National Stocktake of Organisational Cultural Competence in public Maternity Care for Aboriginal and Torres Strait Islander Women

Report

2016-2017
Acknowledgments

In the spirit of respect, the researchers acknowledge the people and the Elders of the Aboriginal and Torres Strait Islander Nations who are the Traditional Owners of the land and seas of Australia, and values the contribution that Aboriginal and Torres Strait Islander midwives, nurses, researchers, leaders, human research ethics committee members and community members make to generating new ideas, innovative solutions to improving health in general and have made specific to this research.

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Executive summary

Introduction

This report was commissioned by the Australian Health Ministers Advisory Council (AHMAC) to provide a National Stocktake of the progress that public (government) maternity services have made towards improving the experiences of Aboriginal and Torres Strait Islander women when accessing antenatal, birthing and postnatal care. The project was undertaken by the Northern Territory Department of Health Office of the Chief Nursing and Midwifery Officer. The National Stocktake was underpinned by three key aims. The first aim was to assess the degree to which 14 previously identified characteristics of effective culturally competent care (Kruske, 2012) have been incorporated into the fabric of maternity services nationally. The second aim was to raise health service organisational awareness of how to work towards creating a culturally safe environment for Aboriginal and Torres Strait Islander women. The third aim was to validate a tool for the cyclic assessment of progress as a driver for implementing positive change. This executive summary provides an overview of the outcomes in respect to each of these aims.

1. Assessing progress towards adopting organisational characteristics of cultural competence:

The National Stocktake was undertaken through exploratory research that involved maternity service representatives completing an opt-in, on-line survey to self-assess the progress made toward incorporating each identified characteristic in their organisation in a way that is respectful to Aboriginal people and their culture.

The research took the approach that cultural competence, along with cultural security and cultural responsiveness is one element of creating a culturally safe environment for Aboriginal and Torres Strait Islander women and that it is a developmental process that evolves over an extended period. Accordingly, it was hypothesized that organisations would be at various levels of awareness, knowledge and skills along the cultural competence continuum. The findings upheld this hypothesis, with the results revealing that a range of activities are underway in each Australian jurisdiction. There was most
action in engaging with family and improving communication between practitioners and Aboriginal women, sharing information so that women do not need to tell their story over and over and improving transfer of care between services. There was least action in providing information in local languages, and involving consumers, community members and elders in governance and formulation of health information. There was also limited activity in assessing cultural competency of the individual and the organisation. A significant correlation was found between the level of Indigenous employment within services and progress towards implementing actions for a range of characteristics. That is, organisations who indicated that they employed Aboriginal and/or Torres Strait Islander people within their workforce (Characteristic 3) identified that more actions were underway than in organisations where there was limited or no representation of Aboriginal people within the workforce. There was a positive relationship between organisations who cared for more Aboriginal and/or Torres Strait Islander women and staff evaluating maternity outcomes for Aboriginal women as a specific cohort (Characteristic 2). Overall, sixty percent of participating maternity services rated positive progress in implementing initiatives to improve organisational cultural competency.

2. **Raising awareness of the organisational characteristics of cultural competency**

The findings of this research are based on responses from 44 public maternity services from a potential sample of 149. Although this rate represents only 29.5% of potential participants, the sample includes responses from all Australian jurisdictions and covers the range of maternity service models implemented nationally. Moreover, the level of awareness about organisational characteristics extended far beyond the respondents themselves. A key difference between this research and research usually conducted in cultural competency, is that it did not seek information about the perceived competency of individuals providing care (Bainbridge, Clifford & Tsey, 2015). Instead, the research asked key health service representatives to respond on behalf of their organisation to identify organisational level actions. This approach required complex engagement with the national network of Human Research Ethics Committees, Aboriginal and Torres Strait Islander sub-committees, the research governance committees at health network and
health service levels, and site specific assessments. As a consequence, the researchers engaged with individuals, committee members and service executives at each step of this process, providing multiple written, telephone, distance and face-to-face explanations of the characteristics under investigation as well as sharing their knowledge of theoretical concepts relating to cultural competence, cultural safety and cultural responsiveness and day-to-day experiences of Aboriginal people documented in other research and identified through the expert reference group. Of significance was not only the reach of the research process, but also that once an organisation consented to participate, the response rate of key representatives was 51.8%. Also of importance was that organisations received immediate feedback on their progress, with an automated copy of their responses to each characteristic made available upon submitting the on-line survey.

3. Reliability and validation of a cyclic survey
The tool showed good test-retest reliability and internal consistency when pilot tested in two jurisdictions prior to national distribution. Face validity was verified by distribution to expert stakeholders from three states of Australia including a specific Aboriginal Health and Wellbeing unit. Factor analysis of the surveys completed as part of the study verifies the validity of specific questions in respect to the 14 characteristics and suggests some further refinement for future use as a cyclic tool. With such refinement, this validated tool should be considered for use in mandatory reporting requirements in all public maternity services, in order to obtain a more accurate assessment of progress towards adopting organisational characteristics of cultural competence.

Introduction
Aboriginal and Torres Strait Islander mothers and babies experience higher rates of mortality and morbidity compared to non-Indigenous women and babies. Reducing the health inequalities experienced by Aboriginal and Torres Strait Islander women and babies compared to non-Indigenous Australians is essential to the Council of Australian Governments (COAG) closing the gap strategy (2013). The Australian Health Minister’s
Advisory Council (AHMAC, 2011a) have responsibility for achieving specific Closing the Gap targets in government (public) health services. The *National Maternity Services Plan 2010-15* describes a work schedule to achieve the AHMAC vision for all Australian women to “have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live”. In 2010, AHMAC commissioned research to identify the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people (Kruske, 2012) as an action under the *National Maternity Services Plan* (NMSP): “2.2 Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people” (AHMAC, 2011a).

Following a review of the literature and selected stakeholder consultations, the characteristics of effective culturally competent care in maternity services were presented by Kruske (2012) under the following headings:

1. Physical environment and infrastructure
2. Specific Aboriginal and/or Torres Strait Islander program
3. Aboriginal and Torres Strait Islander workforce
4. Continuity of care and carer
5. Collaborating with Aboriginal Community Controlled Health Organisations and other agencies
6. Communication, information technology and transfer of care
7. Staff attitudes and respect
8. Cultural education programs
9. Relationships
10. Informed choice and right of refusal
11. Tools to measure cultural competence
12. Culture specific guidelines
13. Culturally appropriate and effective health promotion and behaviour change activities


Kruske’s (2012) research emphasised that the indicators identified were preliminary in nature, requiring future development and testing in line with ‘middle year’ activities of the NMSP. A key activity to be achieved within the middle years of the five year plan was that AHMAC undertake a stocktake of access to culturally competent maternity care for Aboriginal and Torres Strait Islander people. The Maternity Services Interjurisdictional Committee (MSIJC), on behalf of AHMAC, commissioned the Northern Territory Department of Health to undertake this research. The purpose of this report is to document the outcomes of the stocktake.

**Background and Aim**

In comparison to Non-Indigenous women, Aboriginal women are more than twice as likely to have pregnancy ending in pre-term birth and fetal death; give birth to smaller (low birth weight) babies, premature babies and babies more likely to spend time in Special Care Nursery/NICU; have three times higher rates of smoking; are more likely to be teenagers; live in more remote and disadvantaged areas; have higher rates of obesity; experience higher rates of diabetes, hypertension and chronic disease and have increased hospital admissions while pregnant related to domestic violence (AIHW, 2016). Many factors contribute to health inequities between Indigenous and non-Indigenous Australians. Dispossession, interruption of culture and intergenerational trauma are significant contributing factors (COAG, 2013) with the social determinants of health playing a major role (Osborne, Baum & Brown, 2013). Of particular relevance to this *National Stocktake* is that there is also evidence that poor cross-cultural communication (Cass et al, 2002; Larson & Bradley, 2010; Reibel & Walker, 2010; Shahid et al, 2009) and lack of cultural safety within health services contributes to health disparities (Betancourt et al, 2016; Larson, et al, 2006; Freeman et al, 2014).
The 2012 – 2013 Health Survey (AHMAC, 2015) found that 13% of Aboriginal people did not access health care when they needed to, with 4% of respondents indicating that the reason was related to discrimination, lack of culturally appropriateness, and language problems. These types of barriers were particularly high in relation to hospitals (27%), with around 5% of Aboriginal people who did access hospital care leaving against medical advice compared to 0.5% of non-Indigenous Australians (AHMAC, 2015). This trend translates to maternity services, where Aboriginal women engage with antenatal services later in their pregnancy and have significantly less antenatal care sessions compared to non-Indigenous women (AIHW, 2016). Maternity services, like other health service providers, appear to fall short of delivering culturally competent care (Kildea, 2006; Reibel & Walker, 2010).

Improving the cultural competency of health services and health care providers is a key strategy to achieving the Closing the Gap priority of a culturally respectful and non-discriminatory health system (COAG, 2013). The work of Cross et al (1989) provides the most commonly cited definition of cultural competence and underpins the commissioning of the National Stocktake and its organisational focus:

[Cultural competence is] ‘a set of congruent behaviours, attitudes and policies that come together in a system, agency, or amongst professionals that enables the system agency or those professionals to work effectively in cross-cultural situations... and culturally competent system of care acknowledges and incorporates- at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs’(pp iv/7).

Adaptation of services to meet culturally-unique needs of Aboriginal people has been identified as a particular challenge for government-run services providing health care to a culturally diverse consumer group, with Aboriginal and Torres Strait Islander people making up only a small percentage of the overall health care population (Larson & Bradley, 2010). In contrast, Aboriginal women are more likely to access services that are
tailored specifically to the needs of Aboriginal women (Larson & Bradley, 2010; Rumbold & Cunningham, 2008). They are also more likely to access mainstream health services if there is an Aboriginal workforce (Reibel & Walker, 2010; Reibel & Morrison, 2014; Ring and Brown, 2003). There is also a significant body of research nationally and internationally that identifies that increasing the participation of Indigenous nurses and midwives within the health workforce is an important mechanism for improving cultural safety within health care facilities (AHMAC, 2011b; AHMAC, 2012; Commonwealth of Australia, 2002; NATSIHC, 2008). A number of research projects specifically identify employing Aboriginal women within maternity services that provide care to Aboriginal women as a key initiative to address organisational cultural competence (Campbell & Brown, 2004; Carter, 2004; Eades, 2004; Herceg, 2005; Hunt, 2003; Jan, 2004; Mackerras, 1998; Panaretto, 2005; Tursan d’Espaignet, 2005).

Kruske’s (2012) research identified 14 characteristics of culturally competent maternity care, it does not provide these as measurable indicators, nor does it recommend a tool for assessing organisational cultural competency. Although there is much written about individual health practitioner competency and patient experiences of health care, there are however, limited data available for measuring the incidence of institutional racism (Paradies & Cunningham 2009; Paradies, Truong & Priest, 2014) or evaluating cultural competence of health services (Suarez-Balcazar et al, 2011). More generally, such tools are valuable for enhancing organisational accountability for workplace practices, and to act as a driver to improve the quality of health service provision (ACSQHC, 2012). When used specifically to assess organisational performance in relation to cultural competence, Trenerry et al (2010) argue that auditing and assessment approaches are of significant value for supporting resource development, role-modelling, adoption of positive behaviours and reducing discrimination.

In a systematic review of cultural competence in health services for Indigenous people, Clifford et al (2015) identified that there are promising evidence based strategies that integrate cultural competence performance indicators with clinical indicators, auditing
and continuous quality improvement approaches, but that more needs to be done using such indicators to measure what works in efforts to develop culturally competent health services for Indigenous Australians.

Of significance to this commissioned *National Stocktake* then, is a Western Australian audit of antenatal care (Reibel & Walker, 2010). This study found that 75% of public health services did not provide a model of care consistent with culturally competent principles as they apply to the care of Aboriginal women. Although the research was limited to one Australian jurisdiction, Reibel and Walker (2010) examined organisational cultural competence alongside individual cultural competence. They were among the few researchers to make such a distinction and to develop a tool for organisational level assessment. The tool Reibel and Walker (2010) developed for this purpose measured four key indicators: the presence of an Aboriginal specific antenatal protocol; confirmation of an Aboriginal specific programme of antenatal care; access optimised by location of service and availability of unbooked antenatal appointments and transport and inclusion of Aboriginal Health Workers as members of the multidisciplinary antenatal care teams. The particular value of using this audit process to heighten awareness about cultural competency and to prompt individual practitioner self-reflection and organisational review of practice was highlighted by the researchers. They also identified the benefit of such research for prompting participating organisations to engage in planning, policy making and resource allocation to improve cultural competency based on the audit findings.

Earlier work by O’Brien et al. (2003, 2004, 2007) researched cultural competence in New Zealand’s mental health services. O’Brien’s (2003) study is particularly relevant to conducting the *National Stocktake* as it audited clinical practices, measuring them against validated standards to determine levels of organisational achievement. Also of relevance is that this research provided a framework to improve health services’ cultural competence by measuring existing practices against standards of expected health care delivery.
A number of other approaches and tools to assess cultural competence have been developed in the last decade; most draw upon earlier work from the United States; and most have opted for the self-assessment mode of audit (Axelby et al, 2006; Kruske 2012, MMHA 2010, Government of South Australia 2006). Areas that are audited in these tools include: the presence or absence of a policy framework that acknowledges and recognises cultural diversity and the need for cultural competence, access to tailored and specific services, engagement with culturally diverse populations, employment of people from within a culturally specific population, recognition of cultural diversity within policies, services, recruitment and staff training, and consumer input into services (Bainbridge, Clifford & Tsey, 2015; Cherner, 2014).

Organisational level self-assessment tools developed for the Australian context include:

1. National Cultural Competency Tool (NCCT) for Mental Health Services, developed for culturally and linguistically diverse (CALD) backgrounds (Multicultural Mental Health Australia (MMHA), 2010),
2. Cultural Competency Self-Assessment Instrument developed by the designed for public sector agencies (Axelby et al., 2006),
3. Cultural Competence Assessment Tool Kit, a purpose specific audit tool to measure access or utilisation of antenatal services by Indigenous women in Western Australia (Walker, 2010, 2011a).
4. Aboriginal Cultural Inclusion Checklist for Maternity Services (Office of Kids and Families NSW Health, 2016)

Although they provide an excellent basis for tool development, these existing cultural competency tools are either for contexts broader than the maternity service context (1 & 2), or do not entirely capture the 14 characteristics of organisational cultural competency (3 & 4). Nor has information on interventions to address cultural competency in health care services been captured before at a national level. With this in mind the National Stocktake project will build on research methodologies and findings to date, with three aims in mind. Firstly, the research aims to identify maternity services self-assessed level
of organisational achievement of Kruske’s (2012) 14 characteristics of cultural competence. The primary purpose of the self-assessment is to provide AHMAC with a national stocktake/baseline of progress that maternity services have made toward developing public sector culturally competent maternity care. Informed by the positive links between improved knowledge and better performance, the second aim is to use the National Stocktake process to raise health service organisational awareness of how to work towards creating a culturally safe environment for Aboriginal and Torres Strait Islander women. The third aim is to validate a tool for the cyclic assessment of progress as a driver for further implementing positive change.

**Definition of terms**

**Cultural competence** as a term is used in this research in line with the actions of the National Maternity Services Plan (AHMAC, 2011a), other key National policy documents relating to Closing the Gap between Indigenous and non-Indigenous health (AHMAC, 2015; Commonwealth of Australia, 2013 & 2017) and the seminal definition from Cross et al. (1989) used earlier in this report. Importantly, this research bears in mind the advice of the Western Australian Aboriginal Human Research Ethics Committee who stressed the importance of identifying that cultural competence is a broad concept that is an ongoing process for each individual employee and organisation. Cultural competence is not assessed as either a categorical concept, as “being culturally competent or not being culturally competent” but as a continuous learning journey towards achieving the best possible progress for all health workers working in all facets of health care. As Dudgeon and colleagues expressed:

> Cultural competence is a developmental process that evolves over an extended period. Both individuals and organisations are at various levels of awareness, knowledge and skills along the cultural competence continuum (Dudgeon Wright & Coffin, 2010, pp. 34)

To this end, the survey used in this National Stocktake project assessed the organisation’s progress of achieving or demonstrating cultural competence characteristics as identified
by Kruske (2012) along a Likert scale, rather than as ordinal achievement. The researchers also acknowledge that cultural competence has more far reaching effects, and broader meaning and scope than the 14 identified characteristics.

**Organisational cultural competency** in this project is defined by Pat Dudgeon and colleagues (2010) as organisations having a:

- Defined set of values and principles, and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally (Dudgeon Wright & Coffin, 2010, pp. 34)

In line with the work of Dudgeon Wright & Coffin (2010), the researchers have also adopted the position that cultural competence includes elements of cultural awareness, cultural respect, cultural responsiveness, cultural safety and cultural security. The definitions below are adopted from the Northern Territory Health Aboriginal Cultural Security Framework, 2016-2026 (NT DoH, 2016).

- **Cultural awareness** demonstrates a basic understanding of relevant cultural issues or practices

- **Cultural respect** recognises, protects and continues to advance the inherent rights, cultures and traditions of Aboriginal peoples

- **Cultural responsiveness** takes into account and responds to people’s cultural, linguistic, spiritual and socio-economic backgrounds, tailoring care in a dynamic way to each factor.

- **Cultural Safety** is defined by the Indigenous person’s experience of care and is best achieved when health professionals have considered their own beliefs and attitudes towards difference and have acknowledged and managed power relations between Aboriginal and non-Aboriginal people.

- **Cultural Security** is achieved through a commitment to Aboriginal people’s rights to self-determination, empowerment and access to health care services by creating a health care environment where these are not compromised.
Methods
Research design

This *National Stocktake* project was an exploratory study using an on-line self-assessment tool, which was developed based on the literature and consultation with the research reference group. The research reference group was comprised of midwifery clinical experts, midwifery researchers, an Indigenous Nurse/Midwife, a representative of an Aboriginal Community Controlled Health Organisation, a representative of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; and two members of the National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIIHSC) with expertise in assessing cultural competence. Its purpose was to strengthen the research project governance by providing: advice and general guidance in cultural competence, framed by the major reports on cultural competence; advocacy for progressing cultural competency of maternity services for Aboriginal and Torres Strait Islander people; strategic advice regarding the conduct and impact of the project in participating maternity services; and a mechanism for connecting with local organisations as the project rolled out. The membership of the reference group appears as Attachment 1. Resource constraints meant that an appropriate consumer representative could not be identified to participate in the reference group.

The survey tool appears as Attachment 2 and consists of three sections:

- **Section one** was designed to obtain demographic information relevant to the study.

- **Section two** included questions relating to a self-assessment of the degree to which health service delivery reflects the characteristics of culturally competent maternity care.

- **Section three** consisted of questions relating to the relevance, consistence, clarity, length and efficacy of the self-assessment tool.
Prior to being used for data collection the tool was piloted in maternity services in two jurisdictions that did not participate in the national sample.

Human Research Ethics approval was received from all Australian jurisdictions either directly, or via the National Ethics Assessment Form (NEAF) process. Approval was also received from Aboriginal Human Research Ethics sub-committees in all jurisdictions where this was required.

Participant recruitment

Maternity services are defined for this project as services that provide maternity care to women that includes any or all elements across the continuum of antenatal, intrapartum (birthing) and postnatal periods. The participant group included public sector maternity services for populations greater than 1000 people. Excluding services providing care to populations less than 1000 people was based on minimizing the possibility of identification of an individual service and the likelihood that the number of Aboriginal and Torres Strait Islander women receiving care in these services is low and intermittent. Such a profile was considered likely to negatively affect the validity and reliability of self-assessment.

The researchers acknowledge that private sector maternity services, General Practitioner Practice and Aboriginal Community Controlled Organisations also provide maternity care to Aboriginal and Torres Strait Islander women. However they were out of scope for the commissioned work. In addition, the short duration of the project was not considered adequate to gain access to Aboriginal Community Controlled Organisations as the timeframe did not provide time for the extensive consultation required to develop the necessary genuine engagement and culturally secure relationships with organisational representatives in a position to complete the self-assessment survey. In Western Australia, however, an information sheet was sent to the Aboriginal Medical Service (AMS) in each health service region requesting support for this project as being an important step in improving the cultural competence of public maternity services used by
Aboriginal and Torres Strait Islander women who are clients of the Aboriginal Community Controlled Health service.

Recruitment of participants was a three step process. Although there is a national database for organisations that provide birthing services there was no national database of maternity services. Accordingly, members of the MSIJC were asked to identify eligible maternity services and an executive contact to consent to the organisational participation in the research. The executive was invited via email to consent to their organisation participating and nominate a person best equipped to respond on behalf of the health service. Once nominated, the health service representative was invited via email to consent to participate. Both the executive and nominated organisational representative received an information package about cultural competency in maternity care, an information sheet to read, and consent form to sign. Once the organisational representative consented they were emailed the web link to access the survey. Participation was anonymous. No information was required on the survey tool that would identify the respondent or their organisation. The survey however, could be downloaded immediately after completion and used internally as feedback on progress and as a tool to guide immediate initiatives for service improvement.

Sample size

Of the 149 maternity services identified as eligible to participate, consent to participate was gained from 85 organisations, with 44 responses from organisational representatives received. Using the Kaiser-Meyer-Olkin method of assessment, the sample was deemed adequate for sample size. However, at the time of writing, further responses were still being received and future research would enable and ensure collection of larger samples for further analysis and investigation.
Assumptions

It was assumed that the person nominated was able to provide accurate assessment of progress of evaluation of organisational maternity care for Aboriginal and Torres Strait Islander women on behalf of the organisation.

Analysis

Statistics were analysed in SPSS (Statistical Package for Social Sciences, Version 23). As the survey was newly developed for this particular project, reliability was assessed in the first instance on the pilot study by way of test-retest reliability and Cronbach’s alpha. Correlational analyses were performed to determine associations between questions in the survey and enabled certain associations or relationships between all questions to be identified. Spearman’s correlation coefficients (responses were measured at an ordinal level as Likert scale) were calculated on all reliable questions in the survey. Factor analysis was assessed to demonstrate construct validity to enable assessment of correct groupings of questions into appropriate themes.

Findings

Jurisdictional organisational response rates

Organisational consent to participate in the study was received from 85 of the 149 eligible health services, representing a response rate of 57%, and including representation from all jurisdictions. Of the 85 maternity services who agreed to participate, 44 surveys were completed by nominated representatives, representing a response rate of 51.8% compared to organisational consent, and an overall response rate of 29.5%. There was a similar distribution of responses across jurisdictions within both the cohort of organisations who consented and the surveys submitted. The highest number of both organisational consents and survey responses were received from Victoria (29% and 36% respectively), with Queensland contributing the next highest proportion (27% and 21% respectively). New South Wales contributed the third highest number of responses (19% and 16%), followed closely by South Australia (17% and 14%). The Northern Territory contributed five percent of organisational consents and seven percent of all responses, with maternity services in the Australian Capital Territory,
Tasmania and Western Australia each contributing one percent of organisational consents and two percent of the overall surveys received (see Figure 1).

**Figure 1** Jurisdictional respondent response rates

- **Organisational respondents** included those with a leadership role in maternity services (44%), those directly responsible for supervision of maternity services (20% each) and practice oversight of maternity services (16%).

**Demographics of respondents**

Almost half (48%) of the respondents were from maternity services in localities with a total population of between 10,000 to 99,000, with maternity services in localities with populations of 10,000 – 24,999 and 25,000 – 99,000 roughly equally represented.

Approximately one-third (36%) of responses were from maternity services in localities with populations of greater than 100,000. Minimal responses came from maternity services in localities with populations of 5,000 to 9,999 (2%) and less than 5,000 (14%) (see Figure 2).
Women accessing maternity services per annum

Three-quarters (75%) of responses were from maternity services accessed by approximately 1,000 women (both Indigenous and non-Indigenous) per annum, with almost a fifth (18%) providing care to between 1,000 and 5,000 women and a small percentage (7%) providing care to between 5,000 and 10,000 women per year.

Levels of services of organisations relating to the Maternity Services Capability Framework

Five percent of respondents comprised of level one services, with forty percent representing level two and three services, and over half (55%) the respondents representing service capability levels four to six. Two-thirds (66%) of surveys were from organisations that provided services to Aboriginal women of both high and low risk, and sixty-one percent providing the same level of service to non-Indigenous women. Thirty-four percent of participating services only provided care to Aboriginal women classified as low risk and thirty-nine percent to non-Indigenous women at this level of risk. Together with the population and birthing figures, these figures suggest that the respondents were predominantly from metropolitan hospitals and larger regional hospitals.
Women identifying as Aboriginal and/or Torres Strait Islander accessing maternity services per annum

The majority (93%) of respondents identified that there were less than 500 women per year who identified as Aboriginal and/or Torres Strait Islander women accessing their services. Only a small percentage (5%) of services identified that between 500 to 1,500 women identifying as Indigenous accessed their maternity services. Similarly, of those respondents who provided birthing services and were able to provide data on Indigeneity, half of the respondents reported that less than 50 births per year were identified as Aboriginal or Torres Strait Islander babies. A quarter (25%) of respondents identified between 101 and 500 Aboriginal and/or Torres Strait Islander babies born each year. A fifth of respondents (20%) reported between 50 and 100 babies being identified as Aboriginal and/or Torres Strait Islander descent, and eight percent reported greater than 500 births of Aboriginal and/or Torres Strait Islander babies.

When correlational analyses were performed, the number of Aboriginal women accessing services had a significant positive relationship with progress against Characteristic 2: Specific Aboriginal and/or Torres Strait Islander program. That is, organisations who cared for larger numbers of Aboriginal and/or Torres Strait Islander women were more likely to evaluate maternity outcomes for Aboriginal women as a specific cohort.

Progress towards key characteristics of culturally competent care

Overall, the majority of respondents (63%) identified that they had made some progress towards the goal of achieving organisational cultural competency in relation to services provided to Aboriginal and Torres Strait Islander people. Just over one quarter (26%) identified that they had almost achieved the goal, with only nine percent of participating respondents perceiving that they had successfully achieved the goal of cultural competency. There were only two percent of maternity services who self-assessed no progress at all (see Figure 3).
Figure 3 Overall self-assessed achievement of organisational cultural competency for Aboriginal and Torres Strait Islander people

The following information provides an overview of the descriptive results as frequencies and correlational analyses for each of the 14 characteristics of culturally competent maternity care.

**Characteristic 1: Physical environment and infrastructure**

Maternity services reported strong progress made in displays of artwork and / or flag with two-thirds of respondents self-assessing that they had successfully achieved this goal (see Figure 4).

Figure 4. Organisation displaying artwork or flags
Characteristic 2: Specific Aboriginal and/or Torres Strait Islander program

Organisations were asked if they can identify Aboriginal and/or Torres Strait Islander women accessing their services. The majority (70%) of organisations included information about Aboriginal and/or Torres Strait Islander identification in women’s care records. Approximately one-fifth (18%) reported almost achieving this goal and a small percentage (7%) had made some progress or no progress (5%) (see Figure 5).

Figure 5 Organisation including information about Aboriginal and/or Torres Strait Islander identification in women’s care records.

Organisations were asked to report on whether the maternity service had access to community services that specifically pertained to Aboriginal and Torres Strait Islander women. The majority (61%) self-assessed achieving this goal for the majority of the time, almost a third (30%) reported that services were fragmented and a minimal (9%) number of organisations reported not providing any community services (see Figure 6).
Organisations were also asked to report on whether they collected data about utilisation of services used by Aboriginal and/or Torres Strait Islander women within their maternity services, and maternity outcomes for Aboriginal women as a specific cohort. Approximately two-thirds of respondents reported varying degrees of progress with approximately one third reporting no progress for either characteristic.

When correlational analyses were performed, there was a positive relationship between organisations who cared for more Aboriginal and/or Torres Strait Islander women and staff evaluating maternity outcomes for Aboriginal women as a specific cohort ($r = 0.355$, $p < 0.05$).

**Characteristic 3: Aboriginal and Torres Strait Islander workforce**

Organisations were asked to report on how actively they recruited Aboriginal and/or Torres Strait Islander employees. Over half had made some progress (59%), one fifth (20%) perceived they were successful, a minimal number reported almost achieving this goal (7%) with approximately one-sixth of organisations (14%) reporting no progress (see Figure 7).
The most common Aboriginal and Torres Strait Islander employment group were Indigenous Liaison Officers (25%), followed by Aboriginal and Torres Strait Islander Health Practitioners (17%), then Aboriginal and Torres Strait Islander Community Workers (16%). The least common employment group were interpreters (7%) for Aboriginal and Torres Strait islander women (see Figure 8). However, interpreters are often outsourced, so this result should not be considered a reflection of the availability of interpreter services.
Correlation analyses identified some relationships between organisations that reported actively recruiting Aboriginal and/or Torres Strait Islander employees and positive achievements in other characteristics of cultural competency. For example, organisations actively recruiting Indigenous people had a significant relationship with applying selection criteria relating to cultural competence for new employees, \( r = 0.369, p < 0.05 \), including Aboriginal and/or Torres Strait Islander women in the design of their health promotion programmes \( r = 0.505, p < 0.01 \), and involving Aboriginal and/or Torres Strait Islander people in the design, monitoring, evaluation and improvement of services \( r = 0.466, p < 0.01 \).
Organisations that actively recruited Aboriginal and/or Torres Strait Islander employees also rated their organisations as making more progress towards achieving cultural competence (r=0.413, p<0.01) and assessing employees’ knowledge about culturally competent maternity care (r=0.499, p<0.01). Specifically, the organisations employing Aboriginal and Torres Strait Islander Health Practitioners had a significant relationship with providing antenatal records through to discharge summaries for all women (r=0.357, p<0.05).

Employing Indigenous Liaison Officers had a significant relationship with providing mandatory education to employees to inform them about cultural competence in the workplace (r = 0.310, p < 0.05), displaying Aboriginal and Torres Strait Islander artwork or flags (r = 0.380, p < 0.05), involving Aboriginal and Torres Strait Islander women in design and implementation of health promotion materials (r = 0.371, p < 0.05) and involving Aboriginal people in the design, monitoring, evaluation and improvement of services (r = 0.456, p<0.01).

Employing senior women showed a positive relationship with recruiting Aboriginal & Torres Strait Islander employees (r = 0.489, p < 0.01), specifying cultural competence as selection criteria for employment recruitment (r = 0.409, p < 0.01), involving Aboriginal people in design, monitoring, evaluation and improvement of its services (r = 0.385, p <0.05) and having guidelines and policies specific to Aboriginal people that support culturally competent maternity care (r = 0.380, p < 0.05).

Employment of Aboriginal and Torres Strait Islander managers showed a positive relationship with providing accessible information to consumers about services for pregnant Aboriginal and Torres Strait Islander women (r = 0.379, p < 0.05).

For this sample, the one maternity service that responded who identified employing Aboriginal and Torres Strait Islander midwives did not have any statistically significant higher levels of self-assessed progress in achieving organisational cultural competence compared to organisations not employing Indigenous midwives.
Characteristic 4: Continuity of care and carer

Organisations were asked if they provided continuity of care services for women. The majority (84%) answered ‘yes’, with approximately sixteen per cent answering ‘no’. For those services that provided continuity of care services for women, the majority reported providing continuity of care for both Aboriginal and Torres Strait Islander women and non-Indigenous women (84%). Only around ten per cent provided services specifically for Aboriginal and/or Torres Strait Islander women, with slightly fewer services (7%) providing specific continuity of care services for a non-Indigenous cohort of women (see Figure 9).

Figure 9 Provision of Continuity of Care maternity services for women

Characteristic 5: Collaborating with Aboriginal Community Controlled Health Organisations and other agencies

Organisations were asked if they invited Elders and community members into maternity care settings as a part of collaborative care. More than half (55%) did not, over a third (34%) did occasionally and smaller percentages invited Elders and community members regularly (9%) and always (2%).

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Organisations were also asked to report if they liaised with other key stakeholders about the effectiveness of services (eg Aboriginal and Torres Strait Islander community controlled health organisation and/or National Aboriginal and Torres Strait Islander Health Standing Committees). Eighty percent of respondents self-assessed varying degrees of progress towards this goal with just under twenty percent (19%) reporting no progress at all (see Figure 10).

**Figure 10 Organisation liaising with key stakeholders about effectiveness of Services**

Characteristic 6: Communication, information technology and transfer of care

Participants were asked if they provided educational resources designed specifically for Aboriginal and/or Torres Strait Islander women. Over 90% of respondents self-assessed that they had made progress with achieving this goal, with less than ten percent (9%) having made no progress at all (see Figure 11).
Participants were also asked about their organisational activities relating to providing accessible information to consumers about their services for pregnant Aboriginal and/or Torres Strait Islander women. Over ninety percentage of organisations had made progress in some way in this goal, with under ten percent (7%) reporting no progress (see Figure 12).

Participants were also asked about their organisational activities relating to providing accessible information to consumers about their services for pregnant Aboriginal and/or Torres Strait Islander women. Over ninety percentage of organisations had made progress in some way in this goal, with under ten percent (7%) reporting no progress (see Figure 12).

Figure 11 Organisations providing educational resources designed specifically for Aboriginal and/or Torres Strait Islander women

![Figure 11](image1.png)

Figure 12 Organisations providing accessible information to consumers about their services for pregnant Aboriginal and Torres Strait Islander women

![Figure 12](image2.png)
Whilst designed specifically for Aboriginal and/or Torres Strait Islander women, information about services and educational resources were not developed in Indigenous languages. Over half (57%) of participating organisations had made no progress in achieving this goal with just under ten percent (9%) of respondents reporting that they provided education materials in Aboriginal and/or Torres Strait Islanders languages relevant to the local Aboriginal and/or Torres Strait Islander community (including signage).

**Figure 13. Organisation providing information about service and educational materials in Aboriginal and/or Torres Strait Islanders languages relevant to the local Aboriginal and Torres Strait Islander community (including signage)**

Sharing health records, discharge from one organisation to another and transfer of care also falls within this characteristic. Over half (59%) of respondent organisations reported successfully providing antenatal records through to discharge summaries to all relevant stakeholders including Aboriginal and/or Torres Strait Islander women. Almost forty percent of organisations self-assessed progress along the continuum with almost one-quarter (23%) almost achieving this goal and sixteen percent making some progress. Only two percent of respondents reported making no progress at all (see Figure 14).
Correlational analyses identified that organisations who provided this documentation had a significant relationship with encouraging family members to accompany and support Aboriginal women during their pregnancy \( (r = 0.514, p < 0.01) \).
**Characteristic 7: Staff attitudes and respect**

Organisations were asked if they specified cultural competence and compliance with cultural competence/policy guidelines as selection criteria for employee recruitment. The majority of organisations (73%) reported either successfully achieving this goal or had made progress in achieving this goal. Just over one-quarter (27%) had made no progress at all (Figure 15). Most often this selection criteria was reported as being included as essential as part of the job description, and/or information about organisational expectations, with Aboriginal and/or Torres Strait Islander membership of the selection panel also used as a mechanism to implement these guidelines.

**Figure 15 Organisation specifying cultural competence and compliance with cultural competence / policy guidelines as selection criteria for employee recruitment**

Correlational analyses showed that organisations that specify cultural competence as selection criteria for employee recruitment showed a positive relationship with having guidelines specific to Aboriginal people to support maternity care ($r = 0.515$, $p < 0.01$), providing mandatory education to inform all employees about culturally competent care in the workplace ($r = 0.408$, $p < 0.01$), providing educational resources designed specifically for Aboriginal and/or Torres Strait Islander women ($r = 0.328$, $p < 0.05$) and assessing employees’ knowledge about culturally competent care ($r = 0.360$, $p < 0.05$).
Organisations were also asked how they responded to employees breaching cultural policies and guidelines. Almost two-thirds (61%) of organisations assessed themselves as successful in having processes in place to performance manage employees who behaved in a manner which demonstrated a lack of acceptance, racism or discrimination. Similar numbers of organisations had almost fully achieved the goal or made some progress (16% and 21% respectively). Only a small percentage (2%) had made no progress at all (see Figure 16).

**Figure 16 Organisation performance managing employees demonstrating racism**

Correlational analyses identified that organisations who performance managed employees who demonstrated racism had a significant relationship with involving key stakeholders about effectiveness of services ($r = 0.381, p < 0.05$), displaying Aboriginal artwork ($r = 0.428, p < 0.01$), including information about Aboriginal and Torres Strait Islander identification in care records ($r = 0.633, p < 0.01$), providing antenatal records through to discharge summaries to all relevant stakeholders including Aboriginal women ($r = 0.425, p < 0.01$) and encouraging family members to support Aboriginal and Torres Strait Islander women ($r = 0.582, p < 0.01$).
**Characteristic 8 Cultural education programs**

Half of organisations were successful in achieving the goal of providing mandatory education designed to inform all employees about culturally competent care in the workplace. Almost a quarter (23%) were almost fully achieving this goal or had made some progress (23%) with only a small percentage (4%) reporting no progress (see Figure 17).

![Figure 17 Organisation providing mandatory education about culturally competent care](image)

Respondents identified that Aboriginal Health Workers/Aboriginal and Torres Strait Islander Health Practitioners, Liaison Officers, Care Coordinators, community Elders and Human Resources Managers were responsible for facilitating cultural training. Some health services also identified that their training was delivered online as opposed to face to face training.

**Characteristic 9 Relationships**

The importance of relationships was self-assessed by asking organisations whether their service encouraged family members to accompany and support Aboriginal and/or Torres Strait Islander women. Approximately two thirds (68%) of organisations reported that all staff did this. A quarter (25%) reported that their organisation showed a proportion of...
staff that did this at all times and a small percentage (7%) reported that a proportion of staff provided encouragement some of the time (see Figure 18).

**Figure 18 Organisational encouragement for family members to accompany and support Aboriginal and/or Torres Strait Islander women**

![Graph showing percentages for organisational encouragement](image)

**Characteristic 10: Informed choice and right of refusal**

Kruske (2012) recommended that this characteristic was related to cultural competence policy such as the inclusion of “appropriate guidelines that protect and support both health professionals and women when women’s choices are at variance with professional advice and may place the mother or fetus at increased risk” (pp.20). In this survey, informed choice and right of refusal was assessed with questions under the characteristics relating to Specific Aboriginal and/or Torres Strait Islander program (Characteristic 2); Communication, information technology and transfer of care, (characteristic 6); Staff attitudes and respect (characteristic 7), and relationships (Characteristic 9).

**Characteristic 11: Tools to measure cultural competence**

Organisations were asked if they assessed an employee’s knowledge about providing culturally competent care in the workplace. Half of respondents self-assessed having made no progress in employing tools to assess their employees’ knowledge about cultural competence. The other fifty percent of participants made
some progress (29%), have been successful in advancing this process (14%) and only a small percentage have almost fully achieved this goal (7%) (see Figure 19).

**Figure 19 Organisation assessing employee’s knowledge about providing culturally competent care in the workplace**

For those organisations who reported making progress, the respondents identified that the method of assessment was achievement of the objectives of cultural competence training, rather than assessing workplace behaviours, or linking with performance assessment processes.
Characteristic 12: Culture specific guidelines

Organisations were asked if they had guidelines and policies specific to Aboriginal and/or Torres Strait Islander maternity care and/or whether they supported culturally competent care for Aboriginal and/or Torres Strait Islander people. Three-quarters of respondents self-assessed making progress in achieving this goal, with a quarter (25%) making no progress (see Figure 20).

Figure 20 Organisations with guidelines and policies specific to Aboriginal and Torres Strait Islander women

![Bar chart showing progress towards the goal of having guidelines and policies specific to Aboriginal and Torres Strait Islander women.](chart.png)
**Characteristic 13: Culturally appropriate and effective health promotion and behaviour change activities**

Organisations were asked if they involved Aboriginal and/or Torres Strait Islander women in design and implementation of health promotion activities and programs in pregnancy. Around sixty percent had made some progress with over forty percent (41%) having made no progress at all in achieving this goal (see Figure 21). This result indicates the lowest level of achievement in terms of the fourteen characteristics of organisational cultural competency excepting for progress towards achieving participation of Elders and community members in maternity care settings as a part of collaborative care.

**Figure 21 Organisations involving Aboriginal and/or Torres Strait Islander women in design and implementation of health promotion programs**

![Bar chart showing progress towards the goal of involving Aboriginal and/or Torres Strait Islander women in design and implementation of health promotion programs.](chart.png)

Not surprisingly was that respondents stated that the primary mechanism for involvement was through consultation either with community representatives or Aboriginal employees. Health facilities caring for smaller numbers of women and with lower levels of acuity reported less involvement of Aboriginal people in the design and implementation of health promotion activities than larger maternity services.
Characteristic 14: Engaging consumers and clinical governance

In addition to receiving input from Aboriginal and/or Torres Strait Islander women into health promotion materials, organisations were also asked if they involved Aboriginal and/or Torres Strait Islander people in the design, monitoring, evaluation and improvement of their services. Approximately eighty percent of respondents had made progress with this goal, with those making some progress representing around half all respondents (55%). Almost a fifth (19%) reported no progress at all (see Figure 22).

Figure 22 Organisations involving Aboriginal and /or Torres Strait Islander people in the design, monitoring, evaluation and improvement of their services
Overall progress mapped across all elements appears in Figure 23 below.

**Figure 23 Overall progress towards organisational cultural competency**

This figure demonstrates that the lowest levels of progress are in the areas that relate to specific expertise (language), engaging with elders and community members, and evaluation of cultural competence of the individual or the service.
Raising awareness of organisational work towards cultural competence

Sampling at an organisational level through the multiple levels of the national ethics governance system resulted in the tool being identified as a speaking point amongst most jurisdictions for research governance officers, executive directors of hospitals/health services and maternity managers. The process was complex and time-consuming, involving multiple requests and replicated submissions including ethics committee approvals, access requests and site specific applications. For the 44 responses received there was a total of 79 access requests and site specific requests.

Assessment of survey

The third section of the survey asked respondents about the format, clarity, the benefit and the consistency of the intended objective of the survey. The majority of respondents answered that they believed the survey was good in all of these areas, with remaining respondents answering adequate and extremely good. Of significance, approximately eighty percent of respondents ranked the benefit of the survey as good or extremely good. Minimal respondents ranked the survey as less than adequate. These results highlight that organisations value the need for future work in this area.

Figure 24 Assessment of survey
Reliability and validity of the survey

Cronbach’s reliability testing was conducted on both the pilot and final survey. With a coefficient alpha of 0.70 being acceptable for a new survey (DeVon, Block, Moyle-Wright, Ernst, Hayden, Lazzara, Savoy & Kostas-Polston, 2007) a Cronbach’s reliability of 0.810 was achieved across the main study, establishing evidence of a reliable survey. There were a number of questions and responses that were deemed unreliable through this testing. Whilst reported on for descriptive statistics these questions were not included for inferential analyses Amendments will be considered in a next iteration of the survey.

Three questions were poorly constructed, asking for response to more than one element:

- Q14. Does your organisation invite Elders and community members into maternity care settings as part of collaborative care?
- Q27. Does your organisation provide information about service and educational materials in Aboriginal and / or Torres Strait Islanders languages relevant to the local Aboriginal and Torres Strait Islander community (including signage)?
- Q29. Does your organisation display Aboriginal and/or Torres Strait Islander artwork or the Aboriginal or Torres Strait Islander flags.

One question included Likert scale options that were too broad:

- Q9. Does your maternity service have access to community based services that are specific to Aboriginal and Torres Strait Islander women?
  - Yes, the majority of the time
  - Yes, although fragmented
  - Previously but not now because funding has ceased
  - No, not at all

Two questions may have included concepts unfamiliar to respondents who were managers of maternity services, but not midwives. As they probably add little value to the survey they will be considered for deletion.

- Q4. The National Maternity Services Capability Framework defines the levels of maternity care in Australia according to a set of criteria which identifies minimum
requirements for each level of service provision. What level of maternity services does your organisation provide according to the Maternity Services Capability Framework?

- Q13. How would you best describe the level of COC services provided by your organisation?

The final question that was deemed unreliable is most likely due to the options being framed as a mix of numbers (xxxx – xxxxx) and ‘greater than’/’less than’ rather than including options for an upper and lower limit. E.g 0 – 1000; 100,000 – 3,000,000

Q1. What is the approximate total population of your locality?
- Greater than 100,000
- 25,000 - 99,000
- 10,000 - 24,999
- 5,000 – 9,999
- Less than 5,000

Factor analysis was used to establish construct validity to determine the appropriate domains and constructs so that the survey can be used for future cyclical use. Factor analysis can only work if there are some relationships between variables and the Bartlett method was used to assess this (Field, 2013). A significant Bartlett test (p < 0.05) demonstrates that factor analysis is therefore appropriate (Field, 2013), and this was demonstrated by the two subscales in the survey, (both subscales p < 0.001). The Bartlett test also assesses sampling adequacy (Field, 2013), and demonstrated further evidence of sufficient sampling for this study.

**Discussion**

The findings of this research present the outcome of a *National Stocktake* of public maternity service organisational cultural competency. This section of the report discusses these findings in terms of the valuable insights they provide into Aboriginal and/or Torres Strait Islander people’s access to culturally competent maternity care and the progress that has been made by Australian public maternity services in respect to incorporating
fourteen previously identified characteristics of organisational cultural competency within their everyday activities. It compares these findings to what has been previously identified in the literature, and makes recommendations for further progress and evaluating the same on a cyclic basis.

Although the sample was small (44 responses; 29.5% of potential participants), the research incorporated responses from all states and Territories, so achieved the aim of providing a National Stocktake. Responses represented maternity services from all population size groups, maternity services of small, medium and large size, and providing care at all levels of the maternity services capability framework. This finding is similar to the work of Reibel and Walker (2010) and is of significance to this stocktake in terms of women’s access to culturally competent maternity care. That is, whilst sixty percent of services have self-assessed that they have made progress towards improving cultural competence, access to a culturally competent maternity service for an Aboriginal and/or Torres Strait Islander woman cannot be predicted based on location, and cannot be guaranteed from a service that is close to home. There was no correlation between the size of the maternity service and the self-assessed progress towards improved organisational cultural competence. Although, it was noted that smaller health facilities reported less involvement of Aboriginal people in design and implementation of health promotion activities (Characteristic 13).

In contrast to the Western Australian research (Reibel & Walker, 2010), the majority of responses in this study were returned from metropolitan areas with minimal representation from rural and remote areas. Accordingly, this research does not offer any insights into the influence of rurality or remoteness on organisation cultural competence. However, this research does identify that when accessing a maternity service that provides care to larger numbers of Aboriginal and/or Torres Strait Islander women, an Aboriginal woman may have the benefit of the health service having evaluated the outcomes of care specific to her Indigeneity. Importantly, conducting such evaluations in terms of recognising Aboriginal women as a specific cohort (Characteristic 2), has been identified by previous studies (e.g Larson & Bradley, 2010; Rumbold & Cunningham,
2008) as a positive step towards improved cultural competence. Unfortunately, the findings reveal that approximately one third of respondents reported no progress towards this characteristic. As such this result was amongst the characteristics that demonstrated the lowest levels of organisational activity, alongside collecting data on which services Aboriginal and/or Torres Strait Islander women use within respondents’ maternity services (60%) and use of tools to assess employees’ knowledge about cultural competence (Characteristic 11: Tools to measure cultural competence).

Consistent with previous research (Suarez-Belcazar, 2011), there was a lack of assessment of cultural competence, with only half of the surveyed organisations assessing employee’s knowledge about providing culturally competent care in the workplace. These findings support the need for a tool such as the one developed through this research, and the subsequent roll-out as identified in the National Maternity Services Plan (AHMAC, 2011a). The findings confirming validity and reliability suggest that with some minor revision to the tool, the research aim of developing an instrument suitable for cyclic use has been achieved.

The areas for revision include simplifying and removing some questions, and enhancing the clarity of others. Whilst the findings indicate a high level of action in creating a welcoming environment with displays of Aboriginal art and flags (Characteristic 1: Physical Environment & Infrastructure), further refinement of the survey is also indicated to take into account the need for ground level facilities and access to outside environments (Kildea, 1999; Mitchell, Wilson & Aitken, 2015). Such questions would address recent work in the area of reducing the incidence of women taking their own leave (TOL) prior to anticipated discharge, which was not included in the literature review by Kruske (2012).

The second edition of the Australian National Safety and Quality Health Service Standards (NSQHS Standards) has been recently promulgated for consultation (ACSQHC, 2017). This draft document has been published since Kruske (2012) identified the 14 characteristics of organisational competency, and since the completion of the literature review for this
National Stocktake the work of the Australian Council of Safety and Quality in Health Care (ACSQHC) confirms both the relevance of the content and the value of cyclic use of the tool produced through this research. The ACSQHC draft document includes a number of new actions that specifically address the need to provide a nationally consistent statement about the minimum level of care Aboriginal and/or Torres Strait Islander health care consumers can expect from health service organisations. As such, the tool developed for this study not only mimics the success of work by O’Brien et al, (2003, 2004, 2007) in mental health, but would be an appropriate quality tool to assess performance and act as a driver to improve the quality of health service standards to specifically address the cultural needs of Aboriginal and Torres Strait Islander women when accessing mainstream health facilities (AHMAC, 2011a; CATSINaM, 2017).

The culturally competent specific guidance provided by the proposed ACSQHC (2017) standards includes actions under Clinical Governance (Standard 1), Partnering with Consumers (Standard 2), and Comprehensive Care (Standard 5). The progress that has been made by participating maternity services in the area of establishing relationships with consumers and their families (Characteristic 9: Relationships/Standard 2) was amongst the areas of most organisational activity with all respondents reporting some level of staff commitment to encouraging family members to accompany and support Aboriginal and/or Torres Strait Islander women when they attend a maternity service.

Guidance under the ACSQHC Standard 1 suggests that clinical governance strategies need to be in place to improve the cultural competency and cultural awareness of the workforce. This research confirms that there is a statistically significant relationship between compliance with cultural competence policy guidelines and progress towards a number of the characteristics of organisational cultural competency. For example, when cultural competence is used as a selection criteria for employee recruitment, there is a positive relationship with, providing mandatory cultural education to employees, and assessing employees knowledge about culturally competent care, having guidelines specific to Aboriginal people to support maternity care, and providing educational resources designed specifically for Aboriginal and/or Torres Strait Islander women.
Inclusion of each of these assessment parameters was in line with previous research that informed the *National Stocktake* (Bainbridge, Clifford et al, 2015; Cherner, 2014), but adds new empirical knowledge of relationships between characteristics not previously identified in the literature.

Previous research also identifies a failure to measure the effectiveness of processes to address institutional racism or low levels of cultural competency (Paradies & Cunningham 2009; Paradies, Truong & Priest, 2013; Suarez-Balcazar et al, 2011). This *National Stocktake* identified progress in this area with almost two thirds of participating organisations assessing themselves as having processes in place to performance manage employees who breached cultural policies and guidelines. New knowledge generated by this research is that there is a positive correlation between holding employees to account for lack of acceptance, racism and discrimination and engagement with family members (Characteristic 9: Relationships), involving key stakeholders in assessing effectiveness of services (Characteristic 14: Engaging consumers and clinical governance and ACSQHS Standard 1 & 2), identifying Indigeneity in care records (Characteristic 2: Specific Aboriginal and/or Torres Strait Islander program, and ACSQHS Standard 5) and providing antenatal records through to discharge summaries (Characteristic 6: Communication, Information technology and transfer of care; and ACHS Standard 6: Clinical Handover).

Of importance is that organisations that documented care across the patient journey also showed a positive relationship in encouraging family members in supporting Aboriginal women during their pregnancy. Both of these findings are good news. In their 2010 study, Reibel and Walker identified deficiencies in cohesive service delivery, findings that supported the perception that services were fragmented. The findings of this study suggest that organisations are making progress towards better integrated care.

Integrating care and information sharing between services has been identified as particularly problematic (Bar-Zeev, Barclay, Farrington & Kildea, 2012; Homer et al, 2009) and is an identified Action in the NMSP (AHMAC, 2011a). Involving family members has been identified as a way to minimise women taking their own leave (Commonwealth of
Australia 2013) and progress in this area may improve women both accessing maternity services and remaining in care.

Two-thirds of organisations also self-assessed good progress in terms of linking into community based services to Aboriginal and/or Torres Strait Islander women. However, despite the positive correlation between ensuring compliance with cultural competence policies, with around twenty percent of organisations identifying no progress in liaising with key stakeholders about effectiveness of services (Characteristic 14) and only one third of organisations inviting elders and community members into maternity services (Characteristic 5: Community Collaboration), the need to improve these relationships resonates with previous recommendations by other researchers (for example, Reibel & Walker, 2010; O’Brien et al., 2003, 2004, 2007).

Organisations provided only around ten percent of continuity of care services specifically for Aboriginal and Torres Strait Islander women and this finding is comparable with Reibel and Walker’s (2010) Western Australian study that found that 75% of public health services did not provide a culturally competent model of care specifically designated for Aboriginal women. On the positive side however, perhaps the most significant finding of this National Stocktake is the positive correlation between organisations that reported actively recruiting Aboriginal and/or Torres Strait Islander employees and positive achievements in a range of characteristics of organisational cultural competency and more action in working towards cultural competence if Aboriginal people were represented in the workforce.

Currently the Aboriginal and Torres Strait Islander workforce is significantly under represented (AHMAC, 2015). The results of this survey support the active recruitment of this vital workforce as a strategy for improving cultural competence identified nationally and internationally (AHMAC, 2011b; AHMAC, 2012; Commonwealth of Australia, 2002; Kruske, 2012; NATSIHC, 2008; Reibel & Walker, 2010; Reibel & Morrison, 2014; Ring and Brown, 2003). Employing senior Aboriginal women also showed a positive relationship with recruiting Aboriginal and/or Torres Strait Islander employees, which is of particular significance with previous work identifying the specific role such a workforce plays in
improving the number of women accessing maternity services (Campbell & Brown, 2004; Carter, 2004; Eades, 2004; Herceg, 2005; Hunt, 2003; Jan, 2004; Mackerras, 1998; Panaretto, 2005; Tursan d’Espaignet, 2005). Organisations identified universal progress with mandatory education programs designed to inform employees about culturally competent care in the workplace (Characteristic 8), with only four percent of organisations self-assessing no progress and fifty percent of organisations reporting successfully achieving this goal. Of importance for those organisations with work still to do is that employing Indigenous Liaison Officers had a significant positive correlation with conducting these courses.

The majority of organisations reported positive progress relating to Characteristic 2: Specific Aboriginal and/or Torres Strait Islander programs. Ninety percent of organisations identified that they provided educational resources designed specifically for Aboriginal women. Similarly, the majority (91%) of organisations self-assessed making positive progress for organisational activities relating to providing accessible information to consumers about their services for pregnant Aboriginal and Torres Strait Islander women. Both activities are consistent with increasing women’s’ access to maternity services and improving women’s’ experiences (Betancourt et al, 2003; Cass et al, 2002; Freeman et al, 2014; Larson et al, 2007; Larson & Bradley, 2010; Reibel & Walker, 2010; Shahid, 2009). Future efforts however, need to be focussed on providing information about services and educational materials in Aboriginal and / or Torres Strait Islander language relevant to the local Indigenous community as almost sixty percent of respondents self-assessed no progress in this area. Not only does this negatively impact on delivery of programs tailored specifically to cohorts of Aboriginal and/or Torres Strait Islander women (Characteristic 2), but also may influence communication, information technology and transfer of care (Characteristic 6) and effective health promotion programs (Characteristic 13).

In summary, this research provides baseline evidence about progress towards achievement of organisational cultural competence measured against the 14 characteristics identified by Kruske (2012). It identifies areas for improvement and
potential factors that would enhance organisational ability to make such progress. Future work could include self-assessment by private hospitals, Aboriginal Community Controlled Health Services, and services located in remote areas of Australia, with populations of less than 1000. The potential to develop the tool further for use to assess these characteristics in the broader health service environment to measure performance in line with Australian Council of Safety and Quality Standards in health care requirements also exists.

**Limitations**

A limitation to this project as a *National Stocktake* is that participation was restricted to public maternity services. Aboriginal and Torres Strait Islander Human Research Ethics Committee members across the country consistently raised concerns about the exclusion of Aboriginal Community Controlled Health services (ACCHOs) in the project. However, they also accepted that the short duration of the project was a barrier to establishing genuine engagement with this health sector and gave approval for the research based upon the support for the research by the National Aboriginal and Torres Strait Islander Standing Committee (NATSIHSC) and the representation of Aboriginal people on the research reference group. With this in mind and the guidance of NATSIHSC, members of the reference group were purposefully selected to include Aboriginal people with a variety of health services expertise, engagement with Aboriginal Medical Services, and from a range of jurisdictions and organisations.

One acknowledged limitation of the reference group however, was the absence of a consumer representative. Given the national scope of the project, the researchers determined that it would not be appropriate to engage a consumer who represented a single jurisdiction and that time and resources allocated to the project did not allow for the engagement necessary to recruit consumers from each jurisdiction.

Similarly, it is acknowledged that the responses of health service representatives is only one perspective and that the perspective of consumers in regard to an organisation’s progress in areas reflecting each of the 14 characteristics of cultural competency may
differ significantly from the progress as self-assessed by organisational representatives. The time and funding allocated to the project however, did not provide the scope for a research design that included a consumer arm to this project.

In terms of research design, it is also acknowledged that the self-assessment method may have contributed both inaccuracy and bias to the results. The potential for organisations overestimating their achievements was minimised through the approach that acknowledged achievement of cultural competency extends across a continuum and is a developmental process, and through guaranteed anonymity of responses. The emphasis upon using the tool as a baseline to measure subsequent improvement was also employed to minimise the potential for elevating estimations beyond the organisations actual performance. It is however possible that responses were inaccurate as the person nominated by the organisation may not have been the appropriate respondent equipped to answer the survey. Reliability testing indicated that some maternity specific questions were not reliable, which may reflect the knowledge of the participant. Refining the survey questions may improve reliability of the tool itself, but tightening the criteria for respondents to ensure they have both maternity specific and organisational knowledge is recommended to address limitations of the research and improve accuracy of results.

Although the research raised awareness and organisational knowledge of cultural competence and will provide a baseline for cyclic monitoring of progress in improving maternity service performance for those organisations that participated, the small sample size does not provide the intended comprehensive national picture. It is also acknowledged that the analysis does not include correlations for jurisdictional specific performance. The survey deliberately did not include jurisdictional identification in order to preserve anonymity of individual maternity services in small jurisdictions, which would be easily identified by virtue of the small number of potential participants. The small sample size and low response rate may also have compromised the reliability of the survey, and repeating the research to include a larger number and involve a wider range of maternity services (e.g. those servicing less than 1000) to have a higher response rate, will assist in further refining the tool, and improve generalizability of findings.
As executives of health organisations were able to opt-in to completing the survey, it is possible that the executives that agreed to participate have already given consideration to the cultural competence of their organisations. Participating in research about cultural competence is itself an act that indicated a level of cultural competence and a desire for improvement. The low response rate to the survey may suggest that results were skewed towards a higher level of cultural competence by a non-response bias. Repeating the research with a higher response rate, or a calculation from a random sampling (alongside extensive efforts to encourage participation, would portray a more accurate national picture of progress towards adopting organisational characteristic of cultural competence.

In terms of enhancing the sample size, a limitation to this research is an underestimation of the complexity of the national research governance framework and the time required at each step of the decentralised process. Accordingly, the time allocated to complete the study and the small size of the research team was a limitation.

**Conclusion**

This research was commissioned under action 2.2 of the National Maternity Services Plan (NMSP) (AHMAC, 2011a): “develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people” (pp.39). The specific aims of the study were to address two action items scheduled for the middle years of the plan, which involved: undertaking a stocktake of access to culturally competent maternity care for Aboriginal and Torres Strait Islander people and identifying mechanisms for evaluating cultural competence in all maternity care settings. The National Stocktake has been completed for public maternity services providing care for Aboriginal and Torres Strait Islander women in locations with populations of more than 1000 people. The National Stocktake has found that there is progress towards improving access to culturally competent maternity care in these settings, and that with further development, the tool used for this research will provide a mechanism for ongoing evaluation of progress across a wider range of maternity services.
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ATTACHMENT 1 – Research Reference Group

The researchers wish to acknowledge the advice provided by the members of the research reference group and thank them for their invaluable contribution:

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Position</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Deb Butler</td>
<td>Member, Director Policy</td>
<td>NATSIHSC&lt;br&gt;Northern Territory Department of Health Office of Aboriginal Health Policy &amp; Engagement</td>
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<tr>
<td>Ms Francine Douce</td>
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<td>Tasmanian Government Department of Health and Human Services</td>
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<tr>
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<td>Judith Lumley Centre LaTrobe University and the Royal Women’s Hospital Melbourne</td>
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<tr>
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<td>Ms Janine Mahomed</td>
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<td>Ms Tanya McGregor</td>
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<td>LaTrobe University, Melbourne</td>
</tr>
<tr>
<td>Ms Maggie Richardson</td>
<td>Outreach Midwife</td>
<td>Northern Territory Health, Primary Health Care Top End Health Service</td>
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</table>
ATTACHMENT 2 - Survey

Evaluating organisational cultural competence in Maternity Care for Aboriginal and Torres Strait Islander Women

(A project conducted on behalf of the Maternity Services Interjurisdictional Committee (MSIJC) and funded by the Australian Health Ministers’ Advisory Council (AHMAC)

ON-LINE SURVEY

Thank you for participating in this research which aims to develop a self-assessment tool to assist public sector maternity service organisations to identify progress toward providing culturally competent care for Aboriginal and Torres Strait Islander women, an ambition set out in the 2010-2015 National Maternity Services Plan (NMSP). Your organisation has agreed to participate and has identified you as holding a leadership role in maternity services with responsibility for development or supervision and practice oversight of direct services.

There are no anticipated risks for yourself or your organisation if you participate in this research project. No employees or Aboriginal or Torres Strait Islander consumers will be asked for information relating to the cultural competency of your maternity services. The name of your organisation, nor other information that directly identifies your organisation will not be disclosed to those analysing the information that you provide, or in any subsequent reports or publications. Your non-identified self-assessment responses will be held in secure electronic storage in the Northern Territory Department of Health for 5 years following collection, after which time it will be destroyed. During that time the information can only be accessed with permission of the Principal Investigator Dr Robyn Aitken and Co-Investigator Dr Virginia Skinner.

Having provided individual consent you have now received the link to this survey and have the opportunity to participate in the research project by completing and submitting this electronic questionnaire. It is anticipated that you will be able to complete the survey in approximately 30 minutes. Completion of the survey will not only provide a self-assessment of your organisational progress against the identified cultural competencies, but will also contribute to further validation of this tool. Continuity of care is defined as ‘continuity of midwifery care’ or ‘caseload practice’ provided by a primary midwife who is her first point of reference and who takes responsibility for her individualized care throughout a woman’s pregnancy, labour and postnatal periods (Homer, Brodie & Leap, 2008).

You can choose not to participate right up until the survey is submitted electronically. After submission of the response, information can no longer be identified, preventing retrieval from the survey database. However, if you would like to keep your own results, once you hit the submit button at the end of the survey, you will be taken to a page with your results. On the top right hand corner you will see a small red button and you can hit on this button to export to a PDF document for your own records.

This project has been considered and approved by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research [2015-2524], and This project has also been approved by the Gold Coast Human Research Ethics Committee Identification Number: [HREC/16/QGC/214] and [insert relevant jurisdiction approval]

If you have any concerns or complaints regarding the ethical conduct of the study, you are invited to contact Ethics Administration, Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research on 8946 8687 or 8946 8692 or email ethics@menzies.edu.au

Thank you for participating.

Dr Robyn Aitken, Dr Virginia Skinner, Ms Louise Clark, Ms Maggi Richardson
Q1 First section of survey- Demographics
What is the approximate total population of your locality?
- Greater than 100,000
- 25,000 - 99,000
- 10,000 - 24,999
- 5,000 – 9,999
- Less than 5,000

Q2 How many women (both Indigenous and Non-Indigenous) access your maternity service per annum?
- Less than or equal to 1,000
- Greater than 1,000 and up to 5,000
- Greater than 5,000 and up to 10,000
- Greater than 10,000 and up to 20,000
- Greater than 20,000 and up to 25,000
- Greater than 25,000 and up to 30,000
- Greater than 30,000 and up to 50,000
- Greater than 50,000 and up to 75,000
- Greater than 75,000

Q3 Approximately how many of the women accessing your maternity service per annum identify as Aboriginal and Torres Strait Islander?
- Less than or equal to 500
- Greater than 500 and up to 1,000
- Greater than 1,000 and up to 1,500
- Greater than 1,500 and up to 2,000
Q4. The National Maternity Services Capability Framework defines the levels of maternity care in Australia according to a set of criteria which identifies minimum requirements for each level of service provision. What level of maternity services does your organisation provide according to the Maternity Services Capability Framework?

- Level one (the mother and baby have normal care needs and are provided antenatal and postnatal outpatient care, and emergency care for critically ill mothers and babies until transfer, but not birthing services) **Go to question 7 if you chose this option**
- Level two (the mother and baby have normal care needs and are provided inpatient services for antenatal, birthing, postnatal, and neonatal care for more than or equal to 37 weeks gestation. Birthing is provided in dedicated birthing rooms or a birthing centre and may also include planned home birthing in the community. On-site 24 hour capability for emergency caesarean section).
- Level three (mother and baby have normal care needs and are provided inpatient services for antenatal, birthing, postnatal and on-site neonatal care for planned birth ≥ 37 weeks gestation. The service has on-site 24 hour capability for emergency caesarean section, elective caesarean section and vaginal birth after vaginal birth after caesarean section ≥ 39 completed weeks gestation).
- Level four (mother and baby may have normal - moderately complex care needs and are provided inpatient services for antenatal, birthing, postnatal, and on-site neonatal care for planned birth for ≥ 34 weeks gestation). A specialist obstetrician / gynaecologist is on-call 24 hours.
- Level five (mother and baby have normal or up to highly complex care needs and are provided inpatient services for on-site neonatal care service for planned birth ≥ 32 weeks gestation. On-site surgical services can support obstetric care of mothers of normal to high complexity).
- Level six (mother and baby have normal or up to highly complex care and are provided antenatal care with access to a maternal / fetal medicine unit and birthing care with on-site neonatal service capability that can support birth at any gestation).
Q5 How many recorded births took place in your service during 2015? Please approximate this number if exact number not known.

Q6 For recorded births in your service in 2015, how many babies born were identified as Aboriginal and Torres Strait Islander?

Q7 Choose the answer that best describes your role in the maternity services organization for which you work. You may choose more than one option.

- Leadership role
- Directly responsible for development of maternity services
- Supervision of maternity services
- Practice oversight of maternity services

Q8 Does your organisation employ any of the following employees?

- Aboriginal and Torres Strait Islander Health Practitioners
- Indigenous Liaison Officers
- Interpreters for Aboriginal and Torres Strait Islander languages
- Aboriginal and Torres Strait Islander Community Workers
- Senior Aboriginal and / or Torres Strait Islander women
- Aboriginal and / or Torres Strait Islander midwives
- Aboriginal and / or Torres Strait Islander managers
- Other (please identify the role)
Q9 Does your maternity service have access to community based services that are specific to Aboriginal and Torres Strait Islander women? This access may include antenatal care and antenatal education, postnatal care and child and family health services.

- Yes, the majority of the time
- Yes, although fragmented
- Previously but not now because funding has ceased
- No, not at all

Q10 Does your organisation provide continuity of care (COC) services for women?

- Yes, our organisation provides COC for women. Go to question 11 if you chose this option
- No, our services provide no COC for women. Go to question 14 if you chose this option

Q11 How would you best describe the level of COC services provided by your organisation?

- For Aboriginal and / or Torres Strait Islander women only
- For both Aboriginal and / or Torres Strait Islander and non-Indigenous women
- For non-Indigenous women only

Q12 How would you best describe the level of risk experienced by Aboriginal or Torres Strait Islander women provided COC services by your organisation?

- Normal risk only
- High risk only
- Both high and normal risk

Q13 How would you best describe the level of risk experienced by non-Indigenous women provided COC services by your organisation?

- Normal risk only
- High risk only
- Both high and normal risk
Section 2: Characteristics of cultural competence in organisation (informed by Kruske, 2012).

The following questions relate to your organisation’s progress towards achieving the goals of a culturally competent maternity service.

Q14 Does your organisation invite Elders and community members into maternity care settings as a part of collaborative care?

- Yes, occasionally
- Yes, regularly
- Yes, always
- No, not at all  **Go to question 16 if you chose this option**

Q 15 As your organisation invites Elders and community members into maternity care settings as part of collaborative care, how does this invitation occur? Please provide example/s.

Q16 Does your organisation actively recruit Aboriginal and / or Torres Strait Islander employees?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q17 Does your organisation specify cultural competence and compliance with cultural competence / policy guidelines as selection criteria for employee recruitment?

- No progress or yet to begin achieving this goal  **Go to question 19 if you chose this option**
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal
Q 18 Please describe in detail how the criteria is being satisfied for your organisation specifying cultural competence and compliance with cultural competence / policy guidelines for employee recruitment.

Q19 Does your organisation have guidelines and policies specific to Aboriginal and / or Torres Strait Islander maternity care and / or support culturally competent care for Aboriginal and / or Torres Strait Islander people?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q20 Does your organisation provide mandatory education designed to inform all employees about culturally competent care in the workplace?

- No progress or yet to begin achieving this goal  Go to question 22 if you chose this option
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q21 What was the designated role of the employee who facilitated the training for the mandatory education designed to inform all employees about culturally competent care in the workplace?

Q22 Does your organisation assess an employee’s knowledge about providing culturally competent care in the workplace?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal
Q23 What specific tools do you use to assess cultural competence of employees in the workplace?

Q24 Does your organisation have processes in place to performance manage employees who behave in a manner which demonstrates a lack of acceptance, racism or discrimination?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q25 Does your organisation include information about Aboriginal and/or Torres Strait Islander identification in patient care records?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q26 Does your organisation provide educational resources designed specifically for Aboriginal and/or Torres Strait Islander women?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q27 Does your organisation provide information about service and educational materials in Aboriginal and/or Torres Strait Islanders languages relevant to the local Aboriginal and Torres Strait Islander community (including signage)?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal
Q28 Does your organisation display Aboriginal and/or Torres Strait Islander artwork?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q29 Does your organisation display Aboriginal or Torres Strait Islander flags?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q30 Does your organisation liaise with other key stakeholders about the effectiveness of services (eg Aboriginal and Torres Strait Islander community controlled health organisation and/or National Aboriginal and Torres Strait Islander Health Standing Committee)?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q31 What type of organisational support is available for Aboriginal and/or Torres Strait Islander students for training and/or scholarship positions within your service? Please write N/A if this does not apply to your organization.
Q32 Does your organisation provide accessible information to consumers about your services for pregnant Aboriginal and Torres Strait Islander women?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q33 How does your organisation seek to ensure consumer feedback is obtained in a culturally safe way? Please provide examples. Write N/A if appropriate.

Q34 Does your organisation provide antenatal records through to discharge summaries to all relevant stakeholders including Aboriginal and / or Torres Strait Islander women?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q35 Does your service encourage family members to accompany and support Aboriginal and / or Torres Strait Islander women?

- Never
- A proportion of staff endeavour to encourage Aboriginal and / or Torres Strait Islander families some of the time
- A proportion of staff endeavour to encourage Aboriginal and / or Torres Strait Islander families at all times
- All staff endeavour to encourage Aboriginal and / or Torres Strait Islander families at all times
Q36 Does your organisation involve Aboriginal and / or Torres Strait Islander women in design and implementation of health promotion activities and programs, for example, cessation or reduction of smoking in pregnancy?

- No progress or yet to begin achieving this goal  **Go to question 38 if you chose this option**
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q37 Please provide examples of how your organisation involve Aboriginal and / or Torres Strait Islander women in design and implementation of health promotion activities and programs.

Q38 Does your organisation collect data on which services Aboriginal and /or Torres Strait Islander women use within your maternity services?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q39 Does your organisation report on evaluation of maternity outcomes for Aboriginal and /or Torres Strait Islander women as a specific cohort?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal
Q40 Overall, how culturally competent would you rate your maternity services in relation to Aboriginal and / or Torres Strait Islander people?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Q41 Does your organisation involve Aboriginal and /or Torres Strait Islander people in the design, monitoring, evaluation and improvement of its services?

- No progress or yet to begin achieving this goal
- Some progress towards this goal
- Almost fully achieving this goal
- Successful in achieving this goal

Section 3: Feedback

Your feedback on this survey will help refine the tool and strengthen validity for future use.

Q42 How would you rate the format of this survey in terms of ease of use?

- Extremely good
- Good
- Adequate
- Less than adequate

Q43 How would you rate the clarity of these questions in this survey?

- Extremely good
- Good
- Adequate
- Less than adequate
Q44 How would you rate the consistency of the questions posed in this survey with the aim of this project?

- Extremely good
- Good
- Adequate
- Less than adequate

Q45 How long did it take to complete this survey?

- Less than 15 mins
- 15 mins to 30 mins
- Longer than 30 mins

Q46 How would you rate the benefit of completing this survey as a self-assessment tool?

- Extremely good
- Good
- Adequate
- Less than adequate

End of survey