Chronic Wet Cough in Aboriginal Children

It’s not just a cough
Acknowledgement

I would like to acknowledge the Larrakia people, the Traditional Owners of the land on which we meet today and to pay my respects to Elders past and present.
How did I get here?

We noticed years of delay before children with CSLD received medical care.

Our question: how can we see children before advanced lung damage occurs and hopefully empower local service providers to do ourselves out of a job?

Respiratory Team: Port Hedland, Karratha & Broome quarterly
Background

• Clinically we have “western medical solutions”
• Problem: “fly in fly out medicine”
• Solution: partnerships
What is the problem?

1. Aboriginal children are at a higher risk for CSLD & Pneumonia
2. Much higher incidence BE ~ 1.5%  (Chang et.al 2003)
3. One of the earliest signs is a chronic wet cough
4. Families may not realize chronic wet cough needs medical review
5. Health practitioners may not be aware that chronic wet cough requires management
Research overview

• Aim
  Improve healthcare of Aboriginal children with chronic wet cough and CSLD through developing culturally sensitive and sustainable solutions for early detection, accurate diagnosis and timely treatment of chronic wet cough

• 2 projects
  – Project 1. Recognition and management of chronic wet cough and CSLD in Aboriginal children in Kimberley: qualitative and quantitative study
  – Project 2. Prevalence of chronic wet cough in Aboriginal children in the Kimberley

Ethics approvals complete and projects well underway
Project 1, phase 1 aims

1. Identify barriers & enablers for families seeking healthcare for chronic wet cough in Aboriginal children.

2. Examine health practitioner knowledge of PBB/chronic wet cough in Aboriginal children & identify the enablers and barriers to management
Method

- Qualitative study - Community Participatory Action Research approach
- Individual semi-structured, in-depth interviews & focus groups
- Study conducted in a town in Kimberley, WA
Figure 1: Recruitment of Study Participants families

Total recruitment of 40 community members

Medical Chart Audit
47 children identified fulfilling criteria: Invitation & study information sent

34 families scheduled appointment for interview

15 attended, 14 consented for interview

Snowball sampling

Focus group discussion: Aboriginal day care 3 community members

Focus group discussion: Aboriginal play group 13 community members

Snowball sampling

Advertising posters in Aboriginal Medical Service
6 Individual interviews

Snowball sampling

3 individual interviews

1 individual interview
Results: family perspective: barriers

- Chronic wet cough normalized in Aboriginal children – 70% of families (29% of those with cough unable to recognize cough).

- 53% belief about cough informed by interactions with Dr who told them cough was viral and nothing cough be done.

- 79% families (children chronic wet cough) reported that doctors had sent them away with no treatment and therefore they felt presenting again would be a waste of time.

- But all were worried about their child’s cough!

D’Sylva, 2018 et.al (unpublished)
Results: Barriers

- 87% of families would not present for chronic wet cough alone

- Other:
  - Long wait times
  - Continuity of care: different dr
  - Disempowerment: difficult to question doctors if concerns dismissed
Barriers

• No families aware that chronic wet cough >4 weeks requires medical review (100%)
• No health information for families (100%)
Results: Barriers

A. Health Information & Language
   A.1. Community belief (general)
   A.2. Community belief (doctor informed)
   A.3. Belief that cough must be accompanied by additional worrisome symptoms to warrant treatment
   A.4. Belief that chronic wet cough has viral aetiolo

B. Social, Cultural & Historical
   B.1. Disempowerment: belief no medical action will be taken
   B.2. Disempowerment: inability to challenge health practitioners

C. Health System
   Service provision: no continuity with doctor, staff not trained in cough management
Enablers

• Train health practitioners to recognize and treat
• Continuity of care
• Health literacy information: Families would present for chronic wet cough if they knew they should. (100%)
  1. Flip chart locally made with local children
  2. Information shared in community via talks: day care, playgroups etc.
  3. Use audio recordings of cough sounds
  4. Use posters, radio ads, YouTube clips with famous Aboriginal person to promote. Other health promotion
Enablers

• Hospital: Different issues
  1. Need Aboriginal work force
  2. Improve cultural safety
  3. Need follow up post hospitalisation for respiratory illness
Enablers

**ENABLERS**

A. Health Information & Language
   - Provide Health Literacy Information
     - Health Promotion: social media, TV, radio
     - Health literacy: Posters, pamphlets & information flip charts

B. Social, Cultural & Historical
   - Improve cultural security through Aboriginal workforce

C. Health System
   - Train health practitioners in cough management
   - Follow up post hospitalization for lower respiratory tract infections
Conclusion

• Key barrier: HP and community normalisation of cough
• Normalisation of cough related to inadequate health information.
• HP’s can facilitate timely health seeking for chronic wet cough through provision of simple and accurate health literacy information to families.
Conclusion

• Need for culturally appropriate information campaign to inform community of the importance to treat chronic wet cough, the dominant symptom of chronic lung disease, a serious chronic health problem.
Preliminary results HP’s: Barriers

- 32 participants
- Most unaware of guidelines for management of PBB-Bronchiectasis in children and not confident to treat
- System barriers
  1. electronic records used
  2. follow-up system
  3. shortage of doctors
- Model of care
  1. suited to acute care rather than chronic disease management.
  2. Doctors may not see the same patient again, making follow up cough difficult
Enablers

- Upskill: Regular training
- Local guidelines with easy to follow flow chart
- Health literacy information tools & campaign
- Staff: more doctors. Case manager to assist with complex care needs
- Post-hospitalization follow up post respiratory illness
Where next?

• Planning intervention:
  • 1. Health practitioners: training and implement new guidelines (similar to CARPA)
  • 2. Families: health literacy and information campaign
  
• Premeasures completed and will post measure to see if effective

• Prevalence of PBB in 2 remote communities – commence measurements in July
Local flip chart

CHRONIC LUNG SICKNESS
Chronic Suppurative Lung Disease and Bronchiectasis
The Lungs

You have 2 lungs
They sit inside your chest and surround your heart.
The lungs and the heart work together to bring
oxygen in the blood to the whole body to give you life
Go and see your doctor

• The doctor can check and help stop the coughing

• Your child might need some antibiotics for the cough

• If your doctor is not concerned about the coughing, but the cough won’t go away and you are still worried, then take someone with you who can help you tell the doctor. Ask the doctor how many times you have come for the coughing
Why are healthy lungs important?

• The lungs in children are still growing, so we have to look after them.

• Strong lungs help children grow strong, live strong, to play and learn.
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