INTRODUCTION:

30 AUG

My name is Helen Stephens.

My qualifications are as follows:-

- General Nurse training was completed at The Alfred Hospital in Melbourne in 1978, followed by an initial period of 18mths as a staff nurse, consolidating practice, in both Medical and Surgical wards. Today the equivalent position is as an Associate Nurse Unit Manager.
- Midwifery training was completed in 1981 at The Queen Victoria Medical Centre in Melbourne.
- Practice continued for many years in a variety of rural and regional hospital settings, working as a both a General Nurse and Midwife.
- Following the birth of my second child it became difficult to maintain competency in both general and midwifery nursing. Increasingly I specialised in midwifery and neonatal nursing, eventually returning to practice within a large metropolitan hospital.
- During this time I studied and completed in 2000, a Bachelor of Nursing Science, post-registration degree at Monash University's Gippsland Campus.
- Later, in 2007, I completed a Postgraduate Diploma in Child Family and Community, at Latrobe University in Melbourne. I achieved sponsorship for this course through the Mornington Peninsula Shire Council. Access to this scholarship provided the finances needed to complete this course of study, and also provided the mentoring support necessary to practice competently in this role, enabling me to successfully make the transition from hospital to community nursing.
- Subsequently, from 2007 to the present time, I have been employed four days per week for Frankston City Council as a Maternal and Child Health Nurse within the Victorian Universal MCH (Maternal and Child Health) service.

OVERVIEW:

My submission will focus on the issues arising from chapter 12 of the Early Childhood Development Draft Report, in particular the removal of midwifery as a necessary qualification for Maternal and Child Health Nurses.

DISCUSSION OF KEY POINTS:

I would strongly dispute that nurses working as practice nurses in General Practice, as a group, have the necessary skills to work in Maternal and Child Health (P.225 ch. 12, of the Draft Report). General nursing as a 'stand-alone' degree provides very limited education and experience in paediatrics, midwifery, and women's health. The Commission makes this point earlier in the document, but then wrongly assumes and cites only one source (Parker et al, 2009), for the sweeping generalisation that many nurses working in general practice have these qualifications, and are therefore an employment pool of potential MCH nurses, without any further educational requirement. The day to day work of practice nurses with GP's deals mainly with adult clients suffering ill health. These nurses are not involved in the routine well child care and surveillance of families with children under five years. Many of these nurses may provide immunisation services to infants and children, but immunisation is not MCH nursing as such.

Over recent years access to sponsorship programs in Victoria, for midwives to complete postgraduate and masters level studies in Child, Family and Community, has been a successful strategy in recruiting midwives into the field of MCH nursing. The program has facilitated the gradual replacement of an the aging and retiring MCH workforce. Three staff are currently employed at Frankston City, including myself, who have successfully completed sponsorships, with two more nurses currently studying, and a further sponsorship being offered later this year. The council that sponsored me (Mornington Peninsula Shire), has sponsored at least six nurses in the past 5 years who have successfully completed and subsequently been employed in MCH. The sponsorship program assists with a significant financial contribution towards the cost of study, but even more importantly provides the

necessary mentoring support for hospital midwives to make the transition from the acute sector, to practice in the community as Maternal and Child Health Nurses.

In Victoria we have long recognised the value of midwifery education and experience as the pre requisite for further post graduate education aimed specifically at meeting the needs of families with children in the critical first five years of life, referred to as **Maternal and Child Health** in this state. The education and experience gained through my earlier qualification as a midwife, has given me a critical body of knowledge and skills to draw on in my daily professional practice as a Maternal and Child health Nurse.

Furthermore, the draft report makes the point that Child Health Nurses are often the first point of contact for the care of well children, and for the provision of parenting advice, particularly in the first year of life. It is noted in Box 12.1 p. 221, that promoting and supporting breastfeeding is one of the activities carried out by Child Health Nurses that has a strong evidence base 'to prevent problems from occurring or to promote or enhance health outcomes'. Given that in Victoria participation rates for Key Age and Stages Visits are 99.8% from the initial home visit consultation, reducing to only 91.5% at 4mths and 80.3% participation by 12mths, within the universal MCH service 2009-2010 (see the attached report), it would seem that the experience gained by midwives prior to practice in Maternal and Child Health Nursing is invaluable in assisting families through the first year in particular. The high levels of voluntary participation by parents in the Victorian MCH service during the first year are a clear indication of the value that individual families place on our service. More than 70% continue to use our service until 2yrs of age, and more than 60% until 3.5yrs.

It is during the first year that families require the most support for the establishment and continuation of breastfeeding. The preceding discussion of statistics provides clear evidence that Victoria is able to keep the majority of families engaged with the MCH universal service during this critical time, through the Key Ages and Stages Framework. Promotion and support of breastfeeding is a significant part of the work of MCH nurses, as well as being a core midwifery skill, in line with the joint WHO/

UNICEF statement produced in 1989, "Protecting, Promoting and Supporting Breastfeeding – The Special Role of Maternity Services". By 1991 WHO and UNICEF initiated a global movement called the Baby Friendly Hospital Initiative (BFHI), which aimed to give every baby in both the developed and developing world the best start in life by creating a health care environment where breastfeeding is the norm. The promotion and support of breastfeeding is not a skill taught or learnt within general or paediatric nursing, but is central to my daily core practice as a MCH nurse.

The health consequences for mothers and babies of not breastfeeding are well documented in the literature. A history of breastfeeding is associated with a significantly decreased risk of many diseases in the infants of mothers in developed countries and not just developing countries (Stanley,Chung, Ramen, Chew, Magula, DeVine, Trikalinos, and Lau, 2007; Cunningham 1990),.

In addition, it is important to note that the number of visits by the Victorian Enhanced Maternal and Child Health cited on p.223 of the draft report is only one aspect of work with vulnerable families. The EHVS is a brief targeted support, for some families only. The bulk of ongoing support for most vulnerable families is within the universal service, the value of which cannot be measured easily, and should not be underestimated.

At which point does a family become or be defined as vulnerable? A high socio-economic family with two full-time working parents may be vulnerable because of isolation from family supports, for example. The ongoing stresses, because a high mortgage requires both parents to work, may put the mother at risk of post natal depression, with all the flow on effects to the children and her partner in terms of her parenting capacity. Is this family more or less vulnerable than the low socio-economic family struggling to make ends meet on one wage, with a full time mother at home!

Here we are not even mentioning the many families vulnerable for other reasons, such as alcohol and drug addiction, young parents, those experiencing family violence, or problems experienced by families because of ethnicity or indigenous grouping. These issues and many more, are the **daily** work of MCH nurses in **both** the universal and enhanced services in Victoria.

The complex nature of this work requires the skills of advanced **Maternal and Child Health** nursing practice, in order to be effective. Midwifery is an essential base on which to build the further skills required by the families who come to MCH nurses for care and support. These skills in the practice of primary health care are not able to be gained in adult settings in acute hospitals that deal primarily with medical and surgical ill health, and have little to do with health promotion and surveillance of families who have children less than five years of age.

CONSULTATION:

Furthermore I am concerned at the limited consultation undertaken by the Productivity Commission with Victorian MCH Nurses. There have been no public sittings with Victorian MCH nurses. Our service is widely considered as best practice in Australia and overseas, and could become the benchmark for other states and territories, over time. The Victorian MCH Framework has many strengths that could be adopted throughout Australia.

Conclusion:

In conclusion I would like to state that I would appreciate being part of a wider consultative process, where the Commission could meet with myself, and other Victorian MCH Nursing colleagues. I thank the Commission for considering my comments. I hope the Commission is able to make recommendations that recognise the unique contribution of the Victorian Maternal and Child Health Service. The quality of our service should not be reduced or diminished, with a 'one size fits all' approach to this essential and valuable primary health care service to Australian Families in Victoria, with infants and young children under five years of age.

Participation Rates for Key Ages & Stages Visits

Statewide

Region	Home Consultation %	2 Weeks %	4 Weeks %	8 Weeks %	4 Months %	8 Months %	12 Months %	18 Months %	2 Years %	3.5 Years %
Barwon South Western	99.7	97.4	95.4	96.3	94.7	83.1	83.2	75.1	71.1	63.9
Eastern	100.6	98.8	98.1	97.1	94.8	88.1	86.5	79.5	76.6	67.3
Gippsland	97.7	95.0	92.1	91.9	91.6	82.1	80.4	70.1	72.0	73.1
Grampians	99.1	97.1	96.2	96.7	96.9	85.5	88.4	81.3	75.1	76.6
Hume	98.0	96.4	95.0	94.8	93.0	83.1	78.6	71.4	71.2	72.0
Loddon Mallee	96.1	92.4	91.4	91.1	90.8	79.8	77.9	64.9	62.6	68.6
Northern	100.1	97.1	94.9	94.6	90.4	83.2	78.9	71.1	68.3	61.4
Southern	100.8	97.3	96.3	95.1	92.1	83.9	81.8	71.8	70.9	63.5
Western	99.5	94.2	94.2	93.0	86.2	75.6	72.1	63.5	58.2	48.3
Total for Victoria	**99.8**	**96.6**	**95.4**	**94.7**	**91.5**	**82.7**	**80.3**	**71.6**	**69.1**	**63.1**

Evidence Report/Technology Assessment
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Breastfeeding, bottle feeding and illness: an annotated bibliography, 1990

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