The Pregnancy Care Checklist Australia

By

Maternal Health Matters Inc.

This book is dedicated to all the women of Australia.

Our vision is that every pregnant woman and newborn infant will receive *respectful maternity care* informed by reliable evidence.

This document provides reliable evidence information to assist you to be informed.

Nothing in this document shall be construed as advice from a maternity care provider. This document is strictly intended to provide information regarding its subject matter and may not apply to you as an individual. It is not a substitute for your own maternity care provider's advice. It you require maternity care, please see a midwife or a doctor.

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Introduction

Maternity care in Australia includes antenatal, intrapartum and postnatal care for women and babies up to 12 months after birth. Quality maternity care includes meeting a woman's physical, emotional, psychosocial, spiritual and cultural needs.

The focus of maternity care needs to be on the right level of care, which is quality care that is tailored to a woman's individual needs and preferences, weighs the benefits and harms, is woman-centered with collaboration between the woman and her health professionals, is provided in a continuity of carer model, informed by reliable evidence.

Extensive research evidence shows that the right level of maternity care achieves the best outcomes for women and focuses on:

- building a woman's knowledge and confidence,
- the knowledge, technical skill and values of the health professional, and
- positive interpersonal relationships between the woman and the health professional

This checklist addresses the first dot point by informing, building knowledge and enabling confidence so women can demand best evidence maternity care and be protected from inappropriate interventions.

It is hoped that you will use this checklist to prepare for each antenatal visit. Using the checklist at your antenatal visits will help you to be confident you are receiving the right level of care based on The Australian Clinical Practice Guidelines Pregnancy Care.

Background

Health advice should be based in evidence, but it can be hard to know if the advice has been properly tested. The Australian Clinical Practice Guidelines Pregnancy Care (The Guidelines) were developed to ensure that women are provided consistent, high quality, evidence-based antenatal care. The Guidelines are intended for use by all health professionals who contribute to pregnancy care.

Maternal Health Matters Inc. (MHM), believe that pregnant women will benefit from having this information available to them. The Pregnancy Checklist is based on the national Clinical Practice Guidelines Pregnancy Care that were developed to support high quality, respectful, safe antenatal care in all settings.

The checklist provides a reliable and standard reference for women with the aim to promote consistency of care and improve the experience and outcomes of pregnancy care.

The checklist covers the core practices in antenatal care required by healthy pregnant women to achieve safe, respectful maternity care, including:

- discussing health and wellbeing during pregnancy
- providing information to support parents to prepare for pregnancy, childbirth and parenthood
- promoting and supporting breastfeeding
- assessing fetal wellbeing
- assessing your health, in particular factors indicating that additional care may be required
- assessing for any condition that may affect your health or the unborn baby
- providing advice on symptoms that are common during pregnancy
- discussing and offering testing for chromosomal anomalies; and
- providing opportunities for you to raise any issues they wish to discuss.

Throughout the checklist we have included the relevant reference to the Clinical Practice Guidelines Pregnancy Care. They are notated as Reference: Chapter X on the right hand side of the page.

For example:

Reference Chapter 8

Respectful Maternity Care

The World Health Organization has included Respectful Maternity Care as a core competency in their 2016 standards for improving the quality of maternal and newborn care.

The World Health Organization (WHO) states *every woman has the right to the highest attainable standard of health, which includes the right to* ***dignified, respectful*** *care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination.*

Dignity is the recognition and acceptance of the value of all humans and the vulnerability in all humans. In maternity care this dual focus on your value and your vulnerability is key to the concept of dignity, where the recognition of your value is based in acknowledging your vulnerability to injury and humiliation.

Respectful Maternity Care is a human right.

Respectful Maternity Care (RMC) is an approach focusing on factors that support your health and well-being. RMC recognises your individual needs (social, emotional, physical, psychological, spiritual and cultural) and ensures your expectations for pregnancy, labour, birth and transitioning to mothering are considered and respected.

RMC is care organized for and provided in a manner that maintains your dignity, privacy, confidentiality; ensures you are free from harm and mistreatment; enables you to make informed decisions and choices about your care; and provides continuous support during pregnancy, labour, childbirth and transitioning to mothering.

Without respectful maternity care, women are not safe.

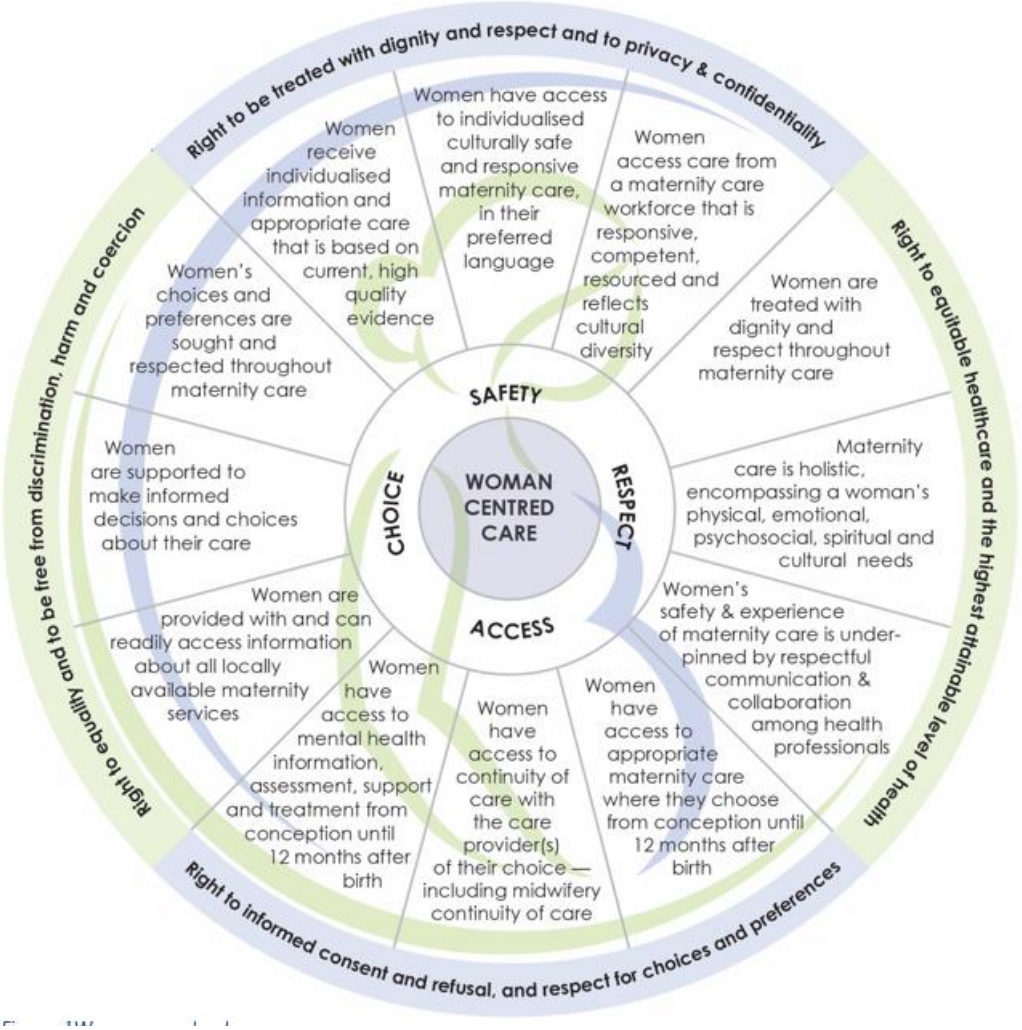
No matter the progress of a pregnancy, women are entitled to empathy, to be heard, respected for their decisions and to be honoured during this special life event. You should know and understand that you are entitled to receive maternity care that at its core provides kindness, understanding, tolerance, and compassion. Throughout the pregnancy, you should be given information in an appropriate form to support you to make an informed decision and choices about your care.

Woman-centred care: Strategic directions for Australian maternity services is based on the values of safety, respect, choice and access. These values align with the *Respectful Maternity Charter: the universal rights of childbearing women.*

Woman-centred care: Strategic directions for Australian maternity services

The Australian Government published in October 2019, a national strategy to support the delivery of maternity services to women, from conception until 12 months after birth. Woman-centred care: Strategic directions for Australian maternity services, (the Strategy). The Strategy aims to ensure that Australian maternity services are respectful, equitable, safe, woman-centred, informed and evidence-based.

The diagram below gives a visual representation of the purpose, values and principles outlined in *Woman-centred care: Strategic directions for Australian maternity services.*



The principles of quality pregnancy care

***Care for women with a normal pregnancy and birth should promote normal reproductive processes and women's inherent capabilities*.** Pregnancy and birth should be viewed as a natural process in life and essential care should be provided to women with the minimum set of interventions necessary.

***Care for women with a normal pregnancy and birth should promote normal reproductive processes and women's inherent capabilities*.** Pregnancy and birth should be viewed as a natural process in life and essential care should be provided to women with the minimum set of interventions necessary

Care should be based on the use of appropriate technology. Sophisticated or complex technology should not be applied when simpler procedures may suffice or be superior.

Care should be evidence-based. Care should be supported by the best available research, and by randomised controlled trials where possible and appropriate.

Care should be local. Care should be available as close to the woman's home as possible and based on an efficient system of referral from primary care to tertiary levels of care.

Care should be multidisciplinary. Effective care may involve contributions from a wide range of health professionals, including midwives, general practitioners, obstetricians, neonatologists, nurses, and childbirth and parenthood educators.

Care should be holistic. Care should include consideration of the intellectual, emotional, social and cultural needs of women, their babies and families, and not only their physical care.

Care should be woman-centred. The focus of care should be meeting the needs of the woman and her baby. Each woman should negotiate the way that her partner and significant family or friends are involved. Care should be tailored to any special needs a woman may have.

Care should be culturally appropriate and culturally safe. Care should consider and allow for cultural variations in meeting these expectations.

Care should provide women with information and support so they can make decisions. Women should be given evidence-based information that enables them to make decisions about care. This should be provided in a format that the woman finds acceptable and can understand.

Care should respect the privacy, dignity and confidentiality of women. All women have the right to be treated with respect and dignity, have their privacy respected, and be assured that all their health information is confidential

Reference: Principles of care | Australian Government Department of Health

Core antenatal care

Weeks One to Four of Pregnancy

Day 1 Start of menstrual period

Week 2 Your baby is conceived

Week 3 You may show early pregnancy signs, for example sensitive breasts, implantation spotting / bleeding and nausea

Week 4 Your period does not occur as expected. You confirm your pregnancy:

- using a home pregnancy test or
- visiting your preferred health service

If you have a 28 day cycle you can calculate your due date by adding 280 days (40 weeks) to the first day of your last menstrual period. Reference Chapter 20

Calculating your due date isn't an exact science. Very few women actually deliver on their due date, so, while it's important to have an idea of when your baby will be born, try not to get too attached to the exact date

Now is an excellent time to explore your options for pregnancy birth and parenting. The following may be helpful:

- Woman-centred care: Strategic directions for Australian maternity services
- Pregnancy Care Options (Appendix 1)
- Choosing the maternity care you need and want (Appendix 2)

Once you have explored your options make an appointment with your preferred provider:

- a midwife
- your local midwifery group practice
- hospital antenatal clinic
- your GP, for shared care
- your GP for a referral to an obstetrician.

Week 5 Preparation for your first antenatal visit

It is helpful to document your health history to bring to your first antenatal visit. Below is a list to consider in preparing your health history.

Existing health conditions

- □ Overweight or underweight
- □ Cardiovascular disease (e.g. hypertension, congenital heart disease, rheumatic heart disease)
- □ Other conditions (e.g. kidney disease; type 1 or type 2 diabetes; thyroid, haematological (blood) or autoimmune disorders; epilepsy; malignancy; severe asthma; HIV, hepatitis B or hepatitis C infection; Female genital mutilation/cutting.
- □ Mental health disorders
- □ Disability
- □ Vaccination history
- □ Infectious illness and immunization history – measles, mumps, rubella, chicken pox, scarlet fever, hepatitis, whooping cough. For further information go to Immunisation for pregnancy.
- □ Family health history

Experiences in previous pregnancies

- □ Termination of pregnancy
- □ More than two miscarriages
- □ Preterm birth
- □ Pre-eclampsia or eclampsia (high blood pressure, fluid retention and protein in the urine)
- □ Rhesus isoimmunisation (blood type incompatibility), or other blood group antibodies
- □ Uterine surgery (e.g. caesarean section)
- □ Antenatal or postpartum haemorrhage (excessive bleeding)
- □ 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 (an abnormality)

Previous major surgery

- □ Cardiac (including correction of congenital anomalies)
- □ Gastrointestinal (e.g. bowel resection)
- □ Bariatric (gastric bypass, lap-banding)
- □ Gynaecological (e.g. cone biopsy, any surgery to the reproductive organs)

Lifestyle considerations

- □ History of alcohol use
- □ Use of recreational drugs such as marijuana, heroin, cocaine (including crack cocaine), amphetamines (e.g. 'ice') and ecstasy

Psychosocial factors

- □ Developmental delay or other disabilities
- □ Vulnerability or lack of social support
- □ Previous experience of violence or social dislocation

Reference Chapter 8

You may find the following helpful:

- WHO recommendations on antenatal care for a positive pregnancy experience
- WHO recommendations: intrapartum care for a positive childbirth experience

Weeks 6 to 10 - The first antenatal appointment

Your first antenatal visit should occur within the first 10 weeks.

Book a long appointment, so you are not rushed and have time to get to know your health practitioner.

Your first appointment is really a selection interview to determine if your chosen midwife/doctor and you are a good fit. It is an ideal time to have a discussion, to help you establish a relationship, to find out their care philosophy and their maternity care outcomes. Trust your gut instincts. It is essential that you develop a strong partnership and good communication with your midwife/doctor to build your confidence during this special time.

Gauge your midwife/doctor's attitude to your questions as well as their responses. Observe for an open, caring and informative manner as opposed to an indifferent or uncaring attitude. Look for a willingness to listen, rather than an attitude of professional arrogance, not listening or unresponsiveness to your questions or a lack of respect of you and your time.

At you first visit your midwife/doctor will discuss with you, your:

- □ expectations,
- □ partner/family involvement,
- □ cultural and spiritual issues,
- □ concerns,
- □ knowledge of pregnancy, birth, breastfeeding and infant feeding options
- □ support networks
- □ information needs and
- □ factors that may affect the pregnancy or birth - physical, social, emotional (e.g. female genital mutilation/cutting).

Reference Chapter 8 & Part B: Core practices in pregnancy care

Health Assessment

Your comprehensive history will be collected by your midwife/doctor including:

1 Current Pregnancy

Your current pregnancy will be discussed including: planned; unplanned; wishes to proceed with or terminate the pregnancy. Reference Chapter 8

2 Gestational Age

Gestational age is the common term used during pregnancy to describe how far along the pregnancy is. It is measured in weeks, from the first day of the woman's last menstrual cycle to the current date. A normal pregnancy can range from 38 to 42 weeks.

If you are unsure of your conception date your midwife or doctor will provide information and may offer you an ultrasound scan between 8 weeks 0 days and 13 weeks 6 days to determine gestational age. Regardless of which method used to determine your due date, it is wise to remember your baby is due plus or minus two weeks from this date. See Calculating the estimated date of birth.

> The agreed due date should not be changed without advice from another health professional with considerable experience in antenatal care.
>
> Ultrasound assessment should only be performed by healthcare professionals with appropriate training and qualifications, within the appropriate scope (e.g. diagnostic or point of care).

Reference Chapter 20

3 Your Obstetric History

- □ Previous experience of pregnancy and birth
- □ Infant feeding experiences

4 Your Medical history

Your Medical history will be collected (your health history, medicines, family history [high blood pressure, diabetes, genetic conditions], cervical smears, immunisation, breast surgery).

Your risk of hyperglycaemia (high blood sugar) will be assessed, including: your age; body mass index; previous gestational diabetes or high birth weight baby; family history of diabetes; presence of polycystic ovarian syndrome; and whether you are from an ethnic group with high prevalence of diabetes, will be assessed by your midwife or doctor. Reference Chapter 32

5 Your Oral Health History.

You will be advised to see a dentist/ dental hygienist to have an oral health check and treatment, if required. Good oral health is important to your health and treatment can be safely provided during pregnancy. Reference Chapter 16

6 Your Lifestyle History

Your nutrition and physical activity will be assessed. Your smoking, alcohol and other substance use/ misuse will be discussed and you will be provided with education and strategies to address any concerns. Reference Chapters 12 & 13

If you wish to stop smoking consider referral for smoking cessation interventions such as cognitive behavioural therapy

While you are pregnant or planning a pregnancy ***not drinking*** is the safest option as your alcohol consumption may adversely affect the developing fetus

While you are pregnant or planning a pregnancy ***not smoking*** is the safest option as your smoking may adversely affect the developing fetus

Early in pregnancy, tell your health midwife/ doctor of your use of illicit substances and misuse of pharmaceuticals and seek advice about any impact. Reference Chapter 8 & 12

7 Clinical Assessment

A range of clinical assessments is offered to promote and enhance your physical and emotional wellbeing and your baby during pregnancy. Reference Chapter 8

□ Your **blood pressure** will be measured to identify existing high blood pressure, Reference Chapter 24

□ Your **weight and height** will be measured at the first antenatal visit to calculate your body mass index (BMI) so as to inform gestational weight gain.

Discuss appropriate weight gain during pregnancy at the first antenatal visit

When discussing weight management, your midwife /doctor will be respectful, positive and supportive, providing information about healthy eating and physical activity that may assist with weight management. Reference Chapter 19

□ **Protein in your Urine** You will be offered testing for proteinuria, regardless of stage of pregnancy. Reference Chapter 25

□ **Depression and anxiety** The Edinburgh Postnatal Depression Scale (EPDS) will be used to screen you for a possible depressive disorder. Further assessment will be arranged for you if your EPDS score is 13 or more. Your midwife/doctor will use appropriately translated versions of the EPDS. Reference Chapter 27

□ **Psychosocial factors affecting mental health** Your psychosocial risk factors will be assessed as early as practical in your pregnancy and discuss with you the possible impact of psychosocial risk factors on your mental health as well as providing information about available assistance. Your midwife or doctor will consider language & cultural appropriateness of any tool used to assess psychosocial risk. Reference Chapter 28

□ **History of Family violence** Asking about family violence is a routine part of antenatal care and your midwife /doctor will enquire about your exposure to family violence.

Pregnancy is a time when violence toward women is known to increase.
For many, it is the first time that they will actually experience family or intimate partner violence. Reference Chapter 29

8 Routine maternal health tests at the first antenatal visit.

Your midwife/doctor will discuss the reasons for testing, harms, benefits and associated treatments and provide appropriate resources as well as give you the opportunity to ask questions. It is your choice to have tests and your consent is required.

If you are diagnosed with a condition that may affect your pregnancy and/or the health of your baby you will be given information about available supports and help to access the supports.

You will be offered testing for:

- □ **Blood group and antibodies**, **full blood count**, a blood test. Reference Chapter 30
- □ **Anaemia haemoglobin** concentration, a blood test. Reference Chapter 30
- □ **Hyperglycaemia.** A blood test. Reference Chapter 32
- □ **Human immunodeficiency virus (**HIV) testing is recommended at the first antenatal visit as effective interventions are available to reduce the risk of mother-to-child transmission. A blood test. Reference Chapter 33
- □ **Hepatitis B** as effective postnatal intervention can reduce the risk of mother-to-child transmission. A blood test. Reference Chapter 34
- □ **Hepatitis C** A blood test. Reference Chapter 35
- □ **Syphilis** testing is recommended, a blood test. Reference Chapter 36
- □ **Rubella** testing for rubella immunity is recommended to identify if you are at risk of contracting rubella and enable postnatal vaccination to protect your future pregnancies. A blood test. Reference Chapter 37
- □ **Asymptomatic bacteriuria** (Also called symptom free urinary tract infection). If you have a history of urinary tract infections, please tell your midwife /doctor. A urine sample will be required. The test is recommended early in pregnancy as treatment is effective and reduces the risk of complications such as pyelonephritis. Reference Chapter 38

For further information please see https://www.health.gov.au/resources/publications/routine-maternal-health-tests

9 Tests for probability of chromosomal anomalies

Your midwife/doctor will discuss the purpose and implications of testing for chromosomal anomalies to enable you to make informed choices. You will be provided information about chromosomal anomalies and tests used to identify their probability in a way that is appropriate and accessible to you. If your baby is diagnosed with a condition that may affect your pregnancy and/or the health of your baby you will be given information about available supports and help to access them. Reference Part H

10 Targeted maternal health tests at the first antenatal visit

Your health history may highlight the need for targeted tests. These may include:

- □ **Chlamydia** You will routinely be offered chlamydia testing at your first antenatal visit if you are younger than 30 years. Reference Chapter 40
- □ **Gonorrhoea** You will routinely be offered gonorrhoea testing if you have known risk factors or live in or come from areas where prevalence is high. Reference Chapter 41
- □ **Trichomoniasis** Your midwife or doctor will offer testing if you have symptoms of trichomoniasis. Reference Chapter 42
- □ **Toxoplasmosis** Your midwife or doctor will not routinely offer testing for toxoplasmosis to pregnant women. Reference Chapter 43

  Measures to avoid toxoplasmosis infection include:
  - washing hands before handling food
  - thoroughly washing all fruit and vegetables, including ready-prepared salads, before eating
  - thoroughly cooking raw meat and ready-prepared chilled meals
  - wearing gloves and thoroughly washing hands after handling soil and gardening
  - avoiding cat faeces in cat litter or in soil

- □ **Cytomegalovirus** Your midwife / doctor will offer testing for cytomegalovirus if you: come into frequent contact with large numbers of very young children (e.g. child care workers); or have symptoms suggestive of cytomegalovirus infection; or when imaging findings suggest fetal infection. Reference Chapter 44

  Your midwife or doctor will advise you about hygiene measures to help reduce the risk of cytomegalovirus infection, including avoiding contact with a child's saliva or urine and hand washing after such exposure.

- □ **Asymptomatic bacterial vaginosis** Your midwife /doctor will not routinely offer testing for bacterial vaginosis. Reference Chapter 45
- □ **Thyroid dysfunction** Your midwife /doctor will not routinely test for thyroid dysfunction. Reference Chapter 46
- □ **Vitamin D status** Your midwife/ doctor will not routinely recommend testing for vitamin D status in the absence of a specific indication. Reference Chapter 47
- □ **Human papilloma virus** (under review) Your midwife or doctor will offer women cervical screening as specified by the National Cervical Screening Program. Reference Chapter 48
- □ **Cervical Screening** If you have not had a recent cervical screening please tell your midwife /doctor Reference Chapter 48

Your midwife/ doctor will discuss the reasons for testing, harms, benefits and associated treatments and provide appropriate resources and give you the opportunity to ask questions. It is you choice to have the tests, your consent is required.

If you are diagnosed with a condition that may affect your pregnancy and/ or the health of your baby you will be given information about treatments, available supports and help to access the supports. Reference: Pregnancy Care Guidelines Part G: Targeted maternal health tests

10 Antenatal Education

At every antenatal visit you will be provided with antenatal education that is suited to your requirements so that you can be informed about pregnancy and be prepared for birth and parenting. Reference Chapter 9

11 Antenatal visits during pregnancy

Determine with your midwife/ doctor a schedule of antenatal visits based on your needs.

This includes information about the likely number, timing and content of antenatal visits associated with different options of care.

- □ 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. Reference Chapter 8

Weeks 14 to 15 Tests

Diagnostic testing for chromosomal anomalies

If you choose to have a diagnostic test for chromosomal anomaly, the choice of test will be decided on gestational age and your preferences:

- chorionic villus sampling before 14 weeks pregnancy; and
- amniocentesis after 15 weeks.

You will be offered rapid access to appropriate counselling and ongoing support by trained health professionals if you receive a diagnosis of fetal chromosomal anomaly.

If you have a high-probability test result but negative diagnostic test you will be referred for further specialist assessment because of the increased likelihood of other fetal anomalies.

Reference Part H & Chapter 51

Weeks 16 to 19 Antenatal Visit

At every antenatal visit between 16 and 19 weeks, your midwife/ doctor will

- □ Discuss how you have been since the last visit
- □ Discuss the results of all tests undertaken and reassess the planned pattern of care in light of the results
- □ Provide you with the opportunity to be weighed

  At every antenatal visit, discuss weight change, diet and level of physical activity with your midwife /doctor. Reference Chapter 19

- □ Measure your blood pressure

  If elevated, you will be given information about the urgency of seeking advice from a health professional if you experience: headache; visual disturbance (such as blurring or flashing before the eyes); epigastric pain (just below the ribs); vomiting; and/or rapid swelling of the face, hands or feet. Reference Chapter 26

- □ Test your urine for protein if you have risk factors for or clinical indications of pre-eclampsia, in particular, raised blood pressure. Reference Chapter 25
- □ Assess your baby's growth
- □ Offer you the opportunity to listen to your baby's fetal heart rate.

  Use of electronic fetal heart rate monitoring is not routine in uncomplicated pregnancies. Reference Chapter 22

- □ Fetal movement will be assessed. You may feel movements as early as 16 weeks - a kick, flutter, swish or roll. As your baby grows, both the number and type of movements will change with your baby's activity pattern

  Your concern about decreased fetal movements overrides any definition of decreased fetal movements. Reference Chapter 22

Weeks 18 to 20 Antenatal Visit

Fetal development and anatomy assessment

You may be offered an ultrasound screening to assess fetal development and anatomy between 18 and 20 weeks gestation.

Ultrasound assessment should only be performed by healthcare professionals with appropriate training and qualifications.

Repeated ultrasound assessment should not be used for routine monitoring.

Reference Chapter 21

Weeks 20 to 27 Antenatal Visit

At every antenatal visit between 20 and 27 weeks, your midwife/ doctor will

- □ Discuss how you have been since the last visit
- □ Discuss the results of all tests undertaken and reassess the planned pattern of care in light of the results
- □ Assess fetal growth - based on a number of indicators not solely on abdominal palpation. At each antenatal visit from 24 weeks, your midwife of doctor will measure your fundal height in centimetres
- □ Discuss fetal movements: timing, normal patterns etc.
- □ Offer the opportunity to listen to your baby's fetal heart rate
- □ Measure your blood pressure
- □ Test for proteinuria if you have a clinical indications of pre-eclampsia (e.g. high blood pressure)
- □ Offer you the opportunity to be weighed
- □ Test for hyperglycaemia (high blood sugars) between 24 and 28 weeks gestation
- □ Repeat ferritin (iron) testing if levels were identified as low in the first trimester

Reference Chapter 8

Whooping cough immunisation is recommended for pregnant women in the third trimester, ideally between weeks 20 and 32 of every pregnancy, at no cost through the NIP Reference Immunisation for pregnancy

Week 28 Antenatal Visit

Your midwife/doctor will

- □ Discuss how you have been since the last visit
- □ Discuss the results of all tests undertaken and reassess planned pattern of care in:
- □ Assess fetal growth and measure your fundal height in centimetres
- □ Discuss fetal movements: timing, normal patterns etc.
- □ Measure your blood pressure
- □ Test for proteinuria if you have a clinical indications of pre-eclampsia (e.g. high blood pressure)
- □ Offer you the opportunity to be weighed
- □ Test for hyperglycaemia (high blood sugars) if this has not already been tested
- □ Enquire about your mental health and wellbeing and ask you to complete an assessment tool such as the EPDS or similar
- □ Offer the opportunity to listen to your baby's fetal heart rate

Reference Chapter 8

Weeks 29 to 34 Antenatal Visit

Your midwife/ doctor will

- □ Discuss how you have been since the last visit
- □ Discuss the results of all tests undertaken at 28 weeks and reassess the planned pattern of care in light of the results
- □ Reassess the planned pattern of care for the pregnancy and identify women who need additional care, arranging referrals if required
- □ Assess fetal growth and measure your fundal height in centimetres
- □ Discuss fetal movements: timing, normal patterns etc.
- □ Offer you the opportunity to listen to your baby's fetal heart rate
- □ Measure your blood pressure
- □ Test for proteinuria if you have a clinical indications of pre-eclampsia (e.g. high blood pressure)
- □ Offer you the opportunity to be weighed
- □ Offer a 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
- □ Give information, and provide you with an opportunity to discuss issues and ask questions on preparation for labour and birth, birth planning, recognising active labour and positively managing the pain of normal labour
- □ Discuss factors that are known to impact on breastfeeding (e.g. 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.

Reference Chapter 8

Weeks 35 to 37 Antenatal Visit

Your midwife/ doctor will

- □ Discuss how you have been since the last visit
- □ Discuss the results of all tests undertaken and reassess the planned pattern of care in light of the results
- □ Assess fetal growth and measure your fundal height in centimetres
- □ Discuss fetal movements: timing, normal patterns etc.
- □ Provide the opportunity to listen to your baby's fetal heart rate
- □ Measure your blood pressure
- □ Test for proteinuria if you have a clinical indications of pre-eclampsia (e.g. high blood pressure)
- □ Offer you the opportunity to be weighed
- □ Offer testing for Group B streptococcus if organisational policy is to routinely test all women
- □ Give information, discuss issues and answer your questions including:
    - care of the new baby,
    - reducing risk of sudden and unexpected death in infancy,
    - newborn screening tests, vitamin K prophylaxis and immunisations,
    - psychosocial support available in the postnatal period including maternal and child health services and psychosocial supports

Reference Chapter 8

Weeks 36 and 37 - Assessment of your baby's

At 36 Weeks

The baby's presentation (position in your uterus) will be assessed by abdominal palpation as presentation influences the plans for the birth.

Suspected non-cephalic (cephalic = head) presentation after 36 weeks should be confirmed by an ultrasound assessment. If your baby is not presenting head down, your midwife/ doctor will discuss a range of options, including external cephalic version.

Reference Chapter 61

At 37 Weeks

If you have a Fetal Breech (bottom first) Presentation and you have an uncomplicated singleton pregnancy you may be offered external cephalic version after 37 weeks of gestation.

Relative contraindications for external cephalic version include a previous caesarean section, uterine anomaly, vaginal bleeding, ruptured membranes or labour, oligohydramnios, placenta praevia and fetal anomalies or compromise. Reference Chapter 8

External cephalic version should only be performed by a health professional with appropriate expertise. Reference Chapter 61

Weeks 38 to 40 Antenatal Visit

Your midwife/doctor will

- □ Discuss how you have been since the last visit
- □ Discuss the results of all tests undertaken and reassess the planned pattern of care in light of the results
- □ 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
- □ Assess fetal growth and measure your fundal height in centimetres
- □ Offer you the opportunity to listen to your baby's fetal heart rate
- □ Measure your blood pressure
- □ Test for proteinuria if you have a clinical indications of pre-eclampsia (e.g. high blood pressure)
- □ Offer you the opportunity to be weighed

Reference Chapter 8

Week 41 Antenatal Visit

Your midwife/doctor will

- □ Discuss how you have been since the last visit
- □ Discuss the results of all tests undertaken and reassess the planned pattern of care in light of the results
- □ 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
- □ Assess fetal growth and measure your fundal height in centimetres
- □ Offer you the opportunity to listen to your baby's fetal heart rate
- □ Measure your blood pressure
- □ Test for proteinuria if you have a clinical indications of pre-eclampsia (e.g. high blood pressure)
- □ Offer you the opportunity to be weighed

If you have not given birth by 41 completed weeks of pregnancy, you will be given the information you need to make an informed decision as well as time to explore the options, including:

- □ options for prolonged pregnancy (e.g. membrane sweeping), and
- □ induction of labour. Reference Chapter 62

The World Health Organization states induction of labour is not recommended for women with an uncomplicated pregnancy at gestational age less than 41 weeks. For more information refer to ***WHO Recommendations for Induction of labour at or beyond term*** .

Summary of pregnancy assessments

Clinical assessment	Advice about assessment
Weight and body mass index	Calculation of body mass index at the first antenatal visit allows appropriate advice to be given about weight gain during pregnancy
Gestational age	Ultrasound scanning is most accurate in determining gestational age between 8 and 14 weeks of pregnancy but can be used in the assessment of gestational age until 24 weeks; after 24 weeks of pregnancy, the date of the last menstrual period is used
Fetal development and anatomy	Ultrasound scanning at 18–20 weeks of pregnancy detects structural anomalies
Fetal growth restriction	Fetal growth is assessed at each antenatal visit, usually by fundal height measurement (from 24 weeks)
Fetal movements	Promoting awareness of the normal pattern of fetal movement assists women in knowing when to seek advice if they perceive alterations in movements, especially if movements are decreased or absent
Fetal heart rate	Listening to the fetal heart is not predictive of pregnancy outcomes although many women like this as part of antenatal care
Risk of preterm birth	Discussing risk and protective factors for preterm birth may assist some women to reduce their risk
Blood pressure	Measuring blood pressure at the first antenatal visit allows identification of women who have chronic hypertension who may require additional monitoring Measuring blood pressure at each antenatal visit allows monitoring for new onset hypertension including pre-eclampsia
Proteinuria	Testing women for proteinuria at the first antenatal visit identifies existing kidney disease or urinary tract infection After the first antenatal visit, proteinuria is tested in women with risk factors for, or clinical indications of, pre-eclampsia

Core Antenatal Education

Preparing for pregnancy, childbirth and parenthood

Antenatal education is part of maternity care. Reference: Chapter 9

Your midwife/ doctor will routinely offer antenatal education as part of the antenatal care provided and plays a vital role in, preparing you to birth your child and supporting your transition to parenting. They will discuss with you other options also available.

Antenatal education may be delivered one-on-one or in groups (e.g. in a women's group, couples' workshop or a class situation).

Antenatal education programs are effective in providing information about pregnancy, childbirth and parenting but do not influence mode of birth.

Psychological preparation for parenthood is an important part of antenatal care as this has a positive effect on your mental health postnatally.

Your midwife/ doctor will provide or will assist parents to find an antenatal education program that is suitable for their circumstances.

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, SIDS safety, immunisation, infant attachment)
- □ Ways to find support and build community networks after the baby is born.

Reference Chapter 9.

Preparing for breastfeeding

Your midwife/ doctor will routinely offer education about breastfeeding as part of routine antenatal care.

Topics to cover include:

- □ The health benefits of breastfeeding for the baby and the mother.
- □ A woman's previous experiences of breastfeeding and any related concerns.
- □ How significant others 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 (2 years 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 (e.g. advice on attachment should be sought if nipple pain continues)
- □ The availability of breastfeeding support locally (e.g. peer support, lactation consultant)

Reference Chapter 10

You may find this link helpful - https://www.breastfeeding.asn.au/

Safe Use of Medicines while pregnant

While you are pregnant or planning a pregnancy the use of prescription and over-the-counter medicines should be limited to circumstances where the benefit outweighs the risk as few medicines have been established as safe to use in pregnancy.

Therapeutic Goods Administration Category A medicines have been established to be safe in pregnancy.

Few herbal preparations have been established as being safe and effective during pregnancy. Herbal medicines should be avoided in the first trimester. Reference Chapter 14

Common conditions during pregnancy

It is important to bring any discomforts and concerns you are experiencing to the attention of you midwife /doctor. The following information is to help you when discussing your concerns with your midwife /doctor.

Condition	Chapter
Nausea and vomiting	
• If you experience nausea and vomiting in pregnancy you can be advised that, while it may be distressing, it usually resolves spontaneously by 16 to 20 weeks pregnancy and is not generally associated with a poor pregnancy outcome.	54
• You may be advised to discontinue iron-containing multivitamins for the period that you have symptoms of nausea and vomiting.	54
Constipation	
• If experiencing constipation, you will be provided information about increasing dietary fibre intake and taking bran or wheat fibre supplementation.	55
• If you choose to take laxatives you will be advised that preparations that stimulate the bowel are more effective than those that add bulk but may cause more adverse effects such as diarrhoea and abdominal pain.	55
Reflux (heartburn*)*	
• If you experience mild symptoms of heartburn you will be offered advice on lifestyle modifications and avoiding foods that cause symptoms on repeated occasions.	56
• If you have persistent reflux you will be offered information about treatments.	56
Haemorrhoids	
• If you have haemorrhoids you will be offered information about increasing dietary fibre and fluid intake. If clinical symptoms remain, you will be advised that you can consider using standard haemorrhoid creams.	57
Varicose veins	
• You will be advised that varicose veins are common during pregnancy, vary in severity, will not generally cause harm and usually improve after the birth. Correctly fitted compression stockings may be helpful.	58
Pelvic girdle pain	
• If experiencing pelvic girdle pain, you will be advised that pregnancy-specific exercises, physiotherapy, acupuncture or using a support garment may provide some pain relief.	59
Carpal tunnel syndrome	
• If experiencing symptoms of carpal tunnel syndrome, you will be advised that that the evidence to support either splinting or steroid injections is limited and symptoms may resolve after the birth.	60

Reference: Part I: Common conditions during pregnancy

Conclusion

This Checklist, based on the Clinical Practice Guidelines – Pregnancy Care, provides reliable evidence recommendations to support you to receive high quality, appropriate care that will contribute to improved outcomes for you and your baby.

Using the checklist will ensure you receive the maternity care you need, at the right level, at the right time, and in a manner that respects, protects, and promotes your human rights, avoiding the extremes of too little, too late (TLTL) and too much, too soon (TMTS), both of which may causes harm to you or your baby.

TLTL because you miss out on vital care.

TMTS because you receive routine over-medicalisation of normal pregnancy and birth, receive unnecessary non-evidence-based interventions, as well as the use of interventions that can be life-saving when used appropriately, but harmful when applied routinely or overused.

If the care are offered deviates from the care described in the checklist, it is appropriate to draw this to your midwife/ doctor's attention.

If an item on the checklist is *not done*, simply ask why.

If an item is *not on the checklist*, it is important that you have the information you need to make an informed decision, to accept or decline the intervention. Questions to ask you midwife/doctor include:

Why do I need this test, procedure or intervention?

What are the risks?

Will there be side effects to test, procedure or intervention?

What are the chances of getting results that aren't accurate?

There is an error rate with all interventions that could that lead to more tests, procedures or interventions. This is called the cascade of interventions.

Is there other simpler, safer options?

What happens if I don't do anything?

What are the costs?

We at Maternal Health Matters Inc. hope that you have found the Pregnancy Checklist helpful.

Appendix 1 Pregnancy Care Options

Your pregnancy Care Options include the following.

- **Continuity of Midwifery Carer:** Midwife-led continuity of care – in which a pregnant woman receives care from the same midwife, or small group of midwives during pregnancy, labour, the postpartum period and transitioning to mothering.
- **Private obstetrician (specialist) care:** Antenatal care provided by a private specialist obstetrician. Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician and hospital midwives in collaboration. Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and may continue in the home, hotel or hostel.
- **Private midwifery care:** Antenatal, intrapartum and postnatal care is provided by a private midwife or group of midwives in collaboration with doctors in the event of identified risk factors. Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home.
- **GP obstetrician care:** Antenatal care provided by a GP obstetrician. Intrapartum care is provided in either a private or public hospital by the GP obstetrician and hospital midwives in collaboration. Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives and may continue in the home or community.
- **Shared care:** Antenatal care is provided by a community maternity service provider (doctor and/ or midwife) in collaboration with hospital medical and/ or midwifery staff under an established agreement, and can occur both in the community and in hospital outpatient clinics. Intrapartum and early postnatal care usually takes place in the hospital by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).
- **Combined care:** Antenatal care provided by a private maternity service provider (doctor and/or midwife) in the community. Intrapartum and early postnatal care provided in the public hospital by hospital midwives and doctors. Postnatal care may continue in the home or community by hospital midwives.
- **Public hospital maternity care:** Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives and/ or doctors. Intrapartum and postnatal care is provided in the hospital by midwives and doctors. Postnatal care may continue in the home or community by hospital midwives.
- **Public hospital high risk maternity care:** Antenatal care is provided to women with medical high risk/ complex pregnancies by maternity midwife/ doctor (specialist obstetricians and/or maternal-fetal medicine subspecialists in collaboration with midwives) Intrapartum and postnatal care is provided by hospital doctors and midwives. Postnatal care may continue in the home or community by hospital midwives.

- **Team midwifery care:** Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives (no more than eight) in collaboration with doctors in the event of identified risk factors. Intrapartum care is usually provided in a hospital or birth centre. Postnatal care may continue in the home or community by the team midwives.
- **Midwifery Group Practice caseload care:** Antenatal, intrapartum and postnatal care is provided within a publicly-funded caseload model by a known primary midwife with secondary backup midwife/midwives providing cover and assistance with collaboration with doctors in the event of identified risk factors. Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.
- **Remote area maternity care:** Antenatal and postnatal care is provided in remote communities by a remote area midwife or group of midwives sometimes in collaboration with a remote area nurse and/or doctor. Antenatal and postnatal care, including high- and low-risk pregnancies, as well as consultations for the management of gestational diabetes is provided via telehealth in a number of areas. Alternatively, fly-in-fly-out models can support clinicians in an outreach setting. Intrapartum and early postnatal care is provided in a regional or metropolitan hospital (involving temporary relocation prior to labour) by hospital midwives and doctors.
- **Private obstetrician and privately practicing midwife joint care**: Antenatal, intrapartum and postnatal care is provided by a privately practicing obstetrician and midwife from the same collaborative private practice. Intrapartum care is usually provided in either a private or public hospital by the privately practicing midwife and/ or private specialist obstetrician in collaboration with hospital midwifery staff. Postnatal care is usually provided in the hospital and may continue in the home, hotel or hostel by the privately practicing midwife.

Reference: *Woman-centred care: Strategic directions for Australian maternity services*

Appendix 2 - Achieving the maternity care you need and want

Prepare for your appointment by creating a list of questions to ask. This preparation will help you get more out of the time with your maternity care provider and help you to remember everything you want to ask.

Below is a range questions you might ask to ensure you are getting the service you want and to help you decide if you can work together. You do not need to ask every question – choose those that will help inform you and fit with your values.

What is important is that they *can* be answered by your maternity care provider. If they *cannot* be answered this is cause for concern

Questions to ask.

1.1 Maternity Care

- Do you provide continuity of care during pregnancy – antenatal, labour, birth and postnatal?
- What tests do you recommend during pregnancy and how often?
- Throughout my pregnancy, what intervention do you use? For example: do you use ultrasounds, antibiotics or perform vaginal examinations?
- What are my choices for place of birth – home, birth centre, hospital?
- What support will you provide in labour?
- How do you support me after birth – to recover from the birth, to establish breastfeeding and to find my footing as a mother?
- What support do you provide as I/we transition to parenting?

1.2 Working in Partnership

- How do you envisage us working together in partnership towards a safe pregnancy and birth?
- How much choice will I have in my care preferences during the pregnancy, birth and postnatally?
- How do you feel about other support people being present at the birth?
- Will there be other health providers working with me during my pregnancy?
- How do you work with me to help me cope physically, mentally and emotionally with the pregnancy and impending parenthood?
- How will you support me to make informed decisions regarding my care?
- What do you expect from me as part of this partnership?

1.3 Skills and availability

- What type of training have you had?
- How many clients do you see a month?
- Do you work alone or in a partnership with another health professional?
- How do I get in contact with you if I need advice at any time?
- Are you planning any holidays that might affect the support you will provide to me?
- What happens if you are unavailable at the time of birth?
- What are your fees? How and when must the fee be paid? Are there Medicare or health fund rebates?

1.4 Professional Practice

- What is your view of pregnancy and birth?
- How do you support a pregnant woman?
- What are my options for birthing?
- What percentage of your clients have an uncomplicated vaginal birth?
- What is your episiotomy rate and in what situations would you perform one?
- What percentage of your clients have post birth complications?
- What percentage of your clients are breastfeeding at 6 weeks?
- What percentage of your clients have post-natal depression at 6 weeks?

Extra questions to ask an Obstetrician

- What is your induction rate?
- When do you think induction of labour should be considered?
- What is your caesarean section rate?
- What is your infection rates?
- In what situations will you recommend a caesarean section?
- How do you feel about mothers being separated from their babies after birth?

You may also find the Health Direct Question Builder useful.

Appendix 3 - Glossary

Amniocentesis: A diagnostic test for chromosomal anomalies, such as trisomy 21 (Down syndrome), where an ultrasound guided needle is used to extract a sample of the amniotic fluid.

Auscultation: The detection of the fetal heart using a Doppler machine or a Pinard stethoscope.

Breech: presentation of a fetus in which the buttocks, rump, or legs are nearest the cervix and emerge first at birth.

Cardiotocography: A technical means of recording the fetal heart rate and uterine contractions.

Cephalic: relating to the head.

Chorionic villus sampling (CVS): diagnostic test for chromosomal anomalies such as trisomy 21 (Down syndrome) where an ultrasound guided needle is used to extract a sample of the placenta.

Edinburgh Postnatal Depression Scale (EPDS): A validated screening tool for depression in the postnatal period from 6 weeks. It has subsequently been validated for use in pregnant women and is therefore appropriate for use throughout the perinatal period.

External cephalic version: A procedure in which a health professional uses his or her hands on a woman's abdomen to turn a breech baby.

Induction of labour: A procedure to artificially start the process of labour by way of medical, surgical, or medical and surgical means.

Nuchal translucency thickness assessment: An ultrasound scan performed between 11 and 13 weeks of pregnancy that measures the thickness of the nuchal fold behind the baby's neck – a marker of chromosomal anomaly, such as trisomy 21 (Down syndrome).

Proteinuria: The presence of an excess of serum proteins in the urine.

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