

Submission by the Australian Nursing and Midwifery Federation

Clinical Practice Guidelines for the Management of Cervical Cancer: Public Consultation Feedback Form (Stage 1)

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Introduction

1. The Australian Nursing and Midwifery Federation (the ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, the ANMF represents the professional, industrial, and political interests of more than 356,000 nurses, midwives, and care workers across the country.
2. The ANMF's members work across public and private health, aged care, and community settings in metropolitan, regional, rural, and remote areas. The ANMF works to ensure that nurses and midwives are supported to deliver safe, evidence-based, and person-centred care.
3. The ANMF welcomes the opportunity to provide feedback on the Clinical Practice Guidelines for the Management of Cervical Cancer (the Guidelines). This submission focuses on implications for the nursing and midwifery workforce, including scope of practice, workload, safety, access, and the capacity of services to implement the Guidelines in practice.
4. This submission addresses Chapter 2, Chapter 3.1, Chapter 3.2, Chapter 3.3, Chapter 4.1, Chapter 4.2, Chapter 4.3, Chapter 6.1, Chapter 7.1, and Chapter 10. The ANMF notes that Chapter 7.2, relating to quality of life and adverse events monitoring, is reserved for Stage 2 consultation and will require further detailed engagement.
5. The ANMF's overarching position is that high-quality cervical cancer care is dependent on a sufficiently resourced, suitably qualified, skilled, and supported nursing and midwifery workforce. Where workforce considerations are not explicitly addressed, there is a material risk that clinically sound recommendations will not be operationally achievable.



Overview

Feedback on Chapter 2: Introduction

6. The ANMF considers that Chapter 2 provides a clear and contemporary overview of cervical cancer care, including epidemiology, screening context, and equity considerations.
7. The explicit inclusion of nurses within the target readership is noted. However, this inclusion is not supported by corresponding guidance on workforce capability, capacity, qualifications, credentialing, scope of practice, or training requirements.
8. The chapter frames optimal care primarily as a system and clinical design issue without identifying workforce conditions as a prerequisite for implementation. This creates a risk that expectations of care delivery are not aligned with workforce availability, particularly across acute inpatient services, primary care, maternity care, hospital in the home, at-home care, regional services, rural services, remote services, and other underserved settings.
9. Equity considerations are appropriately identified. However, the workforce implications of addressing inequity are not articulated. Nurses, midwives, Cancer Care Nurse Practitioners, and nurse practitioners are central to culturally safe care, outreach, education, follow-up, and care coordination for priority populations¹².
10. The chapter assumes that evidence-based recommendations can be implemented consistently without fully acknowledging variability in access to diagnostics, specialist services, multidisciplinary care, and local workforce capacity. The Guidelines should identify practical implementation options, including credentialed nurse-led cervical screening services, authorised and appropriately qualified registered nurses undertaking extended roles where permitted, and nurse practitioner-led or shared-care models in areas of need.
11. The ANMF supports the inclusion of gender-inclusive language and recognition of people with a cervix across gender identities. However, the guideline does not acknowledge that delivering inclusive and trauma-informed care requires workforce training, organisational support, and sufficient consultation time.

¹ Gilroy, J., Henningham, M., Meehan, D., Nila, F., McGlone, J., McAtamney, A., et al. (2024). Aboriginal and Torres Strait Islander peoples' experiences and supportive care needs associated with cancer. *BMC Public Health*, 24(1), 523.

² Ivers, R., Jackson, B., Levett, T., Wallace, K., & Winch, S. (2019). Evaluation of a cancer care team in Aboriginal primary care. *Australian Journal of Rural Health*, 27(1), 88–92.



12. From a service perspective, there is limited guidance on how recommendations should be embedded into local protocols, referral pathways, clinical prompts, and electronic systems.
13. The ANMF recommends that Chapter 2 explicitly identify workforce availability, capability, qualifications, credentialing, scope of practice, and safety as foundational enablers of guideline implementation. Targeted support should include funded education, access to specialist supervision, clinical governance, protected time, and service-level workforce planning for nurses, midwives, Cancer Care Nurse Practitioners, and nurse practitioners across all care settings.

Feedback on Chapter 3.1: Optimal Cervical Cancer Care Pathway

14. The ANMF supports the structured optimal care pathway and associated timeframes for referral, diagnosis, and treatment.
15. The inclusion of guidance that timeframes are indicative and subject to clinical judgement is appropriate. However, this does not address the gap between recommended timeframes and system capacity. Many services may lack mechanisms to consistently meet recommended referral timeframes, particularly outside metropolitan areas.
16. In under-resourced settings, nurses and midwives are already absorbing system pressures through increased workload, unpaid labour, work intensification, and pressure to provide specialised cancer-related care without adequate staffing, training, or support.
17. Responsibility for maintaining patient contact during waiting periods is assigned to the healthcare team. In practice, this responsibility may be undertaken through nursing, midwifery, Cancer Care Nurse Practitioner, nurse practitioner, care coordinator, navigation, or clinical liaison roles, often without dedicated positions or protected time.
18. The ANMF identifies a risk of moral distress and burnout where nurses and midwives are unable to meet pathway expectations due to system constraints or insufficient preparation for specialised cancer care, including in transitions across acute, hospital in the home, and community-based services. This has implications for psychological health, physical health, workforce wellbeing, retention, and patient safety³⁴.

³ Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect. *Journal of Clinical Ethics, 20*(4), 330–342.

⁴ Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics, 9*(6), 636–650.



19. Referral urgency is stated, but there is limited guidance on what should occur when recommended timeframes are not met. This may contribute to patient anxiety, repeated self-advocacy, delayed detection of abnormal findings, and inconsistent escalation.
20. The ANMF recommends that Chapter 3.1 explicitly recognise nursing and midwifery roles in coordination, clinical liaison, patient education, escalation, and communication. These roles must be aligned with applicable qualifications, authorisations, professional standards, and scope of practice. The chapter should also state that timeframe compliance is contingent on adequate resourcing and reference funded roles such as nurse navigators, cancer care coordinators, Cancer Care Nurse Practitioners, and nurse practitioners.
21. The ANMF further recommends that the Guidelines encourage services to identify fast-track referral pathways, nominate responsibility for monitoring referral timeliness, and provide clear communication to patients while they are awaiting assessment or treatment.

Feedback on Chapter 3.2: Multidisciplinary Care

22. The ANMF supports the emphasis on multidisciplinary care. Nursing and midwifery are not peripheral inclusions within multidisciplinary care; they are core clinical disciplines across prevention, screening, diagnosis, treatment, pregnancy care, symptom management, psychosocial support, survivorship, follow-up, and care coordination.
23. However, the guideline does not consistently identify the clinical role, scope, advanced practice contribution, and practical participation of nurses, midwives, cancer care nurse practitioners, and nurse practitioners within multidisciplinary care. The ANMF considers that these roles should be explicitly recognised in a way that reflects qualifications, experience, authorisation, and scope of practice, without narrowing or limiting lawful practice.
24. Nurses, midwives, Cancer Care Nurse Practitioners, and nurse practitioners deliver critical clinical assessment, coordination, advocacy, education, psychosocial support, symptom monitoring, escalation, and continuity functions within multidisciplinary care. Without explicit recognition, their work may be treated as incidental or administrative rather than as skilled clinical care⁵.
25. The ANMF is concerned that the definition and description of multidisciplinary teams do not consistently and explicitly identify nurses and midwives, despite their central role in cervical

⁵ Cancer Australia. (2023). *Multidisciplinary care*. Retrieved April 30, 2026, from <https://www.canceraustralia.gov.au/clinical-best-practice/multidisciplinary-care>



cancer prevention, diagnosis, treatment, pregnancy care, symptom management, psychosocial support, survivorship, and follow-up. Generic references to the healthcare team may also obscure role boundaries and create scope-of-practice risks if tasks are shifted without appropriate qualifications, governance, or resourcing.

26. Nurses, midwives, Cancer Care Nurse Practitioners, and nurse practitioners provide continuity across the cervical cancer continuum, spanning prevention, screening, diagnosis, treatment, pregnancy care, survivorship, and follow-up. Nurses and Midwives are often the consistent point of clinical contact as patients move between primary care, maternity services, diagnostic services, oncology services, regional health services, and community-based care.
27. The workload associated with multidisciplinary participation, including preparation, documentation, communication, care coordination, clinical liaison, and follow-up, is not acknowledged. These functions are frequently absorbed into existing nursing and midwifery workloads without additional staffing, protected time, or recognition in service planning.
28. The guideline does not sufficiently recognise the psychosocial and emotional burden associated with cancer care, which is a significant component of nursing and midwifery practice. Nurses and midwives may also be required to clarify information after consultations, support decision-making, and respond to distress or uncertainty. These interactions require additional time, which must be built into funding, scheduling, and workload expectations.
29. The ANMF recommends that Chapter 3.2 explicitly recognise the clinical role, scope of practice, advanced practice contribution, and workload of nurses, midwives, Cancer Care Nurse Practitioners, and nurse practitioners within multidisciplinary care. This should include practical examples of nursing and midwifery roles in assessment, care coordination, patient education, symptom monitoring, psychosocial support, escalation, survivorship care, and nurse practitioner-led models where clinically appropriate.
30. The ANMF also recommends that the Guidelines include minimum expectations for documented communication following multidisciplinary team decisions and care transitions. This should include communication of treatment decisions, patient preferences, fertility and quality-of-life implications, and agreed follow-up responsibilities.



31. Where patients are managed across services, sectors, or settings, local nurses, midwives, Cancer Care Nurse Practitioners, nurse practitioners, and other clinicians directly involved in the person's care should be included in communication processes. Virtual care platforms should be considered where they support timely, safe, and inclusive multidisciplinary communication.
32. The ANMF notes that continuity of care may be difficult where access to a general practitioner is limited, particularly in regional, rural, and remote areas. In these circumstances, Cancer Care Nurse Practitioners, nurse practitioners, nurse practitioner-led care, shared-care models, and virtual-care models may provide an important role in supporting timely follow-up, escalation, and continuity of care.

Feedback on Chapter 3.3: Improving Access to Cervical Cancer Care

33. The ANMF supports the focus on improving access and addressing inequities in cervical cancer care.
34. The acknowledgement of workforce shortages and the role of nurse-led models is appropriate. However, Chapter 3.3 does not contain formal recommendations or practice statements, including statements that support nurse practitioner-led models in regional, rural, remote, and underserved areas.
35. The absence of actionable statements limits the implementation value of the chapter.
36. The ANMF recommends that Chapter 3.3 include formal practice statements recognising workforce availability as a determinant of access, supporting nurse-led, midwife-led, nurse practitioner-led, and shared-care models of care, recognising the role of Cancer Care Nurse Practitioners and nurse practitioners, and requiring workforce planning and investment⁶⁷. Without a suitably qualified and available workforce, access recommendations cannot be implemented safely or equitably.

⁶ Gifford, W., Rowan, M., Dick, P., Modanloo, S., Benoit, M., Al Awar, Z., et al. (2021). Interventions to improve cancer survivorship among Indigenous peoples and communities: A systematic review. *Supportive Care in Cancer*, 29(11), 7029–7048.

⁷ Rune, K. T., Cadet, T. J., & Davis, C. (2024). Telehealth in rural cancer survivorship care. *Australian Journal of Rural Health*, 32(1), 188–192.



37. The ANMF further recommends that Chapter 3.3 include greater detail on improving access in regional, rural, and remote health services. People in these communities may face limited access to specialists, subspecialists, advanced diagnostic equipment, including positron emission tomography, computed tomography, magnetic resonance imaging, and tertiary cancer centres.
38. While the ANMF supports referral to facilities and multidisciplinary teams capable of providing appropriate care, the Guidelines would be strengthened by clearer referral pathways and community-based management options for regional, rural, and remote settings. These pathways should describe how local nurses, midwives, Cancer Care Nurse Practitioners, nurse practitioners, nurse practitioner-led models, general practitioners, Aboriginal and Torres Strait Islander health workers, cancer care coordinators, and specialist teams work together. They should also outline how this collaboration supports timely assessment, referral, treatment planning, follow-up, and escalation.
39. The ANMF recommends that regional referral and shared-care pathways be evaluated for effectiveness, including timeliness of referral, access to diagnostics, patient travel burden, continuity of care, cultural safety, workforce capacity, and access to specialist advice. Without this detail, the Guidelines may be less useful for health services that do not have the same specialist infrastructure as metropolitan or tertiary centres.

Feedback on Chapter 4.1: Clinical Presentation

40. The ANMF considers that Chapter 4.1 is clinically accurate but would benefit from clearer links to practical decision-support guidance for frontline clinicians, including guidance on escalation, referral urgency, and action where symptoms persist despite a recent normal screening result.
41. The ANMF notes that guidance on managing symptoms suggestive of cervical cancer is addressed in the National Cervical Screening Program Guidelines. Chapter 4.1 would be strengthened by clearer cross-reference to this guidance, particularly for frontline clinicians managing persistent symptoms in the presence of a recent normal screening result.
42. Symptom descriptions are comprehensive but are not clearly linked to referral urgency within this chapter.



43. Equity considerations are not sufficiently embedded. Delayed presentation is more common in priority populations⁸⁹.
44. The ANMF recommends that Chapter 4.1 include clearer cross-references to relevant symptom-based referral pathways, including the National Cervical Screening Program guidance, and clarify that persistent or concerning symptoms require appropriate assessment, escalation, and referral regardless of screening history.
45. The ANMF also recommends that Chapter 4.1, or associated implementation material, recognise that antenatal care, nurse-led models, and nurse practitioner-led models may provide important opportunities to identify people who are overdue or have never participated in cervical screening. Midwives, nurses, and nurse practitioners are well placed to discuss screening history, provide education, support referral, and, where authorised and trained, undertake cervical screening or related assessment within scope of practice.

Feedback on Chapter 4.2: Histologic Diagnosis and Initial Staging

46. The ANMF supports the requirements for histologic diagnosis outlined in Chapter 4.2 and the staging investigations detailed in Chapter 4.3.2.
47. The diagnostic and staging processes are presented across separate sections despite functioning as a connected pathway for the person receiving care.
48. The ANMF acknowledges that histologic diagnosis and staging investigations are primarily ordered, interpreted, and communicated by medical specialists. The related nursing and midwifery requirements arise in patient preparation, education, navigation, culturally safe data collection, communication, follow-up, escalation, and support where care moves across services.
49. The requirement to record Aboriginal and Torres Strait Islander status is supported and should be explicitly linked to culturally safe care, appropriate follow-up, and the role of nurses and Aboriginal and Torres Strait Islander health workers in supporting safe engagement with services.

⁸ Australian Institute of Health and Welfare. (2025). *Aboriginal and Torres Strait Islander health performance framework: Summary report 2025*. Australian Government.

⁹ Powell, A., Morseu-Diop, A., Ninomiya, M. M., Yadav, U., Phillips, E., Singh, D. R., et al. (2023). Gynaecological cancer among Aboriginal and Torres Strait Islander people. *Journal of the Australian Indigenous HealthInfoNet*, 4(3).



50. The ANMF recommends that Chapter 4.2 support clear local processes for communication, referral, follow-up, patient preparation, clinical liaison, escalation, and culturally safe engagement, including where care is provided across multiple services.

Feedback on Chapter 4.3: Staging and Prognostic Assessment

51. The ANMF supports the comprehensive staging framework.

52. Imaging recommendations rely on access to modalities such as fluorodeoxyglucose positron emission tomography and computed tomography. While the Guidelines acknowledge in Appendix Section 12.1.3 that access is variable, particularly in rural and remote settings, this is not translated into actionable guidance in the main chapter.

53. The ANMF considers this a material access issue, particularly for people in rural, regional, and remote areas. The Guidelines should more clearly cross-reference the Optimal Care Pathway and identify system responsibilities for timely access to appropriate staging investigations, including where advanced imaging is not locally available.

54. The distinction between clinical and pathological staging is important but may require clear communication to patients and local care teams to support consistent understanding of diagnosis, treatment planning, and next steps. This may be supported by plain-language summaries, written care plans, and consistent service-level documentation, where appropriate.

55. Documentation requirements should support continuity of care, particularly where care is shared across services.

56. The ANMF recommends clearer communication to patients about staging processes, staging results, and next steps, supported by standardised documentation where appropriate at the service level.



Feedback on Chapter 6.1: Pregnancy

57. The ANMF supports the inclusion of guidance on cervical cancer in pregnancy and recognises the complexity of balancing timely cancer care, pregnancy care, informed decision-making, and psychosocial support, and the rights and preferences of the woman or pregnant person.
58. The ANMF notes that Recommendation 6.1 appropriately recognises the need for multidisciplinary care, including obstetric involvement. The ANMF recommends that the chapter also make clear that midwifery care should continue alongside specialist cancer and obstetric care, regardless of the presence or absence of medical complications. Ongoing midwifery care is essential to support antenatal education, preparation for birth and parenting, psychosocial support, health promotion, and other primary health care activities within a holistic, woman- and person-centred care framework.
59. The ANMF recommends that Chapter 6.1, or associated implementation material, provide greater emphasis on cervical screening during pregnancy and the postpartum period. While the chapter appropriately focuses on management of cervical cancer in pregnancy, maternity care can also provide important opportunities to identify women and gender-diverse people who are overdue for cervical screening or who have never participated in screening¹⁰¹¹.
60. Antenatal care provides predictable contact with the health system and often involves continuity and trusted relationships with midwives and nurses. Child and family health nursing care also provides predictable contact following birth and may create a further opportunity to support cervical screening participation where screening was not discussed, offered, accepted, or completed during pregnancy.
61. The ANMF recommends that the Guidelines address common misconceptions that cervical screening is contraindicated during pregnancy. These misconceptions may contribute to health practitioners not offering screening, or to women and gender-diverse people declining screening despite being eligible. Clear guidance would support consistent, evidence-based communication and informed decision-making¹².

¹⁰ Dixon, J., & Flynn, K. (2026). Cervical screening in pregnancy: An opportunity for nurses and midwives to drive equitable cervical cancer elimination. *Australian Journal of Advanced Nursing*, 41(3).

¹¹ Tran, C. T. T., Wang, M., Plymoth, M., Chen, J., & McGee, T. M. (2026). Accuracy of self-reported cervical screening status among pregnant women. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 66(1), e70057.

¹² Coleridge, S. L., Wiggans, A., Nelissen, I., Hughes, R., Seppala, N., & McSorley, O. (2022). Improving the uptake of cervical screening in pregnant and recently postnatal women: A quality improvement project. *BMJ Open Quality*, 11(2), e001709.



Feedback on Chapter 7.1: Surveillance After Treatment

62. The ANMF supports the structured surveillance framework and risk-based follow-up guidance.
63. The requirement for clinical handover to general practitioner care is appropriate. However, the Guidelines should recognise that access to a general practitioner may be limited in regional, rural, and remote areas. In these circumstances, Cancer Care Nurse Practitioners, nurse practitioners, nurse practitioner-led care, shared-care models, and virtual-care models may provide an important role in supporting timely follow-up, escalation, and continuity of care.
64. Surveillance schedules assume patients can attend frequent in-person appointments. Access considerations for regional, rural, and remote survivors, including virtual care and shared-care surveillance models, are not sufficiently integrated.
65. In practice, surveillance plans are generally developed by the treating oncologist in line with the Optimal Care Pathway. Nurses, Cancer Care Nurse Practitioners, nurse practitioners, and care coordinators may support communication, patient education, appointment coordination, symptom monitoring, psychosocial screening, and escalation where follow-up barriers arise.
66. The absence of clear local responsibility for communication and follow-up can create inconsistency and unrecognised workload.
67. The ANMF recommends that Chapter 7.1 encourage services to clearly identify responsibility for handover communication and patient follow-up, with use of locally appropriate templates or processes that support continuity of care.
68. Psychosocial monitoring is included but would benefit from clearer referral and escalation guidance. The Guidelines should recognise that psychosocial support may involve nurses, Cancer Care Nurse Practitioners, nurse practitioners, general practitioners, psychologists, cancer support organisations, and other community-based services, depending on the person's care setting and stage of follow-up.
69. The absence of finalised guidance on human papillomavirus co-testing represents a gap. The guideline acknowledges uncertainty regarding the role of human papillomavirus testing and cytology but proceeds with conditional recommendations that may confuse clinicians and survivors.



70. Access considerations, including telehealth, are not sufficiently integrated.
71. The ANMF recommends clearer coordination responsibilities, stronger referral and escalation guidance for psychosocial needs, resolution of clinical uncertainty relating to human papillomavirus co-testing, and inclusion of access-focused care models, including shared-care and virtual-care options.
72. The ANMF notes that quality of life and adverse event monitoring will be addressed in Chapter 7.2 in Stage 2 consultation and signals its intention to engage in this process.

Feedback on Chapter 10: Unanswered Questions and Future Research

73. The ANMF supports the inclusion of Chapter 10.
74. Workforce-focused research questions are absent despite reliance on nursing, midwifery, Cancer Care Nurse Practitioner, nurse practitioner, nurse-led, midwife-led, and nurse practitioner-led models.
75. Integration of patient-reported outcomes into nursing-led and shared-care models is not addressed.
76. Equity considerations in surveillance research are limited.
77. The ANMF recommends inclusion of research on nursing, midwifery, Cancer Care Nurse Practitioner, and nurse practitioner workforce models, patient-reported outcomes, antenatal screening pathways, regional shared-care models, nurse-led models, nurse practitioner-led models, virtual-care models, and equity-focused care delivery.



Conclusion

78. The ANMF considers that the Guidelines provide a clinically robust framework for cervical cancer care, supported by the Optimal Care Pathway for Women with Cervical Cancer.
79. However, there is a consistent gap across all chapters in the explicit recognition of workforce requirements necessary for implementation. This includes funded education and training, organisational support, protected time, and the resourcing required to deliver culturally safe care for First Nations patients and inclusive care for gender-diverse patients. As currently drafted, the Guidelines are clinically useful but not operationally complete.
80. The Guidelines refer to nursing roles but do not recognise the nursing and midwifery contribution in the manner required for implementation. They do not adequately identify the qualifications, experience, scope of practice, advanced practice capability, resourcing, governance, training, and support required for these roles. Nor do they clearly articulate how midwives, nurses, cancer care nurse practitioners, and nurse practitioners to lead, coordinate, assess, educate, escalate, and support care safely.
81. This creates and reinforces reliance on existing workforce capacity, leading to increased workload, work intensification, unpaid labour, burnout risk, and workforce strain.
82. The ANMF reiterates that there is a clear relationship between workforce conditions and patient safety and quality outcomes¹³¹⁴¹⁵.
83. Workforce capacity is a foundational requirement for implementation. Without explicit integration of workforce considerations, including recognition of specialised nursing and midwifery knowledge, qualifications, scope, and advanced practice roles, the Guidelines risk being clinically sound but operationally incomplete.

¹³ Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., et al. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet*, 383(9931), 1824–1830.

¹⁴ Needleman, J., Buerhaus, P., Pankratz, V. S., Leibson, C. L., Stevens, S. R., & Harris, M. (2011). Nurse staffing and inpatient hospital mortality. *New England Journal of Medicine*, 364(11), 1037–1045.

¹⁵ Duffield, C. M., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., et al. (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research*, 24(4), 244–255.



84. The ANMF calls for workforce considerations to be integrated across all chapters, including recognition of nursing, midwifery, Cancer Care Nurse Practitioner, nurse practitioner, nurse-led, midwife-led, and nurse practitioner-led models; assessment of workload implications; case studies or practical implementation examples; and alignment with safe staffing and resourcing requirements.
85. The ANMF further recommends that the Guidelines strengthen their practical application in regional, rural, and remote services, including clearer referral pathways, shared-care models, nurse-led models, nurse practitioner-led models, community-based management options, virtual-care options, and evaluation of access pathways.
86. The ANMF strongly emphasises that embedding workforce, safety, and equity considerations is essential to ensuring the Guidelines are deliverable in practice and achieve their intended outcomes for patients and the workforce.