MIGRANT & REFUGEE
WOMEN'S HEALTH PARTNERSHIP

Secretariat
Expert Working Group
Antenatal Care Guidelines Review

Submitted via email: eac@health.gov.au

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Submission to *Antenatal Care Guidelines* review

Prepared by MRWHP Secretariat

The Migrant and Refugee Women's Health Partnership (MRWHP) Secretariat welcomes the opportunity to make this submission to the review of the *Antenatal Care Guidelines*.

MRWHP is a recently established national collaboration bringing together clinicians, community and government to develop a consistent, minimum standard policy framework to address barriers to accessing health care for migrants and refugees, with a particular focus on women. MRWHP seeks to bring about a positive change in health and wellbeing for migrant and refugee communities by promoting a holistic policy and strategy that benefits both health practitioners and consumers. MRWHP draws on clinical and community expertise in the provision of culturally appropriate care to migrants and refugees, with a particular focus on women.

This submission has been prepared with input from individual members of the MRWHP working structures. MRWHP Secretariat would particularly like to acknowledge the contributions of Dr Mitchell Smith, Director of the NSW Refugee Health Service, and of Ms Violet Roumeliotis, CEO of Settlement Services International.

Feedback on Antenatal care guidelines review – Public consultation draft

Optimising antenatal care – Cultural safety

It is noted that the cultural safety considerations, discussed in the context of midwifery continuity of care in the review, are also broadly applicable to migrant and refugee women. Increased understanding of cultural safety and how to overcome the cultural power imbalances of places, people and policies contributes to improvements in the health of Aboriginal and Torres Strait Islander women, and has broad applicability to migrant and refugee women particularly with regard to culturally responsive practice.

Antenatal care guidelines review: Clinical Assessments – Female genital mutilation

While family violence is addressed in the review, there is no specific mention of female genital mutilation (FGM). Additionally, while Module 2 of the Antenatal Care Guidelines describes FGM, there is limited guidance on how to care for women who have undergone FGM. It is proposed that more practical care advice is included.

There are existing authoritative guidelines that offer detailed and practical advice on care for women affected by FGM. As a minimum, these guidelines could be referenced in the Antenatal Care Guidelines. They include:

- *Maternity-Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation / Cutting*[1] (NSW Health); and
- *Female Genital Mutilation / Cutting – Guideline for Care*[2] (Royal Women's Hospital, Melbourne).

Fetal Chromosomal Abnormalities – Discussing tests with women

It is critically important that migrant and refugee women's capacity to understand their clinical care is supported, including the discussion of diagnostic test results and women's provision of consent to treatment. We recommend that the reviewed guidelines emphasise the utilisation of interpreting services when required, so that there can be no question of a woman understanding the implications of test results.

Refer to the feedback on the Antenatal Care Guidelines – Module 2 (below) for further input regarding working with interpreters.

Maternal Health Screening – Hepatitis C

This submission supports the recommendation to screen all pregnant women for hepatitis C, in light of a lack of evidence about prevalence in women born overseas, and the easy availability of successful treatment.

Maternal Health Screening – Vitamin D status

There is a significant gap in *Evidence evaluation report — Vitamin D – May 2017*, with implications for the conclusions and Review recommendations on this issue. The gap relates to the risk of neonatal seizures in infants born to mothers with low vitamin D.

As stated in the 2006 National Position Statement: "The most serious consequence of vitamin D deficiency is hypocalcaemic seizure. While most common in infants aged less than 6 months, seizures can occur at any age."[3]

The current Victorian neonatal handbook states "Hypocalcaemia secondary to vitamin D deficiency should be considered as a cause of seizures in newborns of mothers with risk factors".[4]

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[1] www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2014_016.pdf (accessed June 2017)
[2] thewomens.r.worldssl.net/images/uploads/downloadable-records/clinical-guidelines/female-genital-mutilation-cutting-guideline-for-care_160517.pdf (accessed June 2017)
[3] Prevention and treatment of infant and childhood vitamin D deficiency in Australia and New Zealand: a consensus statement. Munns C et al.MJA Vol 185; 5: 2006
[4] www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/neonatal-ehandbook/conditions/vitamin-d-deficiency (accessed June 2017)

The following case study is an example of the issue: *Maternal vitamin D deficiency associated with neonatal hypocalcaemic convulsions.*[5]

Maternal vitamin D deficiency is of particular importance in migrant women, many of whom have increased risk factors such as darker skin, and in some, religious covering. In the experience of the NSW Refugee Health Service, 75% of newly arrived refugees have vitamin D levels below 50 nmol/l.[6]

Based on the potential severity of consequences of vitamin D deficiency in mothers--i.e. hyposclacamiec convulsions, which has been overlooked in the current documentation—it is recommended that there should be a specific, pro-active recommendation to screen at-risk women for vitamin D, supported by clear information in the guidelines on which women are at risk. Newly arrived refugees should be included as an at-risk group, unless screened recently.

Feedback on Antenatal Care Guidelines - Module 2

Antenatal care for migrant and refugee women

The MRWHP Secretariat commends the inclusion of an expanded section related to care for women from migrant and refugee communities in the *Antenatal Care Guidelines – Module 2*. In particular, we welcome the introduction of additional practice points highlighting the importance of engaging accredited interpreters and involving multicultural health workers.

We recommend strengthening the provisions in practice point (b) to specify that health professionals are responsible, from a medico-legal perspective, for making arrangements, whenever possible, to meet the specific language needs of women, including through the utilisation of accredited interpreting services, when necessary. Culturally safe practice and effective communication with women with limited English proficiency includes the ability to assess the need for engaging credentialed interpreters, to make necessary arrangements through an appropriate language services provider, and to work effectively with the interpreter to communicate with the patient. This is consistent with the Medical Board of Australia *Code of Conduct*.[7] Effective communication is also consistent with the National Safety and Quality Health Service Standards (NSQHS Standards), currently under review by the Australian Commission on Safety and Quality in Healthcare. Draft version 2 provides that communication supports effective partnerships with consumers, and requires health service organisations to use communication mechanisms that are tailored to the diversity of the consumers who use its services.

In this regard, it is important to emphasise that, in the case of migrant and refugee women from non-English speaking backgrounds, a woman's ability to engage in a general conversation in English does not equal their ability to discuss and understand health related matters, which may involved the use of complex terminology. We recommend that the reviewed guidelines emphasise the utilisation of interpreting services when required. This is critically important for supporting migrant and refugee women's capacity to understand their clinical care, including the discussion of diagnostic test results and their provision of consent to treatment.

General practices must be made aware that interpreters can be accessed free of charge. The Australian Government provides the Free Interpreting Service, through

[5] Camadoo L et al. Nutr J. 2007; 6: 23 - www.ncbi.nlm.nih.gov/pmc/articles/PMC2034574/
[6] Unpublished data – personal communication, Dr M Smith
[7] Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (2014)

Translating and Interpreting Service (TIS National), to assist private medical practitioners (defined as General Practitioners and Medical Specialists, as per the Medical Board of Australia List) in providing Medicare-rebatable services and their non-clinical staff in arranging appointments and providing the results of medical tests.

It is also critical to inform general practices of the importance of engaging accredited interpreters. Accreditation is an acknowledgement that an individual has demonstrated the ability to meet the professional standards required by the translation and interpreting industry. The accreditation is provided by the National Accreditation Authority for Translators and Interpreters (NAATI) at various levels.[8] We note that there is currently no medical specialisation in interpreter accreditation standards, but measures are underway, as part of the *Improvements to NAATI Testing* project to implement a new NAATI certification model that will include a certified interpreter specialisation in health.[9]

Part C – Areas for further research

We strongly support further research into ways to promote earlier uptake of antenatal care among migrant and refugee women. Health promotion and antenatal screening may be less effective in reaching migrant and refugee women, as opposed to Australia-born women, resulting in inequalities in maternal and perinatal health outcomes. For example, in 2013, women born overseas in predominantly non-English speaking countries were 10 per cent less likely to attend antenatal care early in pregnancy than women born in Australia. However, they were almost equally as likely as other mothers to attend seven or more antenatal visits throughout the course of the whole pregnancy (86% of mothers born in other countries compared with 87% of Australian-born mothers).[10]

Consideration should also be given to the importance of antenatal care for engaging with migrant and refugee women to identify health and mental health problems and make a substantial intervention on health promotion and prevention, as well as for family violence screening purposes.

We thank the Expert Working Group for their consideration of this submission, and take this opportunity to reiterate that MRWHP is available to contribute its expertise and input to further inform the review of the Antenatal Care Guidelines.

To discuss this submission further, please contact Ms Gulnara Abbasova, Executive Officer, Migrant and Refugee Women's Health Partnership, gulnara.abbasova@culturaldiversityhealth.org.au or 0498 185 164.

[8] www.naati.com.au/media/1109/outline_naati_credentials.pdf (accessed February 2017). Note: A new certification model will be implemented shortly.
[9] www.naati.com.au/media/1449/naati-certification-model-v47_november-2016.pdf (accessed February 2017)
[10] Australian Institute of Health and Welfare, *Australia's Health 2016* (2016)