CULTURAL SAFETY AND MATERNITY CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER AUSTRALIANS

Introduction

Midwives represent the largest numbers of workers providing maternity services in Australia [1]. The western health system in which they work was developed to meet the needs of the majority population which was white, middle class and predominantly Christian [2]. However, the cultural mix of Australian society is now very diverse. Despite this, western health systems remain directed towards the needs and beliefs of the majority group and in many cases are inappropriate for the smaller, less dominant population groups [3]. The situation is compounded by inadequate preparation of professionals to work cross culturally.

Much of the literature around cross cultural care comes from the nursing discipline, including the concept of 'cultural safety'. The term 'cultural safety' originates from Maori nurses in New Zealand. Whilst there are many similarities to the historical and social situation between the Maori and Aboriginal and Torres Strait Islander peoples, there are fundamental differences when applying cultural safety in an Australian context. The purpose of this paper is to apply the concept of cultural safety to the provision of maternity services in Australia care to Aboriginal and Torres Strait Islander women.

Culture

In 1952, Kroeber and Kluckhohn [4] identified 164 different definitions of 'culture'. The 'culture' concept has been challenged over recent years in academic circles [5, 6]. While an acceptable contemporary notion of 'culture' involves the shared meanings, values attitudes and beliefs of a group [7], it has to be acknowledged that individuals within a group vary in their knowledge or interpretation of these meanings and often hold different or even

conflicting values and beliefs. In other words cultures are not rigid, homogeneous entities and should not be thought of as objects or things [8]. However, in everyday discourse this is often occurs with the concept of ‘culture’ being commonly connected to minority groups and frequently refers to the ‘other’ or ‘outgroup’ [7]. In other words, the dominant group assumes that only minority groups have cultures and cultural needs [9]. It is difficult for members of a dominant culture to recognise or accept that each individual is racially and ethnically constructed, because they perceive their own culture as the ‘normal’ and the non-dominant groups are the ‘other’ [10]. It is more often ‘differentness’ rather than ‘culture’ that influences the relationship between practitioner and client [11].

Focusing on cultural components of a person may result in ignoring the differences within that group created by other power differentials including gender, age, economics, poverty and politics. Cultures, therefore, cannot be examined, explored or understood without consideration of the politics and history that influence them, including the power relations within the group [12]. Many health practitioners are constrained by their own cultural perspective with little understanding of institutional racism and discrimination inside the health service or in society in general [13].

This may lead to differences in care provision. This has been found in studies where nurses and midwives spent more time with patients of their own cultural group [14] and identified minority group clients as being ‘difficult’ or ‘non-compliant’ [15].

Providing health care for people who are culturally ‘different’ requires more effort than doing so for people from one’s own group [11]. Minority groups are often seen as inferior and midwives and nurses tend to negatively stereotype [16]. This may be due to the lack of

education around these concepts. Midwives and nurses frequently report feeling ill equipped and poorly prepared to deal with culturally diverse groups [3, 17]. It appears there is insufficient educational preparation for midwives or nurses to work effectively with other groups, and many of the educators themselves are inappropriately skilled to help others learn this [18].

Cultural safety

In the late 1980s a Maori nurse, by the name of Irihapiti Ramsden, led the development of 'cultural safety' as a framework for more appropriate health services for Maori people in New Zealand [10]. Rather than an emphasis on midwives and nurses learning about diverse cultures (learning about *the other),* cultural safety requires them to explore their own cultural make up [19]. Based on attitudinal change, cultural safety aims at educating the health practitioner to become open minded and non judgmental [20]. It encourages health staff to understand, rather than blame, the victims of historical and social processes for their current situation [10]. Cultural safety also encourages health practitioners to have a thorough understanding of poverty and its impact on people [20].

Another important tenet of cultural safety is that the midwife or nurse not only acknowledges her/his own personal culture, but the power of nursing or midwifery culture [21]. It requires health practitioners to question the consequences of the long standing ethic of 'treating everyone the same' regardless of age, ethnicity or gender [22]. A health practitioner cannot assume s/he provides culturally safe care, as only the recipient of care can assess the level of risk or safety they experience [19].

A number of educators initially confused cultural safety with the field of Maori studies, which led to significant tensions in New Zealand [23]. Cultural safety leaders however, discouraged the promotion of traditional Maori culture [24] as this was seen as being harmful to the urbanised Maori who frequently have been denied knowledge of their own culture [25]. Like the Australian Aboriginal and Torres Strait Islander population, cultural practices range in the Maori people, from very traditional to those that are indistinguishable from the dominant culture [20]. For some urban Maori who have not been exposed to traditional practices and beliefs, having a non-Maori practitioner teach, or assume traditional knowledge, would further alienate them from the health service [25].

In contrast to the international literature's focus on 'multiculturalism', cultural safety adopted the term 'biculturalism' [26]. For the developers of cultural safety, multiculturalism was seen as distracting attention away from the power differences involved between the health practitioner and receiver [23]. Earlier publications on cultural safety suggested biculturalism was related to the relationship between Maori, as the traditional occupants of New Zealand and all those who have come since [27]. Ramsden [20] claimed that because of the serious health status of the Maori people of Aotearoa/New Zealand, and the real possibility of the disappearance of their culture and language, cultural safety must begin with the Maori people. However, the Maori, as custodians of the concept of cultural safety, have extended its principles to include those of other cultures, who subsequently came to live in New Zealand [20]. Cultural safety was further developed to include an emphasis on the relationship between any health professional and consumer who differ by: age or generation; gender; sexual orientation; socioeconomic status; ethnic origin; religious or spiritual belief, and; disability [21]. These categories highlight the use of the term 'culture' in its broadest sense [28] rather than the concept of being only ethnic or race specific.

An alternative explanation of biculturalism is that all interactions between health practitioner and service user are 'bicultural' due to the culturally-informed messages that are filtered between the giver of the message and the receiver of that message [23]. The convergence of two 'cultures' – the professional culture of the health practitioner and the culture of the consumer (regardless of ethnicity) – may result in a power imbalance which can cause the recipient of care to feel intimidated and powerless [22].

Cultural safety in New Zealand has been linked to the Treaty of Waitangi [29] which was signed in 1840, and Maori people gave the Crown rights to govern and to develop British settlement. The Crown guaranteed Maori full protection of their interests and status, and full citizenship rights [30]. It is the lack of similar formal acknowledgment of Aboriginal and Torres Strait Islander sovereignty in Australia that makes the New Zealand model of cultural safety more difficult to apply in Australia [31]. Despite this lack of national political recognition by progressive Australian governments of Aboriginal and Torres Strait Islander sovereignty, the fundamental aspects of cultural safety can be incorporated into individual practice and the broader health system.

Maternity care for Aboriginal and Torres Strait Islander Australians

Australia's lack of progress towards providing culturally safe care for the Aboriginal and Torres Strait Islander population is particularly evident in the area of childbirth [32]. It is difficult to find guidelines or policies covering cultural safety in maternity care for Aboriginal and Torres Strait Islander women and there are limited numbers of Aboriginal and Torres Strait Islander Australians working in hospitals [17, 33, 34]. It is routine practice across Australia that women in late pregnancy who live in remote areas must travel

sometimes large distances to give birth in regional settings that provide maternity services. Most hospitals in Australia, do not offer interpreter services for Aboriginal and Torres Strait Islander languages (though they will have many other interpreters available).

A useful example of culturally 'unsafe' service can be illustrated by the concept of 'shame'. Shame is a complex and sensitive concept well known to many Aboriginal and Torres Strait Islander peoples, but often misunderstood by the health practitioner [32, 35]. It 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 [32, 35]. An example of shame in maternity services is when Aboriginal and Torres Strait Islander women are attended by men in childbirth procedures. According to one author [32], in this situation Aboriginal and Torres Strait Islander culture is being breached and can cause great shame and distress. Unfortunately, many health services find the provision of female health practitioners for everything to do with 'women's business' difficult, with few incentives provided to try and achieve this.

Molly Wardaguga, a retired senior Aboriginal Health Worker with many years experience in maternity care, believes giving birth in hospitals is a frightening and traumatic experience which contributes to cultural decline and is putting mothers and babies health at risk [36].

Many consultations with Aboriginal and Torres Strait Islander women around maternity service provision have occurred in Australia over the past 30 years [17, 33, 37-41]. These consultations report similar findings and recommendations. Women highlight the importance of personal safety, both during birth and when awaiting birth in the regional setting [17, 33, 37-39]. Women have identified: choice; cultural considerations around birth (eg. being cared for women and appropriate care of the placenta); having family members with them during

birth; and, their children nearby, as being important factors that are currently missing from the birthing environment [17, 33, 39].

Many Aboriginal and Torres Strait Islander women also report they would prefer to birth in their own communities [17, 33, 37, 39, 42, 43]. Some women feel that their relationship to the land, established through the birthing experience, is vitally important to their culture. This may be compromised by birthing in hospitals where many do not feel 'culturally safe' when experiencing a Western medical model of childbirth [17, 33, 38, 39, 42, 43].

Some women believe that, when babies and mothers return from the regional centres, they return in a weak state and need cultural ceremonies such as the 'smoking ceremony' to be performed to make them strong again [42, 44]. Failing to observe the relevant rituals and laws during pregnancy presents a grave risk to the health of both the mother and baby and the long-term health of the people [45]. Other women report hospital birth as the cause of infant mortality. This is because they believe when appropriate ceremonies are not performed the baby is not welcomed properly into the world and the weakened spirit can get sick [46].

A response from some pregnant Aboriginal and Torres Strait Islander women to the current culturally unsafe maternity services is to avoid the service. These women may not attend for antenatal care for fear of being forced to leave their communities for birth [17]. Some Aboriginal and Torres Strait Islander women will travel to the regional centre but return to their communities before birth, and arrive at the health centre in strong labour when it is too late to be transferred out [17, 47]. Anecdotally, these women are labelled as 'non-attenders' or 'non-compliant' and may incur the disapproval of the practitioner who feels they have been placed in a vulnerable position.

Lack of responses from mainstream health services to the requests of Aboriginal and Torres Strait Islander women and their families through the many consultations, suggest that this group of Australians are marginalised and ignored. Aboriginal and Torres Strait Islander people have a longstanding history of being ignored [31]. Efforts to improve the health of Aboriginal and Torres Strait Islander Australians must encompass their holistic definition of health, which includes the social, emotional, spiritual and cultural well-being of an individual [48]. Additional factors that must be incorporated include Aboriginal and Torres Strait Islander peoples' obligations to the land, their culture and their people, and avoidance of situations that can cause shame [32, 49].

A way forward

It is clear that many maternity services across Australia are currently inappropriate, lacking the cultural considerations necessary to support Aboriginal and Torres Strait Islander women through pregnancy and childbirth. To provide culturally safe care in Australia, changes need to be implemented at all levels of health services.

Educators of midwives and nurses need to be more adequately prepared to teach cultural safety and universities and health services need to involve Aboriginal and Torres Strait Islander women in the provision of education. Focusing on the education of minority group behaviour around food taboos, religion, death and other cultural practices does not address cultural or indeed social safety in the wider social context [50]. Instead of the teaching of cultural awareness or sensitivity, midwifery and nursing education would be more effective if they encouraged the development of critical understanding of the complex political, social

and economic relations that have perpetuated race and class divisions and the fundamental structural reforms required to address it [51].

At an individual level, midwives and nurses need education and support to provide culturally safe services. Fundamental to this is for all health practitioners to reflect on their own cultural makeup and the resulting biasness and ethnocentric influences that exist in all of us [23]. Health practitioners must have an understanding of how Aboriginal and Torres Strait Islander women are treated in mainstream maternity services and the marginalisation that occurs as a result of their culture or identity [52]. This involves an understanding of the social and economic plight that influences Aboriginal and Torres Strait Islander society today. We must be mindful of the past and present influences that shape contemporary Aboriginal and Torres Strait Islander society. Such understanding can potentially address some of the difficulties Aboriginal and Torres Strait Islander women and their families face every time they access mainstream Australian health services. Midwives should also be aware of how the use of medical terminology and even the clothes we wear can be oppressive and exclusionary [53].

Maternity care should be provided by known practitioners, in a community-based, continuity of carer model. Ideally this would be run through Aboriginal or Torres Strait Islander controlled organisations which would replace the often unwelcoming and hostile hospital clinics. Care should be provided by female practitioners. Birthing services should be located as close to the woman's home as possible. International evidence has shown that birthing services can be provided safely in very remote settings [54-56]. It is time to rethink the closure of rural and remote birthing services that is currently occurring across Australia without adequate application of evidence or evaluation.

Women who do need to leave their homes should have support to take their young children with them. Many want to take an ‘escort’ to keep them company when they are in town, as loneliness is one of the most common complaints, often cited as the reason for returning home prior to birth [17]. In labour and childbirth, women should have support people of their choice. Ideally the person who escorts the woman to town would also support them in labour. However, this is becoming increasingly difficult as the more birth occurs away from the community the less experience that Aboriginal and Torres Strait Islander women have in providing childbirth support. In the past, women were present at many births and offering support was second nature but these skills can no longer be assumed. Women should be offered, encouraged and supported to utilise their own cultural practices, and serviced by a facility that is warm and welcoming, where each and every woman feels safe.

Aboriginal and Torres Strait Islander people need to be more involved in both the design and implementation of policy and service provision. Policy makers must respond to the many Aboriginal and Torres Strait Islander voices who have called for greater choice and control over their child birth experience. Australia need governments who are prepared to recognise the past injustices done to a population who remain affected by them today. Whilst practitioners wait for this to occur, they as individuals can reform their own practice. Male practitioners need to take the initiative, recognising the cultural inappropriateness of caring for women in birth and step back from the ‘hands on’ care of Aboriginal and Torres Strait Islander women. Strategies such as the NSW Aboriginal Maternal and Infant Health Strategy where midwives and Aboriginal Health Workers work side by side should be universally available. Programs such as the Townsville Mums and Bubs project [57] should be the norm, not the exception.

Conclusion

This paper raised the issue of cultural safety and its applicability to maternity services for Aboriginal and Torres Strait Islander women in Australia. It is clear that much work needs to be done. Whilst waiting for major structural reform, each practitioner who is involved in the care of Aboriginal and Torres Strait Islander women can pause and reflect on their own contribution to the provision of culturally safe, or unsafe, care. Even for those of us who think we are doing it well, there is room for improvement.

Culturally safe maternity services ensure that all recipients feel physically, spiritually, socially and emotionally safe. Every person who receives health care is entitled to be free from threat, challenge or denial of their identity, or what they require physically, socially or emotionally. Midwives must recognise their potential to intimidate through their powerful position as a health professional within the health system.

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