Australian Nursing & Midwifery Accreditation Council

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Review of the midwifery accreditation standards

First Consultation Paper

June 2013

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Consultation paper 1

Aim of the review

The aim of the review of the Australian Nursing and Midwifery Council (ANMC) *Midwives: Standards and Criteria for the Accreditation of Nursing and Midwifery Courses (2010)*[1] (Midwifery Accreditation Standards) is to review and update these standards in light of the move to the National Registration and Accreditation Scheme (NRAS). Under the National Law the Australian Nursing and Midwifery Accreditation Council (ANMAC) has responsibility for these standards and will synthesise and translate current evidence and feedback into refining and improving the midwifery accreditation standards so as to continue to safeguard and promote the health, safety and wellbeing of those Australians requiring midwifery care.

The work of each of the jurisdictions, community, midwifery profession and the Australian College of Midwives in developing the current midwifery accreditation standards is recognised and valued. The review of these accreditation standards seeks to build on this platform. The process undertaken by the Australian Nursing and Midwifery Accreditation Council (ANMAC) for the successful review of the *Registered Nurse Accreditation Standards* (2012) provides the model for this review. Utilising this model will ensure previous learning enhances the current process and upholds consistency across all accreditation standards development.

Constructive and respectful engagement with stakeholders is ANMAC's hallmark for the review and development of accreditation standards. Consequently, there will be wide consultation with stakeholders and multiple opportunities for engagement with the review process. This consultation, combined with a review of the literature will ensure the midwifery accreditation standards are contemporary, comprehensive, clearly articulated and nationally consistent.

The existing *Standards and Criteria for the Accreditation of Nursing and Midwifery Courses: Midwives (2009)* can be accessed via the ANMAC website. These standards are being reviewed with the support of the Nurses and Midwives Board of Australia (NMBA), who ultimately approve the standards as the basis for the qualification leading to entry to the register as a midwife. For more detailed information about the regulatory context of these standards see Appendix A.

Purpose of the consultation paper

This consultation paper outlines the aim, objectives and context of the review. It describes the process of consultation and proposes a number of key areas for consideration by interested stakeholders.

For the review to be effective, it is essential that the critical input of organisations and individuals with an interest in the education of midwives is optimised. This paper has been distributed to organisations and individuals with an interest in the practice of midwifery,

[1] Australian Nursing and Midwifery Council, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

midwifery education and midwifery accreditation standards and who may wish to contribute in writing or via scheduled consultation forums.

This consultation paper is accompanied by a draft document that proposes the first version of the new midwifery accreditation standards for reflection, review and discussion. Questions are placed throughout the consultation paper to prompt reflection and discussion on big issues and provide an opportunity for feedback on the latest version of the accreditation standards. How feedback is to be provided and incorporated is outlined below in the section entitled' The consultation process'. The final published version of the midwifery accreditation standards will be based on the best available evidence and, where possible, consensus from experts and stakeholders in the relevant fields derived from the consultation process.

Context of the review

In 2010 ANMAC became the independent accrediting authority for nursing and midwifery programs of study and has responsibility for maintaining and developing the integrity of accreditation standards for professions under its mandate. In addition:

> *In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.*[2]

The process of reviewing and developing the midwifery accreditation standards is robust and uses a number of iterative steps to ensure the final outcome is one well supported. It is critical to assess whether the midwifery accreditation standards are complete and with sufficient evidence to address all the domains necessary to assure the NMBA and the community, that a graduate of an accredited midwifery entry to practice program is fit to be registered and can practice in a safe and competent manner. The review process enables stakeholders to validate whether the revised accreditation standards and accompanying criteria are accurate and relevant to a changing Australian health care system and education environment. Furthermore, the review's consultative process provides an opportunity to evaluate whether the expectation of education providers to achieve each of the revised accreditation standard and its accompanying criteria is reasonable.

Under Section 49(1) of the National Law, graduates of programs of study will not be eligible for registration or endorsement unless the program of study undertaken is accredited by an approved accreditation authority and that such accreditation is approved by the NMBA as meeting the education requirements for registration as a Registered Midwife.[3]

The current accreditation standards for midwives were developed by the Australian Nursing and Midwifery Council (ANMC) in 2009, underwent minor changes in 2010, and was subsequently approved by the NMBA in that same year. The review of these standards is now being undertaken by the Australian Nursing and Midwifery Accreditation Council (ANMAC) the

[2] AHPRA (2009), *Health Practitioner Regulation Law Act*, as in force in each state and territory. Viewed at: http//www.ahpra.gov.au/Legislation-and-publications/Legislation.aspxon on 6 May, 2013.

[3] Ibid.

external accreditation entity[4] responsible for reviewing and developing all midwifery accreditation standards for entry programs leading to registration and for achieving the primary objective of the National Law which is 3[5]:

> *…to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.*

The revised midwifery accreditation standards will be the standards against which education providers and programs will be assessed by ANMAC once approval by the NMBA. The objective of entry level programs is to ensure graduates are able to meet the NMBA approved competencies to practice safely and competently in the context of the current Australian health environment. There are three pathways by which graduates can enter the midwifery profession. These pathways are: the Bachelor of Midwifery program, a dual degree program combining both midwifery and nursing degrees, and a postgraduate program in midwifery for registered nurses.

Successful completion of such programs allows graduates to apply for registration with the Australian Health Practitioners Regulatory Authority (AHPRA) as midwives.

Consultation process

Following the decision to review the midwifery accreditation standards the following Expert Advisory Group (EAG) was established by the ANMAC Board:

- Dr Joanne Gray, Chair of the Expert Advisory Group
- Ms Roz Donnellan-Fernandez, Australian College of Midwives nominee
- Ms Janice Butt, ACM: Midwifery Education Advisory Committee nominee
- Ms Alison McMillan, Australian and New Zealand Council of Chief Nurses and Midwives nominee
- Ms O'Bray Smith, Australian Nursing Federation nominee
- Ms Karen Atkinson, Congress of Aboriginal and Torres Strait Islander Nurses nominee
- Professor Sue McDonald, Council of Deans for Nursing and Midwifery nominee
- Associate Professor Lee Stewart, Educationalist for Dual Degree (Nursing and Midwifery) Programs
- Professor Caroline Homer, Educationalist for Entry to Practice Midwifery Programs
- Mr Bruce Teakle, Maternity Coalition nominee
- Ms Jan White, Maternity Services Inter Jurisdictional Committee nominee
- Associate Professor Graeme Boardley, Women's Healthcare Australasia nominee

[4] AHPRA, Section 43, *Health Practitioner Regulation Law Act*, 2009, as in force in each state and territory. Viewed at http//www.ahpra.gov.au/Legislation-and-publications/Legislation.aspx on 6 May, 2013.

[5] AHPRA, *Health Practitioner Regulation Law Act*, 2009, as in force in each state and territory. Viewed at http//www.ahpra.gov.au/Legislation-and-publications/Legislation.aspx on 6 May, 2013.

- Associate Professor Jan Taylor ANMAC, Chair of the Registered Midwife Accreditation Committee
- Ms Amanda Adrian, ANMAC, Chief Executive Officer
- Ms Donna Mowbray, ANMAC, Director of Accreditation Services
- Ms Kate Jackson, ANMAC, Acting Manager of Accreditation Services
- Ms Margaret Gatling, ANMAC, Accreditation Manager
- Dr Ann Alder, ANMAC, Accreditation Manager
- Ms Jackie Doolan, ANMAC, Standards Development and Review Co-ordinator.

The EAG developed a schedule for the project, established for the review of the midwifery accreditation standards, at its first meeting on 20 February 2013. A list of key stakeholders was also identified for the purposes of participation in the consultation process (see Appendix B).

The development of this consultation paper has been guided by the EAG and will be distributed to all identified stakeholders and also placed on the ANMAC website. The consultation process will include a number of methods for stakeholders to provide input into the process of review of the accreditation standards.

Two rounds of consultation forums for identified stakeholders are planned:

Initial forums:

- Two initial consultation forums: Brisbane – 21 August 2013 and Perth 23 August 2013.

Subsequent and final forum:

- Final consultation forum: Melbourne – 11 December 2013.

Feedback from the initial consultation forums will inform the development of a 'green paper' (second consultation paper) that will be circulated to stakeholders for comment and be the subject of further consultation at the final forum to be held in Melbourne.

Additionally, stakeholders and other interested parties will be offered the opportunity to provide feedback in writing following dissemination of each consultation paper. Questions from the consultation papers will be electronically reproduced as a survey and will be accessible online.

- **Draft midwifery accreditation standards Version 1** and the questions from the consultation papers are available via the following link: https://www.surveymonkey.com/s/Midwifery_Accreditation_Standards_Review
    - **Responses to the questions would be appreciated by close of business 12 July 2013** in preparation for the first of the initial consultative forums in Brisbane on 21 August 2013.
- Alternatively, feedback can be sent via the following dedicated email address: standardsreview@ANMAC.org.au.

The ANMAC website will be updated to reflect the stage of the review.

Objectives of the review

This review aims to achieve consensus on a revised set of midwifery accreditation standards that are:

- Able to meet the objectives and guiding principles of the National Law.
- Contemporary and aligned with emerging research, policy and relevant industry guidance.
- Able to ensure midwives are suitably educated and qualified to practise in a safe, competent and ethical manner.
- Acceptable to the community in supporting safe, quality maternity care.
- Acceptable and supported by the profession and relevant education providers.
- Underpinned by the *ANMAC Protocol for Accreditation Standards*.

Shaded boxes throughout this document provide proposed Version 1 midwifery accreditation standards and specific questions. These questions can be answered using the on-line survey link (see above).

ANMAC protocol for standards development and review

ANMAC has developed a protocol to be used in the revision of its standards to ensure consistency of process and where relevant structure and content of the standards.

While ANMAC, the NMBA and nursing and midwifery stakeholders acknowledge the discreteness of both the nursing and midwifery profession, they also acknowledge that in terms of professional education there are areas of commonality. In 2011/12 ANMAC commissioned the review of the accreditation standards for registered nurses and the *ANMAC Registered Nurse Accreditation Standards*[6] were approved by the NMBA in 2012. Therefore the standard structure used in the *ANMAC Registered Nurse Accreditation Standards 2012* has been assessed and is considered an appropriate framework for the midwifery accreditation standards. This structure has been included in Version 1 of the revised midwifery accreditation standards with some changes to language to ensure relevance and appropriateness to midwifery practice and education. These standards relate to governance, conduct, research, risk management and monitoring aspects of the program rather than areas of specific content relevant to each profession. As all ANMAC standards undergo revision over time, the generic elements of these standards will become 'common standards' across the ANMAC suite of standards with the language and criteria adapted to ensure appropriateness for each set of standards. This level of consistency will decrease the compliance burden for education providers in meeting accreditation standards and provide a level of consistency between standards.

[6] Australian Nursing and Midwifery Accreditation Council, *Registered Nurse Accreditation Standards*. Canberra, 2012.

Literature search

A targeted literature search focusing on literature relevant to the review of the standards for midwifery education programs was undertaken to inform this paper and the work of the EAG. The CINAHL and Medline databases were searched using combinations of the following terms: “midwi* education”; “midwi* training”; accreditation; standards; criteria; credentialing; competenc*; beginning practice; transition; pre-registration; "fit to practice"; "fitness for practice"; theory practice; "professional experience"; clinical requirement; "clinical hours"; "clinical practicum hours"; "clinical placement"; "hospital placement"; simulation; "authentic learning environment*"; "situated learning"; "continuity of care"; "follow through*"; "follow-through*"; "legitimate peripheral participation".

Searches were limited to papers published from 2007 and in English only.

A search was also conducted of all State and Territory health department web sites for relevant policy and other documents.

Further documents were provided by professional networks and identified when searching bibliographies of relevant articles.

The Australian midwifery landscape in 2013 and beyond

The review and development of the accreditation standards leading to registration as a midwife in Australia must be undertaken in the context of the current national and international health, education and social policy environment. The implementation of a number of major reforms in the governance, funding and provision of health services are underway in Australia at the present time. In addition, a number of new national agencies[7] have been implemented over the past 3 years. The formation of Health Workforce Australia (HWA) has resulted in a developmental and ongoing influence upon the role and number of midwives within the broader system of professional health services delivery. A similar reform agenda has been evident in the education sector over this period.[8]

Maturation of midwifery as a discrete profession continues in Australia. The midwifery landscape today has the following characteristics:

- Increasing maternal age with 13.7% of mothers who gave birth in 2009 aged 35 years or older.[9]
- In 2010 a ‘baby boom’ occurred with 297,900 births registered in Australia, the highest ever recorded in a calendar year.[10]

[7] For example: Independent Hospital Pricing Authority – IHPA, National Performance Authority – NPA; Australian Commission on Safety and Quality in Health Care – ACSQHC; Australian National Preventive Health Agency – ANPHA; Health Workforce Australia – HWA.

[8] Australian Government, *Review of Australian Higher Education–Final Report*, 2008. Viewed at: http://www.innovation.gov.au/HigherEducation/Documents/Review/Subs2008/091ANorton.pdf on 6 May, 2013.

[9] Li Z., McNally L. & Sullivan EA. *Australia’s Mothers and Babies, 2009.* Canberra: Australian Institute of Health and Welfare, 2011.

[10] Australian Bureau of Statistics, *Year Book Australia, 2012.* Viewed at: http://www.abs.gov.au/aussats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Births~51 on 15 March, 2013.

- High rates of interventions with 31.5% of all births in 2009 occuring by caesarean section.[11]
- Increasing rates of maternal obesity and increasing rates of chronic illness.[12]
- Women requesting more options for maternity care, particularly those focusing on continuity of care.[13]
- An increasing focus on placing maternal care in a wellness model and shifting the balance of care away from acute services to community-based models.
- Increasing use of technology and the emergence of electronic health and medical records.
- A decline in the availability of maternity services in rural and remote areas.[14]
- An ageing midwifery workforce, with increasing rates of part time employment.[15] (The global financial crisis may impact upon this 2002 finding.)
- A shortfall of midwives was estimated at 1847 in 2002[16] and a balance between supply and demand being projected by 2025.[17]
- Increasing numbers of registered midwives without a nursing registration.
- Increasing midwifery led models of care through caseload models; prescribing rights for endorsed eligible midwives; changes to industrial awards; and increased access to professional indemnity insurance.
- An opportunity for eligible midwives to offer a Medicare rebateable service when in a collaborative arrangement with a medical practitioner.[18]

The 2010 *National Maternity Service Plan* identifies as the 5 year vision for maternity services[19]:

> *Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and*

[11] Ibid.

[12] Australian Health Ministers Conference, *National Maternity Service Plan*. 2010.

[13] Ibid.

[14] Ibid.

[15] Australian Health Workforce Advisory Committee, *The Midwifery Workforce in Australia 2002-2012*. Sydney, 2002.

[16] Ibid.

[17] Health Workforce Australia, *Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1*. Adelaide, 2012.

[18] Australian Government Department of Health and Aging, *Eligible Midwives Questions and Answers,* 2012. Viewed at: http://www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-qanda on 6 May,2013.

[19] Australian Health Ministers Conference, *National Maternity Service Plan*. 2010

non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women.

The revised standards must facilitate the preparation of midwives to assist in achieving the above vision and to be competent, safe practitioners in the current maternity environment.

Interprofessional learning and collaborative practice

Midwifery services occur along a continuum of care that involves care givers and health professionals from a broad spectrum of disciplines. The World Health Organisation (WHO) supports the preparation of health workers with interprofessional learning that better prepares health workers for collaborative practice and provides the potential for innovative solutions to health workforce shortages. Interprofessional learning is when two or more health professionals learn about, from, and with each other, to enable effective collaboration and improve health outcomes.[20] Collaborative practice happens when multiple health workers from different professional backgrounds work together with women, families, patients, carers and communities to deliver the highest quality of care. It allows health workers to engage any individual whose skills can help achieve local health goals. Unsurprisingly, the WHO recommends introducing interprofessional education in all pre-qualifying programs.

Further the *Core Competencies and Educational Framework for Maternity Services in Australia Project* recommends that an interprofessional approach to education, learning and practice should be incorporated into all educational programs for all primary maternity service provider groups at all levels (entry to practice, as part of continuity professional development or re-entry to practice program).[21] This is further supported by the *National Maternity Services Plan* having as one of its priorities to facilitate a culture of interdisciplinary collaboration in maternity care.[22] Interprofessional learning has been found to be beneficial in midwifery programs, providing this is valued in practice.[23]

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA for enabling intraprofessional and interprofessional learning. (Criteria 2.4 (i) and (h); 3.5 and 8.4)

The program provider demonstrates:

- **Teaching and learning approaches that:**
    - **promote emotional intelligence, communication, collaboration, cultural safety, ethical practice and leadership skills expected of registered midwives**

[20] WHO, *Framework for Action on Interprofessional Education & Collaborative Practice*. Geneva: World Health Organisation, 2012.

[21] Homer C., Ellwood D., Kildea S., Brodie P & Curtin A. *Core Competencies and Educational Framework for Primary Maternity Services in Australia: Final Report*. Sydney, 2010.

[22] Australian Health Ministers Conference, *National Maternity Services Plan*. 2010.

[23] Murray-Davis B., Marshall M & Gordon F. From school to work: promoting the application of pre-qualification interprofessional education in the clinical workplace. *Nurse Education in Practice*. 2012; 12(5):289-296.

- **incorporate an understanding of, and engagement with, intraprofessional and interprofessional learning for collaborative practice.**

- **Opportunities for student interaction with other health professions to support understanding of the multi-professional health care environment and facilitate interprofessional learning for collaborative practice.**

- **Each student is provided with a variety of midwifery practice experiences with opportunities for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.**

Question 1 in the survey is a demographic question.

QUESTION 2:

Are the above criteria collectively appropriate to enable intraprofessional and interprofessional learning?

a) Yes, these criteria are appropriate.

b) No, these criteria are not appropriate.

c) Some of these criteria are appropriate.

d) I am unsure.

If you answered b), c) or d), please provide a reason for your response.

Competence and midwifery practice experience

Competency based education programs have become a key feature of health profession education. Competency is defined as the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.[24] The scope of practice for the midwife is outlined in the *ICM Definition of the Midwife* and provides the foundation for midwifery competency standards.[25] Midwifery competency in Australia is defined by the *ANMC, National Competency Standards for the Midwife* (2006)[26] and are the standards by which midwifery performance is assessed to obtain and retain registration as a midwife in Australia. There is in principle consistency between the *ANMC, National Competency Standards for the Midwife* (2006)[27] and the ICM – *Essential competencies for basic midwifery practice*[28]. *This is also true of* the Australian Nursing and Midwifery Council (ANMC) *Midwives: Standards and Criteria for the Accreditation of Nursing and Midwifery Courses* (2010)[29] and the WHO – *Global standards for the initial education of professional*

[24] Australian Nursing and Midwifery Council, *National Competency Standards for the Midwife*. 2006.

[25] International Confederation of Midwives, *Definition of the Midwife*. 2011.

[26] Australian Nursing and Midwifery Council, *National Competency Standards for the Midwife*. 2006.

[27] Australian Nursing and Midwifery Council, *National Competency Standards for the Midwife*. 2006.

[28] International Confederation of Midwives, *Essential Competencies for Basic Midwifery Practice* 2010.

[29] Australian Nursing and Midwifery Council, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

nurses and midwives.[30] Higher education providers draw from both the ANMC national competency standards and the ANMC (soon to be ANMAC) midwifery accreditation standards when developing their curricula.

As a diverse and complex profession, midwifery faces a number of issues with the assessment of competence[31] including a reported lack of continuity of preceptorship, applicability of competency standards to midwifery practise within hospitals in the maternity care system and assessor subjectivity.[32] Concerns raised around the difficulties in the measurement of competence have led to the implementation of a minimum number of 'practice experiences' to act as a safety valve to protect the public.[33] Specifying a minimum number of clinical skills in order to register as a midwife is a strategy that has been adopted by a number of regulatory bodies throughout the world.[34] However, a review of the available literature shows there is very little evidence to support this strategy or to guide what the required type and number of midwifery practice experiences should be to develop and demonstrate competence, particularly within an Australian maternity care setting. There is also no evidence to guide the number or configuration of continuity of care (CoC) experiences required as part of entry to practice midwifery programs, although these were not primarily introduced as a marker of competence. Rather, CoC experiences were introduced to ensure students were exposed to continuity of care.

As a result of these challenges and with a lack of clear research evidence and a reliance on 'expert opinion' as the highest level of evidence available, the minimum practice requirements used by other countries, such as the United Kingdom (UK) and New Zealand (NZ), were similarly adopted into the Australian midwifery accreditation standards. (A draft list of minimum midwifery practice experience requirements is provided below in Question 6.) The UK pre-registration midwifery education standards require students to complete CoC experiences but do not stipulate numbers or time frames for these experiences.[35] In NZ, midwifery students are required to complete 25 CoC experiences.[36] The UK and NZ minimum midwifery practice requirements are both derived from the 2005 European Union Directive on the recognition of professional qualifications.[37]

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[30] World Health Organisation, *Nursing and Midwifery Human Resources for Health: Global Standards for the Initial Education of Professional Nurses and Midwives*. Geneva 2009.

[31] Pincombe J., McKellar L., Grech C., Bria K., Ginter E & Beresford G. Midwifery education in Australia: requirements for assessment. *British Journal of Midwifery*. February 2007; 15(2):98-105.

[32] Licqurish S & Seibold C. 'Chasing the numbers': Australian Bachelor of Midwifery students' experiences of achieving midwifery practice requirements for registration. *Midwifery*. Jul 18, 2012.

[33] Australian Nursing and Midwifery Council, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

[34] Pincombe J., McKellar L., Fedoruk M., Bria K., Grinter E and Beresford G. Midwifery education in Australia: requirements for assessment. *British Journal of Midwifery*, 2007; 15(2).

[35] Nursing and Midwifery Council, *Standards for Pre-Registration Midwifery Education Programs*. 2009.

[36] Midwifery Council of New Zealand, *Standards for Approval of Pre-registration Midwifery Education Programmes and Accreditation of Education Providers,* August 2007.

[37] Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. Articles 40-42 and Annex V, point 5.5.1.

Contextual variations in midwifery education and maternity care should also be considered in these circumstances, as in both the UK and NZ, midwifery students are offered greater clinical practicum hours[38] and greater access to CoC experiences.[39] In New Zealand the most common first midwifery qualification is the direct entry bachelor degree (38.4%) and caseloading is the main work undertaken by the midwifery workforce (38.1%).[40] In contrast Australian midwifery students are exposed to a fragmented, medically dominated maternity care system, with a midwifery workforce that has an estimated 7% of registered midwives that are not also registered as nurses.[41] However, the *National Maternity Services Plan: implementation for the Middle Years, 2012-13* states Australian Governments are intending to increase access to midwifery managed models of care for normal risk women and to utilise midwives to their full scope of practice.[42] This reform to expand women's access to midwifery-led primary CoC services[43] is influenced by Level 1 evidence that shows midwifery led CoC models are more beneficial for mothers and babies than other models of care in terms of reducing certain intervention rates, some complications and increasing maternal satisfaction.[44]

Research into the Australian midwifery students' experience of achieving competence, though increasing, still remains limited with studies being of varying quality. These studies focus mainly on CoC experiences rather than covering all minimum practice requirements, and in most cases, recruit participants from a single university's or jurisdiction's student population. Table 1 below provides a summary of the main findings of Australian research exploring the midwifery students' perceptions of midwifery practice experience requirements.

Table 1. Australian midwifery students' experiences.

Reported benefits	Reported burdens
(McLachlan et al, 2013) [45] • Students reported follow throughs provided a unique learning opportunity not possible in standard clinical placements and that having a student undertaking a follow through is a positive experience for women. • Most students agreed that follow-through numbers should be the same for all courses.	**(McLachlan et al, 2013)** • Students had major concerns about the impact of 20 follow throughs of 20 hours on student's capacity to meet university course requirements, including attendance at lectures, tutorials and/or clinical placements and on students' personal lives including paid employment and family responsibilities.

[38] Liqurish S and Seibold C. 'Chasing the numbers': Australian Bachelor of Midwifery students' experiences of achieving midwifery practice requirements for registration. *Midwifery*, 2012. http://dx.doi.org/10.1016/j.midw.2012.06.006.

[39] McLachlan h., Newton M., Nightingale H., Morrow J and Kruger G. Exploring the 'follow-through experience': A state wide survey of midwifery students and academics conducted in Victoria, Australia. *Midwifery* 2013 http//dx.doi.org/10.1016/ j.midw. 2012.12.017.

[40] Midwifery Council of New Zealand, *Midwifery Workforce Survey*, 2012.

[41] Nursing and Midwifery Board of Australia, *Nurse and Midwife Registrant Data*, March 2013.

[42] Standing Council on Health, *National Maternity Services Plan: Implementation for the Middle Years*, 2012-13.

[43] Australian Health Ministers' Advisory Council, *Primary Maternity Services in Australia*, 2008.

[44] Hatem M, Sandall J, Devane D, Solanti H and Gates S. Midwife-led versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2008, Issue 4. Art No.: CD004667. DOI: 10.1002/14651858.CD004667.pub 2.

[45] McLachlan h., Newton M., Nightingale H., Morrow J and Kruger G. Exploring the 'follow-through experience': A statewide survey of midwifery students and academics conducted in Victoria, Australia. *Midwifery,* 2013 http//dx.doi.org/10.1016/ j.midw. 2012.12.017.

Reported benefits	Reported burdens
• Most students reported they were clear about the role of students when involved in follow-throughs and boundaries of clinical practice in this context. **(Gray et al, 2013)** [46] • CoC experiences provided an opportunity to form deeper relationships with women, helping students to understand the many factors that impact upon a woman's pregnancy, labour, birth and early parenting. • Getting to know the woman enabled students to provide care that was centred on trust and students valued having a relationship with the woman prior to labour. • Students reported learning more from being there in the situation with the woman than from the formal structure at university or the institutional structure of the maternity unit. • CoC experiences provided an opportunity to see how different practitioners work. • Follow-through experiences made you feel you were actually studying to be a midwife. • CoC helped to be more independent…to be organised, which built confidence. • Being with a woman whom the student knew provided a better environment in which to learn. • Some students recognised the importance of CoC experiences and, even though a hassle, did not feel the number should be markedly reduced from 30. • The follow through experience helped students to learn that 'normal' was different and could be many things. • This experience provided an opportunity to make a connection which was often not possible on rostered clinical placements. **(Liqurish and Seibold, 2012)** [47] • Some students reported needing 40 births as it contributed to their competency.	• Students believed that 20 follow throughs of 20 hours would have a negative effect on student enrolment and attrition. • Most students believed that students 'sometimes' or 'occasionally' falsified records regarding the follow through at some time. • Students reported recruitment of women for follow throughs is very difficult. • Just over half of the students surveyed reported they were often unsupervised whilst participating in follow-through visits. **(Gray et al, 2013)** • For some students the pressure of 30 CoC experiences was overwhelming due to a lack of time, challenges juggling recruitment [of women], university requirement s and personal commitments (including financial cost) and their awkwardness approaching women. • Students reported feeling like they were 'going through the motions' when trying to complete 30 follow through experiences. • Meeting all the course requirements with the lack of support caused students to despair. • One student whose course only required 10 follow through experiences [prior to 2009] felt they were very valuable, but when questioned about 30 stated it would probably feel more like a nuisance than a benefit [rather than] something I'm enjoying. • Some students resorted to making up records to indicate completion of requirements. **(Liqurish and Seibold, 2012)** • Some students reported too much focus on the birth of the baby and the need for 40 normal births, [resulting in] woman-centeredness not being the focus. • Minimum practice experiences took

[46] Gray J., Leap N., Sheehy A and Homer C. Students' perceptions of the follow through experience in 3 year Bachelor of Midwifery programmes in Australia. *Midwifery*, 2013, 29, 400-406.

[47] Liqurish S and Seibold C. 'Chasing the numbers': Australian Bachelor of Midwifery students' experiences of achieving midwifery practice requirements for registration. *Midwifery*, 2012. http://dx.doi.org/10.1016/j.midw.2012.06.006.

Reported benefits	Reported burdens
(Sweet and Glover, 2011) [48] • CoC experiences provided early exposure to midwifery practice, assisted in motivating students to learn and assisted in developing their professional identity. • Being actively engaged in CoC experience assisted students in developing and/or confirming a woman-centred philosophy. • CoC afforded longitudinal involvement with women and enabled the development of a meaningful relationship to learn about pregnancy and childbirth. • CoC experiences exposed students to many different clinicians which allowed them to identify good and bad role models to base their own practice. • Students learnt from women's feedback about their own care and the care received from other clinicians – this was highly valued by students and motivated their involvement. • CoC experience gives students an understanding of the health system and the service needs from the perspective of the childbearing woman. • As students progressed into third year and became more involved in clinical care…clinicians recognised the students' role and engaged them as a valuable team member, particularly in intrapartum care. • CoC experiences enable students to experience ...different models of care, to see the full scope of midwifery practice, and reflect on their own midwifery identity. • Through CoC experiences students see the complexities of the health service and how they interact and impact on outcomes. **(Liqurish S and Seibold C, 2008)** [49] • Hands on learning was emphasised as the most beneficial learning experience. • A positive midwife preceptor – student	precedence over student's self-identified learning objectives for final placement. • Students reported difficulty in achieving the minimum midwifery practice experience requirements within the clinical hours allocated and an extra 1-4 weeks clinical was needed to achieve the required normal vaginal births as primary accoucheur. • Students expressed a lack of confidence in competency assessments identifying concerns about assessor subjectivity and the overall reliability of the competency assessment process which was further hampered by lack of continuity of preceptorship. • Students believed it was unrealistic to achieve some of the midwifery competencies within the system of maternity care they were exposed to during clinical placements. Hurdles included: reduced exposure to normal vaginal birth and competition with other students both midwifery and medical. **(Sweet and Glover, 2011)** • Students found negotiating the short term relationships and the sheer number of CoC experiences required, time consuming and exhausting over the three years [leading] them to choose women who had had previous births, a history of short labours and were near term in their pregnancy. • The degree to which the clinician engaged the student in authentic learning could positively or negatively affect their CoC experience. • Current health service context negatively impacted on the authenticity of learning in CoC experiences. • Students craved opportunities for responsibility for care under supportive supervision and discussion to develop their competency.

[48] Sweet L and Glover P. An exploration of the midwifery continuity of care program at one Australian university as symbiotic clinical education model. *Nurse Education Today*, 2011, DOI:10.1016/jnedt.2011.11.020.

[49] Licqurish S and Seilbod C. Bachelor of Midwifery students' experiences of achieving competencies. The role of the midwife preceptor. *Midwifery,* 2008; 24, 480-89.

Reported benefits	Reported burdens
relationship was identified as an integral part of effective students learning. • All students felt that they needed to practise skills in order to feel competent and appreciated the preceptor who provided the space to enhance skill acquisition.	**(Liqurish S and Seibold C, 2008)** • Bachelor of Midwifery students were emotionally affected by their experiences on clinical placement, particularly if they encountered care of women contrary to the feminist philosophical framework of the course and reacted by seeking opportunities to work with midwives who imbued their admired philosophy rather than becoming desensitised or socialised into the midwifery culture.

UK research also reports that positive student experiences with continuity of care (in the form of caseloading) are enhanced when there is effective preparation of students for practice realities, realistic caseloads that take account of the student's individual situation and the provision of supportive frameworks, including good planning, record keeping and supervision.[50]

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to guide development of midwifery student competency across all-risk models of midwifery care. (Criteria 8.3, 8.4, 8.5 and 8.6)

The program provider demonstrates:

- **Midwifery practice experiences provide timely opportunities for experiential learning of curriculum content that is progressively linked to the attainment of the current National Competency Standards for the Midwife.**
- **Each student is provided with a variety of midwifery practice experiences with opportunities for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.**
- **Effective and ethical recruitment processes that enable women to participate freely in the continuity of care experiences for students, and enable students to engage readily with women who consent to participate.**
- **Clearly articulated models of supervision, support, facilitation and assessment are in place, including for continuity of care experiences, so students can achieve the required learning outcomes and current National Competency Standards for the Midwife.**

QUESTION 3:

[50] Rawson S. A qualitative study exploring student midwives' experiences of carrying a caseload as part of their midwifery education in England. *Midwifery*, 2011; 27, 986-792.

Do the above criteria collectively provide sufficient guidance for curriculum design and planned midwifery practice experience placement to develop student competency in midwifery practice across all-risk models of care?

a) Yes, these standards provide sufficient guidance to develop midwifery student competence across all-risk models of care.

b) No, these standards do not provide sufficient guidance to develop student competence across all-risk models of care.

If you answered 'no', please provide a reason for your response.

QUESTION 4:

Should minimum requirements for what constitutes 'engagement' in a continuity of care (CoC) experience be stipulated within the midwifery accreditation standards?

a) No, minimum requirement s for CoC experiences should not be stipulated.

b) Yes, minimum requirements for CoC should be stipulated.

Please provide a reason for your response.

If you answered 'yes', please also specify what you consider should be the minimum requirement for CoC engagement:

- Antenatal engagement (eg when to start visits, number of visits).
- Intrapartum engagement (eg present for the labour, present for the birth regardless of mode, is directly and actively involved with the woman as she spontaneously gives birth to her baby vaginally and includes attending to third stage and initial mother and baby interaction).
- Postnatal engagement (eg number of visits, when to end visiting).

QUESTION 5:

This question is about developing a shared understanding of what constitutes 'being with' a woman as she gives birth. The current midwifery accreditation standards describes this as [51]:

> *…where the midwifery student is directly and actively involved with the woman as she spontaneously gives birth to her baby vaginally and includes attending to third stage and initial mother and baby interaction.*

During midwifery students' practice experience, does this definition match what is being regarded as 'being with' a woman as she gives birth?

a) Yes, this definition matches what is regarded as 'being with' a woman when giving birth.

b) No, this definition does not match what is regarded as 'being with' a woman when giving birth.

If you answered 'no', please describe in what way you consider the midwifery students' experience of 'being with' a woman when giving birth differs from the above definition.

[51] Australian Nursing and Midwifery Council, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

QUESTION 6:

Should a list of minimum requirements for midwifery practice experiences (type and number) continue to be stipulated in the midwifery accreditation standards for use across all entry to practice midwifery programs?

a) Yes, minimum requirements for midwifery practice experiences should be stipulated.

Go to Question 7.

b) Some minimum requirements should continue to be stipulated.

Go to Question 7.

c) No, minimum requirements for midwifery practice experiences should not be stipulated, remove the list from the midwifery accreditation standards.

Go to Question 8.

Please provide a reason for your response.

QUESTION 7:

Please review this DRAFT list of minimum midwifery practice requirements and use the right hand column to identify any change you consider may be necessary to the type and/or minimum number of experiences required.

Please provide a reason for your response.

Type and number of minimum midwifery practice requirements	Tick if 'No Change'	Enter Change
(i) **??* (currently 20)** continuity of care (CoC) experiences. Specific requirements of these experiences include: (with a-g following) a) enabling students to experience continuity with individual women throughout pregnancy, labour and birth and the postnatal period, irrespective of the availability of midwifery continuity of care models b) participation in CoC experiences involving contact with women throughout pregnancy and continuing after birth c) supervision by a midwife (or in particular circumstances a medical practitioner qualified in obstetrics) d) consistent, regular and ongoing evaluation of each student's CoC experiences e) CoC experiences distributed across the program and with the student fully involved in providing midwifery care with appropriate supervision f) engagement with women during pregnancy and		

at antenatal visits, labour and birth as well as postnatal visits according to individual circumstances. Overall, it is recommended that students spend an average of **??* (currently 20)** hours with each woman across her maternity care episode g) provision by the student of evidence of their engagement with each woman. (ii) Attendance at **???* (currently 100)** antenatal visits with women, which may include women being followed as part of CoC experiences. (iii) Attendance at **???* (currently 100)** postnatal visits with women and their healthy newborn babies, which may include women being followed as part of CoC experiences. (iv) 'Being with' **??* (currently 40)** women giving birth, this may include women being followed as part of CoC experiences. (v) Experience of caring for **??* (currently 40)** women with complex needs across pregnancy, labour and birth, and the postnatal period, which may include women the student is following through as part of their CoC experiences.		
(vi) Experience in the care of babies with special needs (currently no minimum number specified). (vii) Experience in women's health and sexual health (currently no minimum number specified). (viii) Experience in medical and surgical care for women (currently no minimum number specified). (ix) Experience in (a-i currently have no minimum numbers specified): a) antenatal screening investigations and associated counselling b) referring, requesting and interpreting results of relevant laboratory tests c) administering and/or supplying medicines for midwifery practice (however authorised to do so in the jurisdiction of practice) d) actual or simulated midwifery emergencies, including maternal and neonatal resuscitation e) actual or simulated vaginal breech birth f) actual or simulated episiotomy and perineal suturing		

g) examination of the new born h) provision of care in the postnatal period up to four to six weeks following birth, including breastfeeding support i) perinatal mental health issues including recognition, response and referral. **To be determined*		

It has been recommended that a proposed new criterion be added to the midwifery accreditation standards to emphasise the centrality of woman-centred midwifery to competent midwifery practice.

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION for 'Standard 4. Program content' to facilitate development of midwifery students' understanding of woman-centred midwifery and the midwife's role in supporting women's right of informed choice. (Criterion 4.5)

The program provider demonstrates:

- **Inclusion of content that develops understanding and appreciation of consumers' perspectives of maternity care, the woman's right to make choices and the role of the midwife to provide relevant information and support the woman's informed choices.**

QUESTION 8:

Is this standalone criterion required to facilitate development of a woman-centred approach in midwifery practice?

a) Yes, the addition of this new criterion is required to facilitate the development of a woman-centred approach in midwifery practice.

Please provide a reason for your response.

b) No, the addition of this new criterion is not required to facilitate the development of a woman-centred approach to midwifery practice.

If you answered 'no', please provide a reason for your response.

Length of program and ratio of practice to theory

Standard 3 in the revised midwifery accreditation standards provides guidance to education providers on program structure. Evidence to inform optimal structure for an entry to practice midwifery program is once again absent and has required the review of other literature to obtain guidance on the length of programs and the allocation of clinical and theoretical learning.

The ICM Global Standards for Midwifery Education stipulate that

> *…midwifery curriculum includes both theory and practise elements with a minimum of 40% theory and a minimum of 50% practise … the minimum length of a direct-entry midwifery education programme is three (3) years and the minimum length of a post-nursing/ health care provider programme is eighteen (18) months.* [52]

In the UK and NZ the pre-registration midwifery program standards prescribes the length and clinical and theoretical structure of midwifery programs in the following terms:

- In NZ: Bachelor of Midwifery Programs are to be 3 years in length with a total learning time of 4800 hours with 50% of the hours focusing on midwifery practice and 40% relating to theory *(Midwifery Council of New Zealand, Standards for Approval of Pre-registration Midwifery Education Programmes and Accreditation of Tertiary Education Organisations, August 2007, p. 13).*

- In the UK: Bachelor of Midwifery Programs are to be 3 years in length and pre-registration midwifery programs for registered nurse are to be 18 months with a practice to theory ratio of each program required to be no less than 50% practice and no less the 40% theory. The clinical practice experience must be sufficient to enable students to achieve the standards required by the Nursing and Midwifery Council *(Nursing and Midwifery Council, Standards for Pre-registration Midwifery Education, 2009, p. 19).*

After the development of the current midwifery accreditation standards the minimum length of the post graduate program was set at 18 months. However, following further discussion the minimum length was reduced to 12 months. The review of the midwifery accreditation standards provides stakeholders, including the jurisdictions, community and profession, with an opportunity to evaluate the benefits and/or burdens of this time frame in terms of matters including program popularity; financial cost of the program to education providers, students and maternity services; and the capacity of students to achieve learning outcomes required by the curriculum.

The section below entitled 'Pathways to beginning practice' provides the context for discussion of dual degree (nursing and midwifery) programs, including program length.

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION to guide program development and structure. (Criterion 3.7)

The program provider demonstrates:

- **The minimum length of the pre-registration midwifery program for registered nurse must be at least 12 months full time.**

QUESTIONS 9:

[52] International Confederation of Midwives, *Global Standards for Midwifery Education*, 2010.

Please consider in conjunction with your responses to Q6 and Q7.

What should the midwifery accreditation standards specify in regard to postgraduate program minimum length?

a) 12 months.

b) 18 months.

c) Other.

Please provide a reason for your response and **if you answered 'other'**, please also specify what you consider to be the required minimum length of the program.

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION to guide program development and structure. (Criterion 3.8)

The program provider demonstrates:

- **Theory and practice must be integrated throughout midwifery programs in equal proportions (50% theory and 50% practice).**

QUESTION 10:

Should the ratio of theory to practice in the curriculum be specified within the midwifery accreditation standards?

a) Yes, the ratio of theory to practice should be specified.

Go to Question 11.

b) No, the ratio of theory to practice should not be specified.

Go to Question 12.

Please provide a reason for your response.

QUESTION 11:

The ratio of theory to practice should be:

a) 50% theory and 50% practice.

b) 40% theory and a minimum of 50% practice.

c) Other.

Please provide a reason for your response and **if you answered 'other'**, please also specify what you consider to be the required ratio.

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION to guide program development and structure. (Criterion 3.9)

The program provider demonstrates:

- **A minimum of ????* hours of midwifery practice experience, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health care settings.**

**To be determined*

QUESTION 12:

Please consider in conjunction with your responses to Q9 and Q11.

Is a criterion that specifies the minimum number of hours for midwifery practice (clinical) experience required in the midwifery accreditation standards?

a) No, a specified minimum number of midwifery practice experience hours is not required.

b) Yes, a specified minimum number of midwifery practice experience hours is required.

Please provide a reason for your response and **if you answered 'yes'**, please also specify what you consider should be the required minimum number of hours.

Use of simulated learning environments

Midwifery programs across Australia currently use simulation to varying extents. The simulation models most often used are scenarios, peer-to-peer learning, partial task trainers (mannequins) and standardised patients (actors). Models less often used are full body mannequins depicting a realistic birthing environment.[53] A review of 24 papers found that simulation based learning in midwifery education provides evidence that simulated learning of midwifery skills is beneficial and has an educational and clinical impact. The review does not find sufficient evidence to suggest that simulation should replace clinical practice.[54] Simulation has been found to be a useful adjunct to traditional forms of education, particularly in situations where clinical exposure is limited or infrequent such as for obstetric emergencies. However, more research is required to determine its impact on learning outcomes.[55] The New Zealand standards for pre-registration midwifery education programs state[56]:

[53] Bogossian F., McKenna L., Higgins M., et al. Simulation based learning in midwifery curricula: results of a national electronic survey. *Women and Birth: Journal of the Australian College of Midwives*. 2012; 25(2):86-97.

[54] Cooper S., Cant R., Porter J. et al. Simulation based learning in midwifery education: a systematic review. *Women and Birth: Journal of the Australian College of Midwives*. 2012; 25(2):64-78.

[55] Davis BM., Soltani H & Wilkins H. Using a childbirth simulator in midwifery education. *British Journal of Midwifery*. 2009; 17(4):234-237.

[56] Midwifery Council of New Zealand, *Standards for Approval of Pre-registration Midwifery Education Programmes and Accreditation of Tertiary Education Organisations*, 2007.

> *…the clinical skills laboratories/simulations are [to be] counted as theoretical hours, not as midwifery practice hours except where being used for clinical skills assessment (p. 13).*

A recent survey of all midwifery programs in Australia, conducted on behalf of Health Workforce Australia, identified that effectively embedding simulation in curricula was hindered at present.[57] The overwhelming majority of respondents (90%) felt they did not have sufficient time to develop simulated learning programs, and they lacked adequate training (56%) and staff development opportunities (67%) in simulation.[58]

QUESTION 13:

To facilitate effective embedding of simulation activities in midwifery curricula should the midwifery accreditation standards be explicit about the use of simulation in terms of clinical or theoretical hours?

a) No, it is not necessary for the standards to be explicit regarding use of simulation.

b) Yes, it is necessary for the standards to be explicit regarding the use of simulation.

Please provide a reason for your response and **if you answered 'yes'**, please also specify what you consider is required in the midwifery accreditation standards to make explicit the use of simulation in terms of the curriculum's clinical or theoretical hours.

Aboriginal and Torres Strait Islander people and midwifery practice

Aboriginal and Torres Strait Islander People continue to experience substantially poorer maternal and child health outcomes despite a range of interventions.[59] Consistent with the Council of Australian Governments 'Closing the Gap' reform agenda[60] the ANMAC standards have a number of criteria to assist in increasing the number of Aboriginal and Torres Strait Islander people in the midwifery workforce and improving maternity care to Aboriginal and Torres Strait Islander women.

[57] Health Workforce Australia SLE National Project. *Simulated Learning Environment – Midwifery Curriculum: Final Report*, November 2012, Prepared by the University of Queensland and the Monash University Midwifery Curriculum Consortium.

[58] Bogossian F., McKenna L., Higgins M., et al. Simulation based learning in midwifery curricula: results of a national electronic survey. *Women and Birth: Journal of the Australian College of Midwives*. 2012; 25(2):86-97.

[59] Australian Health Ministers Conference, *National Maternity Service Plan*, 2010.

[60] Council of Australian Government, *Closing the Gap*. In: Department of Families, Health, Community Services and Indigenous Affairs, ed. 2009.

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to develop competence in the midwifery care of Aboriginal and Torres Strait Islander women and their families. (Criteria 1.5, 3.8 and 3.9)

The program provider demonstrates:

- **Terms of reference for relevant school committees and advisory and /or consultative groups, including partnerships with Aboriginal and Torres Strait Islander health professionals and communities.**
- **Consultative and collaborative approaches to curriculum design and program organisation between academic staff, those working in health disciplines, students, consumers and other key stakeholders including Aboriginal and Torres Strait Islander health professionals and communities.**
- **Inclusion of a discrete subject specifically addressing Aboriginal and Torres Strait Islander peoples' history, health, wellness and culture. Midwifery practice issues relevant to Aboriginal and Torres Strait Islander peoples and communities are also appropriately embedded into other subjects across the curriculum.**

QUESTION 14:

Are these criteria collectively sufficient to support the development of culturally competent midwifery practice?

a) Yes, these criteria provide sufficient support for the development of culturally competent midwifery practice.

b) No, these criteria do not provide sufficient support for the development of culturally competent midwifery practice.

If you answered 'no', please specify what you consider is required in addition to these criteria and provide a reason for your response.

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to support Aboriginal and Torres Strait Islander people entering the midwifery workforce. (Criteria 6.8 and 7.4)

The program provider demonstrates:

- **Aboriginal and Torres Strait Islander peoples are encouraged to enrol and a range of support needs are provided to those students.**
- **Staff recruitment strategies:**
    - **are culturally inclusive and reflect population diversity,**
    - **take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples.**

QUESTION 15:

Are these criteria collectively sufficient to support Aboriginal and Torres Strait Islander people

entering the midwifery workforce?

a) Yes, these criteria provide sufficient support for entry to the midwifery workforce.

b) No, these criteria do not provide sufficient support for entry to the midwifery workforce.

If you answered 'no', please specify what you consider is required in addition to these criteria and provide a reason for your response.

Care of women experiencing social, medical and/or obstetric risks

There are groups of women across the Australian population who experience higher risk of poorer maternity outcomes. These groups include (but are not limited to) women from migrant and refugee groups; adolescent mothers; older mothers; women with pre-existing medical conditions; obese women; women using cigarettes, alcohol and illicit substances; women experiencing mental illness; women experiencing domestic violence, women who have experienced some types of female genital mutilation and women in prisons.[61] The revised midwifery accreditation standards will have to continue to provide guidance for curricula and midwifery practice experience placements to facilitate competency development in the care of women and babies experiencing complexity.

In the United Kingdom[62] and New Zealand[63] midwifery students are required to 'Supervise and care for' or 'participate in the care' of 40 women at risk in pregnancy or labour or postnatal period'. Note that the care of women experiencing complexity in pregnancy or childbirth is a significant part of the ANMC *National Competency Standards for the Midwife* (2006)[64] and required by the midwifery accreditation standards to be used in the development of curriculum and for the assessment of midwifery practice experiences. Additionally, the draft midwifery accreditation standards – Version 1, *as they currently stand*, specify a minimum number of midwifery practice requirements that focus on the woman or baby requiring complex care.

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to support the development of competency in midwifery care for women experiencing high risk pregnancy and childbirth. (Criteria 3.3, 3.12, 4.1, 4.2, 4.6, 8.3, 8.4 and draft minimum midwifery practice experience requirements 5, 6 and 8).

The program provider demonstrates:

- **A map of subjects against the current National Competency Standards for the Midwife which clearly identifies the links between learning outcomes, assessments**

[61] Australian Health Ministers Conference. *National Maternity Service Plan*, 2010.

[62] Nursing and Midwifery Council. *Standard for Pre-registration Midwifery Education*, 2009.

[63] Midwifery Council of New Zealand, *Standards for Approval of Pre-registration Midwifery Education Programmes and Accreditation of Tertiary Education Organisation,* August 2007.

[64] Australian Nursing and Midwifery Council, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

and required graduate competencies.

- **Midwifery practice experience in Australia is included towards the end of the program to consolidate the acquisition of competence and facilitate transition to practice. A summative assessment is made at this time against all National Competency Standards for the Midwife in a midwifery practice setting.**
- **A comprehensive curriculum document, based on the conceptual framework discussed in Standard 2, that includes:**
    - **linkages between subject objectives, learning outcomes and their assessment and the national competencies,**
    - **a midwifery practice experience plan across a variety of midwifery practice settings.**
- **The central focus of the program is on midwifery and contemporary midwifery practice; this comprises how woman-centred midwifery care and primary health care principles underpin the National Competency Standards for the Midwife and how regional, national and international maternity care priorities, research, policy and reform are incorporated.**
- **Inclusion of subject matter that gives students an appreciation of the diversity of Australian culture and develops their knowledge of cultural respect and safety.**
- **Midwifery practice experiences provide timely opportunities for experiential learning of curriculum content that is progressively linked to the attainment of the current National Competency Standards for the Midwife.**
- **Each student is provided with a variety of midwifery practice experiences with opportunities for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.**
- **Minimum midwifery practice experience requirements**
    - **Experience of caring for ?? (currently 40) women with complex needs across pregnancy, labour and birth, and the postnatal period, which may include women the student is following through as part of their continuity of care experiences.**
    - **Experience in the care of babies with special needs.**
    - **Experience in medical and surgical care for women.**

**To be determined*

QUESTION 16:

Please consider in conjunction with your responses to Questions 6 and 7 (ie whether or not to stipulate the minimum midwifery practice experience requirements).

Do the above standards provide sufficient guidance for curriculum design and midwifery practice experience placements to support the development of student competency in the care of women and babies with complex needs?

a) Yes, these criteria sufficiently guide the development of student competency in the care of women and babies with complex needs.

b) No, these criteria do not sufficiently guide the development of student competency in the care of women and babies with complex needs.

If you answered 'no', please specify what you consider needs to be changed or added to these criteria and provide a reason for your response.

Pathways to beginning practice

Midwives can be prepared for registration by either completing a:

- Bachelor of Nursing followed by a post-graduate program in midwifery
- Bachelor of Midwifery
- Dual degree, most commonly Bachelor of Nursing: Bachelor of Midwifery.

In recent Australian history the post graduate pathway was the only way to become a registered midwife. With the development of the profession of midwifery as discrete from nursing a direct entry Bachelor of Midwifery evolved, with the first programs commencing in South Australia and Victoria in 2002. Direct entry midwifery programs were also developed in part with the aim to prepare midwives for registration in a shorter timeframe and add to workforce flexibility.[65] Dual nursing and midwifery degrees also add to workforce flexibility and have evolved in part due to the need of those wishing to work in small facilities where both nursing and midwifery skills are required, particularly in rural and remote areas.[66]

Davis et al[67] found that midwives prepared through the undergraduate and postgraduate routes commence practice with similar levels of confidence. Those from postgraduate programs had higher confidence after the first year of practice. Hammond et al found that graduates from both pathways had similar intentions to work post registration although Bachelor of Midwifery graduates were older and more likely to want to work part time. Graduates from post graduate midwifery programs seemed to more quickly be socialised into the workforce than other graduates, possibly due to their previous exposure to the health care system as registered nurses.[68]

There are a number of domains and skill sets that are generic to both nursing and midwifery for example assessing haemodynamic status, wound management and medication management. The context or the some health care setting may require midwives (who are

[65] Leap N, Barclay L and Sheehan A. The AMAP report, Volume 1 and 2: Australian Midwifery Action Project, 2003.

[66] Yates K., Usher K & Kelly J. The dual roles of rural midwives: the potential for role conflict and impact on retention. *Collegian: Journal of the Royal College of Nursing Australia*. 2011; 18(3):107-113.

[67] Davis D, Fourer M, Clements V, Brodie P & Herbison P. The self-reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia. *Women and Birth: The Journal of the Australian College of Midwives*. 2012; 25(3):e1-e10.

[68] Hammond A., Gray J., Smith R., Fenwick J & Homer C. Same but different: expectations of graduates from two midwifery education courses in Australia. *Journal of Clinical Nursing*. 2011; 20:2315-2324.

not registered nurses) to participate in the care of non-maternity patients[69], under the supervision of a registered nurse. This need may arise as a result of midwives working in low volume birthing areas such as in rural and remote areas or because bed limitations require the admission or outlying of non-maternity patients to midwifery clinical areas. Graduates with dual midwifery and nursing registration may be seen as a more flexible addition to the workforce in such clinical settings.

Both the post-graduate and undergraduate entry-level midwifery programs are accredited using the same set of midwifery accreditation standards. The dual degree programs are accredited by ANMAC against both the midwifery and registered nurse accreditation standards. There are no specific standards for dual degree programs.

The standards currently state that the entry to practice midwifery programs should be a minimum of a degree or a postgraduate qualification and listed on the Australian Qualification Framework (AQF) registry for the award.[70] The AQF stipulates that a minimum timeframe for a Level 7 degree is 3 years.[71] Furthermore, the AQF stipulates that 50% credit can be given for an Advanced Diploma or Associate Degree and provides no guidance as to credit limits for a dual degree arrangement.[72]

Additionally, the midwifery accreditation standards currently require evidence that midwifery students are exposed to an extended period of midwifery experience at the end of the entry to practice midwifery program to consolidate the acquisition of competence and to facilitate transition to practice. This can prove somewhat challenging in a dual degree situation where there is the same sequencing requirement for nursing students. The sequencing of both degrees to meet these requirements can make structuring the program complex.

QUESTION 17:

Do the midwifery accreditation standards need to give separate and specific guidance to the education provider for the Bachelor of Midwifery, dual degrees (nursing and midwifery) or postgraduate midwifery programs?

a) No, separate and specific guidance is not required as the same standards should apply to all entry to practice midwifery programs.

b) Yes, separate and specific guidance is required.

Please provide a reason for your response and **if your answered 'yes'**, please also specify what you consider is required to increase guidance for the education providers of these programs.

[69] Yates K., Usher K & Kelly J. The dual roles of rural midwives: the potential for role conflict and impact on retention. *Collegian: Journal of the Royal College of Nursing Australia.* 2011; 18(3):107-113.

[70] Australian Qualification Framework Council, *Australian Qualification Framework*, 2011.

[71] Ibid.

[72] Ibid.

Question 18:

Should the midwifery accreditation standards contain specific criteria for the Bachelor of Midwifery component of the dual degree in terms of, for example, length of program or sequencing and proportion of midwifery practice experience?

a) No, specific criteria for Dual Degrees is not required.

b) Yes, specific criteria for Dual degrees should be identified.

Please provide a reason for your response and if you answered 'yes' please also specify what you consider are required in regard to the dual degree in terms of, eg, length of program or sequencing and proportion of midwifery practice experience.

Workforce issues and impact on education

An ageing workforce, an increase in part time hours and an increase in the demand for services places significant pressure on graduates in all health disciplines to be appropriately prepared for practice in the shortest time possible. Program duration is specified by the AQF.

Retention, another key strategy in maintaining an adequate workforce, relies in part on the successful transition of new graduates into the workforce.[73] Important in that transition is the socialisation into the profession. This requires graduates to have obtained the adequate skills, familiarisation with the workforce and work setting, and confidence as students. Some studies have identified that more needs to be done to support midwives in their first year in practice after registration.[74]

Health Workforce Australia notes that, improving consistency of assessment and supervision, cost effective use of simulated learning and a greater focus on 'work-readiness' of graduates also needs to be considered to ensure Australia's ability to meet its health workforce needs.[75]

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION to facilitate the midwifery student's transition to practice as a graduate midwife. (Criterion 3.12)

The program provider demonstrates:

- **Midwifery practice experience in Australia is included towards the end of the program to consolidate the acquisition of competence and facilitate transition to practice. A summative assessment is made at this time against all National Competency Standards for the Midwife in a midwifery practice setting.**

QUESTION 19:

[73] Carolan M. 'A good Midwife stands out': 3rd year midwifery students' views. *Midwifery,* Feb 2013; 29(2):115-121.

[74] Clements V., Fenwick J & Davis D. Core elements of transition support programs: the experiences of newly qualified Australian midwives. *Sexual & Reproductive Healthcare: Official Journal of the Swedish Association of Midwives*. 2012; 3(4: 155-162.

[75] Health Workforce Australia, *Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1*. Adelaide 2012.

Within the context of accreditation standards for entry to practice midwifery programs:

Is this criterion sufficient to facilitate the midwifery student's transition to practice as a graduate midwife?

a) Yes, this criterion sufficiently facilitates transition to practice.

b) No, this criterion does not sufficiently facilitate transition to practice.

Please provide a reason for your response and **if your answered 'no'**, please also specify what you consider is required in addition to this criterion to facilitate transition to practice.

The last question has been added to ensure the review process for the midwifery accreditation standards has captured issues that are considered important by stakeholders.

QUESTION 20:

Within the context of accreditation standards for entry to practice midwifery programs:

Are there other areas where the draft midwifery accreditation standards – Version 1 require amendment or change to ensure they adequately prepare midwives for beginning practice in the context of contemporary Australian maternity services?

Conclusion

The aim of the review of the ANMAC midwifery accreditation standards is to review and where necessary update the midwifery accreditation standards as part of the transition to the National Registration and Accreditation Scheme. The consultation process will be conducted in an open and transparent manner to ensure that the revised midwifery accreditation standards are nationally consistent, contemporary, comprehensive, clearly articulated and respected by the profession and relevant education providers.

The ANMAC Board will oversee the process of review which will be coordinated by the Board appointed Expert Advisory Group and led by ANMAC's Director of Accreditation – Ms Donna Mowbray. The review is expected to be completed by January 2014 with the intention of providing updated midwifery accreditation standards that provide sufficient protection to the public and are acceptable to the community, the profession, the jurisdictions, employers, and relevant education providers, for the approval of the NMBA in February 2014.

Glossary and abbreviations

AHPRA is the Australian Health Practitioner Regulation Agency (AHPRA, an organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. AHPRA supports the National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme.

ANMAC is the Australian Nursing and Midwifery Accreditation Council, an independent accrediting authority for Nursing and Midwifery under the National Registration and Accreditation Scheme. ANMAC sets standards for accreditation and accredits nursing and midwifery courses and providers.

AQF is the Australian Qualifications Framework and is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector into a single comprehensive national qualifications framework.

EDUCATION PROVIDER is a university or other higher education institution, or a recognised training organisation (RTO) that is responsible for a program the graduates of which are eligible to apply for nursing or midwifery registration or endorsement.

HEALTH PRACTITIONER REGULATION NATIONAL LAW ACT 2009, OR THE NATIONAL LAW, the National Law is contained in the Schedule to the Act. This second stage legislation provides for the full operation of the National Registration and Accreditation Scheme for the Health Professions from 1 July 2010 and covers the more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health and performance arrangements, and privacy and information-sharing arrangements. The purpose of the National Law is to protect the public by establishing a national scheme for the regulation of health practitioners and students undertaking programs of study leading to registration as a health practitioner.

HWA is Health Workforce Australia, an initiative of the Council of Australian Governments. It was established to meet the future challenges of providing a health workforce that responds to the needs of the Australian Community.

INTERPROFESSIONAL LEARNING occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care[76]

NMBA is the Nursing and Midwifery Board of Australia and works in partnership with AHPRA to protect the public and guide the professions of Nursing and Midwifery. The functions of the NMBA include registering nursing and midwifery practitioners and students; developing standards, codes and guidelines for the nursing and midwifery professions; handling notifications, complaints, investigations and disciplinary

[76] Australian Nursing and Midwifery Accreditation Council, Registered Nurse Accreditation Standards, 2012.

hearings; assessing overseas trained practitioners who wish to practice in Australia; and approving accreditation standards and accredited programs of study.

NRAS is the National Registration and Accreditation Scheme.

PRIMARY HEALTH CARE PRINCIPLES:

- Reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience.
- Addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.
- Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.
- Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.
- Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.
- Should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.
- Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.[77]

PROGRAM is the full program of study and experiences that are required to be undertaken before a qualification, recognised under the Australian Qualifications Framework (AQF), such as a Bachelor of Nursing can be awarded to a graduate who successfully completes the program.

PROGRAM PROVIDER is the school or faculty responsible for the design and delivery of a program of study in midwifery leading to the award associated with the entry to practice midwifery program.

[77] WHO; UNICEF (1978). Declaration of Alma-Ata: report on the International Conference on Primary Health Care, 6-12 September, Alma-Ata, USSR. Viewed at http://www.who.int/publications/almaata_declaration_en.pdf on 15 May.

SIMULATION refers to any education method or experience evoking or replicating aspects of the real world in an interactive manner.

TEQSA is the Tertiary Education Quality and Standards Agency which was established in July 2011 to regulate and assure the quality of Australia's large, diverse and complex higher education sector. From January 2012 the Tertiary Education Quality and Standards Agency will register and evaluate the performance of higher education providers against the new Higher Education Standards Framework. TEQSA will undertake both compliance assessments and quality assessments.

WOMAN The term "woman" includes the woman, her baby (born and unborn), and, as negotiated with the woman, her partner, significant others and community.[78]

WOMAN-CENTRED MIDWIFERY principles are identified in the Australian Collage of Midwives Philosophy Statement: *Midwife means 'with woman'*. This meaning shapes midwifery's philosophy, work and relationships. Midwifery is founded on respect for women and on a strong belief in the value of women's work of bearing and rearing each generation. Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman's life. These events are also seen as inherently important to society as a whole. Midwifery is emancipatory because it protects and enhances the health and social status of women which, in turn, protect and enhance the health and wellbeing of society.

Midwifery is a woman-centred, political, primary health care discipline founded on the relationships between women and their midwives. Midwifery:
— focuses on a woman's health needs, her expectations and aspirations encompasses the needs of the woman's baby, and includes the woman's family, her other important relationships and community, as identified and negotiated by the woman herself.
— is holistic in its approach and recognises each woman's social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself.
— recognises every woman's right to self-determination in attaining choice, control and continuity of care from one or more known caregivers.
— recognises every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals.
— is informed by scientific evidence, by collective and individual experience and by intuition.
— aims to follow each woman across the interface between institutions and the community, through pregnancy, labour and birth and the postnatal period so all women remain connected to their social support systems.
— the focus is on the woman, not on the institutions or the professionals involved.
— includes collaboration and consultation between health professionals.

[78] Australian Nursing and Midwifery Council, *National framework for the development of decision-making tools for nursing and midwifery practice*. September 2007.

Appendix A

On 14 July 2006, The Council of Australian Governments (COAG) agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions. COAG further agreed to establish a single national accreditation scheme for health education and training, in order to simplify and improve the consistency of current arrangements.[79] Bills were successively put before state and territory parliaments, commencing with Queensland, to enact the legislation known as the Health Practitioner Regulation National Law Act (or the 'National Law') to establish the scheme**.** The Act provides for the adoption of a national law to establish a national registration and accreditation scheme for health practitioners. The object, objectives and guiding principles are articulated in Section 4 Part 1 and are reproduced below with phrases relating to accreditation of education providers and programs of study highlighted.[80]

(1) *The object of this Law is to establish a national registration and accreditation scheme for—*

(a) the regulation of health practitioners; and

(b) the registration of students undertaking—

(i) programs of study that provide a qualification for registration in a health profession; or

(ii) clinical training in a health profession.

(2) The objectives of the national registration and accreditation scheme are—

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

[79] Council of Australian Governments. Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions. 2008.

[80] Health Practitioner Regulation National Law Act 2009 Qld.

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

(3) The guiding principles of the national registration and accreditation scheme are as follows—

(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;

(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;

(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Following the introduction of the National Law, the Australian Nursing and Midwifery Council (ANMC) was approved under the National Registration and Accreditation Scheme (NRAS) as the independent accreditation authority, commencing on 1 July 2010, for all nursing and midwifery education providers and programs of study leading to registration and endorsement in Australia.

Subsequently, the ANMC changed its name to the Australian Nursing and Midwifery Accreditation Council (ANMAC) to reflect its principle role as an accrediting authority. Along with responsibility for accrediting education providers and programs of study leading to a qualification in the professions of nursing and midwifery, the Council has legislated responsibility for regular review and improvement of the Accreditation Standards underpinning this accreditation function for all professional categories under its mandate.[81]

Professional education accreditation is concerned with the quality of the profession and its work, from the perspective of the public interest and community safety. It is part of a broader process of assuring the community that, having completed an accredited education program, beginning professional practitioners have achieved agreed professional outcomes and are able to practise in a safe and competent manner equipped with the necessary foundation knowledge, professional attitudes and essential skills. This process itself however, relies on two other fundamental building blocks:

1. That the education providers themselves are authorised to issue the relevant qualification and are evaluated to assure continued quality learning outcomes for their graduates.

   Qualifications are specified, classified and defined by the Australian Qualifications Framework (AQF)[82] and their associated Register lists Authorised Issuing Organisations. The Tertiary Education Quality and Standards Agency (TEQSA) has responsibility for

[81] Health Practitioner Regulation National Law Act 2009 Qld.

[82] Australian Qualifications Framework Council. Australian Qualification Framework 2011.

evaluating all higher education providers for quality assurance purposes and protecting the integrity of the Australian higher education system. See section 5 for more information on TEQSA.

2. That there exists a set of agreed and contemporary competency standards for the profession, against which the capability of graduates can be assessed.

   The Nursing and Midwifery Board of Australia (NMBA) adopted the ANMC's National Competency Standards for enrolled and registered nurses, midwives and nurse practitioners in 2010[83] These standards articulate the core competencies by which individual performance is assessed to obtain and retain a licence to practice, issued by the NMBA, as an enrolled nurse, registered nurse, registered midwife and nurse practitioner in Australia. However, these Competency Standards are used not only by the NMBA for health professionals to self-assess their competence as part of the annual renewal of licence process; but also to assess nurses and midwives educated overseas seeking to work in Australia; and to assess nurses and midwives returning to work after breaks in service. They are also used to assess the performance of nurses and midwives involved in professional conduct matters. Higher education providers use the National Competency Standards when developing nursing curricula and to assess student performance; as do employers when evaluating graduate performance.

The accreditation process administered by ANMAC is an efficient and effective proxy for the external assessment of each individual graduate against the relevant competency standards. Professional course accreditation must ensure that necessary professional standards are protected, while not inhibiting diversity and innovation nor constraining continuous quality improvement. However, it is critical that the relevant professional accreditation standards are regularly reviewed to ensure their continued relevance in the light of changes in pertinent health and education legislation, policy, delivery or ethos.[84]

[83] Australian Nursing and Midwifery Accreditation Council. Registered Nurse Accreditation Standards. Canberra 2012.

[84] Australian Nursing and Midwifery Council. Consultation Paper: Review of Registered Nurse Accreditation Standards 2011

Appendix B

Other interested parties or individuals not listed here are able to provide feedback by:

- Answering questions from the Consultation Papers via the following link: https://www.surveymonkey.com/s/Midwifery_Accreditation_Standards_Review by **close of business 12 July 2013**
- Submitting comments via the following dedicated email address: standardsreview@ANMAC.org.au.

Table 1: Key Stakeholder List

Principal Agents	Stakeholder Consultation	Expert Advisory Group
Australian Health Practitioner Regulation Agency (AHPRA)	Australian College of Midwives (ACM)	Australian College of Midwives (ACM)
Australian Nursing & Midwifery Accreditation Council (ANMC)	ACM: Midwifery Education Advisory Committee	ACM: Midwifery Education Advisory Committee
Commonwealth Department of Health and Ageing	Australian Society of Independent Midwives	Australia and New Zealand Council of Chief Nurses
Ministerial Council for Tertiary Education and Employment	Australian & New Zealand Council of Chief Nurses (ANZCCN)	Australian Nursing Federation
Nursing and Midwifery Board of Australia (NMBA)	Australian Nursing Federation	Congress of Aboriginal and Torres Strait Islander Nurses
Standing Council of Health	Commonwealth Chief Nurse	Council of Deans for Nursing and Midwifery
Tertiary Education Quality and Standards Agency (TEQSA)	Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN)	Educationalists for Entry to Practice Midwifery Programs including Dual Degree (BNBM)
Australian Health Ministers' Advisory Council (AHMAC)	Consumer Health Forum of Australia	Maternity Coalition
	Council of Deans of Nursing and Midwifery Australia & New Zealand	Maternity Service Inter Jurisdictional Committee
	Council of Remote Area Nurses of Australia plus Remote Health Professionals (CRANA*plus*)	Women's Healthcare Australasia
	Forum of Australian Health Professionals Councils	ANMAC Chief Executive Officer
	Health Workforce Australia	ANMAC Director of Accreditation Services
	Maternity Coalition	ANMAC Accreditation Manager (2)
	Maternity Service Inter Jurisdictional Committee	ANMAC Acting Manager of Accreditation Services
	MIDAC – Midwifery Academics Victoria	ANMAC Standards Review and Development Officer
	Midwifery Council of New Zealand	
	National Association of Childbirth Educators	
	National Midwifery Network (Midwifery Advisors for States and Territories)	
	National Rural Health Alliance	
	Nursing Council of New Zealand	
	Women's Healthcare Australasia	