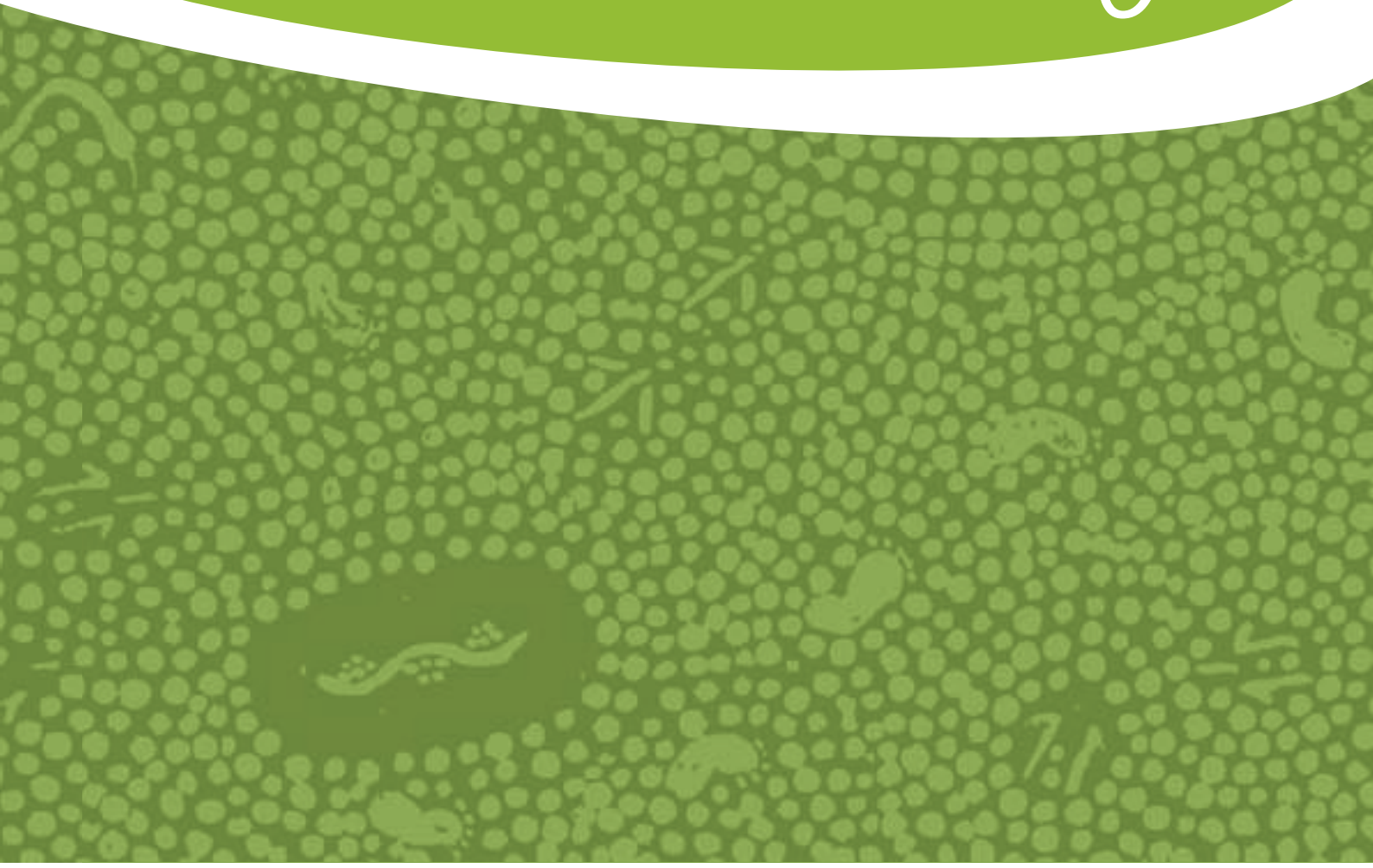
Pregnancy & Maternity



Supporting and Promoting Aboriginal Maternal Health and Wellbeing

Contents

About this booklet

Aboriginal Health Workers have identified maternal and child health and wellbeing as critical issues in their communities. Specific concerns included maternal nutrition, alcohol use, mental health, and ante and post natal care. Health workers were concerned that women, particularly young women, were not aware of the connection between these issues and the lifelong health and wellbeing of themselves and their children.

This booklet provides information to Aboriginal Health Workers about some of the main issues in Aboriginal maternal health. It provides information on the nature of the health issues, key messages and advice for patients, as well as information on and links to available resources and services. All of the information can be used in health education and promotion activities in maternal health.

The Life-Death-Life Cycle

Many experts recognise and acknowledge health as being holistic rather than just bio-medical. It is widely understood that:

"Health is not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life"[1]

Research tells us that good maternal nutrition and healthy infant and childhood growth are fundamental to achieving and maintaining good health throughout the life cycle. The lifelong impacts of poor maternal and infant health and nutrition are well known and include:

- Low birth weights
- Failure to properly grow and develop in infancy
- Higher blood pressure in adulthood
- Low glucose tolerance (diabetes risk)
- High levels of blood lipids (fats – heart disease risk)
- High rates of heart disease
- High risk of stroke
- High risk of lung disease[2]

Researchers know that a person's susceptibility to these diseases is determined during pregnancy and are a response to a mother's exposure to risk factors and behaviours.[3] The primary risk factors include poor maternal nutrition and substance use during pregnancy.

Aboriginal Health Workers have an important role to play in promoting good maternal health and educating all women of the importance of their health and wellbeing to the lifelong health of their children.

1 Department of Health and Ageing, 1989
2 Barker, 1989
3 Barker, 1989

Maternal Nutrition and Foetal Development

The Barker hypothesis states that:

"Events before, during and after pregnancy establish lifelong physiological patterns that may manifest as disease processes in later life."[4]

The health, wellbeing and nutrition of the mother prior to conception and during pregnancy can have an impact on the birth-weight, growth and survival of her baby.[5] Birth-weights are an important determinant of how well the baby will grow and the chances of survival into childhood. A baby born at less than 2.5 kilograms is considered to be of low birth weight.

Low birth-weights may be due to:

- Inter-Uterine Growth Retardation (IUGR)
- Being born before 37 weeks of gestation (pre-term birth)
- or a combination of IUGR and pre-term birth

These factors are partly influenced by maternal diet. Women who are healthy, active and well-nourished are more likely to have a healthy pregnancy: these factors increase her chances of delivering a baby at a healthy birth-weight.

Good nutrition can also protect the unborn baby against a number of congenital diseases and conditions. For example, an adequate intake of dietary folate during pregnancy is important to preventing neural tube defects (NTD)[6]. There is also a known connection between low folate levels and low birth weights.

In some Aboriginal communities, the rates of neural tube defects have been found to be approximately 40% higher than for the rest of the population. This might suggest that the diet of Aboriginal mothers is lower in nutrients than for other women.

Aboriginal Health Workers have an important role to play in reducing this deficit. You can do so by empowering mothers to make good nutritional choices through education and awareness programs. This could include informing women of the connection between their nutrition and their child's development, teaching them about important sources of nutrients, and advising them on how to make the best dietary choices from their available resources.

4 Barker, 1998
5 National Public Health Partnerships, 2001
6 Bower, 1989.

Maternal Nutrition and Foetal Development continued

Promoting Good Maternal Nutrition

Aboriginal Health Workers can help increase the chances of women having a healthy pregnancy and delivering a baby at a healthy birth-weight by advising them of their changed dietary needs.

Pregnant women require higher levels of calories and nutrients to fuel the growth and development of their baby. Women need to maintain a steady weight increase during pregnancy – weight gain is a sign that the baby is growing and that the body is building its energy stores (in bodily fat) in preparation for breast feeding and the post-natal period. Pregnant women, like all people, should have a diet that includes:

1. Enjoying a wide variety of nutritious foods
2. Eating plenty of wholegrain cereals, vegetables and fruits
3. Eating a diet low in fat, particularly saturated fat (e.g. animal fats)
4. Maintaining a healthy weight through physical activity
5. Eating moderate amounts of sugars and sugary foods (e.g. lollies and soft drink)
6. Choosing low salt foods
7. Encouraging and supporting breastfeeding
8. Eat foods containing calcium – especially for girls and women (e.g. dairy)
9. Eat foods containing iron - especially girls, women, athletes and vegetarians (e.g. meat, cereal, pulses)
10. Drink plenty of water[7]

In addition to this, pregnant women need to increase their intake of essential vitamins and minerals. The most important ones are:

Mineral	Reason	Source
Folic Acid	Prevents neural tube defects	Fruits and vegetables, bread
Iron	Circulate Oxygen Muscle development Maintain energy levels	Read Meat, Wholegrain Cereals
Calcium	Bone strength Muscle and nerve health	Dairy products
Omega 3	Foetal brain development Prevent Post-natal Depression	Oily fish such as Tuna Some processed foods such as bread, cereals and margarines have Omega 3 added

7 For more information on dietary requirements refer to the nutrition booklet in this Toolkit.

They also need to slightly increase their calorie intake – these calories should come from nutrient rich rather than junk foods. On average, pregnant women need to increase their calorie intake by:

First Trimester	Second Trimester	Third trimester
300 kilojoules/day*	600kJ/day	900kJ/day

*300 kJ = 1 slice of bread

A good maternal diet is not just about eating the right foods. There are certain foods that should be avoided during pregnancy because they contain bacteria and other contaminants that can adversely affect the health of the mother and the unborn child. Such foods include:

- Raw seafood
- Soft cheeses such as brie and camembert
- Pate, raw or undercooked meat, poultry, and eggs
- Liver and liver products – high levels of Vitamin A can cause birth defects
- Peanuts if you, your partner, or any of your other children have an allergy. This will reduce the risk of the unborn child developing an allergy
- Alcohol – there is no known safe limit so it is best to avoid alcohol
- Caffeine – can increase the risk of miscarriage and low birth weight

By making women aware of dietary risks and benefits, you can help them to have a healthy pregnancy and increase the chances of them delivering a healthy baby.

Maternal Exposure to Health Risk Factors

The adverse effects of substance use on the developing foetus are well documented. Research further shows that many of the adverse effects begin very early in pregnancy often before women discover they are pregnant.[8] Because of this, health promotion and intervention must focus on women in their childbearing years in addition to care during the antenatal period. Young women need to be aware of the effects of substance use on the unborn child and advised that they should stop using any substance prior to conception, and to stop using when they find out they are pregnant. Aboriginal Health Workers can use the information here for health prevention and intervention purposes.

8 Abel, 1995; Astley and Clarren, 2000; O'Leary, 2002.

Maternal Nutrition and Foetal Development continued

Smoking

The use of drugs, alcohol and tobacco before and during pregnancy is known to be harmful to both the mother and the unborn baby.[9] Parental smoking poses a risk both before and during pregnancy. The harmful effects of tobacco smoking include:

- Reduced fertility for men and women
- An increased rate and risk of miscarriage
- Risk of pre-term birth
- Risk of low birth weight
- Risk of perinatal death
- Risk of Sudden Infant Death Syndrome (SIDS)[10].

When a pregnant woman smokes, her baby smokes. The chemicals and nicotine she inhales pass through the placenta and into the baby. Because of this, the baby gets less oxygen and this can compromise growth and development. The Nicotine increases the baby's heart rate and breathing[11] causing foetal stress.

Alcohol

Research into the effects of alcohol consumption during pregnancy has identified a number of risks to foetal development that impact across the life cycle. When a pregnant woman consumes alcohol, so does her baby: alcohol passes through the placenta and into the baby's bloodstream. Exposure to alcohol in utero disrupts the passing of oxygen and nutrients to the baby. This can compromise foetal growth and development, increasing the risk of:

- Birth defects – physical and neurological
- Miscarriage
- Still birth
- Low birth weight

Maternal alcohol consumption is also known to be responsible for a number of developmental, psychological and behavioural problems in children, including:

- Brain damage
- Developmental delays (for more on this see the Infant and Child booklet)
- Growth restrictions
- Poor social and emotional development
- Behavioural and learning problems
- Low IQ

Maternal alcohol consumption is recognised as the most preventable cause of birth defects and poor infant and child development.

9 Ministerial Council on Drugs Strategy, 2006.
10 Ministerial Council on Drugs Strategy, 2006.
11 Department of Health and Ageing Guidelines (online)

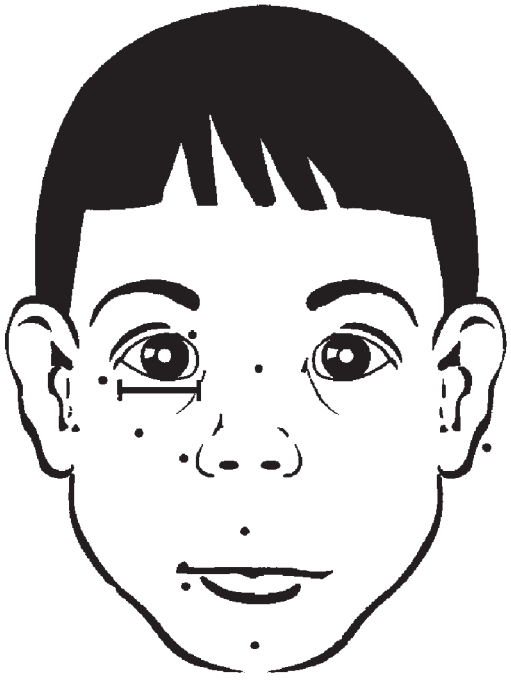
Foetal Alcohol Syndrome/Spectrum Disorder

Maternal alcohol consumption is known to cause foetal alcohol syndrome/spectrum disorder (FASD). FASD encompasses a spectrum of effects on the foetus caused by exposure to alcohol during pregnancy. It is estimated that 1% of babies are born with FASD. Common signs and effects of FASD include a number of physical and behavioural characteristics, including:

1. Growth restrictions, with at least one of the following present:
   - Low birth weight
   - Failure to thrive not related to nutrition
   - Low weight to height ratio

2. Central nervous system abnormalities, with at least one of these present:
   - Small head size at birth
   - Structural brain abnormalities
   - Impaired fine motor skills
   - Hearing loss
   - Poor eye-hand coordination

The face of a child with FASD might look similar to the diagram below:



Common FASD facial features include:

- Small eye opening
- Thin upper lip
- Flattened philtrum (space between the nose and upper lip)
- A flat mid-face
- Flattened bridge of the nose
- A short nose[12]

12 Diagram reproduced from Alcohol and Pregnancy Project. Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder: a Resource for Health Professionals (1st revision). Perth: Telethon Institute for Child Health Research; 2009.

Maternal Nutrition and Foetal Development continued

Infants and children who fall within the FASD spectrum may experience and/or display one or more of the following:

- Brain damage
- Poor growth
- Developmental delay
- Hearing problems
- Sleeping problems
- Vision problems
- High levels of activity
- Difficulty remembering
- A short attention span
- Language and speech problems
- A low IQ
- Poor judgement
- Social and behavioural problems
- Difficulty making and keeping friends/relationships[13]

These effects have a lifelong impact on the child and future adult. To prevent FASD and other alcohol related birth and developmental defects, pregnant women need to be given information about the risks of alcohol consumption during pregnancy. They should also be advised of governmental guidelines on alcohol consumption during pregnancy. The National Health and Medical Research Council recommend that:

"For women who are pregnant or planning to be pregnant, the safest option is not to drink alcohol."[14]

Women who use substances during pregnancy need to be made aware of the risks to themself and their baby. They should also be encouraged and supported to cut down and quit. Aboriginal Health Workers are important to this type of health promotion and intervention activity. It is recommended that in order to do this effectively, they should engage with women in a way that is *"based on respect and non-judgmental attitudes; of engaging the woman into adequate antenatal care through this relationship; and of maintaining continuity of care, and of carers, throughout the pregnancy and postnatal period."*[15]

13 These guidelines have been adapted from Alcohol and Pregnancy Project. Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder: a Resource for Health Professionals (1st revision). Perth: Telethon Institute for Child Health Research; 2009.
14 National Health and Medical Research Council, 2009.
15 National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn, Ministerial Council on Drugs, 2006

Maternal and Post Natal Mental Wellbeing

In our research, maternal mental wellbeing, particularly in the post-natal period, emerged as an area of concern. The information here is intended to help Aboriginal Health Workers to promote and support mental wellbeing in new mothers and intervene where they might suspect a post natal mental illness. It should help Health Workers understand the causes and symptoms of conditions such as post-natal depression, and provides resources on where to refer women for further help.

It is not uncommon for women to feel mentally low in the weeks following birth. Changes in hormone levels, lack of sleep and the demands and challenges of looking after a new baby can take a toll on the mental wellbeing of both the mother and the father. Short term low mood in the weeks following birth are often referred to as the 'baby blues', which is *"…a time of extra sensitivity and women may feel tearful, irritable or low. Symptoms tend to peak three to five days after birth and usually disappear within two weeks without any specific treatment"*[16]

There are a number of recognised postnatal mental illnesses. The most common are:

- Postnatal anxiety – characterised by persistent feelings of heightened fear that interfere with ability to function
- Postpartum Psychosis – is the least common illness. It usually presents within the first month, and women who suffer from, or who have a family history of, bi-polar disorder are most at risk
- Postnatal Depression

Postnatal Depression (PND)

The persistence of the baby blues beyond two weeks could be a sign of Postnatal Depression (PND). PND is the onset of depression in the weeks and/or months following birth. Although there might be signs of PND immediately following birth, the onset of PND is often gradual and may take up to a year to present.

PND is fairly common, affecting around 20% of post-natal mothers. Like other forms of depression, PND can range from mild or moderate through to severe. In mild cases, many women might not recognise that they have PND. Some women do not want to own up to their symptoms or even try to hide them, because they feel ashamed, guilty or like they have failed. It is important to reassure women that PND is a common and genuine illness and that with the right treatment they can make a recovery or learn to manage their illness.

It is important to encourage women to seek help as soon as they suspect PND. Early detection and intervention can lessen the impacts of PND on the mother, her baby, her partner, and the family. If left untreated, PND can develop into chronic depression or even suicide in extreme cases.[17] There are a number of referral and support services available to women with PND: these are listed in this booklet.

16 Matthey, 2004
17 Information and guidelines adapted from Women and Newborn Health Service (2009).

Maternal and Post Natal Mental Wellbeing continued

Signs of Postnatal Depression

Aboriginal Health Workers have an important role to play in the early detection of PND. The information here explains some of the main symptoms which can help you to do this.

Individual experiences of PND vary, but there are some common symptoms. The persistence of four or more of these symptoms for longer than two weeks might indicate the onset of PND. Common symptoms include:

Feelings

- Feeling sad all the time
- Hopelessness, you are no good at anything or feeling like a failure,
- Exhausted, crying, guilt and or shame,
- Worthlessness confusion, anxiety, panic
- Fear for and of the baby
- Fear of being alone or going out

Behaviours

- No interest or pleasure in usual activities (including sex)
- To little or too much sleep, nightmares
- Under or over eating
- Lack energy and motivation
- Withdrawing from family and friends
- Lack of self care – i.e.. showering
- Unable to cope with daily tasks.

Thoughts

- Unable to think clearly or make decisions
- Lack of concentration and poor memory
- Desire to run away
- Fear of being rejected by your partner
- Worry about harm or death to partner or baby
- Thoughts about suicide

Some women are more at risk of developing PND than others. In understanding these risk factors, Aboriginal Health Workers can make women aware of their chance of developing PND, and also monitor a woman as part of an early intervention and prevention strategy. Factors that increase the risk of PND include:

- Personal or family history of depression
- Depression during pregnancy
- Difficulties in relationship with partner or
- Single parenting
- Lack of practical and emotional support
- Stressful life events
- Complications during the pregnancy or delivery
- A demanding baby (temperament, feeding, sleeping, and settling difficulties)[18]

18 Women and Newborn Health Service, 2009.

Treatment, self help and self care are important to recovering from PND. The earlier a woman seeks help, the faster and more likely she is to recover. Health specialists offer several forms of treatment. The main ones include:

1. Medication – anti-depressant medications are used to treat the biochemical imbalances that cause the mental illness
2. Psychotherapy – Cognitive Behavioural Therapy, in individual or group settings, which helps people to understand their illness and develop strategies for managing their symptoms
3. A combination of both

Many Aboriginal women can not readily access specialist treatment services. In this setting, Aboriginal Health Workers have an important role to play in supporting women with PND. Some strategies you can use to help women manage their condition include:

- Being available to talk and listen
- Reassure them of their ability to cope
- Help them develop support networks
- Encourage them to talk with their partner or a trusted loved one
- Encourage them to make time for themselves – even if only for an hour
- Give them information on support and referral services

There are a number of information and support services that women and health workers can access. These include:

Your local GP	Your nearest AMS or Women's Health Centre
Local Child Health Nurse	Community Health Centre
Postnatal Depression Support Association Phone: (08) 9340 1622	Mental Health Emergency Response Line: Phone: (08) 9224 8888 1300 555 788
Rural Link 1800 552 002 (after hours)	Ngala Family Resource Centre Phone: (08) 9368 9368 1800 111 546
Post and Antenatal Depression Association (PANDA) 1300 726 306 Mon-Fri	Beyond Blue 1300 22 4636

Ante and Post Natal checks

Lack of access to and/or awareness of ante and post natal health checks emerged as another concern in our research. Aboriginal Health Workers were concerned that women were not accessing services and they wanted more information to advise women on the benefits of these checks and inform them about what to expect. The information here is intended to support Aboriginal Health Workers in educational and promotional activities on this issue.

Antenatal care is provided to improve the health of both the pregnant woman and her baby. It involves monitoring the progress of her pregnancy, and the detection, management and treatment of any problems. In addition to this, antenatal care also provides an opportunity for *"…preventive care… to reduce pregnancy-related complications for both mother and baby."*[19] Because Aboriginal women are at higher-risk of pregnancy related complications, it is vital to the health of the woman and her baby that she access antenatal care.

The usual schedule of antenatal visits is:

- Monthly until 28 weeks
- Fortnightly until 36 weeks
- Weekly visits until birth[20]

Many women attend their first antenatal visit much later than the recommended 14-16 weeks. Given the high rate of medical and behavioural risk factors amongst Aboriginal women, it is vital that health workers encourage them to attend ante-natal checks as early in their pregnancy as possible and tell them that these checks are important in every pregnancy, not just their first.

19 Eades, 2004
20 Hunt and Lumley, 2002

Some women might be scared of what ante-natal because they do not know or understand what is involved. There are many tests, some of them are invasive. You can help reassure women by letting them know what they can expect at their visits. Some of the more common tests and procedures are:

- **Urine Tests** - Urine is tested at each visit for the presence of sugar or protein, which can signal gestational diabetes or pre-eclampsia (high blood pressure).
- **Blood Pressure** - Blood pressure and pulse rate are measured at each visit. High blood pressure can maternal and foetal health, and might also be a sign of pre-eclampsia (high blood pressure).
- **Palpation**: A nurse of midwife will perform this at each visit. It involves feel the outside of the belly to work out the size and position of the baby. It also involves using a stethoscope to listen to the baby's heartbeat. Some clinics may also use a Doppler (an ultrasound microphone) to let parents hear the heartbeat. Normal foetal heart-rates are very fast, around 120 to 160 beats per minute.
- **Blood Tests** – These are performed to test for blood type and blood born viruses. An HIV test is performed as standard
- **Nuchal Translucency (NT) Test** – Is performed at 11-13 weeks to determine the risk of Down Syndrome. It involves a scan and blood test.

Postnatal care involves a number of checks and visits in the 40 days after birth. These checks, usually performed by a community health nurse or GP, are for mother and baby, and are *"an opportunity to assess the mother for any medical, mental, emotional and social issues, and early assessment of risk factors and physical problems in the baby."*[21] Postnatal checks are an important part of preventative care and early intervention.

Women should be encouraged to access postnatal care services, and be made aware of the importance of these checks and services to the health and wellbeing of herself and her family. Many women experience physical, mental and emotional problems after birth, and many to not seek treatment for these. A mother's ability to nurture and care for her new baby, as well as other children she may have, is compromised if she unwell.

Postnatal checks are carried out daily for the first five days, and then at six weeks after birth. If a woman is in hospital, the early checks will be conducted by a doctor of midwife onsite. If the woman is discharged before the fifth day, home visits by a midwife of community health nurse are usually arranged. The final six week check is usually performed by a GP.

12 Eades, 2004

Resources

The following resources can be used by Aboriginal Health Workers and their patients seeking more information on the issues covered in this booklet, or for links to support and referral services.

Breastscreen WA 1st Floor, Eastpoint Plaza, 233 Adelaide Terrace, Perth WA 6000 Phone: 9323 6700	**Breastfeeding Centre of WA** **King Edward Memorial Hospital** Agnes Walsh House, Ground Floor 374 Bagot Road, Subiaco WA 6008 Phone: 9340 1844
Australian Breastfeeding Association http://www.breastfeeding.asn.au/ Phone: 1800 686 2 686 WA Branch: 9340 1200	**King Edward Memorial Hospital for Women** 374 Bagot Rd, Subiaco, 6008 Phone:(08) 9340 2222
Central Immunisation Clinic 16 Rheola Street, West Perth WA 6005 Phone: 9321 1312	**Children, Youth and Women's Health** www.cyh.com
Family Birth Centre **King Edward Memorial Hospital** Bagot Road, Subiaco WA 6008 Phone: 9340 1800	**Health Information Resource Service for Women** **King Edward Memorial Hospital** Bagot Road, Subiaco WA 6008 Phone: 9340 1100
Home and Community Care (HACC) Program 189 Royal Street, East Perth WA 6004 Phone: 9222 4060	**Ngala** www.ngala.com.au Phone: 9368 9368 1800 111 546 (Freecall)
Statewide Obstetric Support Unit "O" Block, Hensman Road PO Box 134 Subiaco WA 6904 Phone: 9340 1605 Hours: 8.30am - 4.30pm Email sosu@health.wa.gov.au Can provide contact details for regional SOSUs	**WA Cervical Cancer Prevention Program (WACCPP)** 2nd Floor, Eastpoint Plaza, 233 Adelaide Terrace, Perth WA 6000 Phone: 13 15 56
WA Metro and Country Child Health Clinics A list of all clinics is available at; www.health.wa.gov.au/services or see the Services Directory in this resource	**WA Perinatal Mental Health Unit** **King Edward Memorial Hospital** 15 Loretto Street Subiaco, WA 6008 Phone: 9340 1795 Email wapmhu@health.wa.gov.au

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