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22 June 2018

National Strategic Approach to Maternity Services (NSAMS)
MDP 515
Australian Government Department of Health
PO BOX 9848
CANBERRA ACT 2601

Re: Response to National Strategic Approach to Maternity Services Consultation paper

The Australian Christian Lobby (ACL) welcomes the opportunity to provide a submission to the National Strategic Approach to Maternity Services Consultation paper.

ACL's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 100,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

Please feel free to contact me if I can be of further assistance in the consideration of this matter. I would be pleased to meet to discuss our submission or any other aspect in respect to this review.

Yours sincerely,

Martyn Iles
Managing Director

1. Can you in one or a few brief sentences provide what you think would be an overarching key outcome statement for the NSAMS?

While noting that Australia provides a high level of health care for pregnant women and babies, the NSAMS is ideally placed to actively implement programs that promote best practice and outcomes for 'getting it right in the first 1000 days of life' – from conception to the end of a child's second year. This has the greatest potential to affect the health and wellbeing throughout the life course.[1]

2. Do you think there should be a set of values that underpin the NSAMS? If so, could you list the top four values you would like to see included?

a) The central value should be the wellbeing of mother and baby. This requires a holistic approach not just a service-delivery model.[2] It seems this is best achieved through enhancing relationships which are responsive to the individual needs of mothers and babies. The best outcomes seem to occur when these relationships are with women-centred professionals such as midwives, and maternal and child health nurses.

b) Promoting the family as the best social unit for children. Motherhood, by definition has its focus on women, however the wellbeing of the family is integral to the wellbeing of mothers and babies. Providing support to fathers/siblings/extended family is important for the mother and baby to thrive. Evidence suggests that fathers and male caregivers have a unique role in early childhood development.[3]

c) Promoting perinatal mental health. Figures show that 10–15% of women suffer from perinatal mental health issues either during or after pregnancy.[4] Recent studies also show that 1% of men suffer from depression and/or anxiety during their partner's pregnancy and after childbirth.[5]

d) Supporting breastfeeding. Breast milk should be a child's exclusive nutrition in the first 6 months of life and as a complementary food up to the age of two years.[6] These advantages include a lower risk of gastrointestinal infection for the baby, more rapid maternal weight loss after birth, and delayed return of menstrual periods…No adverse effects on growth have been documented with exclusive breastfeeding for six months.[7] In Australia the Statistics from the *2010 Australian National Infant Feeding Survey* results indicate that 96% of mothers initiate breastfeeding. Thereafter, exclusive breastfeeding rates drop off. Less than

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[1] Centre for Community and Child Health, Policy Brief: The First Thousand Days – Our Greatest Opportunity; Edition no.28, March 2018, and Moore, Tim; Arefadib, Nousin; Deery, Alana; Keyes, Megan; and West, Sue; "The First Thousand Days: An evidence paper". Centre for Community Child Health, Royal Children's Hospital Melbourne https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/CCCH-The-First-Thousand-Days-An-Evidence-Paper-September-2017.pdf (accessed 17 June 2018)

[2] ibid p2.

[3] Ibid p17.

[4] Black Dog Institute: "Depression during pregnancy and the post-natal period" https://www.blackdoginstitute.org.au/docs/default-source/factsheets/depressionduringpregnancy.pdf?sfvrsn=6 (accessed 18 June 2018)

[5] Perinatal Anxiety and Depression Australia (PANDA): "Perinatal anxiety and depression in men". https://www.panda.org.au/images/resources/Resources-Factsheets/Perinatal-Anxiety-and-Depression-in-Men.pdf (accessed 18 June 2018)

[6] World Health Organisation: "Exclusive breastfeeding for six months best for babies everywhere". http://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/ (accessed 20 June 2018)

[7] Ibid.

half (39%) of babies are still being exclusively breastfed to 3 months (less than 4 months) and less than one quarter (15%) to 5 months (less than 6 months).[8] Extended breastfeeding is also a factor in preventing childhood obesity.[9]

3. Can you outline three or four positive aspects of maternity services in Australia?

a) High level of provision of services with linkage between Federal, State and local government in health and community contexts such as child and family services and maternal and child health services. This also includes provision 24 hour phone access to maternal and child health advice.
b) Midwifery group practice. These services deliver a very high level of care which demonstrate that relationships matter and are more effective than a 'service-delivery, hospital centred model.'
c) Australia has a high standard of care for maternal and child health with relatively low infant and maternal morbidity and mortality

4. What do you think are the three or four key gaps or issues for maternity services in Australia? Of these which is most important to you?

a) Urban/rural/regional divide. The NSAM Consultation paper identifies the reduced availability of facilities faced by women in rural and regional areas. There is a desperate need for second level perinatal services – including perinatal mental health services – to be available in all regional centres where they would be more accessible to women in regional and rural areas.

   Many families suffering financial difficulties move to regional and rural areas because of the availability of cheaper housing but then suffer from the lack of other services they may require. A recent conversation with a community advocate in a rural town in Victoria revealed that a woman and four children escaping domestic violence had rented a house without running water. This is not an unusual occurrence.

b) Better co-ordination across sectors midwives/maternal health/family violence.
   There is excellent co-ordination between midwives, including hospital midwives, and maternal health care where information is shared between the two services and the initial home visit is initiated by the maternal child health nurse. However, after this first visit, the onus is on the mother to initiate future appointments. This leaves the most vulnerable mothers as the ones most likely to fall through the cracks. There should be, at the very least, phone contact initiated by Maternal and Child Health after the first appointment. Many states have cut funding to this area and it is no longer as effective as it once was – especially for lower socio-economic families and those at risk of violence.

   There should be some co-ordination between the police and Maternal and Child Health Services in the event of domestic violence. It is alarming that domestic violence is often first experienced during pregnancy. The effects of this violence can have obvious detrimental effects for the mother, but also exposes the child to risk through an increase in the mother's cortisol production which can be transmitted to the child through the placenta and umbilical veins. This can adversely affect the growing brain. Studies have found a correlation between domestic violence during pregnancy and behavioural problems, poor maternal attachment,

[8] Austalian Breastfeeding Association; "Breastfeeding rates in Australia" https://www.breastfeeding.asn.au/bf-info/general-breastfeeding-information/breastfeeding-rates-australia (accessed 20 June 2018)
[9] Moore et al. Op.cit. p24.

poor performance at school and aggressive behavior.[10] These women and their children are particularly vulnerable to future violence after the birth of the child. This issue may be addressed in Victoria as the result of recommendations of the Royal Commission into Domestic Violence.

c) Inadequate provisions for working mothers to continue breastfeeding.
Inadequate parental leave contributes to the current problem where the majority of babies are not receiving the ideal benefits of breastmilk for the optimal amount of time to ensure their best future health outcomes. This is not surprising when mothers are pressured to return to work as soon as six weeks after birth. For many women, fulltime work makes continued breast feeding extremely difficult, if not impossible. Until recently, not even the Federal public service could provide privacy for women needing to express breastmilk.[11] There are many possible options which could alleviate this situation, including payments for all mothers of young children, flexible working hours, work-at-home provisions, adequate maternity leave/family benefit provisions for the first 1000 days.

d) Provision of perinatal palliative care. It is a stressful time for parents to learn that their baby has been born with a life-shortening condition or to have their baby diagnosed in utero with such conditions. At present, perinatal palliative care options are inadequate. Perinatal care can refer to care of babies born prematurely or with conditions that indicate a short life-span but it can also mean the care of mother and baby when a life-threatening condition is diagnosed in-utero and the mother continues with the pregnancy. At present there is little availability of perinatal palliative care in either circumstance. It is an important service in the provision of holistic maternal care.

A study by Victoria Kane identified a series of problems experienced in hospital Neonatal Intensive Care Units (NICU) in relation to dealing with dying babies.[12] She identifies shortcomings in terms of inadequate staffing; an inconducive environment for supporting a palliative model of care; lack of flexibility due to the intensive nature of the NICU environment and the needs in caring for a dying baby. Kane recommends policy development; curriculum development and further research and development of neonatal palliative care guidelines.[13]

Most pregnant women undergo screening during the pregnancy. For many this is simply viewed as a first glimpse of their baby. Few give much thought to the possibility of the diagnosis of an abnormality when they attend their first screen. Often, when receiving news of a serious abnormality, parents feel they are given little choice but to terminate the pregnancy.[14] Some parents are swept along by the advice of the medical experts but

[10] Ibid p18
[11] https://www.canberratimes.com.au/national/act/liberal-giulia-jones-brandishes-breast-pump-in-act-parliament-saying-women-need-privacy-to-express-at-work-20170322-gv47hx.html
[12] Kain, Victoria. Exploring the Barriers to Palliative Care Practice in Neonatal Nursing: A Focus Group Study [online]. Neonatal, Paediatric & Child Health Nursing, Vol. 14, No. 1, Mar 2011: 9-14. Availability: <https://search-informit-com-au.divinity.idm.oclc.org/documentSummary;dn=182188488386566;res=IELHEA> ISSN: 1441-6638. [cited 21 Jun 18].
[13] Ibid. p8.
[14] McGovern, Kevin. Continuing the pregnancy when the unborn child has a life-limiting condition [online]. Chisholm Health Ethics Bulletin, Vol. 17, No. 3, Apr 2012: 5-16. Availability: <https://search-informit-com-au.divinity.idm.oclc.org/documentSummary;dn=244211963514979;res=IELFSC> ISSN: 1443-3591. [cited 21 Jun 18] p6.

subsequently find themselves grieving the loss of their child. Informed consent is essential but not easily

> *One study found that many women who had terminated because of feotal anomaly "67% screened positive for post-traumatic stress at 6 weeks, 50% at 6 months and 41% at 12 months. Emotional distress was experienced by 53% at 6 weeks, 46% at 6 months and 43% at 12 months, and grief by 47% at 6 weeks, 31% at 6 months and 27 %at 12 months." Another study found that "termination of pregnancy due to foetal malformation is an emotionally traumatic major life event which leads to post-traumatic stress response and intense grief reactions which are still evident 2–7 years after the procedure." Yet another study found that "among 196 women aborting for foetal abnormality, grief and post-traumatic symptoms did not decrease between 2 and 7 years after the event… pathological post-traumatic scores were found in 17.3% of participants."*[15]

5. What four to six key improvements would you like to see in maternity services in Australia? Please consider these from a national perspective.

a) Implementation of policies that take into consideration the entire life cycle. The first 1000 days of life from conception shapes the development of the child and is consequential to youth development, and both are significant to adult functioning.[16] The approaches to the care of pregnant women and young children is critical in ensuring a healthy adult population. The focus needs to expand to include the first 1000 days.

> *Right from conception, the foetus uses cues provided by the mother's physical and mental state to 'predict' the sort of world it will be born into, and starts to adapt its bodily systems to meet the anticipated demands of that world (Coe & Lubach, 2008; Gluckman & Hanson, 2005; Gluckman et al., 2009; Robinson, 2013). This powerful capacity is a double edged sword: adapting to challenging experiences and environments may help in the short term, but be harmful to optimal long-term health and wellbeing (Bateson, Gluckman & Hanson, 2014; Gluckman & Hanson, 2005; Prescott, 2015). Reversing early adverse adaptations becomes progressively more difficult after the first 1000 days.*[17]

b) Access to a lactation consultant in the first week after hospital discharge. Many mothers and babies are discharged from hospital before breastfeeding is fully established. A visit from a lactation consultant in the first week of hospital discharge may assist in improving breastfeeding outcomes.

c) Improve the Metro/rural divide particularly through the provision of:
   a. Psychiatric units specializing in perinatal mental health. There is a shortage of such services in regional area and an absence in rural and remote areas. There is need for specialist hospital services and day centres;
   b. Early parenting centres to assist with a range of issues addressing basic parenting skills and more specialist services such as mental health, breastfeeding advice, attachment issues, etc., are essential in rural and remote areas.

[15] Ibid p7.
[16] Centre for Community Child Health, Policy Brief No 28, March 2018: The First Thousand Days – Our Greatest Opportunity https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/1803-CCCH-Policy-Brief-28.pdf and, Moore, et al. op.cit.
[17] ibid. Policy Brief: The First Thousand Days.

d) Group support for all mothers in the local community. Mothers' groups are common after the first baby and facilitated through maternal and child care services. These should be encouraged for all mothers to provide peer-to-peer support and with access to a maternal and child health nurse skilled in identifying perinatal health issues and domestic violence issues. Some mothers have expressed a need for a variety of supports such as lactations consultants, access to occasional childcare, parenting advice, etc.[18]
e) Provision of perinatal palliative care services, as outlined in response to question 4 above.

6. Are there specific strategies that you could suggest for rural and remote services and/or, Aboriginal and Torres Strait Islander women and/or, women from culturally and linguistically diverse backgrounds?

It is evident that outcomes need to be improved for Aboriginal and Torres Strait Islander women. Part of this can be addressed through the provision of more services in rural and remote areas as outlined above. Other strategies for both Aboriginal and Torres Strait Islander women and for women of other cultures might include:

a) Training in understanding of cross cultural attitudes to pregnancy, child birth and child care
b) Provision of interpreter services
c) Recruitment of women from these diverse cultural backgrounds into midwifery and maternal and child health services
d) Development of community support networks in regional, rural and remote areas

7. How will success be measured or how will we know if strategies are being successful?

While Australia performs well in most areas of maternal and infant care within the OECD community there is room for improvement in all the indicators listed in the NSAMS Consultation paper.[19] Improvement in all or any of these indicators would be measures of success.

Additional measures would be:

a) An improvement in maternal and child morbidity and mortality rates, particularly in remote indigenous communities;
b) Greater availability of perinatal mental health facilities in rural and remote areas;
c) Establishment of early parenting centres/programs in rural and remote areas;
d) More women continuing breast feeding for a longer period of time;
e) Workplace and community facilities for breastfeeding mothers;

[18] Dunning, Polly; *A Baby Bundle from the government or maybe something a little more practical.* Fairfax press. https://www.thecourier.com.au/story/5478282/a-baby-bundle-from-the-government-or-maybe-something-a-little-more-practical/?cs=24

[19] Developing an National Strategic Approach to maternity Services Consultation Paper. Pp7-11.