- Listening respectfully to the needs of all parties to ensure the most appropriate care and treatment care plan is realistic and achievable.
- The interaction is supportive to the client and family.

## Interprofessional communication

The interaction between the health care team demonstrates:

- Communication that is consistently authentic and demonstrates trust.
- Active listening to team members (including the client and their family).
- Communication that ensures a common understanding of care decision making and resultant treatment plan.
- The development of trusting relationships with clients /families and other team members.

## Role clarification

The interaction between the health care team demonstrates:

- Clear communication of the health care professional's role, knowledge, skills, and attitudes in an appropriate manner.
- Health professionals are respectful and understand the important role of others in the health care team.
- Performing their roles in a culturally respectful way.



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### Team functioning

Professionals support a team approach by:

- Establishing and maintaining effective and healthy working relationships and team interactions.
- Respect team ethics and demonstrate trust and mutual respect for members of the team.
- Be an active participant in collaborative decision making.
- Be an effective and engaged participant in discussions and interactions among team members demonstrating open communication and attentive listening.

## Key discussion points

Before considering the scenario in detail, it may be useful to consider the following general discussion points.

- Where were you born? What is your family history? How has your family history shaped who you are today?
- How would you describe yourself to a stranger? What labels would you use (e.g. parent, career, interests, religion, cultural background)? What do these labels reveal about you? What assumptions and stereotypes might people make about you based on your personal description? What assumptions and stereotypes might people make about you before you have provided your personal description?
- What terms are commonly used to describe Indigenous Australians? What stereotypes are associated with an individual who would describe them self as Aboriginal or Torres Strait Islander?
- What are the Aboriginal and Torres Strait Islander health policies in your State and nationally? What are the current priorities and how have these been determined?

The following discussion points are useful in considering the *Kaylene* scenario.

### Interview with midwife 1

- How do you perceive the characters in this scenario? What beliefs and attitudes may have shaped your perception?
- What perceptions and attitudes do you think the characters have brought to this scenario:



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  - the midwife?
  - Kaylene?
  - Coreen?
  - Aboriginal Health Worker?
- How would you describe the quality of communication in this scenario? Why is this so? Who is responsible for that?
- How would you describe the introduction process at the start of the consultation? How could this be improved?
- How would you describe Kaylene's body language during the consultation? What might explain Kaylene's body language?
- Describe the communication between Kaylene and the midwife.
- Given Kaylene's history with health services, how would you feel about the interaction?
- Are there any specific instances that exacerbate the tense environment during the consultation?
- Can you identify any environmental factors that might be making Kaylene feel uncomfortable (e.g. furniture, where people are sitting etc)?
- What changes could be made to improve the interaction between the midwife and Kaylene?
- How would you describe the role of the Aboriginal Health Worker? What do you think her role could be during the consult?
- What impact, if any, would Kaylene's interaction with the health service in this scenario have on her community's perception and future engagement with health services?

## Debrief and Interview with midwife 2

- What was the role of the Aboriginal Health Worker in this scenario? What value did this role add to the interaction between the client and the health service?
- How do you think Kaylene and her mother felt in the revised scenario? Why?
- What were some of the specific improvements made in regards to communication – with the client, her mother, between the Aboriginal Health Worker and the midwife?
- How important do you think Kaylene's past health experiences were in shaping her antenatal visit?



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- How important do you think it was for Kaylene to have her mother in the consult with her? How did this affect the interaction?
- Do you think Kaylene feels like an active participant in her own health care? Why? How could she be better empowered?
- How important do you think it is that Kaylene is treated by the same health care professionals during her next visit? Why?
- How can you make sure you are sensitive to the impact of a client's beliefs and attitudes in their interaction with health care professionals?
- How can you make sure that your personal beliefs and attitudes do not negatively affect the care you provide in your (future) practice?



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## Literature review

**'Aboriginal and Torres Strait Islander' is currently a commonly accepted way of referring to specific populations (Taylor & Guerin, 2010). In this literature review this terminology has been adhered to as the literature reviewed related to both Aboriginal and Torres Strait Islander populations. Wherever possible the term is used in full as a sign of respect to those it represents. The term 'Indigenous' has been used sparingly, but on occasions has been used for readability and brevity. No disrespect is intended.**

This resource includes a range of statistics related to the health status of Aboriginal and Torres Strait Islander people as they compare to the general Australian population. This will inform the reader of the disparities in health outcomes of Aboriginal and Torres Strait Islander people compared to the rest of the Australian population. Increased knowledge and awareness of the health challenges faced by Aboriginal and Torres Strait Islander peoples allows the health practitioner to be empathetic towards the issues Aboriginal and Torres Strait Islander clients and patients face.

Whilst these statistics are important in understanding the health care challenges faced by Aboriginal and Torres Strait Islander people, it is important to recognise individual differences and not assume every Aboriginal or Torres Strait Islander person will present with the health issues summarised in statistics. Each individual seeking health care services from a health practitioner, regardless of cultural background, has their own unique personal, social and health characteristics that will shape the development of their care plan. In order for optimal care to be realised, it is important that health professionals are aware of their own attitudes, experiences, training and knowledge which can influence interactions with clients.

## Key indicators of the current health status of Aboriginal and Torres Strait Islander people in Australia

Aboriginal and Torres Strait Islander people suffer poorer health outcomes than any other cultural group within Australia (Taylor & Guerin, 2010). Their life expectancy is significantly less than the general population, with the average life expectancy for males being 11.5 years less than non-Indigenous Australian males (67.2 compared with 78.7 years), and for females 9.7 years less than non-Indigenous Australian females (72.9 compared with 82.6 years) (Australian Bureau of Statistics, 2009).



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Aboriginal and Torres Strait Islander people have significantly higher morbidity than the general Australian population with their burden of disease occurring at younger ages and at higher proportions (Australian Health Ministers' Advisory Council, 2011; Westwood & Westwood, 2010). Despite composing only 2.6% of the population in 2010, they were estimated to carry 3.6% of Australia's disease burden (Australian Health Ministers' Advisory Council, 2011; Thomson et al., 2010). Rates of hypertension, respiratory diseases, stroke, diabetes, cancer, renal failure, suicide and drug dependence all occur at higher levels than the general population (Australian Health Ministers' Advisory Council, 2011). These health disparities are evident from birth and continue across the lifespan (Comino et al., 2010).

The World Health Organization has declared that Australia's Aboriginal and Torres Strait Islander peoples have the worst health of all Aboriginal populations within comparable developed countries (Westwood & Westwood, 2010). Evidence of this is summarised in Table 1.



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**Table 1:** Selected Indigenous health indicators in Australia, Canada, New Zealand (Aotearoa) and USA (Taylor & Guerin, 2010).

| | Australia | | Canada | | NZ | | USA | |
|---|---|---|---|---|---|---|---|---|
| | Total | Indigenous | Total | Indigenous | Total | Indigenous | Total | Indigenous |
| Male life expectancy (in years) | 77 | 67.2 | 77.1 | 70.4 (First nation)<br>64.4 (Inuit) | 77.2 | 69 | 74 | 72.8 |
| Female life expectancy (in years) | 82 | 72.9 | 82.2 | 75.5 (First nation)<br>69.8 (Inuit) | 81.9 | 73.2 | 79.7 | 82 |
| Infant mortality (per 1000 live births) | 4.1 | 11.5 | 5.2 | 6.4 | 5.0 | 8.1 | 6.8 | 8.7 |
| % babies low birth weight | 6 | 13 | 5.5 | 5.5 | 5.6 | 6.8 | 8.2 | 7.4 |
| Maternal median age | 37.3 | 21 | 39.2 | 26.5 | 36.6 | 21.9 | 36.7 | 30.3 |

*Source:* (Taylor & Guerin, 2010)



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The poorer health of Aboriginal and Torres Strait Islander people has been attributed to a range of factors. Aboriginal and Torres Strait Islander people have experienced a significant erosion of their traditional lifestyles since European settlement (Nelson & Allison, 2000). Major impacts on the overall health and wellbeing of Aboriginal and Torres Strait Islander people have arisen from the loss of traditional lands and associated lifestyle and cultural ceremonies; the removal of children from the family unit during the twentieth century and the struggle to maintain a strong cultural identity as a minority group (Australian Health Ministers' Advisory Council, 2011; Liaw et al., 2011; Nelson & Allison, 2000).

A history of repression has been further perpetuated by social, economic and environmental factors, commonly referred to as 'the social determinants of health' (Thomson, et al., 2010). This concept espouses not just biomedical factors but also other significant influences on the health of individuals and communities, such as economic opportunities, physical infrastructure, educational attainment and social participation in society and access to food and transport (Griew et al., 2007; Thomson, et al., 2010). Common social determinant measures include levels of education, employment, income, housing, access to services, and incarceration rates (Thomson, et al., 2010). Figure 1 displays the complex interaction between specific health risk factors resulting in the relatively poor health outcomes for Aboriginal and Torres Strait Islander people, including socioeconomic, environmental, social, and political factors, as well as a lack of access to primary care.



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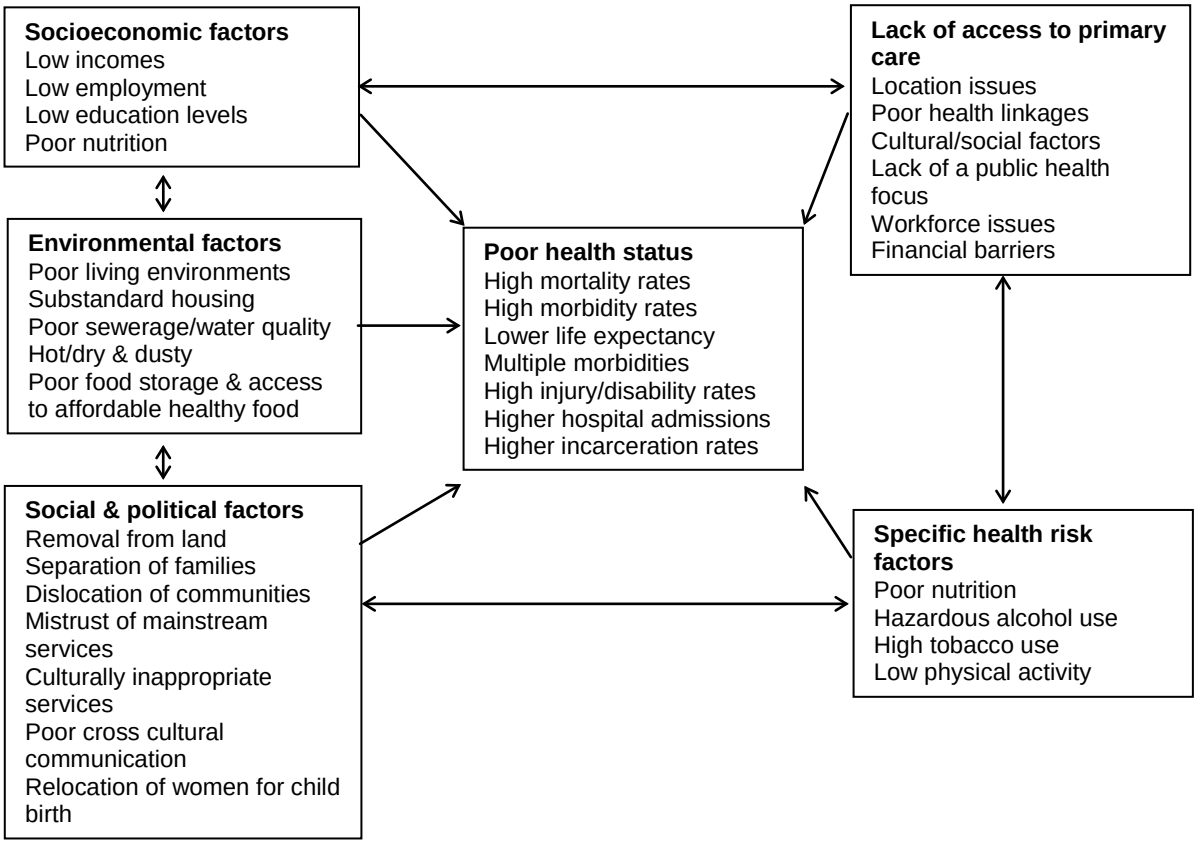
**Figure 1:** Factors impacting on Aboriginal and Torres Strait Islander health status – Interactions of social and physiological determinants of health (Queensland Health, 2010)




*Source:* (Queensland Health, 2010, p. 7)



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Aboriginal and Torres Strait Islander people have significantly lower incomes, education, employment and home ownership rates than the overall Australian population (Kildea, 2006; Sayers & Boyle, 2010). In regards to education, over 90% of all Australian school children achieve the national reading benchmarks for Grades Three and Five, compared to only 68% of Aboriginal and Torres Strait Islander students in Grade Three and 63% in Grade Five (Thomson, et al., 2010). This disadvantage continues throughout formal schooling with only 22% of Aboriginal and Torres Strait Islander people completing Grade 12 compared to 47% of non-Indigenous people (Thomson, et al., 2010).

The rate of unemployment for Aboriginal and Torres Strait Islander people is three times higher than for non-Indigenous people (Sayers & Boyle, 2010). According to Australian census data, the most common occupation for Aboriginal and Torres Strait Islander people is classified as a 'labourer' (24%) compared to the overall population where the most common occupation is classified as a 'professional' (20%) (Thomson, et al., 2010). This is also reflected in income statistics which reveal that 'professionals' received the highest median gross weekly incomes whilst 'labourers' receive the lowest (Thomson, et al., 2010). More concerning is that even within these individual occupations Aboriginal and Torres Strait Islander people earn less than non-Indigenous peoples (28% less than other 'professionals' and 16% less than other 'labourers') (Thomson, et al., 2010).

According to the 2006 Australian census, the mean equivalised gross household income was $460 per week for Aboriginal and Torres Strait Islander people compared to $740 per week for non-Indigenous people (Thomson, et al., 2010). Forty-five-percent of Aboriginal and Torres Strait Islander people were in the lowest income quintile (Thomson, et al., 2010). This is also reflected in living conditions where many Aboriginal and Torres Strait Islander people experience higher housing costs relative to income level (Queensland Health, 2010). Aboriginal and Torres Strait Islander people are more likely to live in dwellings that are overcrowded, poorly maintained and which lack basic infrastructure, such as running water and adequate sanitation (Queensland Health, 2010).

### Maternal and perinatal health

In Australia during the twentieth century, complications arising from pregnancy and childbirth diminished with improved public health and advances in medical care (Australian Health Ministers' Advisory Council, 2011). Despite these improvements, Aboriginal and Torres Strait



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Islander women continue to have poorer perinatal outcomes compared to the general population (Reibel & Walker, 2010).

The maternal mortality rate for Aboriginal and Torres Strait Islander women is between two and five times higher than for non-Indigenous women with figures reported of 7.2 per 100,000 direct maternal deaths compared to 3.6 per 100,000 direct maternal deaths for non-Indigenous mothers (Australian Health Ministers' Advisory Council, 2011; Reibel & Walker, 2010). Whilst comprising only 3% of all childbirth labours, Aboriginal and Torres Strait Islander women account for 30% of Australia's direct maternal mortality (Nel & Pashen, 2003).

Aboriginal and Torres Strait Islander babies are also at a higher risk of death before their first birthday compared to non-Indigenous babies (Prime Minister's Science Engineering and Innovation Council Working Group, 2008). From 2001 to 2004, the foetal death rate for babies born to Australian Indigenous mothers was calculated at 12 per 1000 births; almost twice that of those born to non-Indigenous mothers (7 per 1000 births). This was also reflected in the neonatal death rate which was also twice as high for Aboriginal and Torres Strait Islander babies compared to non-Indigenous babies (Sayers & Boyle, 2010).

Some positive news is that there have been some improvements in the rates for Aboriginal and Torres Strait Islander perinatal and infant mortality over the last two decades (Australian Health Ministers' Advisory Council, 2011). However, it has been argued that this is due in large part to improvements in acute care rather than health improvements in maternal and perinatal health of Aboriginal and Torres Strait Islander women (Australian Health Ministers' Advisory Council, 2011).

Birth weight is used as a key indicator of perinatal health and babies are considered of low birth weight if they are born weighing less than 2,500 grams (Kelly, Graham, & Sullivan, 2010). Low birth weight babies are at higher risk of dying, greater susceptibility to disabilities, illness and hospitalisations during childhood and into adulthood (Griew, et al., 2007; Kelly, et al., 2010). In the longer term, low birth weight babies are less likely to perform well at school impacting on later educational and economic opportunities (Griew, et al., 2007). There are also indications that low birth weight in Aboriginal and Torres Strait Islander babies results in poorer autoimmune and pulmonary health in adulthood (Australian Health Ministers' Advisory Council, 2011; Griew, et al., 2007).



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Based on Australian Institute of Health and Welfare data, Aboriginal and Torres Strait Islander babies weigh on average 200 grams less than those born to non-Indigenous women; Aboriginal and Torres Strait Islander babies are twice as likely to be of low birth weight (Li, McNally, Hilder, & Sullivan, 2011; Thomson, et al., 2010). The prevalence of low birth weight in babies born to Aboriginal and Torres Strait Islander mothers has also increased by over 10% over the last decade (Australian Health Ministers' Advisory Council, 2011).

There is some research to suggest a relationship between low birth weight and social disadvantage in Aboriginal and Torres Strait Islander babies (Australian Health Ministers' Advisory Council, 2011). Other factors seen to influence the incidence of low birth weight include remoteness, smoking, mother's nutritional status, illness during pregnancy, previous pregnancies and preterm delivery (Australian Health Ministers' Advisory Council, 2011).

Preterm birth, in which delivery occurs before 37 weeks gestation, also occurs at almost double the general population rate in Aboriginal and Torres Strait Islander pregnancies (14.6% versus 7.7% in the general population) (Sayers & Boyle, 2010). Preterm births place a major burden on health, education and social services (Langridge, Nassar, Li, & Stanley, 2010). Economic modelling has estimated that the direct cost of intensive care for a preterm infant is $1,500 a day with the cost of hospital care for infants born before 26 weeks totalling $90,000 (Langridge, et al., 2010). Neuro-developmental disabilities are associated with one-quarter of all preterm births (Sayers & Boyle, 2010).

### Smoking

Aboriginal and Torres Strait Islander women have much higher smoking rates compared to the general population (Gilchrist et al., 2004). They are also more likely to continue to smoke during pregnancy and whilst breastfeeding (51.8% compared to 14.8% for non-Indigenous pregnant women) (Gilchrist, et al., 2004; Kelly, et al., 2010). This pattern is consistent across geographic location and age (Australian Health Ministers' Advisory Council, 2011). As a whole, smoking prevalence is high within the general Aboriginal and Torres Strait Islander community and as such has been normalised (Gilligan et al., 2010). This creates particular challenges in encouraging pregnant Aboriginal and Torres Strait Islander women to quit smoking, as smoking is perceived as a means of relaxation and stress reduction, which pregnant women are not always willing to give up (Homer et al., 2011).



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Smoking during pregnancy results in a range of adverse outcomes for both the mother and baby. Spontaneous abortion, ectopic pregnancy, preterm labour and ante partum haemorrhage all occur at higher rates in smokers than in non-smokers (Australian Health Ministers' Advisory Council, 2011). The unborn foetus is also exposed to a range of chemicals, including nicotine and carbon monoxide, which pass through the placenta and reduce the supply of oxygen (Australian Health Ministers' Advisory Council, 2011). Smoking during pregnancy poses an unnecessary health risk to the unborn foetus which can contribute to continued health problems in both childhood and adulthood (Gilligan, Sanson-Fisher, Eades, & D'Este, 2007). The consequences of smoking during pregnancy also place pressure on the provision of health services (Gilligan, et al., 2007). Smoking is also associated with a range of poor perinatal outcomes including stillbirth, preterm birth, birth anomalies and perinatal deaths (Griew, et al., 2007). There is a 4–5-fold increased risk of sudden infant death syndrome (SIDS) connected to maternal smoking, and smoking during pregnancy also places the baby at increased risk of developing asthma, respiratory illnesses (such as bronchitis or pneumonia) and middle ear diseases (such as otitis media) (Australian Health Ministers' Advisory Council, 2011; Gilchrist, et al., 2004; Griew, et al., 2007).

As touched on earlier, smoking is associated with low birth weight, pre-term birth and foetal growth restriction, which can negatively impact on an infant's subsequent quality of life (Australian Health Ministers' Advisory Council, 2011; Kelly, et al., 2010). It has been reported that babies born to smoking mothers are 200g lighter on average (Sayers & Boyle, 2010). For Aboriginal and Torres Strait Islander mothers who smoke there is a three-fold increase in risk of having a low birth-weight baby (Sayers & Boyle, 2010).

The health benefits of quitting smoking during and after pregnancy to improve healthcare outcomes for Aboriginal and Torres Strait Islander people provides a real impetus to direct efforts towards this goal (Sayers & Boyle, 2010). Research has demonstrated that pregnant women who quit smoking see a reduction of between 15–20% in rates of preterm delivery and low birth weight (Sayers & Boyle, 2010). More encouragingly, research has found that average birth weights return to the general population average for pregnant women who quit smoking in the first 3–4 months of pregnancy (Gilligan, et al., 2007). However, mainstream interventions have not been demonstrated to be effective in reducing smoking levels in Aboriginal and Torres Strait Islander communities (Herceg, 2005). It has been recognised



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that culturally appropriate, locally tailored interventions specifically targeting smoking during pregnancy are required (Australian Health Ministers' Advisory Council, 2011).

### Alcohol

The impact of exposure to high levels of alcohol in utero can be significant for the developing foetus with the development of cognitive and mental health problems persisting through childhood and into adulthood (Prime Minister's Science Engineering and Innovation Council Working Group, 2008). Increased risk of foetal death and low birth weight associated with alcohol consumption during pregnancy have also been linked to cases of moderate consumption (Griew, et al., 2007). Heavy alcohol consumption during pregnancy can result in a condition known as Foetal Alcohol Syndrome which results in a range of physical and neurodevelopmental abnormalities (Sayers & Boyle, 2010).

The rate of Foetal Alcohol Syndrome in Aboriginal and Torres Strait Islander babies is estimated to be 14-times higher than the general population (Sayers & Boyle, 2010). Recent research has demonstrated that compared to the general Australian population, Aboriginal and Torres Strait Islander people are overall generally less likely to drink alcohol, but rates of alcohol consumption are more likely to be at hazardous levels for those that do consume alcohol (Thomson, et al., 2010).

### Sexual health

Aboriginal and Torres Strait Islander women have higher rates of sexually transmitted infections (STI) compared with the general population (Griew, et al., 2007; Prime Minister's Science Engineering and Innovation Council Working Group, 2008). Poor sexual health, especially STIs and urinary tract infects (UTIs), are implicated in preterm birth and low birth weight in babies (Griew, et al., 2007). In one study, only 13% of non-Indigenous mothers of low birth weight babies had genitourinary tract infection, whereas 50% of Aboriginal and Torres Strait Islander mothers who gave birth to low birth weight babies (Griew, et al., 2007) suffered from the infection. The prevalence of UTIs in Aboriginal and Torres Strait Islander women at the first antenatal visit is estimated to be as high 15.7% (Sayers & Boyle, 2010). It is imperative that screening and early treatment of these infections be undertaken, ideally prior to conception, to improve perinatal and maternal health outcomes (Sayers & Boyle, 2010).



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## Nutrition

Adequate nutrition has been identified as a priority area for improving maternal and perinatal health outcomes, as evidenced by increased incidence of anaemia in Aboriginal and Torres Strait Islander pregnant women ranging from 26–34% (Prime Minister's Science Engineering and Innovation Council Working Group, 2008). Undernutrition during pregnancy is linked to an increased risk of preterm birth and foetal growth restriction (Sayers & Boyle, 2010). The Aboriginal and Torres Strait Islander population also experiences a high prevalence of gestational diabetes and hypertensive disorders in pregnancy, which both can impact on the growth of the developing foetus (Prime Minister's Science Engineering and Innovation Council Working Group, 2008).

The transition from a more traditional to a Westernised diet in Aboriginal and Torres Strait Islander communities has lead to reported increases in rates of obesity and related chronic diseases (Sayers & Boyle, 2010). The risks during pregnancy of obesity include congential abnormalities, miscarriage, pre-eclampsia, gestational diabetes and operative delivery (Sayers & Boyle, 2010). The incidence of neural tube defects is twice as high in Aboriginal and Torres Strait Islander pregnancies than the general population (Sayers & Boyle, 2010). Folate, a vitamin found in green leafy vegetables, fruits, beans and peas has been found to significantly reduce the incidence of neural tube defects if taken immediately prior to conception (Griew, et al., 2007). Medical advice now recommends Folate supplementation for women planning pregnancy or capable of conception (Sayers & Boyle, 2010). However it has been found that less than 10% of Aboriginal and Torres Strait Islander women are prescribed Folate prior to conception (Sayers & Boyle, 2010).

Thus, an important goal is to improve the diets of pregnant Aboriginal and Torres Strait Island people via access to affordable, healthy food and appropriate education. However, food security affects almost a quarter of Aboriginal and Torres Strait Islander people in a given year (Thomson, et al., 2010). Remoteness plays a key role in access to food with many remote communities having limited access to perishable foods (e.g. fruit, vegetables and dairy) and at costs higher than in urban areas (Thomson, et al., 2010). Therefore, people in remote communities may be required to spend a considerably larger proportion of their income on food which is exacerbated by lower average incomes (Australian Health Ministers' Advisory Council, 2011).



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### Maternal age

Approximately 3.6% of all Australian mothers are Aboriginal and Torres Strait Islander people (Boyle, Rumbold, Clarke, Hughes, & Kane, 2008). Whilst the birth rate for non-Indigneous women averages 2.0 births, the birth rate for Aboriginal and Torres Strait Islander women is 2.5 births (Thomson, et al., 2010). This higher fertility rate can be attributed in part to the fact that Aboriginal and Torres Strait Islander women give birth at a younger age (mean age 25 years) compared to non-Indigneous women (mean age 30 years) (Boyle, et al., 2008). Approximately 70% of Aboriginal and Torres Strait Islander women give birth before the age of 30 years compared to only 46% of non-Indigneous mothers (Thomson, et al., 2010).

The Aboriginal and Torres Strait Islander population also has a higher rate of teenage pregnancy compared to the non-Indigenous population. The fertility of teenage Aboriginal and Torres Strait Islander women is more than four-times that of all teenage women (Thomson, et al., 2010). Kelly, Graham and Sullivan (2010) report that almost one-fifth of Aboriginal and Torres Strait Islander mothers are teenagers compared to only 3.5% of mothers in the non-Indigenous population. Socio-economic disadvantage, tobacco smoking, alcohol use and poor prenatal attendance are all common to Aboriginal and Torres Strait Islander teenage pregnancy, which can have a negative impact on perinatal outcomes. However, even when controlling for these factors, teenage pregnancy in this population in itself contributes to an increased risk of preterm delivery, low birth weight and foetal growth restriction (Kelly, et al., 2010; Sayers & Boyle, 2010).

### Antenatal care

Approximately 97% of Aboriginal and Torres Strait Islander women access antenatal services during their pregnancy but generally at a later point in the pregnancy compared to other women and less often (Australian Health Ministers' Advisory Council, 2011; Reibel & Walker, 2010). One study identified that approximately 10% of Aboriginal and Torres Strait Islander women did not attend their first antenatal care visit until after 30 weeks into the pregnancy (Griew, et al., 2007). These poorer rates of antenatal attendance have been attributed to a lack of culturally appropriate services for Aboriginal and Torres Strait Islander women (Langridge, et al., 2010; Prime Minister's Science Engineering and Innovation Council Working Group, 2008; Simmonds et al., 2010).



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The higher rates of smoking, anaemia, diabetes, UTIs and STIs found in pregnant Aboriginal and Torres Strait Islander women, as well as the increased risk of pre-term birth, low birth weight, neural tube defects, foetal growth restriction and neonatal death in Aboriginal and Torres Strait Islander babies makes quality antenatal care particularly important (Australian Health Ministers' Advisory Council, 2011; Simmonds, et al., 2010). Late commencement of antenatal care has been associated with poorer birth outcomes including low birth weight (Australian Health Ministers' Advisory Council, 2011). As such, it is generally recommended that antenatal care begins in the first trimester (before 13 weeks) so risk factors can be assessed early and appropriate management undertaken as well as the provision of education and advice regarding pregnancy and child birth (Australian Health Ministers' Advisory Council, 2011; Robinson, Comino, Forbes, Webster, & Knight, 2011). Visits should then be scheduled monthly until 28 weeks, fortnightly between 28 to 36 weeks and weekly from 36 weeks until childbirth (Griew, et al., 2007).

It has been demonstrated that when antenatal services have been developed to meet the needs of Aboriginal and Torres Strait Islander women, the frequency of attendance increases and reduces the risk of complications (Reibel & Walker, 2010; Simmonds, et al., 2010). Attendance at even one antenatal care visit reduces the likelihood of having a low birth weight baby for Aboriginal and Torres Strait Islander women(Australian Health Ministers' Advisory Council, 2011). In addition, this risk is further reduced as the number of antenatal visits increases (Australian Health Ministers' Advisory Council, 2011).

In a comprehensive review examining the health care needs of Aboriginal and Torres Strait Islander mothers, babies and young children, the following elements were identified in existing health care programs that provide quality and culturally appropriate healthcare services to Aboriginal and Torres Strait Islander communities:

- Community based and/or community controlled services
- A specific service location intended for women and children
- 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



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- 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

Source: (Herceg, 2005, p. 12)

## Culturally appropriate care

It is important to provide a service which is both culturally appropriate and safe for Aboriginal and Torres Strait Islander women (Nel & Pashen, 2003). Culturally safe health care is a key issue if maternal and perinatal health outcomes are to be improved, as research has shown that Aboriginal and Torres Strait Islander women often feel alienated from mainstream health services (Boyle, et al., 2008).

Cultural safety has been defined as 'an environment in which identity isn't challenged or denied and client needs are met through shared respect, meaning, knowledge and experience' (Adams, 2010, p. 36). This requires that interactions with Aboriginal and Torres Strait Islander women are not demeaning or devalue their cultural beliefs and do not make assumptions based on stereotypes (Taylor & Guerin, 2010).

Health practitioners need to be open and respectful to differences in culture and to have a desire to discover how an individual's culture frames their healthcare experience (Zander, 2007). It is particularly important to understand and respect that within Aboriginal and Torres Strait Islander culture, health beliefs are complex and involve spiritual associations to country and family (Boyle, et al., 2008). It is necessary to be aware of the key aspects associated with Aboriginal culture as they relate to the provision of health care.

## Concept of health

Within Australia, health services traditionally adopt a western medical approach which focuses on physical and anatomical changes within the body and is primarily disease-focussed (Taylor & Guerin, 2010). Many Aboriginal and Torres Strait Islander people, however, adopt a more holistic view of health, sickness and wellbeing which encompasses



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'*everything important in a person's life, including land, environment, physical body, community, relationships and law*' (Thomson, et al., 2010, p. 4). Health is viewed as not only the health and wellbeing of the individual but also encompasses the social, emotional and cultural wellbeing of the community as a whole (DiGiacomo, Abbott, Davison, Moore, & Davidson, 2010; Liaw, et al., 2011).

Land is also thought to be central to wellbeing (Taylor & Guerin, 2010). Aboriginal and Torres Strait Islander people have a strong identification with their traditional land and it holds particular spiritual significance for them (Nelson & Allison, 2000). Research in 2008 found that 62% of Aboriginal and Torres Strait Islander people identified with a particular clan group and 25% currently lived in their traditional lands (Australian Health Ministers' Advisory Council, 2011). Due to a cultural connection to the land, hospitalisation during childbirth can be viewed as culturally inappropriate in some communities as it disconnects mother and baby from their land and country (Watson, Hodson, & Johnson, 2002). Women in remote communities often must travel vast distances by themselves for antenatal services, removing them from their family, land, language and culture (Kildea, 2006). The western medical model of childbirth is therefore perceived by many as not culturally safe and results in some Aboriginal and Torres Strait Islander women avoiding such services (Kruske, Kildea, & Barclay, 2006).

## Women's business

Within traditional Aboriginal and Torres Strait Islander culture sexual health, pregnancy and childbirth are considered 'women's business' and are not discussed in mixed company (Simmonds, et al., 2010; Taylor & Guerin, 2010). Traditionally 'women's business', also referred to as 'Grandmothers' Law, was passed from one generation to the next through the active participation of female kin in pregnancy and childbirth (Simmonds, et al., 2010). This custom is often translated in health care services in a strong preference by Aboriginal and Torres Strait Islander clients for same sex health care providers (Wilson, 2009). The inclusion of 'aunties' and grandmothers in women's health services has become more prevalent in an effort to provide practical and emotional support to new Aboriginal mothers and improve feelings of cultural safety (Brooks 2009; Reibel & Walker, 2010). Early discharge and perceptions of non-compliance have occurred as a result of not recognising this cultural custom (Taylor & Guerin, 2010).



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## Kinship and family obligations

Within Aboriginal and Torres Strait Islander culture there is a strong prioritisation of family and community attachments (Nelson & Allison, 2000). Kinship is a significant and complex concept within Aboriginal and Torres Strait Islander culture. Kinship involves a set of social structures which determine 'how people are to relate to one another and what obligations and responsibilities they may hold towards one another' (Taylor & Guerin, 2010, p. 127). Within this system, for example, responsibility for certain aspects of child rearing may be undertaken by members of the extended family such as aunties and grandmothers instead of the biological parents (Griew, et al., 2007; Nelson & Allison, 2000; Taylor & Guerin, 2010). Avoidance relationships may also exist where certain interactions between certain individuals are not permitted (Taylor & Guerin, 2010). This has important implications in the health care setting as two Aboriginal and Torres Strait Islander people may not be allowed to remain in the same waiting room or it may be inappropriate for an Aboriginal and/or Torres Strait Islander Health Worker to interact with certain clients (Taylor & Guerin, 2010).

Thus, the kinship system has a significant influence on the interactions of Aboriginal and Torres Strait Islander people, even if they currently have limited contact with their family, community and culture. It is therefore important for health care professionals to be familiar with local kinship structures (Taylor & Guerin, 2010).

## Shame

Shame is a complex and sensitive concept for Aboriginal and Torres Strait Islander people and encompasses '*feelings of guilt and can occur when an individual is singled out, or is involved in actions not sanctioned by the group, or in those that conflict with their cultural obligations*' (Kruske, et al., 2006, p. 75). It is a concept that is often not fully understood and appreciated in the healthcare setting and can cause great distress (Wilson, 2009). 'Shame' might be experienced by an Aboriginal and Torres Strait Islander woman when treated by a male health practitioner in what is traditionally perceived as 'women's business' (Watson, et al., 2002). Likewise a young Aboriginal and Torres Strait Islander woman might be reluctant to seek early antenatal care because of the 'shame' experienced in getting pregnant at a young age, having contracted a STI, being asked personal questions regarding who the father is, or family reactions (Wilson, 2009).



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The concept and feelings of 'shame' are not universal, however, and vary from individual to individual and place to place (Wilson, 2009). One strategy for minimising 'shame' when attending health services is having access to Aboriginal Health Workers (AHWs) (Wilson, 2009). Wilson (2009) suggests that health practitioners must consider shame when interacting with Aboriginal and Torres Strait Islander people and '*ensure that there are private spaces for conversation; avoid pressuring the women to speak or use words; avoid direct questions; suggest a pregnancy test but only in private; offer women choices and options regarding terminations; support the woman in her decision-making; validate her choices where appropriate; and reassure her of her own worth'* (Wilson, 2009).

## Communication and language barriers

For many Aboriginal and Torres Strait Islander people English is not their first language and communication with health care professionals can be a frustrating and embarrassing experience (Taylor & Guerin, 2010). There is often an expectation that Aboriginal and Torres Strait Islander people should speak English but there can be significant cultural communication differences between them and mainstream health care service providers (Taylor & Guerin, 2010; Watson, et al., 2002).

It is not uncommon for Aboriginal and Torres Strait Islander people to be labelled as 'non-compliant', 'non-communicative' or not interested in their own health (Liaw, et al., 2011; Taylor & Guerin, 2010). These attitudes place the responsibility for health care outcomes on the Aboriginal and Torres Strait Islander clients rather than acknowledging the responsibility of health care providers to provide a culturally appropriate service (Taylor & Guerin, 2010). Unfortunately, health care professionals are not always adequately trained in effective communication with people for whom English is not their first language and those from cultural minorities (Taylor & Guerin, 2010).

Taylor and Guerin (2010, pp. 126-127) outline the following elements to consider when reflecting on communication with Aboriginal and Torres Strait Islander people:

- **Make an effort to build trust and rapport**: it is useful to invest time identifying a point of contact, similarity or shared experience with Aboriginal and Torres Strait Islander clients early on and not immediately start probing and questioning on personal matters.
- **Awareness of language useage/conventions (how is language used):** In some Indigenous languages, direct questioning is avoided and it is polite to first spend time



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discussing other matters. Whilst this may be viewed as evasive or 'time wasting' in Western cultures it is actually perceived as polite in Indigenous cultures.

- **Use plain English and limit the use of medical jargon**: explain concepts in terms a layperson would understand without oversimplifying it, considering the age and educational background of the client.
- **Model appropriate English**: Link technical words to commonly used words or terms.
- **Use visual aids when appropriate**: however it is important to keep these age and culturally appropriate.
- **Consider the use of silence:** Carefully considering a response to questions is viewed as polite in many Indigenous communication styles although it may be perceived as not understanding or a reluctance to answer the question. Silences may also reflect the time taken to translate the question into their own language and then formulate the response back into English.
- **Consider the use of abstract concepts:** certain medical concepts such as 'anxiety' or 'pain' can be difficult to translate and consideration should be given to the purpose and use of difficultly defined terms. Taylor and Guerin (2010, p. 127) suggest asking 'what would you like for your pain?' rather than questioning how much pain they are experiencing.
- **Body language**: the use of non-verbal communication, including hand signals and facial gestures, is used extensively in many Australian Indigenous cultures. Aboriginal and Torres Strait Islander people may respond in conversation using non-verbal cues that may not be noticed by non-Indigenous people. Aboriginal and Torres Strait Islander people often do not make eye contact with those they are conversing with, and in some instances may not be allowed.
- **Reluctance to make a decision or 'yes' response**: in some Aboriginal and Torres Strait Islander communities it might be considered impolite to contradict others (including health care professionals) and so whilst agreement might be indicated this does not necessarily mean it will be undertaken or enacted upon.

## The health care professional

Nguyen (2008) provides a useful list of questions which health professionals can use to guide their development in this area. Reflecting on personal attitudes, skills and knowledge in regards to interactions with people from other cultures enables a better understanding of



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how health care interventions are mediated by the characteristics of those who provide the care as well as those of the client.



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**Table 2:** A checklist for enabling cultural competence

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| **Attitudes** | • Are you open to cultural differences and different ways of doing things?<br>• Do you respect diverse practices and requests without judgement?<br>• Do you react adversely to patients' accents and language styles? |
| **Skills** | • Do you recognise, elicit and actively accommodate patients' choices about their care?<br>• Do you facilitate your culturally and linguistically diverse (CALD) or Aboriginal and Torres Strait Islander patients' access to the available resources and support?<br>• Do you use an interpreter when interacting with a patient from a CALD or Aboriginal and Torres Strait Islander background whose proficiency in English is inadequate?<br>• Do you integrate culturally influenced health protective/prevention factors in your practice?<br>• Do you integrate the following in diagnostic protocols:<br>- Knowledge of diverse values and belief systems to health and disease?<br>- Individuals' perceptions of what caused their disease/illness?<br>- Culturally relevant information from family members?<br>- Screening/diagnostic tests based on age, race/ethnicity or gender? |
| **Knowledge** | • Are you aware that you are legally liable if you do not organise an interpreter when necessary?<br>• Are you aware of the sources of extra social support, community organisations and resources available to CALD or Aboriginal and Torres Strait Islander patients to overcome barriers such as lack of English proficiency or support networks?<br>• Are you aware of the impact of family dynamics on health care decisions (e.g. high value placed on decisions of elders, differing gender roles, role of extended family)?<br>• Are you aware of the influence of spirituality or religiosity on perceptions of health and wellbeing?<br>• Are you aware of the impact of the social and environmental indicators on the health and wellbeing of the communities you serve? |

*Source:* (Nguyen, 2008, p. 993)



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## Conclusion

Whilst there have been some improvements in the disparities between health outcomes for the general population and those of Aboriginal and Torres Strait Islander women and their babies, a large gap still remains to be closed, making improved access to good-quality antenatal care, which is culturally appropriate, necessary (Boyle, et al., 2008; Sayers & Boyle, 2010).

Interventions to improve health outcomes must incorporate the views and beliefs of the local community and consider Aboriginal and Torres Strait Islander peoples' holistic definition of health, which encompasses social, emotional, spiritual and cultural aspects of well-being as well as obligations to the land and their community (Kildea, 2006). It is useful to consider the following principles of cultural safety outlined by Taylor and Guerin (2010) when working with Aboriginal and Torres Strait Islander people:

- Provide care that is regardful of culture
- Engage in dialogue. Ask what your clients want and how they want you to provide the services they want. Consider how you ask.
- Be mindful of whose values are being valued.
- Reflect on your own power and role in empowering others.
- Process is more important than outcomes.
- Continually ask yourself, 'are my actions empowering or disempowering?'

Source: (Taylor & Guerin, 2010, p. 173).

Health professionals are not required to become experts on Aboriginal and Torres Strait Islander culture but rather, be 'aware of cultural differences that exist, appreciate and have an understanding of those differences and accept them' (Westwood & Westwood, 2010, p. 424). It is also important to recognise that not all Aboriginal and Torres Strait Islander women will want the same thing – individual differences exist as within any cultural group (Simmonds, et al., 2010). Each Aboriginal and Torres Strait Islander woman will desire an antenatal service which enables her to best utilise aspects of both Western medical practice and traditional culture (Simmonds, et al., 2010).



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## Medical glossary and acronyms

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| **AHW** | **Aboriginal Health Worker**<br>An Aboriginal and/or Torres Strait Islander person employed in an identified position in the health system and providing health services or health programs directly to Aboriginal and Torres Strait Islander people and their communities. |
| **Aboriginal and/or Torres Strait Islander** | A person who:<br>• is of Aboriginal and/or Torres Strait Islander descent; and<br>• identifies as an Australian Aboriginal and/or Torres Strait Islander person; and<br>• is accepted as such by the community in which s/he lives or has lived. |
| **Birth weight** | The first weight of the baby (still born or live birth) obtained after birth (usually obtained within one hour of birth) (Kelly, et al., 2010). |
| **CALD** | **Culturally and Linguistically Diverse**<br>Encompasses the differences that exist between people such as language, dress, traditions, food, societal structures, art and religion. |
| **Cancer** | A large group of almost 100 diseases characterised by the uncontrolled growth of the cells in human body and the ability of these cells to migrate from the original site and spread to distant sites. If not controlled cancer can result in death. |
| **Culture** | The ideas, customs, beliefs and social behaviour of a particular people or society. |
| **Hypertension** | High blood pressure defined as a repeatedly elevated blood pressure exceeding 140 (systolic) over 90 (diastolic) mmHg. |



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| **Interdisciplinary teams** | A team that is collaboration-oriented. The team meets regularly to discuss and collaboratively set treatment goals and carry out treatment plans. There is a high level of communication and cooperation among team members (Korner, 2008, p. 2). |
| **LBW** | **Low birth weight**<br>Birth weight of less than 2,500 grams (Kelly, et al., 2010). |
| **Maternal age** | The mother's age at the birth of her baby (Kelly, et al., 2010). |
| **Multidisciplinary teams** | A team that is discipline-oriented. Each professional works in parallel, with clear role definitions, specified asks and hierarchical lines of authority (Korner, 2008, p. 2). |
| **Perinatal mortality** | Death of the child at any time between 20 weeks gestation and 28 days after birth (Kelly, et al., 2010). |
| **Preterm birth** | Birth before 37 completed weeks of gestation (Kelly, et al., 2010). |
| **Renal failure** | Partial or complete loss of kidney function. |
| **Respiratory disease** | Respiratory disease is a medical term that encompasses pathological conditions affecting the organs and tissues that make possible the gas exchange the body needs to function. This group of conditions includes conditions of the upper respiratory tract, trachea, bronchi, bronchioles, alveoli, pleura and pleural cavity, and the nerves and muscles of breathing. Respiratory diseases range from mild symptoms such as the common cold, to life-threatening conditions such as bacterial pneumonia, pulmonary embolism and lung cancer. |
| **Social determinants of health** | The conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at |



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| | global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries (World Health Organization, 2012). |
| **Still birth** | Death prior to the complete extraction from it's mother where baby is 20 or more weeks into gestation or 400 grams or more birthweight (Kelly, et al., 2010). |
| **Stroke** | Occurs when blood flow is interrupted to part of the brain. Without blood to supply oxygen and nutrients and to remove waste products, brain cells quickly begin to die. Depending on the region of the brain affected, a stroke may cause paralysis, speech impairment, loss of memory and reasoning ability, coma, or death. |
| **WHO** | **World Health Organization**<br>WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. |



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## Further information

**Australian Indigenous Health*InfoNet***

http://www.healthinfonet.ecu.edu.au/

An Internet resource that aims to inform practice and policy in Indigenous health by making research and other knowledge readily accessible.

**Australian Institute of Aboriginal and Torres Strait Islander Studies**

http://www.aiatsis.gov.au/

Provides information and research about the cultures and lifestyles of Aboriginal and Torres Strait Islander peoples, past and present.

**Department of Families, Housing, Community Services and Indigenous Affairs (FaCSIA)**

http://www.indigenous.gov.au/

A gateway to information on Australian Government Indigenous initiatives and programs.

**Department of Health and Ageing - Aboriginal and Torres Strait Islander Health**

http://www.health.gov.au/internet/main/publishing.nsf/Content/Aboriginal+and+Torres+Strait+Islander+Health-1lp

Provides information and links regarding Aboriginal and Torres Strait Islander health programs.

**National Aboriginal and Torre Strait Islander Education**

http://www.natsiew.edu.au/site/home.aspx

An educational portal that catalogues Internet resources related to Aboriginal and Torres Strait Islander peoples, with a special emphasis on education.

**Office for Aboriginal and Torres Strait Islander Health (OATSIH), Department of Health and Ageing**

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-about

OATSIH ensures a focus to the health needs of Aboriginal and Torres Strait Islander peoples in mainstream health programs in Australia, and is responsible for the administration of funding to Aboriginal and Torres Strait Islander community controlled health and substance use services.



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**Reconciliation Australia**

http://www.reconciliation.org.au/home

The peak organisation promoting reconciliation between Aboriginal and Torres Strait Islander peoples and the broader Australian community. Its vision is for an Australia that recognises and respects the special place, culture, rights and contribution of Aboriginal and Torres Strait Islander peoples; and where good relationships between First Australians and other Australians become the foundation for local strength and success; and the enhancement of Australia's national wellbeing.



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