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## **Are Primary Health Care Services Culturally Appropriate for Aboriginal People: Findings from a Remote Community**

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## **Abstract**

**Objectives:** To explore the views of **key** stakeholders on cultural appropriateness of Primary Health Care (PHC) services for Aboriginal people.

**Methods:** A total of 78 participants, involving health care providers and administrative team members (n=24, ≈30% of study sample) and Aboriginal community members (n=54, ≈70% of study sample) living in remote North-West Queensland took part in this study.

Outcome measures were assessed by administering survey questionnaires comprising of qualitative questions and various sub-scales, e.g., provider behaviors and attitudes, communication, physical environment and facilities, and support from administrative staff. Descriptive statistics were used to present quantitative findings, while inductive thematic analysis was used for qualitative data.

**Results:** In contrast to the views of PHC providers, the majority of Aboriginal people did not perceive that they were receiving culturally appropriate services. The physical environment and facilities were inadequate in meeting the cultural needs of Aboriginal people. Though, PHC providers acknowledged cultural awareness training for familiarizing them with Aboriginal culture but found training to be general, superficial and lacking prospective evaluation.

**Conclusion:** There is a gap between the perceptions of providers and Aboriginal consumers for cultural appropriateness of PHC services. PHC providers should understand that culturally inappropriate clinical encounters generate mistrust, and dissatisfaction, often leading to delays or refusal in seeking needed care. Therefore, a broad approach involving culturally respectful association between PHC providers, Aboriginal consumers

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and administrative staff is required to bring sustainable changes at the practice level to improve the health of Aboriginal people.

### **Summary Statement**

#### **What is known about the topic?**

Culturally appropriate Primary Health Care (PHC) services are essential to ensure health services uptake by Aboriginal people.

#### **What does this paper add?**

Cultural awareness training alone are not sufficient to deliver culturally appropriate PHC services, a broad approach incorporating the inputs from Aboriginal Health Workers (AHWs) and Aboriginal community leaders, ensuring culturally appropriate ambience and amenities at the PHC, and improved liaison between PHC providers and AHWs is needed.

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## Introduction

The human and financial cost of poor health among Aboriginal Australian is well recognised and has driven initiatives in helping Primary Health Care (PHC) services to meet the needs of Aboriginal consumers [1]. However, under-utilization of health care services by Aboriginal population is still a big challenge for PHC services [2]. Poor uptake of health services cannot be attributed to “patients” factors alone and indicates that perhaps health care services are not meeting the expectations of Aboriginal people [3].

Since Aboriginal Australians have a complex and holistic notion of health encompassing spiritual, social, and cultural factors [4], it is unlikely that health care services that are planned and developed without considering the role of these factors will be successful in improving health outcomes for Aboriginal people [5]. Preliminary evidence from some studies report positive results when clinicians use a holistic approach accounting for not just the illness, but cultural and social aspects as well [6].

Unfortunately, much of the evidence on the provision of culturally appropriate PHC services is based on the perceptions of PHC providers [7] less so that of Aboriginal patients [8]. Therefore, there is a need to check the concordance in the perceptions of Aboriginal consumers and PHC providers for cultural appropriateness of PHC services. The identification of any misalignments, if present, will help in designing effective interventions at the practice level.

Considering the scarcity of evidence on this issue main objective of this study is to compare the perceptions Aboriginal community members and PHC providers in remote North West Queensland (NWQ) on cultural appropriateness of PHC services, and explore their views on factors affecting the delivery of culturally appropriate PHC services.

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## **Methodology**

### **Study Setting, Participants, and Procedures**

This research was conducted in Mount Isa, a remote mining town in North-West Queensland (NWQ) with a significant Aboriginal population ( $\approx 17\%$ ) [9]. PHC service providers and Aboriginal community members were surveyed for their perceptions on cultural appropriateness of PHC services. Aboriginal participants were included if they were 18 years or older; resident of Mount Isa and a current user of a local PHC service. Health care providers were included in this study if they were directly involved in the delivery of PHC services in Mount Isa.

Aboriginal community members were recruited by snowball sampling and were informed about the research aim and significance for the community. Participants were asked to sign the consent form before data collection.

### **Survey Instrument Development**

Although, few international questionnaires are available to explore cultural sensitivity in health care services [10], there was a lack of tools that could probe cultural appropriateness of PHC services from the perspective of Australian Aboriginal population. However, previous research in Australia has identified provider behaviors and attitudes; liaison among PHC providers; physical environment and facilities at the health care centre; and support from the health service and staff as important determinants of cultural appropriate PHC services for Aboriginal people [11-13]. Therefore, we utilized evidence from the published literature and tools as well as inputs from Aboriginal community leaders to develop the survey questionnaires.

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The qualitative component of the questionnaire included an open-ended question to explore participants' views on the factors affecting the delivery of culturally appropriate health care services. The questionnaire for health care providers also included an open-ended question about the effectiveness of cultural awareness training.

The quantitative component included some socio-demographic questions soliciting the following information: gender, age, cultural background, the number of years living/practicing in the community. The second set of questions included subscales, exploring main determinants of culturally appropriate PHC services, i.e., cross-cultural compatibility, communication, respect and equity, support, ambience, and amenities.

### **Survey Instrument Validation**

Participant rated their level of agreement for each listed question using a rating scale from 1 (strongly disagree) to 5 (strongly agree). Cronbach's alpha coefficients were used to estimate the internal consistency of the subscales in the questionnaire. Face validity was checked by interviewing a small subgroup on whether the question was easy to understand and maintained sensitivity.

The preliminary reliability and validity data for the survey instrument were obtained from pilot testing on a convenience sample of 13 medical students and 15 Aboriginal community members. The internal consistency (Cronbach's alpha coefficient) of all subscales was more than 0.70 with acceptable face validity. The pilot test results supported the use of these questionnaires for research purposes. All questionnaires with the response scales are provided in supplementary material (S1-S5)

### **Ethics**

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Ethics approval was obtained in 2015 from the Human Research Ethics Committee James Cook University (H5935). This research was also approved by the Mount Isa Aboriginal and Torres Strait Islander Reference Group, a representative of leaders in the Aboriginal and Torres Strait Islander community.

### **Survey Data Analysis**

For quantitative component, the total score for each subscale was computed as summated mean scores for all items. The questions phrased negatively were reverse coded. The combined scores were categorized into three levels, namely “Poor” “Moderate” and “High (Good),” for scores between 0-2.33, 2.34-3.66 and 3.67-5.00, respectively. Due to small sample size, the response categories were further dichotomized to represent participant's choice between “disagreement” or “agreement.” Differences in responses were explored according to participant survey category and presented as simple descriptive statistics.

Inductive thematic analysis was used to generate themes from the qualitative data. All transcripts were reviewed by two investigators (KS, YF) to identify patterns. All themes and subthemes were revised several times until no further themes could be identified, and the resulting themes accounted for all relevant information found in the transcripts. All transcripts were cross-checked to ensure all responses had been validated. The findings from quantitative subscales were compared with the outcome of thematic analysis to triangulate the findings.

### **Results**

A total of 78 participants participated in this study, involving four doctors, two mental health facilitators, one pharmacist, four Aboriginal health workers (AHW), five front desk staff, eight managers and board members, and 54 Aboriginal consumers (>90%

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participation rate) belonging to 20 different traditional language groups. The majority of survey participants were female (67.8%) with around half of the survey participants belonging to the age group of 35-50 years. Most of the PHC providers were non-Indigenous, and many of them (60%) had lived in the community for <1 to 3 years (Table 1). All of the PHC providers and front desk staff reported received cultural awareness training and rated themselves high on the subscale for cross-cultural compatibility, 90.9% and 60%, respectively.

### **Comparison of the Perceptions of PHC providers and Aboriginal community members on cultural appropriateness of PHC service**

There was a considerable difference between the perceptions of PHC providers and Aboriginal people on the provision of culturally appropriate PHC services (Figure-1). While most of the PHC providers perceived that communication between them and Aboriginal patients was clear and understandable (85.7%), yet only half of the Aboriginal community member (46.3%) agreed with that. However, there seemed a concordance between the perceptions of Aboriginal consumers (57.1%) and PHC providers (50%) on receiving high respect and support from PHC providers.

Although, all AHWs were satisfied with the level of support they provided to Aboriginal community members in receiving culturally appropriate PHC services, but only 40.7% of the Aboriginal participants were happy with the efforts of AHWs. Similarly, while most of the front desk staff (80%) were satisfied with the respect and support they provided to Aboriginal patients, only a small percentage of Aboriginal participants (35.2%) perceived the same. Nonetheless, there was considerable concordance in the views of managers and

board members (62.5%) and Aboriginal participants (75.9%) on the poor performance of PHC centre for providing culturally appropriate ambience and amenities.

### **Qualitative Analysis Results**

A total of 45 survey participants provided their views on the factors influencing the delivery of culturally sensitive care. The following themes emerged from the qualitative analysis of survey transcripts (Table 2).

#### **Non-supportive front desk staff**

Among the barriers affecting the delivery of culturally appropriate PHC services, lack of support from the front desk staff was one of the recurring themes. Consumers were unhappy that front desk staff never asked for their preference for seeing a male or female doctor. They emphasized the need for front desk staff to be respectful and be able to hold a culturally appropriate conversation, especially with the elders. As one of the participants recalled her experience:

*“The Admin needs to be more happy towards all of their clients that come to their service. Moreover, just because they had one person upset them do not take it out on everyone.”*

#### **Culturally inappropriate waiting area**

Aboriginal consumers, board members, and managers highlighted inadequate and culturally inappropriate physical space as another potential barrier. Consumers suggested that PHC services should be designed to accommodate the need for separate areas for men and women, and maintaining privacy at the reception. Some Aboriginal participants indicated that having culturally appropriate signs and paintings in the waiting areas will add to the cultural appropriateness of the service

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The following excerpt highlights Aboriginal consumers' concerns for appropriate clinic design to ensure their privacy:

*“Triage counter needs to be set up, so there is a bit more privacy for those wanting to see a Doctor. At the moment when you walk in the triage counter is right there where everyone in the waiting room can hear”.*

### **Communication**

The need for clear communication between the health providers and consumers was another recurring theme found in the transcripts of consumers. Aboriginal consumers felt that information provided by PHC providers was inadequate and needed to cover all aspect of health care. However, PHC providers in this study believe that communication gaps in explaining medicine are due to a lack of interest from Aboriginal people, as it seems that they do not want to listen. The following excerpt from pharmacist's transcript highlights health care providers' perspective on communication barrier:

*“Sometimes a barrier between patients when trying to explain medications.....It feels like they do not want to listen.”*

Whereas, Aboriginal patients emphasized the need for clear communication from health care providers to improve patients' uptake of PHC services:

*“Doctors, nurses, and administration at the hospital needs to ensure that clients and their family and friends understand all aspect of their health, including their medication – side effects, why meds been changed, important of keeping their and their children appointment either at the local hospital or another hospital ....., if they don't understand the whys, they will never understand the importance of it all”.*

### **Aboriginal workforce development**

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Many Aboriginal consumers and suggested that AHWs should be used for their knowledge of Aboriginal people and 'country.' The Board members also raised concerns that AHWs are not acknowledged for their skills and their ability to connect the clinic with the **Aboriginal** community and extended families. Some doctors and managers suggested that having an Aboriginal mentor to provide cultural information to new and locum staff will facilitate the delivery of culturally appropriate care.

### **Cultural sensitivity training**

Aboriginal consumers were very vocal about the need for cultural awareness training for PHC providers, as in the following examples:

*“Unless the health practitioner has had cultural competency training within this region, discussing men and women’s business would be pointless.”*

Also, a significant number of consumers in this study believed that it was not the non-indigenous people alone requiring cultural sensitivity training, but AHWs should also attend cultural training.

*“The AHW at -- -- are not culturally appropriately trained or friendly with all patients. They are very clinical mainstream health workers therefore not able to assist with managing or improving the health needs of their patients”.*

Most of the PHC providers agreed that cultural awareness training provided knowledge about Aboriginal culture and was helpful in preparing them for daily cross-cultural consultations. However, some participants raised questions about the effectiveness of this training. The most common concern was the training being too general and superficial and, therefore, was unable to provide in-depth knowledge about delivering culturally appropriate services. As one participant commented:

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*“Generally short one-day training help raises awareness but doesn't instill a deep understanding of the way to behave/address cultural matters.”*

Some participants raised concerns about cultural training being provided by non-Indigenous people with no prospective evaluation.

Consumers were happy that they received transport services and suggested to use better promotional activities to inform about health events and specialist visits. They also emphasized promotional activities should be broader in approach and be able to reach all **Aboriginal** people in the community.

## **Discussion**

The findings of this study indicate a considerable gap between the perceptions of Aboriginal community members and health care providers on the provision of culturally appropriate PHC services. While a considerable number of Aboriginal participants in this study did not perceive to receive culturally appropriate PHC services and adequate support from PHC services and providers, the majority of PHC services providers believe in delivering culturally appropriate health care services. Some improvement areas identified in this study include the provision of culturally appropriate ambience and amenities at PHC services; Aboriginal workforce development and better utilization of AHWs by PHC providers.

Aboriginal consumer perceptions of a health centre's cultural appropriateness are affected by the health centre's facilities and policies, including consideration of the culturally appropriate ambience of the centre and its amenities. Displaying Aboriginal artwork is an economic intervention that validates the commitment of PHC services in providing culturally respectful service to Aboriginal consumers. The positive impact of displaying

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Aboriginal artwork in PHC services is seen in some other studies; however, this strategy is yet to be embraced by many PHC services [14]. The participants in this survey also suggested that waiting areas should display Aboriginal artwork as it will indicate the recognition and value of Aboriginal culture.

Aboriginal consumers perceive that having AHWs as a part of PHC team demonstrates the commitment of PHC centres for the improvement of Aboriginal health and well-being [15]. Therefore, health care providers and policy makers need to acknowledge the role of AHWs as the cultural brokers between clinicians and Aboriginal community members. Active involvement of AHWs in health care team can help in overcoming the communication barrier between clinicians and Aboriginal patients and lead to culturally respectful clinical encounters.

Some Aboriginal consumers raised concerns about the lack of clear communication in the clinical setting. PHC providers should understand that the use of medical terminology and other types of health jargon can impact on patient understanding and compliance.

Therefore, clear, simple and empathic communication is critical for cross-cultural communication [16].

Apart from the behavior of PHC providers, the attitude of administrative staff at PHC services also plays a pivotal role in health services utilisation by Aboriginal consumers.

Since, most of the times, front desk office staff are the first points of contact with patients at PHC centre, it should be considered that culturally disrespectful interaction with front desk staff will deter Aboriginal patients from the further utilization of PHC services.

Therefore, cultural competency goals should also include the role of front desk staff in achieving successful PHC services [17].

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The success of PHC services depends on gaining the trust of community members and building a relationship with Aboriginal people. Appreciation of cultural diversity and demonstrated respect for Aboriginal culture and beliefs in the health care paradigm can help in winning the confidence of Aboriginal consumers. One way of familiarizing clinician with Aboriginal culture and traditions is cultural awareness training. Cultural awareness training enables clinicians to become culturally competent providers so that they can acknowledge cultural differences without feeling threatened [18]. Cultural competency, in turn, leads to cultural safety where patient feels respected and empowered during clinical encounters [19]. Although cultural awareness training is useful in providing cultural knowledge about Aboriginal traditions, its impact on the provision of culturally appropriate PHC services is not well established [20]. In line with previous research, the findings of this study also question the effectiveness of cultural awareness training as all PHC providers received these training. Most of the study participant suggested a refinement of existing cultural awareness training and providing community-specific training. Participant also suggested that current one-off form of cultural awareness training is not very useful, rather ongoing sessions are needed with prospective evaluation. This observation is also reported in previous research where it was seen that attending one session of cultural awareness training was not enough to result in culturally safe practice, since cultural competence may be present in theory without significant influence on actual practice [21].

Ineffective cultural awareness sessions do not impart the skills to sensitively and respectfully deliver health care services to Aboriginal people [22]. As indicated by some participants, potential reasons for the ineffectiveness of this type of training may be due to short delivery timeframes; limited involvement of Aboriginal people in the development

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and dissemination of training; and lack of longitudinal evaluations to assess whether preliminary changes in behaviour or practice are sustained [23]. Therefore, based on our findings we suggest that cultural awareness training should be developed considering the specific community that services are working within, and engage local Aboriginal community leaders in developing and delivering these training. Along with PHC providers, extensive cultural training should be mandatory for front desk staff and AHWs as well. Front desk staff should be trained for culturally appropriate communication with elders, asking for patients' preference for seeing a male or female doctor, and offering help with the paperwork. Instead of a just a single session, there should be multiple sessions running throughout the year by different facilitators and prospective evaluation should be conducted to ensure that attending these training is bringing sustainable changes at the practice level.

### **Strength and Limitations**

The under-representation of older, unemployed and male participants is an important limitation of this study. This limitation may be partly due to the primary interviewer being a female person and, therefore, was more successful in recruiting female subjects. The generalizability of our findings is constrained due to non-random sampling and single geographic location. Nonetheless, as a small study, it provides a snapshot of the perspectives of Aboriginal people on receiving culturally appropriate PHC services in remote NWQ. Furthermore, considering that Aboriginal PHC services research is a resource-intensive and challenging process [24], the fact that this study was successful in recruiting and interviewing 78 participants in a remote location should be deemed acceptable for an exploratory study. Additionally, the subscales in our survey instruments are derived from established determinants of culturally appropriate healthcare services,

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and are supported by the results of qualitative data; therefore, imparts considerable reliability to our findings.

## **Conclusion**

These results highlight a practice level gap between PHC providers' and Aboriginal consumers' perceptions for the provision of culturally sensitive health care service delivery. PHC providers need to value diversity; conduct self-reflection; acknowledge Aboriginal culture and embed their cultural needs in clinical practice and in the physical environment of PHC centre. PHC services improvement goals can be achieved by considering the historical, cultural and social circumstances of Aboriginal people while delivering health services and seeking the active involvement of AHWs, and Aboriginal community representatives in developing and implementing strategies to ensure better health and wellbeing of Aboriginal people.

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Table 1: Demographic attributes of the participants in the survey exploring culturally appropriate health care services for Aboriginal people in North-West Queensland

Demographics	Survey Results n (%)						
	Cons	Pharm	MHF	AHW	FDS	MBM	Doc
<b>Gender</b>							
Male	17 (32.7)	1 (100)		1 (25)	5 (100)	3(37.5)	2 (50)
Female	35 (67.3)		2 (100)	3 (75)		5(62.5)	2 (50)
<b>Age</b>							
20-35 years	14 (25.9)	1 (100)	1(50)	1 (25)	2 (40)		1 (25)
35-50 years	25 (46.3)		1 (50)	2 (50)	2(40)	5 (71.4)	2(50)
>50 years	15 (27.8)			1(25)	1(20)	2 (28.6)	1(25)
<b>Years In the community</b>							
<1-3 years	6 (11.1)	1 (100)	2(100)	1 (25)	2 (40)	3 (37)	2 (50)
4-10 years	3 (5.6)				2(40)	2 (25)	1 (25)
>10 years	45 (83.3)			3 (75)	1(20)	3 (37)	1(25)
<b>Cultural Background</b>							
Indigenous		1(100)	2 (100)		5 (100)	3 (37.5)	1 (25)
Non-Indigenous						5 (62.5)	3 (75)
<b>Education</b>							
Incomplete high school	22 (40.7)						
Complete high school	14 (25.9)						
College/TAFE	12 (22.2)						
University	6 (11.1)						
<b>Employment Status</b>							
Working	42 (79.2)						
Non-working	10 (18.9)						
Pensioner	1 (1.9)						
<b>Health Service</b>							
Gidgee	29 (55.7)						
Sonic	3 (5.8)						
MIBH	8 (15.4)						
Others	12 (24.1)						

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**Table 2:** Results of qualitative analysis exploring the factors associated with the delivery of culturally appropriate primary health care services for Aboriginal consumers

<b>Survey Group</b>	<b>Barriers</b>	<b>Facilitators</b>	<b>Suggestions for improvement</b>
<b>Consumers (n=30)</b>	<ol style="list-style-type: none"> <li>1. Non-supportive staff</li> <li>2. Long waiting time</li> <li>3. Inadequate and culturally inappropriate physical space</li> <li>4. Inadequate Support for out of Town referrals</li> </ol>	<ol style="list-style-type: none"> <li>1. Transport Facility</li> </ol>	<ol style="list-style-type: none"> <li>1. Promotional activities for specialist visit</li> <li>2. Cultural awareness training</li> </ol>
<b>Health Care Providers (n=6)</b>	<ol style="list-style-type: none"> <li>1. Communication gap</li> </ol>		<ol style="list-style-type: none"> <li>1. Indigenous Mentors</li> <li>2. Local workforce development and retention</li> <li>3. Culturally appropriate ambience and amenities</li> </ol>
<b>Front Desk Staff (n=2)</b>			<ol style="list-style-type: none"> <li>1. Local workforce development and retention</li> <li>2. Cultural awareness training</li> </ol>
<b>Managers and Board members (n=7)</b>	<ol style="list-style-type: none"> <li>1. Lack of grievance management system</li> <li>2. Inadequate and culturally inappropriate physical space</li> </ol>		<ol style="list-style-type: none"> <li>1. Local workforce development and retention</li> <li>2. Promotional activities for specialist visit</li> <li>3. AHW services acknowledgement</li> </ol>

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