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Senate Inquiry into universal access to reproductive healthcare

Introduction

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 full scope of practice. ACM is also focused on ensuring better health outcomes for women, babies and their families. Midwives are primary care providers working directly with woman, in public and private health care setting across all geographical regions (metropolitan, regional, rural and remote). There are over 36,000 midwives in Australia of whom 908 are endorsed to prescribe scheduled medicines. (Nursing and Midwifery Board of Australia, 2022 (NMBA)).

The Australian College of Midwives welcomes the Government's enquiry into the universal access for reproductive healthcare, particularly in addressing the impediments to achieving key priorities of the National Women's Health Strategy 2020 - 2030. This inquiry clearly reflects the requirements of Priority Area 1 (maternal, sexual and reproductive health) and in particular the rights of 'women to empower choice and control in decision-making about their bodies'.

Midwives as primary health practitioners are well-placed to address issues regarding equity, accessibility, and availability of vital sexual and reproductive health services for women, their babies and their families. This is highlighted in the international definition of scope of practice for the midwife, which clearly articulates the role of the midwife in the provision of women's health, and sexual and reproductive health care:

'The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

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 (SRH) and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.' (International Confederation of Midwives, 2019).

In the Australian context this is also identified in the midwifery professional standards by the national regulator, NMBA (2018) for practice relate to sexual and reproductive health topics across a woman's lifespan.

Midwives are experts in the sexual and reproductive health space. The midwifery scope includes provision of women's health support, care and advice before conception, during pregnancy, labour, birth and the postnatal period (Nursing and Midwifery Board of Australia [NMBA], 2018).

The midwifery workforce is an underutilised resource that if enabled, could play a crucial role in providing universal access to reproductive healthcare and women's health underpinned by women's choice and autonomous control. In ACM's submission, we provide a comprehensive overview of the issue and barriers for universal access in this space and provide actionable recommendations for change. These solutions will not only improve health outcomes for women but will also improve future health outcomes for all Australians.

Response to Terms of Reference

Note: ACM recommendations are provided within the response to each question.

Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to

a. cost and accessibility of contraceptives, including:

i. PBS coverage and TGA approval processes for contraceptives,
ii. awareness and availability of long-acting reversible contraceptive and male contraceptive options, and
iii. options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;

Cost and accessibility of contraceptives

i. PBS Coverage

In Australia endorsed midwives are eligible for an MBS provider number and can prescribe medicines within scope. The number of endorsed midwives in Australia has doubled in the last four years to over 900. This number is increasing and further to ACM's recommendations below would immediately improve access for women for sexual and reproductive health outcomes. There are barriers currently however:

PBS coverage is limited for endorsed midwives (EMs) to provide contraception:

- EMs can prescribe contraceptives listed on the PBS for Midwives (PBS, 2022) (Small et al., 2016). However, the list under the PBS is very limited and both intrauterine devices listed on the Pharmaceutical Benefits Scheme (PBS, 2022) are not available for midwives to prescribe despite national regulation that supports prescribing and credentialing that enables procedural insertion

This limitation in PBS access for midwives needs to be addressed as:

- It restricts accessibility to contraceptives for women in a trusted midwifery continuity of care (CoC) setting
- It is discriminatory as it necessitates private script pricing vs PBS pricing for women prescribed some contraceptives by a midwife. It can disrupt midwifery CoC due to the prohibitive cost of gaining a private script or the requirement to seek a script from an alternative health practitioner which contributes to unnecessary over servicing by a medical practitioner to bridge this EM – PBS-access deficit
- It does not allow the midwifery workforce to work to full scope of practice, which limits sexual and reproductive health care for women, particularly in rural and remote areas and those with known barriers to access such as Aboriginal and Torres Strait Islander people, migrant and refugee women, adolescent mothers etc
- Midwives are the only profession in Australia that routinely assess and provide care for each of the 300,000 women a year that give birth in the nation. Preconception, postnatal and interconception care are key periods when individuals seek contraception. Midwives are well scoped to provide this care

ii. Awareness, availability and access of LARC and male contraceptives

Midwives are experts in primary maternity care, a key feature of which is assessment, health planning in partnership with women based in an understanding of their priorities, education and clinical care.

Awareness: Broadening midwives' presence in primary care models through an expanded MBS preconception funding would improve midwives' ability to enhance individuals' awareness of contraceptive options and considered approaches to reproductive life planning as well as proactive screening and management of Sexually Transmissible Infections (STI) by integrating testing into existing health service delivery (as per draft Fifth National STI Strategy 2023-2030). Midwives' established expertise in Sexual and Reproductive Health (SRH) would serve the education and health optimisation functions best in the primary care settings. Enhanced and equitable access to MBS funding for such care is imperative to improve access.

Availability: Midwives' expertise in primary care means that they are often the first profession a woman has contact with once she is pregnant. Counselling and education regarding contraception that is not able to be provided at point of care is an opportunity cost for health optimisation, agency and bodily autonomy. Midwives should be able to provide any individual seeking contraception with the education and the supply of a contraceptive agent within the one appointment. Adding barriers such as impeded PBS access, variable medication access, reduced access to LARC contributes to negative health outcomes.

Access: There are a number of barriers for **access** to contraceptives, these include, in particular for regional, rural and indigenous settings:

- Limited access to a medical professional, including GP, endorsed midwife, Nurse Practitioner (NP) (and more critical for abortion services)

- Limited access to health practitioners who are trained to prescribe and insert Long-acting Reversible contraceptives (LARCs)

LARCs: Midwives with credentialing can insert and remove the most effective forms of contraceptive, LARC, in addition to providing ongoing counselling and care (Grzeskowiak at al., 2021). However, only Implanon is currently within the scheduled medicines that midwives are able to prescribe and only up to six weeks postpartum. Access to the full range of LARCs on the PBS is required to enable women's choice and access to contraception.

Midwives are able to provide preconception care and counselling. A midwife is a known and trusted professional and is well placed to provide counselling, advice and prescribing in this setting. A midwife is also the primary provider of contraceptive information postpartum and could easily bridge the gap for the full interconception periods.

iii. Improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;

Improved access to contraceptives and autonomy over sexual and reproductive health planning is a fundamental human right, essential to improving health and economic outcomes for women as well as reducing gender-based violence (Mundkur, et al., 2020).

Condoms and the morning after pill can be purchased over the counter and can be provided free by some GPs and sexual health clinics in Australia. For many people in Australia, access to condoms in general is not free, especially for those living in rural and remote areas. In France condoms are now available free charge via Government funding to all under 25 (previously this was limited to u18s). The Federal Government should consider making condoms free for all u25s. This will not only reduce the prevalence of unintended pregnancy and abortion, but it will also reduce the health risk of Sexually Transmissible Infections (STIs). In France the pill, IUD and morning after pill are all now provided at no cost.

The most recent evidence suggests that a quarter of women in Australia have experienced unintended pregnancy in the past decade and 30% of these pregnancies have ended in abortion (Taft et al., 2018). If unhindered access to contraceptives was free of charge these statistics would reduce. In France it was found that once contraception was made free for u25s there was a decrease in the number of abortions from 9.5% in 2012 to 6% in 2018. To fulfil reproductive autonomy and reduce potential adverse health outcomes increased access to contraception options in general, and free access to contraception for all women of reproductive age should be proactively adopted by the Australian Government.

Recommendations

Midwives are qualified and educated professionals well placed to provide improved access to contraception. The Federal Government could enable health workforce capacity to create equity for women in particular, ensuring that they are able to exercise choice and control in their decision making, reduce financial barriers as well as social, economic, cultural or geographic

barriers. These opportunities will also allow women experiencing family violence to access contraception in a safe, trusted setting.
We make the following recommendations

- Undertake a review of the PBS medicines to expand PBS for endorsed midwives to prescribe all contraceptives
- Expand the MBS schedule for all LARCs for all endorsed midwives e.g. Mirena, Paragard and Implanon and resource associated education and training.
    a. Provide MBS item for endorsed midwives to work to full scope by providing LARCs across the reproductive lifespan
    b. Universal access to, supply and insertion of LARCS should be freely available to all women regardless of age
- Extend postnatal care MBS items to provide women with comprehensive postnatal care, breastfeeding support, and interconception care
- Fast track changes to registration standard for endorsement for scheduled medicines for midwives to incorporate these qualifications as standard into national midwifery accreditation standards and reduce the number of practice hours (currently 5,000hrs) required for a midwife to become endorsed to 1,000hrs, thereby creating a possible 35,000 more providers
- Provision of scholarships for registered midwives who seek to undertake the endorsement for scheduled medicines training.
- Consider making condoms, the pill, IUDs free of charge for all women of reproductive age as per France's proven approach
- This should also benefit vulnerable groups including those who do not have access to Medicare such as international students and temporary visa holders who are at increased risk of gender based disadvantage (Centre for Women's Safety and Wellbeing, 2021)
- Resourcing of a consumer education campaign for contraceptive options. This should also include increased promotion and utilisation of male contraceptives to reduce the health and cost burden for women who are predominantly responsible for contraception

b. cost and accessibility of reproductive healthcare, including pregnancy care and abortion services across Australia, particularly in regional and remote areas;

Reproductive healthcare, including pregnancy care: Cost and Accessibility

Investing in the health of the first 2000 days of future Australians is a critical public health investment which begins with access to evidence-based continuity of midwifery care throughout the life course from pre-conception, through the whole of reproductive life cycle and beyond. This is even more important in regional and remote areas where access to GPs in particular can be problematic, and women may need to wait three weeks and more for an appointment during a time critical phase. Midwives who are already embedded within rural and remote settings are well placed to undertake this work. A key feature of the national women's health and maternity strategies is that women must have upheld, their right to access services of their choice for their pregnancy and reproductive care, wherever they might choose to live.

These choices include continuity of midwifery care by a known midwife, midwifery group practice, GP shared care, home birth, obstetric care. Continuity of midwifery care is proven to improve health outcomes (reduced rates of stillbirth, preterm birth) it also reduces direct health costs by as much as 20% (Callander et al., 2021) and it aligns with the key recommendations of the Primary Health Care strategy 2022-2032, National Breastfeeding Strategy (2018), National Obesity Strategy (2022), National Preterm Birth Prevention Plan (2022), National Stillbirth Action Plan (2022), Closing the Gap (2022) and National Mental Health Plan (2021). Broadening access to women's healthcare and necessarily midwifery continuity of care across the reproductive lifespan should be a central tenet of the broader strategic governmental agenda in Australia. Incorporating fundamental service redesign, the removal of collaborative arrangements is a key strategy to enhance equitable access and prioritise the health of Australia's women, their families and babies.

Continuity of midwifery care with a known midwife throughout the childbearing continuum demonstrates that preterm birth is reduced by 24% and by 50% in Aboriginal and Torres Strait Islander babies. It reduces pregnancy loss and neonatal loss by 16%. It improves mental health through having a known and trusted carer, who is also able to provide on-going counselling and support in a community setting (Cummins et al., 2022). Continuity models are sustainable and support workforce retention by enabling midwives to work to full scope in a flexible model of care (Fenwick et al., 2017).

Successful examples of this in the regional and rural space include Aboriginal Community Controlled Health Organisation (ACCHO) models such as Birthing in our Community (BioC), in Brisbane which provides a wraparound service for the Aboriginal and Torres Strait Islander community. It provides midwifery continuity of care, women's health and child and family health and family wellbeing in a culturally safe community setting. The outcomes (as seen in the Close the Gap report, 2022) speak for themselves.

- Increased attendance at antenatal appointments (5+)
- 50% less likely to be premature
- Less likely to require medical intervention for birthing
- Half the national rate of low birth weight and neonatal admissions

These reduced risks equate to improved childhood and adult health outcomes, such as reduced risk of diabetes, cardiovascular disease and kidney disease. It also allows the trust of a known midwife and family support worker through 'family-centred practice' with whom women can discuss their reproductive choices throughout the reproductive lifespan. Women also have access to integrated care via a social worker, psychologist, transport support, child and family health and allied health, thereby accessing holistic care and any mental health, domestic violence or other issues can be proactively managed.

This philosophically aligned and culturally safe model provides both improved outcomes for reproductive healthcare and pregnancy care and leads to significantly reduced health costs.

Separately, another mode of increased accessibility in the rural and remote setting is the 'hub and spoke model' whereby telehealth appointments are used via the caseload model of continuity of midwifery carer in the antenatal and postnatal period within the rural and remote

space, with intrapartum care taking place in the hospital or where appropriate, other primary care settings. The caseload model of midwifery is a 24/7 model whereby the woman is allocated a primary midwife who partners with the woman throughout the childbearing period to provide essential maternity care, including referral for consultation if required , whilst maintaining the lead or primary maternity care role. This works well in rural and remote settings where there is very limited accessibility of care.

It is important to note here that in the Australian birthing environment where medical birth is increasing with current caesarean rate of 37%, in the midwifery continuity of carer model these rates are significantly lower (Miller et al., 2022).

Recommendations:

- Make evidence-based midwifery continuity of care the primary and default reproductive and maternity care model in Australia
- Implement models with endorsed midwives embedded in ACCHOs models i.e. family and woman centred models across all community settings, in all jurisdictions, targeting preconception to the first 2000 days
- Incentivise skilled midwives to work in typically underserviced areas such as in remote settings or with those experiencing social disadvantage ie unstable housing, poverty, disability. Incentives could include waiving of HECS debts for midwives
- Remove barriers to women's choice about setting and model of care, especially where these exist in relation to access to evidence based primary care models and settings. Equitable access to MBS for those seeking care in home or other primary settings the same as their counterparts receive when choosing care in a hospital
- Pilot multi-disciplinary care models within women's health centres and primary settings such as primary health networks, schools, community centres
- Government to remove collaborative arrangements requirements for midwifery to allow increased access and women's choice by amending the relevant legislation, namely the National Health (Collaborative arrangements for midwives) Determination 2010, the Health Insurance Amendment Regulations 2010 [No. 1] and associated Medicare Benefits Schedule (MBS) item descriptors

Cost and Accessibility of Abortion Services

ACM supports a woman's right to bodily autonomy and to access legal, safe, timely and compassionate abortion care as an essential health service. Across Australia there are many 'abortion deserts' (Swanell, 2022), where women are unable to access the limited number of medical practitioners qualified to perform abortions and/or pharmacists to prescribe medical abortion. Given the limited access to medical practitioners who are registered Mifepristone and Misoprostol composite pack (MS-2 Step) providers, women may need to wait up to 3-4 weeks for a medical termination, which is a time critical procedure. This limitation to women's access to this prescription increases the likelihood of the need for, and associated risks and cost of surgical abortion and potential downstream health issues. Delays additionally increase the burden of mental health issues if women are unable to access services promptly. Midwives are the primary

providers of medical abortion in Sweden, globally this model is associated with a reduction in abortion-related mortality, increased access, reduced health costs and increase in continuity of care without decreasing quality of care Desai, A. et al (2022).

As experts in primary reproductive care endorsed midwives are able to provide counselling, and as existing prescribers are ideally placed to provide prescriptions for those seeking medical abortion. Endorsed midwives are already living and working in the identified 'abortion deserts' of Australia. By undertaking the same credentialing and training required by medical practitioners (currently not available to midwives), these midwives will improve access and quality of care for women (Bradfield (2022), Desai (2022)). To improve access and remove barriers, legislative change is required. Currently abortion procedures are only able to be performed by medical practitioners.

Recommendations:

- Legislative amendment which allows midwives to perform medical abortions
- PBS access for midwives prescribing Mifepristone/Misoprostol (MS-2 Step)
- Change to Drugs and Poisons Act in some states to facilitate the prescribing of MS-2 Step
- In very remote regions enable authority dispensary to ensure timely access to medical abortion by women living in these areas
- Additional MBS midwife numbers for necessary pre and post-abortion consultations
- Education to enable midwives to develop and practise the required skillset; this could be achieved through universities incorporating abortion education in midwifery programs.
    - Government funded scholarships for training
- Ability for midwives to refer to counselling and psychology services (if the woman so chooses)
- Full access to MBS items for diagnostic investigations required (ultrasounds and pathology)

c. workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals;

This section c notably excludes midwifery from the frame of reference, however as per section b. clearly the 36,000 midwives in Australia are well placed to be a key workforce solution to increasing access to reproductive healthcare services for all women and their families. As indicated in the introduction, midwives' full scope of practice includes sexual and reproductive health care including pre-conception care counselling, contraception prescribing for endorsed midwives.

As indicated in section b, facilitating women's access to continuity of midwifery care models is critical for improved health outcomes for the first 2000 days (WHO, 2018). The physical and emotional health benefits for women and babies associated with having access to a known midwife during pregnancy, birth and the postnatal period has been well established, with the

World Health Organisation (WHO) recommending access to this model of care as best practice. (WHO 2018).

The endorsement for scheduled medicines for midwives clearly provides increased workforce accessibility at low cost, in existing underrepresented locations such as rural, remote and indigenous settings. As at 30 Sept 22 there are 908 endorsed midwives in Australia. The number of midwives with endorsement for scheduled medicines qualifications should be fast tracked. ACM recommends that the endorsement for scheduled medicines module is incorporated into midwifery accreditation standards and the number of practice hours (currently 5,000hrs) required for a midwife to become endorsed, reduced to 1,000hrs, noting the recommendation by the national regulator NMBA for this registration standard. It is noted that a review of the registration standard will be undertaken in early 2023 and ACM recommends that these changes are made in a timely manner to ensure that women are able to access services where they live via the midwifery workforce cohort and thus have increased choice, better health outcomes and the benefit of a known carer on an ongoing basis. We have seen in point b. the significantly improved health outcomes that come from this approach in the ACCHO setting.

Despite midwives being a separate registered profession, there continue to be structural barriers which preclude midwives working to full scope. ACM (2022) recommends that the current mandated Collaborative Arrangements requirement is removed by amending the relevant legislation, namely the National Health (Collaborative arrangements for midwives) Determination 2010, the Health Insurance Amendment Regulations 2010 [No. 1] and associated Medicare Benefits Schedule (MBS) item descriptors.

ACM also recommends that endorsed midwives are approved to have access to and complete training to prescribe all contraceptives for women in their care as standard, including medical abortion care.

Recommendations:

- That the Government ensure midwifery continuity of care is the lead maternity care model in Australia
- Changes to registration standard for endorsement for scheduled medicines to incorporate into undergraduate midwifery program qualifications as standard and the number of practice hours (currently 5,000hrs) required for a midwife to become endorsed is reduced to 1,000hrs
- Provision of scholarships for registered midwives who seek to undertake the endorsement for scheduled medicines training
- That the current mandated Collaborative Arrangements requirement is removed by amending the relevant legislation, namely the National Health (Collaborative arrangements for midwives) Determination 2010, the Health Insurance Amendment Regulations 2010 [No. 1] and associated Medicare Benefits Schedule (MBS) item descriptors

d. *best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery;*

Best practice approaches to SRH, including investing in the health of the first two thousand days of future Australians, is a critical public health investment which begins with access to evidence-based continuity of midwifery care throughout the life course from pre-conception, through the whole of reproductive life cycle and beyond. As per our earlier recommendations, the intentional expansion by Government of access to continuity of midwifery models of care with a known midwife will facilitate more trusted respectful and holistic care for women as they do not need to repeat their stories to multiple clinicians, as is required in fragmented models of care such as shared care. This will improve health outcomes and is more likely to reduce mental health issues.

Trust is vital for culturally safe care. Culturally safe service delivery models, such as the Birthing in our Community models underpinned by Birthing on Country principles (the RISE framework) have shown significantly improved health outcomes for Aboriginal and Torres Strait Islander mothers, families and babies compared with standard services (Kildea et al., 2021) (See section b).

Culturally informed care and cultural safety training is paramount to improve trust and improved health for all. Whilst cultural safety is now legislated in National Law there is still a long way to go. In this setting, ACM endorses the CATSINaM Genke II strategy (2022) which includes a focus on increasing the number of Aboriginal and Torres Strait Islander midwives in Australia, to include culturally safe clinical placements whilst studying and the embedding of cultural safety in national standards for CPD.

The recent research by Keedle et al., (2022) shows that 1 in 10 women in Australia experience obstetric violence and/or birth trauma. Informed consent is paramount in this setting. All practitioners should have access to and be required to undertake trauma-informed care education in order to be able to not only consistently deliver respectful and appropriate care but also recognise, appropriately respond to, report and therefore be able to care for women with a history of birth trauma and also proactively reduce the level of birth trauma that exists in the maternity setting today.

e. *sexual and reproductive health literacy;*

Midwives provide education to women and their partners along the continuum of childbearing from preconception care. This is essential for improving health literacy and health outcomes. This involves adapting sexual and reproductive health education to suit low health literacy needs and ensuing understanding of information by way of informed consent. Evidence shows women who experience levels of low literacy require empathy and opportunity to discuss sexual health needs (Matin et al., 2021), midwives are experts at addressing health literacy in a variety of settings (Lori et al., 2017).

A key feature of midwifery care is the provision of education to women and their families in and around the perinatal period. A core component of this education involves counselling on sexual and reproductive health (SRH). Ensuring women are informed and have access to evidence-based

knowledge around SRH is a fundamental human right and an important step in enabling women to control their health outcomes. Further to the study done by (Bradfield et al, 2022) it is clear that midwives require comprehensive SRH education post-registration to confidently ensure that they are able to provide this education in all setting.

f. experiences of people with a disability accessing sexual and reproductive healthcare.

People with disabilities have the right to inclusion in all health settings. Some have reported experiencing discriminatory treatment when interacting with clinicians providing reproductive health and maternity services. The designing of health care services for persons with a disability in collaboration with key stakeholders with lived experience of disability is essential to ensure equitable access to sexual and reproductive healthcare. Furthermore, more education of the health workforce is required, in order that clinicians are able to provide respectful and individualised sexual and reproductive healthcare and information to women and men with disabilities, including pre and interconception care.

g. experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare.

Midwifery professional philosophy is underpinned by principles of individualised care. With modern roots in feminist theory, the process of actively partnering with the person seeking care, understanding health and agency as it is viewed by each individual is critical to the trusting partnership at the centre of midwifery care. It is recommended that midwives and other health professionals are offered education in this space as not all clinicians are sufficiently informed, or confident in this space. Separately it is also key to ensure that persons with lived experience of gender and sex diversity are proactively consulted on future models of care and programs to support their own sexual and reproductive care in all settings.

h. availability of reproductive health leave for employees.

The establishment of reproductive health leave, including menstrual leave, IVF leave, menopause leave is an emerging approach for some employers, however for many this is still a taboo subject. Women who experience menstrual pain, endometriosis, menopause symptoms, pregnancy or hysterectomy for example are disproportionally affected by the requirement of use of personal leave for these health issues. This is a gendered inequity, and it is not for positive workplace outcomes compared to those who do not experience these health issues. ACM recommends the creation of formal reproductive health leave policies to enable female workers to take reproductive leave without being penalised in the requirement to use personal leave, or indeed the requirement to take unpaid leave.

i. Any other related matter.

National Women's Health Strategy Outcomes Measurement

The National Women's Health Strategy 2020-2030 outlines a national approach to improving health outcomes for women and girls in Australia, including increasing access to sexual and reproductive health information and services. However, it is unclear what progress has been made in women's health since the preceding strategy nor how the impact of the current strategy will be measured. There is a need for a measured implementation and monitoring plan for reporting progress, a clear evaluation plan to measure impact, as well as transparency on the level and nature of funding being made.

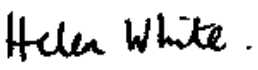
ACM recommends the development of an implementation plan to outline key outcomes from the strategy, in particularly relating to sexual and reproductive health (Priority Area 1) will be actioned at Federal level, to include KPIs for monitoring and reporting against the strategy. An annual progress report against these KPIs should also be published and key stakeholders, including the midwifery profession, to be consulted with regards to implementation of KPIS, including recommendations in this document where relevant.

Conclusion

The Australian College of Midwives welcomes the Government's enquiry into the universal access for reproductive healthcare, particularly in addressing the impediments to achieving key priorities of the National Women's Health Strategy 2020 - 2030. This inquiry clearly reflects the requirements of Priority Area 1 (Maternal, sexual and reproductive health) and in particular the rights of 'women to empower choice and control in decision-making about their bodies'.

Midwives as primary health practitioners are pivotal to improving equity, accessibility, and availability of vital sexual and reproductive health services for women, their babies and their families. ACM commends this submission, and its associated recommendations to the Senate enquiry for due consideration.

Yours Sincerely,



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