CORE PRACTICES IN PREGNANCY CARE

Providing antenatal care services (see Guideline Chapter 7)

Collaborative practice	Collaborative maternity care includes clearly defined roles and responsibilities for all involved, especially for the person the woman regards as her primary care provider.
Continuity of care and carer	Continuity of care involves shared understanding of care pathways by all professionals involved in a women's care, with the aim of reducing fragmented care and conflicting advice. Continuity of carer is when a health professional who is known by the woman provides all her care, working in partnership with the woman.
Providing antenatal care for women with complex social needs	For women with complex social needs, maternity care may be provided in partnership with other agencies including mental health services, domestic violence teams, illegal substance use services, drug and alcohol teams, youth and adolescent pregnancy support services, learning disability services and children's services.
Antenatal groups	Group antenatal care may provide a sustainable alternative to the provision of one-to-one antenatal visits (replacing some or all) and has been shown to effectively provide social support and the sharing of information for women.

Antenatal visits (see Guideline Chapter 8)

Consensus-based recommendation

At the first contact with a woman during pregnancy, make arrangements for the first antenatal visit, which requires a long appointment and should occur within the first 10 weeks.

Recommendation **Grade B**

Determine the schedule of antenatal visits based on the individual woman's needs. For a woman's first pregnancy without complications, a schedule of ten visits should be adequate. For subsequent uncomplicated pregnancies, a schedule of seven visits should be adequate.

Consensus-based recommendation

Early in pregnancy, provide women with information in an appropriate format about the likely number, timing and content of antenatal visits associated with different options of care and the opportunity to discuss this schedule.

Woman-centred care

Support women to make informed decisions and choices about their care
Ask open-ended questions and provide an opportunity to discuss issues and ask questions
Offer verbal information supported by written or other appropriate form of information
Discuss involvement of the woman's partner/family in antenatal care, using gender neutral language until the gender of the partner is established
Provide emotional support and empathy
Discuss any costs that may be involved in a woman's antenatal care

Undertake a comprehensive history at the first antenatal visit

Current pregnancy (planned, unplanned, wishes to proceed with or terminate the pregnancy)
Medical (history, medicines, family history, cervical screening, immunisation, breast surgery)
Obstetric (previous experience of pregnancy and birth including stillbirths)
Infant feeding experiences
Lifestyle factors (nutrition, physical activity, smoking, alcohol, substance use)
Expectations, partner/family involvement, cultural and spiritual issues, concerns, knowledge, pregnancy, birth, breastfeeding and infant feeding options
Factors that may affect the pregnancy or birth (eg female cutting)

Support networks and information needs
Clinical assessment
Discuss date of conception and last menstrual period and offer ultrasound scan for gestational age assessment (carried out between 8 and 14 weeks of pregnancy)
Measure height and weight and calculate body mass index and provide advice on appropriate weight gain for her BMI
Measure blood pressure
Test for proteinuria
Delay auscultation of fetal heart until after 12 weeks gestation if using a Doppler and 28 weeks gestation if using Doppler or a Pinard stethoscope
Assess risk of pre-eclampsia and advise women at risk that low-dose aspirin from early pregnancy may be helpful in its prevention
Assess risk of preterm birth and provide advice on risk and protective factors
Administer the EPDS at this visit or as early as practical in pregnancy
Ask questions about psychosocial factors that affect mental health
Routine maternal health tests
Check blood group and antibodies, full blood count and haemoglobin concentration and consider testing ferritin in areas where prevalence of iron-deficiency anaemia is high
Recommend testing for HIV, hepatitis B, hepatitis C, rubella non-immunity, syphilis, and asymptomatic bacteriuria
Offer screening for chromosomal anomalies
Targeted maternal health tests
Assess risk of hyperglycaemia and offer testing to women with risk factors
Offer chlamydia testing to all women who are younger than 25 years
Offer testing for gonorrhoea to women with risk factors (eg previous gonorrhoea or other sexually transmitted infection, new or multiple sex partners)
In areas with a high prevalence of sexually transmitted infections, consider offering chlamydia and gonorrhoea testing to all pregnant women
Offer testing for trichomoniasis to women who have symptoms
Offer cytomegalovirus testing to women who have frequent contact with large numbers of young children
Offer thyroid function testing to women who have symptoms or high risk of thyroid dysfunction
Only offer testing for vitamin D status if there is a specific indication (signs, symptoms or other test results)
Offer cervical screening to women who have not had a screen in the recommended period
Advise women about measures to avoid toxoplasmosis or cytomegalovirus infection
Assessment
Estimated gestational age
Risk factors: physical, social, emotional
Need for referral
Need for further investigation/ treatment/ preventive care
Actions
Advice on options for antenatal care and place of birth
Referral and further investigation as required
General advice (also for the partner/family): pregnancy symptoms, supplements, smoking, nutrition, alcohol, physical activity, substance use, dental visits
If required, access to counselling and termination (where permitted under jurisdictional legislation)
Preventive interventions: folate, iodine, others as needed (eg iron supplement)

Specific vaccinations including influenza and pertussis

Women who may require additional care

Existing conditions
Overweight or underweight
Cardiovascular disease (eg hypertension, congenital heart disease, rheumatic heart disease)
Other conditions (eg kidney disease; type 1 or type 2 diabetes; thyroid, haematological or autoimmune disorders; epilepsy; malignancy; severe asthma; HIV, hepatitis B or hepatitis C infection)
Mental health disorders
Disability
Female genital mutilation/cutting
Experiences in previous pregnancies
Termination of pregnancy
More than two miscarriages
Preterm birth
Pre-eclampsia or eclampsia
Rhesus isoimmunisation or other significant blood group antibodies
Uterine surgery (eg caesarean section)
Antenatal or postpartum haemorrhage
Postpartum psychosis or postnatal depression
Four or more previous births
A stillbirth or neonatal death
Traumatic birth experience (as defined by the woman)
Gestational diabetes
Small or large-for-gestational-age baby
Baby with a congenital anomaly (structural or chromosomal)
Previous major surgery
Cardiac (including correction of congenital anomalies)
Gastrointestinal (eg bowel resection)
Bariatric (gastric bypass, lap-banding)
Gynaecological (eg myomectomy, cone biopsy, large loop excision of the transformation zone [LLETZ])
Lifestyle considerations
History of alcohol misuse
Use of recreational drugs such as marijuana, heroin, cocaine (including crack cocaine), amphetamines (eg ‘ice’) and ecstasy
Psychosocial factors
Developmental delay or other disabilities
Vulnerability or lack of social support
Previous experience of violence or social dislocation

Specific activities at subsequent antenatal visits

16–19 weeks

Review, discuss and record the results of all tests undertaken
Reassess planned pattern of care and identify whether additional care or referral is needed
Assess fetal growth
Offer fetal anatomy scan to be carried out at 18–20 weeks gestation
Offer women the opportunity to be weighed, encourage self-monitoring of weight gain and discuss weight change, diet and level of physical activity

20–27 weeks

Assess fetal growth
Discuss fetal movements: timing, normal patterns etc
Measure blood pressure
Test for proteinuria in women who have clinical indications of pre-eclampsia (eg high blood pressure)
Offer women the opportunity to be weighed, encourage self-monitoring of weight gain and discuss weight change, diet and level of physical activity
Test for hyperglycaemia between 24 and 28 weeks gestation
Repeat ferritin testing if levels were identified as low in the first trimester

28 weeks

Assess fetal growth
Discuss fetal movements
Screen for anaemia, blood group and antibodies
Recommend Anti-D to rhesus-negative non-isoimmunised women
Measure blood pressure
Test for proteinuria in women who have clinical indications of pre-eclampsia (eg high blood pressure)
Offer women the opportunity to be weighed, encourage self-monitoring of weight gain and discuss weight change, diet and level of physical activity
Test for hyperglycaemia if this has not already been tested
Enquire about mental health and administer the EPDS

29–34 weeks

Assess fetal growth
Discuss fetal movements
Review, discuss and record the results of tests undertaken at 28 weeks
Reassess planned pattern of care for the pregnancy and identify women who need additional care, arranging referral if required
Give information, with an opportunity to discuss issues and ask questions on preparation for labour and birth, including her birth plan, recognising active labour and positively managing the pain of normal labour
Discuss breastfeeding (eg skin-to-skin contact at birth, early feeding, rooming-in, attachment, exclusive breastfeeding, feeding on demand, partner support). Discuss safe infant formula feeding if a woman chooses to formula feed.
Measure blood pressure
Test for proteinuria in women who have clinical indications of pre-eclampsia (eg high blood pressure)
Offer women the opportunity to be weighed, encourage self-monitoring of weight gain and discuss weight change, diet and level of physical activity
Offer repeat ultrasound at 32 weeks to women whose placenta extended over the internal cervical os (the opening of the cervix into the vagina) in the 18–20 week scan.
Recommend a second dose of Anti-D to rhesus-negative non-isoimmunised women at 34 weeks

35–37 weeks

Assess fetal growth
Discuss fetal movements
Give information, including care of the new baby, reducing risk of sudden and unexpected death in infancy, newborn screening tests and vitamin K prophylaxis, psychosocial support available in the postnatal period including maternal and child health services and psychosocial supports, with an opportunity to discuss issues and ask questions
Assess fetal presentation by abdominal palpation from 36 weeks and confirm suspected malpresentation by ultrasound
For women whose babies are not a cephalic presentation, discuss a range of options, including external cephalic version for breech presentation
Offer testing for Group B streptococcus if organisational policy is to routinely test all women
Measure blood pressure
Test for proteinuria in women who have clinical indications of or risk factors for pre-eclampsia (eg high blood pressure)
Offer women the opportunity to be weighed, encourage self-monitoring of weight gain and discuss weight change, diet and level of physical activity

38–40 weeks

Assess fetal growth
Give information, including normal length of pregnancy and onset of labour, with an opportunity to discuss any fears and worries and ask questions
Discuss fetal movements, including the need for prompt contact with a health professional if there are any concerns about reduced or absent movements or changes in patterns of movements
Measure blood pressure
Test for proteinuria in women who have clinical indications of pre-eclampsia (eg high blood pressure)
Offer women the opportunity to be weighed, encourage self-monitoring of weight gain and discuss weight change, diet and level of physical activity

Women who have not given birth by 41 completed weeks pregnancy

Give information, including discussion about options for prolonged pregnancy (eg membrane sweeping), with an opportunity to discuss issues and ask questions
Discuss fetal movements, including the need for prompt contact with a health professional if there are any concerns about reduced or absent movements or changes in patterns of movements
Measure blood pressure
Test for proteinuria in women who have clinical indications of pre-eclampsia (eg high blood pressure)
Offer women the opportunity to be weighed, encourage self-monitoring of weight gain and discuss weight change, diet and level of physical activity

Preparing for pregnancy, childbirth and parenthood (see Guideline Chapter 9)

Recommendation	Grade B
Advise parents that antenatal education programs are effective in providing information about pregnancy, childbirth and parenting but do not influence mode of birth.	

Help parents to find a suitable antenatal education program

Assisting parents to find an antenatal education program that is suitable to their learning style, language and literacy level may improve uptake of information.

Topics generally covered in antenatal education programs

Physical wellbeing (nutrition, physical activity, smoking, alcohol, oral health)
Emotional wellbeing and mental health during pregnancy and after the baby is born (maternal-fetal attachment, adapting to change, expectations, coping skills, knowing when to get help)
Labour (stages of labour, positions, breathing and relaxation, support, managing the pain of labour)
Birth (normal birth, assisted births, caesarean section, perineal tears, episiotomy)
Options for women with previous pregnancy or birth complications
Breastfeeding (skin-to-skin contact, benefits of early breastfeeding, attachment, breastfeeding as the physiological norm)
Early parenthood (normal newborn behaviour, settling, sleep safety, immunisation, infant attachment)
Ways to find support and build community networks after the baby is born.

Psychological preparation for parenthood

Recommendation	Grade B
Include psychological preparation for parenthood as part of antenatal care as this has a positive effect on women's mental health postnatally.	

Practice summary

When: At an early antenatal visit.

Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker.

- ☐ **Discuss the benefits of antenatal education**: Explain that, while antenatal education is unlikely to change the overall experience, including mode of birth, it may help women to prepare for the birth. It is also a good opportunity to establish a network of peers and to develop skills for adapting to parenthood.
- ☐ **Involve significant other(s)**: Discuss the benefits of people who are significant to the woman (eg partners and/or other family members) attending antenatal education with the woman.
- ☐ **Provide information**: Support antenatal education by asking women about any topics on which they would like additional information and suggesting or providing appropriate resources (eg written materials suitable to the woman's level of literacy, audio or video, web sources).
- ☐ **Take a holistic approach**: Give information about locally available antenatal education programs and assist women to select a program that is suitable for them. Give expectant parents booklets/ handouts relating to emotional health and wellbeing during pregnancy and early parenthood.

Preparing for breastfeeding (see Guideline Chapter 10)

Discussing breastfeeding

Recommendation	Grade C
Routinely offer education about breastfeeding as part of antenatal care.	

Topics to cover in discussing breastfeeding

The health benefits of breastfeeding for the baby and the mother
A woman's previous experiences of breastfeeding and any concerns related to these
How significant other(s) can support breastfeeding and be involved in other aspects of care
The importance of uninterrupted skin-to-skin contact at birth and of early breastfeeding
The recommended duration of exclusive (6 months) and continued breastfeeding (1 year or more)
The importance of good positioning and attachment, rooming in and feeding on demand
Indications that the baby is ready for a feed and is receiving enough milk
The need to avoid bottles, teats and dummies while breastfeeding is being established
That water is not necessary for the baby: breast milk is sufficient food and drink for the first 6 months
The importance of healthy eating and maternal iodine supplementation when breastfeeding
When to seek advice (eg advice on attachment should be sought if nipple pain continues)
The availability of breastfeeding support locally (eg peer support, lactation consultant)

Maternal conditions and lifestyle choices and breastfeeding

Women with HIV should avoid breastfeeding if replacement feeding is acceptable, feasible, affordable, sustainable and safe
Women with hepatitis B or hepatitis C can breastfeed without risk of transmission to the baby
Breastfeeding remains the best choice, even if the mother continues to smoke
Not drinking alcohol is the safest option for women who are breastfeeding
Illicit drugs should be avoided especially while breastfeeding (specialist advice is needed for each individual)

Practice summary

When: At all antenatal visits.

Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker; lactation consultant; peer breastfeeding counsellor; childbirth educator; accredited dietitian.

- ☐ **Discuss why breastfeeding from birth is important:** Explain that exclusive breastfeeding is biologically and nutritionally appropriate to support growth for 6 months and means that the baby receives only breast milk (ie no other liquids or solids except vitamins or medications if indicated).
- ☐ **Provide practical advice**: Give information about local support for timely assistance with breastfeeding difficulties (eg postnatal home visits, lactation consultants, Australian Breastfeeding Association, peer support).
- ☐ **Involve significant other(s)**: Discuss the importance of support for the mother to enable breastfeeding.
- ☐ **Provide information:** Give booklets/ handouts relating to breastfeeding that are appropriate for the woman. Information should be available in a language that is understood. All information should be free of marketing for formula, bottles and teats.
- ☐ **Take a holistic approach:** In discussing breastfeeding, do not assume that a woman knows how to breastfeed. Reinforce positive attitudes to breastfeeding and tailor advice and support to a woman's individual circumstances, including cultural background. Be aware of different beliefs and cultural practices and explore these with women during pregnancy. Discuss solutions for potential difficulties (eg need to return to work).
- ☐ **Document discussions**: Note a woman's intentions about breastfeeding in her antenatal record. A checklist may provide a prompt for health professionals to ensure discussion about feeding intentions has taken place.