



# ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

VOLUME 26, NO.5  
JAN-MAR 2019

## NURSE PRACTITIONERS BARRIERS TO PRACTICE

### INSIDE

#### **ANMF Priorities 2019**

The union details what's in store for the ANMF leading up to Australia's Federal election

#### **Birthing on Country**

The importance of advocating for culturally safe maternity care for Aboriginal and Torres Strait Islander women

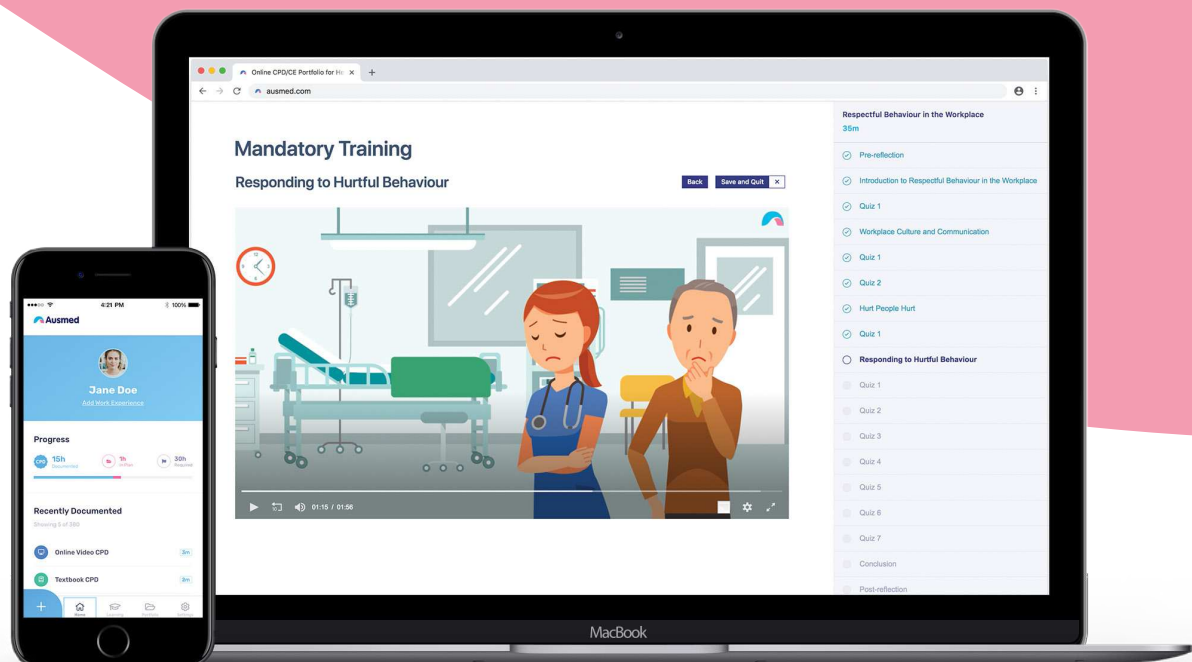
#### **The race against time to end nuclear weapons**

How healthcare professionals formed and drove a treaty to ban nuclear weapons that was adopted by 122 countries at the United Nations

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Reflecting on 2018, I can honestly say that this has been an incredible year.

#### Annie Butler

ANMF Federal Secretary

I am very proud of the ANMF Federal Office team, all of whom have worked consistently and diligently for the benefit of all nurses and midwives and the healthcare of all Australians.

There is no doubt that we have scored plenty of wins over the past 12 months but there still remains much work to do. With our batteries recharged, we are ready and willing to take on the challenges that 2019 brings.

In order to meet these challenges we have set out a list of critical priorities that we plan to work on in the upcoming year.

On top of the priority list is aged care. Building on the momentum of our aged care campaign during 2018 **Ratios for Aged Care – Make them Law Now**, the ANMF will ramp up the pressure on federal politicians to commit to aged care ratios in the lead up to the federal election this year. As we enter the next phase of the campaign, we will continue to build alliances with key politicians, extend our alliances with key stakeholders and supporters and work with members on the ground to grow community support. All the while, we will work cooperatively with the Royal Commission during its investigations into aged care. This is just the tip of the iceberg of what we have in store to ensure that minimum staffing ratios in aged care are legislated - so watch this space!

Of great importance to the ANMF is supporting the ACTU's national **Change the Rules Campaign** which aims to restore workers' rights including wages that keep up with the cost of living. This incorporates the protection of penalty rates, stable employment for nurses and midwives in all sectors and fairer conditions for aged care workers.

Other priorities for the ANMF include tackling the detrimental impacts of climate change on health outcomes and maintaining and developing international affiliations with causes such as the global campaign **Nursing Now**, to improve health outcomes globally. Details of all these priorities can be found on page 8 of this issue.

On the back of the success of ANMJ's first quarterly publication in October 2018, the team has been intently writing and sourcing a wide variety of interesting and informative articles for this issue.

Nurse Practitioner Jo Perks, who is on the cover, explains barriers to her practice and what is necessary to enable NPs to work to their capacity.

The importance of women, particularly nurses and midwives, being leaders and on boards is also explored.

Associate Professor Tilman Ruff, who was one of the founding members of the International Campaign to Abolish Nuclear Weapons, is interviewed about the organisation's drive to form a treaty to ban nuclear weapons that was adopted by 122 countries at the United Nations in 2017.

And Nyoongar woman and midwife Valerie Ah Chee speaks about advocating for culturally safe maternity care for Aboriginal and Torres Strait Islander women and for birthing on country.

I hope you enjoy reading these stories and others in this latest issue of the ANMJ.

The outlook for 2019 is promising and I look forward to working with you in building and achieving positive outcomes for nurses, midwives and the community.

Annie



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## Moving state?

### Transfer your ANMF membership

If you are a financial member of the ANMF, QNMU or NSWMA, you can transfer your membership by phoning your union branch. Don't take risks with your ANMF membership – transfer to the appropriate branch for total union cover. It is important for members to consider that nurses who do not transfer their membership are probably not covered by professional indemnity insurance.

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# Atlas pinpoints unwarranted health variations

The third *Australian Atlas of Healthcare*, recently released by the Australian Commission on Safety and Quality in Health Care, has found a wide disparity in health outcomes over a number of clinical areas.

The purpose of the *Atlas* helps to identify and promote investigation of variations in healthcare use, reduce unwarranted variation and promote appropriate care by recommending actions.

"The data and recommendations in this *Atlas* will be used by clinicians, consumers, policymakers, and researchers across Australia to deliver important improvements in healthcare," said the Commission's Clinical Director Professor Anne

The main findings of the *Atlas* included:

- Early planned caesarean section without medical or obstetric indication.
- Antibiotics frequently and inappropriately prescribed to children with viral respiratory tract infections.
- Inappropriate proton pump inhibitor medicines in infants which is sometimes prescribed to treat infants with symptoms such as irritability and crying in case this is due to reflux.
- A rise in the rates of gastroscopy, despite low and stable rates of oesophageal and stomach cancers. The pattern suggests overuse of gastroscopy.
- High rates of combined gastroscopy and colonoscopy hospitalisations suggest inappropriate use.
- High rates of Antipsychotic prescriptions dispensed, 65 years and over.



## Trailblazer Florence Nightingale dramatised

A new movie highlighting the trailblazing life of nursing pioneer Florence Nightingale is being made and is to be released during 2020-the bicentennial of her birth.

The script, *Legacy of Light*, written by Nurse Researchers and Nightingale Scholars, Barbara Dossey and Deva-Marie Beck, also delves into Nightingale's continuing impact on the world.

The objective of the movie is to reach an estimated 22 million nurses and midwives who globally carry the light of healing into the 21st century and advocate for health as a basic human right.

The researchers have started the project based on crowd-funding and donations to raise the necessary budget for creating the film and promoting it globally.

The movie is also being supported by many peak nursing organisations including the International Council of Nurses, the Commonwealth Nurses and Midwives Federation and the Florence Nightingale Foundation. If you wish to participate and contribute to the film, go to: [indiegogo.com/projects/spotlight-on-nursing-the-epic-nightingale-story#/](https://indiegogo.com/projects/spotlight-on-nursing-the-epic-nightingale-story#/)





## Bullying increases CVD risk

People who are bullied or experience workplace violence are at higher risk of cardiovascular disease (CVD). Scandinavian researchers found those who were bullied or experienced violence (or threats of violence) at work had a 59% and 25% higher risk of CVD respectively compared to people not exposed to bullying or violence. People bullied almost every day in the past year had a 120% higher risk of CVD.

– *European Heart Journal*

## \$7 million to reduce stillbirth

The Australian government will hold a national roundtable to address the rate of stillbirth and direct \$7.2 million towards medical research and education programs in the wake of an eight-month long Senate Inquiry.

In its report, the Selected Committee on Stillbirth Research and Education outlined a set of national recommendations to improve education and research surrounding stillbirth in Australia.

Responding swiftly to the report's calls, the government announced it would develop a National Action and Implementation Plan in collaboration with clinicians, researchers and advocacy groups touched by the tragedy of stillbirth.

The roundtable will cover education, counselling, research, clinical care, funding priorities and weigh up the Select Committee's recommendations.

The Australian Institute of Health and Welfare defines stillbirth as fetal death after 20 weeks gestation or weighing 400 grams or more.

Nationally, one in every 137 women who reach 20 weeks' gestation will have a stillbirth.

Part of the funding includes \$3 million for stillbirth education and awareness programs for women and medical practitioners, including \$1.2 million for University of Melbourne researchers to explore minimising preventable stillbirth through the use of biomarkers and ultrasound late in pregnancy.



## Sleep deprivation road risk

Drivers who have less than four hours sleep are at least as likely to be involved in a car accident as drink-drivers, according to US research.

Drivers who had slept for less than four hours had crash risks similar to drivers with blood alcohol concentrations of 1.2g/L. In addition, drivers who had recently changed their sleep or work schedule had about a 30% increase in their risk of causing a crash.

– *Sleep Research Society*

## Hand hygiene to stop post-op infection

Up to 7% of patients undergoing surgery continue to contract at least one postoperative infection, according to University of Iowa researchers.

Despite improved practices of hand hygiene, vascular access and patient skin infection, "adherence to evidence-based, basic preventive measures is abysmal", the US study found. Adherence to proven protocols for disinfecting surgeons' hands, patients' skin and operating room surfaces could halt the spread of *Staphylococcus aureus*.

– *American Journal of Infection Control*







**Lori-Anne Sharp**

ANMF Assistant  
Federal Secretary

## Resilience: learning to bend but not break in the ebb and flow of life

**I was extremely fortunate to hear the inspirational and witty Malala Yousafzai speak in Melbourne last December.**

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Malala gave such a powerful address and generously shared her remarkable story about her life under the Taliban regime in Pakistan's Swat Valley. Malala who is now 21 started blogging at the age of 11 to campaign for the rights of girls to receive an education.

At the age of 15, while travelling home from school on the bus, Malala was the victim of a targeted attack and was shot twice, one bullet narrowly missing her brain. After the attack, Malala made a remarkable recovery and is now studying at the University of Oxford. She continues to campaign for the right of every child to go to school and is the youngest ever recipient of the Nobel Peace Prize. Reflecting on Malala's inspiring story and her ability to adapt and overcome the worst of situations encouraged me to reflect on the importance of resilience.

So, what does resilience actually mean? It is not the ability 'to just move on and get over it'. It is also not about being unaffected by life's hardships. Resilience is the ability to accept and work through whatever challenges cross our path and the ability to move on and accept normality again. The ability to keep functioning, and to bend instead of break. The good news is that research indicates almost 80% of humans are resilient. For many nurses and midwives this may not be surprising, as we witness on a daily basis the remarkable strength and recovery of those we care for as they experience and work through traumatic or life changing events. Caring for these people can also place considerable demands on nurses and midwives and can contribute to stress, emotional exhaustion and burnout, all of which have negative impacts on our wellbeing. Recognising that there are situations that may compromise resilience is as important. We know that trauma can adversely affect us, but it can also be the catalyst of change and become a base on which strength is built.

We have seen many acts of resilience in the public eye in the last year. Apart from those affected by natural disasters, another that stands out is the resilience of the LGBTIQ community during the recent postal survey. We witnessed an unnecessary plebiscite of Australians to decide the fate of a group of people for the basic right to marry whom they love. The discriminatory and at times hurtful debate during this time had significant impacts on mental health and wellbeing of the LGBTIQ community. We witnessed an extraordinary show of resilience and forgiveness from a group of people whose families and way of life was judged, discussed and voted on by an entire country.

When reflecting on other examples of resilience, an individual who stands out is Indigenous singer/songwriter Archie Roach. Archie was part of the Stolen Generation, and never had the opportunity to reconnect with his birth mother before her death, a story he has shared with his audience when performing. His strength and capacity to forgive and share his story through song is compelling. His resilience is evident, and he demonstrates that despite hardships in his life he is able to remain positive, provide hope and contribute richly to life through his songs and storytelling.

Because of the challenges faced by nurses and midwives daily, it is important that we learn to be resilient. The resilience of nurses and midwives contributes to better patient care and outcomes, and generally has a positive impact on both our professional and personal lives. We all have the capacity to build resilience in ourselves and there are some proactive steps we can take that may assist in building on that protective layer of resilience. Some of these include fostering opportunities for wellbeing by building strong relationships in daily life, working towards a work-life balance, maintaining adequate sleep, striving for a balanced diet, investing in regular exercise, showing compassion for ourselves and others and developing emotional awareness. It may sound like a long list, but many of you will be achieving these things already.

It is impossible to prevent all stressful situations, as they are a part of life, but it is important to try to accept that there will be circumstances, which are out of our control. Keeping a long-term perspective, remaining hopeful and trying to keep a positive attitude will all help build resilience.

Coping with adversity and life's challenges takes strength and resourcefulness. As much as we need the ability to cope and overcome, we also need the support of a close network of family, friends and colleagues.

Generous hearts and listening ears from those around us can make all the difference, and the value of support in achieving resilience cannot be underestimated.

As we embark on a new year in 2019, no doubt there will be both exciting and challenging times ahead for us all. Let us hope that we have the strength and necessary supports around us to go forth, recover, contribute, grow and be our best selves.

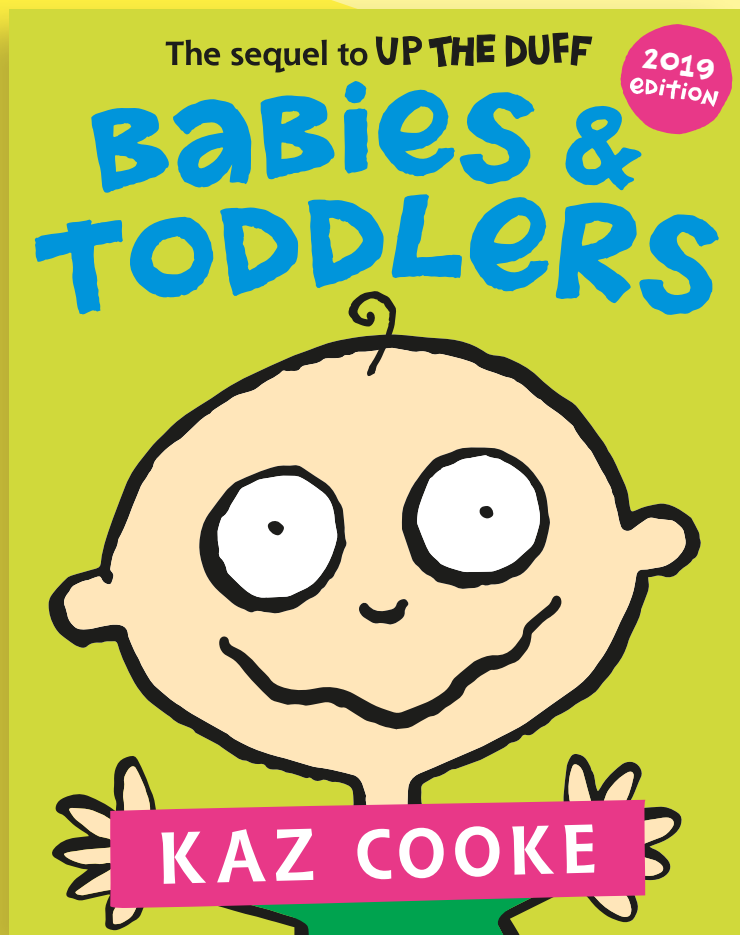
# The *NeW* book for *NeW* parents

A HUGE thanks to the midwives, child & family health nurses  
and other medical experts who contributed and advised.

**Babies & TODDLERS** is friendly, reassuring and full of practical,  
evidence-based advice on newborns; breastfeeding and bottle-feeding; health and  
wellbeing for new mums; illness and immunisations; developmental milestones for kids  
from zero to three; worries about toddlers; and much more. It will be updated each year.

I hope you'll be happy to recommend  
**Babies & TODDLERS** to your patients!

— KAZ



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# ANMF PRIORITIES 2019

## LEADING THE CHARGE

- ✓ Aged Care
- ✓ Change the Rules
- ✓ Climate Change
- ✓ Nursing Now







ANMF Federal Secretary Annie Butler speaking at the Ratios for Aged Care – Make them Law Now rally in Melbourne last year



Supporters at the Ratios for Aged Care – Make them Law Now rally in Melbourne last year

## In 2019, the Australian Nursing and Midwifery Federation (ANMF) will lead the way on a wide range of issues facing nursing, midwifery and the broader community.

An impending federal election will see the ANMF ramp up pressure on federal politicians to legislate minimum staffing ratios in aged care through its national public awareness campaign – *Ratios for Aged Care – Make Them Law Now*.

Last September, the Morrison Government announced it would establish a Royal Commission into Aged Care Quality and Safety examining the crisis facing the sector.

With growing research showing chronic understaffing is contributing to inadequate care in nursing homes, ANMF Federal Secretary Annie Butler says the sector cannot wait at least two years for a Royal Commission as it continues to decline.

"All political parties must make a commitment to protect residents and support legislative change to introduce minimum staffing levels and hours of care for all residents," Ms Butler says.

"Vulnerable elderly residents deserve access to affordable and high-quality aged care services delivered by a professionally trained and dedicated workforce."

As the country's largest union, the year ahead once again presents the ANMF with an opportunity to use its influential voice to lead the way on important issues facing the professions and the Australian population.

The 2019 priorities include:

- Aged Care
- Change the Rules
- Climate Change
- Nursing Now

### AGED CARE

As aged care comes under the microscope during the Royal Commission into Aged Care Quality and Safety, the ANMF will increase pressure on federal politicians to support aged care ratios in law in the lead-up to the federal election.

The ANMF's campaign – *Ratios for Aged Care – Make Them Law Now* – moves onto its next phase where it will continue building alliances with politicians, key stakeholders and supporters through on the ground lobbying.

Backers of the ANMF's push for mandatory minimum staffing ratios in aged care include Federal Senator Derryn Hinch, who introduced a Private Member's Bill seeking to amend the Aged Care Act and mandate aged care ratios, the Australian Medical Association (AMA), who is calling for regulated nurse-to-resident ratios in aged care and a registered nurse on duty around the clock, and numerous pledges of support

from politicians such as Wentworth MP Dr Kerry Phelp and Longman MP Susan Lamb.

Last month, a report tabled by The Standing Committee on Health, Aged Care and Sport investigating Australian residential aged care facilities recommended Parliament pass the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 introduced by Mayo MP Rebekha Sharkie that would force aged care providers to publicly disclose their staffing ratios.

The committee also recommended the government legislate to ensure that



ANMF Federal Secretary Annie Butler and ANMF Assistant Federal Secretary Lori-Anne Sharp with Senator Derryn Hinch





Assistant Federal Secretary Lori-Anne Sharp (centre) at a *Change the Rules* rally

residential aged care facilities provide a minimum of one registered nurse on site at all times, and that it specifically monitor and report on the correlation between standards of care, including complaints and findings of elder abuse, and staffing mixes to help shape future decisions in relation to staffing requirements.

“New evidence is emerging by the day demonstrating the link between an appropriate level of staffing and the delivery of quality aged care,” Ms Butler says.

“This report marks another step in the right direction and adds momentum to our campaign as we move forward and intensify our action.”

Building on growing evidence reinforcing why minimum staffing ratios in aged care are vital, the ANMF commissioned Flinders University to undertake an independent economic analysis of its 2016 *National Aged Care Staffing and Skills Mix Project Report*.

Findings showed the benefits of implementing minimum staffing hours outweigh the costs and warn there would be significant costs in not implementing the report’s recommendations.

Further, the ANMF has developed a plan to implement an ideal staffing and skills mix it believes can ensure proper care of Australia’s elderly residents and have a positive impact on overworked aged care staff.

“The only way we can ensure elderly Australians have access to safe and quality care is to legislate minimum staffing ratios

in aged care immediately,” Ms Butler says.

“They do not deserve the chronic understaffing currently plaguing the sector. The Royal Commission into aged care is an important step but it cannot mean a delay in urgently needed reforms and another 18 months of pain and suffering for the elderly.”

Ms Butler maintains the ANMF will work cooperatively with the Royal Commission as it unfolds to provide accurate and important information relevant to the investigation.

The ANMF has informed its members about their rights during the aged care Royal Commission and called on them to contact the union for further advice at any stage.

The union has also penned an open letter to Prime Minister Scott Morrison detailing why older Australians are entitled to safe and quality care delivered by a dedicated and qualified workforce.

“We know fixing the crisis in aged care will take time and requires significant investment,” Ms Butler said.

“But our plan for minimum staffing ratios in aged care is achievable and gives Australia the opportunity to lead the way globally in the delivery of aged care just as it does with healthcare.”

## CHANGE THE RULES

In 2019, the ANMF will continue to stand in solidarity with the Australian Council of

Trade Unions’ (ACTU) national *Change the Rules* campaign aiming to restore workers’ rights and ensure people receive pay rises that keep up with the cost of living.

Launched in 2017, key objectives of the campaign include increasing Australia’s minimum wage, protecting penalty rates and driving a number of amendments to the Fair Work Act in a bid to shift power back to working people.

Last October, ANMF members were among hundreds of thousands of protestors who took to the streets in a show of support during nationwide rallies held across capital cities and selected regional towns.

“We know that the cost of living is spiralling out of control yet wages are just not keeping up. ‘Trickle down’ economics does not work and inequality is at a 70 year high,” Ms Butler points out.

*Change the Rules* is broadly seeking to fix widespread inequality, a broken tax system that rewards big business, the underpayment of workers, weak industrial rights, increasingly insecure work arrangements and restrictive rules surrounding enterprise bargaining.

The movement’s significance to nursing and midwifery is widespread and felt across a variety of workplace settings.

Areas of focus for the ANMF include calling on the incoming Australian government to support policies that give nurses, midwives and carers on casual contracts greater control over their employment and the option of moving to permanent employment.

Due to a growing ‘gig economy’ typified by organisations temporarily employing independent or freelance workers infiltrating health and aged care, the ANMF is also seeking support for policies that give this group equal protection, rights, entitlements and a minimum living wage.

Similarly, responding to agency nurses working under labour hire arrangements who face potentially poorer job security, working conditions and entitlements than those in permanent positions, the ANMF is calling for a national labour hire system that would guarantee companies do not cut wages or impose poorer working conditions.

The ANMF will also draw attention to the need for the next Australian government to stop employers from unreasonably terminating enterprise agreements, support equal pay and rights for women workers, increase access to vocational education and training in aged care, and safeguard equal rights, entitlements and pay for staff working

under temporary visas in the health system.

The ANMF is also supporting greater recognition for nurses and carers working in the aged care sector that experience a vast wage disparity of between five and 17% less when compared to their counterparts in the acute sector.

To this end, the union is asking for pay to include a minimum living wage that improves over time, that penalty rates are protected, and that workers have access to a fair bargaining system.

“Care provided in aged care and hospitals is frequently comparable and should merit equal pay,” Ms Butler argues.

“Installing pay levels that respect and value the work being carried out will help improve recruitment and retention across Australia’s aged care sector.

“The ANMF encourages all nurses, midwives and carers to band together with other unions to change the rules and achieve better pay and conditions for everyday working Australians.”

[changetherules.org.au](http://changetherules.org.au)

## CLIMATE CHANGE

The growing negative health impacts of climate change presents a defining challenge of our time and the ANMF believes everyone has a role to play in tackling the global issue.

Australia and the South Pacific region are both vulnerable to the effects of climate change, which range from adverse impacts to physical and mental health due to air pollution and illness and injury or death triggered by more frequent natural disasters.

One of the ANMF’s longstanding climate change interventions has involved helping its neighbours in the South Pacific region tackle and respond to the issue.

While the South Pacific region emits well below 1% of total global greenhouse gases responsible for climate change, its island nations remain among the most exposed globally to its negative impacts.

“Hundreds and thousands of people around the world are already dying directly from the effects of climate change,” Ms Butler says.

“Unfortunately, many of those experiencing the worst of the effects of climate change, such as the South Pacific region, have not caused it.”

In high-risk regions like the South Pacific, climate change now poses a real threat to the survival of future generations and is

likely to cause ripple effects on economic and social development, Ms Butler adds.

“In addition to the physical effects of climate change in the Pacific – that is, villages disappearing under water, there are mental and psychological effects on culture that need to be taken into consideration as well.

“The ANMF is committed to working collaboratively with nurses from these nations to address the problem.”

From an overall picture, the ANMF will continue actively tackling climate change at a national level.

The union believes governments have unduly focused their attention on the impacts of climate change on the economy and industry and failed to acknowledge what it means for the health and wellbeing of the population.

It argues the energy, mining, agriculture and transport sectors should form a key target for policy interventions because they produce the greatest amount of emissions in the country.

In 2019, the ANMF is calling on the incoming Australian government to commit to some of the following:

- Developing a standalone policy on climate change that includes a key focus on health and wellbeing
- Reducing greenhouse gas emissions that exceed the current 2030 Paris carbon emissions target of 26-28%
- Implementing a fair and effective carbon tax during stages that does not adversely affect Australian households.
- Developing an energy policy to transition from fossil fuels to at least 50% renewable, zero-emission sources by 2030
- Increased government funding for climate-resilient health systems and climate change research

## NURSING NOW

The ANMF has long recognised the importance of developing an international network of affiliations to advance the interests of the professions and safeguard the health of communities worldwide.

In 2019, one of the ANMF’s key partnerships involves getting behind landmark three-year global campaign *Nursing Now*.

Launched in February last year, *Nursing Now* is aiming to improve health and raise the profile and status of nursing worldwide.

“The campaign aims to highlight the contribution nurses make to improving health outcomes so the profession can be empowered to work to its full scope and

help push for universal health coverage,” Ms Butler says.

*Nursing Now* evolved from a global nursing review undertaken by the UK’s All Party Parliamentary Group on Global Health that produced a report in 2016 titled *Triple Impact*, which argued strengthening nursing would trigger a threefold effect – improving health, promoting gender equality and supporting economic development.

The campaign includes backing from the International Council of Nurses (ICN) and the World Health Organization (WHO).

According to WHO, nurses represent nearly one-half of the total number of health workers worldwide and an additional nine million nurses would be required by 2030 for all countries to reach the Sustainable Development Goal 3 to ensure health and wellbeing at all ages.

*Nursing Now* encourages health leaders to invest in nursing and introduce new models of care that maximise nurses’ contributions to achieving universal health coverage, which would guarantee everyone the right to quality healthcare without financial hardship.

Since the campaign’s launch, the ANMF has been actively working together with key national nursing organisations to formulate Australia’s contribution.

The strategy is likely to focus on encouraging nurses to promote the contribution of nursing and midwifery to health, and enhancing access and equity to healthcare for all Australians.

“We have a wonderful universal health insurance scheme in Australia, the problem is unequal access,” Ms Butler says.

“If you are an Indigenous person, live in rural or remote Australia, are disabled, have a mental illness or are below the poverty line, you can expect much worse health outcomes.

“We need to see the expansion of nurse-led models of care that are innovative, increase access and lead to better health outcomes for communities.”

[nursingnow.org](http://nursingnow.org)



WORKING LIFE

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# Mary Wong: The road to recovery

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Victorian nurse Mary Wong hopes her journey will help inspire other stroke survivors. The nurse who had a stroke in 2016 completed a 10 kilometre run in the Melbourne Marathon in under 60 minutes late last year.





By Natalie Dragon

**R**unning makes me feel free. I am so proud of how far I have come."

Mary still finds it difficult to talk about the day the stroke happened.

"The emotions are still very raw. I was at home reading to my daughter Cassie who was 11 at the time. I became really unwell. I had nausea and vomiting and was unable to weight-bear.

"I didn't recognise I was having a stroke, I didn't think of it at all. I was 50, fit and in good health. I just knew something was wrong. The ambulance asked me to walk and I just couldn't. The rest is a blur."

Mary suffered a cerebral aneurysm and was unconscious for 72 hours.

"It was a freak accident. I have hypertension but I have been on medication and it has been well managed for 20 years.

"When you have a stroke, your whole life changes in an instant. I was a busy mum and nurse and I was also training for triathlons."

At the time of her stroke, Mary had been DON of the Cardiovascular, Renal and Endocrine division at the Royal Melbourne Hospital (RMH) for 10 years. The operational role involved managing hospital wards in the division, including 600 staff.

"I then found myself in a hospital ward where I had to learn to balance and walk again. Most days were filled with headaches, fatigue and frustration."

Mary attempted to return to work at six months post-stroke but wasn't ready.

"Mentally I was overwhelmed. I couldn't focus; I was in a cloud. I had a lot of frustration, anxiety and a bit of depression; I also experienced self-doubt. I had to give myself more time to heal.

"I had gone from being an independent person to being dependent on others. After stroke, it took a long time to accept that. Some days were really dark."

A type 'A' personality and highly driven, Mary changed her treatment and saw a neuropsychologist who specialises in cerebral stroke and mental illness.

"In seven to eight months, I slowly rebuilt mentally and physically. I saw a physio. I had goals to get back to running, to get back to work. I got back running, got back swimming - it gave me a sense of purpose."

Mary also started to do volunteer work with people going to a hydro-pool for rehabilitation one day a week.

"It gave me the routine and motivation to get up early. Then I increased it to two days a week. Then I started a project two days a week in cardiac care management at the RMH."

Mary's nursing career spans 33 years, largely at the RMH. She has always worked in acute and cardiac care. Hospital-trained in 1985, Mary completed a postgraduate certificate diploma in intensive care and in advanced nursing practice. She has also completed a Masters of Business Administration. She aims to return to her DON position, hopefully in 2019.

"I love my nursing and want to get back to it. I was nursing for 33 years; I never moved away from it. My mission has always been to improve patient care."

Mary is part of a Stroke Survivors Group and the Stroke Foundation.

"The journey has been hard, you don't realise how hard unless you've been through it. It's all part of stroke - some days are good and some days bad. It's how I live my life now.

"The cerebellum which was affected by my stroke, affects my emotions. I get overwhelmed and anxious."

Mary ensures she practises self-care and has the support of her husband Glenn and daughter, family and friends.

"It's been a rollercoaster and it [stroke] is an ongoing part of my life. I have come to accept it and be easy on myself. I do meditation and mindfulness and I run.

"I know my body really well now and how to manage it; I have a lot of strategies for when I am anxious or overwhelmed, and know when to pull back on my exercise. It's day by day."

Mary runs three to four times a week and also cycles a couple of times a week. She hopes her journey gives hope to other stroke survivors.

"A lot of people think this is it, but it's not the end - you have choices. I have gone down the positive road. I have purpose in my life and my passions - exercise and nursing."

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FEATURE

# NURSE PRACTITIONERS: BARRIERS TO PRACTICE





By Cathy Beadnell

**Jo Perks was one of the first nurse practitioners in Australia, gaining authorisation over a decade ago in 2005. Despite being authorised for many years Jo still experiences barriers in providing optimal care to her patients due to restrictions imposed on her practice.**

Having worked at Leichhardt Women's Community Health Centre in Sydney with patients who were largely disadvantaged and from culturally and linguistically diverse backgrounds, Jo was determined to provide the best quality care to her patients.

"Working at Leichhardt Women's Community Health Centre gave me a strong background in grassroots primary healthcare. I was a leader in the sector and working autonomously with the support of a doctor at the centre," Jo says.

"I was really excited when the nurse practitioner opportunity opened up in Australia. It took a bit of work to prove advanced practice because women's health centres work on a multidisciplinary team model. I had to go through hoops to get authorised because of the way women's health services operate."

Jo was one of the first 100 nurse practitioners to be authorised in Australia but found it difficult to get a position once she gained her qualification.

"I was authorised in NSW in 2005 by the former Nurses Registration Board (state-based precursor to AHPRA). Leichhardt Women's Community Health Centre was really supportive but once I was qualified they couldn't afford to pay me the going rate," Jo says.

"I got a position with Penrith Women's Health Centre one day a week in 2009 and that was prior to changes to the MBS and PBS. At the time I was working collaboratively with a GP and not able to initiate a lot because I didn't have access to the MBS and PBS."

Changes to the PBS in 2010 allowed Jo to work more independently when she was able to register for a prescriber number.

"I started working at Liverpool Women's Health Centre and a few of my hours were in private practice because I had applied for and been granted a prescriber number. In NSW if you work in private practice you can submit a scope of practice document that allows limited ability to prescribe. So I had some access to PBS medications."

This is where things get frustrating for Jo, she now has limited access to prescribing rights but can't order diagnostic tests under the MBS or vital PBS medications that are essential for her work in women's health. These restrictions are not just professionally frustrating but financially disadvantage the women she works with.

"I am currently working across women's health services in the western suburbs of New South Wales. My work is with women aged between 14 to 90, many are from disadvantaged backgrounds. I can do some prescribing on the PBS but I still can't order a mammogram or pelvic ultrasound without the women paying the full fee due to restrictions under the MBS."

Jo says a lot of the women who visit her clinic don't want to go to male GPs because of cultural issues and don't feel comfortable talking about reproductive health with a male.

"We do a lot of reproductive health and a lot of the things women tell us they don't want to tell a male doctor," Jo says. "One of the biggest barriers I face is the inability to order an ultrasound. A lot of women

come to see me for a cervical screening test reporting pelvic pain.

"In order to investigate properly I need to order an ultrasound but I can't do that under the MBS so the patient would have to pay the full cost. I have a good collaborating GP working with me and she orders the test under her name. Not all doctors are so supportive though and I've had a woman tell me a specialist ripped up a referral letter from me and refused to acknowledge my scope of practice."

Vulnerable women are at risk of missing out on vital care due to MBS and PBS restrictions on nurse practitioners working in women's health according to Jo. "I have countless stories of women who come to us for cervical screening many of whom have experienced sexual assault and I don't want to send them off to a GP who might not have the appropriate background to provide the best care," she says.

"I've had women who have waited for hours in a GP's office only to be told they don't have the necessary equipment. I've had a woman who was told she was too fat for a pap smear examination. This is happening to our clients because I can't provide continuity of care due to outdated restrictions on my ability to order diagnostic tests."

Jo has worked with the ANMF to lobby for changes to the MBS to allow nurse practitioners to provide the best quality of care to their clients.

"I provided a presentation to the MBS taskforce about a few months ago that the ANMF asked me to be involved in. I

*"If the barriers we face in women's health were addressed I feel we could provide a timely and streamlined approach to the care we give. And I think it would be cost effective in the long run if my clients didn't have to go to a GP who doesn't need to see them."*

had some slides that had evidence-based information on pelvic ultrasound evidence to inform new guidelines," Jo says.

"The taskforce has NPs on the panel as well as doctors so that is encouraging, but we need increased lobbying by the industrial and professional bodies as well to ensure nurse practitioners can provide the best care to patients and improve health outcomes."

Jo works with a lot of women experiencing reproductive health issues and women with breast cancer and while she can prescribe continuing therapy for these women she can't initiate medications.

"I can't prescribe a first dose of tranexamic acid, which is a drug that plays a part in helping women who are experiencing heavy

menstrual bleeding. Women experiencing hot flushes from breast cancer treatment are often helped by SSR drugs, but I can't prescribe an initial dose, so I have to find a supportive GP to order that first dose," Jo says. "These are the glitches in the system that prevent me from providing a complete cycle of care.

"It feels like women's health was overlooked when deciding on MBS and PBS access for NPs back in 2010," Jo says. "If the barriers we face in women's health were addressed I feel we could provide a timely and streamlined approach to the care we give. And I think it would be cost effective in the long run if my clients didn't have to go to a GP who doesn't need to see them."

Jo intends to keep lobbying for greater access to PBS and MBS items for nurse practitioners working in women's health so that NPs can provide continuity of care and improve patient outcomes.

"There is quite a way to go for nurse practitioners realising their full potential in women's health," Jo says. "I would like to see changes happening before I retire. There are so many women in our communities across Australia who rely on us and we must make sure we do the right thing by them. That's why I will keep campaigning for positive changes and removal of the barriers that prevent us from providing that optimal care for some of the most vulnerable women in our communities."



Photo credit: Michael Amendolia



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# BIRTHING ON COUNTRY

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IMPROVING ABORIGINAL AND TORRES STRAIT  
ISLANDER INFANT AND MATERNAL HEALTH

By Natalie Dragon

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**Nyoongar woman and midwife Valerie Ah Chee started her midwifery training aged 41. It followed the birth of her youngest son Raphael who was her most complex at 28+4 days. He weighed 1,650gms and was in NICU for eight weeks.**



“He was really tiny compared to his brothers. It started me on a journey of reflection: the impacts both positive and negative of my birth experiences.”

Valerie shared her experience of birthing and midwifery at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) conference last October.

The mother of six sons and a daughter is an advocate for culturally safe maternity care for Aboriginal and Torres Strait Islander women and for Birthing on Country. Valerie never came across an Aboriginal midwife during her pregnancies. She was the only Aboriginal student in her cohort at Curtin University where she completed her degree in 2015.

“We do not have enough Aboriginal and Torres Strait Islander midwives. Birthing on Country does not automatically mean culturally safe birthing, not until we have enough Aboriginal and Torres Strait Islander midwives.”

Valerie's passion is for Aboriginal and Torres Strait Islander women to be empowered to question their care and to have culturally appropriate care to be able to make informed choices.

Birthing on Country was high on the agenda at the three-day CATSINaM conference held in Adelaide and is an area that is gathering momentum. Largely as there has not been significant improvement in Indigenous infant and maternal health since it was recognised as an area of disparity and great need in 2012.

Indigenous mothers still suffer three times the mortality rate of non-Indigenous mothers. Premature babies are double the rate when compared to non-Indigenous babies and this is the same for low birthweight babies. There is a growing body of evidence which shows that factors affecting babies in utero and in early life have an effect on their long-term health.

Birthing on Country generally refers to an Aboriginal mother giving birth to her child on the lands of ancestors, ensuring a spiritual connection to the land for her baby.

When a woman gives birth off country, away from ancestral homelands, the belief is that it breaks the child's spiritual place in the community raising emotional, social and spiritual issues for the mother and child.

Aboriginal and Torres Strait Islander women have been advocating for many years that Birthing on Country will improve maternal and infant outcomes because of the integral connection between birthing, land (country) and place of belonging.



It is a relatively new phenomenon to not birth on country, says CATSINaM CEO Janine Mohamed.

“Birthing on Country is not something new, it is a continuation of thousands of years of knowledge and practice.”

Birthing on Country is described as ‘... a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families which provides an appropriate transition to motherhood and parenting, and an integrated, holistic and culturally appropriate model of care for all (Kildea et al. 2013).

Birthing on Country ensures a spiritual connection to land for Aboriginal mothers and their babies and was highlighted in the 2010-2015 National Maternity Services Plan.

The plan outlined three recommendations to improve outcomes for Aboriginal mothers and babies:

- Increasing the Indigenous workforce;
- Increasing culturally competent maternity care; and
- Developing dedicated programs for Birthing on Country.

In 2017, a \$1.1 million NHMRC grant was awarded to the Birthing on Country project. It followed a call in 2016 from three peak bodies for radical reform to maternity care services for Aboriginal and Torres Strait Islander women across Australia. ‘Birthing on Country Models’ was a joint initiative of CATSINaM, CRANaplus and the Australian College of Midwives.

The collaboration came about from an urgent need to address the lack of progress

on the COAG mandate on closing the gap in healthcare. Despite a COAG commitment in 2012 to addressing inequality in life expectancy between Aboriginal and Torres Strait Islander people and other Australians, and halving deaths among children aged 0-4 years by 2018, progress had been slow and inconsistent.

Current initiatives were not working, perpetuating poor health outcomes for Aboriginal and Torres Strait Islander mothers and newborns which continued to have an impact in later life, says Ms Mohamed.

“We still have a long way to go if we are to close the gap on health inequity for Aboriginal and Torres Strait Islander people.

“Projects such as Birthing on Country are about making sure Aboriginal and Torres Strait Islander people have access to the health services needed to change the trajectory of poor health outcomes.”

The Birthing on Country program aims include increasing and supporting the Indigenous maternity workforce, expanding culturally competent maternity care, and establishing primary maternity units.

“Birthing on Country models of care provide integrated, holistic and culturally safe and respectful care for the ‘best start in life’ for Aboriginal and Torres Strait Islander families and communities,” says Ms Mohamed.

It has been identified 600 more Indigenous midwives are required to reach parity with non-Indigenous midwives.

“By incorporating our knowledge into clinical practice we also open the door for



more Aboriginal and Torres Strait Islander people to enter the health workforce – this empowers the community to deliver on health and wellbeing outcomes across the board,” says Ms Mohamed.

Birthing on Country Models can be incorporated in any setting, from highly urbanised to very remote environments and are designed, developed, delivered and evaluated for and with Aboriginal and Torres Strait Islander women and midwives. According to CATSINaM’s position statement, Birthing on Country Models encompass some or all of the following:

- they are community based and governed;
- provide for inclusion of traditional practices;
- involve connections with land and country;
- incorporate a holistic definition of health;
- value Aboriginal and/or Torres Strait Islander as well as other ways of knowing and learning; and
- encompass risk assessment and service delivery and are culturally competent.

A Birthing on Country study conducted in Western Australia highlighted the lack of access to high-quality, culturally secure maternity care for Aboriginal women.

The four-year on Noongar Boodjar Project study led by Murdoch University, found more Aboriginal midwives and culturally secure care were critical to closing the gap in maternity care and childbirth outcomes for Aboriginal mothers and their babies.

Researchers investigated the experiences of 39 Aboriginal women, almost half who first gave birth during adolescence.

The results were presented in a three-day symposium in Perth in April 2018 aimed to inform national policy for a culturally competent midwifery workforce.

While all women interviewed reported having both positive and supportive experiences; just over half reported having had a negative experience.

Aboriginal women and practising midwives reported experiencing or witnessing racism or culturally unsafe practices. There was also a deep sense of shame, with some women reporting being unable to ask questions or engage with midwives during their birthing experiences in urban and regional maternity wards, especially when women were alone or only had one member with them.

“The cultural needs of Aboriginal women are not always met or acknowledged once they reach the maternity wards of our hospitals,” Director of Murdoch University’s Ngangk Yira Research Centre Professor Rhonda Marriott says.

Some Aboriginal women did not encounter another Aboriginal person throughout their childbirth experience in metropolitan Perth and major regional centres. The importance of having family members present for birthing in line with cultural practices was not always well known or received by midwives or hospital staff.

Many were often alone during their experience, with family members unable to be present to provide support.

“We need to understand what women want and ensure that they get the right maternity care, especially culturally rich birthing experiences in hospitals, and safer assisted births in the bush,” says Professor Marriott.

Birthing on Country, family support and providing an environment in which mothers felt empowered to ask questions and make decisions were vital to maternal wellbeing, she says.

“More change is needed to ensure that experiences for all Aboriginal women in our maternity services change for the better.”

CEO Janine Mohamed and fellow CATSINaM members presented to a Parliamentary Friends of Close the Gap meeting last October. CATSINaM called on all MPs present to support its call for a Senate Select Committee to investigate the barriers to wider implementation of Birthing on Country. The Inquiry could draw on the national and international evidence that demonstrates the wide-ranging benefits of Birthing on Country, according to Ms Mohamed.

“We need such an Inquiry to systematically identify the barriers that are holding back wider implementation of Birthing on Country and to make recommendations for solutions.”

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# The worth of scalp cooling to prevent chemotherapy-induced alopecia

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**Chemotherapy-induced alopecia (in this paper called ‘alopecia’) can instantly turn a person into a cancer patient. In the outside world, patients have to deal with the stigma of baldness should they choose not to wear a wig.**

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By Corina van den Hurk, Professor Annie Young and Professor Frances Boyle

Inside their homes, cancer patients will see their changed appearance in the mirror every day, reminding them of their disease; hair loss is a distressing experience for the majority of patients. In fact, when patients rank side effects of cancer treatment, alopecia is indicated as one of the most burdensome, even six months after treatment has ended (Batchelor 2001). Cancer patients cope very differently with alopecia: some experience an altered sense of self because of the changed appearance; others try to look normal, use wigs or head covers and/or sharing being bald (Williams, Wood, and Cunningham-Warburton 1999). Alopecia is however not inevitable; it can be prevented by using scalp cooling, the topic of this issue.

## CLINICAL BACKGROUND OF ALOPECIA

Hair matrix cells in the anagen phase are rapidly proliferating and remain in this phase for two to eight years. These anagen hair follicles are highly susceptible to cytotoxic agents. However, hair follicles have a high capacity of damage control: follicle repair between chemotherapy cycles means that many patients do not experience total alopecia but more frequently have patchy, unevenly distributed hair loss. If follicle damage is substantial, hair synthesis is seriously


impeded, causing a fracture in the hair and subsequently severe hair loss (Paus et al. 2013). In patients receiving agents toxic to hair follicles, loss usually starts one to three weeks after the first chemotherapy and patients become bald within several days (Batchelor 2001). Less toxic agents may cause slower hair loss, which becomes clinically apparent after several chemotherapy courses. Permanent alopecia has been described after high dose chemotherapy in haematological malignancies, and after taxane therapy in early breast cancer. This has been attributed to damage to stem cells in the hair bulge (Dunnill et al. 2018).

## INCIDENCE AND SEVERITY OF ALOPECIA AND REGROWTH

The incidence of alopecia is rarely quantified in clinical trials or observational studies. If incidence is reported, the literature shows a large variation and thus healthcare professionals inform patients about the chance for hair loss according to their clinical experiences (Hurk van den et al. 2015). It is estimated that half of the patients undergoing cytotoxic treatment experience severe alopecia (Hurk van den 2013). For Australia this would mean that thousands of patients each year suffer from it. The severity of alopecia depends on many







factors, including the type, dose, method and frequency of administration of the cytotoxic agents. Other possible factors are the patients' age, comorbidities, nutritional and hormonal aspects, psycho-emotional stress and multiple other factors within the individual patient (Paus et al. 2013).

Hair growth is usually only temporarily inhibited by chemotherapy. The hair starts growing again because the stem cells of the hair follicle have been protected against cytotoxic agents, presumably by their slower growth rate and enhanced repair mechanisms (Paus et al. 2013). The normal hair growth rate usually returns within several weeks to several months after the last chemotherapy infusion (Trueb 2009; Karakunnel and Berger 2008). When hair grows again, around 65% of the patients experience a change from their previous hair colour or texture (dryness, curling, straightening) (Batchelor 2001), also generally transient. The altered shape of the hair shaft (curly or straight) probably results from asymmetric proliferation and differentiation during recovery of the hair follicle. Changes in colour are among other changes caused by the melanocyte response to cytotoxics (Paus et al. 2013).

## OPPORTUNITIES TO ADDRESS ALOPECIA

Since the 1970s, attempts have been made to prevent alopecia. Currently, there are no pharmacological agents which are effective in prophylaxis; however, there is data showing faster regrowth of hair after chemotherapy with eg. minoxidil (Wang, Lu, and Au 2006; Shin et al. 2015). Several cosmetics are on the market which claim to reduce hair loss or to stimulate hair growth, also during and after chemotherapy. However, to our knowledge, no studies have been published about the effectiveness of these products against alopecia.

Scalp cooling is currently the only method to prevent alopecia. It was originally practised using ice or cryogel packs that were applied on the head (Timothy, Bates, and Hoy 1980). Cool caps stored in the refrigerator are sometimes still used but continuous cooling machines are the main scalp cooling systems utilised.

Scalp cooling induces vasoconstriction and a reduced biochemical activity, both minimising cytotoxicity for the hair follicle. After scalp cooling, diminished hair shaft diameters have been observed, indicating only moderate damage and quick repair of the hair follicle (**Figure 1**). Thus, hair keeps growing during chemotherapy with scalp

cooling (Hurk van den et al. 2013), and a faster hair growth rate has been observed following scalp cooling (Sahadevan, Ding, and Del Priore 2016; Shaw et al. 2016).

Scalp cooling is indicated for all patients with solid tumours receiving chemotherapy. Contraindications are patients with haematological malignancies, cold sensitivity, cold agglutinin disease, cryoglobulinaemia, cryofibrinogenaemia, cold post-traumatic dystrophy and patients who will have whole head radiation therapy before or following chemotherapy.

Scalp cooling is continuously applied 20–45 minutes before, during and 20–150 minutes after chemotherapy infusion. Cooling times have been arbitrarily chosen, except for docetaxel mono- or combination therapy (75/100 mg/m<sup>2</sup>) where randomised trials showed that a post-infusion cooling time of 20 minutes is sufficient (Komen et al. 2016).

Traditionally, some doubt has existed whether scalp cooling is safe. The incidence of scalp skin metastases in solid tumours is very low and does not differ between scalp cooled and non-scalp cooled breast cancer patients after more than five years follow up (Rugo, Melin, and Voigt 2017). In addition, no difference in patient survival has been observed (Lemieux et al. 2015).

Tolerance of scalp cooling has been studied using overall comfort and acceptability scores. The majority of patients tolerate scalp cooling very well, headaches and coldness are the most frequent complaints (Rugo et al. 2017; Nangia et al. 2017). The majority of scalp cooling participants are satisfied with their decision to undertake scalp cooling, and regardless of hair loss would likely scalp cool again (Shaw et al. 2016). Injuries due to extreme cold have only been reported following the use of cool caps from the refrigerator (Belum et al. 2016).

Efficacy of scalp cooling has been proven in randomised trials, supported by many observational studies (Shah et al. 2017). Two American studies showed that approximately 50% of patients with early breast cancer receiving anthracycline and taxane combinations had satisfactory hair preservation (Rugo et al. 2017; Nangia et al. 2017). Taxane based regimens had better outcomes.

Determinants of efficacy of scalp cooling are first of all type and dose of chemotherapy. Besides, multivariate analyses indicated lower efficacy at shorter infusion times, older age and with African/Asian hair types (Hurk van den et al. 2012). One more recent univariate study showed negative influence

of comorbidities, smoking and neutropenia (Schaffrin-Nabe et al. 2015).

Optimal scalp skin temperature has been shown to be below 22 °C. Efficacy may be improved by a more individualised approach as at present the scalp skin temperatures vary between 10–31 °C between patients when using a scalp cooling machine (Komen et al. 2016). The influence of temperature on cooling-mediated cytoprotection has also been shown in in vitro models for the culture of human keratinocytes, in which cooling markedly reduced or completely inhibited drug cytotoxicity (Al-Tameemi et al. 2014). Other determinants of improved efficacy for scalp cooling remain controversial and knowledge on biological factors is lacking (Dunnill et al. 2018).

### THE ROLE OF NURSES

Nurses play a very important role in scalp cooling. They inform the patient about this supportive care opportunity and in most cancer centres, nurses fit the cap after switching on the cooler and monitor the patient during scalp cooling. The fitting of the cap is of utmost importance as air between the cap and the scalp skin increases the temperature, causing additional hair loss (Komen et al. 2013).

Nurses also support patients to cope with the coldness, especially at the start of scalp cooling, and they guide patients to the bathroom, as they might feel somewhat dizzy because of the cold cap.

Because the patient has to stay in the day care unit for a longer time period than without using scalp cooling, there is the challenge of organising the time schedules. Close collaboration between oncologists and nursing staff is essential to overcome these initial difficulties (Shaw et al. 2018), as is support from the institution. There are some excellent champion units in Australia eg. the Mater Hospital in North Sydney, where scheduling of patients having chemotherapy and scalp cooling is optimised, and other units can adopt their practices.

Traditionally, nurses advise patients to cut their hair short before treatment, but this is less relevant when scalp cooling is used. In fact, maintaining some length in the hair is helpful in styling to cover possible patchy hair loss, which is most often present on the crown. Earlier advice to avoid washing and colouring hair has given way to a more pragmatic approach, where gentle hair management and avoidance of matting are favoured. Advice for hairdressers has been developed and can be found on the website

of the Mater Hospital ([mns.org.au/our-services/list-of-services/cancer-care/scalp-cooling-system](https://mns.org.au/our-services/list-of-services/cancer-care/scalp-cooling-system)).

### RESULTS

The use of scalp cooling increases worldwide. In Australia, the first site – the Mater Hospital – started scalp cooling in 2008. They performed studies on the implementation of scalp cooling (Shaw et al. 2016; Shaw et al. 2018) and have treated over 500 patients to date. At present, about 100 scalp cooling machines are installed in over 40 Australian hospitals. The Mater Hospital also published videos about the topic for patients and healthcare professionals, which are also available through the website mentioned above. Patients are not charged for use of scalp cooling in Australia, as most of the machines have been donated by philanthropic organisations.

International collaboration of researchers with various professions led to the formation of the CHILL group: Cancer-related Hair loss-International Linkage and Leadership. This group published a website with information about alopecia and scalp cooling, including a decision tool ([cancerhairloss.org](https://cancerhairloss.org)).





## CONCLUSION

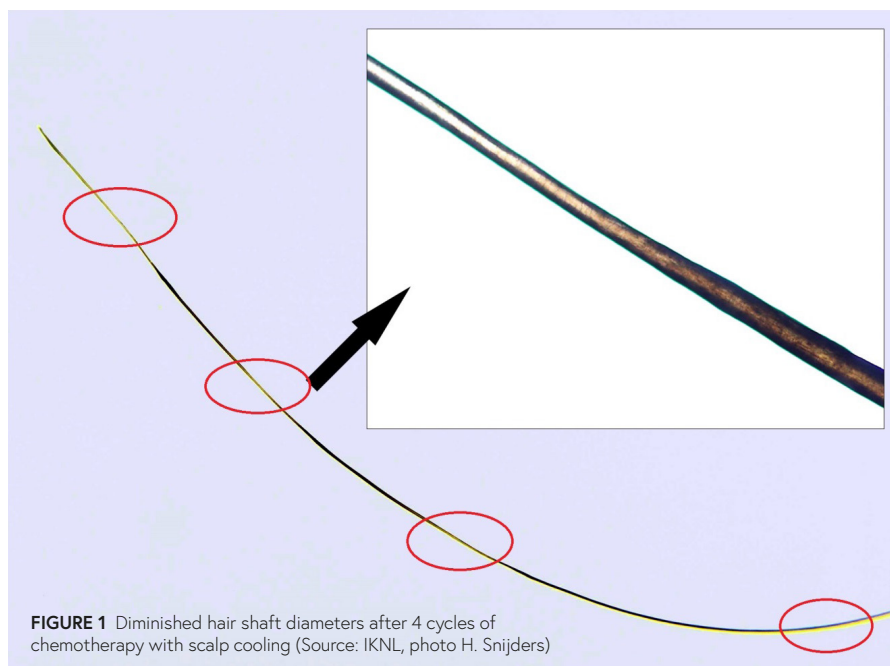
As alopecia has a high impact on many cancer patients and scalp cooling shows to be effective, safe and tolerable, it is worthwhile to offer it on a regular basis. Logistical constraints are there to be solved, as has been done in many Australian hospitals already.

## Authors

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**FIGURE 1** Diminished hair shaft diameters after 4 cycles of chemotherapy with scalp cooling (Source: IKNL, photo H. Snijders)

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# THE RACE AGAINST TIME TO END NUCLEAR WEAPONS

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By Robert Fedeles



**In 2007, Associate Professor Tilman Ruff and a small group of anti-nuclear activists founded the International Campaign to Abolish Nuclear Weapons (ICAN) in Melbourne. Last year, the global non-governmental organisation captured the first Nobel Peace Prize born in Australia after years drawing attention to the catastrophic humanitarian consequences of nuclear weapons and driving an historic UN prohibition treaty.**

Tilman Ruff's life's mission to help end nuclear weapons traces back to growing up in Melbourne in the 1980s living with the genuine fear that nuclear war could strike at any moment.

His family background passed on a profound awareness of the impacts of war.

"My family were German Christians living in communities in Palestine," Professor Ruff explains.

"My great grandparents married there. They were in turn displaced, imprisoned, and quite a few of them were killed in both World Wars and then brought to Australia as prisoners and locked up until 1947.

"So the indiscriminate trauma, loss, madness and horror of war and its terrible legacy across generations was something I heard from my grandmothers and my old people all the time."

As an adolescent, several empowering experiences shaped Professor Ruff's activism, including joining the movement to end Australia's involvement in the Vietnam War and setting up the world's first Amnesty International high school faction in 1970 to support the release of a young man imprisoned for writing a political slogan on a wall.

They made the 15-year-old Professor Ruff truly believe he could make a difference.

A Public Health and Infectious Diseases Physician, Professor Ruff's diverse career has included establishing the Nossal Institute for Global Health at the University of Melbourne, where he currently teaches on public health dimensions and nuclear technology, and a longstanding position as the International Medical Advisor for Australian Red Cross.

Looking back to his early days as a medical student, he reveals the presence of nuclear weapons struck him as "the most urgent global health threat and most demanding of urgent health professional attention."

"Many of us had this daily visceral fear that nuclear war could happen at any time. It was palpable reality in your life."

Professor Ruff suggests the birth of his daughter in 1982 added an emotional

dimension that spurred him further to want to make the world a safer place for generations to come.

Soon he joined the International Physicians for the Prevention of Nuclear War (IPPNW), awarded a Nobel Peace Prize in 1985 for contributing to the end of the Cold War, where he became inspired by how effective and influential evidence-based advocacy imparted by health professionals could be.

Professor Ruff maintains overwhelming evidence shows nuclear war would cause catastrophic consequences and make it impossible to provide any effective health or humanitarian response.

The evidence is epitomised by the World Health Organization (WHO), which commissioned an expert group in 1983 to examine the issue and labelled nuclear war the greatest immediate threat to human health and welfare, with no health service in the world capable of responding to the devastation even a single nuclear weapon could inflict on a city.

"Nuclear weapons are different from any other weapons in two ways," Professor Ruff says.

"One is the simple scale of the destruction. There have been single nuclear weapons built and tested that contained four times the explosive power of all explosives that have been used in all wars throughout human history.

"Of course, they're qualitatively different too in producing radiation that transcends borders, that transcends its effects across generations, effects that can't be undone, increasing the risk of cancer and genetic damage and chronic disease long-term for the lifetime of those exposed."

Professor Ruff says recent scientific evidence points to nuclear weapons triggering climate disruption and a nuclear winter.

Specifically, less than 1% of the world's nuclear weapons targeted on cities would loft so much soot and smoke into the atmosphere that it would blanket the globe in darkness and cool the climate, decimating agriculture for decades and putting billions at risk of starvation across all corners of the globe.



"It doesn't matter where they get used. It doesn't matter whether you're targeted by them or not. The idea that these gargantuan instruments of destruction could provide security for anybody is completely evidence free."

The evolution of ICAN in Melbourne in 2007 was sparked by intense frustration and despair among members of IPPNW, and its Australian affiliate the Medical Association for Prevention of War (MAPW), that nuclear disarmament had fallen off the radar.

Importantly, Professor Ruff and his co-founders were encouraged by the success of the International Campaign to Ban Landmines and felt it could be replicated for nuclear weapons.

The plan was not to recreate a new organisation but instead form a coalition of existing organisations fixed on developing a treaty to ban nuclear weapons on account of their shattering humanitarian consequences.

"It's got to be global, it's got to engage young people, and balance horror, humour, hope and humanity," Professor Ruff recalls of the group's philosophy.

After launching a decade ago at Victoria's Parliament House, ICAN has risen to a coalition of more than 500 partner organisations, including the Australian Nursing and Midwifery Federation (ANMF), across 103 countries.

Fittingly, years of raising awareness about the dangers of nuclear weapons reached a pivotal point in July 2017 when the ICAN-led treaty to ban nuclear weapons was adopted by 122 countries at the United Nations in New York.

The treaty prohibits the use of nuclear weapons, their development, testing, stockpiling, production and threat of use, underlining that any use of these weapons

*“There’s no question that if these weapons are retained they will one day be used and we absolutely have to get the job done before that happens.”*

contravenes the rules of international humanitarian law.

Unsurprisingly, the world’s nuclear-armed states – Russia, France, US, India, North Korea, UK, Pakistan, China and Israel – boycotted the treaty, as did many of their close allies like Australia.

“They’re not only not disarming they’re actually investing massively in adding new capacities and modernising those weapons,” Professor Ruff says.

As the treaty negotiations unfolded at the UN General Assembly in New York, Professor Ruff says stories told in person by victims and survivors of nuclear bombings in Japan, together with survivors of nuclear testing around the world including Indigenous test survivors from Australia, exposed the reality of nuclear weapons like nothing else.

The room burst into joy when the treaty was adopted.

“It was a very emotional moment,” Professor Ruff recalls.

“These are normally very formal and dry proceedings. When the vote happened, 122 to 1, the room just erupted with hugs, tears of joy. It was one of the most extraordinary moments you could ever witness.”

Almost 70 states have signed the treaty and 19 have ratified it.

It will enter into force once 50 states have signed and ratified it.

“It’s not the final perfect all-in-one solution that’s going to magically get rid of nuclear weapons overnight,” Professor Ruff concedes.

“But it’s the best thing that the rest of the world that doesn’t own the weapons could do.”

Professor Ruff is adamant the treaty marks a major step forward of historic significance, and through growing international support and an increased focus on stigmatisation, can finally help rid the world of nuclear weapons.

If anything, the fierce and bitter opposition expressed by the nuclear-armed states in the wake of the treaty has further reassured him.

“They wouldn’t do that if this didn’t matter. If this didn’t put them on notice and on the defensive.”

Professor Ruff praised the involvement of key health professional federations from around the world, such as the International

Council of Nurses (ICN) and World Medical Association (WMA), in helping to reinforce how nuclear weapons pose a planetary health threat of the highest magnitude.

In this vein, he believes real change can only occur by influencing government policy and all health professionals, including nurses and midwives, should champion the power of health evidence.

“Our responsibility as health professionals is not just to alleviate suffering and try and cure diseases but to prevent illness, keep people and our communities healthy and be advocates.”

Several months after the treaty, ICAN was awarded the first Australian-born Nobel Peace Prize at a ceremony in Norway for its efforts.

“It was hugely important, humbling and just wonderful for a couple of reasons, apart from just the fact this has been blood, sweat and tears for me, endless nights and weekends, 365 days a year for more than a decade and for 20 years before that,” Professor Ruff reflects.

“It provides really important attention to the urgency of the issue and the need to make progress. It provides historic recognition for the importance of the treaty and gives enormous encouragement to civil society and governments.”

Disappointingly, Professor Ruff says the glaring lack of support and recognition from Australia’s leaders, both for the treaty and Nobel Peace Prize, remains difficult to comprehend.

“Basically, our policy is that we might need the US to use nuclear weapons on our behalf and we actually provide, through facilities and personnel assistance, for the possible use of nuclear weapons. That’s a completely immoral position. We’re part of the problem, not the solution.”

Regardless, Professor Ruff says the Nobel Peace Prize has opened doors and allowed ICAN to spread its message further.

The immediate task rests in getting as many states to sign and ratify the treaty as possible to strengthen its legal and political force.

Pressure will also be ramped up on financial institutions, such as several of the big banks, invested in companies that make nuclear weapons.

In Australia, the strategy will likely focus on gaining a commitment that the next Labor Party government will adopt the treaty, given its current policy platform from 2015 specifically calls for negotiations of a global treaty banning nuclear weapons.

Professor Ruff says its imperative civil society organisations, including unions, band together to push for elimination.

While decades have passed since he was a youth growing up in Melbourne with the threat of nuclear war hovering Professor Ruff remains visibly determined to close the final chapter.

“Objectively, the danger of nuclear war is growing,” he declares.

“There’s no question that if these weapons are retained they will one day be used and we absolutely have to get the job done before that happens.”

To learn more about the International Campaign to Abolish Nuclear Weapons (ICAN) [icanw.org/au](http://icanw.org/au)

## THE FACTS ABOUT NUCLEAR WEAPONS

Nuclear weapons release vast amounts of energy in the form of blast, heat and radiation, with no adequate humanitarian response possible

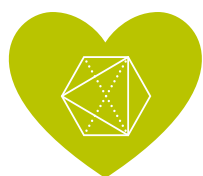
A single nuclear bomb detonated over a large city could kill millions of people and the use of tens or hundreds of nuclear bombs would disrupt the global climate and cause widespread famine

Nuclear weapons have been used twice in warfare – on the Japanese cities of Hiroshima and Nagasaki in 1945, killing more than 210,000 innocent civilians

Nine countries possess around 15,000 nuclear weapons, with the US and Russia keeping about 1,800 of their nuclear weapons on high-alert, ready for launching within minutes.



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## Eye Health and Vision Care

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**Approximately 314 million people worldwide live with low vision and blindness, yet 90% of vision impairment is treatable or preventable.**

**T**o tackle this issue a global initiative, *Vision 2020: The Right to Sight*, was set up to: “Intensify and accelerate prevention of blindness activities so as to achieve the goal of eliminating avoidable blindness by 2020.”

It is a joint program of the World Health Organization and the International Agency for the Prevention of Blindness with an international membership of non-government organisations, professional associations, eye care institutions and corporations.

Vision 2020 Australia manages *The Vision Initiative* which is an integrated health promotion program funded by the Victorian government.

### VISION 2020 AUSTRALIA AND THE VISION INITIATIVE

The *Vision Initiative* draws together partner organisations across the full continuum of care including primary, secondary and tertiary health and eye health providers, local and state government and community organisations.

The *Vision Initiative* has identified the people with an increased risk of eye disease as people who:

- are over 40 years of age;
- are of Aboriginal and Torres Strait Islander descent;

- have a family history of eye disease;
- smoke;
- have diabetes; and
- CALD communities.

Approximately 500,000 Australians are affected by blindness or vision impairment. Eighty percent of these are caused by five common eye conditions:

1. age-related macular degeneration (AMD);
2. cataract;
3. diabetic retinopathy;
4. glaucoma; and
5. under or uncorrected refractive error.



**“In Australia in 2009, there were almost 575,000 Australians aged over 40 with vision loss. Of these, around 66,500 were blind. It is projected that the number of people aged over 40 with vision loss will rise to almost 801,000 by 2020 and those who are blind will rise to 102,750.” (Clear Focus Report 2010).**

### PEOPLE WITH VISION IMPAIRMENT ARE:

- twice as likely to fall;
- three times as likely to suffer from depression;
- at risk of hip fractures by up to eight times more than the rest of the population; and
- are admitted to nursing homes three years earlier than the rest of the population.

The good news is that almost 90% of vision impairment is preventable or treatable.

Saving your client's sight could be as easy as encouraging them to have regular eye tests.

Regular eye tests will help detect any problems early and allow for the best treatment.

### COMMON EYE CONDITIONS

In order to refer your client appropriately, you need to understand:

- what the condition is;
- what the symptoms are;
- who is at risk;
- treatment; and
- where to find more information.

### AGE-RELATED MACULAR DEGENERATION (AMD)

AMD is a major cause of vision loss in the over 50 year age group in Australia.

Two out of three people will be affected by AMD in their lifetime and vision loss will occur for one in four.

AMD gradually destroys central vision, which is essential for common everyday tasks such as reading and driving.

AMD may advance so slowly that the gradual deterioration of vision is not noticed, other cases progress rapidly but both can lead to a permanent loss of central vision.

### THERE ARE TWO FORMS OF AMD:

#### Dry AMD

When cells in the retinal pigment epithelium die, the retinal cells above them also die, leading to patches of 'missing' retina. This is dry AMD. This is a slower form of the disease, causing gradual loss of vision. Dry AMD does not cause sudden vision loss or distortion. If you know you have dry AMD and you experience any sudden change in vision, then it is likely that you have developed the 'wet' form. It is critical that you see your eye care professional immediately (Macular Disease Foundation Australia 2016).

#### Wet AMD

The wet form of AMD occurs when retinal pigment epithelium cells fail to stop the choroidal blood vessels from growing into the retina. When these cells enter the retina, they grow wildly, and they leak fluid and blood into the retina, leading to scarring and loss of vision. When left undetected or untreated, rapid and severe loss of central

vision can occur within a short period of time. The Amsler grid will help you to detect changes in vision (Macular Disease Foundation Australia 2016).

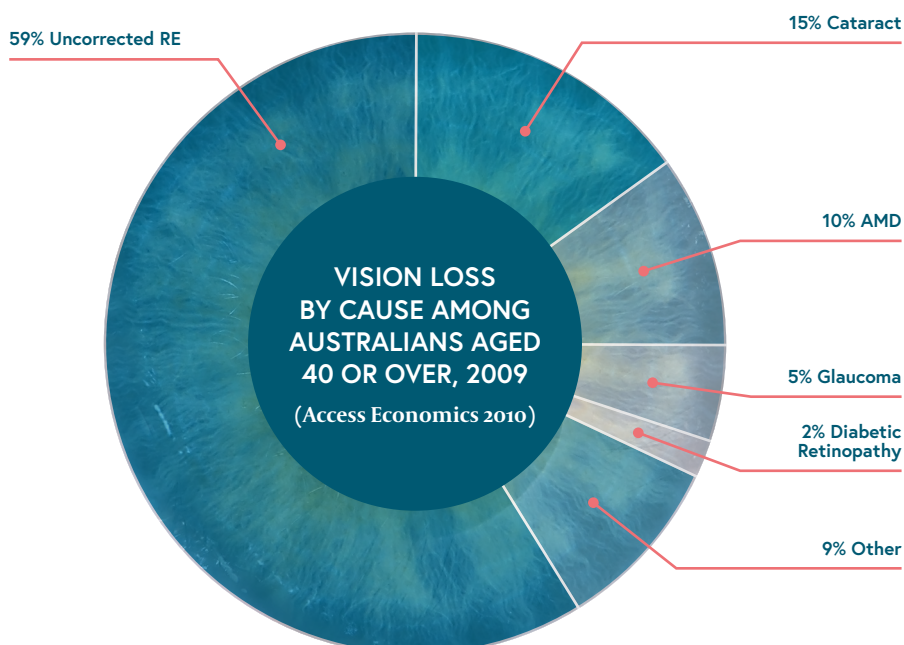
### CATARACTS

Cataract is a clouding of the lens inside the eye. Poor vision results because the cloudiness interferes with light passing through the lens to the retina. Most cataracts form due to ageing and long-term exposure to ultraviolet light. Cataracts are a leading cause of reversible vision loss in Australia. Thirty one percent of the population over the age of 55 years has a cataract.

Cataracts typically develop slowly and are usually associated with a gradual, painless blurring of vision that may not improve with prescription glasses. They may also be associated with increased sensitivity to bright lights, such as while driving at night. Changes in how colour is seen may also occur and objects may appear to have a yellow or brown tinge.

### DIABETIC RETINOPATHY

Diabetic retinopathy is a complication of diabetes that can affect individuals with type one or two diabetes. The condition affects the small blood vessels of the retina at the back of the eye. It remains one of the leading causes of vision loss, despite availability of effective treatment if the disease is detected in the early stages.



It is estimated that 2.8% of the population aged over 55 years have diabetic retinopathy.

Within 15 years of being diagnosed with diabetes, almost three out of four diabetics will have some form of diabetic retinopathy.

There are often no early warning signs of diabetic retinopathy, so early detection through regular eye examinations is essential. Vision may become hazy or blurred and objects may float across the field of vision. Central vision may become distorted and straight lines may appear bent or wavy. Fine details may become difficult to see during everyday activities.

**There are three types of diabetic retinopathy:**

- non-proliferative
- proliferative
- high risk proliferative

### GLAUCOMA

Glaucoma is a group of eye diseases characterised by progressive damage to the optic nerve and subsequent vision loss or blindness.

It is often associated with high pressure inside the eye, but it can also occur in people with normal intraocular pressure. The average intraocular pressure is 21mmHg.

Three percent of the Australian population over 55 years is affected. Only half of Australians with glaucoma know that they have the condition.

Primary Open Angle Glaucoma (POAG) is the most common form of glaucoma. POAG causes painless damage to the optic nerve resulting in irreversible loss of vision.

There are usually no symptoms of glaucoma in its early stages. It can lead to the loss of peripheral vision over time. It can develop in both eyes, but one eye may be more affected than the other. Very rarely, people may develop a sudden-onset painful form of glaucoma with rapid loss of vision. This is a medical emergency.

### REFRACTIVE ERROR

Refractive error is a disorder, not a disease.

A refractive error means that the shape of the eye does not focus light correctly on the retina, resulting in blurred vision. Refractive error can progress as a person ages.

It is estimated that nearly 300,000 Australians have correctable vision impairment as a result of refractive error. Refractive error is easily correctable with glasses.

### TYPES OF REFRACTIVE ERROR

**Long-sightedness** (hypermetropia/hyperopia)

**Light focuses behind the retina** – trouble with near vision.

**Short-sightedness** (myopia)

**Light focuses in front of the retina** – trouble with distance vision.

**Astigmatism** (oval shaped eye)

**Difficulty focusing at all distances.**

**Presbyopia** (age-related near focus difficulty)

**Trouble with near vision which develops with age;** and

**Loss of elasticity of the lens, which reduces ability to change focus for near.**

Refractive error can affect people of all ages. Timely detection of refractive error is particularly important in children as uncorrected refractive error can interfere with the development of the visual centres of the brain.

People with a family history of refractive error are at an increased risk.

All types of refractive error can change over time. Presbyopia is more common with age.



**30 minutes  
CPD**



This excerpt is from the ANMF's Eye Health and Vision Care tutorial on the Continuing Professional Education (CPE) website. Reading and reflecting on this excerpt will give you 30 minutes of CPD towards ongoing registration requirements.

The complete course provides two hours of CPD and covers the anatomy and physiology of the eye; types of eye tests; detailed information on the common eye conditions listed including symptoms, treatment and management; low vision service referral; correct use of eye drops; the eye health sector and resources for patients and health professionals.

The ANMF's Eye Health and Vision Care tutorial has been developed by the Vision Initiative in collaboration with the ANMF Federal Education Officer. The tutorial is relevant to all levels of nurses and midwives.

To access the complete tutorial, go to [anmf.cliniciansmatrix.com](http://anmf.cliniciansmatrix.com)

For further information, contact the education team at [education@anmf.org.au](mailto:education@anmf.org.au)

**[anmf.org.au/cpe](http://anmf.org.au/cpe)**

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# Systematic reviews: If in doubt, refer to the instructions

## Is full symptom assessment complete if only some of the items have been assessed?

Clinicians often trust that the guidelines that underpin their practice are rigorous and dependable, but recently, systematic reviews – the pinnacle of the evidence hierarchy and most trustworthy source of evidence for clinical guidelines – have come under fire for problems with rigor and bias (Demasi 2018).

Reporting guidelines have been developed to improve review quality and rigor and numerous methodologies for the conduct and reporting of different kinds of evidence synthesis have been developed, including for clinical guidelines (Guyatt et al. 2008).

The quality of systematic reviews themselves can easily be assessed using standardised tools such as AMSTAR 2 (Shea et al. 2017) or by comparing what the authors have reported with their stated methodology.

Many of these approaches highlight the importance of transparency, detail, and accuracy to ensure rigor and dependability.

While often challenging, undertaking a systematic review is essentially a process of following specific, step by step instructions and clearly documenting how you have followed them or where and why you have done differently.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) is widely regarded to be the 'gold standard' for reporting traditional systematic reviews (Moher et al. 2009). Some journals endorse the use of PRISMA as a prerequisite for publication, and the growing adoption of PRISMA has been linked with higher methodological quality and reporting (Panic et al. 2013). However, not all reviews citing PRISMA appear to have followed its recommendations.

A review on a current topic – mandated nurse staffing ratios in acute care – is a very recent example of how

reporting against guidelines can be a challenge (Olley et al. 2018). This review, omits key elements defining PRISMA adherence including: citation of a protocol, detailed inclusion criteria, at least one search strategy, and an assessment of the quality of the included sources of evidence. Combined, these issues could limit the confidence a reader may have in the findings. To briefly explain why these issues are important; a protocol minimises bias and is considered integral to true systematic reviews, detailed inclusion criteria also limit bias and further enhance a reader's ability to understand the scope of the review, a reproducible search strategy allows authentication of the review's process, and an assessment of quality enables appraisal of bias and the relative veracity of the findings and conclusions (Shamseer et al. 2016). Without knowing that the review was conducted according to the instructions or accounted for the quality of the included evidence, trustworthy recommendations and conclusions are difficult to make.

Non-adherence to reporting standards is not rare. In fact, a field of meta-research has examined the issue in depth (Page and Moher 2017). It may be that restrictive word-limits hamper some authors' best efforts to explain their process in detail but use of supplementary data and separately published protocols can assist by linking to important information elsewhere. To justify their place at the top of the pile for informing evidence-based care, systematic reviews must uphold certain standards (Campbell 2017). This can be most easily done by authors understanding and transparently reporting against respected guidelines. Readers and users of systematic reviews must also ensure they are aware of reporting guidelines and can themselves critically appraise what they're reading by not taking even 'level one' evidence at face value.

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# Inclusive healthcare for members of the sexual and gender diverse community

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Recent changes in socio-political ideology have allowed for a more open discussion about the views of contemporary Australian society in relation to diversity.



**Damian Wilson**

*Damien Wilson holds a RN BN, Grad Cert. Emerge Care, Grad. Cert. Higher Education, MN and is a PhD candidate*

The discussion surrounding the marriage equality postal survey in 2017 provided an opportunity for the Australian government and Australian community to openly show their support (or not) for same-gender attracted and gender diverse (SGD) people and provide equal status under the law through the legalisation of marriage between two people of the same gender.

The overwhelming support for changing the *Marriage Act* signifies that Australia as a country is a strong advocate of equality and acceptance of SGD people.

For this reason Australian society is becoming an environment that fosters the ability for SGD adolescents and adults to explore their sexual and gender identities earlier, and more publically thanks to the global sensation of social media.

Social media permeates our society with everyone's likes, dislikes and personal opinion (Humphrey

2016), but also presents the erroneous perception of an increase in the number of people that are now identifying as same-gender attracted or gender diverse ie. transgender/trans.

Openly SGD people require access to healthcare just like other people in society. An understanding of the history of the relationship between healthcare services and the SGD community provides a historical tale of how professional health organisations, eg. the World Health Organization (WHO) and American Psychiatric Association (APA), pathologised SGD people as a mental health illness. As such SGD people have suffered at the hands of healthcare professionals undergoing psychological interventions (eg. gay-conversion therapy) and faced stigma and discrimination by healthcare professions.

In 1973 same-gender attraction (homosexuality) was removed by the APA. The WHO later changed





their definition in 1992; but transgender or gender dysphoria remained a mental health illness until 2018 (WHO 2018).

Even so the lack of awareness of correct terminology eg. pronouns or appropriate conversational language, causes the healthcare consultation to be a negative experience for an at-risk health population (ie. high-risk behaviours, elevated rates of depression, substance abuse and other mental health presentation). Consequently, this population is less likely to approach a healthcare facility or actively avoid them all together (Beagan et al. 2012; Quinn et al. 2015; Parameshwaran et al. 2017).

Anecdotal experience has shown evidence of SGD being disrespected by nursing staff during handover and actively mocked during general staff interactions, highlighting a culture of ignorance and the need for education.

Figure 1

#### PRESENTATION:

- confidentiality;
- avoid presenting the person's gender identity as their presenting complaint; and
- use of their preferred pronouns.

#### EQUIPMENT:

- de-gender procedure names and body parts, instead referring to them by their actual names (eg. urethral catheterisation); and
- utilise computerised record keeping that can reflect the person's gender identity and intimate partner relationship.

#### EDUCATION/SUPPORT:

- educate other healthcare professionals, and advocate for the correct use of pronouns for the person that is under your care;
- promoting an inclusive environment establish Equality and Inclusion Committee; and develop a LGBTIQ liaison worker to provide ongoing support and training for healthcare professionals.

Nursing (and medical) healthcare professionals need to do better, by modifying their behaviours or interactions with other healthcare professionals and in doing so advocating for the person they are caring for provides more inclusive or optimal healthcare for members of the SGD especially those exploring their gender identity.

To facilitate and improve the experience that SGD have when accessing healthcare, simple interventions can be applied (see figure 1).

As nurses, we are educators, and we are advocates. We actively seek out learning opportunities to stay up to date with changes in nursing practice, or hospital policies and procedures in order to be able to provide optimal care for the people under our care and their families. Why can this not be done for SGD issues? To improve healthcare experiences for the SGD community all that is required is the respect that acknowledges their diversity and the compassion to work with this at-risk group to improve healthcare accessibility.

Making these changes does not change how we provide care, but it will improve on the healthcare experience for SGD people who are accessing and receiving our care. The SGD community are not asking to be special, just to be treated with respect.

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Debbie Richards

Federal Industrial  
Research Officer

# Change of rules to restore the balance

**Over recent months ANMF members have joined thousands of union members and community supporters in a national campaign to ‘Change the Rules’.**

Rallies held throughout the country called for a major overhaul to Australia's workplace relations system to reduce the massive imbalance in power between employers and employees under the current Fair Work laws.

*The Fair Work Act 2009* provides the legislative framework for our national industrial relations system and among other matters, deals with National Employment Standards, modern awards such as the *Nurses Award 2010*, enterprise agreements and bargaining.

The majority of workplaces are covered by the national system including nurses, midwives and carers employed in the public sectors in Victoria, ACT and NT, aged care, private hospitals, private practice, community health and diagnostic clinics for example.

A major exception is nurses, midwives and carers employed in the public sectors in NSW, QLD, SA, WA and Tasmania whose employment is regulated by respective state based legislation.

‘Change the rules’ is about restoring some balance in the system and providing a fair go for all workers. While there always is an imbalance of power between employers and workers, key elements of our current industrial relations system have shifted that power even further in favour of the employer. Stronger rights at work, including the ability to organise, participate and be represented by your union are fundamental to securing and maintaining decent jobs and a reasonable living standard for all working people.

For many in our community, the system is unfair and ineffective and evidence from a range of indicators continues to show that the system is indeed broken.

Wages growth remains at an all-time low with zero growth in real wages over the 12 months between June 2017 and June 2018 taking into account the CPI.

The relevant ABS data for this period for all industries shows hourly rates grew by just 2.1%,<sup>1</sup> while CPI was also 2.1%<sup>2</sup> resulting in no real increase. The September ABS data tells a similar story with hourly rates of pay increasing 2.2% between September 2017 and September 2018 while CPI for the same period was 1.9% meaning real wage growth overall was just 0.3%<sup>3</sup>.

At the same time, company profits increased a healthy 16% on the previous financial year,<sup>4</sup> with median executive pay increasing by 12.4%, (much of it made up of huge bonuses for cutting staff numbers).

This sits in stark contrast to a recent survey commissioned by the ACTU indicating that 80% of working people either did not get a pay rise that kept

up with the cost of living, or hadn't had an increase at all in the last 12 months.

Even more alarming, the Household Income and Labour Dynamics (HILDA) survey reports that, in real terms, working people have not had a pay rise in almost a decade.

On the back of this, the decision by the Fair Work Commission (FWC) to cut penalty rates in Awards covering the retail and pharmacy sectors continues to take effect reducing 15% in 2018 and falling a further 15% in 2019 and again in 2020.

Similarly, in the hospitality sector penalty rate cuts continue to bite reducing by 10% in 2018 and the same again in 2019.

For the thousands of workers in hospitality and retail, who are already in low paid and insecure work, the cuts to penalty rates are a double blow.

The Reserve Bank's answer to record low wages growth? Easy – workers should just ask their employer for a pay rise!

Well, yes we do. An annual pay increase is always part of the claims put forward by members in an enterprise agreement negotiation. And as ANMF members and other union members have shown, any chance of success requires members working together to build bargaining power in the negotiation process.

It's not to say that there are not successful bargaining outcomes under the current system, certainly there are many examples of ANMF wins with a strong membership driving the bargaining process. However it's true to say that where good outcomes are achieved it is despite the system. Bargaining is much harder in the current environment with excessive and unnecessary rules restricting our rights, our organising ability and reducing our bargaining power. Moreover, from a human rights perspective, the current rules are not consistent with long standing international labour standards set out in International Labor Organisation Conventions ratified by Australia<sup>5</sup>.

The system is broken and we need to change the rules to provide all workers with the basic rights needed to ensure decent jobs and a fair day's pay for a fair day's work.

Watch out for upcoming campaign activities in your state/territory and check your ANMF Branch website. For further information on why we need to change the rules go to the ACTU website [changetherules.org.au/](http://changetherules.org.au/)

## Footnotes

1. [abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6345.0jun%202018?OpenDocument](http://abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6345.0jun%202018?OpenDocument)

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# WOMEN ON BOARDS

A LEADING FORCE

By Natalie Dragon

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**Resignations of high profile women leaders last year have thrown the spotlight on the culture and gender disparity in Australian workplaces. Natalie Dragon talks to some prominent nurse leaders who are board members about their roles.**

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The disparity between men and women in leadership roles perpetuates existing stereotypes about the role of women, both at work and in wider society, and exacerbates gender pay inequity, according to the Australian Human Rights Commission. Research shows that having significant numbers of women in leadership positions encourages and sustains other women.

Corporate Australia's female problem was highlighted last May when all four female directors of AMP resigned following revelations at the Banking Royal Commission.

Liberal backbencher Julia Banks, who left the party after tactics that toppled Malcolm Turnbull were played out, told Parliament that only gender quotas would work in politics. Only 17% of Liberal MPs are women

compared to nearly half of all Labor MPs. The Victorian ALP re-elected last November announced women would constitute 50% of the front bench.

The number of women on the boards of ASX-listed companies grew from 8.3% in 2009 to 26.2% in 2017. ASX guidelines emphasise voluntary but transparent targets, there are no mandated quotas for gender diversity on boards.

Some countries, including France, Spain and Germany, have quotas for gender representation. Finland introduced 40% quota legislation in 2006; and Norway in 2008, where all listed companies must have corporate boards composed of at least 40% of each sex or face dissolution.

No one disputes it should be the best person for the job, the issue is whether there is unconscious bias against women in selection for the roles.



"We need to be proactive, personally I believe the setting of quotas to ensure equal female representation on boards is essential," says ANMF Assistant Federal Secretary Lori-Anne Sharp. "It encourages companies to achieve gender diversity. A cultural shift is emerging that supports equal gender representation, but we still have a way to go."

"Women with the necessary qualifications should be encouraged to sit on boards and claim the same opportunities as their male counterparts. Women bring a unique set of skills, have understanding of the many social and financial factors impacting on communities such as caring responsibilities and challenges of family/work life balance. Equal gender representation gives a fair democratic process to the 50% of women that are representative of the adult population."

Ms Sharp joined the HESTA Super Fund Board in July last year. A registered nurse for 25 years, with experience in community health, aged care and the acute sector, Ms Sharp has extensive industry experience. Her position on the ANMF Victorian Branch Council has given her firm grounding on governance.

"I have broad experience and understand the needs of members and their everyday lives, the challenges they face and the impact of the decisions we make."

HESTA is embedded in the community services and health sector and is particularly focused on all its members having a dignified retirement, says Ms Sharp.

More than 80% of HESTA's 850,000 members are women. HESTA has a female independent Chair and CEO and 57% of its senior leadership are women. The super fund is a signatory to the 30% Club's Investment Statement of Intent and a member of ACSI. Both advocate for the boards of Australia's biggest companies to have a minimum of at least 30% female directors.

"Having women in senior leadership flows through to all levels of an organisation, creating a more inclusive work culture and greater career opportunities for women," Former HESTA CEO Debby Blakey says.

Any company not looking at 50% of the population when identifying its next leaders will not attract the best people, and performance of the organisation will eventually suffer, argues Ms Blakey.

Evidence shows companies with a higher proportion of women in leadership roles have better overall corporate governance and performance, according to Ms Blakey.

A Deloitte Access Economics report (October



ANMF Assistant Federal Secretary

2016), found increasing the number of women in corporate leadership positions is likely to significantly increase financial returns.

"We see diversity as an accurate indicator of a well-run company more likely to deliver long-term value to shareholders, and therefore better long-term returns for our members," says Ms Blakey.

Women in senior leadership are also important role models who can foster diversity and champion a work environment that encourages other women to stay in the workforce and seek advancement, she says.

"While a lot of attention has rightly been paid to the number of women on boards, we also need to increase the number of female senior executives to improve decision making and support a healthy pipeline of women qualified to join boards in coming years."

Boards make decisions that can also positively impact the broader community, according to Ms Sharp. HESTA was among the first Australian super funds to implement a portfolio-wide tobacco exclusion. The super fund also sold its \$23 million stake in offshore immigration detention centres Transfield in 2015 after consideration of whether its investment met with its environmental, social and governance policy.

"If you are a board member, your responsibility is to make decisions in the best interests of the members, at times these decisions can also have a flow on effect to the wider community in advocating for positive social change," says Ms Sharp.

While a considerable time commitment, being a board member is a very rewarding experience, Ms Sharp says. "It's an opportunity to expand your professional network and develop decision-making skills transferrable to other professional roles."

Ms Sharp undertook a Company Director course with the Australian Institute of Superannuation Trustees (AIST) last November.

"To better understand investments, financial governance and corporate knowledge. It's a learning curve and a great opportunity to develop new skills and make a valuable contribution at the board level."

Not every board appointment is a career-enhancing or rewarding opportunity.

"It's important to be on the right board for you that is clearly aligned with your goals," says former Commonwealth Chief Nurse and Midwifery Officer Dr Rosemary Bryant AO.

Dr Bryant has served on state registration boards, was on the International Council of Nurses Board (ICN) for 12 years, the last four years (2009–2013) of which she was President. She was Executive Director of the then Royal College of Nursing, Australia. Dr Bryant now chairs two boards in South Australia – The Rosemary Bryant AO Research Centre and the Rosemary Bryant Foundation. She has been a director of the NPS MedicineWise Board since October 2017.

"Ever since I was a student nurse, I have always been an advocate for nursing and then nursing and midwifery. Being on a board gives me access to the decision makers whichever arena it is.

"For me, it's always been about ensuring



Dr Rosemary Bryant AO

## PREPARATION FOR BOARD ROLES

- Get a mentor
- Education – develop knowledge in areas such as accounting and finance; strategy and planning; human resources; legal knowledge and governance; knowledge of a director's responsibilities; and risk management. Complete a Company Directors Course; CV or LinkedIn training; any other education or training programs required.
- Professional development in areas such as: emotional intelligence ie. conflict resolution; collaboration; leadership; networking; time management; public speaking; commitment to diversity and inclusion; and strategic thinking.
- Expand your networks
- Join a professional association or industry body
- Social media presence.
- LinkedIn is the world's largest professional network. Before applying for board positions, consider attending a LinkedIn development training course.

that nurses' voice is heard and that we have outcomes which are appropriate for us and our patients and ultimately our communities."

NPS MedicineWise Board is comprised two thirds from the health industry and one third consumers and business people.

"It doesn't matter what board you are on, whether it's nursing or midwifery or outside your profession, there are still a lot of elements of the work which are similar and skills you need in order to negotiate your way through," says Dr Bryant.

Negotiation and interpersonal skills are key requirements, she says. "One of the big things while on the Board of the ICN was how to negotiate, and more importantly than that, was how to listen because there were 14 people on the Board and they came from very diverse backgrounds – for example from India, Latin America, Japan.

"I saw through the prism of being Australian and how we do it. I learned to listen and identify the genesis of the issue at hand and form possible solutions and see where a solution wouldn't work in one country. We have 130 plus [member countries] of the ICN and that for me was very important to learn – how to listen and not jump to conclusions."

While profession-specific boards are more homogenous, others such as government committees often comprise different clinicians with different perspectives. Dr Bryant says it's difficult to be the lone voice in representing your profession.

"It's very hard for one person to carry the aims of the profession. I have a lot of experience in observing. Some of the time, I do not know the details, I am not an expert clinician in every field but I get the gist and my role is to make sure the nursing and midwifery voice is heard.

"You really need arguments and evidence if you are going to challenge and participate properly in a debate on the board. Put the time in and read the papers. If there's a problem or something you do not understand then talk to the Chair or CEO before the meeting."

Dr Bryant says she has experienced sexism on boards and says it's important to call it out.

"You've got to be pleasant but just call it. You need to speak up. I say it how it is; I can be direct. Of course, I push the nursing, and now the nursing and midwifery perspective. Present your argument in a cogent way. Be unemotional and present the facts as they are and the evidence of what you are saying."

It's important to have credibility around a board table to get recommended and supported by your board, Dr Bryant says. Participation in social activity with other board members fosters relationships.

"Make an effort to attend the dinners and talk to board members. Get to know your fellow members and the main reasons they are on the board and their perspective. It builds a more cohesive board and builds trust. Once everyone understands the aims

and objectives of each person, it makes for better conversations."

Financial literacy is another skill needed for the decision-making required on a board. The three sentinel roles of a board are to appoint the CEO; to set the strategic direction; and to keep the doors open – to make sure it stays financially viable, says Dr Bryant.

"You need to be able to read financial statements. I have done some accounting subjects and have learned to read a balance sheet and profit and loss statement; I understand the finances."

Dr Bryant says she enjoys being on boards. "If you are that way inclined, I would highly recommend it. It's very interesting and there are lots of knotty issues that you may never have even thought about; you learn a lot."

Lori-Anne Sharp sees nurses and midwives taking on more leadership roles, not just on boards.

"Nurses and midwives are passionate advocates for those they care for and understand the frailties of life. They are also great communicators and contributors, very effective problem solvers and generally just get on and get the job done.

"Transferring these skills to new roles, extending and challenging yourself is important. It's essential that nurses and midwives are in those spaces, influencing and making the decisions that can positively impact people's lives and future."





Julie Reeves

ANMF Federal  
Professional Officer

# Nurses in schools – making a positive difference

**The role of registered nurses and enrolled nurses in the school environment is pivotal to improving the health of children and adolescents.**

Not only is our country experiencing increases in non-communicable diseases such as asthma, diabetes, obesity rates in this group of the Australian population, we also have significant increases in mental health concerns for young people.

These nurses can (and do) undertake an enormous role in primary healthcare prevention and early intervention in a broad range of physical and mental health issues. This occurs through regular screening, immunisation, education and ongoing health promotion and care.

School nurses have proven to be a trusted member of the school community in which they practise.

They are often specifically identified by students as a trusted person in whom to confide very personal information.

The diverse role of the school nurse may include acting as an advocate, emergency/crisis management, or health counselling. School nurses are perfectly placed to improve the health and wellbeing of young people.

Statistics retrieved from the *National Health Workforce Dataset on nurses working in Primary Health Care (2016)* show there were 1,511 nurses who identified, in 2016, as school nurses – working in both the private and public school sector.

States and territories have different models of care in which nurses undertake their role, with the context of practice for a school nurse varying significantly depending on the needs of the school community. In some jurisdictions, school nurses are primarily in the private school sector and in others their numbers are higher in public school settings. Community nurses also visit schools to conduct health screening and vaccinations.

ANMF members across the country have identified nurses working in schools are an important context of practice for the nursing profession. There are a number of Special Interest Groups for school nurses within the ANMF Branches, who meet regularly to provide an opportunity for continuing professional development and support. As the role of a school

nurse is independent, and in many instances, a professionally isolated one, providing collegial support and development is essential.

In 2012, the ANMF developed the *National School Nursing Professional Practice Standards*. These standards are currently undergoing a comprehensive review. Many stakeholders provided significant feedback, and in 2017 a draft document *National School Nursing Standards for Practice* was produced. Consultation on these draft standards has included both an online questionnaire and focus groups that have been held across the country over the last 12 months.

It has been a privilege to conduct the review for the school nurse standards. These nurses are committed to the role of school nursing and the difference they make for young people's health and wellbeing. Capturing the role variations within these standards is a difficult task, however at an overarching level, these nurses are undertaking primary healthcare. One of the things that struck us as being so pertinent to the broader profession of nursing is the role school nurses undertake in caring for the whole school community, teachers, parents, older siblings, by connecting people. They connect students and families with the school team, external health services and welfare professionals within their local school community.

Have you ever really contemplated the influence nurses and midwives have on every aspect of our lives? They connect people.

As the largest combined professions, nurses and midwives are everywhere, making a difference to the lives of the people they care for: their families, our families, friends, colleagues and even politicians.

Nurses working in the school environment are making a significant difference to the health and wellbeing of not only young people but also the entire school community. The ANMF strongly advocates for positions in all school settings for nurses.

The new *National School Nursing Standards for Practice* will be available in early 2019.

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**Linda Starr**

*An expert in the field of nursing and the law Associate Professor Linda Starr is in the School of Nursing and Midwifery at Flinders University in South Australia*

## Familiar Findings

In June 2018 the Gosport War Memorial Hospital Report (GWMHR) was released. Themes within these findings are familiar, a reflection of past Inquiries into healthcare failures in acute and aged care across the globe. What happened at GWMH?

From as early as 1988 concerns had been raised by staff regarding the use of diamorphine via a syringe driver without clinical indication causing patients to die prematurely. These concerns were classified as - a small number of staff making waves - internal investigations effectively silenced those raising the alarm. Twenty-two years later a panel was established that examined more than 2,000 deaths at the hospital between 1987 and 2001, finding that at least 450 older people had their lives shortened:

‘... as a consequence of the prescription and administration of opiates, often given in combination with other powerful sedatives in the absence of any demonstrated clinical need. It is thought that “there were probably at least another 200 patients similarly affected but whose clinical notes were not found” (GWMHR 2018).

These patients were not in extreme pain nor were they for end of life care with many admitted for respite or rehabilitation. The ‘prescribing policy’ gave authority to the nurses to administer PRN medication across a wide dose range, eg. 20–200mg of diamorphine, resulting in inappropriate high starting doses for continuous periods of time which became ‘the culture and norm’ for practice on wards in GWMH. Few patients survived this regime for more than a few

days. The panel concluded that there was a disregard for human life (GWMHR 2018).

It was clear that both clinicians, management and a number of institutions were aware of what was happening at GWMH and failed to challenge these behaviours, placing the reputation of the organisation and the professions ahead of patient safety and welfare. In this case such a failure led to tragic consequences. There is no doubt that challenging a colleague’s practice or a workplace culture is complex and can be confronting. However, it is critical that we learn how to do this constructively and professionally. But it is also important that we learn how to respond professionally to such challenges.

Take a moment to think about how challenges and questions on norms are dealt with in your workplace. Is there a culture that welcomes challenges and views these as opportunities to reflect on current practice and make improvements or do we silence those who question the current norm? If it is the latter Darbyshire & Ion (2018) made the following comment:

‘If you are the kind of nurse, educator, dean, doctor or other professional who deems such questions or challenges from students or colleagues to be a form of insult, disloyalty, insubordination or questioning of authority and who reacts with indignation, petulance, anger, retribution or worse, then either change your attitudes and behaviour, or get out of healthcare or health professional education now, for you are part of this seemingly intractable problem that is costing patients their lives. We simply cannot afford to have you around anymore. You are far too dangerous to keep.’ (p 133)

A sobering thought. Furthermore, in the GWMH case it was held that the nurses should not have been made the sole arbiters of when to begin continuous opioids and at what doses as it was beyond their scope - which is true. However, as Darbyshire & Ion (2018) point out – these were registered health professionals who should not allow themselves to be ‘put in any positions’ that conflict with their professional responsibilities. Their job is to challenge and question these ‘positions’ and to refuse to adopt any actions or inactions that may cause patients harm or death.’ (p 133).

It is important that practitioners acknowledge that they are accountable for their own actions – whether they choose to take appropriate action or remain silent. It is important for managers to realise that staff need their support to do so.

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## How breathing correctly can help manage stress, anxiety and panic

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By Robert Fedele

**Registered Nurse Mary Birch stumbled across breathing retraining in the late 1990s. Before long, she was teaching the program to people and helping them overcome conditions such as anxiety and panic attacks. Now, she has penned a book explaining the links between breathing and these conditions with strategies and techniques people can follow to improve their breathing patterns.**



For the past two decades, Melbourne-based RN and Buteyko practitioner Mary Birch has been teaching people with conditions including stress, anxiety and panic attacks to breathe more effectively.

Birch offers a course underpinned by the Buteyko Method of breathing retraining, developed in Russia in the 1950s.

The Buteyko Method comprises a program of breathing exercises and posture, health and lifestyle guidelines to support functional breathing.

It focuses on normalising the rhythm, the rate and pattern of breathing, effective use of the diaphragm, and gentle nose breathing to reduce hyperventilation.

Birch was teaching nursing at university when she read an article in the *Medical*

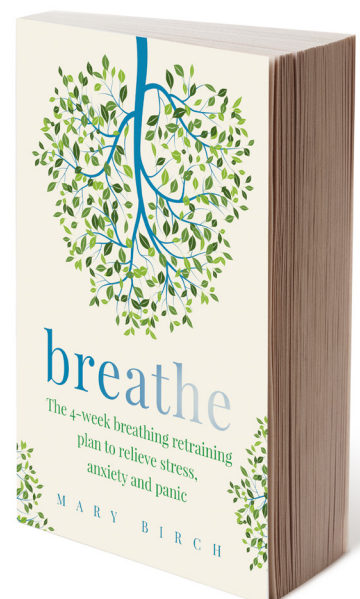
*Journal of Australia* about the first clinical trial of the Buteyko Method outside of Russia.

The trial was held in Australia and focused on asthma.

“A family member had asthma so I was interested in learning about it and when I read about the trial I was very impressed by the results so I decided to investigate further,” Birch recalls.

“Then I went along to a course and saw how effective it was. I thought ‘this should be mainstream’.”

The Buteyko Institute of Breathing & Health is the professional body that represents and accredits practitioners delivering breathing retraining courses.





## GUIDELINES FOR HEALTHY BREATHING

**BECOME AWARE** of your breathing and your posture.

**AVOID MOUTH-BREATHING** especially at rest, sitting, standing or walking around.

**BREATHE GENTLY** through your nose. You should not be able to hear yourself breathe while at rest. Nasal breathing leads to warming, humidifying and filtering of air and reduces the volume of air inhaled.

### ADOPT CORRECT POSTURE

An upright but relaxed posture will lead to more effective use of the diaphragm and intercostal muscles and help improve breathing and reduce tension in the neck and shoulders.



"You have to be able to teach it. We don't call it a therapy. It's actually an educational program and it's taught to people with conditions such as asthma, anxiety, and panic attacks."

Birch says studies in the US suggest 10–25% of people over-breathe, and that anxiety-related conditions are as prevalent as asthma in Australia but social stigma prevents open discussion.

"It's a very practical course in breathing retraining. I'm not a psychologist. Most of the people I teach have seen a psychologist already and have had counselling. Most of them have tried medication already."

Birch was inspired to write her new book, *Breathe – The 4-week breathing retraining plan to relieve stress, anxiety and panic*, after clients and fellow practitioners suggested people were experiencing benefit.

Launched this month in Australia, New Zealand and the UK, the user-friendly book covers how breathing retraining can improve a disordered breathing pattern.

Part one outlines links between disordered breathing and stress, anxiety and panic and how most sufferers unknowingly over-breathe.

At Birch's practice, equipment monitors people's breathing patterns before and after courses, and statistics and case studies are provided in the book.

"We measure the end-tidal carbon dioxide levels before and after, amongst other things, but that's the important one," Birch says.

"If people are over-breathing their end-tidal carbon dioxide levels are low because they're

exhaling too much carbon dioxide and after the course the carbon dioxide levels are normalised and their breathing pattern is very steady with a regular rhythm."

The second part of the book runs through a step-by-step 4-week course on awareness and improving the breathing pattern, including breathing exercises, strategies and techniques for healthy breathing, and sleep, lifestyle and diet guidelines.

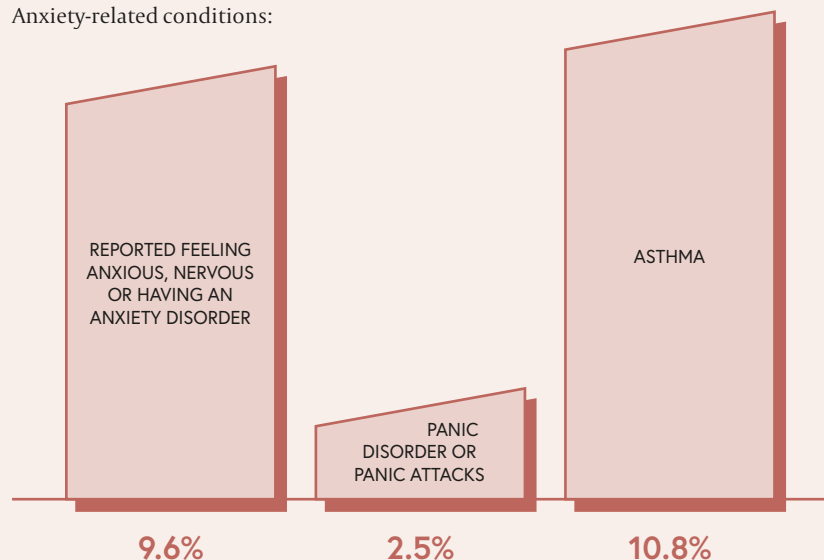
Birch hopes the book will help dispel the myth that deep breathing, a habit many people develop from childhood, is beneficial.

"Breathing should be appropriate for the activity. Why would we want to deep breathe if we're just sitting in a chair? It doesn't make sense. In hospital it may be necessary to encourage some patients to breathe more deeply following surgery or anaesthetics or who are on medications that may affect breathing, but that's a different scenario.

*Breathe – The 4-week breathing retraining plan to relieve stress, anxiety and panic* is being released in Australia and New Zealand by Hachette Australia on 8 January and in the UK on 24 January by Little, Brown Book Group.

## PREVALENCE OF CONDITIONS

Anxiety-related conditions:



Source: Australian Bureau of Statistics, National Health Survey, 2014–15



By James Lloyd

ANMF Federal  
Vice President

## Is it possible to be both a Nurse Unit Manager and Tasmanian Branch President?

**Seven years ago, I joined Tasmanian ANMF Branch Council. I joined to find my voice. I joined to fulfil that desire to be an advocate for those who don't have a voice.**

However, this action has led to an interesting deliberation. In my day-to-day work, I began hearing challenging questions from my peers and those I was managing: Don't unionist and always managers clash and isn't there a conflict of interest between being a Nurse Unit Manager and an ANMF Branch Council President? My answer has always been ... no.

The rationale for my answer is straightforward. Unions exist to represent the rights and interests of workers. Unions provide advocacy for their members.

This is precisely the same as the philosophy behind what nurses and midwives do: we are advocates for our patients, we stand up for their needs, and we protect their human rights and dignity. Nurses and midwives are guided by evidence, research, human rights, laws, ethics, safety, and legislation.

Both tenets, as unionist and nurse, guide my decisions. When I am asked what my union leave entitlements are, I can point to the direct clause in my nursing award that states what leave is available. This entitlement does not give me wriggle room, however,

it is black and white legal document. The document is not created for personal interpretation or ignoring content that you don't agree with.

Being Branch President and a Nursing Unit Manager involves wearing different, but similar, hats. But both roles involve representing those who don't have a voice or whose voice has not been heard.

For example, recently on a shift I had to both advocate for a patient who wanted to stop life-saving treatment, and represent a staff member who had a dispute with the manager. Both roles involved being an advocate.

Conflict occurs between unions and employers when rules are bent, ignored or misinterpreted. So how can I be a unionist and NUM without this conflict of interest? I simply abide by the written rules that guide both practice and employment conditions. I respect confidentiality of the workplace and remember my rights when it comes to speaking out when I witness a wrong.

It's that straightforward.

### Would you like to write for ANMJ's Focus section?

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Drug and Alcohol Mental Health Community Health	April-June 2019	7 Feb 2019
Aged care Medical/surgical nursing Maternal health and midwifery	July-Sep 2019	7 May 2019
Wound care Infection control Education	Oct-Dec 2019	6 Aug 2019



**FOCUS:**  
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SEXUAL HEALTH





## Respecting the meaning of culture and gender for older Greek women

By Georgia Tziros, Oliver Burmeister and Maree Bernoth

**The understanding of gender and culture is imperative in any welfare setting. The 2016 census identified that 37% of people aged 65 and older were born overseas. Of those in the 65 years and older population, the 2016 Census identified that to every 100 women, there were only 86 men (Australian Bureau of Statistics 2016).**

These figures clearly support international findings that women tend to live significantly longer than men, and thus more research is needed to understand how gender and culture interplay (Bernoth et al. 2014; Burmeister et al. 2016).

Research currently being undertaken into the psychological health of Greek older people, their migration to Australia and the subsequent impact on connection to culture

and social connectivity, reveals gender differences. One example is that older Greek women tend to use more physical contact. Within Greek culture it is common to greet each other with a kiss on each cheek whether you be male or female, but women tend to be more affectionate. Women will hug each other and at times will also touch each other in comforting ways, such as stroking each other's hand or placing a hand on each other's shoulder or waist.

Another important gender difference is the role that older Greek women play in the family. They often play a very active role as a grandparent and parent and will often care for grandchildren and also help their adult children with keeping their home (by cooking, cleaning, etc.). Often older Greek women have a philanthropic nature. It is common to be offered food or drinks on arrival at an older Greek women's home; this is considered a friendly and welcoming gesture and can cause offence if one is not offered this on arrival.

Another important gender difference to note is the use of terms of endearment. Older Greek women commonly use several terms of endearment towards each other and towards people who are younger than them words like 'koukla' 'agapi' and a hybrid Greek and English word 'darlin'. This is another form of showing affection and being friendly towards others. These

findings are important to welfare and health practice as they provide valuable insight into the intricacies that gender and culture play in a Greek individual's life. These findings can aid nurses to better understand and build working relationships with older Greek women.

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### Authors

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**Associate Professor Maree Bernoth is Community Engagement Lead in the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University**

**Associate Professor Oliver Burmeister is Associate Professor in Information Technology in the School of Computing and Mathematics at Charles Sturt University**



## It's time to focus on masculinity in mental-health training

**Men's vulnerability to poor mental health and risk of suicide is being compounded by training programs offered by Australia's medical schools and professional bodies, a new study shows.**

An audit of available online information from all 18 Australian medical programs in 2017 reveals that 'masculinity-based constructs' are rarely integrated into men's health or mental-health related training.

One program makes specific reference to masculinity in the curriculum.

"The audit of publicly available information from Australian medical programs and their professional bodies reveals increasing

awareness of the needs of men. However, there is limited practical inclusion of masculinity models in training and practice," said study author, Zac Seidler, a PhD candidate in the School of Psychology at the University of Sydney.

"Men account for three-quarters of deaths from suicides in Australia and despite initiatives like beyondblue and headspace promoting help-seeking and early intervention for men and boys, Australian males engage less with mental-health services than their female peers.

"However, men will seek help for mental-health concerns when both practitioners and the services they work in employ practice-changes in line with social determinants of health, such as masculinity."

Mr Seidler said men present with "complex, diverse and often contradictory expressions of masculinity that are relevant to their health status".

The study was published in *Australasian Psychiatry*.



## Imminent birth education program

By Michelle McElroy

**With approximately 350 nurses employed within Queensland Health's North West Hospital & Health Service (NWHHS), there are around 62 at any one time working in remote and very remote sites away from core maternity services.**

Imminent birth education has been a mandatory requirement for these nurses since mid-2014 with NWHHS showing a commitment to not only the vulnerability of women who may inadvertently deliver their babies in a non-birthing environment, but also the nurses working outside of their usual scope of practice. Prior to the

development of the state wide Imminent Birth Education Program, NWHHS training consisted of an eight hour face to face program split into four hours imminent birth and four hours neonatal resuscitation.

The complexities of delivering an eight-hour study day to all nurses in all sites was challenging. NWHHS covers a radius of approximately 300,000 square kilometres with Mount Isa being the base for maternity birthing services and the education team.

The nearest site to travel to deliver training is 121km with four sites being over 500km and one only accessible by air; innovation in education delivery is the key.

As a site already delivering an education program, and being part of the statewide maternity and neonatal clinical network, we were actively involved in the steering committee for the development of the new program. Following its introduction with the online component, I conducted an audit of the nurses who had completed both programs.

Responses showed an increase in knowledge from 63 to 92%, while this could be accredited to an accumulation of information over time, respondents answered 100% to the iLearn program giving them a better knowledge of imminent birth.

The only recommendation made was regarding iLearn registration problems and having access to a computer/internet. One hundred percent of respondents said they would recommend the new program.

Being able to assist our remote nurses to deliver appropriate emergent care is essential for patient safety. While NWHHS continues to lead the way with imminent birth education, the commitment of Queensland Health and other HHS within the state can only lead to better outcomes for mothers and babies, and support for nurses working remotely.

### Authors

*Michelle McElroy is a Midwifery Lecturer at James Cook University*





## Sexual health: assessing women

By Rebekkah Middleton

**A focused and comprehensive sexual health assessment is a critical aspect of assessing the female reproductive system.**

This is inclusive of an interview to collect subjective data, and a physical assessment to collect objective data. Diagnostic tests may be adjuncts that provide additional information. All health assessments are to be taken in partnership with the woman, as outlined in the National Safety and Quality Health Service Standards (2017), Standard 2. Ensuring person-centred approaches to the woman enables accurate and individualised questions to be asked.

An important aspect of all care provided is documentation. As defined in Standard 6 of the National Safety and Quality Health

Service Standards (2017) it needs to be accurately detailed so all information and risks are disclosed, ensuring the woman's safety.

Being mindful of potential embarrassment or fear in the woman, an assessment should be performed in a sensitive, open and objective manner. This includes being aware of and considering psychological, social and cultural factors that affect sexuality and sexual activity.

Simple and impartial language is essential so no perception of judgement or offence is felt, but only safety and professionalism.

As part of the health assessment determining sexual health, the following aspects should be included in the interview:

- Duration, frequency, precipitating and relieving factors, treatment so far.
- History, inclusive of menstrual, obstetric, contraceptive, sexual relations and cautions.
- History of smoking – as it increases the risk of circulatory problems, as well as the risk of cervical cancer, when the woman is taking oral contraceptives.

- Chronic conditions that may impact the reproductive system (eg. diabetes raises vaginal infection and dryness risk).
- Family history.
- Explore particular issues further, such as vaginal bleeding or discharge.
- Sexual activity and devices used for contraception and satisfaction.

As registered nurses and midwives, it is important that we maintain a professional approach and attitude when performing a sexual health assessment of women we care for and do not allow our own issues, embarrassment or caution to impede or impact this process.

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## Changing the Paradigm: gender orientated healthcare needs to embrace the LGBTQIA+ community

By Sara Geale

**Patient centred care has become the cornerstone of the care we deliver as nurses (Saha, Beach & Cooper 2008).**

To deliver safe effective care each patient is understood as a unique individual. That is, as nurses, to look at the individual needs of the patient in the context of their social, cultural and ethnic background.

With this as the cornerstone of our care, we treat patient groups as opposed to disease processes. In Australia, we have moved forward to an understanding that age and gender play a significant role in healthcare needs. We have a focus on women's health and men's healthcare. However, we need to consider not only perceived born gender but also the sexual orientation of our patients.

Currently there are no clear statistics on the numbers of Australia's intersex population.

The Australian Human Rights Commission (2014) states that 11 in 100 Australians may have a diverse sexual or gender orientation.

The Australian Bureau of Statistics (2016) estimated that there were 48,000 same-sex couples in June 2015, accounting for 0.9% of all couple of families.

These figures may actually be higher due to a fear of disclosure related to inherent discrimination may affect these figures (ABS 2016). LGBTQIA+ people in Australia still experience discrimination, harassment and hostility when accessing healthcare (Australian Human Rights Commission 2014).

Healthcare providers have limited or no training around the importance of a comprehensive, non-judgmental history taking and assessment (Vector 2017). Our consideration is that partners and relationships are heterosexual as opposed to the possibility of them being same sex and hence our interviews reflect this (Steelman 2018). While accessing healthcare, the LGBTQIA+ individual often face interpersonal barriers related to knowledge deficit and discrimination as well as internalised homophobia. The continued view of LGBTQIA+ identities as pathological



remains in society and affects the care provided and indeed reduces the potential for LGBTQIA+ to seek care.

LGBTQIA+ communities also face structural barriers to quality healthcare. Transgender individuals often face inaccurate medical record keeping that do not reflect their chosen names, genders or pronouns.

Despite the time-sensitive nature of hormone therapy, Australia still requires transgender adolescents to gain Family Court approval to access this therapy and the legal process can take up to 10 months and cost thousands of dollars.

LGBTQIA+ individuals have poorer mental and sexual health than the heterosexual community. LGBTQIA+, are five times more likely to attempt suicide in their lifetimes with transgender people eleven times more likely (Vector 2017).

LGBTQIA+ people are also twice as likely to be diagnosed and treated for mental health disorders, and about a quarter of LGBTQIA+ people aged 16 and over experience a major depressive episode (Vector 2017).

Along with poor mental health it has been identified that women who have sex with women (WSW) are at higher risk for cervical cancer and men who have sex with men have greater prevalence of HIV, HPV, and other sexually transmitted infections (Vector 2017). Anal sex predisposes men who have sex with men to anal cancer. The LGBTQIA+ also has an increased incidence of certain chronic diseases such as cardiovascular disease, asthma and diabetes (Vector 2017).

Because of the combination of fear of disclosure related to inherent discrimination and the lack of training around comprehensive, non-judgmental history taking, assessment and specific care our LGBTQIA+ population in Australia does not receive the standard of care that should be available to all Australians. Healthcare providers, education providers and accrediting bodies need to work together to improve understanding of the diverse needs of LGBTQIA+ across the healthcare continuum.

### Note:

LGBTQIA+ refers to distinctly heterogeneous community who identify sexually as lesbian, gay, bisexual, transgender, queer and questioning, intersex, asexual and aromantic individuals, with the "+" denoting other diverse sexualities, sexes and genders (Vector 2017).

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**Dr Sara Geale is Director of Clinical Education in the School of Nursing and Midwifery, Faculty of Health and Medicine at the University of Newcastle**



## Call for doctors to keep up the HPV work

**Doctors are encouraged to stay vigilant of HPV vaccination and cervical screening in South Australia, particularly in populations who experience significant barriers to screening.**

This comes amidst recent research launched at the International Papilloma Virus (Human Papillomavirus) Conference in Sydney which suggests that by 2022 cervical cancer could be considered rare to the point of virtual elimination should vaccination and screening programs be continued.

South Australian sexual and reproductive health agency SHINE SA, runs a cervical screening program, which ensures doctors and nurses are skilled to conduct screening tests for the human papilloma virus (HPV).

SHINE SA's CEO Natasha Miliotis looks forward to virtual elimination however warns against complacency on HPV vaccination and screening.

"Virtual elimination relies on clinicians continuing to ensure high rates of vaccination for all young people prior to becoming sexually active, as well as regular five yearly screening for all people over 25 with a cervix," she said.

"Young people who missed the HPV vaccination in Year 8 should receive a catch up vaccination. But regardless of HPV vaccination status, all people over 25 with a cervix should still receive cervical screening."

However Ms Miliotis said some South Australians were at risk of being left behind. Groups such as Aboriginal people and new arrivals are still experiencing significant barriers to screening due to geographic isolation or language difficulties.

"For others, internal examinations can be difficult, particularly for trans men or people who have experienced trauma. The good

news for high risk groups is that there is now an option of self-collected samples for those who meet criteria as outlined in the national guidelines (NCS Program)," she said.

"We would encourage all GPs to continue working to close the gaps on HPV vaccination and cervical screening for their patients."

[shinesa.org.au](http://shinesa.org.au)

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## HIV risk fuelled by STIs

**The University of NSW Kirby Institute's latest surveillance report (2018) highlights significant risks and inequities for South Australians, in particular for Indigenous communities where STI rates are increasing.**

This is despite the report finding that across Australia HIV new diagnoses have hit a seven year low.

In fact, HIV diagnoses among Indigenous Australians have increased in the past five years from 26 to 31 new cases in 2017; 1.6 times the rate in the non-Indigenous population.

SHINE SA is a key South Australian sexual and reproductive health agency. SHINE SA's CEO Natasha Miliotis raises concerns about the lack of reductions in HIV and other STIs in SA, amidst a national syphilis outbreak: "What most people don't realise is that having any STI makes you more likely to become infected with another one, including HIV.

STIs left undiagnosed and untreated can fuel HIV infection. Without treatment either syphilis or HIV can become a fatal infection. Syphilis left untreated during pregnancy can cause serious illness, disability and even death for the baby.

Lack of investment, particularly in Indigenous communities has created a significant differential in sexual health status that is unacceptable in modern day Australia."

Recent South Australian State Budget cuts to STI, HIV and viral hepatitis services have

triggered serious concerns about the ability to meet the state's public health obligations, respond to outbreaks and continue previous years' work towards meeting targets set under the Australian government National HIV Strategy.

In addition to maintaining investment in metropolitan areas, adequate funding is needed for Indigenous rural and remote services. Such funding is essential to develop rapid testing, treatment and access to preventive measures such as HIV pre-exposure prophylaxis medication (PrEP) which protects against HIV infection.

[shine.org.au](http://shine.org.au)

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### Impact of menopause can be treated

**After menopause it is not uncommon for women to experience sexual problems which can severely impair their relationships, mental health, social functioning and overall quality of life, according to the Australasian Menopause Society.**

The good news is that it is treatable.

“Sexual wellbeing is complex and many other personal factors in your life could be involved,” said Australasian Menopause Society (AMS) President Clinical Associate Professor Amanda Vincent.

“It’s important to look at all aspects of your sexual health and wellbeing. Your doctor, a pelvic health physiotherapist or a counsellor may need to work with you to look at the many factors that might be affecting your sexual wellbeing.”

Difficulties with sexual wellbeing is common in women with premature menopause or menopause in the setting of a cancer diagnosis, related to multiple factors and needs individualised management

directed at the contributing factors. Many women experience vaginal dryness because of lower oestrogen and this can make sexual activity uncomfortable or painful. This can often be treated with vaginal oestrogen, moisturisers and lubricants during sex. Hormonal treatments include oestrogen or testosterone therapy but only use testosterone designed for women.

AMS has developed a patient information sheet called Menopause – will it affect my sex life?

These and other resources relating to menopause and sexual wellbeing are available on the AMS website [menopause.org.au](http://menopause.org.au)

### Digital stories shine light on multicultural health

**Videos that aim to break down concerns about accessing reproductive and sexual healthcare within the multicultural community, have been launched by Family Planning NSW.**

The videos tell true stories of clients from across south west Sydney, who have used Family Planning NSW services for their own reproductive and sexual health needs.

Senior Health Promotion Officer Stephanie Ross said interviewing clients from suburbs like Fairfield, Bonnyrigg Heights, Bossley Park and Canley Vale highlighted real issues and stigmas that can exist within culturally and linguistically diverse (CALD) communities when accessing reproductive and sexual health services or information and she was excited to see these stories come to life in the short videos.

“Clients are telling us they simply don’t know where to get this healthcare and there are still a lot of barriers and fears for them about walking into a Family Planning NSW clinic or other health provider to get reproductive and sexual health advice,” Ms Ross said.

“These videos aim to create positive attitudes towards talking about reproductive and sexual health so men and



women from these communities can access the very best care without fear or worry.”

“We hope the videos will increase understanding in these multicultural communities around key reproductive and sexual health issues, service awareness and access.

“We also want to make accessing our services as easy as possible by providing friendly and non-judgemental services, with resources in languages other than English and interpreter services.”

The videos have been developed in community languages including Arabic, Mandarin and Vietnamese to make them accessible to people who have low English literacy.

The client stories focus on a range of reproductive and sexual health issues

including contraception, cervical screening and testing for sexually transmissible infections.

One video features the story of Priscilla, a Maori woman who has been using Family Planning NSW services for 35 years for contraception, cervical screening and now menopause. She now brings her daughter and emphasises that access to information and support means that people are better able to make the right decisions for their own health.

The videos can be viewed on the Family Planning NSW website [fpnsw.org.au](http://fpnsw.org.au) and are being distributed through social media, community education and community service providers.



## Barriers and facilitators to Chinese and Thai gay and other bisexually active men attending testing services

By V Knight, L McCormack, B Clifton and A McNulty

**There is a documented lack of HIV testing among Asian-born Australian gay men.**

### METHODOLOGY:

We sought to determine the personal and clinical facilitators of Chinese and Thai men who have sex with men (MSM) for attending a sexual health clinic and the acceptability of an express model among Chinese and Thai GBM clients, in order to inform strategies to increase attendance.

### METHODS:

Between January 2016 and May 2017, first time Chinese and Thai speaking gay and other bisexually active men (GBM) attendees to the Sydney Sexual Health Centre (SSHC) and a community based testing site were offered a 25-item survey.

### RESULTS:

Approximately 80% of participants indicated that the most important facilitators for testing were confidentiality and expert staff. About two-thirds of participants indicated they would use an express model.

### CONCLUSION:

In order to increase first-time testing among Asian GBM in Sydney, promotion of testing services across diverse platforms should continue.

### BACKGROUND

In NSW, GBM of Asian descent are reported to test for HIV at an overall lower rate than GBM of Anglo heritage (Mao et al. 2002).

HIV diagnoses have shown an increase among Asian-born GBM in NSW. The proportion of GBM diagnosed with HIV who were born in Asia doubled from 15% in 2006 to 30% in 2015, and of 85 new diagnoses at SSHC in 18 months to June 2017, 22% were born in either China or Thailand.

The relevant literature acknowledges several known barriers to testing for

Asian-born GBM, including many related to cultural stigma surrounding HIV and homosexuality (NCHSR 2011). What was found to be lacking in the literature was a meaningful way in which facilitators for testing could be leveraged into developing targeted interventions specifically aimed at increasing attendance among Chinese and Thai GBM.

This study aimed to determine the personal and clinical facilitators of Chinese and Thai MSM for attending a sexual health clinic. It also aimed to determine the acceptability of an express model for these groups of GBM in order to inform strategies to increase attendance.

### METHODS

We developed a 25-item survey for GBM of Chinese and Thai origin attending SSHC and a [TEST] for the first time. The questionnaire was piloted with Thai and Chinese attendees and changes were made based on feedback. The questionnaire was translated into Mandarin and Thai and was also available in English. The survey explored the clinical, personal, cultural and social facilitators and barriers present, with regard to HIV testing, and was conducted between January 2016 and May 2017 out of two sites.

### SYDNEY SEXUAL HEALTH CENTRE

Based in Sydney, SSHC is the largest sexual health clinic in New South Wales. SSHC is located in the Sydney central business district and is in close proximity to the gay precinct of Darlinghurst offering testing and management of STIs and HIV.

### COMMUNITY-BASED TESTING SITE

The community-based testing site is a collaboration between SSHC and ACON, which is New South Wales' leading health promotion organisation specialising in HIV and LGBTI health. The service began operation in 2014 and operates out of a purpose built shopfront clinical space located in Darlinghurst, Sydney.

### RESULTS

A total of 198 surveys were distributed and 102 (51%) completed; in English (28, 27%), Chinese (56, 55%) and Thai (18, 18%). Mean age was 28 years (range 17-47) and 70% were 29 years and under. There was no significant difference in age across language groups ( $P=0.11$ ). Twenty percent had not told anyone they were a GBM. Approximately 80% of participants indicated that the two most important facilitators for attending for testing were confidentiality and expert staff.

Of 35 (34%) participants who had never previously tested in Australia; one quarter

equally described not knowing where to go, not needing a test and being worried about the result as the main reasons for not testing. About two-thirds of participants indicated they would use an express model with no difference between language groups or recruiting site.

### DISCUSSION

Our study recruitment had limitations in that we drew upon a convenience sample of men already attending services, however this was a valuable source of information regarding facilitators to testing among Chinese and Thai GBM. Our sample was further limited by an approximate 50% return rate (51.5%).

The strengths of this study are that it specifically targeted and received valuable data from a hard to reach population, who were less community engaged than other surveyed Asian GBM and less likely to test for HIV regularly (Mao et al. 2002).

### CONCLUSION

In order to increase first-time attendance of Asian GBM at HIV testing sites in Sydney, promotion of testing options should continue across broad and diverse platforms with an emphasis on the confidential, free, and non-judgemental services available.

Based on survey responses, more express testing options highlighting confidentiality and staff expertise would be worthwhile.

### DISCLOSURE OF INTEREST STATEMENT

SSHC is funded by the NSW Ministry of Health. No pharmaceutical grants were received in the development of this study.

### Acknowledgements

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## CONGRATULATIONS!

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Thank you to all who entered our funny caption competition in the last issue of ANMJ.

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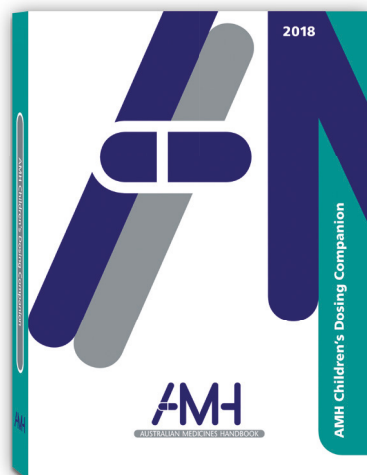
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