Australian College of Midwives

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Inquiry into economic self-determination and opportunities for First Nations Australians

ACM Submission

Issued May 2024

Inquiry into economic self-determination and opportunities for First Nations Australians

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written submission to the ***Inquiry into economic self-determination and opportunities for First Nations Australians***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are 34,318 midwives in Australia and 1,195 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address item 1 of the terms of reference: 'opportunities for, and barriers to training, employment and business development', in regard to First Nations potential midwives, midwifery students and registered midwives.

The priority opportunities for ACM include;

1. Reconsider how First Nations people are recruited, retained and supported to study health-related courses, including midwifery, and provide a wraparound support service co-designed with and for First Nations midwifery students
2. Ensure that postgraduate professional development opportunities are provided to First Nations midwives, and that First Nations midwives are represented at all levels of maternity care, including in leadership positions
3. Action the recommendations in the CATSINaM 'gettin em n keepin em n growin em': *Strategies for Aboriginal and Torres Strait Islander nursing and midwifery education reform* report (GENKE II)
4. Explore innovative education alternatives such as the Canadian community-based midwifery education programs
5. Fund and prioritise the upscale of culturally specific MCoC models
6. Fund and prioritise the upscale and roll out of Birthing on Country / Birthing in our Community models of care
7. Re-open rural and remote birthing services and establish new services in under-serviced areas, prioritising MCoC models of care
8. Remove the clinical requirement of 5,000 hours for Endorsement for Scheduled Medicines and incorporate prescribing into undergraduate programs via ANMAC
9. Ensure an MBS item is added for homebirth alongside the extended insurance policy to support BoC models of care.
10. Work with health services to establish visiting rights for PPMs and midwives working in Aboriginal Community Controlled Health Services (ACCHS) nationwide
11. Provide appropriate software and education to enable PPMs to access digital interoperability

Background

Currently, First Nations people are underrepresented in the midwifery workforce, and this impacts on Communities self-determination for maternal, infant and family services and the promotion of the best start to life for families and Communities in diverse cultural contexts and geographical settings. Midwifery care by First Nations midwives provides the best start to life and positively impacts on long term health, psychosocial outcomes and life expectancy of First Nation people. Flexible midwifery education options and access also provides career and work opportunities, along with the stabilising of maternal and infant health services in under-resourced areas.

ACM survey

The ACM conducted a survey to inform this submission. Four out of eight respondents identify as First Nations. Quotes from respondents will be used throughout this submission, however some general themes are outlined below.

Barriers identified by respondents included:

- Systemic racism
- The need to relocate for study, placement blocks and work
- Lack of support services for First Nations midwifery students
- First Nations midwives are less visible and more judged, so 'need to be better'
- Lack of cultural safety in University, placement, and the workplace
- Not enough existing First Nations midwives to provide mentoring and a sense of safety
- Insufficient cultural supervision and support
- Leadership with limited understanding of social and cultural challenges that impact on study and work

Solutions proposed by ACM survey respondents included:

- Culturally safe mentoring programs
- Flexible learning opportunities especially for mothers and mature age students
- More support services for First Nations midwifery students
- First Nations student support run by First Nations midwives
- More external midwifery study options
- Traineeships/cadetships with paid placements and the opportunity to work within Aboriginal led maternity service

One survey respondent offered some particularly specific and proactive suggestions for recruiting First Nations midwives:

'A website about pathways to midwifery for Aboriginal women explaining the entrance requirements, alternative pathways, different modes of study, support available. Increasing the profile of Aboriginal midwives and advertising midwifery degrees to Aboriginal women - via social media, face to face, online, in schools etc. Enable Aboriginal and Torres Strait Islander students to complete clinical placement in Aboriginal-led services, rather than forcing them to complete clinical placement in unsafe tertiary institutions that further perpetuate harm.'

Opportunities for, and barriers to training, employment and business development

First Nations individuals are under-represented in health care in general, and midwifery specifically. First Nations people who train as midwives improve both their own economic self-determination, and health outcomes for their community [2].

First Nations midwifery workforce

First Nations midwives are in critically short supply across Australia. The involvement of First Nations health professionals in the care of First Nations individuals increases culturally safe care[2].

Table 1: First Nations midwives[1]

Principle place of practice (PPP)	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Midwife	8	69	8	78	14	2	13	11		203
Nurse & midwife	5	145	11	84	16	11	48	34	2	356
Total	13	214	19	162	30	13	61	45	2	559

The total number of midwives in Australia is 34,318[1], so First Nations midwives make up only 1.63% of the midwifery workforce. This is in contrast to the fact that First Nations births account for approximately 6.1% of Australian births each year[3]. This number has increased over time, but progress is slow, and these numbers remain insufficient and not representational of the number of First Nations women and babies requiring maternity care.

Table 2: Number of First Nations midwives 2016-2023[1,4]

Year	2016	2019	2023
Midwife	50	92	189
Nurse & midwife	205	259	350
Total	255	351	539

In 2022, only 46% of full-time equivalent staff of Indigenous-specific maternal/child health services were First Nations, and only 15% of midwives at these services were First Nations[5]. Given the importance of culturally safe care for First Nations birthing families, there is an imperative to increase the First Nations midwifery workforce.

The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 sets a target of 3.43% First Nations health workforce by 2031. This is intended to match the predicted First Nations working age population. The framework sets out six strategic directions, from pre-registration to First Nations representation across all health system roles. The recent appointment of Queensland's inaugural First Nations Midwifery Director is a significant step forward in prioritising both First Nations women and midwives. Increasing First Nations leadership at all levels of the maternity care system nationally would demonstrate respect and Cultural Safety both for First Nations midwives, and mothers and babies, and would increase recruitment and retention of First Nations midwives.

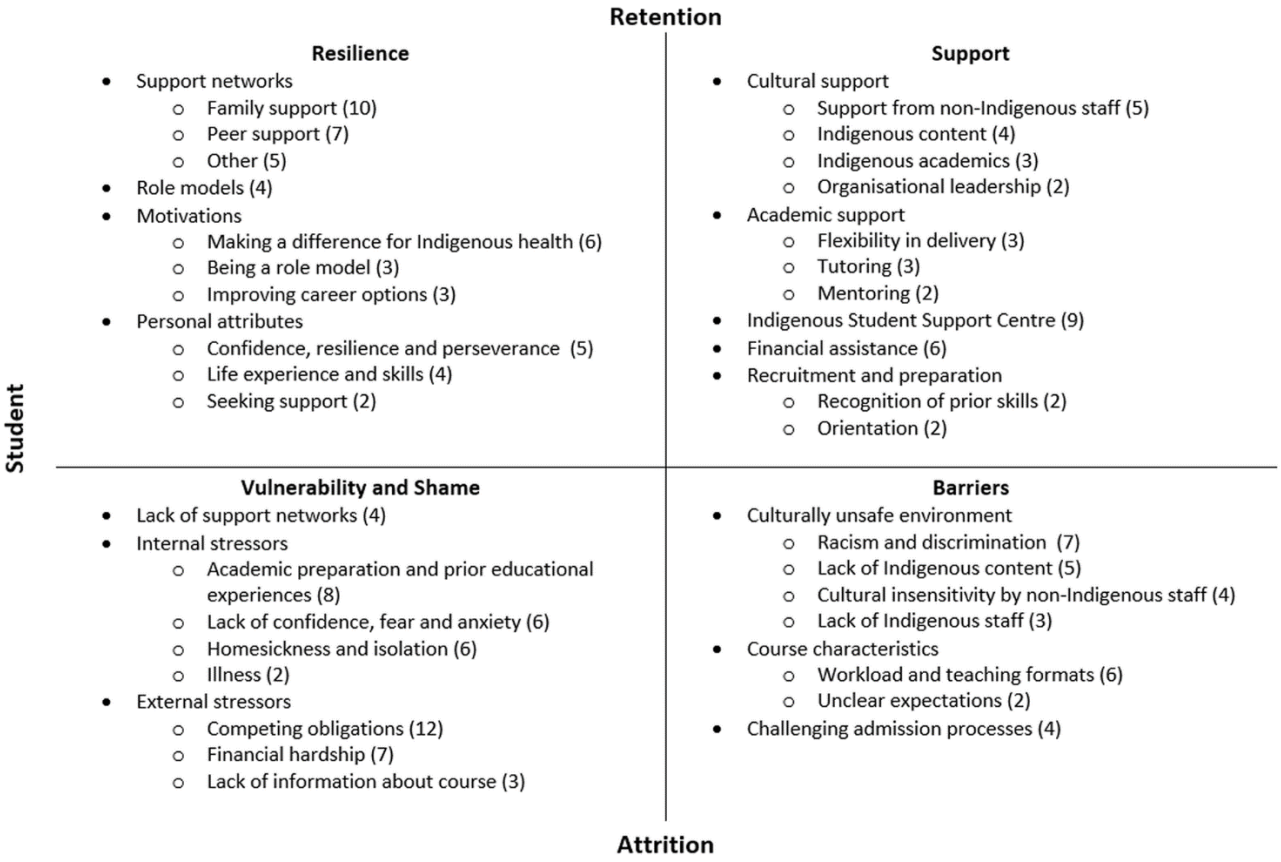
States and Territories also have their own strategies. For example:

- The QLD Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026 aims to increase employment of First Nations healthcare professionals in the public sector.
- The NSW Aboriginal Nursing and Midwifery Strategy aims to increase the number of First Nations midwives employed in NSW and improve career development pathways for First Nations midwives in the public sector.

First Nations midwifery students and midwifery career progression

Successful engagement in higher education by First Nations individuals has multiple flow-on financial and psychosocial effects, both for the individual and their community[2]. Multi-generational systemic disadvantage makes enrolling in and graduating from higher degrees more challenging for many First Nations students, and retention is an issue which needs addressing.

A literature review[2] identified multiple factors affecting retention of First Nations students, which are summarised below:



Factors affecting the retention of Aboriginal and Torres Strait Islander health students.
Numbers in round brackets refer to the number of articles identifying this factor[2]

'Having to travel interstate for study blocks and placement (for universities offering external study) or students having to relocate to study is a barrier to training as a midwife. Some students have never left their home towns before.'

First Nations ACM survey respondent

Strategies to improve retention were also summarised:

Point of Departure

- Leave door open (3)
- Graduation – celebrate success (1)

Time at University

- Cultural support
  - Organisational leadership and fostering an enabling culture (7)
  - Indigenous academics (6)
  - Embed Indigenous content throughout curriculum (5)
  - Cultural training for staff and non-Indigenous students (4)
  - Indigenous community involvement and collaboration (4)
  - Address racism (2)
- Academic support
  - Mentoring (8)
  - Tutoring (8)
  - Flexible delivery (7)
  - Clinical placement support (4)
- Indigenous Student Support Centre (7)
- Social and economic support
  - Financial support (5)
  - Foster peer networks (4)
  - Personal contact (3)

Preparation

- Pre-entry preparation (6)
- Comprehensive orientation (3)

Recruitment

- Selection (4)
- Multiple entry pathways (4)
- Recruiting a cohort (3)
- Quotas (2)

Strategies for growing strong students.
Numbers in brackets represent number of articles identifying this strategy[2]

A further review focussing on the barriers experienced by First Nations students studying midwifery found only three articles exploring the experiences of First Nations midwifery students, and broadened their search to include all undergraduate health students[6]. This demonstrates a gap in the literature which limits attempts to improve retention of First Nations midwifery students. The review concluded that relationships with Indigenous academics and mentors, and clinical placements in First Nations health services, improved students' sense of empowerment and ability to navigate between Indigenous and non-Indigenous worlds successfully [6].

The 'gettin em n keepin em n growin em' report (GENKE II) by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) calls for formalised partnerships between CATSINaM, the Australian Nursing and Midwifery Accreditation Council (ANMAC), CATSINaM, the Nursing and Midwifery Board of Australia (NMBA), and the Australian Government to co-design nursing and midwifery education reform in relation to First Nations health. Recommendations for reform include a First Nations nursing and midwifery clinical placement plan, and a comprehensive education strategy incorporating pre-registration to doctoral qualifications. Targeted funding initiatives are also recommended, to support recruitment and retention of First Nations nurses and midwives.

'The barrier to training is lack of support with study requirements and placement, in an environment that is not culturally safe. Not having access to cultural supervision and support.'

First Nations ACM survey respondent

The recent budget announcement promising financial support to students attending mandatory midwifery clinical placements is to be applauded. This is a step towards enabling enrolment in midwifery degrees for students without extensive personal or family financial backing. There are several other supports currently offered to First Nations midwifery students and midwives. Some examples include:

- In QLD, First Nations graduate nurses and midwives are supported with their job application and with connection to other First Nations employees, and are provided with additional career development support.
- A range of scholarships and cadetships for First Nations undergraduate and postgraduate students are offered by NSW Health.
- Indigenous Honours scholarships and bursaries are offered by Southern Cross University, supported by funding from the Department of Health and Aged Care.
- The University of Southern Queensland offers a scholarship for one Aboriginal and / or Torres Strait Islander student studying either Nursing or Midwifery.
- The Government of Western Australia offers scholarships for midwifery students, and gives priority to First Nations applicants.
- The NT Health Aboriginal Scholarship Scheme provides five scholarships worth up to $5,000 each to students studying any pathway leading to a health occupation, including midwifery.
- The Aboriginal Health Scholarship Program, offered by SA Health, provides $5,000 per year of full time study for Indigenous students enrolled in a health related course.
- The Ida West Aboriginal Health Scholarship is offered by the Tasmanian Government and provides $5,000 per year for Aboriginal and Torres Strait Islander students enrolled in a human services related course.
- The Rhodanthe Lipsett Indigneous Midwifery Charitable Trust provides $5000 scholarships to assist First Nation peoples who are training to be midwives and $1000 professional develop Scholarships to First Nation Midwives.
- Puggy Hunter Memorial Scholarships Scheme.
- CATSINaM Scholarships.

While these incentives are a positive step in encouraging and supporting First Nations people to study midwifery (and pursue postgraduate midwifery education in a few cases), they are mostly only available for a small number of students, and they require the student to relocate to a major city to undertake the study. In some instances, applicants are competing for a small number of scholarships against students in other disciplines, and / or against non-Indigenous students, and some are offered only if the student is full time. The sum provided, while supportive, may not be sufficient to cover relocation and additional travel and living expenses when students need to move to an unfamiliar city in order to study.

It is important to remember that financial is not the only (or possibly even the most important) support required to mediate First Nations recruitment and retention in health courses, including midwifery. Cultural, psychosocial, and infrastructure support are some other priority areas. It is also essential that support is not withdrawn upon graduation, but that First Nations midwives are provided with Continuing Professional Development and career progression opportunities. First Nations midwives should be represented at all levels of maternity care.

'Colonised healthcare systems are culturally unsafe places for First Nations midwives to be training and working in. They have likely experienced racism when accessing healthcare themselves and therefore may have negative experiences in hospital. There is a significant lack of understanding amongst White midwives and

managers of how to be an Ally for Aboriginal and Torres Strait Islander midwives. HETI training on 'Respecting the Difference' is woefully inadequate and serves as a 'tick a box' exercise that doesn't require the learner to reflect deeply on their own internalised White superiority and how this shows up at work. Universities are also very elitist and the classroom environment can be culturally unsafe for First Nations students. The ATAR for admission to Bachelor of Midwifery is very high.'

ACM survey respondent

In addition to student attrition, workforce attrition is also a challenge, with lower workforce satisfaction among First Nations midwives impacting on retention[7]. Some culturally safe mentoring programmes are offered and support retention as well as developing cultural capability across the workforce [7], however these are not universally available.

Internationally, Canada is offering community-based midwifery education programs which bring the training to the community. Partnering with Universities, the program does involve the student needing to relocate for a portion of their study, but the majority is undertaken within community health centres with Indigenous instructors. The course includes traditional Indigenous practices in addition to standard midwifery education, some is taught in the local language, and there is a focus on community health education. This is an innovative program which effectively addresses a wide range of cultural and practical considerations, and supports communities to 'grow their own' midwives, who will have an unparallelled understanding of the local culture and practices.

In New Zealand, the te ara o Hine program, a Government initiative, provides care, academic and financial support to Indigenous midwifery students at all Universities offering a midwifery degree, and works to actively recruit new Maori and Pacific students.

'Make it mandatory for all non-Aboriginal staff to participate in ongoing reflective practice about power, privilege and race.'

ACM survey respondent

Recommendations

- Reconsider how First Nations people are recruited, retained and supported to study health-related courses, including midwifery, and provide a wraparound support service co-designed with and for First Nations midwifery students
- Ensure that postgraduate professional development opportunities are provided to First Nations midwives, and that First Nations midwives are represented at all levels of maternity care, including in leadership positions
- Action the recommendations in the CATSINaM 'gettin em n keepin em n growin em': *Strategies for Aboriginal and Torres Strait Islander nursing and midwifery education reform* report (GENKE II)
- Explore innovative education alternatives such as the Canadian community-based midwifery education programs

Continuity of care

Midwifery Continuity of Care (MCoC) is a maternity care model where women see the same midwife or small team of midwives throughout their pregnancy, birth and postnatal experience. Midwifery Continuity of Care is known to be the gold standard of maternity care[8]. Women and babies experience reduced interventions and better outcomes, both physically and psychosocially[9,10,11]. MCoC improves satisfaction with the birthing experience and can reduce birth trauma[12]. Midwives are also more satisfied working in MCoC models[13], with lower levels of burnout and psychological distress[14]. In addition, MCoC costs the healthcare system 22% less than other models of care[15]. Midwives provide MCoC in publicly funded models and in private practice.

In remote areas where there is genuinely not a safe referral pathway for women experiencing intrapartum complications, an adapted MCoC model which excludes intrapartum care is an option which provides effective primary maternity care during the antenatal and postnatal period. This model of care, known as Maternal and Postnatal Service (MAPS), has demonstrated positive outcomes, and is well received by women[8]. It is the ACMs position that the majority of women in Australia should be cared for in a full MCoC model, and that all women for whom this service is not available should be offered care in a MAPS model. Models of care for First Nations women should include access to Aboriginal Health Workers or Aboriginal Maternal Infant Care (AMIC) workers in partnership with midwives. The ACM cautions against health services assuming MAPS is an acceptable replacement for full MCoC and defaulting to MAPS models of care due to assumptions about midwives' preferences or challenges setting up MCoC models.

Women having a First Nations baby report high levels of satisfaction when cared for in a culturally specific MCoC model[16]. Clinical outcomes and breastfeeding rates are also improved, and midwives are highly satisfied[16]. Despite this, scale up of MCoC models is slow, including for First Nations mothers. One of the barriers to widespread implementation includes a lack of midwifery staff. Research has demonstrated that new graduate midwives are prepared and well supported to transition to work in midwifery continuity of care models, and this addresses the staffing barrier to implementation of the models[17]. In MCoC models, midwives work in small teams, and this environment is more conducive to collegial support and mentorship than a large health service with fragmented shift work. This model is therefore well suited to support retention of First Nations midwives. It is noted that First Nations midwives are not necessarily well-supported in their workplaces, particularly in mainstream services, and often work in isolation in culturally unsafe environments where there is institutional racism. First Nations midwives often work best in Aboriginal and Torres Strait Islander specific MCoC models and/or in ACCHS which provide maternity care to First Nations women and families.

Recommendations

- Fund and prioritise the upscale of culturally specific MCoC models

Rural and remote birthing services

First Nations communities are spread unevenly across Australia, with a higher percentage of the population in remote areas identifying as Indigenous (1.9% in major cities – 32% in remote and very remote areas)[18].

Birthing services in remote areas have seen progressive closure over a number of years, with 138 rural maternity units closed across Australia between 1995 and 2005[19]. Closure of local birthing services increases cost and risk for women and babies, including financial, emotional and safety risks[20]. These

closures also impact on midwives, removing a source of income and potentially forcing midwives to give up working in maternity care.

Closures have been based on concerns about distance to the nearest facility with the capacity to perform an emergency caesarean section, however these concerns do not take into account the volume of high-level evidence for the safety of midwifery models of care for low-risk women [20]. Outcomes for women being cared for in small centres are as good as or better than for women in larger hospitals [19].

Small maternity facilities are often closed when workforce pressures change, or availability of medical professionals fluctuate. An alternative to closure of these essential services is to accommodate the option for facilities to flex between level 2 and 3 birthing services (supporting more or less complexity and intervention) depending on relevant factors.

Priority opportunities

- Re-open rural and remote birthing services and establish new services in under-serviced areas, prioritising MCoC models of care

First Nations midwives caring for First Nations families - Birthing on Country / Birthing in our Community models

For Indigenous women and babies, intrapartum care in their community is culturally important. Deep spiritual connection to their homeland is a part of their heritage, and ensuring their babies spiritual connection to the land by Birthing on Country is deeply significant[21]. In addition, Indigenous women often experience racism from health professionals, and travel to distant urban hospitals does not allow for inclusion of family support [21].

Indigenous babies are twice as likely to be born preterm as non-Indigenous babies, which leads to increased morbidity and mortality rates[22] and Indigenous mothers are 2-3 times more likely to die in childbirth[23]. In the Birthing in Our Community model, designed by Mater Hospital, women are cared for by a midwife in a continuity of care relationship alongside a First Nations Family Support Worker. Care in this model has shown a 5.34% to 14.3% reduction in preterm births, along with a saving to the health care system of $4810 per mother-baby pair (in a 2023 study) [22].

Birthing on Country models are being implemented around Australia, but face barriers. These include legislative[23], as well as issues such as inadequate MBS items and lack of Professional Indemnity Insurance policies for out-of-hospital births[24]. Other challenges include requirements for medical practitioner presence to licence a Level 2 private maternity facility, inflexible and expensive unsubsidised insurance policies for hospital birth, and funding[24]. The RISE framework has been proposed and tested as a model to support widespread implementation of Birthing on Country models[25].

'More Birthing on Country Models should be set up/rolled out across the country; tailored to individual Aboriginal Community needs. This is where the money should be going. This will attract more Aboriginal Midwives who want to care for and improve outcomes for their people.'

ACM survey respondent

Recommendations

- Fund and prioritise the upscale and roll out of Birthing on Country / Birthing in our Community models of care

First Nations midwives in private practice

Private midwifery practice is a self-employment option available to midwives. Women cared for by midwives in private practice have better clinical outcomes than the national average[26]. Private practice would provide First Nations midwives with autonomy and an independent income. However, Private Practice Midwifery (PPM) is unachievable for a lot of midwives. Some barriers are outlined below:

Endorsement to prescribe medications

Endorsed Midwives are midwives who have met the requirements of the Nursing and Midwifery Board of Australia to qualify to prescribe scheduled medicines. This means that they can provide PPM services which meet all the perinatal needs of a well woman and baby. There are low but increasing numbers of Endorsed Midwives in Australia (see below):

Table 3 – Midwives with scheduled medicines endorsement[1]

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	**Total**
As at 31 March 2024	24	183	21	383	95	21	197	224	110	**1258**

Since endorsement for midwives was introduced in 2010, uptake has been slow, which indicates there are challenges for midwives gaining and utilising this additional qualification[27]. The endorsement application process for midwives is time consuming and challenging[28]. There are multiple barriers to midwives gaining endorsement, including the requirement for 5,000 hours of recent clinical experience, which is prohibitive for midwives working part time, midwives who take maternity leave, and midwives working in rural and remote settings who work in hybrid jobs which include a proportion of general nursing work. The post-registration clinical practice hours are not based on evidence, and there are calls to include prescribing in pre-registration programs so that midwives graduate workforce-ready[24]. Removing this requirement would result in a significant upturn in the number of endorsed midwives, and would increase self-employment opportunities for midwives, including First Nations midwives. This will also enable Aboriginal Commmunity controlled organisations to collaborate with or employ endorsed First Nations midwives and promote the sustainability of maternal and infant services in regions that are lacking these.

Medicare rebates

Medicare rebates are not sufficient to cover the cost of a midwife in private practice, especially in remote areas where the midwife may need to travel long distances for an appointment. This leads to the need to charge a gap fee, reducing the availability of affordable maternity care options for women[29]. The budget announcement of funding to implement the recommendations from the MBS Review Taskforce – Participating Midwives report is warmly welcomed. The ACM urges the Government to ensure that these changes translate to genuine adequate MBS funding of an entire perinatal episode of care when delivered by a PPM.

Planned birth at home is safe for mothers and babies[30,31]. In rural and remote locations, planned homebirth may be a safer option than travelling large distances while in labour or relocating prior to

birth. Intrapartum care, which is the most expensive component of perinatal care, is not rebated by Medicare when attended at home by a Privately Practicing Midwife. There is also the requirement for a second midwife at the birth, and the cost for this is passed onto the woman[29]. While professional indemnity insurance for PPMs is expanded to include homebirth in the budget announcement, there is no mention of an MBS item for labour and birth at home.

Insurance

All midwives must hold Professional Indemnity Insurance when practicing as a midwife, even when in a volunteer capacity. There is currently only one Professional Indemnity Insurance product available to Privately Practicing Midwives, and this product is only available for endorsed midwives, and does not cover intrapartum care outside of hospital. The ACM welcomes the budget announcement of funding for insurance for PPMs providing labour and birth care outside of a hospital setting, while recognising that there is a significant amount of work to be done to ensure that the insurance policy does not dictate PPM's scope of practice or restrict women's choices. An insurance option for midwives who are not endorsed and wish to work in private practice would increase options for women and financial opportunities for midwives, including First Nations midwives. Without this option, midwives who are not endorsed can only practice when employed by a health service.

Digital health capability

Midwives need to be educated on their access rights to MyHealthRecord and usability function. In addition, software is unavailable, and this is a barrier for midwives in terms of cost. Furthermore, midwives require other digital interoperability to ensure safer and more effective handover of care and collaboration when necessary. This needs to include education for midwives, especially midwives in private practice, on use of digital health tools.

Hospital admitting rights

Most hospitals in Australia do not allow visiting rights for endorsed PPMs, despite clinical outcomes for women cared for by PPMs with visiting rights being more positive than national statistics[32]. This is a significant barrier to midwives working in private practice. The table below presents statistics on the number of Medicare item 82120 claims. Item 82120 is management of labour and birth in hospital by an endorsed midwife in an MCoC relationship with the woman.

Table 4 – Medicare item 82120 processed from July 2010 to March 2024

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
Item 82120	232	506	4,525	23	215	1	4	21	5,527

Endorsed midwives in Waminda recently became the first privately employed endorsed midwives to be granted visiting rights to hospital to provide intrapartum care for First Nations mothers and babies.

Recommendations

- Remove the clinical requirement of 5,000 hours for Endorsement for Scheduled Medicines and incorporate prescribing into undergraduate programs via ANMAC
- Ensure an MBS item is added for homebirth alongside the extended insurance policy to support BoC models of care.
- Provide appropriate software and education to enable PPMs to access digital interoperability
- Work with health services to establish visiting rights for PPMs nationwide

Conclusion

Midwifery is a profession that offers First Nations individuals personal financial self-sufficiency, either when employed by a health service or in private practice. Increasing the number of First Nations health professionals in Australia will also improve the health and psychosocial outcomes for First Nations communities. First Nations midwives are in critically short supply and do not represent the number of First Nations women and babies requiring maternity care each year. There are a number of barriers to the recruitment and retention of First Nations midwives in Australia. Actioning the ACM's recommendations would address many of these barriers and improve economic self-determination and opportunities for First Nations people.

Helen White
Chief Executive Officer

E: Helen.white@midwives.org.au

Alison Weatherstone
Chief Midwife

E: Alison.Weatherstone@midwives.org.au

W: https://www.midwives.org.au

Attribution: Aya Emery, ACM Policy Officer

Consent to publish
ACM consents to this submission being published in its entirety, including names.

Consent to provide further information
ACM is available to provide further expert opinion and advice if required.

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CATSINaM
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Unity and Strength through Caring

1300 006 267
enquire@catsinam.org.au
@catsinam

Committee Secretary
Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs
PO Box 6021
Parliament House
Canberra ACT 2600

Dear Committee Members,

Re: Endorsement of Australian College of Midwives (ACM) Submission to the Inquiry into Economic Self-Determination and Opportunities for First Nations Australians

On behalf of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), I am writing to formally endorse the Australian College of Midwives (ACM) submission to the Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs *Inquiry into economic self-determination and opportunities for First Nations Australians*.

CATSINaM is the peak advocacy body for Aboriginal and Torres Strait Islander nurses and midwives in Australia. Our purpose is to lead the nursing and midwifery workforce to improve health outcomes for Aboriginal and Torres Strait Islander peoples. We recognise the importance of economic self-determination as a foundational element of health and wellbeing for our communities.

The ACM's submission provides a comprehensive overview of 'opportunities for, and barriers to training, employment and business development', in regard to the potential of Aboriginal and Torres Strait Islander midwives and midwifery students. The submission highlights important areas including actioning CATSINaM's 'gettin em n keepin em n growin em': *Strategies for Aboriginal and Torres Strait Islander nursing and midwifery education reform* (GENKE II) report. The GENKE II report was released in August 2022 and contains key recommendations to strengthen the place of Aboriginal and Torres Strait Islander nurses and midwives across education and healthcare.

In particular, CATSINaM strongly supports ACM's recommendations addressing the most pressing needs to both scale up Birthing on Country (BoC) midwifery continuity of care/carer models and to grow and develop the Aboriginal and Torres Strait Islander midwifery workforce to support BoC. CATSINaM believes these recommendations will significantly contribute to advancing economic self-determination and creating more equitable opportunities for Aboriginal and Torres Strait Islander peoples.

We urge the Committee to give due consideration to the ACM submission and to incorporate its recommendations into the final report of the Inquiry.

Yours sincerely,

Dr Ali Drummond
Chief Executive Officer
Meriam and Wuthathi