CHAPTER 2

ANTENATAL CARE

The nature and content of antenatal care

2.1 Antenatal programs vary greatly in their approach, content and the ways in which they are provided. The following discussion relates to antenatal care for the majority of pregnant women - those at low risk. The Committee was advised that they constitute about 80% of all pregnant women. They are healthy, neither very young nor close to the end of their fertile life and have no history of problems in pregnancy or childbirth. Women deemed to be at high risk because of their own health status, previous problems in pregnancy or childbirth or because of concerns about foetal abnormalities require, and normally receive, a different antenatal regime. This will vary for each woman.

2.2 Antenatal care usually has three distinct elements:

- the provision of information about pregnancy and childbirth generally and about arrangements for the birth of individual babies;
- antenatal classes; and
- screening of pregnant mothers.

Each of these elements is discussed later in this chapter and in the following chapter.

2.3 While antenatal screening is normally provided by doctors and specialists in hospitals and surgeries, antenatal education and information are provided by midwives, childbirth educators and other health professionals such as physiotherapists.

2.4 The frequency of antenatal visits also varies greatly. No agreement exists in Australia on the optimum frequency of antenatal visits nor has any link been established between visit schedules and outcomes. Women's Hospitals Australia is currently analysing the variations in visit schedules within its own hospitals to try to reach consensus on best practice.[1]

2.5 Notwithstanding the variations in practice, evidence to the Committee suggests that a typical schedule of antenatal care visits is:

- first consultation during the first 8 weeks of pregnancy;
- monthly visits until 28 weeks gestation;

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1 Submission No. 69, p.7 (Women's Hospitals Australia and Australian Healthcare Association).

- fortnightly visits from 28 weeks to 36 weeks gestation; and
- weekly visits from 36 weeks until birth.

2.6 The purpose of these visits is to monitor the wellbeing of the mother and child during pregnancy. The doctor or midwife records physical signs and doctors order tests as required. They can then act upon any symptoms of illness or abnormality detected in this process.

2.7 An area of increasing concern is the frequency and extent of some sophisticated antenatal screening, and especially ultrasound. This issue is discussed in the next chapter.

Range and provision of services

2.8 Antenatal care may be provided by:

- general practitioners;
- midwives in public hospital clinics or birth centres attached to hospitals;
- midwives in private practice (independent midwives) at the woman's home, for women who will normally deliver at home, at a birthing centre or, more rarely, in a labour ward with the same midwife in attendance;
- obstetricians;
- junior obstetric staff;
- a team which may include people from several of the above groups; and
- a team which may include Aboriginal health workers, for services targetted to indigenous women.

2.9 A range of antenatal care services is available in each State and Territory. The nature of the antenatal care provided to an individual will depend upon the model of care which she accesses, her insured status and the State in which she lives.

2.10 Once a woman has her pregnancy confirmed, normally by her general practitioner, he/she will generally advise her to book into a hospital for the birth. Certain models of antenatal care are unlikely to be available to women without private insurance, for example antenatal care provided by the same obstetrician throughout the pregnancy.

2.11 Women with private insurance are often referred by their general practitioners directly to obstetricians. The general practitioners and specialists may be unaware of other antenatal services. Some submissions argued therefore that women with private insurance in fact have fewer choices than those who do not.

> It should be noted that in many instances public patients [are] better served with choices in models of care generally, while these choices are not denied to private patients they may not be offered as currently happens to public

> patients. Women who elect to be treated by the public hospital have access to Family Birth Centre; midwife care, Team Midwifery model of care, Shared Care Programs with community GPs. Especially for those women who fit into the low risk category. Women with private insurance attending consultant Obstetricians for their care may not always be aware of the choices available to them. Many women attending Private practices fit the low risk category and could well be cared for by GP and midwifery models of care developed specifically to fit the private sector needs.[2]

2.12 Antenatal care provided by an independent midwife is restricted to those who can afford to pay for it, since it is not covered by Medicare and very few private health funds cover the costs.

2.13 Other factors limiting access to the full range of models of care include cost, geographic location and social and cultural appropriateness of services. Women at high risk may be directed to specific services and may therefore not be able to access locally provided services.

2.14 Some antenatal care services formerly funded by State governments have had their funding withdrawn or reduced and they are restricted now to those who can pay for them. This is particularly the case for antenatal classes (known as child birth education in some States) and will be discussed in greater detail in that context.

2.15 There has been considerable interest by consumers, health professionals and administrators in models of 'shared antenatal care,' the objective of which is to ensure that women enjoy continuity of care and/or carer throughout the pregnancy and birth and into the post natal period. It was claimed that such an arrangement is beneficial to women, who have an opportunity to develop rapport with, and confidence in, their carer. As the carer is present at the birth they do not have to give birth surrounded by people they have never seen before.

2.16 Shared care may involve individuals from different professional groups, such as general practitioners and midwives, or a number of people from within the same professional group. Variations on the shared care model are extensive. The Committee was told, for example, that in Victoria alone there are currently 18 models of shared antenatal care.[3]

2.17 The Committee received a number of submissions providing details of existing shared care models of antenatal care and generally extolling their virtues. The following excerpt is from the Team Midwives Model of care based at the John Hunter Hospital in Newcastle, which has since been replicated in a number of other hospitals, including Liverpool Hospital, Cairns Base Hospital and Geelong Hospital.

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2 Submission No. 46, p.5 (The Royal Women's Hospital, Vic).

3 *Committee Hansard*, 27.8.99, p.9 (Department of Health and Aged Care).

> The team functions with seven midwives (5.6FTE's) i.e. four fulltime midwives with three part time midwives.
>
> …One of our main objectives is to provide care in labour with a midwife whom the woman has come to know during the antenatal period. Our latest survey shows that 83% of our clients were supported in labour by a midwife known to them.
>
> …One to one care during labour has been an objective of the team since its beginning. Our latest figures show that 71% of our clients are supported by the same midwife for the entire duration of labour.
>
> The team provides continuity of care across the spectrum of antenatal care, with three clinics provided over morning, afternoon and evening providing flexibility of appointment times on three different days through out the week. This flexibility is not offered by other local service providers. During the antental visits rapport is built, the length of these visits is greater than eight minutes giving the women the opportunity to ask questions and discuss issues of importance to them as individuals. The woman and her family then have with them a midwife that they have come to know when labour begins.[4]

2.18 The merits of continuity of antenatal care provided by a single care giver were described in a number of submissions. These claimed that it was particularly valuable if the same care giver also attended the woman during birth and post natally. In South Australia, for example, the Community Midwifery Program in the Northern Metropolitan Area (funded through the Alternative Birthing Services Program described later in this chapter) provides continuity of carer through pregnancy, birth and the post natal period.

> Each woman will be allocated a primary midwife who will provide her care throughout pregnancy, labour, birth and post natal period, supported by a second midwife providing back-up. A midwife will be available for contact 24 hours a day.[5]

2.19 A similar approach has been adopted at St George Hospital in south Sydney where midwives provide antenatal care from community centres (an early childhood centre, a community centre and a family planning clinic).

> …those women received all their antenatal care in the community with these two teams of midwives and obstetricians. When they came to birth their babies, they came to the hospital and the same midwives came in and cared for them. They were on a 24-hour rotation roster. After the babies were born

4 Submission No. 165, pp.7-8 and pp.1-2 (Team Midwives, John Hunter Hospital).

5 Additional information, 24.9.99 (Community Midwifery Program, SA).

> they went to the postnatal ward or they went home, and they were still cared for by those same midwives.[6]

2.20 Some submissions differentiated between continuity of care and continuity of care giver. Implicitly, if not explicitly, they made the case for a shared care approach.

> I think there are a number of misconceptions and aberrant usages of the term "continuity of care" and my way of getting around this is to differentiate continuity of care from continuity of care giver. The way that I perceive this issue is that continuity of care can occur in a major obstetric unit where policies and clinical paths have been devised by consensus amongst the various care givers to provide a clear and consistent frame of management for the care of maternity patients. This means that every time a new medical officer sees the patient or a new midwife sees the patient they are aware of what has gone before and what is considered the unit policy within that hospital.
>
> Continuity of care giver on the other hand, refers to the same person providing care throughout the whole pregnancy delivery and post natal period. In order to provide continuity of care giver, requires that the obstetrician, GP or independent midwife see the patient for each of their antenatal visits, remain available for 24 hours per day 7 days per week should this patient come into labour at a non scheduled time, then be available for the total duration of their labour which may be up to 36 hours without any breaks and then to regularly see the patient during the post natal period.[7]

2.21 The following excerpt extolling the virtues of continuity of care giver is from a mother who received pregnancy care from the Childhood Information Service, a home birth group in Tasmania. The Committee received many supportive submissions from women associated with this group.

> …the midwife may be able to conduct antenatal visits at the woman's own home. This is an aspect of the service which is rarely available through hospitals, but which can be very convenient late in pregnancy. Certainly, such an arrangement is preferable to a woman failing to appear for her antenatal checks during the final weeks of pregnancy, when complications such as pre-eclampsia may arise and require immediate attention.
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> The continuity of care provided by the midwife throughout the pregnancy, combined with long appointment times (often up to one hour) facilitates the development of a personal relationship…Under the CIS model, the midwife is able to build familiarity and knowledge of the woman and her family, including their values and preferences.[8]

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6 *Committee Hansard*, 14.9.99, p.434 (Midwifery Practice and Research Centre).

7 Submission No. 8, p.2 (Dr Andrew Child, King George V Memorial Hospital, Sydney).

8 Submission No. 36, p.4 (Ms Clarissa Cook, Tas).

2.22 The Committee strongly supports the concepts of shared care and continuity of care. It notes that a number of State and national reports have also supported them. The *Final Report of the Ministerial Review of Birthing Services in Victoria* and the *Final Report of the* Ministerial *Task Force on Obstetric Services in New South Wales* (the Shearman Report)[9] made a number of recommendations concerning the desirability of extending shared care models of antenatal care. So did the National Health and Medical Research Council (NHMRC) Report *Options for effective care in childbirth.* These were Recommendations 5.1 – 5.4, which read:

- Public hospital clinics should be adapted to enable links to be developed with general practitioner obstetricians and midwives to improve shared care.
- Public antenatal clinics should take all steps necessary to enable most women to have continuity of care and carer, in hospital or with a medical practitioner.
- Shared care involving small teams of general practitioners obstetricians and midwives should be encouraged. This should promote satisfaction for both the woman and the service providers.
- Guidelines for shared care should be drawn up locally having regard to State and National guidelines.

2.23 The Committee notes with concern the failure of governments, hospitals and professional groups to act upon the recommendations of these reports. Given the Commonwealth's role in providing national leadership and consistency across States in the provision of services the Committee considers it appropriate that the Commonwealth Government take a leadership role in implementing the recommendations of earlier reports.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to implement the recommendations of the National Health and Medical Research Council as they relate to continuity of care and shared care during pregnancy and birth.

2.24 While most evidence to the Committee was generally supportive of the shared care model of antenatal care and emphasised the importance of continuity of care, a note of caution was expressed by Women's Hospitals Australia and the Australian Healthcare Association. They pointed out the lack of Australian data on the impact of transferring antenatal care from hospital clinics to other centres and the need for a proper evaluation of different models of shared care in different settings throughout Australia.[10]

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9 National Health and Medical Research Council. *Options for effective care in childbirth,* 1996; Health Department of Victoria. *Having a Baby in Victoria,* 1990; *Final Report of the Ministerial Taskforce on Obstetric Services, NSW, 1989.*

10 Submission No. 69, pp.8-9 (Women's Hospitals Australia and Australian Healthcare Australia).

2.25 Dissatisfaction with some models of shared care has also been expressed by Victorian consumers.

> Women indicated a low level of satisfaction with Shared Care in the 1993 Victorian Survey of Recent Mothers (Centre for the Study of Mothers' and Children's Health). In this survey 33% of women receiving Shared Care rated their antenatal care as very good compared with 72% of women attending a private obstetrician, 46% attending a public clinic and 80% who received team midwifery care in a birth centre.[11]

2.26 Even team midwifery care in a birth centre can fail a woman who has chosen it, as was the experience of one witness in Melbourne.

> I blame the system, actually. Even though they are offering you a team of midwives, in reality it really means discontinuity of carer. This girl, this midwife, was on my team but because of the way my antenatal appointments were organised, when it came time for me being in labour she was the one who was there and I had never met her before. She had no idea who I was…So I blame the system. I do not blame her or that team of midwives.[12]

2.27 Potential problems with the shared care model include the possibility of duplication of services or gaps in the provision of services and of test results being lost or not followed up. To overcome these difficulties it has been suggested that antenatal records should be held by the individual woman to whom they refer. A number of witnesses before the Committee supported this recommendation.[13]

> I think a patient held record which involves a multidisciplinary approach and puts the woman at the centre is absolutely the right way to go.[14]

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> That is the beauty of the South Australian woman-held pregnancy record card because each provider potentially provides it to the woman at her first visit so that the range of information that is being provided at that initial visit is the same whether you are visiting a hospital or a GP.[15]

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11 Submission No. 163, p.6 (Department of Human Services, Vic). Refers to 1993 '*Survey of Recent Mothers*' conducted in Victoria by Stephanie Brown and Judith Lumley.

12 *Committee Hansard*, 6.9.99, p.134 (Maternity Coalition, Vic).

13 For example by the NHMRC Report *Options for effective care in childbirth*, Canberra,1996, p. xii.

14 *Committee Hansard*, 6.9.99, p.156 (Royal Women's Hospital, Vic).

15 *Committee Hansard*, 7.6.99, p.254 (Department of Human Services, SA).

2.28 The Committee is aware that patient[16] held maternity records are provided to women in some Australian hospitals and that their use is well established in a number of European countries.

Recommendation

The Committee RECOMMENDS that all pregnant women in Australia be provided with a maternity record by their principal carer giving details of their health as it relates to their pregnancy and any test results or treatment, with a duplicate to be held by their principal carer.

Access to antenatal care

2.29 Antenatal services are widely available, (at least in metropolitan areas), but take up rates are very variable. Access to antenatal care is an issue, where there are language difficulties or where culturally appropriate services are not available. Take up rates are low among some groups such as Aboriginal and Torres Strait Islander women, women from non English speaking backgrounds and adolescent women. Such groups include women, whose health status is poor, so that they could derive significant benefit from antenatal care.

Access for women in rural and remote areas

2.30 Residents of rural and remote areas are significantly disadvantaged compared with residents of metropolitan areas in respect to access to, and choice of, health care services generally. This is also the case for antenatal services. There is a significant shortage of general practitioners, midwives and specialists outside major regional centres. In 1997, 16% of all medical practitioners worked in rural and remote areas in their main job, but 28.8% of the total population lived there. For obstetricians and gynaecologists the figure was 15.3% and for midwives it was 23.7%. In remote areas there is one medical practitioner per 1,395 of the population. This compares with 1 per 824 of the population in capital cities. Only seven obstetricians and gynaecologists had their main job in a remote area.[17]

2.31 The situation is expected to deteriorate with the ageing of the specialist medical workforce (the average age of obstetricians is now 51.1 years) and the reluctance of general practitioners to undertake obstetric work because of fears and costs associated with litigation as well as more general lifestyle considerations.

2.32 The Commonwealth Government is attempting to address the problem through the Rural Incentives Program which provides initiatives funded under the

16 The Committee recognises that the majority of pregnant women are not ill and that use of the term 'patient' is therefore problematic. It is used here, and occasionally elsewhere in the Report, where it clarifies the issues being discussed.

17 Figures are from Australian Institute of Health and Welfare. *Medical labour force 1997*, Canberra 1999, p.3 and p.29, Australian Medical Workforce Advisory Committee. *The Obstetrics and Gynaecology Work Force in Australia: Supply and Requirements 1997-2008*, Sydney 1998, p.8 and Australian Institute of Health and Welfare. *Nursing labour force 1998*, Canberra 1999, p.58.

National Rural Health Strategy. These include payments designed to encourage general practitioners to relocate to rural areas and to support those already practising there. It has also negotiated with each State and the Northern Territory to provide for the establishment of 37 specialist positions in major provincial and rural centres during 1999. It is anticipated that these positions will provide the selected centres with access to advanced trainee obstetricians and at the same time expose the trainees to the special issues facing women giving birth in rural areas.[18] The Committee considers that while these initiatives may go some way to addressing the shortage they are most unlikely to overcome it.

2.33 Some rural residents are therefore obliged to travel long distances to access services. This is especially difficult for women in the later stages of pregnancy, those with small children and those without their own transport.

2.34 Some major teaching hospitals provide satellite clinics with visiting specialist medical teams to rural and remote communities. They travel to regional centres and examine women referred to them by local general practitioners. At present they reach only a small proportion of those who could benefit from them. When problems are identified, treatment is normally available only at major centres. The Committee considers that satellite clinics with visiting teams of obstetricians have the potential to overcome many of the disadvantages faced by women in rural and remote locations in accessing specialist obstetrical care.

2.35 Mater Misericordiae Mother's Hospital in Brisbane provided information about a successful pilot project in foetal ultrasound telemedicine which it conducted in conjunction with Kirwan Hospital for Women in Townsville in 1998.

> The project, the first of its kind in Australia, demonstrated that realtime fetal ultasound consultations could be performed using high quality video conferencing systems network interface units and ISDN access…The majority of these consultations were completed in 30 minutes at a line cost of approximately $70 per consultation.[19]

2.36 While the service received strong support from the women using it and from clinicians in North Queensland, Mater advised the Committee that the number of consultations performed to date had been too small to determine the true costs of a consultation. Initial set up costs were high and the extension of the system to other hospitals may be limited by the type and quality of video conferencing equipment in use in these hospitals. A further concern for Mater was the difficulty of calculating factors such as the costs of additional clinician time, and costs borne by the woman and her family, including the costs of travelling to Townsville.

2.37 Despite these concerns and the fact that rural women are still obliged to travel to a major regional centre for antenatal screening, the Committee believes the model

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18 See Submission No. 97, p.31 (Department of Health and Aged Care).

19 Submission No. 78, p.31 (Mater Misericordiae Mothers' Hospital, Qld).

warrants further study and application in order to increase rural women's access to antenatal obstetrical services.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government fund major tertiary hospitals to extend the provision of satellite clinics and visiting teams of obstetricians to assist women in rural and remote areas.

Access for Aboriginal and Torres Strait Islander Women

2.38 While morbidity and mortality rates for Australian mothers and babies generally are among the lowest in the world, this is not the case for indigenous mothers and babies. The Aboriginal and Torres Strait Islander Commission indicated that:

- Infant mortality rates [for indigenous babies] are still three to five times as high as the rates for other Australians.
- The mean birthweight of babies born to indigenous mothers was 3,140 grams, compared with 3,370 grams for babies born to non-indigenous mothers.
- Babies born to indigenous women were more than twice as likely to be of low birthweight (12.6% compared with 6.2%).[20]

2.39 The reasons for the higher incidence of maternal and infant health problems in the Aboriginal and Torres Strait Islander population are complex. They relate, at a macro level, to poverty and social disadvantage. Furthermore, indigenous mothers tend to give birth at younger ages, to have more children and to have them more closely spaced than does the non indigenous population. Their own health is likely to be significantly worse than that of women of equivalent age in the general population and they are more likely to engage in high risk behaviour that can be damaging to them and their babies during pregnancy.

2.40 In the Northern Territory in 1995, for example, 4.1% of Aboriginal mothers aged 20-29 were diagnosed with gestational diabetes compared with 2.3% of non Aboriginal mothers. The equivalent figures for anaemia were even more disturbing: 18.9% for Aboriginal mothers, and 3% for non Aboriginal mothers.[21]

2.41 A greater percentage of indigenous babies are born prematurely, and with low birthweight. Their perinatal[22] death rate is high. The New South Wales Midwives Data

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20 Submission No. 156, p.3 (Aboriginal and Torres Strait Islander Commission). Figures issued by the Australian Bureau of Statistics in November 1999 show the infant mortality rate for indigenous Australians was at least three times the Australian rate in 1998.

21 *Trends in the health of mothers and babies, Northern Territory 1986-95,* Northern Territory Midwives Collection, Territory Health Services, 1998, pp.16-18.

22 A perinatal death is a still birth plus a death of a baby within 28 days of birth.

Collection estimates that the death rate is 13.8 per 1,000 births to indigenous mothers, compared with 6.8 per 1,000 for non indigenous mothers.[23]

2.42 The picture is not uniformly bleak. There have been some significant improvements in the last 15 years, especially in perinatal mortality rates for babies of indigenous mothers.

> In Western Australia, for example, the perinatal mortality rate for babies of Indigenous mothers fell from 23.3 per 1,000 births in 1986 to 17.2 in 1995, although the rates remain more than double the non-Indigenous figure of 6.8 per 1,000 in 1995…In the Northern Territory, the perinatal mortality rates per 1,000 births for babies born to indigenous mothers fell even more dramatically, from 48.9 in 1986 to 26.4 in 1995.[24]

2.43 These improvements result from a general improvement in health and nutrition among indigenous mothers and from specific initiatives designed to reduce morbidity and mortality among indigenous mothers and babies.

2.44 Appropriate antenatal care is a significant contributor to improved health outcomes for indigenous mothers and babies, yet Aboriginal and Torres Strait Islander women have significantly fewer antenatal visits and generally have their first visit later in pregnancy than do non indigenous mothers.

> Almost 38% of Aboriginal women present after 20 weeks gestation for their first antenatal visit, compared with 15% in NSW overall.[25]

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> The Aboriginal women were generally younger at delivery…made their first antenatal visit later (Aboriginal 49% after 20 weeks vs non Aboriginal 10%) and made fewer antenatal visits (Aboriginal 43% fewer than 4 visits vs non Aboriginal 2% fewer than 4 visits).[26]

2.45 Factors identified as inhibiting access to antenatal services by indigenous women were cost, lack of transport, the culturally inappropriate nature of the services offered and lack of appreciation of the value of antenatal care. The Koori Health Unit in Victoria, for example, commented that:

> One of the greatest difficulties in getting Koori women to attend antenatal classes and check-ups was that pregnancy was seen as normal and most

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23 NSW Department of Health, *NSW Midwives Data Collection*, 1995.

24 Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 1999, p.88.

25 Submission No. 45, p.18 (Australian Midwifery Action Project, NSW).

26 Powell J. and Dugdale A.E. *Obstetric Outcomes in an Aboriginal Community. A Comparison with the Surrounding Rural Area.* Australian Journal of Rural Health, Feb 1999, 7, pp.13-17.

> women did not feel sick. As a result, they did not see the need for antenatal care or for changes to their lifestyle.[27]

2.46 A number of antenatal programs for indigenous mothers are currently being trialled. They are designed to overcome the difficulties referred to above and some have been very successful. The Committee was particularly impressed by the evidence it received on the *Strong Women, Strong Babies, Strong Culture* program in the Northern Territory.

2.47 This program began in 1993 in three communities in the Northern Territory where low birthweight was a problem causing community concern. The program is run by Aboriginal women and supported by Territory Health Services. The women were carefully selected and trained. Their role is to encourage a range of practices including regular antenatal visits, compliance with medications and proper nutrition. They work within a traditional framework and so have gained the confidence of the women concerned and of the wider community.

2.48 The program was adopted by a further seven communities in 1997. It was evaluated in 1998. The main findings of the evaluation were:

> In the three pilot communites, the mean birthweight increased by 171 grams between 1990-91 and 1994-96 (from 2,915 grams to 3,086 grams), and the proportion of babies who weighed less than 2,500 grams decreased from 19.8% to 11.3%. There were improvements over the same period in communities that did not have the program, but they were not as large… Other changes in health services occurred in the pilot communities, and these may have had an effect on birthweight, but the evaluation team concluded that it was likely that the program had been beneficial.[28]

2.49 An antenatal program targetted to indigenous women in a metropolitan areas is the Daruk Aboriginal Medical Services Antenatal Program in Mt Druitt, west Sydney. This program employs a full time midwife and an Aboriginal health worker. They work in conjunction with a general practitioner from the Aboriginal Medical Service and obstetricians at Nepean Hospital, providing antenatal care, birth support, transport, home visits, social and family support and education. The program has significantly increased the number of indigenous women accessing antenatal care and encouraged them to seek this care early in pregnancy.

> The program evaluation compared outcomes for Aboriginal women who accessed the Daruk service with those of Aboriginal women who accessed mainstream antenatal care at Nepean and Blacktown Hospitals. Thirty six percent of Daruk women had their first antenatal visit in the first trimester of pregnancy compared with 21% at Nepean and 25% at Blacktown. Despite Daruk women having a higher burden of antenatal risk factors than

27 Department of Human Services, Koori Health Unit, 1996.

28 Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples,* 1999, p.87.

> Aboriginal women at Blacktown and Nepean hospitals, there was no concurrent increase in perinatal morbidity or mortality.[29]

2.50 In Alice Springs, Congress Alukura was established under the Alternative Birthing Services Program. This is a Commonwealth Government funded program designed to promote greater choice for women giving birth and to encourage State health services to carry out trials of a range of care models. Congress Alukura provides antenatal, birthing and post natal services to Aboriginal women using culturally appropriate approaches including the employment of a grandmother educator/ traditional birth attendant. It has been very successful in encouraging Aboriginal women to access antenatal care.

> During 1994 the Alice Springs Urban area had the highest rate of Aboriginal presentation for antenatal visits before 13 weeks gestation than any other centre in the NT…The figures for 1994 showed 122 Aboriginal women presented for antenatal care in the Alice springs urban area, of these 119 (98%) attended congress Alukura.[30]

2.51 A very diverse range of programs has now been conducted aimed at improving access to, and quality of, antenatal programs for indigenous women. Others are currently being established, for example through the *Healthy Women Strong Families Program* funded by the Commonwealth Government through the Office for Aboriginal and Torres Strait Islander Health. Many programs have been carefully evaluated. As a result it is possible to identify elements common to successful programs. Such elements include:

- consultation with Aboriginal communities, especially women, at every stage of development, implementation and evaluation;
- the provision of culturally appropriate services;
- the training of indigenous health workers and midwives to provide such services;
- training in cultural issues for non indigenous staff involved in programs;
- a team approach involving the Aboriginal Medical Service general practitioners and rural GPs as well as community midwives and health workers;
- links with hospitals, especially through Aboriginal outreach and liaison workers;
- links to broader health services;
- adequate transport; and
- continuity of program funding for successful projects, through provision of Commonwealth and State funds.

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29 Submission No. 38, p. 15 (NSW Midwives Association).

30 Territory Health Services, Women's Health Unit. *Evaluation of the Alternative Birthing Service Program in the Northern Territory,* 1997, p.11.

2.52 None of these findings are new. Similar conclusions have been reached in a range of publications and reports such as the National Aboriginal Health Strategy of 1989 (currently in the process of modification), the NHMRC Report on *Options for effective are in childbirth*, the Report of the Ministerial Review of Birthing Services in Victoria, *Having a Baby in Victoria* and the *Review of Birthing Services in the Northern Territory of Australia*.

2.53 The Committee is therefore extremely disappointed to note that a number of pilot programs targetted to improving the care of Aboriginal and Torres Strait Island women and babies have had to close through lack of funding, despite their successful outcomes. Several submissions, for example, drew the Committee's attention to a series of pilot programs in Victoria funded by the Commonwealth through the Alternative Birthing Services Program, which closed upon cessation of Commonwealth funding.

2.54 Work funded by the Alternative Birthing Services Program as well as through programs funded directly by the Aboriginal and Torres Strait Islander Commission and, more recently, by the Office of Aboriginal and Torres Strait Islander Health, has established the elements which contribute to the success of antenatal programs. What is needed now is not further pilot programs but for existing pilot programs to be made permanent and for new antenatal care services to be established incorporating the elements demonstrated to be critical to the success of such programs.

Recommendation

The Committee RECOMMENDS that the Office of Aboriginal and Torres Strait Islander Health provide recurrent funding to ensure continuity for existing antenatal programs for Aboriginal and Torres Strait Islander women and to establish new programs in areas of need.

Access for women from non English speaking background

2.55 The importance of providing culturally and linguistically appropriate antenatal services for women from non English speaking backgrounds has been well recognised, for example in *Having a Baby in Victoria,* in *Options for effective care in childbirth* and in the Turnbull Report.[31] The issue is a complex one. The social isolation and poverty experienced by some women from this group are undoubtedly contributing factors to their lower take up rates of antenatal services but language barriers, practices which they find culturally inappropriate and ignorance of Australian services undoubtedly deter some women from seeking antenatal care or fully benefitting from it they when they do so.

2.56 Following concerns expressed in the Shearman Report of 1989 the New South Wales Government funded a number of initiatives designed to improve access to

31 Health Department of Victoria. Final Report of the Ministerial Review of Birthing Services in Victoria, *Having a Baby in Victoria, 1990; NHMRC. Options for effective care in childbirth*, 1996; Legislative Assembly of Western Australia. *Report of Select Committee on Intervention in Childbirth, 1995.*

antenatal care for women from non English speaking backgrounds.[32] As a result, hospitals and area health services in areas of New South Wales with high concentrations of women from non English speaking backgrounds employed ethnic obstetric liaison teams and bilingual midwives and expanded interpreter services. These initiatives were successful in improving access to antenatal services.

> The lack of access to interpreter services can deny women adequate and timely health care. The ethnic obstetric liaison program has been very effective in meeting this need, particularly for antenatal care.[33]

2.57 It appears however that despite the success of these programs their funding has been reduced.

> Ethnic Obstetric Liaison Officers were introduced into a number of Sydney hospitals following the *Shearman Report* (Shearman 1989). The funding for these have since been reduced, or removed in some centres, and many of these positions no longer exist.[34]

2.58 Nor have funding cuts been restricted to services operating in New South Wales.

> Because of budgetary reductions that have been imposed on all maternity health care centres in Australia, interpreter services have been severely restricted and in many cases withdrawn.[35]

2.59 Given that the programs were introduced in response to the findings of the Shearman report, that they have been well supported in the community and that they are relatively inexpensive, the Committee finds it extraordinary that they have been defunded.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to reinstate programs to assist women from non English speaking backgrounds to gain access to antenatal services, using funding provided through the Public Health Outcome Funding Agreements.

Access for adolescent women

2.60 The Committee's attention has been drawn to the particular difficulties faced by adolescent women in obtaining appropriate antenatal care. Some large maternity hospitals do run programs targetted to this group.

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32 Shearman, R. *Final Report of the Ministerial Task Force on Obstetric Services in New South Wales,* New South Wales Health Department, 1989.

33 Submission No. 104, p.1 (Central Sydney Area Health Service).

34 Submission No. 51, p.11 (Midwifery Practice and Research Centre, NSW).

35 Submission No. 69, p. 32 (Women's Hospitals Australia and Australian Healthcare Association).

> We also have clinics for young pregnant women, with peer support workers and other teenage mothers to help them.[36]

2.61 However, little is done for those outside metropolitan areas, despite the greater likelihood of their suffering significant disadvantage such as lower education levels, poorer nutrition and a greater likelihood of high risk behaviours.

2.62 The Committee is concerned that very few programs currently address the needs of adolescent mothers.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to promote antenatal programs targetted to adolescent mothers.

Antenatal information and education

2.63 Antenatal information is provided to Australian women in a variety of ways. The most usual of these are:

- by hospital based midwives and/or nurses in hospital clinics;
- by community based midwives in community health centres;
- by childbirth educators in hospital clinics or community health centres;
- by a team consisting of midwives, general practitioners, obstetricians, and sometimes other health professionals such as physiotherapists, normally but not necessarily held in a hospital clinic;
- by independent midwives in a woman's own home; and
- by general practitioners or obstetricians.

2.64 For many women, the type of antenatal information they receive, as well as its quality, is largely determined by their general practitioner, who in the majority of cases will be the person confirming the pregnancy. On the first visit the general practitioner may herself/himself provide information on choices for the birth, conduct preliminary tests to ascertain the woman's health status, provide some preliminary antenatal information and direct the woman to other sources of information. The general practitioner's awareness of sources of information and assessment of their value is a critical factor for many women in the information they access.

2.65 As noted earlier, some women considered their general practitioners were ill informed about the range of birthing options available or failed to mention those options they did not support. This lack of information curtailed women's choices, an issue of particular concern to women who favoured home birth. This option was rarely

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36 *Committee Hansard*, 7.9.99, pp.195-196 (Professor Keirse, Flinders Medical Centre).

supported by general practitioners and obstetricians and in many cases it seems they do not advise women that it is a possibility.

> In discussions about initial antenatal practices, we believe two items should be paramount:
>
> 1. Women who attend their first antenatal visit should be well informed…Information about the option to birth at home should be provided to all women, along with all other options.
>
> 2. The practitioners who see women for their first antenatal visit should be well informed about the practice of homebirth as a safe birthing option.[37]

2.66 A similar position applied with respect to advice on birthing centres.

> …the majority of women, when they first believe that they are pregnant, have their pregnancy confirmed by a medical practitioner. At that visit, the medical practitioner decides with the woman who she will visit for the rest of her pregnancy. With few exceptions, the birth centre here at King Edward, homebirth or other midwifery managed services are not mentioned. Doctors tend to refer to other doctors. Many GPs tend to refer to obstetricians if they are not going to practise obstetrics themselves.[38]
>
> * * *
>
> I believe that GPs who are often the first "port of call" for a pregnant woman exploring her options, need access to high quality information about birth options and their relative safety.[39]

2.67 Similarly, many women who have their first antenatal visit at a hospital clinic are advised only of the services available at that hospital, for antenatal care, for birth and for post natal care.

Access to information

2.68 Some women will independently access sources of information not suggested or not known by their general practitioners. This is likely to be particularly the case for middle class, well educated women with the skills and training to seek out information. Other women may find additional information through family and friends or from community based midwives where they operate successful outreach programs. The Community Based Midwives Program in Western Australia, funded through the Alternative Birthing Services Program, is an example of such a service.

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37 Submission No. 30, p.1 (Homebirth Network of South Australia).

38 *Committee Hansard*, 8.9.99, p.364 (Australian College of Midwives, WA).

39 Submission No.110, p.20 (Dr Sarah Buckley, Qld).

> The program aims to empower and assist birthing women by supporting their right to choose the most appropriate care for the individual circumstances…The program also aims to ensure that women are made aware of all their options with regard to pregnancy and childbirth and assist women in making their personal choice based on sound and unbiased information. Whilst we actively promote home birth as an alternative option among the choices available, we do not encourage home birthing to the exclusion of other models of care.[40]

2.69 Another is the Pregnancy and Childbirth Resources Centre in Fremantle, with which the Community Based Midwives are closely associated.

> Importantly for us, we have a partnership with the Pregnancy and Childbirth Resource Centre, which is also funded through the Alternative Birthing Services program and operates out of East Fremantle. That centre essentially provides women with resources such as books, videos and all sorts of information in terms of choices on childbirth and the process of childbirth. It also provides a network not only for women who use our program but also for women in the broader community to create their own networks and community groups.[41]

2.70 Some antenatal hospital clinics also have very successful outreach information programs. Many of these are targetted to groups thought to be in greatest need of information, and to have the most difficulty in obtaining it, such as adolescents and women from non English speaking backgrounds.

> We are the only hospital in the state that runs morning, afternoon and evening clinics, as well. We do two evening clinics a week. We are also the only one that delivers antenatal care for public patients off-location, 20 kilometres to the south, where there is an area of greater need.[42]

2.71 However, the Committee also heard from a number of consumer groups about some 'user unfriendly' antenatal clinics. A problem raised consistently was the extended delays experienced in many clinics.

> There are problems in the management of antenatal clinics in hospitals. Women often report extended delays that can regularly run well more than an hour past their appointed time. There are no incentives to change existing practices in this area and Maternity Alliance strongly recommends that strategies be implemented to improve performance.[43]

2.72 Aboriginal women generally face significantly more difficulty than the general population in accessing antenatal information because most of the information

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40 *Committee Hansard*, 8.9.99, p.314 (Community Based Midwifery Program, WA).

41 Ibid, p.318.

42 *Committee Hansard*, 7.9.99, p.195 (Professor Keirse, Flinders Medical Centre).

43 Submission No. 153, p.3 (Maternity Alliance, NSW).

available is not culturally sensitive to their needs. As noted, Aboriginal women tend to begin their antenatal visits later in pregnancy and to have fewer visits overall. This reduces their opportunities to access the information available to them.

2.73 Some recent programs have been very successful in presenting culturally appropriate information for Aboriginal and Torres Strait Islander women. These include the *Strong Women, Strong Babies, Strong Culture* program and the Congress Alukura program, already described.

2.74 Other programs with a particular focus on the provision of antenatal information to Aboriginal women include the Wurli Wurlinga project at Katherine and the Darwin rural maternal health project which is developing an antenatal care model for women in the Oenpelli area. Both projects are funded through the Alternative Birthing Services Program. The Oenpelli project has only recently started but the Wurli Wurlinga project:

> …although in its early stages, has already begun to document an increase in the number of Aboriginal women in the Katherine area receiving ante natal care prior to 28 weeks, and improved early presentation figures.[44]

2.75 Women living in rural and remote areas may also be disadvantaged in accessing antenatal information, but this is not always the case. Some excellent programs exist in rural and remote areas. However, because they have fewer sources of information, women in rural and remote Australia are more dependent on their general practitioners to refer them to appropriate sources and may have more difficulty in obtaining information in cases in which their general practitioner is ill informed about the options available.

2.76 The Committee concluded, on the basis of the evidence received during its Inquiry, that availability of antenatal information, and access to it, varied greatly. Factors influencing availability and access included:

- knowledge of information sources on the part of the professional primarily responsible for a woman's care;
- education and skill of the woman concerned;
- general practitioner's knowledge and referring practice;
- geographical location;
- familiarity with the English language;
- Commonwealth and State health department commitment to the provision of information, and concomitant allocation of resources; and

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44 Territory Health Services, Women's Health Unit. *Evaluation of the Alternative Birthing Services Program in the Northern Territory*, 1997, p.16.

- successful promotion of existing sources of information.

2.77 The quality and relevance of the information provided are also significant factors affecting the take up of available information and its impact.

Quality of antenatal information

2.78 The quality of antenatal information and its timeliness were issues raised repeatedly by both practitioners and consumers. It is perhaps more critical now than ever before, partly because the range of possible interventions and other 'treatments' is so much greater than previously and also because, with small families, most women have minimal experience of pregnancy and childbirth in their immediate families.

2.79 A concerted effort has been made in Western Australia to address these issues, in part in response to the Turnbull Report of 1995, which raised concerns about the inadequacy of information available to most women during pregnancy.[45] In 1998 the Health Department of Western Australia, with input from consumers and professional groups, published a booklet available to all pregnant women (from general practitioners, antenatal clinics, chemists etc) outlining **all** their birth options, suggesting questions they might like to raise, covering issues of informed consent and providing a comprehensive list of service providers throughout the State.[46]

2.80 One of the aims of the booklet is to inform women at low risk of the feasibility and benefits of a natural birth.

> All mothers need assistance in going through the pregnancy process. This booklet reassures them that, if they are a low risk patient, they are safe to be delivered by a midwife or a general practitioner/obstetrician. That is part of the objective of this book. The objective is to get out the news to people that safe delivery for low risk patients can occur in any one of these establishments in the whole of Western Australia. Your guarantee of having a good delivery of a baby that is as perfect as can possibly be managed in our society is excellent in any one of these facilities throughout the whole of Western Australia.[47]

2.81 The Committee was advised that almost all of the 35,000 copies originally printed have been distributed and a revised edition is planned.[48] The Committee considers that the West Australian example is deserving of wider emulation.

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45 Dr Hilda Turnbull MLA. *Select Committee on Intervention in Childbirth,* Perth, 1995.

46 *Your Birth Choice. Planning Ahead for Birth.* Health Department of West Australia, 1998.

47 *Committee Hansard,* 8.9.99, pp.289-90 (Dr Turnbull MLA).

48 By the West Australian Department of Health. See *Committee Hansard*, 8.9.99, p.352.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that comprehensive, accurate and objective information is made available to all pregnant women on the antenatal and birth options available to them, with funding provided through the Public Health Outcome Funding Agreements.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that comprehensive, accurate and current information is made available to all principal carers of pregnant women about the antenatal and birth options and services available in their area, with funding provided through the Public Health Outcome Funding Agreements.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that antenatal information is made available to all indigenous women in a language and format that meets their needs, with funding provided through the Office of Aboriginal and Torres Strait Islander Health.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that antenatal information is made available to all women from non English speaking backgrounds in a language and format that meets their needs, with funding provided through the Public Health Outcome Funding Agreements.

2.82 Concern focussed on the quality, accuracy and depth of information provided to women on the procedures available during the antenatal period and during the birth itself. Both consumers and practitioners repeatedly stated that without the provision of quality, current information and advice it was not possible to guarantee that a woman was in fact giving informed consent to the interventions proposed. In the case of interventions possible at birth, advice and information obviously needed to be provided well ahead of the event and not, as is often the case, at the point when they are needed.

> Women need to be given information about childbirth procedures in a timely way - preferably during pregnancy, but better explanations should be given before procedures are commenced. Women need to know the reasons for an intervention, what is involved and the potential consequences for themselves and their baby(s).[49]

49 Submission No. 153, p.15 (Maternity Alliance, NSW).

2.83 One witness questioned the whole concept of informed consent at the time of birth, given the unequal power relationship existing at that time between the woman in labour and her clinician.

> In my opinion, I cannot imagine people being in more different positions of power than a woman who is naked, in labour, prone on a hospital bed and someone who is a clinical care provider who is in a position of responsibility. I find it very hard to accept that you can give fully informed consent in such circumstances, which is not to say that we should not try to give it. I do not think we should pretend, though, that such a thing is possible.
>
> I believe that it is in fact very difficult for women to give informed refusal in such circumstances, because they are very fearful that care will be withdrawn if they refuse recommendations that their baby's life is in danger or their own life is in danger and that these procedures are necessary. So my other concern is that we need to look very carefully at the ethics of decision making in these fairly extreme circumstances.[50]

2.84 An issue of major concern was the quality of information provided to women on the possible adverse consequences of some of the antenatal screening procedures now routinely offered. It appears that many women are very ill informed about such consequences. They do not appreciate that screening tests cannot determine with certainty the health status of the foetus, so that uncertainty and anxiety might well follow, for example an unclear ultrasound. Nor do they understand that where ultrasound tests suggest irregularities they will then be required to undertake further tests such as amniocentesis, which carries a risk of miscarriage, thus prolonging the uncertainty.

> Antenatal tests particularly in regard to pregnancy screening are an example which misunderstandings can occur. The opportunity to view an image of their unborn baby at their 18-week diagnostic ultrasound is a special occasion for many women and their families. Few women understand that the primary clinical purpose of the test is to diagnose foetal anomalies. The consequence of an adverse finding [may] be not only devastating but completely unexpected. Limits in the sensitivity of obstetric ultrasound are also not well understood or explained.[51]

2.85 These concerns are most marked in the case of ultrasound because that is the most widely used of the screening tests, but they are not confined to that test.

2.86 The Committee acknowledges the importance of these screening measures. However, it is persuaded that currently too many scans are carried out without adequate knowledge and counselling of the women concerned about their possible consequences.

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50 *Committee Hansard*, 6.9.99, p.87 (Dr Jane Fisher, University of Melbourne).

51 Submission No. 153, p.3 (Maternity Alliance, NSW).

2.87 Clinicians are certainly concerned about the problem. Guidelines for antenatal screening issued by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, for example, are emphatic about the need for counselling and information on all antenatal screening tests before they are performed.

> Such screening tests should only be undertaken with the informed consent of the patient after adequate and appropriate counselling as to the implications, limitations and consequences of such screening.[52]

2.88 However, evidence to the Committee and to complaints bodies such as the Victorian Health Services Commissioner and the Health Care Complaints Commission in New South Wales suggests that in practice such counselling is not universally offered and certainly is not always understood.

> Women felt that they were not adequately advised of their choices about the risks and benefits of interventions and not sufficiently involved in the choice of whether or not these should take place.[53]

2.89 The Victorian Health Services Commissioner stated that, in her view, if informed consent were obtained from women for any intervention performed on them they would be much less likely to resort to litigation in the event of any adverse outcome. The Committee shares this view.

> All I can tell you is that our experience is that, where proper explanations are provided, people are unlikely to go to law. We see that over and over again. That is what the [medical indemnity] insurers are telling their members.[54]

2.90 The issue of informed consent to interventions performed during birth was also a major concern to consumers and clinicians. The risk of problems occurring in childbirth is low. There is a general expectation of a successful outcome for mothers and babies. It appears that many women are ill advised about the possible adverse consequences of interventions at birth. They are not advised that the interventions can be painful and that, although each type of intervention has merit in certain circumstances, each also has inherent disadvantages. Women may therefore be totally unprepared on those occasions on which the outcome is less than ideal.

2.91 Lack of adequate advice and information on the experience of childbirth in general, and the impact of a range of interventions in particular, has been pinpointed by complaints commissioners as the basis for many complaints, and perhaps for litigation. In the experience of the Victorian Complaints Commissioner, as noted, when such information is provided following an adverse outcome, many complaints

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52 Submission No. 17, Appendix 1 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

53 *Committee Hansard*, 6.9.99, p.121 (Health Services Commissioner, Vic).

54 *Committee Hansard*, 6.9.99, p.123 (Health Services Commissioner, Vic).

are withdrawn or conciliated. Provision of the information before the event therefore could be expected to greatly reduce the number of complaints and cases of litigation, as well as reducing anxiety and trauma for the family.

Recommendation

The Committee RECOMMENDS that the National Health and Medical Research Council, in conjunction with professional medical bodies and midwives' organisations, establish guidelines governing the prior provision of counselling and information on all antenatal screening tests, for adoption and implementation by the professional bodies.

Recommendation

The Committee RECOMMENDS that the National Health and Medical Research Council, in conjunction with professional medical bodies and midwives' organisations, establish guidelines governing the provision of counselling and information on the benefits and disadvantages of the various forms of intervention which may be required by women during birth, for adoption and implementation by the professional bodies.

2.92 The issue of informed consent to interventions during childbirth is discussed in greater detail in chapters 5 and 6.

Antenatal Education Classes

2.93 Antenatal education classes are an important means of overcoming some of the problems described above, for example those relating to informed consent. A woman who is well informed about pregnancy and birth is better able to make the choices facing her, and to understand the implications of these choices. She is likely to be less passive and to feel more empowered.

2.94 A complaint frequently made to the Committee during the Inquiry, by women and by midwives in particular, was that pregnancy and childbirth, both perfectly natural processes, have become unnecessarily medicalised. They are now the province of doctors and hospitals rather than of the women themselves. Education was seen as a means by which women might reduce the medical dominance of birth.

2.95 As with other aspects of antenatal information, the content of antenatal classes, their quality and their accessibility are very variable. Most provide information to pregnant women and their partners on the development of the baby in utero, maternal health during pregnancy, the process of birth and parenting skills. Antenatal classes are usually held in hospital clinics or community health centres but sometimes take place in schools or other educational or community facilities such as public libraries. Most are run by midwives or nurses although they increasingly include segments provided by other professionals and associations such as the nursing mothers' associations, nutritionists, physiotherapists and obstetricians.

2.96 The move away from midwife run antenatal education has been deplored by some.

> Teaching is an integral part of a midwife's practice, and as a midwife I have always believed that the midwife is the best health professional to provide antenatal education. I have looked on in despair as yet another area of midwifery practice has been gradually eroded, with physiotherapists and childbirth educators 'taking over' what was once the domain of the midwife.[55]

2.97 The very variable quality of antenatal education and information in Australia may be partly explained by the fact that there are no nationally or State agreed standards for childbirth educators or for the content of the courses they run.

> Our concern is that anyone can call themselves a childbirth educator without any specific training and that many maternity units still roster midwives untrained in group processes to conduct these educational courses.[56]

2.98 Antenatal classes are usually funded by the institutions which run them. However, they may be held in hospital clinics and run by hospital based staff (usually midwives) but funded from non hospital sources. This is the position at the Queen Elizabeth Hospital in Adelaide, for example.

2.99 Classes may be funded from the general health budget or from education budgets. The Committee was concerned to learn that in the Northern Territory, Victoria and New South Wales, State government funding for antenatal education was being cut. Consequently, classes that were formerly free now attract a fee. In Victoria for example, this was said to be approximately $200 for eight classes.[57] In south east Sydney it was $170 for seven classes. The result is that women on low incomes are increasingly unable to attend antenatal classes.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that adequate and appropriate antenatal education classes are generally available, using funding provided through the Public Health Outcome Funding Agreements.

2.100 Other concerns about antenatal classes raised during the Inquiry related to their accessibility. Classes were said to be held at times when working women and their partners could not attend, and in locations which could not be reached by public transport.

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55 Gilkison A. *Antenatal Education – Whose Purposes Does it Serve?* New Zealand College of Midwives Journal, May 1991, p.13.

56 *Committee Hansard,* 14.9.99, p.398 (National Association of Childbirth Educators).

57 See *Committee Hansard*, 6.6.99, p.140 (Maternity Coalition, Vic).

> The difficulty faced by many in our community arises from an inability to attend groups or information sessions because of the cost. Often working, as long as possible, is a priority for some women, in our present climate. This situation, coupled with the partner's work means that they are unable to attend free programs, which if available, are usually offered during the daytime.[58]

2.101 The presentation of antenatal classes was also an issue for some. They were said to be too formal and technical for some potential participants, especially adolescents although, as noted, some centres have designed particular programs to meet their needs. There is certainly a case for more targetted antenatal classes which can better meet the needs of the groups concerned. In fact however, the trend is in the other direction. As funding is reduced, antenatal classes become increasingly the preserve of middle class, English speaking urban dwellers. These are precisely the women best able to access the range of information on offer outside the classes.

2.102 Some overseas commentators have suggested that where hospitals both fund and run antenatal classes these classes may be designed to accommodate the requirements of the institution rather than those of the women concerned.

> The institution which offers the classes has a high level of control over them; deciding for whom the classes will be provided, what should be taught, who should teach it and the nature of the evaluation.
>
> …Much of the material covered in classes aims to "prepare" women for childbirth in that particular institution.
>
> …Women are encouraged to ask questions about the procedures, and offered "choices" within certain boundaries, but to question the status quo or to challenge the system is definitely not a part of most antenatal classes.[59]

2.103 This Committee heard that a similar situation existed in Australia.

> In the [last] 10 or 15 years…childbirth education pretty well exclusively happens within the hospitals where the care is provided. Childbirth education then becomes the dissemination of information about what happens in that particular hospital, what the routines are and what women can expect in that situation, rather than a broad range…I think that childbirth education in general is in a very sorry state because it is exclusively happening within the hospitals and fairly well under the control of the dominant medical system about what is being disseminated.[60]

2.104 The extent of hospital control was illustrated by a Brisbane witness.

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58 Submission No.37, p.1 (Ms Pauline Green, National Association of Childbirth Educators).

59 Gilkison A. *Antenatal Education – Whose Purposes Does it Serve?* New Zealand College of Midwives Journal, May 1991, pp.13-14.

60 *Committee Hansard*, 6.6.99, p.139 (Maternity Coalition, Vic).

> The antenatal information that women are given is so poor, because midwives are controlled by the organisations for which they work, when they try to give information to women they are often severely criticised. I am sure some burn out because of it.
>
> Very recently somebody gave information to women about the side effects of epidural blocks…and she was absolutely prevented from saying that any more in her classes. She was stopped from doing it.[61]

2.105 Some exceptions to this rather dismal picture were also brought to the Committee's attention.

> The QEH antenatal class actually starts from the premise that you will deliver your baby naturally without drugs…From day one it is based on the premise that you are going to have a healthy pregnancy and you are also going to deliver your baby naturally.[62]

2.106 While some evidence to the Committee was critical of certain aspects of antenatal classes, as noted, none was as savage as the criticism made of antenatal classes in some other countries.

> Because the antenatal education most women receive is a product of the system which effectively deprived women of freedom and choice in childbirth, its agenda has generally been narrow, conformist, patronizing and disempowering. There have been many studies of its effectiveness, but few have been able to report positively on its outcomes.[63]

2.107 Evidence to the Committee suggests that information and education are relatively neglected areas of antenatal care in Australia. The Turnbull Report, for example, made a series of recommendations for improvements in this area. A number have since been adopted by the West Australian Government, most notably through publication of *Your Birth Choice*, discussed earlier in this chapter. The Committee considers there is scope for publications along similar lines to be produced in those States which lack a comprehensive and current directory of maternity services

2.108 The Committee concludes, on the basis of the evidence it received during the course of the Inquiry, that antenatal care and information can make a difference to birth outcomes for mothers and babies. The Committee strongly supports the provision of high quality, accessible antenatal care and information for all pregnant women.

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61 *Committee Hansard,* 15.9.99, p.590 (Dr Fahy, University of Southern Queensland).

62 *Committee Hansard*, 7.9.99, p.235 (Keep the Queen Elizabeth Hospital Delivering Community Action Group).

63 Nolan M. L. *Antenatal education – where next?* Journal of Advanced Nursing, London,1997, 25, p.1200.