



O&G  
MAGAZINE

# PEOPLE OF THE LAND

Vol. 25 No.1 | Autumn 2023

a RANZCOG publication



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***RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.***

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# From the President



**Dr Benjamin Bopp**  
President

The one constant throughout human history has been relentless change involving movement, migration, encroachment, colonisation, or invasion. What we then have is historical and ongoing, permanent consequences of the newcomer's culture for those who were there prior.

Indigenous peoples are culturally, physiologically, and immunologically adapted to their home, its food resources and its environment, and the nature of their existence reflects those realities. As the Australian Institute of Health and Welfare says, for Aboriginal and Torres Strait Islander people, good health is more than the absence of disease or illness; it is a holistic concept that includes physical, social, emotional, cultural and spiritual wellbeing, for both the individual and the community.

This edition of *O&G Magazine* addresses some of the contemporary challenges in First Nations Health – we are grateful to all who have contributed.

Last year I had the privilege of attending the Aotearoa New Zealand Annual Scientific Meeting in Christchurch. This is a very well organised and received event, and thanks goes to the organising committee, College staff, presenters of lectures and posters, and to our generous trade display and event sponsors. Our New Zealand colleagues are showing the way in tackling the challenges of First Nations health.

The important focus is on more than the obvious medical and the physical needs but also the cultural. RANZCOG is committed to advancing cultural awareness, sensitivity, and safety for First Nations people through education, advocacy, and recognition of diversity.

In September last year I attended the Pacific Society for Reproductive Health (PSRH) conference in Samoa. The commitment of women's healthcare workers to their communities across the Pacific and their ability to provide care with limited resources is inspirational. The College remains determined to continue its engagement with our colleagues in the Pacific through ongoing financial, advocacy and resource assistance.

The key to anchoring permanent improvement and engagement for First Nations people within any health system is that the system, particularly its providers, also reflect the culture and language of those consumers.

Commencing work this year, RANZCOG's Cultural Safety Steering Group will steer the College to embed cultural safety across all aspects of RANZCOG training programs, education frameworks, codes of conduct and professional standards, and suggest ways in which culturally safe practice can be best included in RANZCOG activities and through the development and revision of existing RANZCOG statements, guidelines and other documents.

Through the efforts of the College's Aboriginal and Torres Strait Islander Working Group and He Hono Wāhine committee, along with engagement of other stakeholders including the Australian Indigenous Doctors Association (AIDA) and Te ORA, RANZCOG is working to have our First Nations College membership reflect First Nation population percentages across Australia and New Zealand.

We hope you enjoy this edition of *O&G Magazine*!

# From the CEO



**Vase Jovanoska**  
Chief Executive Officer

Welcome to 2023 and Happy New Year. I hope you had a wonderful, safe and festive holiday season with your loved ones, and you have had a great start to the year.

I would like to thank all of our members and trainees who continued to work tirelessly over the busy holiday period to provide ongoing quality service and care to patients and communities across Australia and Aotearoa New Zealand.

A new year always brings new renewed motivation, ideas and perspective. As mentioned in my last article for 2023, we have some major projects taking place at RANZCOG this year.

This year we will announce a new President Elect, as well as members of the College Board and the new 13<sup>th</sup> Council, following a formal election process. The 12<sup>th</sup> College Council will complete their term in November and induction of a new Council and College committees will take place.

RANZCOG will submit our Reaccreditation report with the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) in May. Assessing the extent to which the College meets accreditation standards for its FRANZCOG, subspecialty, CPD and SIMG programs, the AMC will review the College's written submission, observe the College's exam and various operational aspects. College stakeholders (trainees, supervisors and external stakeholders) will be invited to comment on the College's training programs and a number of training sites will be visited to gather feedback from key hospital stakeholders. The AMC will also visit the College during July 2023 Council week, to meet with relevant committees and other key stakeholders involved in College governance and operations. The theme of this issue of *O&G Magazine* is *People of the Land* and I think this is a perfect theme to start

the year with. It signifies the idea of embedding our cultures, and the cultures of those who came before us, into the fabric of the work that we do.

Last year, RANZCOG had the privilege of being a notable sponsor at the Australian Indigenous Doctors' Association (AIDA) Conference in the Yugambeh region of the Gold Coast, where we heard from some inspirational Indigenous speakers and had the opportunity to meet with prospective Indigenous doctors to our O&G workforce. It reiterated the importance of the land as the heart and soul of Indigenous culture, the spirit of community and how these aspects weave into every facet of life, including healthcare and the provision of appropriate care and services to First Nations people.

This year, RANZCOG is working towards finalising the next iteration of our Reconciliation Action Plan and a key focus of this Plan is on recruitment and retention, to build and empower a sustainable First Nations workforce in Australia.

In Aotearoa New Zealand, the health reforms are focused on te Tititi o Waitangi, and transforming the health system will create a more equitable, accessible, cohesive and people-centred system that will improve the health and wellbeing of all. RANZCOG's Te Rautaki Māori me te Ara Whakamua (Māori Strategy and Action Plan) continues to guide our work in improving equity in O&G care. Some completed actions from Te Ara Whakamua so far are creating a te reo Māori style guide, review of CPD points for the MIHI501 cultural competence course, and hosting our Aotearoa ASM with a foundation of Māori health equity. All these actions, and others, will continue to grow our understanding of how RANZCOG can best make change towards health equity in Aotearoa.

RANZCOG continued our relationship with Te ORA, and we had the chance to host a webinar where some of our Māori doctors discussed various topics, including O&G during the pandemic, muka and Māori birthing practices. Te ORA also worked alongside the Council of Medical Colleges to develop a cultural safety framework that RANZCOG is excited to implement.

As RANZCOG continues our journey, Te Rautaki Māori me te Ara Whakamua will grow and adapt, and lay the pathway. 2023 will have a large focus on how we support our Māori trainees, with a research project regarding Māori trainee recruitment and retention a top priority.

Cultural safety needs to be acknowledged, understood and respected by all.

I hope that you enjoy this edition of *O&G Magazine*.

# LEADERS FOCUS



**Dr Nisha Khot**  
**MBBS, MD, FRCOG, AFRACMA, FRANZCOG**

This feature sees Dr Nisha Khot in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter  
#CelebratingLeadership @RANZCOG @Nishaobgyn

## **Dr Kirsten Conan** **FRANZCOG**

Welcome to the new year, and I hope all our readers have had some time to rest over the festive season. Dr Kirsten Conan is no stranger to readers of this column. In fact, she is the founder and the brains behind it and I have tried my best to carry on her legacy.

Many of you will also be familiar with Kirsten's work on gender and leadership. This work, and her presentation as the Ella Macknight lecturer at the RANZCOG Virtual ASM 2021, was a clarion call to our profession to change the paradigm of leadership at all levels within O&G. It led to the setting up of the Gender Equity and Diversity Working Group (GEDWG) and Kirsten was the inaugural deputy chair of the GEDWG. The statistics on women's participation in RANZCOG leadership speak for themselves<sup>1</sup> but there is much more to achieve if we are to truly represent ALL the diversity of our membership. On that note, 2023 is an election year for RANZCOG. I urge you to watch out for announcements related to elections and

volunteer to take on leadership roles at the College. This is OUR College, and we all belong equally.

However, I digress... Back to Kirsten who runs a busy private practice, TasWomen (by TasOGS), in Hobart, Tasmania. In 2016, she won the Telstra Tasmanian Business Women's Entrepreneur Award for combining her clinical excellence with business excellence. She has just completed four years on the AGES (Australasian Gynaecological Endoscopy and Surgical Society) Board. She is an avid runner and a national level hockey player.

I hope you will enjoy getting to know the person behind some of the most interesting interviews to feature in this column.

### **Could you please tell me a bit about your childhood and early influences?**

I was born in the Kingdom of Tonga in the Pacific to missionary parents. My parents had originally planned to go to Tonga for a year but ended up staying there for more than a decade. My early years in the Pacific can be best described as idyllic. I went to the only English primary school on the main island, Tongatapu. Pacific Islander culture laid the foundations of kindness, community, and connectedness that I have carried with me ever since.

Growing up in Tonga made me realise, at a very early age, the privileged position I enjoyed as an Australian and as a white person. I was part of a minority population in Tonga. Yet, I had so much more than the people of Tonga. I learned to recognise inequity and to question it very quickly. This set me up for the rest of my life where I have continued to question inequities.

When I was 12, we moved from Tonga to Pasadena, California where I lived for a few years. This move was a huge cultural shock. Those vastly different experiences of living in Tonga and America provided powerful lessons in adapting to change, embracing new relationships, and thriving in new environments.

### **How did you choose to study medicine?**

I knew from a very early age that I wanted to work with people. I had a great affinity for science, and loved 'caring' for others. Medicine seemed like the perfect option.

I do not have anyone else working in healthcare in my immediate or extended family. To ensure my view of a doctor's life was realistic, I spent some time doing clinical placements in my local hospital. I loved being in the clinical environment, I loved the teamwork, the continuous learning and evaluating, and the ability to combine practical hands-on work with academic work. I have not yet had any regrets with my choice (although sometimes the nights are very long)!

### **Why did you choose to specialise in O&G?**

I had always assumed I would study paediatrics because I absolutely love babies and children. My paediatric term at Sydney University was just before the O&G term. I enjoyed the term at the Royal Children's hospital, but it did not draw me in enough.

My next term was O&G. I loved everything about it! Working with women, the blend of surgery and



Dr Kirsten Conan

medicine, and the fact that this essential healthcare could make such a difference for more than one generation. I also appreciated that women's health was often neglected in under-resourced countries (as I had seen in Tonga), and I saw myself involved in aid work overseas in a very needed area.

I also love the physical aspect of O&G, running around the labour ward, and being in the operating theatre. I enjoyed the adrenaline rush that came from obstetrics and admired the physical demands and finesse I saw with surgery. If I had to go back in time and make a choice I would still choose O&G, even with the long hours, the highs and the lows, and the difficulty of combining parenthood. I feel very fortunate to have a career that I genuinely love.

**You were a medical student in Sydney, and an O&G trainee in Melbourne. What made you choose to live and work in Tasmania?**

Tasmania is a stunningly beautiful state. For us, the call to move from the mainland was to improve our 'work and play' balance. As hoped, the slower life of Tasmania has fostered our genuine connectedness with people, our chosen activities, and with nature here.

Why work in Tasmania? Tasmania is an impoverished state, and one with complex health problems and needs. We have held some of the highest preterm birth rates in Australia, some of the highest rates of teenage pregnancies, and some of the highest rates of smoking in pregnancy in Australia. Whilst committed doctors are changing this narrative, the clinical work remains incredibly fascinating and challenging. Plus, it's usually an incredibly short commute to work!

**Could you please tell our readers about your work around return to work practices after a baby?**

I had two children during my training. My first was born when I was a third-year trainee and my second

when I was a fifth-year trainee. I took just over 10 weeks off after the birth of my first daughter, and 14 weeks off after the birth of my second daughter.

Feeding my babies with breastmilk for 12 months was an important personal goal for me (while acknowledging that I am a proponent of a 'fed baby' and 'healthy mum' being the ideal).

Going back to work with fully breastfed babies was challenging, but not a reason not to try (at least not me). At the time I did not know of any trainees who had gone back to work in the same capacity, worked the same hours (98 hours in my first week back), and had managed to continue to feed their babies breastmilk for 12 months. Instead of seeing barriers, I saw this as an opportunity for change.

At the time the Royal Women's Hospital in Melbourne didn't have a breastfeeding room, staff breast pumps, or training structures to facilitate pumping during labour ward shifts or operating days. I was often pumping in toilet cubicles or behind doors. I decided it was time to change that – more out of necessity than anything else. I worked with the hospital to create dedicated spaces for pumping and feeding and looked at how we better supported trainee rosters for those pumping or feeding. At the time I did not recognise how fortunate we were to have this happen, and with minimal opposition (I was aware of other institutions who were less responsive). I remain very grateful to everyone who supported the changes during this time, and those who have continued to move this space further forward.

I also must mention my mum, and my nannies, who were incredible sources of support during these early months, often bringing my babies to work for feeds around my busy roster.

**What led you to the study of gender and leadership?**

I have always loved learning and I equally love teaching. As doctors we are expected to be able to teach. Some of us have a natural talent for it, but I suspect many of us would benefit from formal teaching education. I have always seen the value in having formal education underpinning professional skills and this led me to a Master's in Clinical Teaching at the University of Melbourne.

The choice of studying gender and leadership was a happy rostering accident. At the time I was working in Darwin as a junior consultant, with both clinical and teaching responsibilities. The subject 'Gender and Leadership' was a good timetabling match, and much less of an interest. However, once the subject began, I was drawn in and found myself having multiple light bulb moments. My awareness of gender bias and discrimination, that had personally felt subtle (much of which, I appreciate now, was because it was 'normalised'), was now clear and evident in medicine all around me. I became incredibly curious to learn how gender bias and discrimination was experienced by others around me. It was this curiosity that led me to do my Masters project on Gender and Leadership in O&G in 2018.

**Please describe your own leadership journey for our readers.**

I would describe myself as an introvert. However, when I feel strongly about a particular subject, I will always use my voice and advocate for change (so an introvert with moments of being an extrovert!)



*Dr Conan (front, second from right) with her hockey team*

My leadership journey has come about from a combination of hard work, planned and unexpected opportunities, and a desire to change or progress an environment, especially when it appears unequal or unjust.

Leadership is a huge privilege, but equally a huge responsibility. To ensure I am leading and supporting my team, board, or organisation in the most appropriate way, I have participated in multiple leadership courses, including the Australian Institute of Company Directors (AICD) foundational course, and Monash University's Women in Leadership program. This year I am undertaking the Royal Australasian College of Medical Administrators' (RACMA) Executive Leadership course.

One of my favourite opportunities with leadership is platforming others. I have had the fortune of some amazing mentors to guide me in my leadership journey, and platforming others is one way to express my gratitude for those who led before me.

#### **What advice would you give to anyone who has leadership aspirations?**

We are all leaders in different ways, so we should all embrace the privilege and responsibility that leadership brings, whether it be at home or at work.

Doing this however it not always easy. Finding good mentors is such a valuable key to successful leadership. You may need to have more than one mentor for the different roles you have, for example, you may have a mentor to guide you through the challenges of a private practice, another mentor might help facilitate your development as a surgeon, and another to aid your professional growth as a leader. Don't limit your number of mentors.

Engaging in formal learning in the leadership space can be incredibly helpful in both understanding the principles that underpin effective leadership, as well as teach you non-clinical skills such as public speaking, chairing meetings, reconciling accounts, or performance appraising your board members.

One of the most important pieces of advice I have in leadership is to please open the leadership door for others, especially for those who are different from you, to ensure that we achieve both depth and breadth in leadership.

#### **What changes have you witnessed in O&G and what does the future of O&G look like to you?**

If I think too hard about that it makes me feel old!

I perhaps belong to one of the last cohorts of trainees who learned predominantly open surgery (abdominal and vaginal). The advent of laparoscopic surgery has been the single biggest change in O&G I witnessed during training. Within the first few years as a consultant, I realised that my practice would be mainly laparoscopic surgery and these days I rarely do any open surgery.

Another game-changer was noninvasive prenatal testing. It was a novel idea when I started in O&G training, and now is offered to all pregnant women (acknowledging the limitation of cost for many).

The future for O&G (and other specialties') training will need to evolve. We should no longer train all O&Gs in the same way, while expecting them to work in vastly different environments. The skills required to be a rural generalist obstetrician-gynaecologist are very different from those required to be a city-based private obstetrician. I do feel RANZCOG continues to respond to our evolving workforce issues, but our

best response will likely come if we all collectively grapple with these issues and together work out progressive solutions.

The question of splitting obstetrics from gynaecology (and vice versa) remains a valuable one. I am not yet settled on an answer.

**The last two years have been challenging for all of us. Have you found some silver linings, and what have they been?**

I am so very fortunate to be living in Tasmania. The impact of COVID-19 was not as far-reaching as seen in Victoria or New South Wales. We benefitted from the lessons learned from mainland Australia before we had our peak in December 2021.

As for silver linings, COVID-19 shone a light on healthcare. Not a silver lining, but a light on our struggling healthcare system, that I hope will now get the attention and investment it deserves.

On a personal level, COVID-19 was a reminder of the value I place on time. How I spend it, and the importance of time with family and close friends. Reducing the amount of travel was a silver lining as I had more time with my husband and daughters. However, I very much missed the connectedness of visiting family and friends, and the collegiality of colleagues at face-to-face conferences and board meetings (such as AGES). As a regional Fellow during the era of 'living with COVID', hybrid conferences might be the 'silver lining' I value most professionally.

**How do you unwind?**

My absolute favourite way to unwind is to run. I often have my best reset, as well as most creative and inspired ideas, when my mind is focused on simply putting one foot in front of the other.

I also now love playing Hockey, less so to unwind, but as a constant in my toolbox to maximise my mental health and physical wellbeing. I returned to the sport four years ago at the insistence of my oldest daughter (who is a Tasmanian state goalie) and her coach, an ex-Hockeyroo (Bianca Pritchard).

I have so deeply valued being back in a sports team (having last played at university, aged 19 years). I have found myself inspired to update my learning on nutrition, tactics, skills, mindset, as well as all things strength and fitness! Refreshingly, during my first season most of my teammates didn't know what I did professionally, and I was simply teammate 'KC'. At times my teammates have been a lifeline, and the sport a valued gift during difficult professional times. I have now also had the enormous privilege of representing my adopted state at the national level in the Australian Hockey Masters, and hope to do so for many years ahead.

**Reference**

1. RANZCOG Activities Report 2021. Available at <https://ranzco.edu.au/wp-content/uploads/2022/08/Activities-Report-2021.pdf>

# Get to know College staff

With so many people working behind the scenes with a shared passion for excellence and equity in women's health, here's a chance to get to know College staff and the diversity of skills and experience they bring to our vision and mission. Catch up with previous issues' featured staff on the *O&G Magazine* website.



**Cynthia Tapiwa**  
Project Lead, Engagement and Rural Health

Cynthia leads the *Maternal Health and Gynaecological Services in Rural, Regional and Remote Australia: Uptake, Barriers and Recommendations - Mapping Research Project*. The aim of the project is to develop an overview of rural, regional and remote services. This will help identify workforce and service gaps. Recommendations will then be made to the Federal Government to support service and workforce planning.

Cynthia has over ten years' experience leading projects that helped improve healthcare access in Australia and the United Kingdom. These include a project that focused on bowel cancer late diagnosis in North London, and most recently, programs that helped address health and workforce inequalities faced by rural Victorians when accessing primary care.

Cynthia completed the UK National Health Service Graduate Management Program, has a degree in Finance and Information Management (with honours) from the University of Westminster, and completed postgraduate studies at Kings College London in Managing Healthcare Education.



**Sara MacArthur**  
RANZCOG Events Lead

Sara is responsible for managing the operational aspects and successful delivery of the College's major Events: RANZCOG Presentation Ceremonies, the RANZCOG ASM and the RANZCOG State Symposium. Sara has also been responsible for the delivery of RANZCOG's virtual and hybrid events including the RANZCOG Virtual ASM 2021, RANZCOG Women's Health Summit 2021, the RANZCOG Melbourne Symposium 2022 and the RANZCOG Webinar Series 2020 to present.

Sara's experience extends to over 19 years across the higher education and live music sectors. Sara is extremely passionate about events, undertaking pro bono work in live music in her spare time, and has worked on the Big Day Out, Falls Festival, Meredith Music Festival, Soundwave and the Reservoir Stomp. She is also a member of the Media, Entertainment and Arts Alliance (MEAA) and the Professional Conference Organisers Association (PCOA).

Sara holds a Bachelor of Commerce degree with a double major in Business Economics and Accounting.



**Lai Yue Aitken**  
**Fetal Surveillance Education Program Team Lead**

Lai Yue joined RANZCOG in 2005, working in the Nuchal Translucency, Ultrasound, Education and Monitoring Program (NTUEMP). After five years with the program, Lai Yue moved into Assessment Services (Examinations) as Coordinator for the RANZCOG written examinations.

In 2017, Lai Yue joined the Fetal Surveillance Education Program (FSEP) team, providing support to both administrative staff and twelve educators in Australia and New Zealand. Working with both internal and external stakeholders, Lai Yue manages the business operations of the program. The team delivers over 300 multidisciplinary face-to-face workshops and webinars per year to all professionals involved in antenatal and intrapartum care.

Lai Yue holds a Bachelor of Economics and has previously worked in Information Technology in both private and public sectors.



**Holly Robb**  
**Education Development Lead**

Holly is responsible for leading the eLearning and education programs teams within the Learning and Continuing Professional Development department. In collaboration with subject matter experts, Holly oversees the design, development, implementation, and evaluation of RANZCOG workshops and eLearning modules that support our training and CPD programs. In her first 18 months at RANZCOG, Holly has supported several significant projects, including launching the Acquire eLearning platform, updating the PEMNeT Facilitator Guide in consultation with the Global Health Committee and PSRH, and assisting resource development for the OGET Program.

With a double Bachelor's degree in Education and Science, Holly worked for six years as a Secondary School maths and science teacher before shifting into the world of education design and development. She worked at Victoria University as a Learning Designer for two years before joining RANZCOG in 2021. Skilled in collaborative problem-solving, quality assurance, and instructional design, Holly is excited to continue improving RANZCOG's education programs in 2023 and beyond.



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# Editorial



**Dr Marilyn Clarke**  
**Chair, Aboriginal and Torres Strait Islander**  
**Women's Health Committee**  
**O&G senior staff specialist**  
**Clinical Director, O&G Coffs Clinical Network**  
**Worimi**  
**Senior academic advisor,**  
**Southern Cross University, Coffs Harbour**

This issue is timely in both Australia and Aotearoa. In Australia, there is current discourse around a referendum for a Voice to Parliament, and subsequent Makarata (truth telling commission) and treaty.

Not being a 'clinically heavy' issue, the temptation for many, we suspect, will be to have a brief flick through the issue and not pay

much attention to the articles within. As doctors and responsible members of society, we have a duty to uphold principles of health equity and advocate for those in society who do not enjoy the same health as the incumbent majority. It is just as important to be well informed and across the issues in Indigenous health as it is to know about a surgical procedure or an obstetric guideline.

Australian Aboriginal and Torres Strait Islander peoples were Australia's first peoples. There were over 500 nations when the early European settlers arrived. Hence First Nations people is an apt description. Our sovereignty was never ceded, there was never a treaty. Colonisation, or invasion, led to irrevocable impacts on First Nations people, with an ongoing legacy to this day.

For far too long, discussion on Indigenous health issues has been through a deficit lens. We are all well aware of the disparities that exist, and the time has come for action. The stories in this issue are inspiring and speak to the strength of our culture and language. We need to be empowered to make positive changes. Non-Indigenous culture and knowledge can be so much richer if Indigenous ways of knowing and holistic approaches were valued and incorporated.

## Further reading

Uluru Statement from the Heart. Available from: <https://ulurustatement.org/the-statement/view-the-statement/>

Aboriginal and Torres Strait Islander Voice. Available from: <https://voice.niaa.gov.au/#>

*Please note: Dr Leigh Duncan, Chair of He Hono Wāhine, is a co-editor for this issue, but was unfortunately affected by the devastating floods in Aotearoa. Her editorial notes were lost when her home was flooded. We will make Dr Duncan's editorial available in the digitised version of this article on the O&G Magazine website as soon as is practical. Our hearts go out to all those affected by cyclone Gabrielle.*

## Have you read about changes to CPD?

Continuing Professional Development (CPD) is an essential part of maintaining your RANZCOG Fellowship, and we are committed to making it as straightforward as possible to meet your CPD requirements.

Recently, changes have been made to the way RANZCOG delivers CPD, to simplify the process and ensure that all of our Fellows are supported in gaining hours.

Read about the changes on the RANZCOG website:

[ranzocg.edu.au/cpd](https://ranzocg.edu.au/cpd)

Changes comes into effect from 1 July 2022.

More information:

E [cpd@ranzocg.edu.au](mailto:cpd@ranzocg.edu.au)



# Cultural safety



**Dr Kasey Tawhara**  
**Ngāti Raukawa ki te Tonga, Ngāti Ruanui,**  
**Te Arawa, Ngāti Porou**  
**FRANZCOG**  
**He Hono Wahine committee member**  
**O&G, Rotorua Hospital, Aotearoa**

*"In Aotearoa people have differences in health that are not only avoidable, but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."*

– Ministry of Health New Zealand.<sup>1</sup>

This article focuses on the history and development of cultural safety practice for health professionals in Aotearoa. While the definitions have been adapted over time, the primary goal remains to actively contribute to optimal health for Māori.

As an Indigenous clinician, the author also acknowledges those First Nations Australian academics, health professionals and equity champions who continue to advocate and push for equitable health outcomes in Australia. It is well documented that Indigenous peoples around the world have disproportionately worse health outcomes compared to non-Indigenous people. The colonial history of dispossession of land and resources, the suppression of Indigenous culture, and the exposure to racism have put Indigenous peoples at a disadvantage in accessing quality health care and achieving equitable health outcomes.

Achieving health equity is both a health need for Māori, and also a right under Te Tiriti o Waitangi. Tino rangatiratanga or self-determination, the provision and proper resourcing of Māori-led initiatives, and working with Māori in partnership

to design and deliver health care are some of the principles that outline the Crown's obligations to Māori in achieving health equity.<sup>2</sup>

Cultural safety was first introduced in the late 1980s by the nursing profession here in Aotearoa, and much is owed to Dr Irihapeti Ramsden and those Māori nurses who defined cultural safety as:

*"A focus for the delivery of quality care through changes in thinking about power relationships and patients' rights".<sup>3</sup>*

In 2019, Curtis and colleagues<sup>4</sup> conducted a review of cultural competency and cultural safety terms and definitions, which provided an analysis used to inform the New Zealand Medical Council who were reviewing their approach to cultural competency standards for New Zealand doctors. The definition for cultural safety Curtis et al proposed is as follows:

*"Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment."*

The Medical Council of New Zealand then released their *Statement on Cultural Safety*<sup>5</sup> in 2019 which outlined standards of practice for New Zealand doctors. These drew on work by Ramsden and Curtis with the following key points:

1. Cultural safety focuses on the patient experience to define and improve the quality of care. It involves doctors reflecting on their own views and biases and how these could affect their decision-making and health outcomes for the patient.

2. The Medical Council has previously defined cultural competence as: “a doctor has the attitudes, skills and knowledge needed to function effectively and respectfully when working with and treating people of different cultural backgrounds”. While it is important, cultural competence is not enough to improve health outcomes, although it may contribute to delivering culturally safe care.
3. Evidence shows that a competence-based approach alone will not deliver improvements in health equity.
4. Doctors inherently hold the power in the doctor-patient relationship and should consider how this affects both the way they engage with the patient and the way the patient receives their care. This is part of culturally safe practice.
5. Cultural safety provides patients with the power to comment on practices, be involved in decision-making about their own care, and contribute to the achievement of positive health outcomes and experiences. This engages patients and whānau in their health care.
6. Developing cultural safety is expected to provide benefits for patients and communities across multiple cultural dimensions which may include Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability. In Aotearoa New Zealand, cultural safety is of particular importance in the attainment of equitable health outcomes for Māori.

Recognising that doctors need support in developing their skills and knowledge of cultural safety, the Council of Medical Colleges New Zealand, in partnership with Te Ohu Rata o Aotearoa (Te ORA Māori Medical Practitioners Association), have developed the Cultural Safety Training Plan for Vocational Medicine in Aotearoa,<sup>6</sup> released in January 2023. This document outlines a conceptual framework of cultural safety, placing at its centre the commitment to actively contribute to optimal health for Māori. It discusses key concepts that underpin optimal health for Māori which include Te Tiriti o Waitangi, equity of health outcomes, Indigenous rights, actively challenging racism, and social justice.

It defines key proficiencies for culturally safe practitioners as:

1. engaging in ongoing development of a critical consciousness,
2. examining and redressing power relationships,
3. committing to transformational change, and
4. ensuring that cultural safety is determined by patients and the communities served.

The Training Plan then provides a teaching and assessment rubric to support understanding and development of cultural safety, and a self-assessment tool for monitoring progress. The Training Plan is intended to be used across the medical disciplines, and “to present new training in a format that is easily recognised by practitioners using teaching and assessment methods that are familiar.” The Training Plan is an important step in embedding cultural safety as a normal and standardised practice for medical professionals. Read the full document on the Council of Medical Colleges (CMC) website.<sup>7</sup>

Cultural safety is not confined to the individual health professional. Health practices and health systems are often structured in ways that do not engage patients, further exacerbating health inequities. The principles outlined for cultural safety also need to be applied to our clinics, our hospitals and our health system. In Aotearoa, the recent health reforms and the formation of Te Aka Whai Ora (the Māori Health Authority) are a recognition that the previous health system has historically underserved Māori, and that in order to strive for equitable outcomes a “new” approach to providing health care for Māori is required.

The challenge for us all as health professionals is to be the change agent. To reflect on our own beliefs and attitudes when engaging with patients and whānau. To take a step back and critique the environment and culture we work within and question whether it truly serves the patient in front of us. To challenge the unsafe practice of our colleagues, of our clinics and hospitals that perpetuate health inequities. To actively seek feedback from and listen to what patients and whānau are saying about the care we provide. To be open to sharing our power and influence. May we all be courageous and open to changing the status quo in the pursuit of health equity.

*Mā te rongo, ka mōhio  
Mā te mōhio, ka mārama  
Mā te mārama, ka mātau  
Mā te mātau, ka ora*

*From listening, comes knowledge  
From knowledge, comes understanding  
From understanding, comes wisdom  
From wisdom, comes wellbeing*

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# A day in the life of a Health Worker

**Genavie Tabuai**  
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Wadda Moolie!

Meet Genavie, Natalie, and Joanne, members of the Aboriginal and/or Torres Strait Islander Health Worker and Health Practitioner workforce who currently work with the Torres and Cape Hospital and Health Service (TCHHS) Midwifery Navigation Service. This service supports women who travel to Cairns from the Torres Strait, Northern Peninsula Area and Cape York to access specialist obstetric and maternity services.

Genavie Tabuai (née Sambo) was born and raised on Gimuy (Cairns) and has cultural connections to Daly River in the Northern Territory and the Eastern and Central Islands of the Torres Straits – Meuram clan of Mer (Murray Island) and Masig (Yorke Island) of the Kulkalgal nation. She has a Diploma of Aboriginal and Torres Strait Islander Primary Health Care and is currently working as an Advanced Health Worker.

Joanne Taylor grew up in Cooktown on the beautiful land of the Yuku Baja-Muliku, Kuku Bididji and Kuku Nyungkul clans. Her mum is from Murray Island (Mer), part of the Eastern cluster of the Torres Straits, and her clan is the Komet tribe. Her mum's great grandmother was part of the stolen generation, believed to be moved from Frazer Island to Yarrabah. She holds a Certificate III in Health Service Assistance, Certificate III in Community Services, Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Community) and is currently enrolling into the Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice), and is employed as a Trainee Health Worker.

Natalie Thaiday (née Nicol and Hodges clans) is a proud Juru woman with family kinships connected to Gregory Downs, Burketown, Bowen, royal nobility to Tudu and Gebar Island in the Torres Straits and families from stolen generation survivors. She has a Diploma in Enrolled Nursing, Certificate IV in Aboriginal and/or Torres Strait Islander – Primary

Healthcare Community, Certificate IV in Aboriginal and/or Torres Strait Islander – Primary Healthcare Practice and a Diploma in Aboriginal and/or Torres Strait Islander Primary Health Care. Natalie is currently working as a Health Worker.

Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners are the world's only culturally-based health professions underpinned by national training and regulation. Within Aboriginal and Torres Strait Islander communities, this workforce is renowned as a vital and reliable community resource with evidence directly connecting them to improved health and wellbeing outcomes in their communities. Yet, across mainstream Australia, few recognise them as standalone professions or that they are trained with clinical skills to work in primary health care. Subsequently, they continue to be under-supported, under-recognised and under-utilised.

Genavie, Natalie and Joanne work within a multidisciplinary team of Midwifery Navigators, in partnership with the individual women and their Midwifery Group Practice Midwife. They support and advocate for a collaborative approach that enables women-centred maternity care, whilst integrating clinical care with traditional and cultural practices. Establishing and strengthening formal partnerships with external service providers is critical to facilitate positive outcomes for their patients.

Although there is no standard day in their roles, a typical day might entail reviewing and triaging referrals, providing continuity of care to pregnant women prior to arriving, during their stay in Cairns, and on their return to community. This includes making contact through telehealth or video before arrival, to introduce the team and assist with any logistics for travel or appointments. When the women arrive in Cairns, either for a few appointments or for an extended stay prior to birth, they are warmly greeted by the familiar faces of Genavie, Natalie and Joanne.

They assist their patients by acting as cultural navigators of the health system and partnering with other services to provide transport, coordinate patient travel bookings, organising appointments at hospital or through other external providers such as radiology or pathology services. Additional support is sometimes needed, particularly for high-risk pregnant women who require specialist appointments, scans or confinement. No matter what support is required, they consistently go above and beyond to support women and their families by providing orientation to the town and facilitating access to food, schooling, pharmacy, accommodation and anything else they may need. They do home visits at their accommodation to check in on the condition of the women and their families, assess whether accommodation or housing is appropriate and advocate and support any moves when necessary.



L-R: Joanne Taylor, Natalie Taylor and Genavie Tabuai

Additionally, a key component of their roles involves health promotion and education, early detection and prevention, and health coaching. They address many of the cultural and social determinants to improve health outcomes for women and their families. Some of the focus areas include, but are not limited to, healthy lifestyle, smoking cessation, alcohol and other drugs, sexual health education, prevention and management of chronic conditions, social and emotional wellbeing, perinatal mental health, domestic and family violence, housing and empowering women to self-manage. They also provide antenatal support; assessing fetal growth and baby movements, birthing support; attending appointments, patient advocacy and postnatal support; safe sleeping, breastfeeding and postnatal health checks.

"Growing up, I always questioned why so many First Nations people were passing away from preventable diseases at a younger age-range compared to non-Indigenous people. This always triggered me and became one of the main reasons I joined the health force. To ensure that my people weren't constantly falling through the cracks of the system, I made it my goal to study and learn about the human body and then share that knowledge with everyone, with the hope to encourage them to improve their health and take proper control of their care in an effective way" says Joanne Taylor.

Their cultural knowledge, skills and life experiences allow Genavie, Natalie and Joanne to provide cultural, social and emotional wellbeing support to women and their families. This is an important consideration for those who are travelling away from Country and family. Having cultural knowledge allows them to provide and care through a holistic approach, providing and advocating for culturally safe care and promoting social and emotional wellbeing which can be critical for some women who are birthing away and off Country. They often need to address racism and advocate for

appropriate care, follow up, access, cultural needs and practices and child protection supports. They take an active approach in community health clinics by communicating and encouraging transparency around child alerts and concerns. Having family and community knowledge, the workforce plays a vital role in providing advice and support to other staff and health professionals who may not be familiar with the community.

Although they facilitate positive health and wellbeing outcomes for their communities, the workforce consistently faces many unnecessary challenges and barriers. Firstly, they are under-valued and under-utilised while their scopes of practice don't reflect their qualification and skills. They experience a lack of professional development opportunities to progress their careers, and inequality between salary and work levels. They are also met with challenges in the systems they are working in, with inadequate support services prior to their patients' initial referrals and a lack of facilities, programs and access for women in their communities when they return home. They encounter racism on a regular basis which they need to navigate for their patients whilst also looking after their own wellbeing and cultural needs. It is critical for improvements in human resources to address racism and cultural safety training and practices.

Genavie Tabuai says her motivation is "giving back to my people and community. We as First Nations peoples are disadvantaged in every aspect of life and continue to fight and struggle for adequate opportunities to healthcare, with prolonged chronic conditions due to historic events (colonisation)."

As with most or even perhaps all members of this workforce, Genavie, Natalie and Joanne continue to overcome adversity and work in their roles because they are passionate about improving health and wellbeing outcomes for their mob. They know it is critical to address Indigenous health inequality, and how important it is to support and empower their communities to take their health into their own hands. They want to advocate and support their communities to access enhanced health care, provide education in social, emotional and clinical aspects, and continue as cultural navigators of health systems that are not designed for their mob and their holistic views of health.

They love giving back to their people and find it a privilege to walk beside and care for women that are carrying future generations, and future elders. They are breaking down cycles of intergenerational trauma and reducing the severity of chronic conditions for the next generations. Knowing that they're making a difference by ensuring their communities feel safe and secure is what really matters. Fronting the many challenges gives them the drive to continue their important work and ensure that issues are addressed and prevented for others.

Natalie Thaiday explains, "I love what I do. It is more than a job; it is my passion. As an educated woman I want to continue to encourage, support and advocate for my people so they can take back ownership of their health and health outcomes."

For more information on the important work of Health Workers, go to [www.NAATSIHWP.org.au](http://www.NAATSIHWP.org.au).

*Special thanks to the National Association of Aboriginal and Torres Strait Islander health Workers and Practitioners (NAATSIHWP) for assisting with this article.*

# Tangata whenua



**Dr Sarah Te Whaiti**  
**Ngāi Tahu, Ngāti Mamoe, Waitaha**  
**FRANZCOG Advanced trainee, Te Whatu Ora;**  
**Capital, Coast, Hutt Valley and Wairarapa**

"The only reason you got into medical school is because you are Māori." I have heard it muttered around friends, said to others, and received the comment to my face, not once, but several times throughout undergraduate medical training. I've had similar messages inferred in specialist training too. 'Friends' asked, "why do Māori get in above me when I have the same or higher grades?" Justifying their remarks that I don't deserve my position because being Māori holds no value, certainly not above anyone else's culture. And we all care, so the 'best' people should be doctors, and no special allowances should be made. My question was: best for who?

*Ko Maungatere te maunga  
 Ko Tākitimu te waka  
 Ko Rakahuri te awa  
 Ko Ngāi Tahu te iwi  
 Ko Ngāi Tūāhuriri te hapū  
 Ko Mahuunui II te marae  
 Ko Sarah Te Whaiti tōku ingoa*

My pepeha above explains that Maungatere is the mountain below which my ancestors settled. Tākitimu is the canoe my ancestors used to intentionally traverse the Pacific Ocean hundreds of years ago. Rakahuri is the Ashley River, the water source that has provided life to my people for generations. Ngāi Tahu is the collective name of my tribe, and Ngāi Tūāhuriri my subtribe. Mahuunui is our meeting house where people gather to celebrate, discuss matters of importance, and mourn our dead. I am Sarah Te Whaiti, and my lineage makes me tangata whenua, a person of the land. In particular, I am a person of my ancestral lands in Te Waipounamu (the South Island of New Zealand).

As tangata whenua, you not only come from your specific land but also belong to it; you are a part of it. Your environment begat you. The mountain is an ancestor, likewise, the river and the rest of

the environment are part of your genealogy. They give you strength, prosperity and authority in your region, and you owe them your existence, strength, prosperity, and mana. The reciprocal relationship is a state of being, ensuring both parties are looked after for future generations. This philosophy of connectedness extends to your iwi and community. Your whakapapa (genealogy) tells you who you are, who you are connected to, and what role you have within the community. These connections and relationships span generations. You are your ancestors' realities and hopes unfolding, and your mokopuna (grandchildren) will be yours. This interconnectedness and responsibility to people and place are what being tangata whenua means to me.

I didn't always know that about myself. I didn't grow up in my ancestral lands. I was born and raised in Wellington by a young pakeha (non-Māori) mother. Mum invested in my culture; she sent me to a bilingual unit in a mainstream school, anticipating my desire to be in a Māori environment she couldn't provide herself. My dad moved back to Christchurch, and although he too was disconnected from our iwi and wider whānau, it was through him being back in our ancestral home that our reconnections began. Dad found out about our whakapapa, got in touch with an aunty and, from there, he could link me to our whānau. Over the years, I visited and built relationships. Inadvertently I was opening the wounds of broken relationships, migration, racism and hurt I didn't understand. Yet throughout these years of discovery, I began reconnecting to the depth of who we are and where we belong as Māori.

Sadly, my experience is not unique. The impact of colonisation has been long-lasting, diverse and painful. While some Māori faced land confiscation through force and war, others, like my people, Ngāi Tahu were coerced into unfair land sales.<sup>1</sup> The consequences of these sales were displacement, disconnection from whenua (land), whānau (family), and culture.<sup>1</sup> The Crown's actions also aimed to stifle the language.<sup>2</sup> It was beaten from our ancestors' mouths and marked down for extinction. The Crown also reneged on building promised roads, schools, and hospitals, entrenching inequity for our people. The colonial agenda repeatedly undermined Māori, undermined Māori ideas and ways of doing things, tried to sabotage our successes, and dismissed our claims, entitlements and right to self-determination. The expectation was that Māori would assimilate to be British as if it was superior.<sup>2</sup> Another question: Why was one better than another? What was this based on?

I see the distrust, confusion and hurt continue in many Māori patients. The hospital and its systems weren't built in a Māori friendly way or even with Māori in mind. Many Māori find the environment intimidating, and threatening, a place people go and don't come back from. So, it's hard for Māori to believe that people within the hospital really want to



*Sarah with her future generation: Te Ukiihikitia...*

help, want to change things for the better and can offer support. In the thinking of Māori we ask, why? Why trust this? Why trust these institutions when history repeatedly taught us not to?

Some ask me what's it like to be a Māori trainee/doctor. The truth is more complex than the answer, "It's a tough, demanding, but rewarding responsibility." I have experienced excitement, fulfilment and joy as I have had consultations with women in te reo Māori. If you see a familiar face in a hospital, share a language, share tikanga (customs) and share similar experiences of intergenerational trauma and distrust, you forge a unique relationship. Together, we face the hospital system and its biases, inequity and hostility and make it a little safer for one another. I've had patients thank me for being there. Some patients have waited in clinic to see me because they feel culturally safe and medically acknowledged. I've been humbled to have had patients ask me to welcome their newborn pēpi (baby) into the world using te reo Māori, to ensure Māori was the first language heard.

My experience is that being recognisably Māori helps. Both medical schools, the University of Otago and The University of Auckland faculties of medicine recognised their responsibility to better reflect New Zealand's society in their medical enrolments.<sup>3,4</sup> The policies of the university admissions schemes began to change in the 1990s to prioritise entry of certain groups and rectify the medical fraternity to be a fair representation of society. There is clear evidence that people from different ethnic and socioeconomic backgrounds are more likely to serve their own populations.<sup>4</sup> This service leads to better health outcomes for diverse populations. To better care for, that is, to reduce the inequity faced by Māori, Pacific, rural and now refugee and lower socioeconomic people, students from these backgrounds need priority entry.



*... and Te Rauhuia*

Today we have more Māori doctors than we ever have had. But still, it is probably not enough. We know that our demographics are changing in New Zealand, and by 2050, Māori, Pasifika, and Asian will make up most of our population. So, what's the next step? We need to keep encouraging more Māori into the system and supporting them when they start to follow speciality training. I hope RANZCOG and other training programs find ways to put more value on what the Māori workforce brings to our people. I hope people's commitment to learning te reo Māori and connection to their whakapapa is rewarded. I hope trainees can attain points towards an entry application based on their fluency in te reo Māori, and that RANZCOG facilitates paid leave for trainees and Fellows to attend language courses. I hope RANZCOG meets the responsibility many Māori feel to their community with options to train in their turangawaewae (ancestral lands). I hope the networks of Māori clinicians and He Hono Wahine are invested in, because these groups effectively support our Māori clinicians with understanding, empathy and care. The time has come for our medical fraternity to take these brave moves forwards to keep our healthcare relevant to and fit for our communities. Let us value our patients and our workforce and change the design of our system to provide better care for future generations.

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# My experience as a First Nations trainee



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**Acting Head of Department, New Maitland Hospital**  
**Staff specialist, John Hunter Hospital**  
**AIDA Cultural Safety Facilitator**

Anikanya yantiyn, Amuwang-kinpa. Let me introduce myself. My name is Leila and I am a proud Wonarrua woman who works and plays on Awabakal, Worimi and Wonarrua country. I have three boys and a cat. I try to connect with Country on a daily basis, grow native plants to cook with, weave, and nothing makes me happier than to be with family. I am an Aboriginal woman first, and am never far from my mob. I just also happen to be a Fellow of RANZCOG.

To be clear, this article by no way is reflective of all First Nations people's experiences in training – as I am sure you are aware, we are not a homogenous group. We are all so very different, yet innately there are similarities.

Personally, I grew up in a single-parent family with five siblings and a mother who regularly struggled to ensure we had food and a home with electricity. 'Poor' would be an understatement and ultimately, at the age of 15, I was kicked out from the two-bedroom apartment housing the seven of us (including my sister's children resulting from a teenage pregnancy), where I was forced to find a path for myself. My childhood was entangled with poverty, surrounded by drug abuse and criminal behaviour. However, my parents taught me two clear things: resilience and perseverance.

I got a place, finished school and was offered entry into a university degree. Did I know why I was going to university? Not really, just that this whole poverty thing wasn't all it was cracked up to be and university would help get me out of it. Education mattered. And there I found a new mob, my university mob at Wollotuka at the University of Newcastle. With them gently pushing (an oxymoron I know) me into new open doors, I got into medicine. Throughout my medical degree came a few more life hurdles in the form of an unplanned pregnancy and sadly, domestic violence (a situation known all too well to many First Nation women).

The life lessons leading me to my current career really started growing at this time. What I had the unpleasant experience to learn was, that if you were a young Aboriginal woman, you were treated different. And if you had domestic violence added, you got to learn the unfortunate reality that the law and supports for domestic violence at that time were turned more toward you than the perpetrator. The shame this comes with is unfathomable.

I learnt that my voice wasn't important, that even if you were smart and capable you would be judged. And if you were able to hide your Aboriginality, you should.

I got through that dark space and started working. But ever more, obstetrics and gynaecology was calling, until I inevitably started training. This was thrilling, spectacular and all kinds of "How in the hell am I going to do this?" There were several clear things to overcome:

1. Financial
2. Workload
3. Sorry business
4. Family emergencies
5. Racism and discrimination

Financial barriers were clearly the most difficult. I did not come from a family with any money and had children to provide for. So any extra courses, books or resources were already out, even if this put me behind my peers. That left the minimum financial expectations the College has, annual fees and mandatory courses. Covering this required selling things I owned, borrowing off dear friends and at the end, accepting the added late fees that came and begging for payment plans. Let me tell you the effect on one's wellbeing when you have to apply for a payment plan and have to tell strangers the personal details of why you're broke. It is mortifying. Fortunately, payment plans for training fees are now offered to all trainees to reduce this financial burden.

In regard to workload, well this was excessive but something I was good at until it came to exams. I actually was so afraid of judgement that some of my seniors had no idea I had three kids at home. I didn't want to be seen as not taking the training seriously, or that I was going to require excessive time off. I didn't want to be that registrar who is a burden on the team. This in hindsight was the most ridiculous part of my training experience. This was the College for women's health after all, and if anyone would be advocating for women, it's us. I am so proud of changes the College has made like fractional FTE, no mandatory 1<sup>st</sup> year continuous training, and all the other things that are making training for women easier. I still, however, find the strain we can put on our trainees to work and pass exams to be something we should aim to be better at.

Sorry business, for those that don't know, is the mourning period when a family member passes away and all the following required responsibilities



My 'doctor mob': with (top) Dr Jessica Webb, Dharuk woman (5<sup>th</sup> year trainee) and Dr Nicole Whitson, Gomeroi woman (1<sup>st</sup> year), and (bottom) with Dr Webb and Dr Rhiannon Potter, Kamilaroi woman (1<sup>st</sup> year)

in accordance with traditional custom. Why is this a thing likely to affect training? Well, Aboriginal and Torres Strait Islander peoples die much younger than our non-Indigenous counterparts, so during training there are a significant number of times sorry business will likely interfere with training. This also includes the fact that interpretation of family isn't nuclear. During my training, I lost both my grandparents, mother and then recently, in my first year as a consultant, my father. When you include uncles and cousins, there is an added level of stress. And lastly, the way in which our family members may pass is also likely to be traumatic. A cousin committed suicide, and my father fought a slow battle with dementia and bladder cancer. Competing obligations between training, work and to mob pulling in opposite directions brings a lot of trauma and shame. I missed part of my grandmother's funeral. I am deeply ashamed of this and will likely not forgive myself. My life expectancy is projected to be substantially shorter than my non-First Nations colleagues, meaning I'm already past my middle age and family time is so precious.

This leads into family emergencies – the range and diversity of what can go on in my family never ceases to amaze me. And as the only university-educated family member with a steady income, this can come with its own difficulties. Mental health crises, health scares, accidents and requests for assistance can be a regular occurrence. Things many of my colleagues fail to understand at times but are part and parcel of coming from a low socioeconomic background.

Racism. This is really the only word I've ever seen cause a whole room of white people to become visibly uncomfortable. I am a facilitator of AIDA Cultural Safety training and it is a passion for me to help people assess their unconscious bias and how to improve. A lot of the time, being non-First Nations grants people a level of comfort, being in the position of privilege. Helping people to acknowledge this is powerful. It allows them to see themselves as responsible for equality for all Australians.

We as First Nations people unfortunately can be left in a perpetuity of discomfort. I am tan at best. The most common racism I encountered during training was regarding this and the ongoing racist implications of blood quantum. So many times I just attended the downward gaze and changed the subject, or having to justify to a non-First Nations person my Aboriginality and identity. Utterly exhausting. But, when a fellow trainee asked, "How did you prove you are Aboriginal, because that gets you lots of points?" I found being silent was no longer an option. The lack of cultural education amongst the medical community is obvious and abhorrent. It is also not the responsibility for First Nations people to educate our peers on a daily basis. Australia has a black history, and its lack of acknowledgement is strongly prevalent, which feeds into the chronic disparity of poor outcomes and mistreatment in health.

To illustrate the inconsistencies, historian Peter Read has offered the following conflation, drawing on documented sources:

*"In 1935 a fair-skinned Australian of part-indigenous descent was ejected from a hotel for being an Aboriginal. He returned to his home on the mission station to find himself refused entry because he was not an Aboriginal. He tried to remove his children but was told he could not because they were Aboriginal. He walked to the next town where he was arrested for being an Aboriginal vagrant and placed on the local reserve. During the Second World War he tried to enlist but was told he could not because he was Aboriginal. He went interstate and joined up as a non-Aboriginal. After the war he could not acquire a passport without permission because he was Aboriginal. He received exemption from the Aborigines Protection Act and was told that he could no longer visit his relations on the reserve because he was not an Aboriginal. He was denied permission to enter the Returned Servicemen's Club because he was."*

I could list a million things that helped me get through, but it was my fellow doctor mob who got me there. I am so incredibly lucky to have trained in HNELHD with so many other First Nations women, friends, mentors, and the unwavering support of Dr Marilyn Clarke. This new O&G family surrounds me with support to this day and I hope I have provided the same support for them, which I intend to continue as a Staff Specialist.

If you made it this far, thank you. The overall take home message is – First Nations trainees are an invaluable investment. They are able to support First Nations women and their families on a much deeper level, emotionally and culturally. The positive effect we can have on our communities can be exceptional, which I have experienced firsthand. Closing this immense cultural gap and improving health disparities for our women is a crucial priority. Improving obstetric outcomes leads to improved perinatal and childhood outcomes. It starts with our mothers and their babies. Supporting our First Nations trainees through their RANZCOG training to Fellowship is an urgency that must be championed by the College and its members.

I feel very privileged to be in the position I am as an Aboriginal RANZCOG Fellow, but also extremely proud of my journey and the resilience I hold.

No shame.

# Te ORA heads to PRIDoC

**Te Aniwa Reedy**  
**Kaiwhakahaere/Te ORA Manager**  
**Te Ohu Rata o Aotearoa (Te ORA)**

In July 2022, more than 300 physicians, residents, medical students, and other health advocates from throughout the Pacific gathered for the Pacific Region Indigenous Doctor's Congress (PRIDoC) in Vancouver, British Columbia, Canada, on the unceded traditional territories of the x̣ṃəθḳʷəỵəm (Musqueam), Sḳwx̣wú7mesh (Squamish), and səliwətaɬ (Tsleil-Waututh) Nations.

PRIDoC was founded in 2002, meets every two years, and is made up of six jurisdictions: The Indigenous Physicians Association of Canada (IPAC)<sup>1</sup>, 'Ahahui 'o nā Kauka<sup>2</sup>, Te Ohu Rata o Aotearoa (Te ORA)<sup>3</sup>, The Association of American Indian Physicians (AAIP)<sup>4</sup>, The Australian Indigenous Doctors' Association (AIDA)<sup>5</sup>, and The Medical Association for Indigenous People of Taiwan (MAIPT)<sup>6</sup>.

The intention is to provide a safe space for Indigenous medical practitioners, residents, medical students and allies from throughout the Pacific Rim to share knowledge and experiences, to advocate for better health outcomes for Indigenous populations, and to come together in collegial support.

The theme of PRIDoC 2022 was 'Connecting to the Spirit of the Land'. Jurisdictions were asked to provide 'fresh faces and perspectives' as keynote speakers. RANZCOG Fellow Dr Kasey Tawhara, *Ngāti Raukawaki te Tonga*, was selected by the Board to represent Te ORA in her specialty. Working in an area with a very high Māori population, where inequitable outcomes blight the community, Dr Tawhara focuses on the prevention of cervical cancer, equitable outcomes across her specialty, and cultural safety with RANZCOG. Dr Tawhara has been very active in the Te Rōpu Whakakaupapa Urutā (COVID-19) efforts to secure appropriate resources and positive health outcomes for Māori communities.

Dr Tawhara's keynote was supported by Taonga Puhoro artist Elizabeth Grey, *Ngāti Rēhia*, *Ngāti Uepōhatu*, *Tama Ūpoko ki te awa o Wanganui me Ngāti Tūwharetoa*, from the Haumanu Collective. Elizabeth's skillful display of traditional muscianship was coupled with imagery from artist Turumakina Duley, *Tuhoe*, *Ngati Awa*, *Ngaiterangi*, who's artwork 'Te Ahuri Mowai, a Safe Haven' depicts a space of creation and a space for potential which needs to be nourished and nurtured. The accompaniment of these two Māori artists to Dr Tawhara's words created a moving and stimulating keynote address, which held the PRIDoC delegation enthralled.

Kasey's keynote speech can be viewed here:



Dr Tawhara speaking, accompanied by Elizabeth Grey

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2. <https://kauka.org/>
3. <https://www.teora.maori.nz/>
4. <https://www.aaip.org/>
5. <https://www.aida.org.au/>
6. <http://maipt.blogspot.com/>



Delegates at the Pacific Region Indigenous Doctor's Congress (PRIDoC) in Vancouver, British Columbia, Canada



'Te Ahuri Mowai, a Safe Haven' by Taonga Puhoro artist Elizabeth Grey,



# The Birthing Tree

by Dr Deanne Gilson

The cover image for our *People of the Land* issue is *The Birthing Tree* (2017) by Dr Deanne Gilson.

Dr Gilson is a proud Wadawurrung woman, mother, grandmother and emerging Elder from Ballarat in Victoria. Dr Gilson's art practice is made up of a multidisciplinary approach, drawing on ochre sourced from her Wadawurrung Dja (Country), ancestral history, oral storytelling and incorporating traditional marks alongside new contemporary symbols.

Dr Gilson loves painting the many Indigenous plants of the Australian bush and using her art to visually capture lost cultural knowledge for the future generations to come. This knowledge is often intangible and not visible to the eye as it incorporates the notion of spirit and deep listening that in turn creates a space for healing and overcoming

trauma. Drawing on her Creation Story and tree knowledge, she creates an ongoing series titled *The Wadawurrung Cultural Trees of Knowledge*, incorporating different trees in each painting, and including ancestral knowledge coupled with ways of being and doing through lived experience.

Furthermore, Dr Gilson mixes the beauty of Country with truth telling, exposing the objectification and negative narratives placed on Aboriginal people through the post-colonial male and female gaze. Her art takes the appropriated ceramic kitsch objects of the 1900s, turning them back and opening up the space for revealing the truth behind the artefact and object.

For more on Dr Gilson's practice, visit her website, [www.deannegilson.com](http://www.deannegilson.com).

# Koori Maternity Services



**Storm Henry (Pitjantjatjara)**  
**RM, RN**  
**Koori Maternity Strategy Senior Project Officer**  
**Victorian Aboriginal Community Controlled**  
**Health Organisation Inc.**

The Koori Maternity Services (KMS) program is a unique model of care, and has proven to be an integral component of the Victorian maternity sector for over 20 years. Approximately 30% of all Aboriginal and Torres Strait Islander families birthing in Victoria will receive some care through the KMS program [unpublished data]. The term Koori refers to Aboriginal people from South Eastern Australia, mainly Victoria and parts of New South Wales, but not all people who access the KMS program are Koori.<sup>1</sup> The KMS program provides access to holistic, culturally safe maternity care for Aboriginal and Torres Strait Islander women, boorai (babies) and their families during pregnancy. KMS also supports non-Aboriginal women having Aboriginal and Torres Strait Islander babies, as well as all carers of Aboriginal and Torres Strait Islander babies – such as grandparents and kinship carers.

## Victorian Aboriginal maternity context

Aboriginal and Torres Strait Islander women in Victoria and their babies continue to experience higher rates of severe acute maternal morbidity (3.6% v 1.5%), smoking in pregnancy (41.3% v 7.5%), preterm birth (13.4% v 7.8%), low birth weight (10.9% v 6.5%), stillbirth (7.8 v 6.3 per 1,000 births), neonatal mortality (3.5 v 2.5 per 1,000 births) and perinatal mortality (11.3 v 8.7 per 1,000 births) when compared to non-Aboriginal women.<sup>2</sup>

Culturally specific models of care (sometimes called 'Birthing on Country' services) which align to the RISE framework, have been well established as effective in many domains, including in the reduction of preterm births.<sup>3</sup>

## Koori Maternity Services background

It is important to acknowledge that Aboriginal Community Controlled Organisations (ACCOs) across Victoria have been delivering care and providing

support to growing Aboriginal families for decades, regardless of whether they have ever been formally funded to provide maternity services.

The KMS program was first established in the year 2000 at eight ACCO sites as an advocacy-linkage-health promotion model. KMS was designed by Aboriginal women for Aboriginal families in response to inequity of access to culturally safe care in the mainstream maternity sector. In 2009, the program expanded to incorporate midwives in a clinical model of care, recognising the need to respond to the disparity in health outcomes experienced by Aboriginal mothers and boorai.

Today, eleven KMS programs are located in ACCOs and three have been established in public hospitals.

## Koori Maternity Services program

The objective of the KMS program is to improve equity of access to culturally responsive and high-quality primary maternity care, to each Aboriginal family, in the context of their local Aboriginal community. Each KMS team:

- Provides comprehensive, flexible and holistic pre-conception health care, sexual and reproductive health care, family planning advice, pregnancy choices information and care, antenatal care, childbirth education, postnatal care, bereavement support, breastfeeding assistance and early parenting support;
- Facilitates relationships between women and birthing hospitals;
- Embeds culture and health promotion activities into holistic pregnancy care;
- Delivers continuity of care across the antenatal and postnatal periods to birthing families;
- Provides additional support and care co-ordination for families who may be experiencing vulnerabilities;
- Collaborates with other healthcare professionals, specialists and services to ensure each family's needs are met; and
- Utilise trust and relationships to improve outcomes for Aboriginal and Torres Strait Islander women and babies.

The KMS program also strives to improve health and wellbeing outcomes and specifically aims to:

- Optimise the health and wellbeing of women and their babies;
- Identify and manage maternal and fetal risk factors, particularly early in pregnancy; and
- Reduce perinatal morbidity and mortality, including incidence of preterm birth and low birth weight babies.<sup>4</sup>

This state-wide program is delivered by Registered or Endorsed Midwives, Aboriginal Health Workers and Practitioners and Aboriginal Hospital Liaison Officers who work in a complementary team of two or more



The ultimate goal for the KMS program is that all Aboriginal and Torres Strait Islander families in Victoria receive culturally safe maternity care. This encompasses the health and wellbeing of boorai, parents, and entire kinship network from pre-conception through to the conclusion of the postpartum period, acknowledging that healthy pregnancies and positive early parenting experiences have the power to transform the health and wellbeing of the entire Aboriginal community. This aligns with the overall vision of the Victorian Aboriginal Community Controlled Health Organisation (VACCHO): “Vibrant, healthy, self-determining Aboriginal communities”.<sup>5</sup> VACCHO is the peak representative body for Aboriginal health and wellbeing in Victoria. The Koori Maternity Strategy team within VACCHO support the KMS programs across the state and advocate for systemic maternity care reform.

## A social model of health

KMS programs and the ACCO sector meet the needs of the Aboriginal and Torres Strait Islander community in Victoria by operating as social models of health, recognising how cultural, spiritual, social, political and environmental factors contribute to physical and emotional health and wellbeing. Even when a client may require obstetric input, KMS programs and ACCOs are well placed to provide additional or intensive support to families, including:

- dental care;
- nutrition and exercise initiatives, including community lunches;
- social and emotional wellbeing, including mental health support;
- housing support;
- smoking cessation programs;
- alcohol and other drugs recovery and support;
- sexual and reproductive health services;
- respectful relationships programs and specialist family violence support;
- maternal and child health;
- visiting specialist services, such as paediatricians;
- dedicated groups for men, women, Elders, children, youth, “mums and bubs”;
- community events for culturally significant dates and health promotion opportunities; and
- transportation to medical appointments.

KMS programs are not bound by the same time structures, busy clinic lists and rigid hospital policies



Figure 2. The RISE framework of First Nations maternity care

as mainstream services. Structured booking and triage processes keep hospitals ticking, but prevent most women from receiving pregnancy care in the hospital during the first trimester. In hospital, social and cultural support is often limited by visitor policies. At the same time, rigid funding models and service demands in the mainstream sector prevent most women in Victoria from receiving postnatal care in the home beyond one-week post birth.

The KMS teams have access to a dedicated vehicle allowing for the flexibility to offer assertive outreach in a client's home and extended postnatal care up to six weeks postnatally. On average, women who receive care through KMS receive 16.5 hours of care outside of hospital admission/s and mainstream care, which is 3-4 times higher than women receiving care through the public hospital system alone [unpublished data].

Most importantly, KMS provides continuity of care to women who may not otherwise receive it. The benefits of midwifery continuity of care have been well established for all women regardless of risk profile, but Aboriginal and Torres Strait Islander women are often "risked" or "costed" out of midwifery continuity models of maternity care. Outside of Melbourne, there are very few hospitals that offer culturally specific models of maternity care. A recent Victorian study demonstrated that over 90% of Aboriginal and Torres Strait Islander women wanted access to midwifery continuity of care when it was made available to them.<sup>7</sup>

### Partnerships and collaborations are key to KMS success

KMS is not in competition with other care providers or services. The success of KMS comes down to valuable partnerships and collaborations being at the centre of a family's care. The KMS team collaborate with the family, with each other, within the ACCO, and with the birthing hospitals, specialists and other external services. KMS also collaborates with hospital-based cultural models of care.

Families meet with their Maternal Child Health Nurse during pregnancy in alignment with the Aboriginal Maternal Child Health principles to ensure continuity of care across the early years. KMS teams collaborate with some incredible obstetricians and GP obstetricians to provide care to women that primary health and community health services are unable to provide.

Advocating for formal partnerships, streamlined two-way collaborative pathways and referral processes, as well as sharing of information systems and professional development opportunities can build and advance your relationship with local ACCOs and the Aboriginal and Torres Strait Islander community.

It is our shared responsibility to ensure that Aboriginal and Torres Strait Islander families receive equitable access to quality and culturally responsive maternity care.

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# Oriori Mai, Oriori Atu



**Kelly Waiana Tikao**  
**Waitaha, Kāti Māmoe and Ngāi Tahu**  
**PhD, RCpN, Cert.Te Reo, BA Māori, MsciComm**

When I was in high school, I was handed a copy of Bruce Chatwin's book, *The Songlines*, about his journey through the Australian outback researching the Aboriginal Australian Songlines. I was intrigued by the concept of people singing their landscape into being and creating these extensive mind maps. My naive understanding of songlines became etched in my memory to be recalled with more critical awareness many years later.<sup>1</sup>

Songlines trace the Aboriginal Australian routes and roots, that link descendants to their ancestral spirits whom they acknowledge for constructing the terrain they now traverse. By singing about the landscape features, history and natural phenomena they reveal their ancestral pathways. Repetition of their songlines over a span of time intentionally encodes the geographical information and stories into the consciousness of the generations who follow.<sup>1,3-5</sup>

My ancestral land, or turangawaewae, is situated around the Banks Peninsula in Ōtautahi (Christchurch). I was born away from this whenua (land) so I experienced my Marae on major occasions, such as tangihanga (funerals), whānau reunion, hui a tau (annual tribal hui) and Tiriti o Waitangi celebrations. Most of my time in Ōtautahi was at the whānau whare at 54 Cox Street, Merivale. It was worn with the tread of many aunts, uncles and cousins gathering and dispersing.

This little state house carried intergenerational stories expressed in tears, laughter and song. Here, I heard stories of my grandmother when she was younger living at the Pā (village). She attended labouring māmā to assist with their births. She also washed and prepared the tūpāpaku (dead bodies) in readiness for their farewell. This fascinated me that the same person would attend to both ends of life – it made

sense, especially knowing that often at tangihanga creation karakia and recital of whakapapa, and other similar practices could be heard during pregnancy and birth. I stored this precious gem and I called upon it for my Master's and Doctoral research on customary Māori birthing practices.

I was particularly interested in the practices that included: rongoā Māori (specifically herbal remedies for hapū māmā and pēpi care), the use of animal and plant oils, mirmiri (massage), water for cleaning and calming, the use of stones for pressure, the use of whāriki (woven mats) to birth the pēpi and whenua (placenta) upon, the ipu whenua (a repository to carry the placenta), whītau muka (flax cord) for tying the umbilical cord, māripi (knives) made from a variety of natural materials to cut the umbilical cord, karakia (incantations) that endorsed atua as our protectors and waiata as transmitters of knowledge.

Specific waiata known as oriori, pō pō and/or ara reminded me of the Aboriginal Australian's songlines. Oriori can be recited to the pēpi whilst being born and can calm the hapū māmā during labour. The various expression of oriori invites the māmā to move, sing or breathe through the rhythmic chanting or melodic singing. Oriori can express whakapapa (genealogy), highlighting parents, ancestors, victories and defeats from past tribal feuds. Early oriori could include a challenge for the pēpi to avenge a whānau death when they are older. Oriori can also be used to lament the loss of a child and these oriori could be heard at tangihanga as an expression of aroha (love), and to acknowledge the lineage and history of the tūpāpaku (deceased).<sup>2,5,8</sup>

The late Ngāti Porou rangatira (leader) Amster Reedy was instrumental in reinstating oriori and karakia with whānau for many years prior to commencing his doctorate on oriori. He ran workshops to teach and support whānau to write and sing their own oriori.<sup>7</sup>

Ngāi Tahu historian Samuel Robinson wrote that oriori were an iteration of the creation stories that provided insight into the birthing journey the pēpi will commence. Through the many phases of Kore (void) and Pō (darkness) until they arrived in Te Ao Marama (the world of light) – the phenomenon of birth emulates the creation phases of the universe.<sup>8</sup>

*Te kore te Whiwhia – The intangible void*  
*Te kore te kerekere – The unseen void*  
*Te kore te taumaua – The boundless void*  
*Te Po-tipu – The night of growth*  
*Te Po-rea – The night of development*  
*Te Po-tahuri-mai – The night of extension.<sup>3</sup>*

In 1849, Ngāi Tahu rangatira Matiaha Tiramorehu of Moeraki spoke of the atua (Māori deity) singing the world into existence. This was reminiscent of my earlier encounter reading about the Aboriginal Australian songlines.

*Kei a te Pō te tīmatanga o te waiaatanga mai a te Atua.  
Na Te Pō, Ko te Ao, na te Ao, ko te Ao mārama,  
Ko te Ao marama, ko te Ao tūroa.*

*It was in the night, that the Gods sang the world  
into existence.  
From the world of light, into the long-standing day.<sup>2,5</sup>*

Oriori are not only used in the birthing arena but also to settle pēpi post birth. The following is a segment of an oriori that was dictated to historian Herries Beattie by Teone Taare Tikao, my great grandfather, on 18 November 1920.

*E tama, hoki koe nahaku e whakaputa nei koi i tērā  
o te waru  
Oh son, return thou to me bringing forth this vitality  
in the sun for eight months*

*Kai te putanga i tua, kai te putanga i whea, kai te  
Huareare i puta mai ra koe, e tama.  
Appearing on this side, appearing where it is Te  
Huareare (the name of the Moon's mother) brought  
forth by you, oh son, brought forth in the time*

*Ia Te Moretu, Ia Te Moremau, Ia Te Moretaketake  
of Te Moretu (tree planting), of Te Moremau (to  
ensure the roots are embedded in the earth) and Te  
Moretaketake (the tree is firmly planted).*

This oriori acknowledged the gestation period and growth of the pēpi over the nine months whilst in utero. There is a warning or guidance in this oriori to ensure the child is fully prepared for his/her form and to grow strong. It applies a tree metaphor in reference to life and growth.<sup>9</sup>

One of my doctorate recommendations was to create an oriori resource for Māori midwives working in the Ngāi Tahu takiwā (tribal boundary), as an offering to the whānau Māori they were working alongside. An album of 18 oriori were recorded by Ngāi Tahu composers and embedded on a website called Hākui (the Ngāi Tahu term for mother) [www.hakui.nz](http://www.hakui.nz). Two of the oriori were specifically dedicated to whānau who had lost a pēpi, more oriori will be added to this collection throughout the year.<sup>9</sup>

Educator and Te Reo Māori teacher Lynne Te Aika, composed an oriori for her moko that featured on Hākui titled, *Nau Mai Tāku Mere Pounamu*. It was written to welcome a precious child from the womb to the world of light. The aspiration is the child's wairua would ascend to the heavens to be greeted by their tīpuna and be cloaked in whakapapa. Here is a shortened version of this waiata oriori:

*Nau mai rā taku mere pounamu  
Ki te ao mārama e  
Piki mai, kake mai rā,  
kia topa tōu wairua  
Ki kā raki tūhāhā  
Kei reira tūtaki ai ōu tīpuna e kia kakahuria koe e  
tō korowai whakapapa rakatira e  
Kia ako kā mātauraka  
Tuku iho  
I kā whakatipuraka maha  
o Kāi Tahu e*

*Welcome  
my precious pounamu  
into the world of light  
Let your wairua climb, soar  
and ascend to the heavens  
where you will meet your ancestors who will adorn  
you with*

*a korowai of your noble whakapapa  
So, you can learn all of the knowledge that has been  
passed down by the multiple  
Kāi Tahu generations*

Alongside oriori, the Hākui website features information about customary birthing practices, a directory of local Māori midwives and artisans in Te Waipounamu who create art that supports childbirth and a section for Māori Midwifery students. It is an evolving website that in its short lifespan has been an invaluable, free and engaging resource for Māori midwives and whānau Māori in Te Waipounamu and further afield.

As health practitioners working in the childbirth arena, it is essential that we have an awareness that customary Māori birthing practices are currently being rejuvenated around the country. Investing time to find out more about these customary Māori birthing practices will enhance your ability to build rapport and work collaboratively with your whānau Māori who intend to incorporate customary Māori birthing practices in their births. In Ōtautahi, we liaise with researchers, our kaumātua, our Māori midwives, our Ngāi Tahu artists including musicians and composers, our kaimahi hauora Māori (Māori health practitioners), our whānau and our local hapū to assist the liberation of Ngāi Tahu birthing practices. The intergenerational inclusion alongside a wide reach of practitioners will sustain the restoration of Ngāi Tahu birthing knowledge in modern settings.

There is a groundswell of interest amongst whānau Māori and an eagerness to incorporate mātauranga tīpuna (ancestral knowledge) in their birthing journey. What makes rejuvenation a reality is that access to natural resources to create birthing tools is still accessible and often free. Reedy's research, memories of my tāua (grandmother), the skill of the Aboriginal Australian's Songlines and further exploration of customary Ngāi Tahu birthing practices have led to the facilitation of a further seven wānaka (workshops) for whānau Māori and Māori midwives to teach and share knowledge about oriori, taoka puoro (traditional Māori instruments) and whātau muka (flax fibre cords). I am still at the very beginning of this particular kaupapa (area of knowledge) yet I am reassured by the words of Reedy who said, "it's not how far back you go in your culture – it is how far forward you take it."

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# My birthing stories



**Natarsha Bamblett**  
**Speaker, educator and cultural facilitator**  
**Queen Acknowledgements**

My name is Natarsha Napanagka Bamblett; Napanagka is my skin name connected to my Walpiri tribe, as my grandmother was born in Tennant Creek, a part of the Walpiri nation. She was a part of the stolen generation, so that's why we've been integrated down here in Victoria. I also have Yorta Yorta heritage (I was born and raised on Yorta Yorta country in Shepperton), as well as Wiradjuri and Kurnai.

I've got Scottish lines in my ancestry, from my grandfather. My kids have different cultures also in the mix: my first son has Italian and my second son has Lebanese. So we've got a bit of a cultural fusion in the family that makes us as diverse as our own identity.

## A child raising a child

I was a teenager when I had my first son; my partner at the time was younger than me. I was still living under my parents' roof. This huge life event took place and instantly granted me this responsibility, this expectation of maturity and that I should somehow just know what I'm doing. And then on the other hand, medical professionals were saying, 'what do you know? You know nothing.' So I was really hard on myself for not knowing, trying to live up to their expectation, having this feeling of, 'maybe I'm not good enough, maybe I'm not capable, maybe I don't know what is required.' And then society's expectation of, 'oh you're okay you're a mum, you should just know' – and they just leave you. I was a child raising a child. It was a really confusing part of my life.

I was so disconnected from my body. I had been diagnosed with gestational diabetes at 5 weeks, so at 35 weeks they said I had to go back for an extra glucose test, because a scan had picked up that my son's tummy was measuring bigger and they were concerned about it. But I had a different person doing the scan every week, a different doctor, a different midwife or nurse, and there was a lack of communication between the people I saw. I was constantly explaining myself – it started to feel like

I was not just explaining, but having to prove that I could make decisions for myself.

I was induced, they put me on a drip three times, they did every intervention, inserted a catheter, the balloon, the sweeps, they broke my waters and had me on a variety of medications. I did the maximum of everything. After 14 hours labour, a doctor made the decision to get the baby out, using forceps, because meconium was present. But after having an epidural (that didn't work until the third time), they changed their mind to an emergency caesarean. So within 20 minutes he was out and that was it. I remember waking up with about 7 or 8 people at the end of my bed. There was nothing natural about it, and that was the hardest thing for me to process over the years, that it was so forced, and I didn't feel empowered in that situation. I had no idea what was going on with my body. I couldn't make an informed decision in my portal of birthing; I wasn't even asked, I was told. The whole thing was a blur. For a long time I carried this guilt like I'd failed. And that filters into the way we show up as parents.

There was a lot of disconnection in people communicating with me. I remember feeling completely depleted and exhausted, and so afraid of doing something wrong in the eyes of somebody in the healthcare system (a nurse, a doctor) that would lead to a concern of welfare, that my child could be removed – like my grandmother was removed, only two generations before me. That was something I'd carried my whole pregnancy, a feeling of dispossession that was real, and I didn't even trust myself to have my child in my care. As I tried to get my first night of rest after that long labour and birth, I'd asked the nurse – not any nurse; a nurse of colour, another brown woman who I felt safe enough with – I said, 'Can you watch my baby while I get the first few hours of sleep and ready for his first feed?' I didn't want to do anything wrong. But everything that happened made me feel that I was wrong.

Kids teach you a lot about yourself. Over the past eight years of parenting my first son, I've had time to really feel into what I wanted this time around, and how I wanted it to be different. I got to choose that experience for me this time, even though it turned out different to my original plan.

## Older and wiser

I was a lot more prepared even before we conceived my second child. I consciously made the decision to have a baby and I had power in that. I was mentally and emotionally in a position to say, 'this is what I want, and when it happens, I'm ready for that.' We conceived at a beautiful time for both of us; this is my partner's first child, and even being with a partner in a matured relationship was so empowering. Right from the get-go I knew what I wanted and what I didn't want. I didn't want to be handled between different people every check-up; I wanted continuity of care. I paid private midwives and I planned to have a home birth (because of the experience I had last



*Nartarsha Bamblett, strong, empowered and ready for the birth of her second son.*

time birthing in the system) and I had lots of cultural elements and ceremonies set in place.

I went in for a scan at 41 weeks and two days, and my midwife found that my baby was in breech position – but she shared with me the options, and was supportive throughout the whole process. Even though I was emotional (I had just *felt* something was going to be different), it makes me happy knowing that my intuition was right, that I was in tune with my baby and my body. I was just a little saddened that I was going to have this experience in the system again. I knew I carried a lot of fear; that was the emotion that came through when I first found out.

I had to make the decision that day. Within hours they put me in to get a full scan. I was still seeing the same people that I'd been seeing from the beginning. I got given all the relevant information and assured that 'this is your choice. Whatever you choose, we support you.' They outlined all the possibilities and potential complications, so I was able to sit with all this information and make the informed decision, with my partner, to have a caesarean delivery.

I had conversations with the midwife about the cultural elements I had planned for a home birth; she said, 'Bring in all that you want to make you feel supported.' The biggest thing for me was the coolamon, so I brought in a coolamon with possum skin that I had been given. There was communication between the night midwife to the staff doing the morning shift that this was how I wanted to have it, and when we got into the room after me being stitched up, the coolamon was there. After my baby was born, he went with my partner (and the midwife who was with the baby the whole time) where my partner did skin-to-skin, then into the coolamon – and he spent the first two weeks of his life in it. The midwives advocated very strongly for me; people were listening to me.

I had a really empowering experience and for me it was one that I needed. I had the confidence to ask questions that I didn't ask with my first child. It was healing to my fears; to those judgments that I placed on myself, and how medical staff saw me in the system. It was really nice to know that I was heard, I was seen, I was respected and supported. There's still more healing to do from it, and I hope my future births will continue to heal those things.

### Acknowledging and overcoming unconscious bias

Being a teenage black woman, as sad as it is to say, I was seen as the most disadvantaged person in the country. If a person in the system, who has the power to impact my life – in medical care in particular – if they have this view of me, how are they going to treat me? And where does that leave my children? In my experience, there was hostility, there was judgement, there was stereotyping and stigmas like, 'Do you know the dad? Are you with the dad?' Assumptions around how I became pregnant, that I use substances, that I drink, that I smoke – it wasn't *if* I did; it was *how much*? When I went to the doctors to confirm my pregnancy, assumptions were made: 'here's the brochures for your options on termination.' When you are viewed – and constantly reminded that you're viewed – by society through this lens, you can only imagine what picture that paints when you look at yourself in the mirror, and what you believe of yourself.

Unfortunately, that is in great part due to the past 230 years of government policies, and how First Nations people are portrayed by the media. There is a lack of understanding that where a lot of Indigenous people are today is because of the traumatic impacts of colonisation. That lack of understanding creates ignorance in people – they aren't even aware of their unconscious bias.

This is what's led me to the work I do with my business, Queen Acknowledgements: people aren't even aware that they have these stereotypes imprinted on them from something they've seen, something they've heard, that becomes a part of how they interact in every future situation. So instead of wronging them and shaming them for it, I'm there to educate and show people, 1) how they're doing things: the conditioning they already have, and 2) how we can change it moving forward. We all have a responsibility. You don't have to apologise. You don't have to feel shameful (if you do then that's okay too), but I'm not here to hold you accountable for somebody else's actions, a particular history of past generations. But we do have a responsibility for how we show up today, to change what's being done moving forward.

Often, non-Indigenous people are nervous about saying something wrong, offending someone, and I think the worst thing to do is to not say anything at all. Holding compassion for yourself and others when we get it wrong, that's what's missing. Understand that we are all human and we share the human experience of making mistakes, feeling embarrassed.

I come from a culture where women are the glue, the rocks; there's no hierarchy and patriarchy; we're so much more respected, and the respect goes all ways. I think we've lost the true meaning of respect in the translation of what that word is: respect is 're' meaning 'again', and 'spect' – seeing. It's to see someone again and again. We think that respect is earned and there's a power to it. With Indigenous people, we didn't even have 'please and thank you' in our vocabulary. As we shared, we gave, we received,

without any expectation of it meaning anything, or holding a power of 'I've got one over you', or then I owe you, I need to pay back. Everything was ours to share, was ours to give – so respect is that we get to see and give and do this time and time again.

### The power of Country

When I was pregnant with my second son, I went up to Yolngu country, where the Garma festival is held at Gulkula [a sacred ceremonial site]. We were adopted into the family, the kinship there and they shared a little bit with me about birthing, which is very sacred women's business and ceremony. As I was leaving they said, 'you need to come back home, to bring this baby back to this Country.' There they would do a traditional smoking ceremony with the child, where they use smoke to cleanse the baby's energy and any of the trauma associated with birthing. These are some of the practises that are used, and have been used for thousands of generations of women birthing babies – traditional ways and medicines, and the earth, the Country being part of the healing process.

My Wawa taught me that how they know the turtles are ready to lay their eggs was by the inland trees: these trees are 10–20 metres tall, really thin, and when they blossom a flower right on top of the tree, that gives the sign that the turtles are coming in to shore to lay their eggs, and they have this small window of time where they can go and collect them. Everything is speaking and communicating with each other, if you can listen, not just with your ears, but your whole self. This is why Indigenous people have survived for so long; we know how to care for the land because we watched Mother Nature care for itself. We practise imitating it, with the animals, singing to it, deep listening. If you want to learn how to deep listen, go and sit on the Country. Because it doesn't speak to you in the way you want or expect communication to be – it speaks in a different way and you have to listen. You have to be in stillness for it to move you. That's the culture of where I come from.

I was gifted some traditional medicinal balm from up Yolngu country to use on my baby and myself; they go out and collect the leaf fresh on the day, it's not something that you can store (like how we create things that have a long shelf life). That is the beauty of being on Country because you're on the Country's time. Everything has a time and a process, and that creates the patience of life and death, the cycles of it. Your pregnancy has its own season: when women find out they're pregnant, they go and connect to the earth at this time and they'll get what they need, whether it's medicines that they make for when the baby's here, or they collect and make a coolamon for when they are ready to carry the baby, food, water.

The power of being on Country, of birthing on Country, can be incredibly significant. It can be supportive and healing; it can take away a lot of the complications of birth and the aftermath. When we're not born in that environment, for some, it takes a lifetime for us to regain that connection. And that's where a lot of health problems and poor decisions start: the individual trying to seek that understanding and connection with their Aboriginal identity, when they can be so far from Country, place, culture, language, history, family. It's the most incredible trauma, and unfortunately we're still not doing the preventative work [to allow this cultural connection]. I've seen first-hand what the trauma of that impact does to the individual and how it affects others around them. I've seen it kill people.

Think of our body as the body of a river – if it's not flowing, if it's not connected, it's blocked, then we have complications and so much medical intervention. It's because of the interferences along the way before we even get there. But I have such hope and faith in the oldest living culture in the world. I have hope in the knowledge that still is being shared and revitalised, the language and the ways that are being taught, the continuing of the culture.

A dream would be to birth on Country. And that's not just a dream for me, that's for the entire Victorian state and system: to come together to support Indigenous women to birth on their Country. Having the facilities and resources so women can do this their way. To take the technology, the research and combine it with the proven ways of tradition and the resources that our Country holds, to see Western medicine and traditional Indigenous medicine come together to complement one another, and bring Aboriginal ways of birthing into the lives of all birthing women, to experience that love, support and nurture.

### A message for women's health professionals

I would say the most powerful thing that you can do is create a connection. Get to know your patient; get to know your doctor. The best way to support is to ask, and the best way to get supported is to ask. This is the way forward: not to assume, but to ask. When you ask, it gives the person the power to feel informed, to make the decisions, and to give them the control of their experience, regardless of how it turns out.

I understand that we are, as First Nations people, lacking representation on both sides [patients and doctors]. We need to see more Indigenous voices and faces, to feel safe and heard and advocated for.

As a doctor you're there to guide us. You're there to share what you know and support in that medical space, so that the person has as supportive an experience as possible, however the birth goes. Support the desires of the woman, what they want for themselves and for their baby. I believe the way the mother will bond with the baby begins with the birthing experience, and if they feel held and supported, they're going to feel empowered to hold and support their baby.

In this way, you hold and support the future of whole First Nations communities.



*As well as growing her business, Queen Acknowledgements, to work more closely with and advocate for birthing mothers, Nartasha is also filming a documentary of her family's journey as they travel with her grandmother from the place she was raised, back to the Tennant Creek home she was stolen from. To find out more about this project and contribute to the crowd-funding campaign, scan the QR code to visit Funding Napurrula's Homecoming on GoFundMe.*

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# Smear Your Mea

## Raising awareness through cultural connection

**Prof Sandy Morrison**  
**Ngāti Maniapoto, Ngāti Rarua, Te Arawa**  
**Dean, Te Pua Wananga ki te Ao**  
**(Dean, Faculty of Māori and Indigenous Studies)**  
**Te Whare Wānanga o Waikato**  
**(University of Waikato)**

When Talei Morrison, a prominent and respected Māori kapa haka performer, was just 41, she was in Rotorua Hospital supporting a whānau (family) member who was having treatment, when she started to bleed profusely herself. She went to the emergency department and was subsequently diagnosed with cervical cancer – a diagnosis that had been missed by her regular doctor.

In just nine short months between this diagnosis and her passing in 2017, Talei put a phenomenal amount of work into *Smear Your Mea* – a campaign to raise awareness, and to educate and empower wāhine Māori (Māori women) and their whānau about cervical cancer.

Five years on from the campaign's launch, we sat down with Talei's mother, Prof Sandy Morrison, who is continuing to champion her daughter's *Smear Your Mea* legacy.

### On unconscious bias in the medical system

Talei had been visiting her family doctor for 11 years, being continually diagnosed with a urinary tract infection, without it being flagged that she hadn't had a pap smear in that time.

Prof Morrison wonders, "How can you misread flags like that? When do you stop and say, 'This is not right?' That was my shock, that Talei said she was again [mis]diagnosed, and yet she was saying to her doctor, 'I feel like there's something there, and it's really impacting me.' Where we have incredible disappointment is that there was a failure to listen well – and that includes listening to what's not said. If you're a doctor who sees your patient regularly, watch out for these signals when you've got someone who's fitting the high-risk factor. Really feel and listen to the spirit of what they're saying and not saying. Listen to the whānau member who may be with them."

As Prof Morrison explains, "Talei was highly educated, but in her moment of vulnerability, she didn't push for herself. Be aware that even the most educated of us will defer to you as the medical expert. Don't get defensive about your level of expertise – I'm not saying our doctor did, but I've been in situations where the doctor does."

On discovery of cervical cancer, the emergency specialist rang Talei's doctor and asked why there had been no referral for testing. According to Prof Morrison, "Talei's doctor said to us, 'Your ultrasound is going to be far too expensive' – and it was just a couple of hundred dollars. There was just this assumption [that we couldn't afford the test]. When Talei was seeing oncology, again, a doctor said, 'You'll need this medicine that's too expensive, it's going to cost \$300,000.'"

Prof Morrison asks, "How do you know we don't have \$300,000? All these assumptions were made about our capacity and our ability. If they didn't make those assumptions – if they'd just asked 'Would you like to buy this medicine for \$300,000?', I would've said 'Of course, we'll have the money to you by tomorrow.' If they'd have said it's a couple of hundred dollars for an ultrasound, we might still have Talei here today."

"I don't want to say the health system is racist," says Prof Morrison. "I want to say that in this particular circumstance, further investigation didn't happen when it should have, and multiple clinicians assumed something. As a mother, that's the really, really painful part for me."

### Smear Your Mea: How it started....

When Talei decided to launch herself into campaign work following her diagnosis, Prof Morrison says, "I responded with caution and horror – all I could see was attention being diverted from her own level of energy to get herself well. But Talei just did her own thing anyway; she felt this was bigger than anybody."

Prof Morrison admired her daughter's selfless drive to raise awareness and educate, with a higher-level goal of finding culturally responsive ways to target cervical cancer among wāhine Māori, while also embracing wairua (spirituality).

The name itself took a little bit of thinking: "Te Korowai Aroha Rotorua had kindly confirmed that they were happy for us to use the name. You should've seen all the names they'd come up with! Some were very humorous; others were just... not for anybody's ears! But this one was catchy, it was well-considered, and it had meaning; it made people start to think, 'What is this?'"

In Talei's kapa haka world (kapa haka is the expression of Māori culture through dance and song), her fellow performers got behind her, and they leveraged her cultural platform to launch the campaign. Word spread quickly and in no time they

had television coverage. Talei was doing interviews and appearances, and it had a rippling impact.



*Prof Morrison and Smear Your Mea campaigners with then-Prime Minister Jacinda Ardern*

As the campaign gained momentum, more health clinics began requesting to work with communities on the ground. The group set up at kapa haka festivals, sports events and other places where Māori people gather. By simply talking and listening, they were amazed to learn the number of people who didn't have a smear because they found going to medical clinics a very frightening experience.



*The Smear Your Mea information tent set up wherever Māori come together*

Prof Morrison says, "Because we're only a very small charitable trust, and everyone's got limited capacity, we had to really target where we invested our energy. For Talei, it started with the regional kapa haka festivals, but then Te Matatini (Aotearoa's national kapa haka festival) came on board, and through the advocacy work of Te Ururoa Flavell (Former Minister for Māori Development), and the whole whānau, it opened up another avenue where the campaign could have an impact at a higher level."

And that's how the *Ride4Talei* charity bike ride was born. As Prof Morrison explains, "Te Ururoa and Talei were very close, and he promised her before she passed that, 'I'm going to do as much for you [as I can]' – and suddenly he was off just doing it! Finding sponsorship and publicity. It was amazing because the ride meant that we could carry our health message into communities, and promote the fact that we need to be more holistic in looking

after our health – that we all, as whānau, need to take responsibility for our whānau members; that when it comes to cervical cancer, and talking about our 'private parts', the only way that we are going to increase the numbers [of people getting screened] is to actually talk about it, and not be afraid of those conversations. To make sure that we share what we are doing with our families, and that our families encourage that."

Prof Morrison continues, "It gave us access to a whole group of people just through that ride, who started to ask very searching questions, or who would reveal to us past experiences, or anxieties in the present, or looking for help and support – it was such a privilege to visit so many Māori communities and health clinics who showed very genuine and heartfelt manaaki (hospitality, support) to us on that tour. We were thrilled to complete the ride for the pōwhiri (opening ceremony) for Te Matatini, and then be part of the Mana Wahine Collective who set up a clinic for us to educate and do smears – we got close to 50 smears during those three or four days of Matatini, for wāhine who might never have gone into their doctor due to fear. So that was an awesome achievement."

Prof Morrison and those on the ride were able to connect with community members from a place of mutual understanding, creating a safe environment for them to open up. "I was honoured to be privy to all their stories, and hear all of their concerns," she says. "I'm educated, and I'm not afraid to ask questions or to challenge and advocate for others – what a privilege to still hear the concerns that many of our Māori whānau have."

### ... and how it's going

As her health declined, Talei began to consider the future of the campaign and said to her mother, "Well you're mama mia, you make the decision." In reply, Prof Morrison joked, "I don't want to be mama mia! I've got my own life!" But in hindsight, she considers her increased involvement quite serendipitous: "I'm a busy academic, and [my work] has taken a bit of a turn towards the health sector to pay tribute to Talei's work. We had some of my Masters students do an evaluation report. I'm very interested in what research we can do, and I'd really like to give that more attention with other health professionals, on how *Smear Your Mea* can help, so that I've got evidence-based research to help inform our direction forward."



*Te Ururoa Flavell (front left) and Talei's brother Eruera Keepa (front right) leading the ride*

After the *Ride4Talei*, Prof Morrison considered bringing the campaign to a close on a high note. But she was met with protest from the whānau, and Te Korowai Aroha, and other Māori practitioners and health agencies who said, “No, please don’t – the reaction we’re getting is really positive!” And so Prof Morrison was convinced. “It’s encouraging a lot more women to be able to go and have their cervical smears,” she says. “So that’s why we’re still here and we’re about to embark on another *Ride4Talei* [in February 2023]!”

In recognition of the month Talei received her diagnosis, the campaign marks national *Smear Your Mea* day on 30th August each year. Prof Morrison says, “We didn’t know the date was right before cervical cancer month – it was just incredibly opportune! And the number of people who want to use the *Smear Your Mea* campaign to help that month has been incredible.”

Looking to the future, Prof Morrison says, “We don’t want to age the campaign and make it stale – but health inequity is a huge issue, and Māori women still feature disproportionately in all of those numbers. Hence it is normalised – and we don’t want to see cancer normalised. I think as long as there’s inequity, which is going to be a forever job, we’re going to have to exist.”

“But it’s thinking about a more innovative way of existing, and finding ways to get the message across, which may include technology, and champions other than us. The Trust still says it’s kapa haka – Talei’s focus was kapa haka – so reigniting every kapa haka amongst groups. That’s why we thought we’d do it again, [especially as] we had the long break with the pandemic and no Matatini, so in many ways it’s still fresh.”

#### Recognition and support for the campaign

*Smear Your Mea* has been widely awarded and recognised, as follows:

- RANZCOG Māori Women’s Health Award (2020; image below)
- Matariki award (2019)
- Support from Makau Ariki Te Atawhai, the Māori King’s wife
- Continued support from Te Korowai Aroha (ahead of the formal handover of the name)
- Leadership from Te Ururoa Flavell, including support, resources and promotion
- Backing from Trust members and their whānau



Recently, Te Ururoa’s daughter – through her popular clothing label, *Hine* – designed the ‘Poi-Gal’ dress in honour of Talei, and generously supported the campaign with funding and merchandise.

Of their RANZCOG Māori Women’s Health Award, Prof Morrison says, “The College is such a well-established, reputable organisation that embraces clinical practice, as well as culturally responsive strategy. So that meant a lot for us – that we’re not just a community group over here [in Aotearoa], but that the College acknowledged our work from a clinical perspective as well. When you win these awards, and when people give you all this support, you think, ‘Well, I guess we’re going to carry on!’”

#### On working with government to improve outcomes

Since the introduction of the Māori Health Authority in July 2022, Prof Morrison is hopeful that the Trust can work side-by-side with the Ministry of Health for the benefit of wāhine Māori, after a previously fractious relationship. “We don’t know what that relationship looks like,” she says. “We’ve certainly put out feelers on how we can work together. And there was the enquiry into Māori health; we were in a position to have substantive input into that, and therefore we made a submission.”

Additionally, Eruera Keepa – a key leader of *Smear Your Mea* – has had conversations with Riana Manuel (CEO of the Māori Health Authority). Eruera also happens to be Prof Morrison’s son and Talei’s brother.

Prof Morrisons also says, “We’re lucky to have Nadine Riwai (Senior Portfolio Manager, National Cervical Screening Programme at Ministry of Health New Zealand) and Dr Kasey Tawhara (FRANZCOG) working with us in that space, particularly identifying HPV and self-testing as something specific for us to target.”

“We’re aware that lots of people pick up on *Smear Your Mea*, and that it’s catchy. We did start talking about intellectual property, but we’re a bit ambivalent – there’s this common kaupapa (topic, purpose), and in the end, you want women smeared, and you want to know that they’ve taken action with their whānau. So that’s going to be a continual balance.”

Having relied on donations to come this far, Prof Morrison says that a more formal relationship with the Māori Health Authority could be very helpful to secure funding for more resources to spread the message to a wider audience: “We don’t have things like those little pins that organisations put out for breast cancer, but we have ideas on putting out poi (a form of dance) with a message, something that’s really strongly kapa haka. We’re hopeful that we could make quite substantive plans, and all work towards the common end that the Māori Health Authority wants as well.”

Prof Morrison notes that there’s more work to be done when it comes to culturally responsive strategies, and points to the COVID-19 response as an example. “Te Puni Kokiri (the Ministry of Māori Development) asked us to give the key success factors for the work with *Smear Your Mea*, and we did that willingly,” she says. “We saw a lot more targeted campaigns coming from the pandemic, including kapa haka with COVID-19, so we know that the way that our campaign was run has resonance with people who wanted to reach Māori communities. I don’t want that to be lost. It seems so natural to think about who your communities are, and think about a way to respond.”



*"Have conversations with your whānau and friends about each other's health and keep those conversations up. Respect your role as a kaihaka [performer]. Respect kapa haka; the art form that creates discipline, teamwork, commitment and that entices passion, energy, and power, because you never know when your last stand will be."*  
– Talei Morrison [from the Smear Your Mea Facebook page]

#### A message to women's health professionals

If you work in women's health, what can you do to help? Prof Morrison encourages a firm commitment to incorporating mātauranga Māori (Māori knowledge, wisdom, understanding, skill) into your clinical practice.

"It doesn't matter if we've got the Māori Health Authority; whānau should be involved in decision-making, and we're quite capable of supporting our whānau. Even in our discussions with whānau, I just hear all the time about so many whānau that just agree, don't advocate for themselves, and think that the doctor's the expert. Clinicians have to be really, really active in that space when you're with whānau – and I know that limited appointment time is against you, but really reach out to see what whānau think, feel, and can support, because it's absolutely critical in any space. That's incredibly important to us."

"I think that we all need to work together, be aware of what's happening, and leverage off each other's expertise. The complexity of health issues requires a whole lot of clinician knowledge, whānau knowledge, local knowledge; their whānau must be included."

Prof Morrison concludes: "Since Talei has passed, we have had 14 children born into our whānau. Every child that's born then doesn't have their aunty, who would've been a guiding presence for all of them. It's the potential that we've lost, because of people's assumptions. I know that we're not the only whānau to experience cervical cancer, but we're certainly using Talei's platform to highlight some specific errors that were made within that health system."

Our message to women's health professionals is: don't make assumptions about our capacity, our capabilities, or our resources. Whānau is networks. We all want our loved ones with us as long as possible and we really, really need your strong guidance and understanding."

Follow Smear Your Mea on Facebook:  
<https://www.facebook.com/smearyourmea/>

# iSISTAQUIT: change starts with a chat



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These days, how often are obstetricians or GPs likely to come across a pregnant woman who smokes? This largely depends on where you practice and your client base. Socioeconomic status has a marked influence on whether a woman is likely to enter pregnancy still smoking; other factors include

ethnicity. Among Aboriginal or Torres Strait Islander pregnant women, 44% are likely to be smoking.<sup>1</sup> There are many historical and contemporary antecedents behind this figure. Higher smoking rates are often seen in communities with higher rates of poverty and unemployment. It can be used as a coping mechanism for life stressors such as housing stress, grief and loss, and the effects of intergenerational trauma and racism. Smoking is also a vestige from colonisation when tobacco was used as rations. Because of the higher prevalence of smoking in many communities, tobacco smoking may be normalised. Although smoking prevalence is gradually decreasing, the same is so for the non-Indigenous population, which means the gap remains the same. With the draft National Tobacco Strategy aiming for a 5% prevalence by 2030, we must ensure Aboriginal and Torres Strait Islander women are not left behind.<sup>2</sup>

Smoking in pregnancy leads to an increase in complications such as placental abruption, stillbirth, small for gestational age and preterm birth. A multivariate analysis of 2015–17 perinatal data indicates that, excluding preterm and multiple births, 47% of low-birthweight babies born to Aboriginal and Torres Strait Islander mothers were attributable to smoking during pregnancy, compared with 12% for non-Indigenous mothers. After adjusting for differences in the age structure of the two populations and other factors, it was estimated that if the smoking rate by Aboriginal and Torres Strait Islander mothers was the same as that of non-Indigenous mothers, the proportion of low-birthweight babies could be reduced by 33%.<sup>3</sup>

Clinicians will be all too aware of these complications and the importance of smoking cessation in pregnancy. However, how to help women – especially Aboriginal and Torres Strait Islander women – achieve this in an effective, time efficient and meaningful way, is key to reducing the smoking rate. A survey of obstetricians and GP members of RANZCOG and RACGP<sup>4</sup> showed that most health providers (HP's) will "ask", "assess" and "advise", but "assist" and "arrange" had poorer compliance. Additionally, clinicians from more professions in a systematic review across 10 countries globally reported very similar findings.<sup>5</sup> A qualitative systematic review<sup>6</sup> showed HPs found it challenging





to provide effective smoking cessation care (SCC) due to lack of training, time, and role confusion. The inability to address psychological stress in women and inadequate use of pharmacotherapy were additional barriers. Miscommunication and inconsistent expectations between HPs and pregnant women were also commonplace.<sup>6</sup>

**“HPs often asked pregnant women about their smoking status but never provided any practical support to help them quit.”<sup>6</sup>**

**“Clinicians reported they were not responsible for addressing smoking cessation with pregnant women.”<sup>6</sup>**

The elements of effective SCC include carbon monoxide assessment with the use of a smokerlyser, behaviour change techniques, and pharmacotherapy with nicotine replacement. iSISTAQUIT<sup>7</sup> (implementing Supporting Indigenous Smokers to Assist Quitting) has been developed utilising these elements in a training package that is easy to access for HPs as well as visual resources to support their counselling with pregnant women. In addition, the psychosocial context for smoking is addressed in the training, which is crucial to improving quit rates in Aboriginal and Torres Strait Islander women.

The key ingredient of iSISTAQUIT is clinician training. Research has shown that although almost all clinicians state that smoking in pregnancy is a highly important issue, many are not confident or optimistic that their treatment will be successful.<sup>4</sup> Furthermore, many women are motivated to quit when pregnant, but are receiving mixed messages or little support to achieve their aim. iSISTAQUIT aims to address these issues. It includes HP online training that results in clinicians becoming more knowledgeable, skilled and confident to provide culturally appropriate SCC

to pregnant Aboriginal and Torres Strait Islander women. The four-hour training comes as self-paced brief modules to facilitate completion for busy clinicians. It empowers and raises optimism in the clinician to engage in the task themselves rather than only refer on to the Quitline.<sup>8</sup> While the Quitline provides an excellent service, and is a great adjunct, less than 2% of smokers utilise it,<sup>9</sup> and your patient may not take up your referral. CPD points can be applied for completing the training. The supporting resources include a treatment manual, patient flip chart, posters to display in the service, and My Journey booklets for the women. This booklet is a co-designed (with women and community) resource that can be given to women to map and plan their quit journey. Along with easy-to-understand quitting information, the booklet has distraction methods (such as colouring activities) and built-in augmented reality videos (QR codes that can be scanned to play videos). To further improve efficiency in the consultation process, a decision-aid template has also been developed for medical practice software.

The iSISTAQUIT training is currently being utilised in over 30 sites. Trial sites were also provided with smokerlysers, NRT as well as the visual resources and practice software templates. We have received funding to continue to improve the training and resources, and will incorporate further information around vaping, an increasingly seen practice. Our vision is to have the training widely available to services and individual clinicians wishing to utilise them. Our philosophy is that all HPs, including obstetricians, GPs, midwives and trainees, involved in caring for pregnant Aboriginal and Torres Strait Islander women have a role to play in helping her quit. It can be an incredibly empowering process for the woman and if you provide good SCC for Aboriginal and Torres Strait Islander women, you will undoubtedly be providing better SCC to all pregnant women who smoke.

iSISTAQUIT launched a social media campaign last year on World No Tobacco Day with Nova Peris and Donella Mills. This included short films developed by mob for mob aimed at both Aboriginal and Torres Strait Islander pregnant women (inspiring them to join the “smoke free sistahood”), as well as clinicians (with the tagline “change starts with a chat” to encourage HPs to engage with Aboriginal pregnant women in a quit conversation).

We would be interested to receive your feedback on the campaign, which closes at the end of April: scan the QR code to complete the 10-minute survey. You can choose to be entered into a draw to win an iPad when you complete the survey, and your feedback will help us to improve our campaign messages.





## CHANGE STARTS WITH A *Chat*

For more info visit **ISISTAQUIT** today [www.isistaquit.org.au](http://www.isistaquit.org.au)

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# Tukua tō reo kia rere



**Bailey Parata (Ngāi Tahu, Te Ātiawa)  
Kaitohutohu Hauora Wāhine  
(Māori Women's Health Advisor)  
RANZCOG**

*Nei rā te kaupapa o te reo māori e  
He taonga tuku iho nō nga tipuna  
he parekawakawa, he mea hirahira e  
Toku reo, toku ohooho  
mapihi maurea  
Whakakaimarihi*

*My language is my awakening  
It is the object of my affection  
It is the wreath that adorns my head  
My language, my awakening  
A treasure  
It is of the greatest significance*

As a child to a pakeha (non-Māori) mother and a Māori father, who was not raised knowing his language, my journey of learning te reo started as an adult. My Māori grandfather was a member of the New Zealand Māori Council, spoke te reo Māori, and had incredible mana (prestige, influence, status) in te Āo Māori, so I always had a desire to know more, I just didn't know how. As my grandfather has now passed, I will never get the chance to ask the questions of why he may not have encouraged his children and grandchildren to pursue the beauty of our language and capture his incredible knowledge. Although my learning mostly started after he passed, he left me with the most beautiful gift of my culture: my language. This has led to my passion for wāhine Māori health equity.

I remember going to Maori 101 at university in Ōtakou and thinking it's embarrassing to be going to a beginner's class of my own language. Although at first, I was whakama (shy, ashamed) I soon learned that learning te reo is about giving it a go, respecting

te reo as a taonga (treasure), and being part of a generation that will recapture and reignite the use of te reo Māori in Aotearoa.

After graduating from university and moving into my first working role as a Community Kaiāwhina (support worker, health promoter), I knew te reo would be a great asset working within the community. Being whakama often halted me from making big leaps into formal te reo courses or putting myself out there to people who I knew spoke te reo Māori.

When I started at RANZCOG, I was connected with Luke Crawford, one of RANZCOG's kaumatua. When I was discussing with Matua Luke my thoughts around maybe completing a Master's degree, or a full immersion course in te reo Māori, he gave me great advice around learning te reo Māori in wananga-style learning, versus Westernised learning models. Learning te reo also taught me a part of myself that I have not yet explored. This advice has changed my life and my whānau for generations.

From here I went on to enrol in a full immersion te reo Māori course at Te Wananga ō Aotearoa. I decided to jump straight to level 4 with my basic knowledge of some te reo. I was in for a big shock, but the challenge was exactly what I needed to make sure I stayed focused on this journey. Full immersion consisted of three hours of class per week where we only spoke te reo Māori (although my Kaiako Adam was so lovely, and we were so nervous; he was very lenient). We also stayed on marae once a month which was incredible. We learnt through many mediums, waiata, whakataukī, kemu, etc., just like my tupuna (ancestors) would have in the past. When we are on marae, we always do whakawhanaungatanga. An intimidating word to say, but the most beautiful kaupapa. Whanaungatanga represents the sense of family connection. Sharing who we are and where we are from, providing people with a sense of belonging. It is how someone develops a close familial, friendship or reciprocal relationship. As we all learned our reo, we learned more about our whakapapa (genealogy), and the importance of sharing this. We even learned how to speak te reo while cooking, by having a cooking contest and writing recipes in te reo! We learned in so many different ways, it was the most engaging study I have ever done.

As te reo Māori becomes a staple in my own – and my future whānau's – lives, it is important to me for all aspects of my community to be on a journey with te reo Māori also. The language that I have learned has transformed the way I approach my mahi here at RANZCOG. I love practising my te reo with our kaumatua, and te reo-speaking doctors. I feel more confident in contributing to and highlighting RANZCOG's work around equity and cultural safety.



*My beautiful class at Hongoeka Marae*

RANZCOG is on our own language journey, from Djeembana to Aotearoa. Staff and members are encouraged to pursue learning in the languages of the area they live and work, and to take part in any opportunity regarding cultural safety. Although the utilisation of Indigenous language in health care has not been closely examined, articles showing the value of Indigenous language are available.<sup>1,2</sup>

I encourage everyone thinking about learning te reo Māori to have a look at what is being offered in your area, online or in-person. Aotearoa has more and more kaiako (teachers) of te reo Māori; now is the time!

*Tukua tō reo kia rere, let your reo flow!*

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#### Want to learn more?

- **Kupu<sup>3</sup>**  
A Maori dictionary app that translates objects into te reo using your camera
- **Aki Hauora app<sup>4</sup>**  
A free app that teaches te reo medical phrases
- **Te Wananga ō Aotearoa<sup>5</sup>**  
Te reo Māori language of various levels

# Pale, stale, male

## and working in Aboriginal women's health?



**Dr Jared Watts**  
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**Director of Obstetrics/Gynaecology,**  
**WA Country Health Service**

She sat across from me with her eyes looking down. "Any problems with your pap smears or cervical screening?" I asked. She did not say anything back. It was another hot, Kimberley wet-season day and through the clinic window, I could see thunderstorm clouds starting to brew on the horizon. I was sure the pilot was watching them closely.

"Any problems with your periods or your bleeding?" I tried again. She remained quiet, only glancing at me for a few seconds, somewhat warily, out of the corner of her eye.

We were sitting in a small consult room in a remote clinic on the Western Australia border. I had been working in the Kimberley for a couple of years and had started taking on more remote work. That morning, I had driven for a couple of hours, crossed flooded rivers and experienced the tropical weather up close with a very bumpy small plane ride into the community.

I suspected that the patient had travelled about the same distance. She was on my list to be seen as a gynae patient, but I could not find any referral details. With three electronic medical record systems, as well as paper notes, it can be a struggle.

"Do you have any children?" I tried. "Do you want any more children?" I wondered if this was a referral for fertility, or maybe contraception. She shrugged again.

Looking at her, I suspected she might be in her early forties. Her birthdate was the 1<sup>st</sup> of July, which may have meant she was born 'outbush', and her exact age was not known. She was a thin Aboriginal woman who I presumed had lived exclusively in her remote community where there were only a few houses and families.

Getting nowhere, and knowing that English was likely her fifth language, I tried the local word for urine.

"Any problems with your goomboo?" No luck, she remained silent.

After 15 minutes of flicking through paper notes and computer screens, I was no closer to working out why she was on the list to be seen. I started to wonder if the lack of engagement was down to me being a male. From knowing where she lived, I suspected that she held very traditional Indigenous cultural values regarding 'women's business', where such things are not discussed in the presence of males.

I tried again with a general question. "Do you have any women's business problems? Any secret women's business?" For the first time she looked up at me. I was still expecting a short, negative answer when she asked, "You Lady Doctor Jared?" Slightly stunned and somewhat surprised by her answer I replied, "Oh, um, okay, yeah, um, I guess I'm Lady Doctor Jared," also missing the 's' in my answer.

"Oh, I heard about you. You've seen my cousin," she replied. "You come from Broome, Yawuru Country. My cousin says you're okay." While still stunned, I was thankful that I had previously learned that being "okay" in Aboriginal language was actually "pretty good". Otherwise, I would be very worried about my reputation around town! And with that, she continued talking for 15 minutes straight, telling me all about her "secret women's problems." She was then happy for an examination and thankfully Lady Doctor Jared was able to help her with the problem.

A couple of hours later the pilot phoned the clinic and reported that we needed to head off early as storms were coming. As we were heading to the airstrip, I relayed the story to the Aboriginal Health Worker (AHW) who was driving us. I had known the AHW since I was a medical student in Broome. She laughed and told me about the sign in the local store that said: "Lady Doctor here every first Tuesday." That was how I was talked about around the community.

I was somewhat amused and confused as the AHW continued. "Remember your first clinic here when only one patient turned up?" I did. While it had been over a year since that clinic, I remembered being mortified when only one out of 24 patients arrived. The clinic staff had kindly reassured me that it was likely due to the weather, or a funeral in another town.

"Well actually, the women did know there was a young new male doctor coming," the AHW told me. "So they sent one woman to check you out. She reported back that you were 'okay' and thanks to her, your clinics have been busy since." I was stunned silent again, reflecting on what could have been if I had got that consultation wrong!

The AHW laughed, probably reading my face. "Don't worry, remember we taught you well as a medical student back in Broome." I also laughed, remembering our time together with her trying to



Warmun community medical team and patients (L-R) Dr. Catherine Engelke, Dr. Claire Eatwell, Eileen Bray, Mabel Juli, Dr. Jared Watts and Leanne Mosquito.

teach me how to take bloods, dispense drugs and do dressings. But then I realised she was referring to the most important lessons her and other Aboriginal doctors, midwives and health workers had taught me regarding cultural safety.

The AHW replied, "But think about today's consultation and what worked to get the woman to talk to you." I was not sure what she meant, so she continued. "It was once she worked out who you were that you both found a common connection and she knew a bit about you. Then she felt safe and secure, and could tell you about her problems through yarning."

Finally, it started to click. It was the mutual connections, shared relationships, patience, and non-verbal language that had been so vital in ensuring patient-centred care and cultural safety. But it had taken some time to get to this point and it was actually the patient who had done most of the work to ensure the consultation was culturally safe for her.

Embarrassed by this realisation, I decided that I needed to work on this and gain further guidance from other Aboriginal staff and patients on how to improve these vital skills.

Fives years on, I continue to learn every day, to help ensure the care I provide, and the health services I work in, are more culturally safe. The name, Lady Doctor Jared, has also stuck and is proudly on the door when I visit that clinic!

The following is a summary of what I have learnt from my patients and colleagues from working as a cis male in the Kimberley. However, I acknowledge the diversity of all people, in particular within the Aboriginal population right across Australia, and that I still have a lot to learn myself.

### 1. Cultural safety is everyone's business

It could be argued that the gold standard of providing culturally safe obstetric and gynaecological care for Aboriginal women is to have only female healthcare providers. However, we know this is likely not possible and we may cause harm by not teaching and training male doctors in this area.

For example, while the O&G speciality workforce is now predominantly female, there is still a predominance of male Fellows and Diplomates in rural and remote areas with higher percentages of Aboriginal people. With often thousands of kilometres between health services, we need to ensure that all O&G doctors, regardless of their gender, have skills and training in cultural safety, to ensure Aboriginal women feel comfortable and safe to access their local service.

There is also evidence of Aboriginal women presenting to emergency departments or primary care providers, where they are seen by a male clinician who does not enquire about gynaecological symptoms, or offer an examination if required. Without appropriate training and experience, these doctors may feel they do not have the skills to ask such questions in a culturally sensitive and safe way. The patient may not volunteer or disclose these symptoms if they do not feel culturally safe. This can lead to harm through a delay in diagnosis and treatment for these Aboriginal women.

### 2. Relationships

For many Aboriginal people, relationships and personal connections are central to wellbeing. This includes both connections to other people, as well as to their land. I have learned that finding a connection and sharing a part of who you are is essential in creating trust. In my consultations, I try to do this

early through asking where the person has travelled from (their land) and who their community is (their mob). I share where I have come from that day, and which Aboriginal land I grew up on.

Regarding shared connections, I am lucky that I know most of the GPs that refer patients. I always lead with this information. For example: "Oh your GP, Doctor Chevaun, sent you to see me. I know her." Finding these mutual contacts and sharing about myself can quickly give us a connection, and we then have a basis to start talking about personal issues more easily.

### 3. Language

Noting the traditional difficulties in speaking about women's health with a male, I often use local language for certain terms. I am not sure if it is the local words, or the patient laughing at my bad pronunciation, but this further opens discussions. I feel it may also show that I have been around for a while and have a connection to the community.

Personally, I have tried to use local interpreters but without great success, as many remote languages are spoken by only a small number of people who are often known or related to the patient. So instead, I find using a local nurse or doctor who can speak more of the language can assist in smaller communities.

### 4. Non-verbal language

An understanding of local non-verbal customs is also important to ensure cultural safety. In the Kimberley, this can include not making eye contact as a sign of respect. I often sit side-on to the patient during consultations and watch their body language to see how they are reacting.

### 5. Appropriate chaperones

As a male, at times I have found having a female in the room for the whole consultation can create a more relaxed environment. I may speak to the patient, but they then feel more comfortable to address their replies to the female. As with all my patients, having a female in the room for an examination is essential, but it must be someone culturally appropriate. Once again, the AHW or nurse in the community might be a relation, and therefore not appropriate for them to be involved.

### 6. Patience and yarning

In medicine, we are told that often we interrupt the patient within 11 seconds of them starting to talk<sup>1</sup> and this delays us getting to the correct diagnosis. I have found listening and not interrupting is even more essential in Aboriginal health. It is important to let the patient tell their story through yarning, to allow them to 'check you out', develop trust and then tell you the reasons they are there.

### 7. Privacy and shame

In all aspects of medicine, we need to ensure confidentiality, and this is essential in Aboriginal health. For gynaecology, I have learned that when asking patient to do SOLVS or MSU, it is important that when they walk back to the clinic room, that swabs or containers are not seen by others, particularly males. In recalling patients for results, especially in gynaecology, it must also be done in such a way to avoid singling out an individual, which can lead to shame.

Finally, it takes time and effort to build relationships and earn trust. Recently, I was working alongside a female doctor in a remote community. She was about the same age as me but was somewhat new to the area. I noticed the next patient was an elderly Aboriginal woman, and upon reading the referral, I thought she might find it more acceptable to see the female doctor.

Seeing me put her file into the other doctor's box, the patient got angry with me, pointing out she was next. I offered the explanation that she might want to see the female doctor and I received an even bigger telling off. She scolded, "I remember you as a medical student when you came here with Doctor Cherelle. We taught you all about women's business then. I know you have also delivered my grandson, so don't be lazy and you be my doctor."

Feeling both honoured and reprimanded all at once, I quickly hurried her into my clinic room. But she had not finished with me yet. With a huge grin and smirk, she added, "Plus you too pale to be a real man anyway."

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# RANZCOG's work to support cultural safety

## **Sabrina Hanna, Head of Strategic and Cultural Initiatives:**

RANZCOG is committed to ensuring a culturally safe environment for our members, trainees and staff in all aspects of our provision of services.

### **Cultural Safety Steering Group**

The College has set up a Cultural Safety Steering Group (CSSG) that will be responsible for reviewing and recommending appropriate revisions to the College's Cultural Competency statement; revisions to Cultural Competency within the Curriculum Framework and CPD Framework; recommend measures to implement cultural safety culture within and across RANZCOG as an organisation; recommend steps required to ensure RANZCOG meets contemporary standards for a medical College and consulting widely with appropriate stakeholders to obtain their views.

More broadly, the group will steer RANZCOG to embed cultural safety in RANZCOG training programs, codes of conduct and professional standards and suggest ways in which culturally safe practice can be best included in RANZCOG activities, such as through the development and revision of existing RANZCOG statements, guidelines and other documents.

The first meeting of the CSSG took place in February 2023 and was well attended by its diverse representation of members. The group had robust and raw discussions about what cultural safety is, discussed the need for critical reflection and the biases of the clinician (and organisation) in addition to the historical focus on the acquisition of skills and knowledge related to cultural competency.

The drivers to progress work in cultural safety were outlined, including the standards for practitioner competencies in cultural safety as outlined by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ), and the requirements for certification of medical colleges.

### **Cultural Safety Statement**

A draft Cultural Safety Statement is currently being worked on and will seek to clearly define the areas of Cultural Awareness, Cultural Competency and Cultural Safety. The group agreed that as a bi-national College, focus should be on the two main cultures of Aboriginal and Torres Strait Islander and Māori, as our Indigenous populations with specific rights and needs. This is with the intention of embedding cultural safety within our organisation and addressing, acknowledging, and improving Aboriginal and Torres Strait Islander and Māori health inequities, and will expand to provide benefits for patients and communities across multiple cultural dimensions which may include

Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual beliefs and disability.

## **Holly Robb, Education Development Lead:**

### **Aboriginal and Torres Strait Islander Cultural Safety eLearning module**

In December 2022, following consultation with Indigenous Allied Health Australia (IAHA), Aboriginal community members, and the Aboriginal and Torres Strait Islander Women's Health Committee (WHC), the Board approved a recommendation to withdraw the current module and develop a new module that provides meaningful and appropriate cultural safety training to RANZCOG members.

The new module, due to be release in mid-2023, will aim to improve the health and wellbeing of Aboriginal and Torres Strait Islander women, babies, and health practitioners, by increasing the cultural awareness and understanding of O&G Consultants, trainees, SIMGs, and junior doctors. The units will be designed to extend knowledge of Aboriginal and Torres Strait Islander history and culture, explore how bias and the ongoing impacts of colonisation affect the experiences of Indigenous women in healthcare settings, and identify practical ways to promote cultural safety and support Indigenous patients and colleagues.

In the interim, we have recommended trainees watch the 2022 NAIDOC week panel about pregnancy, birthing, & healthcare, explore the C1 Cultural Safety in Women's Healthcare resource page, and complete the AIDA Cultural Awareness Modules.

### **Intercultural competency eLearning module**

This module explores culturally different expectations for clinical communication and behaviours and aims to help trainees develop their own strategies for responding effectively when expectations differ between colleagues, patients, and their family members/carers.

This module was initially developed in 2013 in partnership with the Rural Health Continuing Education (RHCE) scheme from the Committee of Presidents of Medical Colleges (CPMC) and all fifteen Specialist Medical Colleges in Australia. In September 2022, CPMC granted permission for RANZCOG to review and update the content, and RACS has agreed to partner with us on this project.

## **Cynthia Tapiwa, Engagement and Rural Health Project Lead:**

### **Project background**

Women in rural, regional and remote Australia experience unique challenges when accessing

maternal health and gynaecological services (services), compared to counterparts in metropolitan areas. This results in inequitable access of services due to geographical isolation. This inequity extends to workforce shortages, and paucity of service and workforce data to better understand the barriers that impede effective service delivery.

### Project aims

In response to these challenges, the College is undertaking the Mapping Maternal Health and Gynaecological Services in Rural, Regional and Remote Australia: Uptake, Barriers and Recommendations (mapping project) funded by the Australian Government Department of Health (the Department).

The mapping project has the following complementary aims with a focus on the delivery of services in rural, regional and remote Australia:

- mapping the geographic distribution of services, workforce, levels of service, and population demographics; and
- exploring the perspectives of Aboriginal and non-Aboriginal consumers on the facilitators and barriers they face when accessing services.

This is a unique opportunity for the College to produce a comprehensive overview of services, identify current service gaps, emerging workforce and population trends, and barriers to effective service delivery. Recommendations will then be made to the Department to support future service and workforce planning and facilitate steps towards achieving equitable access for all women.

Key highlights of the mapping project pilot:

- The College is consulting O&G Leads in rural, regional and remote hospitals to better understand service delivery. This consultation is part of an ethics-approved research project that covers the following themes: available services, proximity to relevant services, models of care, workforce data, key service delivery achievements and challenges
- The College worked in partnership with Murdoch University's Ngangk Yira Research Centre to conduct yarning circles with 43 Aboriginal and non-Aboriginal women in the Goldfields and Wheatbelt regions of WA
- The College collaborated with Flinders University to conduct yarning circles with 44 Aboriginal and non-Aboriginal women in the Far West Coast and Riverlands regions of SA

### Bailey Parata, Kaitohutohu Hauora Wāhine Māori (Māori Women's Health Advisor):

In Aotearoa New Zealand, RANZCOG continues to prioritise cultural safety and equity for Māori in all we do. RANZCOG's Te Rautaki Māori me te Ara Whakamua (Māori Strategy and Action Plan) continues to guide our work in improving equity in O&G care. Some completed actions from Te Ara Whakamua so far are creating a te reo Māori style guide, review of CPD points for the MIHI501 cultural competence course and hosting our Aotearoa ASM with a foundation of Māori health equity. All these actions, and others, will continue to grow our

understanding of how RANZCOG can best make change towards health equity in Aotearoa.

RANZCOG's relationship with the University of Otago MIHI (Māori Indigenous Health Innovation) Department continues to grow and RANZCOG are so grateful for the amazing mahi MIHI do. With the change in the MIHI501 CPD points allocated, we look forward to not only our trainees filling up these courses, but more and more of our Fellows also. MIHI have adapted their online learning to also create a course for incoming SIMG's who are new to the unique parts of Aotearoa and Māori culture. This is an exciting development to continue to offer cultural competence and safety to RANZCOG members.

As RANZCOG continues our journey, Te Rautaki Māori me te Ara Whakamua will grow and adapt, and lay the pathway. 2023 will have a large focus on how we support our Māori trainees, with a research project regarding Māori trainee recruitment and retention a top priority.

### Sabrina Hanna, Head of Strategic and Cultural Initiatives:

RANZCOG is proud to have made good progress with our First Nations work and our connection to the community over the past year. In early 2022, we had the great privilege of officially opening Djeembana, College Place meaning, 'gathering place', on Boonwurrung land, Naarm (Melbourne) as our new home and head office. Aboriginal Elders David Tournier and Janet Galpin from the Boonwurrung Land and Sea Council conducted the official smoking ceremony and Welcome to Country. Throughout the corridors on each floor of the College are traditional maps of Australia with beautiful colours marking our First Nations communities across the sprawling land. Traditional Aboriginal artwork is on display around the building and various meeting rooms and spaces have been gifted Indigenous names, a reminder and honour to the country on which we work and gather.

We held National Reconciliation Week and NAIDOC Week experiences and events. Natarsha Napanagka Bamblett, a prominent Indigenous leader, storyteller, and advocate for her people, took College staff through a moving session about everyone's connection to land and country. The College also hosted a dynamic and thought-provoking panel discussion with prominent Aboriginal women and leaders in our community, to the 2022 theme 'Be brave. Make Change'.

Through a successful Department of Health (DoH) funding proposal, RANZCOG was able to provide ten professional development scholarships to the value of \$2,500 each, to support Aboriginal and Torres Strait Islander specialist trainees in obstetrics and gynaecology, prevocational doctors, and medical students in attending educational and networking events hosted by RANZCOG.

In late 2022 we had the pleasure of being a major sponsor at the Australian Indigenous Doctors' Association (AIDA) Conference in the beautiful Yugambah, Gold Coast region of Queensland. We had the opportunity to meet with many First Nations medical students, junior doctors, and other organisations. Members of RANZCOG's Aboriginal and Torres Strait Islander Women's Health

Committee, led by Chair, Dr Marilyn Clarke, also facilitated an O&G skills workshop which was very popular at the conference. RANZCOG was also a major sponsor for AIDA's 25th Anniversary Gala in 2022. RANZCOG continues to work closely with First Nations organisations such as AIDA to ensure that the College can understand and provide the necessary supports for our First Nations members and trainees. RANZCOG is a member of the AIDA Specialist Trainee Support Program (STSP) Cross-College Project Group. The aim of the project group is to build cultural awareness across medical Colleges, improve cultural safety for First Nations trainees and members, and remove barriers that impact the recruitment, selection, and retention of First Nations specialists.

A large body of work that is currently being undertaken in a joint capacity with the CPD team, is the redevelopment of our Cultural Safety and more specifically, First Nations health training modules. In 2022, we hosted a small focus group workshop with First Nations women who reviewed our existing modules and provided valuable feedback that has been provided to the CPD team for review.

Work continues our Reconciliation Action Plan (RAP) in collaboration with internal stakeholders and Reconciliation Australia. The upcoming iteration focuses on cultural safety for members, trainees, and staff; recruitment and retention of our First Nations trainees and, the provision of support as they transition through the training program life cycle and into early career. Our First Nations doctors have a profound and significantly positive impact on the Indigenous community and improvement in healthcare outcomes and so it is vital that we support them to continue this important work.

In addition to this, the College welcomed four new Aboriginal and Torres Strait Islander trainees via the trainee Selection process in 2022. We offer support to Indigenous medical students via mentoring and practice interviews, prior to Selection. Where possible, we also provide financial support and mentoring to existing Indigenous trainees on their journey to Fellowship.

## Do you have experience working or volunteering in low- to middle-income countries?

Share your story in O&G Magazine

RANZCOG is committed to improving the health of women and their families, including in the Pacific region.

The College is seeking contributions for O&G Magazine about global women's health. Articles and opinion pieces that highlight women's health issues or initiatives in low- to middle-income countries are appreciated.

Don't have time to prepare a written contribution?  
We can interview you and write the article for you.

Contributions are welcome from all College members.

For more information about contributing to O&G Magazine, go to: [www.ogmagazine.org.au/contribute](http://www.ogmagazine.org.au/contribute)



## Q&amp;A

For the broader *O&G Magazine* readership, balanced answers to those curly-yet-common questions in obstetrics and gynaecology.

Q

## Urodynamics: who, what, when and how?

**Dr Ellen Yeung**  
MBBS, MRMed, FRANZCOG  
Urogynaecology Fellow

**Prof Christopher Maher**  
MBBS, FRANZCOG, CU, PhD

A

It is often said that 'the bladder is an unreliable witness', whereby the symptoms reported by the patient may not necessarily correlate to the underlying pathophysiology. Urodynamic studies (UDS) provide a dynamic and interactive assessment of bladder function to aid in delineating and investigating symptomatology. This Q&A article will aim to answer some of the common questions relating to urodynamics.

### What are the aims of urodynamics?

As with all investigations, urodynamics should not be used in isolation and must be correlated with the clinical picture. The general aims when performing UDS is to determine the ability of the bladder to store urine, empty effectively and to determine the ability of the urethra to provide continence, including during exertion.

### What are urodynamics?

As a tool to investigate lower urinary tract function or dysfunction, UDS is an umbrella term incorporating all invasive and non-invasive tests. This includes uroflowmetry, post void residual, cystometry and urethral pressure profile.

The most commonly used method of urodynamics in Australia is conventional urodynamics where the patient's bladder is filled artificially in the outpatient clinic setting. Ambulatory urodynamics, where the patient's bladder is allowed to fill naturally; or videourodynamics, which involves the use of fluoroscopy, will not be covered in this brief Q&A.

### How is a UDS performed?

UDS is most simply divided into a filling and a voiding phase. Some tests are also conducted at bladder capacity. There are two catheters usually placed into the patient's bladder and vagina or rectum. At the beginning of the filling phase the bladder is confirmed empty with a catheter, artificial filling of the bladder commences. This occurs through a bladder catheter.

Pressure measurements are taken through a pressure catheter placed in the bladder (vesical pressure or  $p_{ves}$ ) and through the vaginal or rectum (abdominal pressure or  $p_{abd}$ ). The true detrusor pressure ( $p_{det}$ ) is measured indirectly using the formula:  $P_{det} = p_{ves} - p_{abd}$ . This gives the pressure that is actually exerted by

the detrusor muscle without the influence of external pressures such as through straining/coughing/sneezing etc.

### What can we tell from a UDS?

During the filling phase, as the bladder is slowly filled, there should be constant interaction between the urodynamicist and the patient so that subjective sensations and symptoms are captured and correlated at the time points in which they occur.

The sensations that are recorded include: first sensation of bladder filling, first desire to void and strong desire to void. Other sensations including absent, reduced or increased bladder sensation as well as pain can also be documented. The detrusor function during filling is classified as stable (normal) or unstable (when detrusor overactivity or involuntary contractions are present). Bladder capacity (maximum cystometric capacity) is documented at the end of filling.

Bladder compliance is also calculated during the filling phase. Compliance describes the relationship between the change in detrusor pressure and the change in bladder volume or more simply, how well a bladder is able to adapt to stretch. Low bladder compliance can be seen in female patients with chronic inflammation (painful bladder syndrome, radiation cystitis), outlet obstruction and neurological conditions (cauda equina syndrome, multiple sclerosis and spinal cord injury) and is important as it increases the risk of upper renal tract dysfunction.<sup>1,2</sup>

Provocative measures are performed during filling and at the end of the filling phase when maximum cystometric capacity is reached. This is when the patient feels that she can no longer delay micturition. Provocative measures such as postural changes and hand washing aim to provoke detrusor overactivity. Coughing aims to provoke the sign of urodynamic stress incontinence when there is an increase in abdominal pressure that occurs without a detrusor contraction.

Urethral function can be assessed during urodynamics using urethral pressure profile measures. It aims to estimate the ability of the urethra and the surrounding supportive tissue to keep the bladder outlet closed. There are multiple measures used to quantify the mechanism along

the whole urethra or at fixed points including MUCP or leak point pressures. Generally, low pressures define intrinsic sphincter deficiency which has been associated with poorer outcomes following continence surgery and increased risk of repeat surgery.<sup>3,4</sup> Poor urethral mobility can be assessed clinically and on USS imaging<sup>5</sup> and is also associated with poor outcomes at continence surgery.<sup>3,6</sup>

During the voiding phase, the volume voided, flow rate, voiding time and voiding pressures can be measured. A post void residual (PVR) is measured at the end of voiding either at the start and/or at the end of UDS. PVRs should be measured immediately post micturition and when elevated is consistent with voiding dysfunction. Urodynamics assessment of voiding pressures in those with elevated residual volumes allows further sub-classification into obstructive voiding in those with high detrusor pressures (eg. post continence surgery) or detrusor underactivity/acontractile detrusor in those with low detrusor pressures (eg. neurogenic causes).

In women with prolapse considering surgical intervention, reducing a prolapse may also be able to demonstrate occult stress urinary incontinence. This assists in counselling for potential concurrent continence procedures.

### What are some important indications for UDS?

Urodynamics have a pivotal role in facilitating the diagnosis and management of female urinary incontinence. It is recommended in those that have complicated histories, those that have failed to respond to initial treatments and prior to continence surgery, except in those with pure stress urinary incontinence demonstrated on history and examination. In 2012 and 2013,<sup>7,8</sup> two papers reported no advantage to the routine preoperative utilisation of urodynamics in women with pure, uncomplicated primary stress urinary incontinence with the sign of stress incontinence on examination. These studies excluded patients with concurrent voiding dysfunction, prolapse or an elevated post void residual of > 150mL on ultrasound or catheterisation. The reader should be aware that 'uncomplicated' stress incontinence as described by these studies represents only approximately a third of women presenting with stress urinary incontinence<sup>9</sup> and that the conclusions from these papers lack generalisability to most women considering continence surgery.

### What can't we tell from UDS?

Whilst UDS are useful to delineate symptoms and inform clinicians, interpretation of a urodynamic trace should always be done in the context of clinical symptoms.

A UDS does not take into account the 'level of bother', and while it is a dynamic test, it is not able to reproduce all symptoms eg. nocturia, significant exertion such as running, steps or heavy lifting or coital incontinence.

When performing a UDS, it is important to rule out concurrent conditions like urinary tract infections (UTI) or artefacts that could lead to misinterpretation of a UDS. A UTI can increase positive findings and diagnoses that may not be usually present such as increased bladder pain and sensation, detrusor overactivity and poor bladder compliance. In this instance, a UDS should be performed again as required.

### Final thoughts

Urodynamic studies remain an invaluable tool in the evaluation of women with lower urinary tract dysfunction. It also presents a unique opportunity to allow clinicians to show patients in real time the pathophysiology behind their symptoms, allowing them to understand and engage with management plans. However, care must be taken when ordering and interpreting each study to ensure that unnecessary testing is minimised and accurate diagnoses are made to inform appropriate treatment.

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## Case reports

# A day at the zoo with Kera the gibbon



**Dr Anna Brownson**  
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The veterinarian team at the Auckland Zoo approached us, and asked for our assistance with a special project, involving a primate under their care. Kera is a 17-year-old female Siamang gibbon (*Symphalangus syndactylus*) bred in captivity and currently living at the Auckland Zoo. Kera and her mate Intan have had two pregnancies, both sadly ending in stillbirth secondary to labour dystocia, necessitating midline laparotomy and caesarean section.

Following Kera's last pregnancy, contraception cover has been maintained by the zoo keepers, disguising the combined oral contraception pill (Marvelon: desogestrel 0.15mg, ethinylloestradiol 0.03mg) in her food, and the contraceptive implant (Jadelle: levonorgestrel-releasing implant 75mg). Given Kera's poor obstetric history, the vet team wanted to explore permanent sterilisation via a minimally invasive surgical approach. Our team, made up of two gynaecology consultants experienced in laparoscopic surgery, and a Fellow, jumped at the chance to help.



Figure 1. Kera and her mate, Intan.



Figure 2. Kera's obstetric abdominal x-ray.

### Pre-operative preparation

Kera was kept nil by mouth with no access to food in her enclosure overnight, but had access to water up to 15 minutes before administration of intramuscular sedation. This was delivered by blowpipe dart and contained a combination of ketamine and medetomidine. To facilitate safe transfer from her enclosure to the zoo's on-site veterinary hospital, Kera was intubated with an endotracheal tube, and anaesthesia was initiated with inhaled isoflurane. On arrival to the hospital, intravascular access was established with cannulas inserted into the left and right cephalic veins.

Kera's abdomen was prepared by shaving and a thorough scrub. Bedside ultrasound scan confirmed an empty uterus (positive endometrial stripe) and therefore excluded a current pregnancy. Socks were placed over her hands and feet for the purpose of thermoregulation. Kera was then positioned on the operating table in dorsal recumbent and draped exposing the entire abdomen, in the event that conversion to laparotomy was required.

Insertion of a urinary catheter was avoided due to the altered location of the urethra in primates, within the anterior vaginal wall, making catheterisation very challenging. We also decided against uterine instrumentation for the purposes of manipulation. Again, this was due to the small female primate reproductive tract (vagina, endocervical canal and uterus), which would be associated with high risk of injury.

### Monitoring and anaesthesia

Intra-operative anaesthesia maintenance was provided by inhaled isoflurane and occasional IV ketamine boluses. Maintenance intravenous

fluids were provided by Ringer's lactate, and inotropic support by a dopamine infusion. Additional analgesia was provided through a single dose of IV paracetamol and continuous remifentanyl infusion. Intra-operative monitoring was achieved by a combination of non-invasive blood pressure, temperature via rectal probe, electrocardiogram, doppler heart rate monitoring and end-tidal carbon dioxide. Kera was mechanically ventilated throughout the procedure. A dose of IV cefazolin was also given intra-operatively as infection prophylaxis.

### Laparoscopy

A well-healed sub-umbilical midline laparotomy scar was noted. Hasson entry was performed by making a 5mm incision to the umbilicus, the fascia exposed, grasped, and elevated with artery clips. The fascia was then incised and entry gained to the peritoneal cavity. A 5mm port was inserted and laparoscope introduced to confirm correct placement with the presence of intra-peritoneal structure (omentum). An insufflation tube carrying carbon dioxide was then attached and pneumoperitoneum established at 7-8 mmHg (paediatric pressures). The operating table was then tilted into the reserve Trendelenburg position to allow for the displacement of the bowel out of the pelvis.

During secondary port site placement, the anterior abdominal wall was inspected, and the inferior epigastric artery and vein identified, with ports placed lateral to these vessels. The skin, muscular and fascial layers were incised with a scalpel, track open with an artery clip and 5mm ports then inserted to the left and right lower quadrants under direct vision.

Examination of the abdomen and pelvis identified normal upper abdominal structures, liver and stomach. The presence of omental adhesions was identified to the uterine fundus, bladder, left adnexa and anterior abdominal wall – most likely the result of Kera's two

previous laparotomies. Adhesiolysis was performed using a combination of sharp dissection with laparoscopic scissors and an advance bipolar sealing device. An additional 5mm suprapubic port was required to displace the prominent urinary bladder.

When access to the pelvis was confirmed, and the fundus of the uterus exposed, both fallopian tubes were then identified by confirming the presence of the fimbria. Salpingectomy was performed using an advanced bipolar sealing device, starting at the fimbria and moving proximal towards the uterus, ensuring no tubal stump was left behind, to prevent future ectopic (interstitial) pregnancy. The specimen was then sent for histology. The pedicle was inspected for haemostasis. The procedure was then repeated on the contralateral side without complication.

At the completion of the procedure, ports were removed under direct vision and pneumoperitoneum was expelled. The fascia at all four port sites was closed with interrupted 3.0 PDS to reduce hernia risk. Skin was again closed with interrupted 3.0 PDS and knots were buried to minimise Kera picking at, and pulling out, the sutures.

### Equipment list

- Laparoscope (30-degree 5mm)
- Light cable
- Insufflation tubing
- Carbon dioxide cylinder
- Automatic insufflator
- Visual display screen
- Ports (4 x 5mm)
- Advance bipolar sealing device
- Laparoscopic instruments
  - » Bowel graspers, Maryland, scissors
- Operating table
- Laparotomy tray



Figure 3. Vet team inserting IV access, shave, scrub, and bedside ultrasound scan.



Figure 4. Post-operative with diamond shaped laparoscopy incisions.



**Figure 5.** Omental adhesion to uterine fundus, uterus, left fallopian tube and ovary.

### Post operative recovery

Kera was kept in her indoor enclosure for a 14-day post-operative period. She received regular paracetamol and meloxicam (NSAID) as analgesia, and made a speedy recovery. Combined oral contraception was continued until histology returned confirming salpingectomy.

### Discussion

Given Kera's poor obstetric history, the zoo's vet team understandably wanted to avoid her breeding again, so the indication for permanent sterilisation was clear. The questions asked of our team were: What is the best way to achieve this in a primate? Was this possible via a minimally invasive surgical approach?

Advantages of laparoscopy over traditional open procedures (laparotomy) are well established and extensively described in medical (human) literature. Advantages include reduced rates of wound complications, decreased postoperative pain, and shorter hospital stay and recovery. It is for these reasons that laparoscopy is considered the gold-standard for most major gynaecological procedures in humans. Given similarities of size, anatomy, physiology and disease pathology with our closest relatives, primates like our friend Kera also stand to benefit from a laparoscopic procedure.

Review of the veterinary literature indicates that laparoscopic surgery in primates was first described in the 1970s. Subsequently, laparoscopic sterilisation in wild primate populations for the purposes of population control, particularly in Macaques (*Macaca*) species throughout Southeast Asia, has been well described.<sup>1-5</sup>

Surprisingly, the same cannot be said for captive primates, with only one case report of laparoscopic sterilisation available in the current literature. Ruby, a 21-year-old female chimpanzee (*Pan troglodytes*), underwent laparoscopic tubal ligation (modified pomerooy technique) at the North Carolina Zoo (2019).<sup>6</sup> To date, laparoscopic procedures in primates have been extrapolated from the standard human experience. Our team encountered some limitations to this one-size-fits-all approach, and these are discussed below.

The female pelvic anatomy of primates is surprising similar to humans, but there is one obvious difference and that is the urinary bladder. In humans, this is an extraperitoneal structure, but in primates (and in Kera's

case) the bladder is intraperitoneal. This anatomical difference presented a challenge, with the prominent bladder inhibiting surgical access. This issue was exacerbated by our inability to drain the bladder.

After some troubleshooting, we solved the issue by inserting an additional 5mm suprapubic port. With the help of a laparoscopic instrument, we were able to displace the bladder enough to access pelvic structures.

Another option would be suprapubic catheterisation. In addition to issues created by the bladder, gynaecologists (and gynaecologists in training) would be very much aware of the importance of uterine manipulation when performing pelvic surgery in humans. Despite this, as a team, we made the conscious decision to avoid uterine instrumentation to eliminate the risk of trauma to the reproductive tract, or uterine perforation.

Our team anticipated that Kera's size would present a challenge, given that at 15kgs, she was much smaller than our usual patient demographic of adult female humans. We consulted a paediatric surgeon as part of the surgical planning process who provided invaluable advice about laparoscopic surgery in little people.

In addition to Kera's size, the anterior abdominal wall anatomy of a primate differs from that of a human. The abdominal wall itself is much thinner, with thick skin and minimal-to-no subcutaneous fat layer, making secondary port site placement difficult, as the ports were never far from the underlying viscera. The anterior abdominal wall was inspected, and the inferior epigastric artery and vein were identified, with ports placed lateral to these vessels. The skin, muscular and fascial layers were incised with a scalpel, track open with an artery clip and 5mm ports then inserted to the left and right lower quadrants under direct vision to minimise uncontrolled trocar insertion and inadvertent visceral or vascular injury.

In the event of an intra-operative complication and conversion to an open procedure, if required, our plan was for a transverse suprapubic or Pfannenstiel laparotomy, aided by a small circumferential (Alexis O) retractor.

During the surgical planning process, multiple contraceptive methods were considered, including less invasive long-acting reversible contraception (LARC). The contraceptive implant (Jadelle:



**Figure 6.** Distended intraperitoneal urinary bladder (post adhesiolysis).

levonorgestrel-releasing implant 75mg) was previously used to provide contraceptive cover for Kera, but in the vet team's experience, the effectiveness of implants in primate populations is unpredictable, often failing before the five years marked (Jadelle is available in New Zealand, effective for five years in humans <60kgs). The reason for this is not completely understood, but unfortunately it does necessitate removal and replacement under general anaesthetic every two years.

Intra-uterine contraceptive devices (IUCD) were also considered, but use is limited in primate populations. Again, this is secondary to primates with altered reproductive tract anatomy, making insertion of such devices very tricky.

After our team determined the use of LARCs would not meet Kera's contraceptive needs, more permanent sterilisation options were considered, including hysterectomy, salingo-oophorectomy, salpingectomy and tubal ligation.

Hysterectomy presents issues, particularly in the absence of uterine manipulation and without expert knowledge of primate pelvic anatomy. Salingo-oophorectomy was also decided against, given the associated risk of ureteric injury at time of ligation of the infundibular pelvic ligament. Also, morbidity associated with menopause in a primate population is not so well understood (again only extrapolated from human studies).

Ultimately, salpingectomy was decided to be the superior sterilisation option, balancing risks against the benefits of lower rates of contraceptive failure and ectopic (interstitial) pregnancy.

Siamang gibbons are an endangered species and mating pairs are known to do so for life. The vet team, considering Kera's best interest, understandably wanted to avoid any further pregnancy. But Intan may be required to breed in the future; therefore, vasectomy was not considered an option for this couple.

### Summary

Despite a few speed bumps, our team successfully performed laparoscopic sterilisation for our newest friend Kera, and thoroughly enjoyed our day at the zoo.



Figure 7. Kera and her keeper (for scale).

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# The lost Mirena

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A 30-year-old para 2 with a medical history of two previous caesareans, migraine with aura, hyperthyroidism, essential hypertension, anxiety and depression and a BMI of 33 presented to primary care with sudden onset abdominal pain.

She had a Mirena intrauterine device (IUD) inserted in primary care two years prior for contraception. She was amenorrhoeic with this and had no immediate complications following insertion.

Blood work on acute presentation was notable for a white cell count of 17.9, neutrophils of 15.4, and CRP 138. A pelvic ultrasound scan showed a linear, echogenic structure within the endocervical canal, likely reflecting a malpositioned IUD.

The same day, she was referred to the acute gynaecology unit where the Mirena strings were seen on speculum examination. However, the Mirena was unable to be retrieved with routine traction on the strings, which snapped. She therefore underwent diagnostic hysteroscopy under general anaesthesia.

On hysteroscopy, the Mirena was not clearly visualised, but the stem was reported to be seen buried within the right posterior aspect of the endocervical canal, halfway between the external and internal os. It was felt that this suggested the Mirena was buried into a false passage on insertion, perforating the cervix and therefore at risk of being partially intra-abdominal and in proximity to the bowel. At this time, a Jadelle contraceptive implant was inserted.

Two days later a diagnostic laparoscopy was performed. Normal pelvic anatomy was noted. Omental adhesions to the anterior abdominal wall were divided and a small amount of blood was seen in the pelvis, which was felt to be associated with a ruptured corpus luteum on the left ovary. This was the likely cause of the patient's presenting pain, which by now was improving.

The Mirena was unable to be located in the peritoneal cavity. Hysteroscopy was repeated and revealed an empty uterus. The Mirena stem that was previously seen in the canal was now no longer visible. A bedside transvaginal ultrasound could not identify the Mirena.

Assistance from the general surgical and interventional radiology teams was requested but the Mirena was still unable to be located despite a thorough search of the entire abdomen. On X-ray, the Mirena was thought to be seen in the right iliac fossa, perhaps buried in the myometrium or parametrium.

A CT was requested to further delineate the location of the Mirena. This showed the Mirena outside the uterus, between the right ovary and right internal iliac vessels, appearing retroperitoneal and deep to the round ligament.

Opinion was sought from the gynaecology oncology team given the proximity to the iliac vessels. As future further invasion of surrounding tissues could not be excluded, and the patient desired removal of the Mirena, she again underwent laparoscopy with assistance from the gynaecology oncology team. The right fossa was opened underneath the round ligament. The Mirena was then visualised overlying

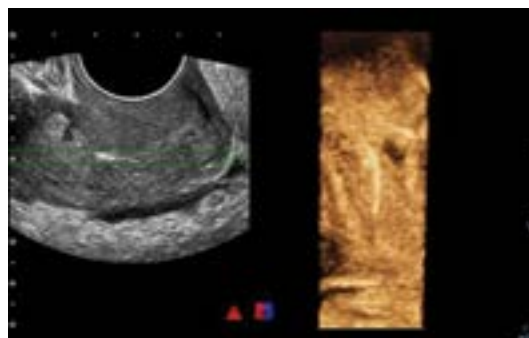


Figure 1. Initial ultrasound scan reported as 'linear echogenic structure within the endocervical canal that may reflect a malpositioned IUD.'

the iliac vein. It was noted to be peritonealised with surrounding adhesions, giving the impression that it had been there for a prolonged period.

The Mirena was dissected and removed in entirety; however, no strings were attached consistent with the history of the strings having been pulled off at the initial removal attempt. The patient made an unremarkable recovery.

## Discussion

Intrauterine contraception is used by 160 million women, or 14% of contraceptive users worldwide.<sup>1</sup> The Mirena IUD was introduced in 1990.<sup>1</sup> In the NZ Family Planning survey 2020, 19% of responders had previously or were currently using a Mirena IUD.<sup>2</sup>

Perforation of an IUD was first described in the 1930s<sup>3</sup> and was thought to be caused by forcing of the device through the uterine wall by contractions. It is now accepted that the most common mechanism of perforation is the device being forced through the uterine wall on insertion.<sup>4</sup>

Associations between risk factors and uterine perforation are difficult to demonstrate but are thought to include:<sup>4,5</sup>

- Insertion by inexperienced clinician
- Lactation
- Insertion <6 months postpartum
- Lower parity
- Higher number of previous abortions

In 90% of cases, perforation is not recognised at the time of IUD insertion.<sup>6</sup> In a 10-year New Zealand cohort study, over half of perforations were diagnosed over one year after insertion.<sup>6</sup> The threads are generally still emerging from the cervical os at the end of the procedure, even with complete perforation.<sup>4</sup> This is consistent with the history of strings being seen on our patient's initial speculum examination.

The discrepancies between clinical findings and that of various modalities of imaging on multiple occasions lead to significant morbidity for our patient, undergoing three general anaesthetic procedures within a few months. One series reported a significant discrepancy between the location of IUDs indicated by USS imaging and subsequent location at surgery.<sup>7</sup> CT and MRI are the most accurate imaging modality for localisation.<sup>4</sup>

However, in comparison, ultrasound is safe, easily accessible, and cheap. The Mirena IUD has a different ultrasound appearance to copper devices as it is not uniformly hyperechoic and has acoustic shadowing only at its proximal and distal ends.<sup>8</sup> This sonographic appearance leads to higher rates of localisation errors with ultrasound.

Whether laparoscopic removal was indicated is also a relevant thought. The patient had no desire for future fertility, and in fact had not conceived for two years while using the Mirena as her only form of contraception, likely due to the local progesterone effect. In fact, it is not unusual to hear of IUDs found intra-abdominally many years after their original insertion, with one case series reporting 43 years between insertion and diagnosis of perforation.<sup>9</sup> However, case reports have shown that migration in the peritoneal cavity can result in bowel obstruction, bowel perforation, mesentery penetration, abscess formation, intestinal ischaemia or volvulus.<sup>10,11</sup>

Therefore, some clinicians recommend that displaced IUDs should always be removed to prevent complications due to intraperitoneal adhesion formation or migration to adjacent organs. However, some deem the risks of surgery and anaesthesia greater than the risk of migration.<sup>12,13</sup> The risk of adhesions is thought to be greatest with copper IUDs; therefore, those made of non-irritating plastic, such as the Mirena, may be at lower risk of this.<sup>13</sup>

The decision to remove the IUD should therefore involve careful consideration of the risks of surgery compared to the risks of conservative management,



**Figure 2.** CT abdomen with report stating 'the Mirena coil is situated outside the uterus, between the right ovary and internal iliac vessels. Appears retroperitoneal and deep to the round ligament.'



**Figure 3.** Mirena located in overlying the iliac vessels at laparoscopy.

while also considering the patient's wishes, fertility plans and psychological wellbeing with regards to their awareness of an intra-abdominal foreign body.

The small risk of IUD perforation can at times lead to significant diagnostic challenges and patient morbidity. We propose that consideration should be given to routine ultrasound at the bedside following insertion to confirm IUD location, but the feasibility and cost effectiveness of this in New Zealand's current health system requires investigation.

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