“You’re always hearing about the stats … death happens so often”: new perspectives on barriers to Aboriginal participation in cardiac rehabilitation

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To the Editor: Engaging patients in cardiac rehabilitation (CR), a program of secondary prevention measures, is crucial to improving outcomes after myocardial infarct. Rates of participation in CR by Aboriginal and Torres Strait Islander (hereafter Aboriginal) people are extremely low.

We conducted a qualitative study on barriers to CR use from November 2007 to March 2008 with 15 Aboriginal cardiac patients (seven women and eight men, aged 31–74 years) living in Perth, Western Australia. Six had participated in some outpatient CR sessions, nine had not. Participants were interviewed face-to-face using a semistructured interview guide, with questions exploring their views and experiences of CR, barriers to use and suggestions for improvement.

Recurring themes included challenges associated with extended family responsibilities and sociocultural inappropriateness of the program. These themes, along with less commonly discussed issues of poor knowledge of CR and the connection between colonialism and health services, reflect findings from previous studies. However, two new themes — media heart health messages and the younger age of the affected Aboriginal population — highlight further factors influencing participation (Box 1).

We found that some patients feel constantly reminded of, and therefore come to expect, poor health outcomes, due to dire statistics repeated in the media. While the dominant theme in the Australian media of Aboriginal fatality and guiltiness has been discussed, heart health messages are often disempowering, negatively affecting motivation to engage with health programs. This is likely reinforced by regular attendance at funerals for Aboriginal people, who die very prematurely from cardiovascular disease (CVD). This highlights the need for a shift in media and public health campaigns from “shock” headlines and statistics to a focus on strengths and successes, inspiring the groups involved and supporting them to make changes.

Younger Aboriginal participants also spoke about feeling isolated in CR sessions among non-Aboriginal people who were 20–30 years older than them. The age demographic of CR program attendees generally reflects CVD epidemiology in the wider community, but the burden of CVD occurs at much younger ages in the Aboriginal population. This widening differential demands rethinkin of how CR should work for this very different demographic group (Box 2). CR programs addressing the needs of younger people may improve receptivity and opportunities for primary prevention in the family and broader community.

Although these two themes were reported by a small number of patients, further research into issues for Aboriginal patients with CVD is warranted. Importantly, it will contribute to understanding of how younger Aboriginal people think about their health, and feel motivated and supported by wider society to do something about it.

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