Australian College of Midwives

ACM: For midwives. With women. For the future.

## Re: Submission to the Select Committee on reproductive, maternal and paediatric health services in Tasmania

The Australian College of Midwives (ACM) is the national peak professional body for midwives in Australia. ACM represents professional interests and supports the midwifery profession to enable midwives to work to their full scope of practice. ACM is focused on ensuring better health outcomes for women, families, and their babies. The Tasmanian Branch of the Australian College of Midwives (ACM) welcomes the invitation to provide a submission to the Select Committee on Reproductive, Maternal and Paediatric health services in Tasmania.

Maternal and infant health and wellbeing, and access to timely and appropriate services are vital to childbearing women and their families across Tasmania. Midwifery care provision is acknowledged as paramount to support optimal health outcomes for women and babies across the childbearing continuum, and midwives have a key role in supporting reproductive health knowledge and wellbeing.

## The ACM Tasmania Branch responses to the Terms of Reference are detailed below:

**(a) to assess the adequacy, accessibility and safety of the following services for Tasmanian parents and their children in relation to:**

**(i) reproductive health services:**

ACM advocates for universal access to reproductive healthcare services. 'The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood women's health, sexual or reproductive health and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units' (International Confederation of Midwives, 2019).

The midwifery workforce is an under-utilised profession in relation to reproductive healthcare for women. In 2022, the ACM submitted a response to a senate inquiry into universal access to reproductive healthcare (see attached). Within this submission there is robust discussion surrounding improvement to access and affordability of contraceptives and the ability of endorsed midwives to prescribe these. It is within the midwifery scope of practice to provide contraception services to women such as Implanon, Mirena and cervical screening tests. Midwives providing these services may alleviate some of the pressure on GPs and doctors.

Endorsed midwives are expert primary care providers, and their scope includes sexual and reproductive health. Support for endorsed midwives to work to their full scope of practice will be an

important step toward improving access to timely and appropriate reproductive healthcare for women, and particularly those in rural and remote areas. The Pharmaceutical Benefits Scheme announced changes in the schedule in late 2023 to allow midwives to prescribe MS-2 Step (mifepristone and misoprostol) for medical abortions. State-based legislation changes are still required to enable endorsed midwives and nurse practitioners to prescribe it, including changes to the midwifery prescribing formulary in Tasmania.

Tasmania is one of only two states in Australia where restrictions on the medications endorsed midwives are able to prescribe are limited by a formulary, rather than inclusive of those within the midwifery scope of practice. When legislative changes are made to support midwifery prescription of MS-2 Step, current restrictions within the formulary will prevent this from being enacted. We recommend that legislation is changed to enable midwives with scheduled medicine endorsement to prescribe within their scope of practice. This will support endorsed midwives working in Tasmania to practice in line with mainland peers and ensure Tasmania women and families benefit from the progress made to support greater access to reproductive healthcare choice.

**(ii) maternal health services**

Centralisation of maternity services continues across Australia, including within Tasmania, with the closure of more than 130 maternity units over the past 20 years (Bradow et al., 2021). While ostensibly fiscal decisions intended to save money and standardise healthcare provision, the impact of maternity service closure does not mitigate against inconsistencies in service provision, and the burden of these changes are unfairly felt by those outside larger cities (Bradow et al., 2021). The way in which women receive and access their care is driven by the maternity service; women who live in regional and remote areas of the state are more likely to be disadvantaged by reduced services than those in larger cities. While some public outreach services exist for antenatal care, there are currently only three public Tasmanian Health Service hospitals for birthing in Hobart, Launceston and Burnie.

The closure of regional and rural maternity services sees some women forced to travel long distances to access maternity services, and is known to result in fragmented care, increased financial constraints, displaced families, increased unplanned birth before arrival and a high emotional burden (Kildea et al., 2015; Sweet et al., 2015). Within Tasmania, the most recent closures were in 2016, when the Mersey Community Hospital lost its inpatient and birthing services in the North West; and in 2023 when the St Helen's mother and baby unit was closed and a smaller unit re-opened within the Royal Hobart Hospital. These choices have been unpopular with women and families, and their impact reported in the media and reports from women to organisations such as the Centre of Perinatal Excellence (COPE) and Women's Health Tasmania.

Continuity of care models such as Midwifery Group Practice (MGP/caseload), whereby women receive care from a known midwife across the pregnancy continuum, are highly sought after, and women continue to express demand for these publicly funded models of care. However, MGP models are oversubscribed, and often have long wait lists and in some places, staff retention issues. Continuity of care is considered the gold standard in maternity care, with benefits demonstrated for women experiencing both low-risk and complex pregnancies. These include reductions in pre-term birth and pregnancy loss, and increased rates of satisfaction, normal birth, and breastfeeding (Sandall et al., 2016). In addition to improved clinical outcomes, caseload offers significant cost-saving of up to 22% to health services through reduced interventions, shorter hospital stays and improved satisfaction (Callander et al., 2021).

Additionally, caseload models for First Nations women and babies are shown to enhance culturally safe care provision and support better clinical outcomes (McLachlan et al., 2022). These include reduced pre-term birth, increased breastfeeding rates, increased satisfaction and greater engagement with care for First Nations women and babies receiving midwifery-led caseload care in programs specifically designed for Aboriginal and Torres Strait Islander families (Bowden et al., 2023; Kildea et al., 2021; McCalman et al., 2023). A key aspect of caseload midwifery care is relational, and developing this between women and midwives in service demand and co-design, and more broadly amongst all stakeholders including health service management and administration has been identified as important in establishing and maintaining these services (Bowden et al., 2023; Prussing et al., 2023). While some First Nations women in Tasmania receive care through MGP models through THS services, this is not a dedicated service and further steps need to be taken to ensure greater access to and provision of culturally safe care to close the gap in health outcomes between First Nations and non-Indigenous people. The ACM calls for increased access to midwifery-led continuity of care models for all women.

Tasmanian-based research by Hargreaves et al. (2022) – see attached – has explored the experiences of women in a Tasmanian regional maternity service, and identified potential improvements for service delivery. Tasmanian women's experiences are improved if maternity services work towards context appropriate continuity of care models, that are informed by the women and their families. Consumer engagement is important and Tasmanian maternity services need to ensure this occurs – these findings are echoed by Prussing et al. (2023). In addition to highlighting access to continuity of care models, care pathways when women are experiencing breastfeeding issues, depression and anxiety were also identified as essential areas for further development.

Birthplace choices in Tasmania are limited to one of three public hospitals, three private hospitals, a single private birth centre, or home. There are no publicly funded birth centres in Tasmania, and Tasmania is now the only state in Australia that does not offer publicly funded homebirth. Women who wish to birth at home (or birth centre/house) have the option of employing a privately practicing endorsed midwife to support them, however the out-of-pocket costs of this and relatively small Medicare rebate means that this is not a viable option for many families. Freebirth, whereby women birth with either unregulated birth workers or alone, is reportedly on the rise. While data for Tasmania is not available, anecdotally, freebirth rates within the state are rising due to the limited number of private practice midwives offering this service, the high costs of homebirth, lack of access to caseload care and concerns about risk of unnecessary intervention within an over-medicalised hospital-based maternity system. These anecdotal reports are similar to women's concerns as reported to Jackson et al. (2020) and Sassine et al. (2021).

A study exploring women's motivations for choosing private birth houses, such as the Launceston Birth Centre (Shakes, 2020), found women are motivated to seek these birthplaces because of the middle ground they inhabit between home and hospital, and the feelings of safety this can offer to women and/or family members. Physiological birth rates increase when birth is not framed within the biomedical model – either philosophically or within physical distance (Dahlen et al., 2021). Compared to hospital, out-of-hospital birth (home or birth centre) for women experiencing low risk pregnancies are associated with increased normal birth rates and no change in infant mortality (Scarf et al., 2018). Publicly-funded birth centres, and particularly those that are freestanding/stand alone, rather than alongside (within the hospital) are associated with improved normal birth rates, and reduced interventions while continuing to demonstrate safe outcomes (Monk et al., 2014). Publicly-funded

homebirth is considered safe (Sweet et al., 2022), and is likely to be associated with cost-savings to health services (Hu et al., 2024).

Birthplace choice is a profound aspect of women's childbirth experience. The limited options available in Tasmania increase the risk of women opting out of maternity care. While respect for women's choice is essential, rising freebirth rates and lack of engagement in maternity care should be understood as a failure of the maternity system to meet women's needs. Greater access to birthplace choice is essential to support safe maternity care for Tasmanian women. Working with women and families to co-design services and models of maternity care will be important steps towards ensuring their suitability and sustainability. Within the state, we recommend expansion of public maternity services to include publicly-funded homebirth and freestanding birth centres.

Breastfeeding support is a key area of midwifery practice. The World Health Organization recommends exclusive breastfeeding for six months and continued breastfeeding for two years to provide optimal nutrition. In Australia, the NHMRC recommends exclusive breastfeeding for six months (no other food or fluid) and continued breastfeeding alongside other food continuing for at least 12 months and beyond. The long-term benefits of breastfeeding for mothers and babies are well documented. Accurate contemporary data on breastfeeding rates in Tasmania are not available, however it is reported that initial breastfeeding rates remain high at above 90%, and fall after this time. The National Health Survey reports that only 30 percent of women exclusively breastfed for at least 6 months in 2020/2021 (AIHW, 2023). These state rates are the lowest in the country for that time period.

While not all women wish to breastfeed, breastfeeding support has been shown to increase breastfeeding rates at six months (Cramer et al., 2021). The ACM recognises the importance of Baby-Friendly Health Initiative accreditation in supporting breastfeeding by ensuring hospital services reflect best practice recommendations and meet international standards for infant feeding care. However, despite BFHI accreditation across facilities in Tasmania, breastfeeding statistics suggest that Tasmanian women are not receiving sufficient support and education to reach optimal outcomes in breastfeeding duration. Barriers to providing care in line with BFHI strategies include lack of time and lack of continuity of care (Pramono et al., 2022). Workforce shortages and poor skill mix undoubtedly challenge provision of quality breastfeeding support. Fragmented care increases the likelihood of longer hospital stays and with this, risk of women receiving conflicting advice. Conversely, continuity of care is associated with improved breastfeeding rates and duration.

Expansion of models of care and support services demonstrated to improve breastfeeding rates and duration should be key focus areas for our health service. These may include expansion of breastfeeding clinics in a variety of settings, including within the community. One example is the "Parent Place" clinic in Ballarat where women can drop in to see a lactation consultant. The cost of running these clinics across the state could be dwarfed by the long-term costs to Tasmania from the 70% of dyads who do not continue to breastfeed. Global economic benefits of breastfeeding are extensive and are represented in healthcare treatment savings and future lost earnings due to premature child and maternal morbidity and mortality (Pramono et al., 2022).

**ACM position on infant feeding**

1. ACM promotes breastfeeding as the gold standard for infant feeding and nutrition. This position is reflected in ACM facilitation of the Baby Friendly Health Initiative (BFHI) program nationally. The ACM position aligns with the WHO Code. The College does not advertise or endorse formula, bottles or teats.

2. Every mother should be encouraged to breastfeed, or to provide her baby with human milk. Because of the vital role midwives play in promoting breastfeeding, ACM offers specific breastfeeding education courses based on the best available evidence for midwives to assist them in this role through the Midwives Learn platform.
3. Some women choose not to breastfeed. For others breastfeeding may not be an option. Provided a woman has had access to support and encouragement to breastfeed, midwives should respect her choice. Women who decide not to breastfeed should be supported and, in the interests of both mother and child, must be protected from judgement and discrimination at this critical stage in the development of the mother-baby bond.
4. Midwives have an overriding professional responsibility to women and babies in all circumstances, including where, for any reason, breastfeeding is not possible. ACM recognises the importance of education for midwives in safe alternatives to breastfeeding so that they can meet their responsibilities regardless of the parents' choice or circumstances.

**(iii) birth trauma**

All women have the right to respectful maternity care. The senate inquiry into birth trauma in NSW highlighted that this issue is of growing concern amongst women, their families and healthcare professionals. Attached to this document is the BESt Study led by Dr Hazel Keedle at the Western Sydney University. This research has revealed that approximately one in ten women across Australia experience obstetric violence, with many more reporting some form of trauma associated with their birth. Tasmanian maternity services and health professionals need to recognise that this can and does occur within their maternity services, and it can have a devastating impact on women, their families and newborns. Broader understandings of what birth trauma and obstetric violence are, and how it can impact women and their families is essential if maternity care providers are to provide meaningful care that mitigates against creating or exacerbating birth trauma.

Maternity care systems and practices that deny women access to choice and unbiased information, undermine women's preferences and use coercion and paternalistic approaches to care provision are associated with increased reports of birth trauma (Tsakmakis et al., 2023). Previous experiences of birth trauma can influence women's decision making for future pregnancies, including who cares for them (Hargreaves et al., 2022) and where they are willing to birth. Some women who have experienced birth trauma report this as their reason for choosing to freebirth in subsequent pregnancies (Jackson et al., 2020; Sassine et al., 2021). Risk is located in these instances within the technocratic environment, and/or care providers within this. Placing support services for women experiencing postnatal depression or other conditions due to birth trauma within hospital environments, may be counter-productive for some and reduce the benefits of this service.

One of the recommendations from the BESt study is that maternity service providers ensure appropriate education for healthcare staff who care for women and their families within the maternity service. The Maternity Consumer Network have a workshop for Trauma Informed Care, targeted to all maternity care providers. This kind training is essential to reduce birth trauma and we recommend that training such as this be mandatory for all midwives and maternity care providers.

**(iv) workforce shortages**

Accurate data on the Tasmanian midwifery workforce is difficult to determine, in part due to it commonly being reported as an adjunct to nursing rather than a profession in its own right. Despite this, midwifery and maternity workforce shortages are evident across Tasmania, with high reliance on

agency and locum staff, and poor retention in some areas. While formal reports of FTE deficits are not available, these are known to have been alarmingly high in some areas over the past 12-18 months, and last year resulted in one service being on bypass, thereby forcing women to travel long distances to access maternity care.

Sufficient staffing and skill mix are essential for the provision of woman-centred midwifery care. A recent study into workforce issues in Victoria (Matthews et al., 2024) reports poor retention of experienced midwives leads to poor skill mix, which in turn presents risk to families receiving care through the service, and increases the burden on remaining staff. In cases of short staffing, postnatal care is sometimes provided by nurses. However, this is a midwifery role and nurses are not clinically trained or professionally registered to provide midwifery care. This increases the possibility that women and babies may not receive optimal care in these instances, and may further increase the burden on midwifery staff. Safe staff ratios include counting babies as well as women. The ACM welcomes recent legislation changes in Queensland that support a ratio of 1:6 (1 midwife to 3 women and 3 babies) and recommends that these changes are implemented across the country.

Blackman and Shifaza (2022) recommend retention and recruitment schemes focus on broadening midwifery skills, competency and full scope midwifery practice, alongside teamwork and communication skill development. Poor communication, low staffing numbers and subsequent increased workload intensity are associated with missed midwifery care episodes. Implementation of schemes designed to retain experienced and new career midwives through providing greater career progression opportunities, improved flexibility in contracted hours, shifts and shift duration may also improve some workforce shortages. Sheehy et al. (2021) found new career midwives reported high levels of satisfaction when working to full scope of practice and being able to develop midwife-women relationships when providing clinical care; interestingly these factors mitigated against some of the more challenging aspects such as inflexible rostering, high workloads and poor management. Given the known midwifery workforce issues including an aging workforce and inequitable geographical distribution of experienced midwives, greater understanding of sustainability, and implementation of measures that increase workplace satisfaction and support retention is essential. Research and investigation that seeks to understand Tasmanian midwives' reasons for leaving is required to determine specific strategies that will best suit our state. Incentives for midwives to relocate to Tasmania, and to work in areas of greatest shortage may also be necessary. Current recruitment incentives offered within Tasmania are out of step with those offered in most if not all mainland states, and are therefore not competitive.

A contributing factor reported to ACM Tasmania regarding workforce sustainability, education and retention is the lack of a university presence dedicated to the midwifery workforce in Tasmania. There are limited transparent pathways for registered midwives to further their education and career, particularly in capacity building, research and higher education within the state. Risks associated with this are a continued paucity of midwifery research undertaken within Tasmania, and that midwives wishing to expand into these areas instead relocate to the mainland. A vested interest from a university such as UTAS into both midwifery undergraduate and postgraduate education would create a far better experience for midwives and help to grow the midwifery workforce from within Tasmania. Investing in Tasmanian residents in this way would be a meaningful step toward capacity building. Developing a robust midwifery training program within the state may also help bring newcomers to the island for education and subsequent employment. While employing interstate staff may be beneficial to broaden knowledge and skills, it is undoubtedly more costly than investing in local training and workforce development.

Currently, the only completely in-state midwifery training in Tasmania poaches from the nursing workforce by offering a two-year Bachelor of Midwifery degree to graduated nurses. Other options include a one-year graduate diploma for registered nurses, and a three-year undergraduate Bachelor of Midwifery with interstate learning residentials. However, many student nurses and registered nurses report they have only studied nursing to subsequently study midwifery. This means that the pathway to becoming a midwife is unnecessarily protracted, and for some has them learning about aspects of healthcare they are unlikely to use if they opt to work exclusively within midwifery, rather than having the opportunity to specialise in midwifery over three years of undergraduate study. There is no undergraduate Bachelor of Midwifery program whereby Tasmanian residents can complete their studies entirely within the state. While ACM recognises that diverse pathways to study midwifery in Tasmania are important, current offerings do not meet demand. We have heard from numerous reports by women wishing to commence an undergraduate Bachelor of Midwifery which they can complete entirely within the state. This requires learning residentials to be offered within Tasmania, rather than requiring a twice-yearly trips to the mainland, and guaranteed placement within Tasmanian Health Service facilities for the duration of their undergraduate studies. Additionally, incentives and support for those wishing to study midwifery are not standardised across the pathways, resulting in registered nurses being better supported to further their qualifications into midwifery (and receiving a higher pay once dual registered) than undergraduate students in midwifery. Investigation into the ways that equitable support to grow the midwifery workforce from within Tasmania are required.

Midwifery group practice requires midwives willing to work on call and to their full scope of practice. Research has demonstrated that midwives who work in MGP are twice as likely to have completed a Bachelor of Midwifery than other pathways (Hewitt et al., 2024). Therefore, encouraging educational pathways that support newly graduated midwives to step into the MGP workforce may be a key pathway to futureproof staffing within this gold standard model of care. Currently, the ability to adequately staff continuity of care models to meet expansion targets is not demonstrated within Tasmania and significant work is required to address this. The ACM has called for increased access to continuity of care models. Investigations into how this may best be achieved in Tasmania are warranted and an exploration of barriers and facilitators may be beneficial.

### (v) midwife professional indemnity insurance

Midwives working in private practice are required to hold professional indemnity insurance; this covers antenatal and postnatal care services, however intrapartum care in the home continues to be exempt from insurance requirements as there are no suitable indemnity insurance products available within the insurance sector. The ACM welcomes the decision by the Albanese Government to further extend the professional indemnity insurance exemption for midwives providing homebirth services until 30 June 2025, however we are hopeful for a resolution to this long-standing issue of intrapartum insurance coverage.

Currently, there is a single provider of professional indemnity insurance for endorsed private practice midwives (EPPMs) in Australia. We welcome a broader exploration of options for state based EPPMs in Tasmania, and are encouraged by reports at a Senate Estimates Hearing that the government is working on the "development of an affordable, low-risk homebirth product with potential insurers." Greater access to affordable professional indemnity insurance will support broader opportunities for

Tasmanian midwives to work in private practice, and importantly may contribute to making private midwifery services more affordable, and therefore more accessible to women and families.

### (vi) perinatal mental health services

Social work and perinatal mental health services are overburdened in Tasmania, and some women who would benefit from this support are known to have been rejected due to their condition not being severe enough. While triage is an important aspect of timely care, concern has been raised for the increased risk of missed care opportunities for vulnerable women. Perinatal mental health concerns are common morbidities experienced by women and can have a considerable impact on women themselves, and relationships within families including parenting and newborn bonding. Beyond Blue reports that one in six women will experience postnatal depression and up to one in ten antenatal depression. The leading causes of maternal mortality in Australia are suicide and cardiovascular disease. While nurses and midwives providing perinatal care may be able to positively identify common mental health issues with women, research has demonstrated less confidence in providing care to women in these instances (Noonan et al., 2019). Therefore, specific training to develop knowledge, awareness and confidence around perinatal mental health and recommended care would be beneficial. Commonly used screening tools such as the EPDS are not validated for use by women from First Nations or CALD backgrounds. Further work needs to be undertaken in this area to ensure suitability of screening tools, and to ensure clear referral pathways and support services access to ensure meaning from conducting screening assessments.

Perinatal loss can have long term impacts on women and families, and heavily influence future pregnancy experiences. Bereavement midwives are uniquely placed and have a specialised role in supporting women and families who have experienced perinatal loss. While providing this care is within the midwifery scope of practice, studies have demonstrated that the emotional pain experienced by parents is exacerbated when midwives and other healthcare workers are unable to provide the required bereavement care (Kalu et al., 2020). Therefore, organisational support for midwives who work in this emotionally challenging area, and to build capacity by having dedicated bereavement midwives will support better outcomes for women and families.

Women with pre-existing mental health who receive midwifery continuity of care experience improved outcomes compared to standard care (Cummins et al., 2022). From a perinatal mental health perspective, longer breastfeeding duration is associated with reduced risk of postnatal depression, however breastfeeding difficulties can be predictive of depressive symptoms (Del Ciampo & Del Ciampo, 2018; Figueiredo et al., 2021). Dedicated units to support mothers and babies with PND and other mental health concerns requiring inpatient stays need to be offered in appropriate and accessible environments. As previously noted, concern has been raised by service users about the closure of the St Helens Mother and Baby Unit and the relocation of this into a hospital environment.

### (viii) The Child Health and Parenting Service (CHaPS)

Midwifery scope of practice is to six weeks postnatal, and provision of continuity of care from a known midwifery care provider throughout this time is beneficial to women and families. While CHaPS form an essential component of paediatric services to children from birth to 5 years, and provide valuable care to families, many CHaPS care providers are nurses without additional qualifications as midwives. This can change the approach to care provided; a midwifery lens seeks to focus on the mother-baby

dyad. Handing over care at two weeks postnatal means that opportunities to support breastfeeding and bonding may be missed if this is not within the experience of CHaPS nurse.

We recommend that caseload midwifery services in Tasmania are provided to six weeks postnatal by the woman's known midwife, and care handed over to CHaPS after this time. Extending this service would facilitate tailored care to women and families at a pivotal time during the childbirth continuum. It can take six to eight weeks to establish breastfeeding; for women planning to breastfeed, continuity of care is associated with improved breastfeeding rates. In Tasmania, where breastfeeding rates are some of the lowest in Australia, this would be a meaningful step towards improving this issue. It would also reduce demand on hospital-based lactation support services (which are notoriously over-subscribed) for issues that can be resolved with specialist midwifery support and knowledge.

ACM welcomes the recent announcement by the Nursing and Midwifery Board of Australia that supports registered midwives who are not nurses as suitable for working within the space of maternal and child health nursing with these additional qualifications.

**Part (b) to examine disparities in the availability of services, staffing and outcomes between**:

**(i) Tasmania and other Australian states and territories**

As outlined above:

- Tasmania is now the only Australian state not offering publicly funded homebirth
- There are limited birthplace choices within the state and some women have to travel long distances to access maternity care. Expansion of these services to including publicly funded homebirth and freestanding birth centres will support greater options and may help prevent rising freebirth rates and ensure access safe maternity care options
- There is no pathway for undergraduate midwifery education whereby Tasmanian residents can complete all of their training within the state
- Incentives to study midwifery in Tasmania are not equally applied to each pathway. Some states offer incentives that are applied by universities to subsidise midwifery students
- Pathways to career progression are not always transparent, or based on qualifications or merit
- Recruitment incentives in Tasmania are not competitive with those offered in most mainland states. This, coupled with Tasmania having a history of some of lowest pay rates for midwives across the country is likely to have impacted attraction to interstate midwives to relocate
- Staff to patient ratio that includes counting women and babies separately will support safer workplaces, and ensure women and babies receive optimal care
- Tasmania midwives with scheduled medicine endorsement can prescribe to a limited by a formulary. All other states except Victoria have listed this to enable midwives to prescribe within their scope of practice.

**(ii) Tasmanians living in regional rural and remote areas**

Evidence suggests that women and their families living in regional rural and remote areas are at risk of increased morbidity and mortality. Maternal health services need to ensure that all women can and do have access to services. Living in these areas, especially within poorer social economic areas can be associated with crippling isolation. As mentioned previously, women living in regional and remote areas of Tasmania can have trouble accessing required maternity services. For example, women in the

North West of the state do not have appropriate services to access if they are experiencing pain and bleeding in early pregnancy. Women should have appropriate maternity services available within reasonable distances, rather than having to wait in emergency departments for care. Comparatively, the North and South of the state have appropriate services for women.

**(iii) Tasmanians experiencing socio-economic disadvantage;**

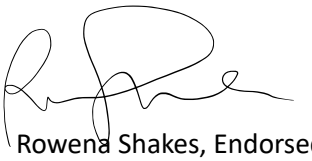
There are many women currently experiencing socio-economic disadvantage across Tasmania. ACM believes all women deserve the right to universal access to timely and appropriate maternity care. Expansion of publicly-funded maternity services including continuity of care models, increasing outreach clinics, re-opening birthing facilities in regional areas and government funding for out-of-hospital birthplaces will help improve equitable access to care. Integration of findings from research such as that conducted by Women's Health Tasmania into the experiences and preferences of people having babies within Tasmania will be an important step towards co-design. The lack of targeted maternal and reproductive health specific programs aimed at Aboriginal and Torres Strait Islander women needs to be addressed and meaningful ways to engage with this population of women and families should be sought in conjunction with the Tasmanian Aboriginal Centre and other relevant stakeholders.

**Part (c) to make recommendations on actions that can be taken by the State Government to ensure reproductive, maternal and paediatric health and perinatal mental health services meet the needs of Tasmanian parent, families and children.**

- Enact changes to ensure endorsed midwives are able to prescribe medication to their full scope of practice, including legislative changes to support these midwives working within reproductive health areas
- Ensure endorsed midwives are supported to use their endorsement to prescribe within the hospital (public and private) systems within their scope of practice
- Further training and support for midwives to work in the reproductive health area including in Implanon and Mirena insertion
- Expansion of MGP models of care and integration of evidence-based practice recommendations into the design and management of these services along with service user involvement
- Review MGP eligibility criteria to ensure inclusivity (eg., Establish dedicated pathways to support Tasmania Aboriginal and First Nations women access MGP care)
- Explore feasibility of offering MGP models specifically for women in vulnerable groups including young women, First Nations women, women experiencing high-risk or complex pregnancies and women from refugee and CALD backgrounds
- Extension of the MGP period of care to 6 weeks postnatal with handover of care to CHaPS after this time
- Commit public-funding to expand birthplace options for women including freestanding birth centres and birth facilities in regional locations
- Extend breastfeeding support services to publicly-funded community drop-in clinics, MGP care to 6 weeks postnatal
- Ensure all women have the opportunity to see a midwife up to 6 weeks postpartum especially those experiencing breastfeeding issues
- Ensure access to out-of-hospital care options for women requiring mother and baby unit support
- Implement mandatory trauma informed care education for all midwives and maternity healthcare professionals

- Implement mandatory perinatal mental health training and awareness for all midwives and maternity healthcare professionals
- Provide pathways and support for midwives to work in dedicated bereavement midwife roles
- Facilitate service user participation and engagement in all maternity policy and guideline development
- Develop and enact transparent pathways for career progression
- Conduct an independent inquest into retention, hiring and workforce issues
- Invest in a dedicated recruitment drive to support adequate staffing and skill mix, including implementation of strategies to support retention of experienced midwives in MGP as this is essential to support appropriate skill mix and ensure more newly graduated midwives are supported to step into these positions early in their careers
- Act to resolve the longstanding insurance issues for midwives in private practice
- Ensure pathways for visiting rights for midwives in private practice are available to support continuity of care and for women to receive maternity care and birth support in their chosen birthplace
- We recommend that Tasmania, like other Australian states move towards separating the roles of Chief Nurse and Chief Midwife. While the Tasmanian population is relatively small, progressive contemporary and dedicated midwifery leadership remains essential to support optimal maternity service provision and development of the midwifery workforce to meet our full potential. Acknowledgement of the separate nature of the nursing and midwifery professions needs to be demonstrated at all levels. Midwifery is not an adjunct to nursing.

We thank you for the opportunity to contribute to Select Committee on reproductive, maternal and paediatric health services in Tasmania and look forward to meaningful changes that improve service delivery and outcomes for women and families, midwives and maternity healthcare professionals.



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Australian College of Midwives Tasmanian Branch Committee

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