Feedback on Antenatal Care Guidelines

Our feedback on the Guidelines is as follows. The Grey highlights reference the Section of the Guideline and the following text is our feedback on that section. We have focused our feedback on any omissions we notice and on any items that require correction or further thought. Aside from a few items, we will refrain from providing feedback on the things we find positive about the Guideline and it can be assumed that if we have not commented on a particular section, we have found no obvious fault with it. We also provide an overall assessment in the final paragraph.

1. Optimising Antenatal Care

FEEDBACK:

We are glad to see that an entire section has been devoted to the care of Aboriginal & Torres Strait Islander women.

1.1.2 Providing woman centred care

Providing information and support so that women can make decisions

Involving women in decision-making about their health care during pregnancy has been endorsed as a key feature of good quality maternity care (Chalmers et al 2001). However, there is indirect evidence that, in some settings, Aboriginal and Torres Strait Islander women have fewer opportunities to be involved in decision-making than non-Indigenous women, or than is desirable (Hunt 2003). This may be improved through providing information to women in a culturally appropriate way and providing strategies to help them achieve positive change (Clarke & Boyle 2014).

FEEDBACK:

The topic of informed decision making, informed consent and refusal needs to be addressed here. Woman are the PRIMARY decision makers in their care and we need to explicitly state that. By saying 'involving women in decision making' you are making it sound as though 'other people' i.e doctors, midwives, partners, family members get to have a say in her care to and get a 'vote' in the decisions she makes. Care providers can empower women to make informed decisions for themselves by talking to them and providing them with necessary evidence-based information that includes all the benefits, risks and alternatives, delivered in a way that ensures the woman understands it and is able to make an informed decision with it. All women should be given general information at the outset of their maternity care about the meaning of informed consent and their rights to receive all of the information they need in order to make informed decisions. This should include a clear statement that the woman can refuse to follow advice and recommendations. This information should also be provided whenever a decision needs to be made during a woman's maternity care.

1.1.3 Successful models of antenatal care for Aboriginal and Torres Strait Islander women

FEEDBACK:

We whole-heartedly agree with the reference to Continuity of Midwifery Care models as successful models of care that have been shown to improve out comes for Aboriginal & Torres Strait Islander women.

1.1.8 Improving Outcomes

FEEDBACK

Include in the list of approaches to improve the health outcomes for Aboriginal women and their babies in pregnancy:

- Put into practice the successful models of care outlined in section 1.1.3 Successful models of antenatal care for Aboriginal and Torres Strait Islander women.

2. Lifestyle Considerations

2.1 Substance use

This section has failed to address the need for building a trusting relationship with the woman, which could be achieved through Continuity of Midwifery Carer in conjunction with other community service providers. In order to encourage the woman to disclose any relevant information and seek additional support and care, she needs to feel she can do so without fear of judgement and being 'reported'. If we want better outcomes for women and babies our primary purpose must be to care for them in the most appropriate way that address' all the needs of the mother and baby.

In the Practice Summary of this section, there is a huge focus on documentation, reporting and discussing the harmful effects of substance use with the woman. There needs to be an equal focus on the importance of developing a caring, non-judgemental relationship of mutual trust between the woman and the care provider and connecting her with a multi-disciplinary team of care providers to care for her unique needs.

This research listed below provides great guidance based on evidence and examples of practical things that can be done to achieve this:

"Supporting pregnant women who use alcohol and other drugs" June 2015, Dr Courtney Breen, Research Fellow at NDARC.
http://connections.edu.au/researchfocus/supporting-pregnant-women-who-use-alcohol-and-other-drugs

3. Clinical Assessments

3.1 Weight and body mass index

Pre-pregnancy weight and weight gain during pregnancy are important determinants of the health of both mother and baby.

There needs to be additional language used in this sentence such as "but are not the only determinants".

This entire section is based on very weak evidence and only a consensus based recommendation. There needs to be a recommendation that informed consent is required from a woman before measuring her weight and taking her BMI as a routine practice in her pregnancy and that the woman needs to be encouraged to make the decision for herself.

We call in to question a lot of the studies and existing Guidelines that have been referenced here and ask that the very poor studies and reference to existing Guidelines be removed from mention in this Guideline.

Routine weighing of women from the first antenatal visit disempowers the woman and calls in to question her body's ability to safely carry, birth and feed a baby, for no good reason. There is no evidence to show that routine weighing improves outcomes for mothers and babies at all and therefore, should not be a recommendation.

4.2 Diabetes

This section is full of contradictory statements. Under the heading of "Lifestyle interventions for preventing gestational diabetes" there is suggestions for women engaging in physical activity and changing their diets. However, the Qualified Recommendation (No. 7) that immediately follows those suggestions states:

Advise women that physical activity and healthy eating during pregnancy help to reduce excessive weight gain, but do not appear to directly reduce the risk of diabetes in pregnancy.

We agree that there is a lack of an agreed standard for diagnosing gestational diabetes and based on what we know and the evidence that is available, we would not agree with routine testing of all women. Women that present with contributing risk factors for gestational diabetes may be offered testing, but again, the decision ultimately lies with the woman as the primary decision maker.

A recommendation in the Practice notes should include informing the woman that it is her choice to be tested or not.

Appendices

A & B: Membership and Administrative Report

We note that of the 12 members of the Expert Working Group, there was only ONE (1) consumer representative. We also noticed that the Consumer Representative did not have an organisation of consumers that she 'represented' for. We draw your attention to the definition of a consumer representative as defined by Consumers Health Forum of Australia is:

"*A consumer representative is a member of a government, professional body, industry or non-governmental organisation committee who voices consumer perspectives and takes part in the decision-making process on behalf of consumers. This person is nominated by, and is accountable to, an organisation of consumers."*

This Guideline exists to "provide evidence-based recommendations to support high quality, safe antenatal care and contribute to improved outcomes for all mothers and babies" and therefore has the intention and potential to shape the type of care women can expect to receive during her pregnancy. We would argue that there is a **great** need for **more** consumer involvement in the EWG and to ensure that that consumer involvement is with consumers who can identify with and are accountable to an organisation of consumers to ensure that women, mothers and babies are fairly and accurately represented. We would recommend

that at least three consumer representatives from different consumer organisations are appointed to the EWG.

Overall Comment on Guideline

We would like to see more reference and recommendation made in the Guidelines to:

1. The use of Continuity of Midwifery Care models of care as a model of care that is successful in addressing a large number of the issues discussed in this Guideline. We believe the development of a trusting relationship between the care provider and the woman is the key to successful antenatal care and we know that model of care provides better outcomes for mothers and babies from the beginning of pregnancy throughout the entire continuum. The investment in CoMC models pays dividends for both service providers and women and their families and our greater community.
2. The importance of informed consent/refusal and on a woman's rights needs to be discussed in greater detail. We would like to see a new section devoted to this topic. We know that women who make informed decisions and see themselves as the primary decision makers in their care report better experiences.

Thank you for the opportunity to provide feedback and we look forward to the inclusion of our feedback in the next draft of the Guidelines.

Kind regards,

Maternity Consumer Network Inc.