COST Challenges for MCH Services:

Discussion Paper October 2025

MUNICIPAL ASSOCIATION OF VICTORIA

THE MUNICIPAL ASSOCIATION OF VICTORIA

As the peak body for the Victorian local government sector, the Municipal Association of Victoria (MAV) offers councils a one-stop shop of services and support to help them serve their communities.

ACKNOWLEDGEMENT

The MAV thanks Allison Kenwood Consulting, the Strategic Advisory Reference Group, and the many professionals across Victoria whose generous insights, expertise, and collaboration ensured this discussion paper reflects the diverse realities and needs of councils delivering essential MCH services.

ACKNOWLEDGEMENT OF COUNTRY

The Municipal Association of Victoria acknowledges the Traditional Owners of Country throughout Victoria and recognises their continuing connection to lands, waters, and culture. We pay our respect to Elders past and present who carry the memories, traditions, cultures, and aspirations of First Peoples, and who forge the path ahead for emerging leaders.

We acknowledge the important role of cultural practices that have supported the health and wellbeing of mothers, families and their babies for thousands of years.

We support local governments' commitment to strengthen relationships with Victoria's First Peoples communities and to encourage greater unity, knowledge, cultural awareness and respect for First occupants of our land – through its strong community links and local representation.

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This discussion paper has been prepared by the MAV. The MAV thanks the Strategic Advisory Reference Group and the many professionals across Victoria whose generous insights, expertise, and collaboration ensured this paper reflects the diverse realities and needs of councils delivering essential MCH services

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1. Executive Summary

Victoria's Maternal and Child Health (MCH) service is a pillar of our public health system and contributes significantly to health, education, social, and economic outcomes across the community.

In addition to the outcomes for children enrolled, both direct health outcomes and early development and education, the MCH service forms a vital social glue. For many parents, their key peer groups and support networks begin with MCH-organised parent and play groups. In the context of growing distrust of government, the benefit of parents receiving support and care through a public system at one of the most challenging stages of their lives can't be underestimated.

There is growing concern among Victorian councils that the funding model for MCH services is approaching a tipping point where they will no longer be able to provide an appropriate level of service.

This discussion paper proposes a model to secure the future of MCH services delivered locally, through:

- An immediate uplift and revised indexation of the base unit cost
- Adjustment of funding on a council-by-council basis on objective criteria to reflect the factors affecting the cost of service delivery
- Funding for professional development for nurses
- Support to improve clinical governance

We also propose further exploration of a model for funding infrastructure, and additional nuance to a funding model to recognise the varying capacity of councils to contribute to the cost of the service.

Without substantial reform, councils will be compelled to reassess the viability of delivering Maternal and Child Health (MCH) services, potentially leading to service reductions or complete withdrawal. Such outcomes would significantly undermine community wellbeing, eroding access to vital early childhood supports and placing additional strain on families, health systems, and local networks.

Should councils withdraw from MCH service provision, the state would face a substantial and immediate burden, not only in replicating service delivery, but in absorbing the operational, infrastructure, and administrative costs currently underwritten by local government. Councils contribute far more than direct funding; their embedded support through facilities, systems, and workforce integration represents a critical, yet largely unquantified, pillar of the service model. To date, the true scale and strategic value of these contributions have not been adequately recognised, placing future planning and reform efforts at risk.

The sector presents a clear, three-year implementation strategy to restore and sustain universal Maternal and Child Health services, beginning with an urgent uplift to the base unit cost, wage-based indexation, and infrastructure support in Year 1. This workforce-driven funding ask responds to escalating pressures on service continuity, equity, and retention. Years 2 and 3 build in clinical governance, professional development, and long-

term sustainability mechanisms. The strategy is structured, costed, and actionable, ensuring the sector is not simply flagging a risk, but offering a solution ready for implementation.

Current Funding Context

Victoria's Maternal and Child Health (MCH) services are delivered through a co-funded partnership between state and local government, with operational funding to councils via formal agreements estimated at approximately $100 million in 2024–25. Over the past five state budgets, total Victorian Government investment in MCH has increased from $134 million to $189 million annually, with the majority of this uplift continuing to flow directly to councils, who remain the primary delivery partners. The remaining investment supports the state's direct functions, including the 24-hour MCH line, Aboriginal MCH programs, statewide resources, administration, and sector-wide initiatives such as the biannual conference. It also encompasses funding for non-council providers.

Despite this layered structure, the scale and strategic value of council contributions, both financial and in-kind, remain under-recognised in broader funding discourse. We estimate council contributions to the service cost to be approximately $115 million per year[1].

The intended funding model for MCH services establishes a 50:50 cost-sharing arrangement between councils and the Victorian Government for the core functions of the Universal MCH Service. The Victorian Government is solely responsible for funding the Enhanced MCH Service and any supplementary components added to the Universal service. Based on these principles, councils' total financial contribution should fall well below half of the combined cost of Universal and Enhanced MCH services.

In practice, councils are contributing well above their nominal 50% share of MCH service costs, often absorbing the majority of total expenditure once extensive in-kind contributions such as infrastructure, systems, and workforce support are accounted for. This structural imbalance is compounded by the fact that the Victorian Government's contribution has not kept pace with rising service demand, wage growth, and the increasing complexity of family needs. Therefore, the proposed uplift to the base unit cost should be cost-neutral to councils. It simply realigns funding with the true cost of service delivery, recognising the depth of council investment already embedded in the system.

The funding framework has evolved significantly since the 2016 Memorandum of Understanding (MoU), which established a specific unit cost subject to indexation arrangements. The current MoU has shifted towards a more principles-based approach, moving away from rigid cost specifications whilst maintaining the fundamental shared responsibility model between state and local government.

This shared investment model reflects a broader economic truth: funding universal MCH services is fiscally smart. The first six years of life offer an unmatched return on investment, with universal programs, such as immunisation, developmental checks, and maternal support, reducing long-term costs in acute care, disability, justice, and welfare. Universal

[1] Estimated totals of Victorian Government and council contributions are derived from projecting information available from a subset of councils across the whole of Victoria based on proportion of children enrolled in the service.

access also avoids the administrative burden of targeted models, ensuring all children receive foundational supports that build resilience and reduce future service dependency. In short, spending early saves later, and positions government as a proactive steward of public value.

The Cost Challenge: A Growing Disparity

Analysis of service delivery costs reveals a concerning trend of escalating expenses that outpace current funding arrangements. The unit cost analysis demonstrates the magnitude of this challenge:

- 2016-17 unit cost: $110 per service hour
- 2024-25 current unit cost: $137.72 (representing a 25.2% increase)
- When indexed to Consumer Price Index: $140.14 (27.4% increase)
- When indexed to state hourly wages: $156.73 (42.5% increase)

These figures highlight that even basic indexation has failed to keep pace with the real cost of service delivery, particularly when considering wage growth in the health sector.

Without immediate new investment and wage-based indexation, councils will struggle to sustain Victoria's universal Maternal and Child Health (MCH) services, posing an urgent, system-wide risk to early childhood outcomes, workforce stability, and cost containment. The erosion of universal access would increase preventable hospitalisations, delay developmental support, and drive long-term costs across health, education, and child protection systems. As a co-funded, council-led platform, MCH is foundational to Victoria's prevention architecture; its sustainability is critical and cannot be deferred.

It is also clear that the practice to date of having a singular unit cost applied across the state is incompatible with an equitable and universal MCH service. Both the costs of delivery and the capacity to fund shortfalls vary greatly from council to council.

We are proposing the following components as part of a contemporary MCH funding model:

- An immediate uplift to the base unit cost for the universal service
- An examination of whether a separate unit cost needs to be implemented for the enhanced service
- Actual unit costs determine funding to be varied at a council-by-council level to represent the varying costs of service delivery
- Indexation of the base unit cost reflecting the increase in hourly rate for an MCH nurse under the public health sector EBA
- Supplementary funding targeted at infrastructure, professional development, leadership development and clinical governance
- Development of further measures to ensure equity of service is achieved for all Victorians, recognising the varying capacity of councils to fund services from general revenue.

This discussion paper is intended as a starting point for collaborative exploration. We are keen to work with the Department and councils to further develop options and scenarios that reflect shared priorities and the principles outlined here.
One such option is the development of regional partnerships to deliver Maternal and Child Health (MCH) services. These models may offer a strategic pathway to achieving economies of scale, particularly for rural and regional councils grappling with workforce shortages and funding constraints. By pooling resources, councils can streamline service delivery, enhance clinical coverage, and reduce duplication, while retaining local responsiveness. Regional approaches also support long-term sustainability through shared governance, coordinated workforce planning, and scalable infrastructure investment across catchments.

However, current funding challenges require urgent attention to safeguard the sustainability and equity of MCH services across Victoria. Without significant intervention, the data indicate the sector faces:

- Continued erosion of service capacity relative to community need
- Increasing inequity in service availability and quality
- Potential withdrawal of services by councils unable to meet unfunded cost escalations
- Risk to workforce retention and attraction in underfunded areas, particularly given that Maternal and Child Health services rely on highly qualified professionals, registered nurses with midwifery and post-graduate qualifications, who are increasingly drawn to better-remunerated roles in other parts of the health system. The loss of such expertise threatens service continuity, clinical quality, and long-term sector sustainability.

The evidence clearly demonstrates that current MCH funding arrangements are inadequate to support sustainable, equitable service delivery across Victoria. The gap between funding and actual costs has reached a critical point where immediate action is required to prevent service deterioration and ensure that all Victorian families have access to quality MCH services regardless of their local government area's financial capacity.

The path forward requires honest acknowledgement of the funding shortfall, coupled with collaborative effort between state and local government to develop sustainable solutions. Even achieving the modest goal of matching 50% of councils' actual costs in the Universal program would require doubling current funding levels, highlighting the scale of the challenge and the need for decisive action.

The government's response to ongoing inquiries into local government funding and services will be crucial in determining whether Victoria's MCH services can continue to meet community needs effectively and equitably into the future.

2. Implementation Strategy

The sector is not simply flagging a risk; it is offering a structured, three-year solution to restore and sustain universal Maternal and Child Health services. The phased implementation strategy begins with an urgent uplift to the base unit cost (proposed at

100% to $275, aligned with Taylor Fry data), alongside wage-based indexation, infrastructure support, and council-level cost variation. This workforce-driven funding ask reflects the true cost of delivery and responds to escalating pressures on retention, service continuity, and equity. Phases 2 and 3 build in clinical governance, professional development, and long-term sustainability mechanisms, making the phasing clear, actionable, and fiscally responsible from Year 1

Phase 1 (Year 1):

- Base unit cost uplift of 100% on 2024-25 levels to $275 to bring it in line with our estimated median cost of delivery based on the Taylor-Fry survey
- Council-by-council unit cost variation based on VLGGC cost adjustors
- Implement indexation of base unit cost tied to public health sector EBA increases
- Introduce infrastructure support funding
- Development of clinical governance toolbox

Phase 2 (Year 2):

- Implement professional development funding
- Rollout of clinical governance toolbox, clinical governance framework and reporting, and clinical governance funding to councils
- Development of the equity of service component

Phase 3 (Year 3):

- Full model operational with all supplementary streams
- Comprehensive review and adjustment based on implementation experience
- Development of longer-term sustainability mechanisms including full review of the base unit cost and equity of service measures

Funding Impact Analysis:

This enhanced model would increase state investment by approximately:

- Initial base unit cost uplift: ~$100 million annually
- Council-by-council variation – Roughly budget neutral[2]

[2] Our modelling indicates that applying a council-by-council varied unit cost would be roughly neutral to the Victorian Government budget as those receiving below the base unit cost largely balance out those services receiving above the base unit cost

- Infrastructure support: ~$15 million annually
- Professional development: ~$10 million annually
- Clinical governance support: $400k in year one then $1.8 million annually

  Total additional investment: ~$127 million annually

Quality Assurance Mechanisms:

- Annual reporting on fund utilisation across all streams
- Outcome-based measures tied to service quality and accessibility
- Regular review of the additional targeted funding rates based on actual cost data
- Integration with existing MCH data collection and reporting systems

Benefits of This Approach:

- Addresses the fundamental funding shortfall whilst recognising legitimate cost variations
- Provides transparency and accountability through separate funding streams
- Supports service quality improvement through dedicated professional development and clinical governance funding
- Acknowledges council infrastructure contributions explicitly
- Creates incentives for continuous improvement and best practice sharing
- Maintains flexibility to adjust individual components without disrupting the entire model

3. A new base unit cost

Our analysis of the cost to deliver service draws upon the responses councils provided to a detailed costing survey conducted by Taylor-Fry.

The survey revealed significant variations in effective unit costs between councils, but what is clear is that the current unit cost is unsustainable.

Numerous factors have contributed to cost escalation in the MCH service including:

- Expanding the scope of MCH services beyond traditional models
- Increased client complexity requiring more intensive interventions
- Integration with broader health and social services reforms.
- Technology and equipment upgrades necessary for contemporary practice

Among respondents, the median cost of delivering an hour of the Universal Maternal Child Health (UMCH) service was, after applying indexation, more than double the current unit cost.

That is, for half of the councils that responded, the current unit cost reflects less than half of the actual cost to deliver the service.

Only three out of thirty-six respondents where an effective UMCH unit cost could be established were in a position where the unit cost matched their contribution to the UMCH service (see figure 1).

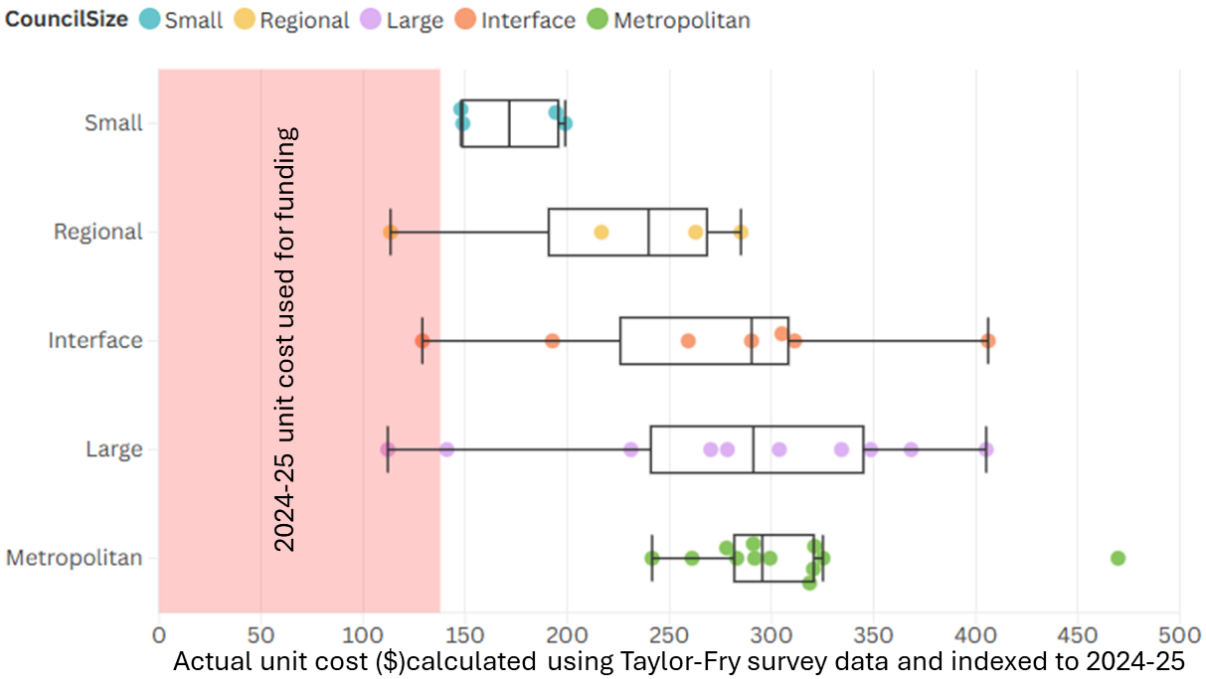


Figure 1

Our proposal is an immediate uplift of the unit cost to the median cost of service delivery for the universal service reported in the Taylor-Fry data. This would provide a more sustainable baseline for councils to operate on while further options are considered.

In our analysis, we also found major variations between the reported cost to deliver the universal and enhanced services.

Of the thirty-one respondents where we were able to identify standalone delivery costs for a unit of UMCH service and a unit of EMCH service:

- Six respondents reported both streams falling within 10% of one another
- Fifteen reported EMCH being at least 10% cheaper to deliver per hour of service than UMCH
- Ten reported EMCH being at least 10% more expensive to deliver per hour of service than UMCH

A further area of inquiry is whether it is appropriate to maintain a single unit cost across both the UMCH and EMCH portions of the service, or whether separate figures should be determined.

4. Cost Adjustors

The Victorian Local Government Grants Commission uses a series of cost adjustors in calculating the distribution of Financial Assistance Grants. These may serve as a useful indicator of the variation in costs of delivering services. In adopting this approach, there would be a base unit-cost applied state-wide, but the actual unit cost informing funding to individual councils would be modified by their cost adjustor.

For Family & Community Services, of which Community Health (and thus MCH) is a part, the adjustors used are:

Measure	Weighting
Indigenous Population	10%
Language	10%
Population Dispersion	20%
Population Growth	10%
Population Under 6 Years	30%
Socio-Economic	20%

Population Under 6 Years is addressed directly in projecting required service hours, so should not be included in a measure of cost per unit. If we remove it and redistribute that weighting to the remaining categories, we arrive at the following.

Measure	Original	Adjusted
Indigenous Population	10%	**14%**
Language	10%	**14%**
Population Dispersion	20%	**29%**
Population Growth	10%	**14%**
Population Under 6 Years	30%	**NA**
Socio-Economic	20%	**29%**

The adjustors applied within these categories using 2024-25 VLGGC data are presented in Figure 2.

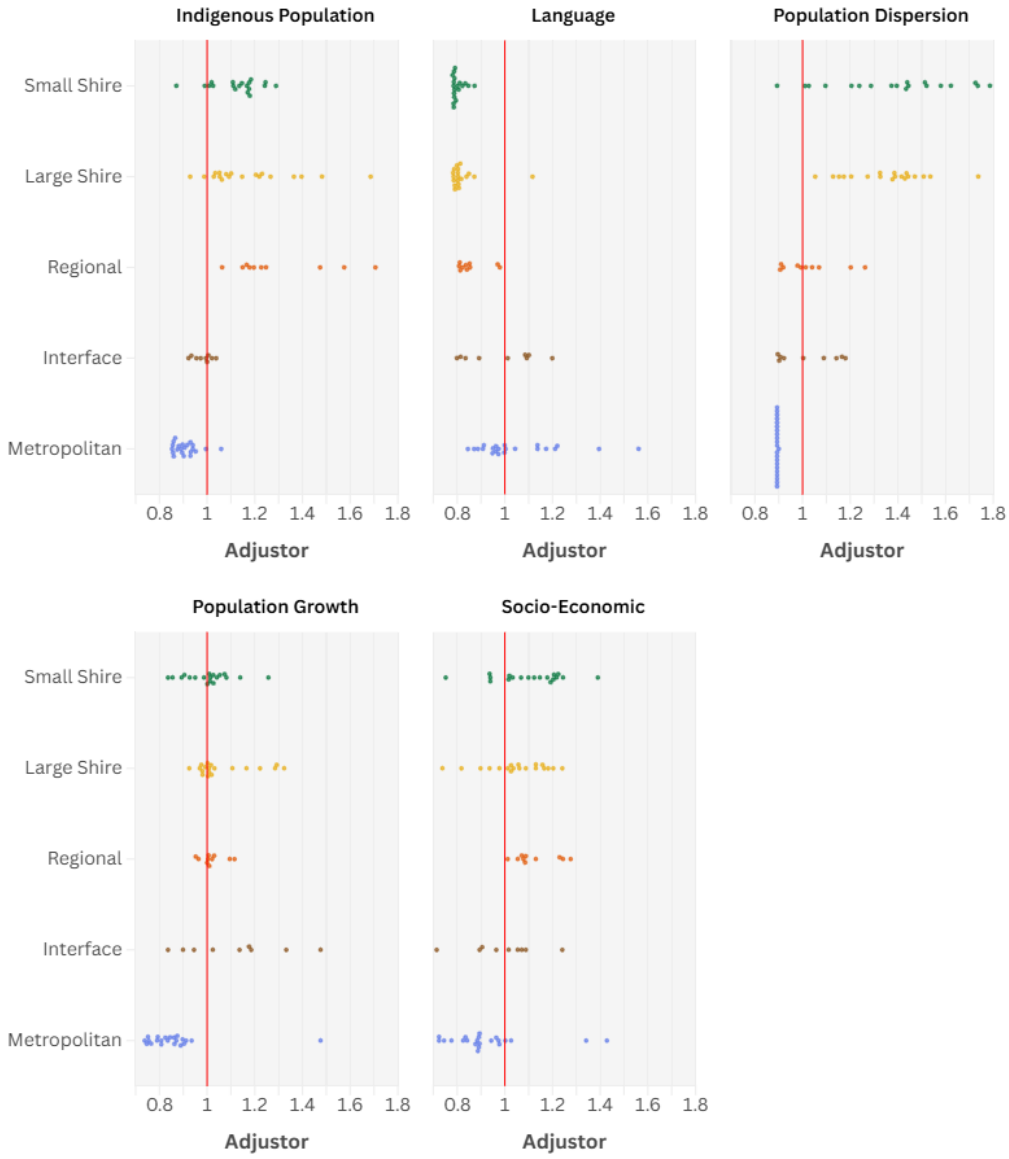

Potential cost adjustors for MCH funding
Above 1 indicates more expensive to deliver a unit of service, below 1 indicates less expensive
Indigenous Population
Language
Population Dispersion
Population Growth
Socio-Economic
Small Shire
Large Shire
Regional
Interface
Metropolitan
0.8
1
1.2
1.4
1.6
1.8
Adjustor

Figure 2

When the weighting is applied, this results in the following composite cost adjustors.

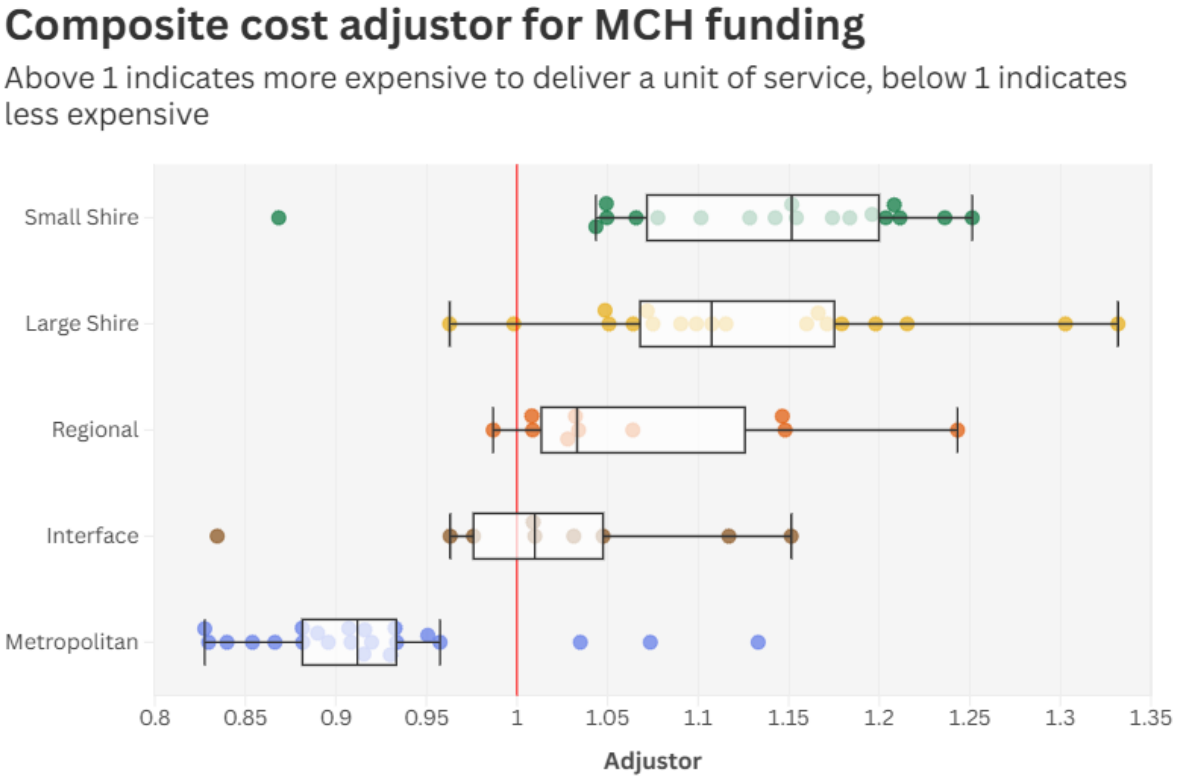


Figure 3

Distribution of composite adjustors

Council group	25th percentile	50th percentile	75th percentile
Small Shire	1.07	1.15	1.2
Large Shire	1.07	1.11	1.18
Regional	1.01	1.03	1.13
Interface	0.98	1.01	1.05
Metropolitan	0.88	0.91	0.93

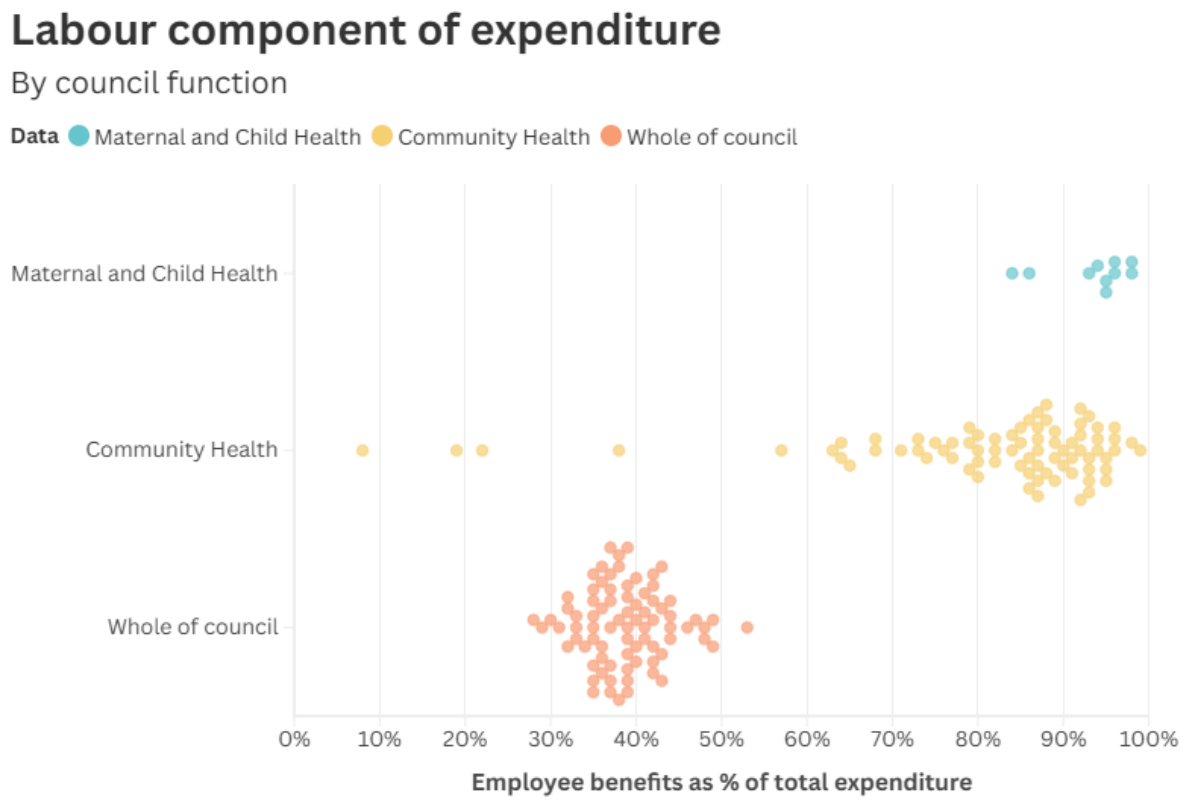
Figure 4

There is significant variation within council categories in the composite cost adjustor. The most stark among these from a service delivery point of view are the three metropolitan outliers. These are driven by a combination of language diversity, socio-economic status, and population growth. Our view is that these differences within categories necessitate the use of council-by-council variations to the base unit cost, rather than variations by group.

5. Indexation

To date, year-by-year indexation has been tied largely to the Consumer Price Index.

Going forward, indexation should instead be tied to a measure of labour cost, as this is by far the largest component of MCH expenditure.



Data sources: MAV Survey (MCH function); Victorian Local Government Grants Commission Council Expenditure Survey (Community Health function and whole of council)

Figure 5

Figure 5 shows that MCH cost is largely driven by employment expenses – around 80-95% for those councils surveyed. The broader Community Health function, which MCH services sit within is also substantially more employment expense concentrated than councils as a whole.

These figures make sense in the context of a service-heavy function, which is largely undertaken by highly qualified staff. Victorian MCH nurses are required to have a triple qualification – Registered Nurse, Registered Midwife, and a postgraduate qualification in child and family health.

Victoria is alone in councils employing a significant number of MCH nurses. The largest competitors for the MCH workforce are the Victorian Government and other State and Territory Governments.

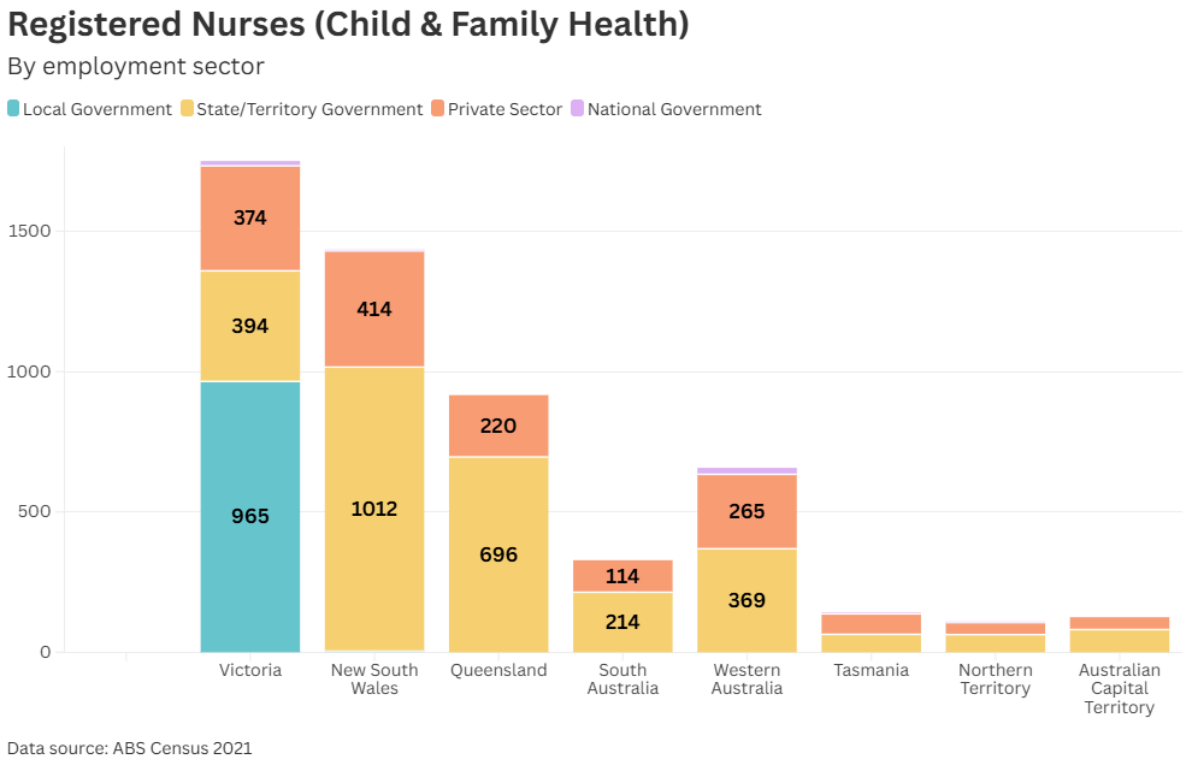


Figure 6

Given these factors, the appropriate measure of indexation is the yearly increase in base allowance for an MCH nurse under the public health sector EBA. The outcomes of bargaining between the Victorian Government and a major union, such as the ANMF, represent a fair cost of labour and reflect the wage pressures councils will face in attracting and retaining staff.

Figure 7 summarises the outcomes of the most recent EBA and thus our proposal for indexation going forward in the immediate future. The 12.71% increase locked in for 2027 points to the challenge for councils in attracting and retaining staff under the current funding model getting much larger in the near future.

Yearly increase to MCH base rate under the *Nurses and Midwives (Victorian Public Health Sector) Single Interest Employer Enterprise Agreement 2024-28*			
2024	**2025**	**2026**	**2027**
5.00%	4.22%	4.09%	12.71%

Figure 7

6. Additional targeted funding

In addition to the base funding delivered through unit costs, we believe transparency, equity, and effectiveness of key elements of service delivery would be improved by separate targeted funding streams.

Professional Development and Leadership Enhancement

- Dedicated funding for workforce capability and service quality improvement
- Annual allocation of $8,000 per equivalent full-time MCH nurse for:
    - Continuing professional development and training
    - Leadership development programs
    - Conference attendance and knowledge sharing
    - Supervision and mentoring support
    - Estimated cost $8 million annually
- Additional $2 million funding to establish a statewide leadership development program for emerging and existing MCH coordinators.

These amounts are significant but reflect the needs of the profession. MCH nurses are required to undertake 40 hours (20 hours nursing and 20 hours midwifery) of compulsory professional development yearly to maintain their registration with AHPRA. This funding would go towards the direct cost of undertaking professional development, as well as ensuring appropriate cover is in place to maintain service continuity.

A statewide leadership development initiative will centrally design and deliver high-impact professional development, equipping senior MCH leaders with the skills, networks, and clinical governance capabilities needed to navigate increasing service complexity, drive workforce sustainability, and strengthen system-wide outcomes. This funding would go towards the direct cost of undertaking professional development, as well as ensuring appropriate cover is in place to maintain service continuity.

Clinical Governance Support

- Separate funding stream to strengthen clinical oversight and quality assurance
- Multi-component approach:
    - $400,000 as a once-off investment to develop a clinical governance toolbox available for councils to use as a largely “off-the-shelf” solution. This could include policies and procedures as well as tools for demand and workforce modelling to promote improved service planning.

- $250,000 annually to maintain the clinical governance toolbox and explore quality improvement projects and innovation opportunities in partnership with council0073
- $20,000 annually per council for fulfilling clinical governance requirements (implementing and reviewing policies and procedures, incident management, etc.)

- Per-council funding would be tied to participation in state-wide clinical governance framework and reporting.
- The clinical governance toolbox is intended to reduce duplication and improve consistency across the sector, as well as particularly alleviating the burden on smaller councils who face governance requirements comparatively large to their staffing levels.

Our estimates of the cost of these additional funding streams are as follows

Stream	**Annual cost**
Professional development	$8 million
MCH Coordinator development	$2 million
Clinical governance	$1.8 million ($400k in the first year for initial development of the toolbox)
TOTAL	**$12 million**

In addition to this, there is a need for infrastructure support. It has been challenging to determine the infrastructure needs driven by the MCH service, particularly with an increased prevalence of facilities shared across multiple functions, such as early years hubs.

We would welcome the opportunity to work further with the Department and councils on a viable model that provides ongoing support for MCH infrastructure. We believe such a fund should be indexed to an appropriate measure, such as the Producer Price Index for Non-Residential Building Construction.

7. Equity of service

One of the primary challenges in developing a new funding model has been the degree to which councils are currently funding well beyond their intended share of 50% of the universal service.

In examining data from the Taylor-Fry survey cost of service delivery in metropolitan councils was consistently above that in rural and regional areas. This trend remained even after controlling for hourly wages and overhead proportions.

In speaking to numerous experienced MCH nurses, managers, and directors, and particularly those with experience in both metropolitan and rural settings, there was a very clear message that delivering an equivalent service in a rural area costs more than doing so in a metropolitan one.

The reason the data does not reflect this is simple and yet difficult (if not impossible) to correct for:

- The base unit cost is insufficient to deliver the type of service communities expect.
- The capacity of councils to fund beyond their 50% varies greatly across the sector.

When examining the Taylor-Fry data, this has the effect of inflating the apparent cost of service delivery. Rural councils are not delivering a service cheaply; they are delivering the service to the extent that they can, generally significantly below metropolitan councils.

This poses a major challenge for a service intended to be universal across the state. We have developed two potential approaches to address this: revenue adjustors and minimum service levels.

Revenue adjustors

In addition to cost adjustors, the VLGGC utilises several revenue adjustors. In the case of the VLGGC, these are intended to represent the capacity of the council to raise non-rate revenue through fees and charges associated with a given function. MCH is a different scenario; there is no user charge attached. Whatever is not funded through grants is funded through general rates.

For MCH, what we need is something to represent the capacity of councils to fund a share of the MCH service through their rate base. This could then be applied as a further modifier to the base unit cost, effectively implementing a system where councils with a healthy revenue base contribute 50% of the cost of universal service. Councils with a lesser revenue-raising capacity would contribute less than 50%. Grant programs across different portfolios are increasingly looking at varied co-contribution requirements to reflect varying council capacity.

An initial option to examine would be the ratio of residential rates collected to household income within the municipality.

Minimum service levels

An alternative approach would be to develop a set of minimum service standards and ensure the funding model is sufficient to meet them state-wide.

This would be a complex process and should involve consideration of at least:

- Workload ratios
- Client-facing vs non-client-facing time split
- Management structure
- Leave coverage
- Administrative support

Part of this would be the development of a consistent workforce modelling tool across the sector, which the MAV is currently exploring.

8. Conclusion

Victoria's Maternal and Child Health (MCH) system stands at a critical juncture. The evidence presented in this paper underscores a widening gap between the cost of service delivery and the funding mechanisms intended to sustain it. Without immediate and coordinated reform, councils face untenable financial pressures that risk undermining service quality, workforce stability, and equitable access for families across the state.

This discussion paper calls for a contemporary funding model, one that reflects the true cost of service provision, accounts for local variation, and supports councils to deliver high-quality care without compromising financial sustainability. The proposed reforms are not radical; they are necessary. They offer a pragmatic pathway to restore balance, reinforce shared responsibility, and ensure that MCH services remain a cornerstone of Victoria's public health system.

Crucially, the reform package includes a statewide leadership development program for emerging and existing MCH coordinators, recognising that workforce capability and clinical governance are central to service resilience. This investment in leadership is not ancillary; it is foundational to sustaining quality, navigating complexity, and embedding system-wide accountability.

Above all, this paper affirms that MCH, delivered as a full, integrated package, is not a discretionary service. It is an essential, universal platform for every Victorian baby, now and into the future. Its continuity is vital to safeguarding developmental outcomes, strengthening families, and upholding our collective commitment to equity and wellbeing.

The MAV welcomes the opportunity to work with the Department of Health and local government partners to co-design a funding framework that is transparent, responsive, and fit for purpose. Together, we can safeguard the future of MCH services and reaffirm our shared responsibility to Victorian families.

Acknowledgement

The Municipal Association of Victoria gratefully acknowledges Allison Kenwood Consulting and the Strategic Advisory Reference Group members whose diverse insights and feedback across Victoria shaped the challenges and opportunities outlined in this paper.

Council	Name	Title
Bass Coast Shire	Colette McMahon	Manager Community Wellbeing & Culture
Brimbank City	Erin Clark	Manager of Community Care
Casey City	Bronwyn Saffron	Manager Child Youth & Family Services
Central Goldfields Shire	Carolyn Bartholomeusz	Manager Childrens & Families
Glen Eira City	Jane Price	Director Community Wellbeing
Hume City	Anne Mallia	Manager Family Youth & Childrens Services
Knox City	Sarah Kleine	Manager Early Years
Loddon Shire	Nicole Taylor	Executive Manager Family & Children Services
Macedon Ranges Shire	Karen Curson	Manager Community Services
Maroondah City	Marianne Di Giallonardo	Director People and Places
Melbourne City	Vishal (Vish) Tandon	Executive Manager Family & Children Services
Melton City	Lisa Bzovy	MCH Manager
Mitchell Shire	Buffy Leadbeater	Acting Director Strategic Partnerships & Communities
Mildura Rural City	Amanda Boulton	Manager Community Care
Monash City	Sharon Bahn	Manager Children, Youth & Families
Moorabool Shire	Rhona Pedretti	Manager Community Connections & Wellbeing
Mornington Peninsula Shire	Cheryl Casey	Director Community Strengthening
Shepparton City	Stacey East	Manager Early Years Operations and Reform
South Gippsland Shire	Shelley Fixter	Acting Manager Community Health & Safety
Strathbogie Shire	Rachel Frampton	Director Community & Planning
Whittlesea City	Amelia Ryan	Manager Children and Families
Wodonga City	Nic Byrnes	Manager Child and Family Services
Wyndham City	Melinda Chapman	Manager Community Support
Yarra City	Angela Morcos	Manager Family, Youth & Children's Services
Yarra Ranges Shire	Jane Sinnamon	Manager Community Support
Yarriambiack Shire	Tim Rose	Chief Operating Officer

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knowledge, and frontline insights to ensure this discussion paper reflects the diverse experiences, contemporary realities, and needs of Victorian councils delivering essential MCH services

MCH Service Reflections from the MAV MCH SRG

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