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I, Margaret Campbell, entered Maternal and Child Health (MCH) nursing after a diverse practice career including Acute Care, Community Nursing, Undergraduate Nurse Education and Midwifery. My qualifications include Immunisation Accreditation as well as those required for the above-mentioned practice. I have not applied for nor received any scholarships. I found a career in MCH nursing a welcome extension to my midwifery practice and this has kept me in the nursing workforce.

This submission is limited to comment on recommendations found in Chapter 12 of the Early Childhood Development Draft Report and the "Child Health Workforce". I am specifically addressing recommendations 12.3 and 12.2 of the Draft Report regarding removal of Midwifery as a prerequisite qualification for MCH nurses, and the questioning of the value of scholarships for MCH programs of study.

This submission argues that MCH nurses both need and use the midwifery knowledge and qualifications. MCH practice generates excellent clinical outcomes. These clinical outcomes reflect best practice in terms of clinical outcomes and use of the healthcare dollars. The MCH Program scholarships are a good investment of health dollars.

Data collection priorities of MCH are not targeted to support my contention that midwifery, as a prerequisite qualification, is necessary for MCH practice. There is however, much raw data within the clinical notes generated by MCH nurses. This evidence base, if collected and made statistically visible, would demonstrate the value and efficacy of MCH practice with its midwifery prerequisite. I will endeavour to supply an example of this data in my vignettes/scenarios following my "perspective Statement" below. For this submission I have only the anecdotal evidence of my own practice.

I cannot directly address the argument that Midwifery qualifications are "not necessary" in MCH practice because I could not find any. That an alternative service other than MCH practice can be cobbled together with ill-defined capabilities and outcomes is not a service that can be defined well enough to argued against. If there is supporting data for this statement, it has not been included in the Child Health Workforce Draft Report Chapter 12. The Draft makes some very good observations but I am frustrated that no MCH nurses or users of the MCH service have had input into the Health Workforce Draft Report thus making it selective in its scope. If child health outcomes were to be prioritised then I would argue that more funding should be made available rather than diminishing current MCH practice service.

Perspectives of MCH practice in its community base Midwifery knowledge is necessary for the MCH Nurse to be proactive in the management of the mother,

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child, and family. I have found my midwifery-generated skills in lactation and early postnatal care increasingly necessary in the "Early Discharge" from hospital of mothers and babies that is common in my practice area. I believe that the inherent midwifery knowledge -based on a wellness and human development model, together with general nursing qualification-based largely in the biomedical model, enables and defines MCH practice. If it were within the scope of this submission, I might t recommend exporting the MCH Program to the other states and territories.

Following are some vignettes/scenarios that are examples of the "raw data" I alluded to earlier in this submission. I believe they demonstrate "best practice " in both clinical practice and use of health dollars.

Scenario 1 Mother presents with "not feeling very good today" I will use targeted interviewing skills –or examination to determine whether the mother has a minor wound infection, early mastitis, has a minor viral illness not related to birthing, or is overwhelmed or tired. Many may be referred to a GP but many will not need to be referred. **I have often avoided a more complicated clinical outcome and have reduced pressure on our very busy GP services. Unlike the GP clinic, I will affirm that baby is safe, well and thriving in this single consultation.**

Scenario 2 Mother requests an extra visit as mother says "my baby won't stop crying" .As I have extensive knowledge and experience of normal newborn behaviour, I am able to listen empathetically, illicit facts and exclude issues which might generate a referral to the GP or Emergency Department. I am in a position to reassure the mother that nothing is wrong with baby and offer some information and techniques for managing her baby. **The mother is supported in her early parenting, contained emotionally, and now has some helpful information and possible further options for managing.**

Scenario 3 Mother presents for "2 week" visit and discloses that she has and "cold sore" on her lip. She is artificially (formula) feeding her newborn baby. **I refer her to her GP knowing the risk to baby of Herpes Simplex in the neonatal period.**

Scenario 4 Mother and father present with baby for a "4 week" visit and I note some discord between the parents. My knowledge of early parenting family dynamics and maternal well being gained through midwifery practice, allow me to explore the possibility of mental health issues such as transition-to-parenting, adjustment issues. and possible postnatal depression. I note that mother is tense and tired and the father is both concerned and distressed by his partners behaviour to him. Exploring possible causes of discord reveals a mother who I suspect is depressed, having scored 16 in the Edinburgh Post Natal Depression Scale (EPDS). I refer the mother to her GP –with EPDS Score and offer the family some well-written information on PND. **I have initiated a timely referral, which will hopefully benefit the mother, parental relationship and no doubt the baby.**

Scenario 5 Mother attends for an 8 week" visit and discloses that she has to wean to formula as she intends to return to work. My knowledge of lactation

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gained through midwifery practice enables me to discuss with her the options for breast feeding and returning to work. I can also offer the excellent literature provided by the Australian Breastfeeding Association on this subject. **The mother can now choose to continue breastfeeding and if she does, statistics affirm that her breastfed child in childcare may be protected from many minor illnesses due to continued breastfeeding, so will remain well. The mother will need less stressful abscesses from her workplace.**

Scenario 6 (general) An agency, e.g. Midwifery, Mother Baby Unit, Refugee, Early Parenting, GP Practice or Child Protection Unit (who do not need permission), ring with concerns about a mother and very young baby living in my community. I am able to fully comprehend and manage this referral to me as I have midwifery qualifications and knowledge. I may also be in a position to advise some agencies in my professional capacity as well. **Due to my robust MCH qualifications, I can manage the family as a unit. (So many families have young babies as well as young children.)**

Scenario 7 (general) Due to my knowledge and clinical awareness gained through midwifery practice. I have, like many of my colleagues, found neonatal tongue tie, sub luxations in hips, discreet clefts in soft palettes, torticollis, equinovarus deformities, and many other conditions that require remedial management.. These conditions may not have been diagnosed till ""later:" or worse, "much later". **Over 98% of families with newborns engage with the MCH service over the first 4 weeks of a baby's life, and many of the above referral diagnoses are made at the first visit to MCH. Midwifery generated-knowledge of the "range of normal" in newborn children is also useful in that it ensure that only appropriate referrals are made.**

Scenario 8 (general) I talk with mothers about health concerns with their babies, e.g. unsettledness, gastric disturbances, altered feeding patterns etc. and help them decide whether a consultation with their GP is necessary. **I may prompt a GP consultation or manage the concern as appropriate by providing suitable guidance in conversation and in literature.**

I conclude that MCH practice does require the prerequisite midwifery qualifications to best manage mothers, babies and their families in the community I have seen and experienced "best practice" in the Victorian MCH Service. I believe that MCH meets "best practice" requirements both clinically and economically. I suggest that scholarships are a good economic investment in the wellbeing of Victoria's families.

Thank you for reading my submission.

M.Campbell.

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