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Mountains in Midwifery: The Importance of Sherpa's
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Good morning everyone,

Nice to see so many bright cheery faces following last night's dinner. Thank you for inviting me to speak this morning. Before I begin I would like to acknowledge the Traditional Owners of this land that we are gathered on. Being invited to do a keynote address and then being given 45 minutes time frame was a little daunting at first. However, being allowed to talk about anything I want with the theme of Adventures in Midwifery made it very easy. I have called my talk Mountains in Midwifery: The Importance of Sherpa's. Any adventure is usually accompanied by challenges and where there are challenges it is important to know who the Sherpas' are, how to find them and how they can help. Today I will tell you a little about some of my adventures in midwifery and some of the challenges I believe lie ahead.

So I thought I would start with the definition of a Sherpa. The Sherpa are an ethnic group from the most mountainous region of Nepal, high in the Himalaya. The term 'sherpa' is also used to refer to local people, typically men, who are employed as porters or guides for mountaineering expeditions in the Himalayas. Sherpa's are renowned international for their hardiness, expertise, experience, good physical endurance and resilience. Today, the term is used casually to refer to almost any guide or porter hired for mountaineering expeditions in the Himalayas. However, in Nepal, Sherpa's insist on making the distinction between themselves and general porters, and they command higher pay and respect from the community.

So if we returned to midwifery then it seems to me that a woman embarking on the journey of pregnancy birth and the first six weeks of her new baby's life, could be likened to someone who is preparing to and then does climb a mountain like Everest . Naturally this would mean that the role of the Sherpa would be referring to the role of a midwife. Professionals who are known for their expertise, experience, physical endurance (how many of you out there work either double shifts or very long days to support a woman in labour?) and resilience (we are after all, the oldest profession in the world). Unlike Sherpa's we haven't quite got to the stage where the term midwife is being used to refer to anyone who assists women on this journey however we do have a situation in Australia where many other people (childbirth educators, doula's, physiotherapists, nurses, doctors) are providing their expertise to areas that clearly fall within the scope of practice of a midwife. Does this, and should this, matter? I think it does and I think it is one of midwifery's greatest challenges today and will return to talk a little more about it later.

But first let me tell you a little bit about some of the adventures that midwifery has led me to. When I finished my nursing training I did what many of us did and went off to explore the world starting with a trip around Australia. When I arrived in Alice Springs a recent outbreak of rotavirus saw every bed and some of the corridors in the hospital filled with young, sick Aboriginal children. They were desperately short of staff and I stayed and worked till things settled down. This was the first time I had met and talked to so many Aboriginal people and I was filled with awe and bewilderment. Something must have got into my blood as although I only spent a short time there (Europe was calling), I knew then and there I would be returning to the Northern Territory.

Back in Sydney with an intensive care certificate and midwifery under my belt I packed up my car and headed to Alice which was a great place to consolidate my midwifery training. It was here that I first realised that the services we provided for Aboriginal women were not meeting their needs. I heard about some women having their babies 'out bush'. One thing I remember clearly was the look of sadness in the women's eyes as they sat waiting for their birth to occur, having left their children and families behind. I thought surely we can do better than this. After a year in Alice I was off again on another adventure.

One of the main reasons I had done my midwifery training was to work for the Royal Flying Doctor Service (RFDS). I saw a job with the Victorian section of the RFDS based in Derby. Looking at a map I thought it must be Derby in Tasmania. Following a successful phone interview I was heading south on another adventure. A quick phone call the day before I left to ask about buying warm clothes in Melbourne had us both confused till I realised the job was in Derby in the Kimberley which was supported by Victoria who themselves had no need for the RFDS! So I turned my car around and headed north instead and what a great thing that ended up being! Here I learnt a lot more about Aboriginal people and Aboriginal culture. Our role encompassed emergency evacuations (often when women had had a normal birth!) and routine health clinics where a doctor and a nurse would fly out to the remote centres for the day. This was my favourite part of the job as I could work in midwifery and the women's health role, some remote areas did not have on-site midwives and those that did were still happy for help in this area. I thought I had a pretty good idea of what it meant to be a remote area nurse midwife; however it was until a few years later I discovered that was not the case.

Although working in the Kimberley was a tremendous adventure it was here that I met Sue Kruske and we had both always wanted to work in Africa. Many letters of inquiry finally led to a position at the Groote Schuur Hospital in Cape Town, South Africa. But first we had nine months travelling through many of the African countries where we visited midwives and midwifery units along the way. Every one of them seemed poorly resourced and staffed by wonderful midwives. Working in the birthing unit of the tertiary referral hospital in Cape Town was an amazing experience. Technically our skills were refined as midwives in the unit were given a high level of responsibility with doctors almost always in theatre. Here we cared mostly for black African women from the townships. Most arrived in our unit in very advanced labour, many had had no antenatal care, rarely were any relatives present and many were very, very sick. We became very fast at assessing a woman's condition. Breech babies, preterm babies and undiagnosed twins were common. Women would arrive having eclamptic seizures, their babies would be dead from abruption and they were fast developing DIC. We were participating in a trial of magnesium sulphate and though it was a blinded trial we could all tell which women were receiving it. At one

end of the unit there would be women who were intubated, ventilated had a Swan Ganz insitu and teetered between life and death. Many times we did not even know what relatives could be called. The 12 hour shifts were exhausting and every 24 hours there would be another row of dead babies in the pan room with a maternal death occurring approximately once a month. Though incredible experience, it wasn't really the midwifery that we had wanted to do and with money almost gone we returned to Australia. My experience in South Africa made me acutely aware of the inequity across the world and gave the maternal mortality statistics a human face that I would never forget. Though magnesium sulphate has seen a decrease in maternal deaths from eclampsia worldwide many people believe that the *Millennium Development Goal 5 - Reducing the maternal mortality ratio by three quarters between 1990 and 2015* will not be realised. The reduction in mortality has been lower than anticipated and the disparities between rich and poor, and, urban and remote dwellers, the most significant. Which brings me on to the next point I would like to discuss: the disparities between urban and remote dwellers in Australia.

But first, a little more of my adventures. Back in Australia with no money so a call was made to a nursing agency. Foolishly I didn't read between the lines, not recognising that the comment "*you don't mind helping out a little bit with some of the management functions do you*" actually meant my next job would be Director of Nursing in the Aurukun Aboriginal community in the Cape York Peninsula. A 2-day orientation ensured I was completely unprepared to work in this cross cultural environment. Everything I learnt was through trial and error and it was here but I really started to understand the important role of Aboriginal health workers. In this setting it is the Aboriginal health workers who are the Sherpa's, their expertise, experience, resilience and patience make all the difference to the success or failure of health service delivery in the remote setting. This was the first of many Aboriginal communities I have now worked in. Returning at regular intervals to work in maternity units to update my skills insured my passion for midwifery grew stronger, with a particular rural and remote focus.

During one of these intervals I was lucky enough to work as a team midwife at the John Hunter Hospital, not long after it had been established as a RCT by Marilyn Fourer and others. Here I worked with a fabulous group of midwives and 14 years on

we are still having reunions and keeping in touch with each other. It was here that I became a complete convert to continuity of midwifery care. But it was also at the John where I developed an interest in education. I had 10 months in the role as midwifery educator in the delivery/birthing unit and loved it. But once again remote was calling and positions being advertised in Maningrida in Arnhem Land were too good to refuse. Ann Saxton just smiled and said *“I knew we wouldn't keep you girls for long”*.

Maningrida was chosen as we knew it was a place where women were choosing to stay at home in their community to have their babies. Although they were encouraged to go to Darwin there were quite a few women who would choose to stay and this meant we would not lose our midwifery skills; a problem I believe we will see more and more as rural and remote maternity services close down across our country. Midwives will either leave these rural and remote communities or will need to rotate into town centres to update their skills regularly, unless we managed to turn the situation around.

But first let me tell you about living in Maningrida. It has now been 12 years since I first moved to Maningrida where and I continue to learn from the Aboriginal people who live in that area. Working as a remote area nurse midwife was one of the most challenging and exciting positions I have ever held. The learning curve is steep, the experiences are hugely varied and the work satisfaction is high. Unexpectedly so, as at times you feel as though you're working in the most poorly resourced part of Australia, providing health care to those who need it the most. Despite all the adversity Aboriginal Australians are survivors and have taught me much. Their patience with my Balanda (white people) enquiries and cultural faux pas' never cease to amaze me. Quietly someone will whisper that I have said or done the wrong thing, with an encouraging smile they accept my apology and on we go, working across what seems to be one of the greatest cultural chasms I have ever experienced.

When I was working in Maningrida the burden of infectious and chronic diseases seemed at times to be overwhelming. We had a TB rate that was 100 times higher than the rest of Australia with 11 active cases and hundreds of people needing preventative therapy. My application for extra funding to employ a nurse and

Aboriginal health worker to run the TB program was knocked back and I was told it would be 20 years before Maningrida managed to get TB under control (would this happen in Melbourne?). Chronic bacterial ear infections and streptococcus skin infections, both related to overcrowding have long-term consequences. Ear infections lead to reduced hearing, an inability to learn and school dropout. Skin infections often result in glomerular nephritis and long-term kidney disease or rheumatic fever which can result in heart disease. The rates of rheumatic heart disease in Maningrida are higher than those in Soweto. When I participated in the census there were some three-bedroom houses that had 28 people living in them, with the latest census showing up to 33 people in a house. The housing maintenance program had a list of jobs a mile long with some houses without running water and others without electricity. People would come in from the outstations during the wet season and camp on concrete slabs that had large tin roofs and no walls which were known as '*the shelters*'. Extension cables crisscrossed the community – often lying in puddles from the rain and frequently being driven over.

Although I was shocked at first it's incredible how quickly you become de-sensitised to the living conditions. We had no on-site doctor in a community of 2,200 people and the type of health conditions I have described. We had to be the doctor, the dentist and the vet. How would these kids ever get a decent chance in life? As the manager of the Health Centre I could not get money from the Health Department to buy what I considered to be essential equipment. We had no IVAC and trust me it just isn't safe titrating Salbutamol in the back of a truck that is bouncing along dirt roads or in a small plane! So we went elsewhere for funding. The outstation organisation donated a four-wheel-drive to assist in the provision of primary health care, the school donated an oximeter and the shop bought us an IVAC. The CDEP program, the same one that is being axed in September, enabled me to employ Aboriginal people to work in the Health Centre as there was minimal funding for what any other small hospital in Australia would consider essential work (ambulance and transport drivers, cleaners, maintenance and equipment personnel, gardeners). I have heard that the latest plans are to replace 8,000 CDEP positions with 2,000 real jobs – real jobs are essential but what will happen to the other 6,000 people who will lose their positions?

This brings me to what I think it is one of the greatest challenges this country has ever seen. On Thursday the 21st of June, just over six weeks ago, the Commonwealth Government announced that there was to be 'War on Sexual Abuse of Young Children' and that they would be taking control of many areas in the Northern Territory. I'm sure many of you have been watching the stories from the Northern Territory, and you may be wondering what on earth is going on up there. We too are wondering where this is all going to lead. For weeks following the announcement I felt I was living on the edge of a war zone. Rumour and innuendo were flying around, people were polarised, with some thinking this was a great thing whilst others felt it was another Tampa: '*black kids overboard*' was becoming a standard saying as was the thought that this was all about land, mining and uranium dumps. There was little information available on what the Commonwealth Government were planning to do but in hindsight we realise that of course, they were making it up on the run, they didn't know what they were going to do. They felt they had come up with a good idea but had absolutely no idea of the logistical nightmare that they were facing. After all, if conditions in remote communities had been easy to fix they would have been fixed many years ago. Personally, I didn't know how I felt, one-day I would be feeling severely depressed with the complete lack of control and input that the Aboriginal people themselves were having and the next day hoping against hope that maybe this intervention would make a difference to the lives of remote Australians. Daily phone calls to Molly in Maningrida told me that many people were worried that someone was going to come and take their kids away. Yes, something desperately needed to be done and the need was urgent, but the process can be just as important as the intervention, and in my opinion the current process has been appalling.

It's been six weeks and we still don't really know how it is all going to pan out. We know many children are having health checks (though these kids frequently have health checks and all the data the Commonwealth needed the Territory could probably have given them). However this time they have said that they will ensure that all the follow up that is required, the ear operations, the heart operations, the dental care etc, will be paid for in full by the Commonwealth Government. But what is the point in having any operation when you return home to a house that has 19 people living in it and doesn't always have running water. What is going to happen if all the kids do go to school? We will need twice as many chairs, tables, teachers, houses for teachers

than what we have today. This is what happened in Wadeye when the no pool no school rule came in. \$1.9 billion is needed for houses in the Northern Territory. Surely this isn't that hard when we have a \$10.6 billion dollar surplus. We know that diverting just 1% of the Australian health funding into Aboriginal Health funding would increase this budget by 50%.

The issues are complex and the strategies to protect the children of today should not be the only focus. This is not a war on sexual abuse of young children, but a war on poverty. Sexual abuse of young children is a hideous crime and no one would argue with that. However, high rates of sexual abuse in any community is usually but one symptom of a very distressed community. Like the high rates of TB, rheumatic heart disease, suicide and domestic violence it is symptomatic of extreme poverty and despair. Communities that have lost much of their social cohesion; communities without hope. Vulnerable members of Aboriginal communities need adequate housing, strong leadership, appropriately resourced health care, schooling that meets their needs and will ensure their children can participate fully in Australian society in what ever way they want, law enforcement and a sense of value and control over their futures. Perhaps when we start to seriously address the social justice issues around being Aboriginal or living in a remote community in Australia we will be able to prevent the social erosion that we see today. None of this can be done without talking to the Aboriginal people themselves, listening to what they believe will make a difference and then putting in the resources to make it happen. A classic example of course is their fight to birth on their land with the belief that a culturally safe birth will lead to stronger communities. A request that has been made over and over again for many years. A request that continues to be ignored and a request that would see a greater role for midwives in this primary health care setting. This is an area that I believe we need to work differently in. We must work side by side with Aboriginal women to begin to understand what culturally safe birth means to them. There are some isolated programs that are providing tremendous leadership in this area and the NSW Aboriginal Maternal Infant Health Strategy is one. But we have far to go before we see community based teams of midwives and Aboriginal health workers providing caseload care to women close to their homes across the country; care which must include birthing support. We need more midwives to be community based.

But before I go on, let me return to the importance of the Sherpa. When I was travelling through Africa I decided to climb Mount Kenya which is 5,000 metres and quite a challenge. I did think about hiring a Sherpa but thought I could do it just as well by myself. How foolish was I? Halfway down the mountain and one of my knees blew up and stopped working properly. A very kind Sherpa put my pack on top of the pack that he was already carrying, carved out some good strong sticks for me and helped me down the mountain. How could I have thought that I could do it without a Sherpa?

And how can we think that it is all right for women to climb their mountain without a midwife? How many of you here have family or friends living in rural or remote areas that are of child bearing age? Can I see a show of hands please? In November 2006 a new Medicare Benefits Schedule Item (16400) was introduced by the Department of Health and Ageing. The item will allow doctors, who do not have to have obstetric training, and may never have worked in the Australian maternity care system, to claim Medicare for nurses, who do not have midwifery qualifications, to provide antenatal care on their behalf. This will only occur in rural and remote areas and both practitioners do not have to be living in the same town. This Medicare item was introduced despite a consensus statement from eight Nursing and Midwifery Organisations and the Australian and New Zealand College of Obstetricians and Gynaecologists. One of the most disappointing things that occurred during this process was that the Royal College of Nursing Australia did not stand side by side with the other organisations and instead has been funded by the Commonwealth to develop the education package for nurses to provide antenatal care. We cannot expect bureaucrats or politicians to understand the finer nuances of what this will mean to Australians living in rural and remote Australia. In fact just this week Tony Abbot called it a turf war which shows a complete lack of understanding of the issues. However we can expect that our nursing colleagues would understand and if we had presented a united front perhaps we would not be in the situation we are in today.

Antenatal care is not within the scope of practice of registered nurses in Australia and I do not believe a short education package is going to change that situation. I do not mean to deride either of these practitioners as they are all performing a tremendous job within their scopes of practice. However, families from rural and remote Australia

are already experiencing higher rates of maternal and perinatal mortality and morbidity. How can we hope to improve these statistics by workforce substitution? Internationally the role of midwives in reducing maternal and newborn mortality and morbidity is a core component of the World Health Organisation's (WHO) Making Pregnancy Safer (MPS) strategy. The International Confederation of midwives (ICM) and United Nations Population Fund (UNFPA) believe that many more millions of women's lives would be saved if the world was to invest more seriously in training, recruiting and retaining midwives, we must strive towards this goal in Australia. Particularly at a time when the most recent Maternal Mortality Report (2000-02) has shown an increase in the maternal mortality ratio in Australia. The money for the education package could be better spent on upskilling and refreshing the midwives who are already trained to provide this care however how do we entice them back without changing the way midwives do business across all settings. How many of you have thought about discussing this with your local member?

In conclusion; there are increasing challenges to the delivery of safe maternity services across Australia. We are seeing the closure of small units across the country. Midwives cannot claim Medicare in their own right. How many of you have registered and enrolled nurses working in your maternity wards and how many are unable to recruit staff? How many are able to provide one-to-one midwifery care for women in labour? How many are seeing doula's perform this role instead? Worse than all of these challenges' are the stories of midwives treating each other poorly, a lack of support for students and friction between midwives who work in different areas or different models. We must have zero tolerance to these kinds of behaviours.

But the flip side of all this of course is that we are starting to see stand alone midwifery units, team, caseload and other derivations of continuity of care models. We are being invited to the table to discuss things with politicians and other medical organisations, we are seeing standardisation of education across the country, Professors of Midwifery are multiplying and increasing numbers of universities are commencing the BMID. The organisation supporting the sherpas', the ACM is going from strength to strength through the hard work and dedication of many. In fact a list of all their wonderful achievements over the last few years would take to long, suffice to say that the college is becoming a force to be reckoned with. We have also started

to develop much stronger friendships and alliances with the women themselves, together we are much stronger. Though there will continue to be mountains to climb we must never forget that we are the real Sherpas' and we need to be vocal and we need to stand up and be counted! And on a personal note may I say: think about a stint in the Territory – you'll never forget it!!

Thank you all very much

* References available on request