

***“Your always hearing about the stat(istics)...death happens so often” Further perspectives on barriers to Aboriginal participation in cardiac rehabilitation programs***

With rates three times the non-Indigenous population<sup>1</sup>, the burden of cardiovascular disease (CVD) in Aboriginal and Torres Strait Islander (hereafter Aboriginal) Australians remains one of the most challenging issues in public health. Engaging patients in cardiac rehabilitation (CR), a constellation of effective secondary prevention measures, is critical to improving post myocardial infarct outcomes<sup>2</sup>. While the underutilisation of CR in the broader Australian community remains an issue<sup>3</sup>, Aboriginal participation rates are extremely low<sup>4, 5</sup>. Previously identified barriers to uptake by Aboriginal patients have included insufficient program knowledge, extended family responsibilities, and socioeconomic issues<sup>4</sup>. Additionally, considerable literature exists identifying challenges for Aboriginal people in accessing health services more generally, including a socio-cultural ‘mismatch’ and lack of access to Aboriginal staff<sup>6</sup>.

We report here perspectives on barriers to CR use based on a qualitative study conducted in Perth Western Australia (November 2007 - March 2008). Seven female and eight male Aboriginal cardiac post-admission patients living in Perth were interviewed to explore barriers to CR usage. While six had participated in at least some outpatient CR sessions, nine had not. Recurring themes identified included challenges associated with extended family responsibilities and socio-cultural program inappropriateness. These themes, alongside less commonly discussed issues of poor understanding of CR and the connection between colonialism and health services, reflect findings from other studies<sup>4, 7</sup>. However, although only referred to by a small number of participants, two previously unidentified themes – media messages and the younger age of the affected population were identified as impacting on participation.

Firstly, our study revealed a profound personal impact for some Aboriginal patients who feel constantly reminded, and come to expect, poor health and heart outcomes resulting from dire statistics repeated in the media. While the dominant theme of Aboriginal fatality and futility in the Australian media has been discussed<sup>8</sup>, in terms of heart health the media message is disempowering, and can contribute to a sense of futility in engaging with health programs. No doubt this is reinforced by regular attendance at funerals for Aboriginal people who die very prematurely from CVD. This highlights the need for a shift in media and public health campaigns from shock headings and statistics to focusing on strengths and successes, inspiring the groups they speak of and supporting them to make changes.

Secondly, younger Aboriginal participants spoke about feeling isolated in CR sessions amongst non-Aboriginal people who were 20-30 years older than them. While CR programs are generally attended by an age demographic that reflects CVD epidemiology in the wider community, the burden of CVD and consequently presentation to cardiac surgery, occurs in a much younger age group in the Aboriginal population<sup>9,10</sup>. The burden of CVD in younger Aboriginal people- and the fact that these differentials are widening<sup>9</sup> demands rethinking how CR will work for this very different demographic group. Rethinking CR approaches to address the needs of younger people may also improve receptivity and opportunities for primary prevention in the family and broader community.

This qualitative study does not claim generalisability as the sample was small. However, the two themes we have discussed may contribute to thinking about ways forward. Research exploring issues for younger Aboriginal CVD patients is certainly warranted. Further, it may contribute to understanding how younger Aboriginal people think about their health, and feel mobilized and supported by the wider society to do something about it.

**Table 2: Recommendations from Aboriginal patients for improving the design of an urban cardiac rehabilitation program**

1. Develop CR programs for working patients – offer them outside working hours
2. Ensure flexibility in CR program session plans and delivery - have opportunistic drop in sessions rather than allocated times
3. Hold CR programs in Aboriginal community health centres
4. Build trust and relationships with patients over time- the importance of yarning
5. Make CR programs more appealing to younger clientele
6. Outreach to homes, developing programs for the whole family rather than just individuals
7. Develop realistic lifestyle & diet modification recommendations for modern Aboriginal family situations
8. Have both male and female Aboriginal health staff delivering CR where possible
9. Target youth with heart health education messages
10. Explore opportunities to re-focus public health education and media from negative, fear-based to positive and strength-based messages
11. Encourage Aboriginal patients to attend sessions together: buddy system

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