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ACCRU Applied Communication Collaborative Research Unit

Project Report 1: Context Analysis of Obstetric Services and Health Promotion Practice 31st July 2012

ARC Health-e Baby: Communication Innovation for Improved Neo-Natal Outcomes

The Applied Communication Collaborative Research Unit (ACCRU)

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ARC Health-e Baby Project

This University of Adelaide-based and Australian Research Council-funded project investigates the persistence of poor health amongst so-called special or vulnerable groups despite recent developments in health communication that have helped improve many areas of health for our population as a whole. Previous research suggests that disparities in health literacy, cultural and linguistic differences, and a lack of health information accessible via popular media channels may in part explain disparities in health outcomes. Therefore we will design, implement and evaluate the efficacy of an innovative approach to health communication that uses new digital and mobile media to address the specific needs of patients from vulnerable groups to help reduce inequalities in health outcomes between Australians.

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Section 1: Report Aims and Scope

1.1 Introduction

The Lyell McEwin Hospital (LMH) provides a wide range of services for pregnant women and their greater networks. This report will discuss the structure and organisation of antenatal and care at the LMH, with a particular focus on the effectiveness of health promotion/communication strategies currently employed in this context. Both onsite and offsite services will be discussed. While the LMH also provides a number of postnatal services, these will not be examined in great detail in this report. In the first section of the report we outline the report aims, methodology and layout.

1.2 Report Aims

The aim of this report is to summarise existing antenatal health promotion/communication practices in the context of the Lyell McEwin Hospital. This report forms one of the outputs of the Health-e Baby project. It is designed to present preliminary research findings in an accessible manner for circulation within the Health-e Baby team and to other key stakeholders. The report findings and recommendations will guide the refinement of the project objectives and contribute to discussions regarding the focus of the project. Health-e Baby is a health promotion/communication project that is jointly funded by SA Health and the Australian Research Council. The aim of the project is to explore the information needs and media uses of pregnant women who are cared for by staff at the Lyell McEwin Hospital. This research will inform the design of a tailored health information intervention. In particular, the project will examine if we can better use different forms of social media or Information Communications Technologies (ICTs) to communicate with pregnant women and their greater networks.

1.3 Methodology

This report is based on interviews with 20 people, nine LMH clients and eleven staff members. It is also informed by participant observation conducted in the Family Clinic waiting room, at two Antenatal and Parenting Education sessions, two ‘triage’ or first antenatal appointments and two Asthma Clinic appointments. Health promotion materials distributed in various locations at the LMH have also been systematically collected and are briefly examined in this report. Because of the small number of interviews conducted to date and the low number of hours spent conducting participant observation, the findings of this report are preliminary and need to be further substantiated with more evidence. In the final section of the report we have provided some recommendations. These recommendations were developed to help focus the future direction of the Health-e Baby project and should not be read as established guidelines.

1.4 Report Structure & Layout

Sections two and three of this report provide a broad overview of the range of services provided by the LMH, both onsite and offsite. These sections are designed to give readers a sound understanding of the organisation of antenatal care at the LMH and to introduce key terms which are referred to throughout. For the most part these sections are descriptive and do not incorporate extensive analysis. Section four is where we begin to explore in more detail the effectiveness of current health promotion practices utilised at the LMH. In this section we use a case study to explore how health messages are communicated in two contexts in the Family Clinic, 1) In the Waiting Room and 2) At the First Appointment. The Family Clinic setting was chosen for more in-depth analysis because it is the first LMH location that women attend before they are allocated to different antenatal care models. As such, it may be the only common experience that the majority of antenatal clients at the LMH share. Thus far, the Family Clinic has been the primary field site at the LMH, however this may change as the project develops.

In section five of the report we discuss several ‘Emerging Themes’ that form the key findings of this report. Although these themes have been separated into distinct headings for ease of reading there are many areas where they overlap and intersect. In order to limit the length of the report we have made judgements about the research findings that have been included in this report. In the final section of the report ‘Knowledge Gaps’ we identify areas of weakness that need to be addressed as the project moves forward.

Section 2: On Site Antenatal, Birth and Postnatal Services

Before we begin an overview of the services provided by the LMH it is important to provide some information about how women book their hospital appointments. The majority of pregnant women who are cared for by the LMH book their first appointment by telephoning the Pregnancy SA Infoline. Women who call this Infoline are allocated to a hospital based on their postcode.[1] They are then given a contact number to call in order to set up their first antenatal appointment at their allocated hospital. Women typically learnt about the Pregnancy SA Infoline through their General Practitioners (GPs) or via Internet searches. These processes will be discussed in more detail in the second project report. For now, it is sufficient to note that public patients are allocated to the LMH based on their postcode and that they contact the hospital to book their first appointment. The models of antenatal care that they will be assigned to and the range of services that they may access from this point onwards are discussed below.

2.1 The Women's Health Unit

The majority of antenatal, birth and postnatal services provided by the LMH are physically located in the 'Women's Health Unit' at the LMH site on Haydown Road in Elizabeth Vale. It should be noted that in this report we use the term 'Women's Health Unit' to refer to a number of units, clinics and services which provide healthcare for women at the LMH. This term should not be confused with the 'Women's Health Ward' which is a ward that primarily caters for antenatal and postnatal women ('Women's Health Unit: Information Booklet', SA Health 2010, p. 5).[2] On the maps provided to LMH clients and staff the 'Women's Health Ward' is labelled the 'Women's Health Unit' which creates confusion (see Appendix 1).

The Women's Health Unit comprises of six core sections: Antenatal and Parenting Education, Family Clinic, Women's Assessment Unit (WAU), Birthing and Assessment Unit (BAU), Women's Health Ward and Special Care Nursery. Each of these sections is discussed in more detail below and represented in a diagram (see Appendix 2). Other services provided in the Unit include a Play Room and Gift Shop.

2.2 Family Clinic

The Family Clinic fulfils a broad range functions, including paediatric and gynaecological health care, Urodynamics and Colposcopy Clinic and Drug and Alcohol counselling. However, in this report we focus on the antenatal and postnatal services provided by the Clinic. These are the: Midwives Clinic, Doctors Clinic, Perinatal Mental Health Service, Continence Clinic and Diabetes Clinic. The Family Clinic is also where women attend their first antenatal appointment. At this appointment their 'risk' level is assessed and they are allocated to a particular model of antenatal care. This decision is based on various factors including their medical history, co-morbidities, mental health, socio-cultural background (e.g. ethnicity, low socio-economic status, non-English speaking), the type of birth that they desire and other potential risk factors such as drug and alcohol use or domestic violence. While women are typically allocated to a particular model of care at their first appointment by the Midwife, sometimes additional information is sought before this decision is made. Additionally, women's circumstances may change over the course of their pregnancy and this may result in their risk level and their model of care being re-assessed or altered.

[1] Although it should be noted that some women subvert this process by giving false information about their permanent address.
[2] The ward also cares for some women who have had gynaecological or other surgical procedures.

The Clinic space itself is oddly shaped with multiple entrances and numerous corridors and pathways. The focal point of the Clinic is the Reception Station and the Midwives' Station which are located in the approximate centre of the Clinic. There are three waiting areas with seating in the Family Clinic. One is a space with toys and books provided for children. The waiting room is discussed in more detail in section 4.1. There are 17 consulting rooms where appointments are conducted in the Family Clinic, however only 12 of these are used for antenatal appointments. In the Clinic there is also a staff tearoom, two offices for senior staff members and a photocopying/supply room.

The Family Clinic is open from 8.30am to 5pm, five days a week (Monday to Friday). The first antenatal appointment, referred to by staff as a 'triage' appointment, is held in the Family Clinic. The structure of the first appointment is discussed later in this report (see section 4.2). The staff in the Family Clinic also provides antenatal care beyond the first appointment, dependent on judgments made about the patients' level of 'risk' and care requirements. Midwives provide antenatal care for women who are classified as 'low risk' but who are not eligible to give birth in the Birthing and Assessment Unit Low Risk (BAUL) (e.g. women who have previously had a c-section or want an epidural). These women will deliver in the Birthing and Assessment Unit High Risk (BAUH).[3] This model of care is referred to as the 'Midwives Clinic'. The Family Clinic also provides Obstetric Team Care or Consultant Care, which is referred to as the 'Doctors Clinic'. Women cared for in the Doctors Clinic are classified as 'high risk' and require health care provided by a team that includes an Obstetrician.

Other specialist antenatal and postnatal services are also located in the Family Clinic. These are the Continence Clinic, for women experiencing continence issues, and the Perinatal Mental Health Service. Both of these services are staffed by specialists who can meet with women to discuss their concerns and provide medical advice. The Perinatal Mental Health Service is staffed by Mental Health Midwives, a Mental Health Nurse and a psychiatrist. This service also offers a number of support groups, which women can attend. A specialised Diabetes Clinic is also held each Monday, which is run by a consultant Obstetrician, an Endocrine Registrar and a Diabetes Educator.

2.3 Women's Assessment Unit (WAU)

The Women's Assessment Unit (WAU) is open from 7am-9pm, seven days a week. This unit is responsible for the assessment of all pregnancy-related conditions (e.g. blood spotting, suspected miscarriage etc). Women are encouraged to contact the WAU if they 'experience any pain, vaginal bleeding, unusual or offensive vaginal loss, headache and visual disturbances, a decrease in baby movements or any other concerns' ('Women's Assessment Unit: Providing Information and Care for Pregnant Woman' SA Health, n.d., n.p.). The WAU also sees women with postnatal problems up to six weeks after the birth of their baby. The WAU is the first contact point for women who have any medical concerns about their pregnancy. The WAU enables the Birthing and Assessment Unit (BAU) to be kept free for women who are in labour. However, after hours (9pm-7am) when the WAU is closed, patients must report to the Birthing and Assessment Unit (BAU) to be assessed for any concerns.

2.4 Birthing and Assessment Unit (BAU)

The BAU is where all LMH clients give birth. However, they are allocated to different areas based on whether or not they have been assessed as low or high risk. Women assigned to the BAUL (Birthing and Assessment Unit Low Risk) have their antenatal care delivered by a team of midwives and give birth in the BAUL section of the unit. Women who are high risk have their antenatal care delivered in

[3] These terms and the role of the Birthing and Assessment Unit are explored in section 2.4.

the Family Clinic and then give birth in the BAUH (Birthing and Assessment Unit High Risk) section of the unit. The Birthing and Assessment Unit is open 24 hours a day, seven days a week.

BAUL: The BAUL caters for women who are classified as having a low risk pregnancy and who have elected to have Midwifery care throughout their pregnancy. In the BAUL women are cared for by Midwives with minimal doctor involvement. This model of care is referred to as 'Total Midwifery Care'. Women who have their antenatal care delivered in the BAUL also give birth in the BAUL. Women who have decided to give birth in the BAUL but then require higher risk interventions (e.g. they decide they want to have an epidural) must be shifted to the BAUH. The key difference between this model of care and antenatal care in the Family Clinic, is that women cared for in the BAUL will form an ongoing relationship with a team of Midwives and one of these Midwives will attend her birth. This model of care was referred to by one Midwife as being more "personalised".

BAUH: The BAUH caters for women who are classified as having a high-risk pregnancy or who require certain interventions (e.g. epidural). Their antenatal care is delivered in the Family Clinic (either Midwives Clinic or Doctors Clinic depending on risk level). This means that they will not know the Midwife/s or Obstetric team who deliver their baby. This is because the Midwives who work in the Family Clinic do not work in the Birthing and Assessment Unit and are not present at births.

2.5 Women's Health Ward

The Women's Health Ward is the ward where women stay after giving birth. The time spent here is variable and depends on whether women are low or high risk amongst other factors (e.g. how soon they want to return home). The ward has 38 rooms, twenty of these are single occupancy and 18 are shared ('Women's Health Unit: Information Booklet, SA Health 2010, p.5).

Breast Feeding Day Stay Clinic

The Women's Health Ward also runs a Breast Feeding Day Stay Clinic. This clinic is run in the Ward on Tuesdays and Fridays and is designed to help women to successfully breast feed. It is available to all women, even those who did not give birth at the LMH, providing their babies are younger than eight weeks of age (Women's Health Unit: Information Booklet, SA Health 2010, p. 6).

2.6 Antenatal and Parenting Education

The LMH offers a range of Antenatal and Parenting Education options. Both group classes and one on one consultations with the Antenatal and Parenting Educators can be arranged. There are two Antenatal and Parenting Educators, both are Registered Midwives and Registered Nurses. One is employed solely as an Antenatal and Parenting Educator working four days a week. The other also works as a Midwife in the Special Care Nursery and the Women's Health Ward. Consultations with the Antenatal and Parenting Educators take place in the Antenatal Education Room.

Group Classes

Group classes are available in the evening (7pm-9pm), and during the day (10.30am-12.30am). There are six topics covered in the classes. These topics are described in a brochure that is given to women at their first antenatal appointment ('Getting Ready for Birth and Early Parenting' SA Health 2011, n.p.). The topics listed in this brochure are:

- Maternity Unit Tour
- Healthy Pregnancy and Dads

> Parenting 1
> Parenting 2
> Normal Labour and Active Birth
> Variations of Labour

It should be noted that the Maternity Unit Tour can also be taken separately at 6pm on most Monday and Thursday evenings.

Class Sizes

The Antenatal and Parenting Group Classes often book up very quickly and this can cause problems for the Educators. While they try to accommodate all requests, they are also mindful about maintaining small class sizes. The maximum class size is 24 people (usually 12 couples). In an interview the Educators stressed that smaller class sizes were more conducive to group discussion, participation and rapport building. They noted that when 24 people attend a class 'it gets a bit crowded' (Interview, Antenatal and Parenting Educators, 14-06-2012) and this can influence people's willingness and ability to be involved in activities like trying different labour positions. This is because of the embarrassment that might be experienced when performing these actions in a large group and the space limitations that can restrict movement in a "crowded" (ibid) class.

Attendees

The Antenatal and Parenting Educators noted that people who participated in group antenatal classes were typically couples, aged in their 30s, who were first time parents. All of the couples that Health-e Baby researchers have observed at the classes comprised of one man and one woman (six couples at an evening class, four couples at a day time class) and I assume that this is the norm.[4] All of the class members observed to date appeared to be Caucasian, although this is extremely difficult to confirm through participant observation alone. However, the Educators did state that people from certain cultural backgrounds were much less likely to attend the sessions: 'we don't have African people coming to antenatal classes' (ibid). The absence of this group from formal antenatal classes provided by the LMH was attributed to cultural differences. In particular, the Educators thought that 'African' people learnt about childbirth and parenting through interpersonal communication and support provided within their communities. As such, formal Antenatal and Parenting classes were thought to be less relevant to them. One of the Antenatal Educators also noted that women from NESB (Non English Speaking Backgrounds) and CALD (Culturally and Linguistically Diverse) backgrounds might not 'trust' them or might feel 'out of place' at the sessions (ibid). These are assumptions that need to be investigated.

This suggests that while Antenatal and Parenting classes have numerous benefits, they tend to appeal to a specific cohort that is not reflective of the diverse population served by the LMH.[5] This is further illustrated by statements made by the Antenatal and Parenting Educators who also described class attendees as 'proactive' and 'very much into looking after their health' (ibid). This raises a key problem for our project, namely, how do we reach people who may not be "proactive" and do not attend or engage with health promotion/communication practices that are already provided by the hospital? One way that the Antenatal and Parenting Educators do reach out to these more 'at risk' groups is through one on one consultations and a specialised program called the 'Young Mums' group which is discussed below.

[4] At the day time class there was also one woman who attended on her own.
[5] It should be noted that these classes provide a very important space for people to learn about pregnancy, childbirth and parenting, to develop new skills and to access social support.

One on One Consultations

Individual consultations with the Antenatal and Parenting Educators can be arranged by appointment. Typically, one on one consultations are made for women and their partners or significant others who are require an interpreter. This is because it is difficult to use an interpreter in a group setting. The Educators reported that they primarily see people who speak Khmer and Vietnamese in one on one sessions. However, they also offer individual consultations to people who enquire about group classes late in their pregnancy when all available classes are already booked out. This means that people who cannot attend the group classes can still have some contact with them and receive some education. Alternatively, they try to mail out written material: 'send them out as much information as we can for them to read' (ibid) or to fit them into one or two group sessions.

Young Mums Group

A specialised 'Young Mums' session is available for women who are up to and including the age of 18. This group is held on a Wednesday from 2pm-4pm. It provides an opportunity for the Antenatal and Parenting Educator (only one of the Educators runs this session) to deliver tailored information that is designed specifically for this age group ('Women's Health Unit: Information Booklet', SA Health 2010, p. 13). One of the key differences between the Young Mums Group and general Antenatal and Parenting Education sessions is that the language used in the group for young mothers is adapted to suit their needs:

> [I]n our Young Mums group, that's highly different and we do put things more into their language. And it's helpful because they usually tell you the word, like 'the boob' or something. Then we can use the word that they use. Because it's no use pitching anything at a level that they're not on. (Interview, Antenatal and Parenting Educators, 14-06-2012)

The use of culturally appropriate language or 'street talk language' (ibid) was a key strategy used by the Young Mum's co-ordinator to communicate effectively with young women who might not use or understand medical terms: "Some people, if you say breast they don't know what you mean" (ibid). This strategy was also employed by other staff members at the LMH and is discussed in the Emerging Themes section under the heading 'Culturally Appropriate Language Use'.

2.7 Special Care Nursery

The Special Care Nursery is where babies who are born prematurely or who are sick at birth are cared for ('Women's Health Unit: Information Booklet', SA Health 2010, p. 7).

Section 3: Off Site or Multi-site Antenatal and Postnatal Services

3.1 Northern Area Midwifery Group Practice (NAMGP)[6]

This program is a free service for 'women who meet the program's criteria and live in the Salisbury, Playford and Tea Tree Gully Council area' ('Women's Health Unit: Information Booklet', SA Health 2010, p. 18). Aboriginal and Torres Strait Islander Women or women with an ATSI partner are automatically included in this service, as are women aged 25 or under,[7] provided that they live in the defined geographical areas (LMH Trial Form NAGMP, n.d, n.p.). Alternatively, women who achieve three 'risk' factors may be eligible. These risk factors include; 'low SEIFA' (assessed using the 2006 Index of Relative Socio-Economic Disadvantage),[8] mental health factors, domestic violence, insecure housing/homelessness, substance abuse and recent arrival in Australia.[9] These risk factors are weighed up against 'protective factors' (ibid) to determine if a woman is best suited to NAMGP care or another form of antenatal care. Protective factors include support from family/social connections and previous positive pregnancy and birth experience/s. A patient's eligibility for the NAMGP is determined at their first antenatal appointment, which is usually held in the Family Clinic. At this appointment the Midwife can complete a referral form for the service.

Women in the program are provided antenatal care by qualified Midwives either in their own home or at three different community centres located in Parafield Gardens, Davoren Park and Kaurna Plains. The Kaurna Plains community centre provides antenatal care 'specifically for Aboriginal, Torres Strait Islander women or women who are carrying an Aboriginal, Torres Strait Islander baby' (Interview, MW, Northern Area Midwifery Group Practice 26-06-2012). Women who use the NAGMP are allocated a primary Midwife and a secondary Midwife who will care for them throughout their pregnancy. This differs from other antenatal care options; particularly care in the Family clinic, where women may see a different Midwife or specialist at each appointment. The Northern Area Midwifery Group Practice also provides support to women in the hospital environment. For example, Group Practice Midwives can accompany women to their hospital appointments (ibid). Women who access this program are also able to give birth in their homes, provided that they fit the inclusion criteria. Women are excluded from home birth if they meet criteria in three different categories, Obstetric History, Medical History and Home Environment (e.g. they live more than 30 mins from the hospital by Ambulance).

3.2 Shared Care

Women can elect to have their antenatal care provided by a GP who is accredited by the hospital ('Women's Health Unit: Information Booklet', SA Health 2010, p. 17). In order to arrange this, women must make an appointment with a Shared Care Midwife. They must also be willing to attend the hospital as required and will be referred to the hospital if they encounter any complications (ibid).

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[6] It should be noted that the NAGMP can also be referred to as the 'Community Midwives Practice', as it is in the Women's Health Unit Information Booklet. In this report we do not use this term because some staff members also call the Home Visiting Midwives service (section 3.4) the Community Midwives Practice or Program. This is another example of a lack of standardisation which can cause confusion.

[7] However, one Midwife stated that she would not refer all women who aged 25 and under. Rather, she would only refer women who had some of the identified risk factors.

[8] Geographical areas defined as low SEIFA are: Angle Vale, Andrews Farm, Davoren Park, Elizabeth (any), MacDonald Park, Munno Para, Paralowrie, Penfield, Parafield Gardens, Smithfield, Salisbury, Salisbury North, Salisbury Downs and Virginia.

[9] Women who have lived in Australia for under two years whose background is Non-English Speaking (NESB) or Culturally and Linguistically Diverse (CALD).

3.3 GP Plus

Every Monday and Friday a Midwife from the Family Clinic goes to the GP Plus Health Care Centre in Elizabeth to conduct women's first antenatal appointments. This service is designed to relieve some of the pressure placed on the Family Clinic because of the limited number of consulting rooms.

3.4 Home Visiting Midwifery Service

The Home Visiting Midwifery Service provides postnatal care for women either in their homes or at the hospital. A team of Midwives visit women up to three times after they have given birth.

3.5 Mothercarer Service

The Mothercarer Service provides in-home support for women who have had a short hospital stay. Mothercarers are not Midwives, although they have had 'training in the health of mothers and babies following childbirth' (ibid, p. 8). They can provide additional help with household duties (e.g. cleaning) to give women, their partners or significant others more time to rest and relax post-birth.

Section 4: Analysing Health Promotion/Communication Practices

As the above overview of antenatal, birth and postnatal services provided at the LMH demonstrates, the structure of antenatal care and the way that health information is delivered to pregnant women and their greater networks at the LMH can vary widely. Numerous factors influence how LMH clients receive antenatal health communication, including their care model (e.g. Total Midwifery Care compared to Consultation Care in the Family Clinic) and the optional services that they access (e.g. if they go on a Maternity Unit tour or attend Antenatal and Parenting Education classes). Furthermore, as demonstrated in earlier Health-e Baby project documents (Maternal Health and Behaviour Determinants Associated with Low Birth-Weight: An Overview of Risk Factors, Contextual Constraints Preventing Behaviour Change and Health Communication Approaches 2009) and Wilmore's recent conference paper (Wilmore 2012), numerous factors such as age, education level and socio-cultural background play a role in determining people's ability to understand and apply health information. In addition to these factors, we also need to consider people's motivation or willingness to use the health messages that they receive (Wilmore 2012) and the barriers that people face. Therefore, it is important to keep in mind that the provision of health communication/promotion cannot simply be equated with changes in knowledge, attitudes, practices and beliefs.

In this section of the report we begin to assess the strengths and weaknesses of health communication practices at the LMH in more detail. We begin by identifying two key moments when a significant amount of health information is delivered to women in the Family Clinic: In the Waiting Room and At the First Appointment. In particular, we focus on the written material that is given to women at their first appointment. This is an important appointment because it is the only appointment that all women attend. At this appointment their model of care will be negotiated and from this point onwards their antenatal care may differ. After we explore how information is communicated in both of these contexts, we provide a broader discussion of the factors that influence the effectiveness of health promotion at the LMH. This section is titled 'Emerging Themes' and incorporates some preliminary recommendations.

Case Study: Analysing Key Health Communication Practices in the Family Clinic

4.1 In the Waiting Room

In section 2.2 we provided some information about the Family Clinic waiting room. In this section we discuss the health promotion practices employed in the waiting room in more detail. These findings are based on participant observation conducted in the waiting room and preliminary findings from semi-structured qualitative interviews conducted with pregnant women and their partners.[10]

Posters

Several posters adorn the walls of the Family Clinic waiting room. Some of these are posters are produced by organisations such as SA Health, while others have been designed and compiled by Family Clinic staff members. The impact of these posters is difficult to measure and varies from person to person. For example, a 33 year old pregnant woman stated that she had read the poster

[10] To date two women have brought their partners to their interviews with us.

about caffeine in the waiting room ‘Caffeine and Pregnancy’ (see Figure 1, p. 14) and that this gave her valuable information about the amounts of caffeine that she could safely consume while pregnant (Interview, 33 year old pregnant woman at 12 weeks gestation, 19-06-2012). This poster comprises of three main panels which are displayed on a notice board with the title ‘Caffeine & Pregnancy’ in large block letters above. Numerous other fliers and brochures are pinned around this poster on the notice board.

Figure 1: Caffeine & Pregnancy Poster in the Family Clinic Waiting Room.

However, another interviewee reported that she had not read any of the posters in the Family Clinic and that it was difficult to do so unless you were very close to them (Interview, 33 year old pregnant woman at 36 weeks gestation, 17-07-2012). To date we have not observed anyone walking up to a poster to examine it in more detail. This suggests that while people may look at a poster’s heading or main points, which are usually written in large font and can be read from a distance, they are less likely to read smaller text. Posters that are reliant on text to communicate a health message are also completely inaccessible to illiterate clients.

Furthermore, it should not be assumed that all people in the waiting room are actively interested in reading posters or observing their surroundings. Indeed, many women and their partners, friends or family members seem to be disengaged from their immediate environment. While they wait, many people use their phones to play games, read text messages and make voice calls.[11] People are not required to turn off their mobile phones in the Family Clinic. Alternatively, some people bring books, typically non-fiction novels, with them to read or talk to the support people who have accompanied them to their appointment. Thus, we should not take it for granted that people in the waiting room are a captive audience. Ironically the effectiveness of the waiting room as a context where health communication can occur is also mitigated by the efficiency of the Family Clinic staff. This is because people do not usually have to wait long for their appointments, particularly if their appointment is with a Midwife not a Doctor. As such, they may not have time to read posters or look at the other forms of health communication, such as brochures and pamphlets which are discussed below.

[11] This finding will be discussed in more detail in the next report which focuses on people’s media habits.

Brochures and Pamphlets

There are two information stands with various brochures and pamphlets for people to take or browse in the waiting room. In addition to these information stands, other printed material and magazines are also displayed on coffee tables which are located around the Clinic. While our researchers have observed a woman reading a parenting magazine taken from a nearby coffee table, they have not seen anyone take any pamphlets from the waiting room. To date our Research Associate has conducted approximately four hours participant observation in the waiting room at different time periods. Additional participant observation needs to be conducted to establish if this is just an anomaly. However, interviews also seem to confirm that a low number of people take printed material from the waiting room. Only one person that we have interviewed thus far (30-07-2012) has discussed taking a brochure from the waiting room. This person had become a member of the Australian Breastfeeding Association (ABA) and saw a brochure produced by the SA Branch which included meeting times. This was information that she had been seeking.

The vast majority of brochures and pamphlets available in the waiting room are different from the brochures and pamphlets that are given out at the first antenatal appointment, although some are duplicates (e.g. provided at the first appointment and available in the waiting room). Many of the brochures offered in the waiting room advertise support services that women and their greater networks can access. For example, the 'Supporting Parents' brochure lists parenting courses, groups and sessions available in the City of Playford such as the 'Kids on Peachey' after school hours sports and activity program for children aged from five to twelve years old (Supporting Parents Brochure, term 1 – February to April 2012). This brochure is produced by the City of Playford and funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. In additional to various support services, many of the provided brochures have an explicit behaviour change/education focus. These brochures discuss issues such as; the effects of drinking alcohol, consuming tobacco or using other drugs during pregnancy and/or breast feeding; nutrition for babies, toddlers and families; safe sleeping and postnatal depression/mental health. A series of information sheets produced by SA Health also cover a number of specific postnatal topics ranging from 'About Babies' to 'Being a Parent'.

Television

Three televisions (TVs) are mounted on the wall in different sections of the waiting room. The volume is always quite low and very few people seem to engage with the free to air television programs that are playing. The TVs themselves are quite old and have poor picture quality. On one occasion we noted that one of the TVs was not working or was not switched on. A number of staff members identified the TVs as a missed opportunity for health communication. After we conducted a group interview with four Midwives from the Family Clinic, one participant stated that there should be a "health channel" that played on the TVs in the waiting room and discussed important information. Another participant noted that if an educational/informative video like this was produced it should use "simple terms" (Field Notes, 30-05-2012). Similarly, the Antenatal Educators stated that the TVs in the waiting room could play 'educational stuff, that's not too heavy but probably repetitive while they're sitting waiting for appointments' (Interview, Antenatal and Parenting Educators, 14-06-2012).

In more recent interviews with pregnant women we have begun asking whether they would watch a pregnancy related educational video that was playing in the waiting room. However, responses have been mixed. While some interviewees have indicated that they would watch such a video and have suggested content that they would like to see included, one participant stated that she would find it difficult to concentrate on a video in the waiting room because of the noise and other disruptions. This is an issue that we will continue to investigate and will discuss in the next report.

4.2 At the First Appointment

The first antenatal appointment, referred to by staff as a 'triage' appointment, is held in the Family Clinic and is conducted by a Registered Midwife. They are booked in two hour time slots, however, they can be longer or shorter depending on people's individual circumstances. Typically appointments run for one hour and the remaining hour is used to fill out paperwork and make referrals. When Midwives know that they have an appointment with a woman who requires an interpreter they make a four hour appointment (two hour consultation, two hours to complete paperwork).

When women arrive at the Family Clinic for their first appointment they report to reception where they are given three forms to fill out while they wait to be called. These forms are the: Antenatal Risk Questionnaire (ANRQ), Edinburgh Perinatal Depression Score (EPDS) and a Smoking Questionnaire. These forms are discussed later in this section. After they are greeted by their Midwife, women are escorted to the 'Assessment Room' where they are weighed and measured. They are then taken to a consultation room which includes a sink, three or four chairs, a hospital bed, a desk and computer. Before the appointment the Midwife will set up the room (e.g. replacing bed covers and other hygiene practices, logging into OACIS on the computer)[12] and prepare for the patient's arrival by reading case notes and manually transferring information from OACIS into the patient's SA Pregnancy Record. A patient identification label, or 'sticky label' as they are commonly referred to at the LMH, must also be placed on every single page of the record.

At the beginning of the appointment the client is given their record, which is typically called the 'orange book' because of its bright orange cover. This record contains a number of loose brochures, which are added by the Midwives before the first appointment, and the record itself, a 16 page form. The contents of this form are discussed in more detail below. The SA Pregnancy Record is kept by women and they are personally responsible for bringing it to all of their appointments. The 'Personal History' section of the Record is filled out by the Midwife during the first appointment.[13] The Midwife begins working her way through the form by asking questions about the woman and her partner (occupation, phone contacts, ethnicity/cultural background, preferred language). Throughout the first appointment they will gather information about women's past pregnancy experiences, their medication history, allergies, medical history, surgical history, anaesthetic history, family history, prenatal diagnostic issues and physical exams (e.g. last pap smear). They also check the date of the woman's last period to calculate their final due date and ask a series of questions about their 'Psycho-Social history'. They ask if women have experienced or are experiencing the following:

- Anxiety/depression
- Postnatal depression
- Other psychiatric disorders
- Emotional issues
- Major stressors, life changes or losses
- Mental health problems (including partners)
- Relationship issues
- Contact with Families SA
- Accommodation issues
- Financial issues
- Other

[12] OACIS is an Information System used at the LMH that enables staff to view patient records online, order tests and track medical trends. OACIS stands for 'Open Architecture Clinical Information Systems'.

[13] Sections of the record, which are filled out in the later appointments, include the results of different screening tests (e.g. Vitamin D screening at 36 weeks) and management plans for pregnancy, birth and postnatal care.

As the above list of questions illustrates, the format of the SA Pregnancy Record is very structured. Based on the above description it could be assumed that the first appointment is a very formal process that may intimidate women or make them uncomfortable. However, while the Midwives that we have observed do ask all the questions listed above, they also intersperse these enquiries with more casual comments, jokes and tailored questions about the woman and her pregnancy (e.g. "Are you going to find out the sex [of the baby]?") (Field notes, 13-06-2012). One Midwife discussed how she used these strategies to build rapport with women and to try to encourage them to relax:

> I try to throw in jokes and things, you're going through a bunch of questions about their health and their lifestyle...if you can throw in a few funny remarks to make them laugh and relax…then they're more into trusting you, understanding you and listening, hopefully. (Interview, MW, Family Clinic 21-05-2012)

In the above quote the Midwives communication style is viewed as an important factor that influences how health messages are received. Trust is also identified as a key factor that contributes to effective health promotion.

The results of the ANRQ, EPDS and the Smoking Questionnaire are also discussed during the first appointment. Both the ANRQ and the EPDS are designed to assess women's psycho-social health. The ANRQ asks questions referring to the past twelve months while the EPDS refers to the past seven days. These questionnaires are scored by the Midwife during the appointment.[14] A flow chart developed by the Mental Health Midwives is used to determine what the triage Midwife should do in relation to the ANRQ/EPDS scores. If the women scores high in the questionnaire or if the Midwife is concerned about their psycho-social circumstances, regardless of the questionnaire, they can highlight these concerns by completing the 'High Risk Psycho-Social Meeting' (HRPM) form and these issues will be discussed at the HRP Meeting. This includes what plan has been set in place to assist the patient. Women's scores and answers to these questionnaires, including the Smoking Questionnaire, are also used to tailor the health information that is delivered in the first appointment. For example, if a woman indicates that she smokes, information about smoking cessation will be discussed and tailored print material will be provided (e.g. brochures from Quitline SA or a Pregnancy Quitline referral form[15]). Similarly, if their answers to the ANRQ and EPDS indicate that they may be dealing with mental and emotional issues, the Midwife would talk about where they could seek help and make any necessary referrals.

Another standard component of the first appointment is the taking of measurements which are recorded in the 'Symphsio-Fundal Chart'. This is a chart which shows the 'fundal height', a measurement from the highest point of the fundus (upper portion of the uterus) to the top of the symphysis pubis (pubic bone). The Midwife will ask the client to lie down on the hospital bed where they will take these measurements. The measurements are then entered into a computer program that will create a chart based on other factors including the women's race, height and weight. This chart is printed out and attached to the Pregnancy Record. At this stage the Midwife will also take the client's blood pressure and may use a Fetal Heart Rate Monitor to listen to the babies heart beat. However, not all Midwives check the fetal heart rate because they are concerned that women may become frightened or worried if they are unable to locate it.[16]

[14] The timing of this process can differ. Some Midwives score these questionnaires early in the appointment while others complete it after they have asked other questions in the Personal History section of the Record.
[15] This form is filled out in the appointment and then faxed to Quit SA who are able to provide quitting support directly to the woman or her partner by telephoning him/her at a time that they have nominated (e.g. 8.30am-12.30pm, Mon to Fri).
[16] This caused some frustration for one woman that we interviewed who expected that listening to the heart rate would be standard procedure. This woman had some questions about the structure of antenatal care at the LMH. In her previous

During this time, Midwives will also begin to ask questions about women's birthing plans and this information will be used in conjunction with other factors such as their medical and psycho-social history to determine the model of care that they will be allocated to. Although the information in the Women's Health Unit Information Booklet indicates that this decision is made in consultation with women, we have not yet observed any women who have asked questions about their different care options or given a preference for their care. In this very early stage of the research, it appears that many women may not realise that they can have input into the final decision about their antenatal model of care. Of course it should be noted that in some circumstances it is simply not possible for woman to be cared for in a low risk setting like the BAUL (e.g. if they have a high risk medical condition). Furthermore, as the above summary of the various antenatal pathways illustrates, the vast range of services available at the LMH and the differences between them are complex and difficult to communicate in a short amount of time. While acknowledging these complexities, our Research team found that the booklet that describes these models is dense, difficult to navigate and uses complex terminology that may lead to confusion.

After the Symphsio-Fundal measurements are completed and the data is entered into the computer program and the patient's SA Pregnancy Record, the Midwife will begin to go through the brochures that are contained in the 'orange book'.[17] This process is fairly brief, taking approximately five to ten minutes. Typically the Midwives introduce each brochure by describing its central themes and holding up the brochure for the woman to view. The contents of each brochure are then briefly examined, with the Midwife highlighting certain points and providing an oral summary of the issues discussed within. Some Midwives use highlighters or pens to underline or draw attention to information such as contact phone numbers. They also use their hands to point to the location of relevant text or visuals in the material (e.g. the location of the BAU on a map, a section of a brochure that lists foods to avoid during pregnancy).

These summaries of the written material are tailored to the individual needs of the woman. Decisions about what to emphasise and how to best introduce the brochures are based on information that the Midwives have read in the patient's case notes and their responses to questions asked during the appointment. For example, a woman who had a two year old child was asked by the Midwife if she had successfully breast fed after her first pregnancy. The woman stated that she had breast fed her daughter for "13 months". When the Midwife was going through the written material about breast feeding she told the patient that she would "be a star, you've done it before". It appeared that less time was spent discussing breast feeding with this woman than would be spent with a first time mother. However, this needs to be confirmed through further participant observation. Research findings to date suggest that even though all women are given the same set of standard brochures in their first appointment, the way that this information is presented depends on the perceived needs of the individual woman. In some cases women themselves explicitly reject the information that is being given to them by making it clear that this information is not applicable to them or is not wanted.

In addition to customising the way that they present the information contained in the standard brochures, Midwives also have access to other brochures which they are able to give women based on their needs. So, if a woman indicates that she drinks alcohol she is then provided with literature discussing the risks associated with alcohol consumption during pregnancy. Although the Midwives summaries of the written material are short, they provide an opportunity for women to ask questions

pregnancy she had been cared for and given birth at the Women's and Children's Hospital (WCH) where listening to the heart beat was standard practice. She was also unsure about some other differences between care at the LMH and the WCH (e.g. the number of antenatal appointments).

[17] See Appendix 4 for a list of the standard brochures that are given to every woman at their first appointment.

and clarify information that they may not understand. They are also an important way of disseminating health messages to women that may be unable to read or have difficulty comprehending written material. Furthermore, they enable Midwives to educate women that are not interested in reading brochures or are not engaged by the written material. These women may never personally examine the brochures that they are given or discuss them with their partners, friends or family.

That said, one of the weaknesses of this health promotion strategy is that the Midwives who conduct the first appointment typically have no ongoing contact with women. This means that they are unable to determine how the brochures have been used and if women understood the information that they were given. They are also unable to re-visit ideas and build on women's knowledge. While the health material that is delivered in the triage appointment is tailored, Midwives reported that they did not have enough time to gain a deeper understanding of women's individual circumstances, past experiences, and their skills and abilities (e.g. education level). These issues are explored in the Emerging Themes section of this report.

At the first appointment women are also asked to provide a urine sample and they are referred to the onsite IMVS Pathology service where they will have a blood sample taken. This can be done at any stage after their appointment. They are also booked in for their next appointment and any other tests that may need to be conducted, such as an optional screening for Down Syndrome. At the end of the appointment they are also given a 'Bounty Bag' which is a bag filled with product samples, advertising, magazines and health information which is compiled by Bounty Pty Ltd. Data from interviews suggest that women conflate the written material provided in the Bounty Bag with material provided in the SA Pregnancy Record. For example, in early interviews when asked about the brochures that were memorable or well designed, some women discussed material provided in the Bounty Bag. Therefore, we have adjusted our questions to distinguish between these two sources of written material.

Section 5: Emerging Themes

5.1 Continuity of Care

As the above discussion of antenatal care models at the LMH illustrates, not all clients receive continuity of care. Specifically, women who are cared for in the Family Clinic, either in the Doctors Clinic or the Midwives Clinic, may see a different Midwife or specialist at each appointment. Furthermore, they will not have the opportunity to form a relationship with the individual/s who will deliver their baby. This model of care can be contrasted with care in the NAGMP and the BAUL, where women have multiple appointments with a small number of caregivers (primary and secondary Midwife in the NAGMP, team of Midwives in the BAUL) one of which will be present during their labour and birth. The lack of continuity of care in the Family Clinic was identified by staff as a potential weakness that influenced their ability to effectively deliver health information. This was because staff in the Family Clinic had less time to foster a positive relationship with pregnant women. This was highlighted by one Midwife who indicated that women may be more willing to seek help from someone who they have an ongoing relationship with:

> If there are problems they tend to tell you and you can help them, where they mightn't tell someone they might only see once or twice, or initially, or they might be embarrassed about their circumstances. (Interview, Research MW 18-04-2012)

This does not mean that staff in the Family Clinic do not forge positive relationships with their clients. Rather, it suggests that in other care models at the LMH, staff have greater opportunities to reinforce health messages, to build trust and to assess women's individual needs. Therefore, they are more likely to gain a sound understanding of whether or not women understand the health information that they are given. This means that they are able to implement changes that might improve women's comprehension.

Because they have ongoing contact with women, staff in the BAUL and NAGMP are also able to introduce and discuss ideas and issues over a number of weeks. This was a strategy which they used to give women additional opportunities to ask questions and to seek clarification. The differences between this mode of delivery and the practices employed in the Family Clinic is emphasised in the following quote from a NAGMP staff member:

> [Midwives in the Family Clinic] don't have the opportunity to sit and talk to a woman and understand, well, you're just shoving pamphlets in their face and hoping to god that they read them. And then there's no follow up from that. The girls don't get to see that same woman again. The week after to go, or the two weeks after to say, look I gave you those pamphlets, have you got any questions? (Interview, MW, Northern Area Midwifery Group Practice 26-06-2012)

Continuity of care also gives staff more time to find out information that cannot always be openly requested. For example, literacy was identified as a sensitive issue that staff members would not ask about directly because doing so could 'damage rapport' (ibid) and cause embarrassment. Asking about literacy was thought to cause women discomfit, typically resulting in non-disclosure. However, in the NAGMP, Midwives are able to learn over time if someone can read or write by

observing their behaviour (e.g. how they fill out forms, if they can sign their name, how they interact with health brochures). In the Family Clinic staff have less time to make these kinds of observations and do not directly ask women about their literacy. As such, they may be providing written material to women who are illiterate or have low levels of literacy.

Recommendations

> Greater continuity of care would give staff members more time to learn about their clients and to tailor their health promotion practices to suit their specific needs. Having time to assess and re-assess women's knowledge, beliefs and behaviours is a critical component of effective health communication.

> However, the cost-effectiveness of continuity of care must also be considered. The high number of women who are seen in the Family Clinic makes it difficult to provide ongoing contact with the same Midwife. This may be an issue that is beyond the scope of our study.

5.2 Tailored Health Communication

Health promotion practices at the LMH are commonly tailored to suit the needs of different groups and individuals. Both the amount of health information that is provided (e.g. additional brochures, referrals to other services) and how this health information is delivered can be changed depending on factors such as: age, education level, literacy, ethnicity/cultural background and socio-economic status. Some services (e.g. NAGMP, Young Mums Group) are specifically designed to target a particular cohort. In this section we examine how health promotion practices at the LMH are modified to suit the skills and abilities of different clients and identify the strengths and weaknesses of these approaches.

Literacy

> There's no point just throwing pamphlets at them and saying well 'just read this and then next week we'll discuss it' because they may not be able to do that…you're going to, keep it as basic as possible for someone who's only got like a year 10 education level and doesn't really understand what you're talking about. (Interview, MW, Northern Area Midwifery Group Practice 26-06-2012)

If staff suspect that a client has a low level of literacy or is illiterate, they alter the way that they utilise written material in their appointment/s. Two staff members indicated that they would 'talk though' (ibid) the material in more detail, 'I would go into a little bit more depth in my discussion with what's in them [brochures]' (Interview, MW, Family Clinic 21-05-2012). Thus, although these women may be unable to read the written material themselves, they have had it explained to them in person. One Midwife also stated that she would encourage women to discuss the brochures with family members or friends.

However, as discussed in section 5.1, Midwives are often unaware of people's level of formal education and their reading and writing abilities. In a group interview with four Midwives from the Family Clinic, literacy skills were described as a key factor that influenced people's ability to understand and implement health information, but also as an area where Midwives have little insight. This is because people do not often discuss their reading and writing abilities and they can

be difficult to assess.[18] Furthermore, staff indicated that the hospital was highly reliant on written material and that alternative forms of health communication needed to be integrated into the LMH's health promotion strategy. Suggestions included the increased use of visual mediums such as videos and Smart Phone Applications that were not text heavy. Additionally, staff stated that when written material is used, more options that are designed specifically for low literacy groups should be provided.

Recommendations

> Alternative forms of health communication need to be provided for women who are illiterate or whose literacy skills are poor.

> Although information provided in written material can be explained to women in person at their first antenatal appointment or discussed over a number of weeks if they are seen in the NAGMP or BAUL, more extensive health promotion strategies need to be developed for this cohort.

> Further research will inform the ideal format of this material. However, in order for this form of health education to be successful, the LMH needs to develop a way to quickly and easily assess literacy at the first antenatal appointment. Even adding a question about women's level of education to the SA Pregnancy Record could provide a basic indication of their literacy skills.

Low Socio-Economic Status

LMH staff members indicated that they faced specific challenges when trying to educate women with lower socio-economic status (SES). Financial pressures were described as a barrier that made it more difficult for these women to implement health advice, to access services and to purchase medications or nutritious foods. The current Antenatal Asthma Educator at the LMH stated that she tries to overcome these challenges by putting herself in 'women's shoes' and developing strategies to ensure that they are able to purchase their asthma medications.

> What do we do? You know you need the medication so how's it best that we work with you? And whether you need to get a pharmacy to do home...medication reviews. Sometimes we talk about friends and can their friend pick them up once a week and take them for an hour drive to go and pick things up? Can they get things delivered? (Interview, Antenatal Asthma Educator 18-04-2012)

As the above quote illustrates, a lack of transport options can create problems for many low SES women. This was reiterated by the former Antenatal Asthma Educator who stated:

> [I]f they haven't come to their appointments…they'll say 'oh I ran out of credit on my phone' or 'I couldn't afford the bus ticket this week'. (Interview, Antenatal Asthma Educator 11-04-2012)

[18] This has also been highlighted in our own interviews where we are asking people to state whether they speak and read English 'Very Well' 'Well' 'Not Well' or 'Not at all' which are categories taken from the 2011 Australian Census of Population and Housing. To date everyone has selected 'Very Well' and we have reservations about the level of insight provided by this question.

Here we can see how poverty directly impacts on people's ability to attend appointments and to notify staff that they cannot attend.[19] These are issues that are not easy to address using health communication alone. Financial pressures and a lack of mobility can be compounded by other problems that this cohort often faces including: homelessness or insecure housing, domestic violence, and drug or alcohol addiction. Encouraging these women to participate in their care was identified as a key problem by the NAGMP Midwife who reported that many women fail to attend their appointments. Furthermore, this Midwife argued that many of the women who are cared for by the NAGMP do not view their pregnancy as an important part of their life and therefore, do not treat it as a priority.

It is clear that how to best deliver pregnancy related health messages to low SES women is a complex and problematic issue. This is a group who do not attend optional health promotion services provided by the hospital such as antenatal classes, are much less likely to read written material 'even if they can they won't' (Interview, MW, Northern Area Midwifery Group Practice 26-06-2012), are less likely to attend appointments, and may lack or have inconsistent access to media forms such as mobile phones and the Internet. Because of these issues, the Antenatal and Parenting Educators stated that they were a group who need a high level of support 'in every possible way that we can think of' (Interview, Antenatal and Parenting Educators, 14-06-2012).

Health communication practices that were suggested to target this group included demonstrations or information sessions held at major shopping centres in the Northern suburbs which are frequented by this cohort. LMH staff also indicated that these women had a lack of community 'role models' and that their peers were a significant influence on their behaviour. Therefore, it would appear that campaigns that feature members of this group speaking to other women in their own words and promote peer-group support may be more effective than top down strategies. Such health promotion practices could model healthy behaviour, providing women and their greater networks with practical health information and the opportunity to develop the skills and abilities that they need to improve their well being:

> They don't have good role models, they really don't, it's such a shame. And what you don't know you don't actively seek out. So if you don't know...that you should be eating five lots of vegetables a day…and going to McDonalds is not a good thing, you're not going to actively seek that out are you?...the majority of them will honestly tell you that they eat KFC and McDonalds. They wouldn't know...what a meal is. Because they haven't had that shown to them. (Interview, MW, Northern Area Midwifery Group Practice 26-06-2012)

Linking women to other services was also a key strategy used by staff to try to provide women with long term solutions to issues that threatened their well being and to give them ongoing support. Thus, although the NAGMP Midwife noted that the '9 months we have with them is valuable time' (ibid), she also noted that the services provided by the hospital are not long term. They are structured around the length of women's pregnancies with a short period of postnatal care. This is an important point because whatever strategy we design must be deliverable in the time frame determined by the typical length of women's pregnancy and the structure of antenatal and postnatal care at the LMH.

[19] This quote also suggests that mobile phones may be a less effective medium for health communication for this cohort. This is further explored in section 5.5.

Recommendations:

> To date, this is a group which we only have secondary information about. This is because pregnant women are currently recruited to Health-e Baby on a referral basis and are self-selecting. It appears highly unlikely that members of this cohort will volunteer to be in our study using our current recruitment strategy. As such, we need to think about ways that we can establish contact with these women and include them in our research.

> The complexity of the issues faced by this cohort should not be underestimated. We need to think carefully about the kinds of strategies that we can develop given our budget and time restraints.

> It should also be noted that regardless of the SES status of our participants, our intervention needs to be designed in light of the typical pregnancy length (40 weeks). We also need to bear in mind that woman usually have their first hospital appointment at 10 weeks and can be difficult to engage before this time. Yet, despite the lack of face to face contact in early pregnancy, our interviews suggest that this is a key time when women may search for information from other sources, particularly online. Therefore, if it is correctly promoted an online or e-health strategy such as a Smart Phone App or updated LMH website could be an effective way of communicating health information to women before their first appointment.

Non-English Speaking Background (NESB) and Culturally and Linguistically Diverse (CALD) Clients

The LMH provides a number of services to assist women, their partners and family members who are from Non-English Speaking Backgrounds (NESB) or are Culturally and Linguistically Diverse (CALD). Staff are able to book interpreters to provide translation services at women's antenatal appointments or in other settings such as meetings with the Antenatal and Parenting Educators. Staff reported that this process was fast and easy, although there were occasionally short delays due to the availability of translators. Some Midwives also indicated that they had concerns about the use of male translators in a Women's Health setting. These concerns stemmed from worries about the power dynamics between a male translator and a female client. In particular, Midwives were unsure if women would be comfortable communicating sensitive issues using a male translator. This power dynamic was thought to be amplified because of the possibility that the male translator would be known to the woman outside of their professional role or have connections with mutual acquaintances from the same language speaking group that would threaten anonymity. Midwives worried about the ramifications that this might have on the quality of care that these women received if they were not willing to disclose important information (e.g. HIV status).

The nature of translation also made some staff members uneasy because they were unable to verify that the information they were providing was being correctly imparted and vice versa. One strategy used to improve staff confidence in the consistency and quality of the health information provided to non-English speaking women was the use of written material. In approximately May 2010 the hospital began providing pregnancy, birth and parenting information in packs of written material in the following languages: Vietnamese, Khmer, Thai, Chinese & Arabic. These resources were compiled by Julia Dalton (RN, RM) who searched for the material and created 'Antenatal Education Packs' and 'Triage Packs'. These packs are available in the storeroom in the Family Clinic. 18 women who received these factsheets were surveyed about their effectiveness with 83% of respondents indicating that they were 'Very Helpful' (ibid, p. 3).

Limited antenatal information is available in other languages and this is why packs were not compiled for all language speaking groups who access the LMH.[20] In a report documenting the impact of these packs, Dalton (2012, p. 4) reported that the development of written material in African and Burmese languages was an urgent priority. In this report Dalton (2012) also indicated that the translated material that she was able to locate was produced in New South Wales or Victoria. Thus, this material contains contact numbers and referral information that relates to these states and is not applicable to South Australian residents. Dalton (ibid) recommended that multi-lingual resources need to be designed specifically for South Australians so that they contain relevant contact phone numbers and accurately reflect how antenatal, birthing and postnatal care is delivered in this state.

In addition to health material that has been translated into their language, staff are also able to provide women with written material that is specifically designed for their cultural/ethnic group. An example of this type of material is the 'Pregnant and Smoking' Brochure produced by the Aboriginal Health Council of South Australia Inc and Quit SA which targets Aboriginal women who smoke during pregnancy. This brochure features illustrations of Aboriginal men, women and children and uses colloquial phrases such as "Don't bum cigarettes off your friends".[21] However, these kinds of customised brochures are not produced for a wide range of different groups. All of the brochures that we have viewed to date target people who identify as Aboriginal or Torres Strait Islander.

The use of interpreters and the provision of specialised brochures and written material in languages other than English are health promotion measures that are designed to improve how the LMH communicates with NESB or CALD women, their partners and families. Yet, as discussed in Section 2.6, other health promotion practices at the LMH, such as Antenatal and Parenting Education classes, are not commonly accessed by recent migrant groups or other ethnic/cultural groups such as Aboriginal and Torres Strait Islander women. The Antenatal and Parenting Educators indicated that a lack of trust in the health professionals providing these services and alternative forms of education provided by community members could account for these absences. Similarly, some staff members discussed the need for the LMH to gain a better understanding of the beliefs and behaviours of different ethnic/cultural groups and to tap into existing community structures. Staff indicated that this would enable them to communicate health messages in a way that was culturally appropriate and therefore, may be more effective. One discussed strategy was communicating health information through a respected community figure or 'elder' (Interview, Antenatal Asthma Educator 18-04-2012) or at a community forum. Reaching women beyond the hospital setting was also identified as a key strategy that would help to foster positive community relations and enable staff to reach women who may not be comfortable attending services within the hospital.

Recommendations

> LMH staff had some concerns about the accuracy of translation and the use of male translators in a women's health care setting. While these concerns may be beyond the scope of our project it is important to note that these factors may limit the effectiveness of health communication delivered by translators at the LMH.

[20] Written material that is available in other languages not represented in the 'Antenatal Education Packs' and 'Triage Packs' were also compiled by Julia Dalton. These resources are located in a 'Multicultural Folder' which is provided in all triage consultation rooms. In these folders there are also links to websites where further information in languages other than English can be accessed and these links were also included on the PC Desktops in the Family Clinic.

[21] Here the term 'cigarette' is used but throughout the remainder of the document cigarettes are referred to as 'smokes' (ibid).

> More written materials in languages other than English need to be developed for the diverse language speaking groups that the LMH caters for. This material should be tailored to reflect the structure of antenatal care at the hospital, or at the very least, should contain information designed for South Australian residents.

> The use of other mediums should also be considered (e.g. videos, community workshops, lectures in community centres) to more effectively engage NESB and CALD women and their communities. Formative research should inform the design of any intervention that targets this group to improve the likelihood of success.

> Why women from certain ethnic/cultural/migrant groups are less likely to attend services such as antenatal classes needs to be investigated.

5.3 Culturally Appropriate Language Use

Staff at the LMH use various strategies to ensure that people understand the health messages and information that they are trying to deliver. Although staff did not use the term 'culturally appropriate' themselves, in interviews they discussed how they tailored their language use to suit the perceived needs of different clients and to ensure that people grasped the concepts that they introduced. One example of 'culturally appropriate language use' that was frequently discussed by staff was simplification:[22]

> ...try to talk down to things, in more common language. (Interview, MW, Family Clinic 21-05-2012)

> If you explain things really simply, they tend to get it. (Interview, Research MW 18-04-2012)

> K.I.S.S. Keep it Simple Stupid. (Group Interview, Family Clinic 30-05-2012)

The effective use of simplification and culturally appropriate terminology is clearly demonstrated in the following quote from a Research Midwife who had previously worked on a project examining drug and alcohol use during pregnancy. In an interview this Research Midwife discussed one of the strategies that she used to educate women about the dangers of drug and alcohol use during pregnancy and other issues:

> My little spiel to them [pregnant women] was, if you have a vegetable garden, that's your cabbage [points to uterus, to illustrate she gestures to their baby bump]. You put that cabbage in that vegetable garden, you tell me how you're going to look after it? And they'll go, 'well, give it a water'. And I'll say right make sure you put some water down there [gestures to throat], two litres a day. So some for you, some for the baby...what else would you do? Go and look at it everyday and make sure it's alright? Ok so you do that for yourself, do I feel alright? Do I need to see a doctor, or a Midwife? Am I attending my antenatal classes as directed? And then I say to them, and the big one is, I say to them, do you put any fertiliser on that garden patch? 'Ohh maybe'. I say, well do you get a bigger cabbage?

[22] One staff member did indicate that simplification had negative implications. In particular, she was concerned about the redevelopment of an Asthma SA Brochure, 'they thought it was too much information on it, for the women, and it was too overwhelming but I think it's gone from one extreme to the other. Now there's not enough information on there…I don't like the idea of underestimating people's knowledge and people's general knowledge and general health knowledge…dumb things down all the time I think it takes some of the power away from people' (Interview, Antenatal Asthma Educator, 11-04-2012).

> Does it look healthier if you do that? 'Oh yeah I spose'. I know that you probably can't afford vitamins but you can eat well. And the other thing is, do you put poison on that cabbage? And they say 'no' and I say; No weed, speed or alcohol! (Interview, Research MW 18-04-2012)

Here, complex ideas such as nutrition, the importance of attending antenatal appointments and the impacts of drug and alcohol use during pregnancy are all communicated in simple terms through a gardening analogy. While this example highlights the use of culturally appropriate language, other staff members identified times when health practitioners failed to communicate with clients in terms that they would understand. These examples included both interpersonal communication and the language used in print material provided to pregnant women. The Antenatal and Parenting Educators indicated that the use of medical terms and complex language can cause confusion:

Antenatal and Parenting Educator 1: …they don't understand the medical terms and they don't call things like we do, do they?

Antenatal and Parenting Educator 2: If you're on the ward and you say 'have you passed wind' half the time they've got no idea what you're talking about.

The Antenatal and Parenting Educators indicated that this problem could be resolved if health practitioners used everyday terms or if clients were provided with a glossary that explained what different terms meant and provided alternatives.[23] This issue was highlighted again by one of the Antenatal and Parenting Educators in an informal discussion that I had with her after I attended an Antenatal and Parenting session. During this talk the Educator stated that she thought that the wording on the current brochure used to promote the antenatal classes was inadequate. This brochure has the heading 'Getting Ready for Birth and Early Parenting' which was described by the Educator as vague, unclear and unsuitable for some of the clientele that the LMH serves. The Educator suggested that while such a brochure could be suitable for women from more affluent South Australian suburbs who may be more highly educated, it was not fit for use at the LMH. Early findings suggest that while staff at the LMH tailor their interpersonal communication to suit the needs of different clients, the majority of written material is not tailored. Although some specialised brochures (see Section 5.1) are used at the LMH, there is a lack of written material designed for groups with different needs. The complexity of the standard brochures given to women at the LMH was critiqued by the NAGMP Midwife:

> For the clientele that we see...they are set at too high a bar, too high a level, much too high. There is nothing simple about them…with all the stats and everything, that means nothing to these young girls…they look at it and go 'that means what?'...They're too hard, they get bored too quick and they look at it and think well I don't understand this so they're just gunna put it away. (Interview, MW, Northern Area Midwifery Group Practice 26-06-2012)

Similarly, the Antenatal and Parenting Educators indicated that the hospital relied too heavily on written material and that when written material was used its content and design needed to be carefully considered:

[23] A glossary of key terms is included on the back page of the SA Pregnancy Record. However, people may not be aware of it and/or it may not include terms that are of most relevance to them (e.g. it focuses on medical terms such as 'parity' and 'gravidity'). This is an area for further research.

Antenatal and Parenting Educator 1:	I guess we give them too much written information. Some of them can't read, some of them won't read because there is just too much of it. So, written should only be a part of it really.
Antenatal and Parenting Educator 2:	I think we need more ways...for low literacy and stuff like that.
Antenatal and Parenting Educator 1:	Small pamphlets that are colourful, low literacy.
Antenatal and Parenting Educator 2:	And straight to the point.

Once again, clarity was identified as a core component of successful health promotion.

Recommendations:

- Early findings suggest that staff at the LMH tailor their interpersonal communication to suit the needs of different clients. However, the majority of written material provided at the LMH is not tailored to the same degree.
- Staff emphasised the need for health promotion practices that were simple, direct and utilised culturally appropriate language. Our project is well placed to conduct the formative research required to develop these kinds of materials.
- Staff reported that a glossary of terms could be created and provided to pregnant women. However, such a glossary is already available in the SA Pregnancy Record. The strengths and weaknesses of this glossary should be investigated.

5.4 Time & Resource Pressures

Staff indicated that their work load was quite demanding and that this influenced their ability to effectively communicate health information. This was because they did not always have adequate time to deliver information, to follow up on people's understanding and to build trust and rapport with their clients (see Section 5.1). The Antenatal Asthma Educator indicated that the high number of women she needed to see had the potential to reduce the quality of antenatal asthma education. This was because time pressures meant that she was:

> ...trying to get the work done, possibly without actually, really finding out what that mum already knows about asthma and what they believe. (Interview, Antenatal Asthma Educator 18-04-2012)

Time restraints were also identified as problematic by one of the Antenatal and Parenting Educators who stated that women were leaving the hospital unprepared because they did not spend enough time in the Women's Health Ward after giving birth. Significantly, she also indicated that other educational mediums, such as a video, could be used to decrease the burden placed on staff who are trying to educate women before they leave the hospital:

> [It] would lighten up the stress load for the staff because the other thing is the admission to the hospital is so short [after labour] and there is so much to learn. Visiting hours are so generous that it's really pressured into a frantic mode of what you've gotta learn. It's just not satisfactory, they go home under prepared. Bottom line. They feel like they're getting thrown out and they're not ready to go home. (Interview, Antenatal and Parenting Educators, 14-06-2012)

Recommendations

- Many staff feel that there are increasing demands on their time which can make it difficult to deliver effective health messages. Although staff workloads are clearly beyond the scope of our project, it is feasible that we could design an intervention that might help to ease some of the time pressures that staff currently face.

- In particular, new communication mediums such as websites and Smart Phone Applications could be utilised to deliver health information that people could access at a time and place that suits them. This kind of communication would not be dependent on staff/client interaction, although it may still require some staff labour in the form of administration or monitoring. However, we need to be careful that we do not idealise or overstate the potential of information and communication technologies (ICTs).

- Therefore, the importance of face to face communication and the potential barriers that would affect the success of these mediums need to be considered. These are briefly examined in the following section and will form the focus of the next report.

5.5 Utilisation of New Communication Mediums

In this section we focus on the use of two communication mediums: 1) Mobile Phones (in particular text messaging and Smart Phone Applications) and 2) the Internet. We use quite a liberal definition of 'new'. This is because the LMH does not utilise newer forms of communication such as social media and makes very limited use of older ICTs.

Websites

LMH Website

Staff stated that the information currently provided on the LMH website (www.lmh.sa.gov.au/) regarding antenatal, birth and postnatal services was completely inadequate. The only information about Gynaecology and Obstetrics provided on the website is the following statement:

> For information regarding Obstetrics or Gynaecology please contact:
>
> The Department of Obstetrics and Gynaecology on:
>
> Telephone: (08) 8182 9586
>
> (http://www.lmh.sa.gov.au/public/content/default.asp?xcid=227 accessed 30-07-2012).

This information is located under the 'Departments and Services' tab under 'Division of Surgery' which is very confusing. Given that other services provided by the hospital are given their own short section on the website (e.g. the Continence Advisor) it seems unusual that the Women's Health Unit

or other services such as the Family Clinic or the BAU are not. Beyond the three lines of text quoted above, there is no indication on the website that the LMH has a Women's Health Unit or that you can give birth there. This is a missed opportunity for health communication. In interviews, staff indicated that the website was under-utilised and should contain information about the various antenatal care options available at the LMH, downloadable content including the brochures which are given in hard copy at appointments and links or referrals to other websites and services (e.g. Beyond Blue). We are beginning to gather information from women regarding their use of the website and to date it appears that the majority of women have not accessed the LMH website. Those that did reported that the website was unhelpful.

Child and Youth Health (CYH) Website

It should be noted that while the LMH website lacks information about pregnancy, LMH staff and staff from other SA Health services do refer women to a South Australian pregnancy website: www.pregnancy.sa.gov.au. This address redirects to the following site:

> http://www.cyh.com/SubDefault.aspx?p=432 (Women's and Children's Health Network: Pregnancy).

It is listed on the last page of the South Australian Pregnancy Record with four other websites:

> www.quitsa.org.au,
> www.foodstandards.gov.au,
> www.beyondblue.org.au,
> www.dh.sa.gov.au/pehs/immunisation-index.htm

In interviews, most women state that they were unaware that these sites were listed in the Record. This suggests that their inclusion in the Record is not enough to prompt women to access these sites. Some women have told us that they were informed about the site when they rang the SA Pregnancy Infoline. However, we are unsure if this is standard procedure. Despite these efforts, interviews suggest that most women do not use this site. Given that we have strong evidence that women do seek information on the Internet, this site needs to be more effectively promoted. In particular, several women have reported that they only look at the first page of results when conducting internet searches for information and that they are most likely to check the first two or three results. Therefore, it is imperative that www.pregnancy.sa.gov.au is ranked highly by search engines or is advertised, either through a search engine or other means.

Other Online Resources

The Antenatal and Parenting Educators also have a hand out titled 'Useful Websites' that lists websites which women and their partners may find helpful. It includes the addresses of numerous websites divided into six categories: 'Pregnancy and Birth', 'Normal Birth', 'Caesarean Section', 'Breastfeeding and Parenting', 'Postnatal Depression' and 'Sexual Health Information'. This list is given to participants at the Antenatal and Parenting group or individual sessions if people ask about which websites they should access. It was produced in 2005 by Helen Weinel and Tracy Semmler-Booth and revised in 2010. Interestingly, www.pregnancy.sa.gov.au is not included on this list but another address that is provided, www.health.sa.gov.au/pregnancy, redirects to the link discussed above (http://www.cyh.com/SubDefault.aspx?p=432). This lack of uniformity could be another factor which leads to under utilisation of the website or inaccurate self reporting about usage. By this we mean that women may be accessing the site but are unable to remember its address or adequately identify it in interviews.[24] Despite its use by the Antenatal and Parenting Educators, other staff at the

[24] To overcome this problem it may be worthwhile printing some examples of the layout of different websites so that women can easily identify them in interviews.

LMH were unaware of this list (e.g. Midwives in the Family Clinic). This is an example of 'silo culture' where resources collated by staff in one area have not been shared with other staff.

Mobile Phones

All calls made from the LMH appear as a 'private' or 'blocked' number. This is important because staff indicated that many people do not answer these calls and this means that they are unable to contact them. Staff suggested that people would be more likely to respond to text messages sent to their mobile phones, a practice that is not currently utilised in general antenatal care.[25] Staff noted that women could view text messages at a later date, whereas they could not return a missed call made from the hospital. Furthermore, this medium was identified as resonating with many LMH clients:

> SMS that's their language. It's what they can read, it's not costing them anything [to receive messages]. (Interview, Research MW 18-04-2012)

Beyond text messages, Smart Phone Applications were also identified by staff as a means for more effective health communication. Interviews and participant observation at Antenatal and Parenting Education Classes suggest that use of pregnancy related Smart Phone Applications is widespread. For example, at one antenatal class, three women reported using a pregnancy related app when our Research Associate spoke to them about the Health-e Baby project during the tea break. Two women used an app produced by the people behind the 'What to Expect When You're Expecting' book, website and foundation.[26] The third woman used an app called the Smiles Factory Pregnancy App.[27] All women used versions of these applications which could be downloaded for free.

In addition to use of pregnancy related apps, every single person at both of the antenatal sessions that our researchers have attended checked their mobile phones during the tea break which suggests that mobile phone ownership is high.[28] All of these phones appeared to be Smart Phones, with large touch screens. However, as previously noted, our interviewees and the people who attend Antenatal and Parenting sessions are not representative of the diverse clients served by the LMH. In interviews, staff raised concerned about the accessibility of both mobile phones and the Internet:

> If you think of someone who lives at Beaumont that's got a computer in their room and an ipod and all sorts of stuff, they can just get stuff in an instant even if they're breast feeding one child and the other one is watching TV. Whereas someone who can't access it as easy, cause they can't afford to. (Interview, MW, Family Clinic 21-05-2012)

> So relevant online information, probably online information from the hospital, if the hospital set up an information base that they could refer to, a Lyell McEwin Hospital base. If they had a computer they would look that up, however, most of these girls don't have access to a computer. (Interview, Research MW 18-04-2012)

As such, use of these mediums would need to take into account the barriers that would mitigate their effectiveness.

[25] Some services, such as the Antenatal Asthma Management Service do use text messages to communicate with women.
[26] http://www.whattoexpect.com/mobile/photo-gallery/pregnancy-tracker-iphone-app.aspx#/slide-1
[27] http://www.thesmilesfactory.com/The_Smiles_Factory/The_Smiles_Factory.html
[28] One male participant checked the football scores using the AFL app.

Recommendations

- To date, the LMH makes limited use of new communication mediums. Although SA Health has a twitter account, the LMH makes no use of social media.

- The LMH website needs to be redesigned and updated to incorporate pregnancy related information. Alternatively, a dedicated site about giving birth at the LMH could be created and/or existing government websites that discuss pregnancy could be more effectively marketed to pregnant women.

- The majority of Midwives and other health professionals in the Women's Health Unit do not utilise mobile phone technologies to communicate with their clients. This is a promising area for health communication.

- More research needs to be conducted to ascertain women's media preferences and the factors that influence their media use. Interviews with staff suggest that some women may not have access to Smart Phones and/or the Internet. This is an assumption that needs to be confirmed with evidence from interviews.

Section 6: Knowledge Gaps

In this section we provide short dot point overviews of current gaps in our knowledge:

- **Focus on the Family Clinic:** To date our research has focused on the Family Clinic and this means that we do not have an adequate understanding of how health information is delivered in other antenatal contexts at the LMH. Staff from different sections of the LMH (e.g. BAUL) need to be targeted for inclusion in the study and additional participant observation needs to be conducted in different LMH settings.

- **Lack of CALD/NESB, Low SES Participants:** Current recruitment strategies are not reaching this demographic. We are currently exploring new ways to reach these women including working more closely with the NAGMP. Despite the NAGMP CSC's early indication that this would be possible, we have been unable to set up further interviews with NAGMP staff or to organise research visits to NAGMP sites. We will continue negotiating access to the NAGMP and begin identifying alternative ways that we can reach these cohorts. We are hopeful that providing monetary incentives (30 dollar gift cards) will improve participation rates.

- **The Production of Health Materials:** As yet, we know little about how the written material provided to LMH staff members are produced and designed. Future work needs to focus on how these materials are developed and disseminated. Preliminary discussions with Julia Dalton suggest that staff have little input into the production of brochures etc and are given minimal direction about how to best utilise new forms of written health communication. In turn, this suggests that LMH staff may need additional training in order to more effectively identify the health communication needs of different clients.

- **The Role of Previous Pregnancy Experience/s:** Interview data suggests that women's previous pregnancy experience/s play a central role in determining how they use and assess health information. This includes information that the hospital provides and that they seek out themselves. As such, the team should consider focusing on recruiting primigravida (first pregnancy) participants.

Section 7: Conclusion

This report has provided a summary of the key antenatal health promotion practices currently utilised at the LMH. A list of tentative recommendations have been made that outline suggestions for how health communication could be improved in this context. These recommendations are based on preliminary research findings from the Health-e Baby project.

Data gathered thus far suggests that current health promotion strategies are well received by women who are eager to learn about how to best care for themselves and their baby during pregnancy and who have high level literacy skills. This cohort was able to confidently navigate through the written material that they were given at their first appointment and the information that they accessed elsewhere (e.g. online). For these women the presentation of the content was not particularly important. For example, in interviews many women indicated that they did not care if brochures were photocopied or if they incorporated a lot of text. One interviewee stated that the format of health communication did not matter because if women wanted the information they would seek it out. This is a key point, because many of the women that we want to target *do not* actively seek out pregnancy related health communication.

We argue that these women are not adequately catered for by current health promotion practices at the LMH. While the LMH offers several specialised services for different groups (e.g. NAGMP, Young Mum's Group), many women are not eligible for these care options or will not participate in them. **New formats of health communication are needed to more effectively engage these women and their greater networks. In particular, the LMH could more effectively utilise new communication technologies such as mobile phones and the Internet.**

One of the key findings of this report is that the LMH relies too heavily on written communication. This medium is inadequate for many of the diverse clients who are served by the LMH. We suggest that when written materials are provided there should be a greater range of options that health care professionals can access (e.g. specially designed low literacy brochures). However, the success of modified brochures and pamphlets relies on the accurate assessment of women's literacy skills. This is an issue that will need to be considered as we move forward with our research.

This report has highlighted a number of issues that the Health-e Baby team need to consider (e.g. our recruitment strategy). However, it also demonstrates that our project is well placed to identify the information needs and media preferences of pregnant women served by the LMH and to design an intervention that is tailored to these requirements.

References

Health-e Baby Project. (2009) Maternal Health and Behaviour Determinants Associated with Low Birth-Weight: An Overview of Risk Factors, Contextual Constraints Preventing Behaviour Change and Health Communication Approaches.

Dalton, J. (2012) Multilingual Educational Fact Sheets for Antenatal Women. Unpublished Report.

Wilmore, M. (2012) 'Media literacy and Health Communication: Methodologies for Patient Assessment' Conference paper presented at ANZCA 2012: Communicating Change and Changing Communication in the 21st Century, 3rd July – 6th July, Adelaide, South Australia.

Appendix 1: List of Participants (30-07-2012)

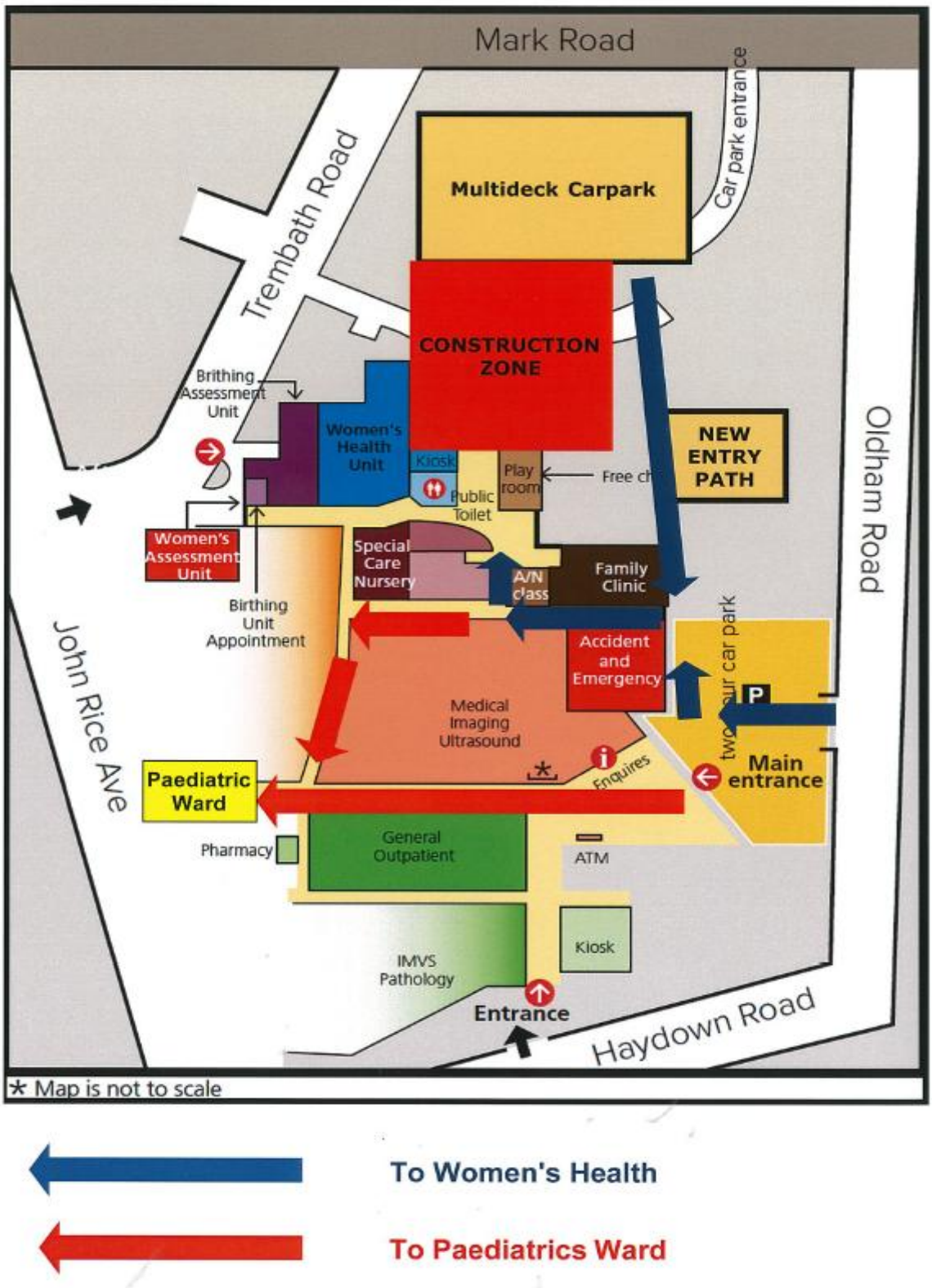
CLIENT PARTICIPANTS

DATE OF INTERVIEW	AGE	POSTCODE	GESTATION
19/6/12	32	5109	12
19/6/12	37	5115	11
25/6/12	39	5109	14
25/6/12	39	5112	13
4/7/12	24	5114	13
9/7/12	25	5113	14
19/7/12	19	5112	14
17/7/12	33	5112	36
26/7/12	23	5110	13

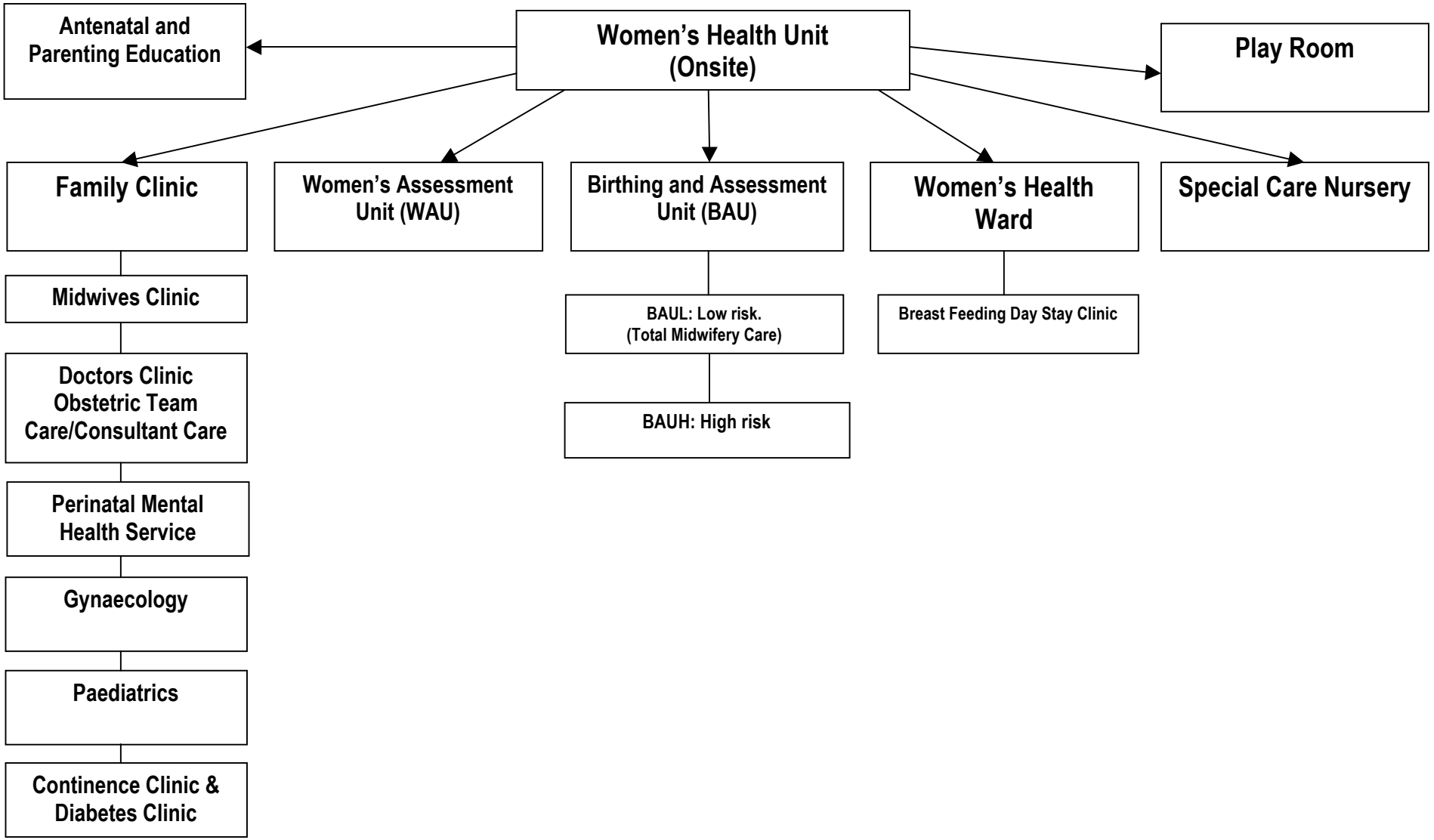
STAFF PARTICIPANTS

DATE OF INTERVIEW	ROLE
26/6/12	CSC NAMGP
30/5/12	CSC Family Clinic
30/2/12	RN RM
30/5/12	CSC GP Shared Care Program
30/5/12	RN RM
14/6/12	Antenatal Educator
14/6/12	Antenatal Educator
18/4/12	Antenatal Asthma Nurse
11/4/12	Antenatal Asthma Nurse
18/4/12	Research Midwife- Asthma Study
21/5/12	RN RM Research Midwife- Health-e Baby

Appendix 2: Scanned Copy of Women's Health Unit Map



Appendix 3: Diagram Representing Onsite Antenatal Services at the LMH



Appendix 4: Table of Standard Brochures Supplied at the First Antenatal Appointment

TITLE	CENTRAL TOPIC	AUTHOR/S ORGANISATION OR SPONSOR	SIZE & PAGE NUMBERS	COLOUR/S
1. Lyell McEwin Hospital Baby Friendly Hospital Accredited: Women's Health Unit: Information Booklet	Describes antenatal and postnatal services provided by the LMH. Sections include: 'About the Women's Health Unit', 'Admission' and 'Antenatal Care'. Contains detailed information about each aspect of antenatal care including the onsite and offsite services discussed in this report, different care options, common complications and other practical information (e.g. parking, visiting hours). It was described by one Midwife in a triage appointment as a "bit of a bible".	Government of South Australia: SA Health.	A6 Half Fold 32 page booklet (including front and back covers).	White background. Text: Yellow and light grey headlining, black text in body of document. Full colour pictures throughout.
2. Lyell McEwin Hospital: Women's Assessment Unit'	Describes the Services provided by the Women's Assessment Unit, including its location.	Government of South Australia: SA Health.	DL Half Fold	Light brown/grey colour scheme front and back cover, yellow SA Health Ribbon front and back spine. Inside: white background with black and grey text. Full colour pictures throughout
3. Getting Ready for Birth and Early Parenting.	Describes the Antenatal and Parenting Education classes offered by the LMH, including session content and how to book classes. Also describes the 'Young Mums' group.	Government of South Australia: SA Health.	DL Half Fold 4 page booklet (including front and back covers).	Front and back cover bright yellow background with black text. Inside white background with black text and yellow headings.
4. No Title: Large Map of Hospital.	Large Map of hospital grounds with arrows indicating the pathway to 'Women's Health' and the 'Paediatrics Ward'.	Not indicated – assume SA Health.	A4 One side.	Each area of the map is shaded in a different colour. Text is either black or white depending on the background.

5. The Women's Assessment Unit has Moved.	Small map indicating the former location of the WAU and where it has moved to. Describes the entrance location (off Trembath road) and states the opening hours of the WAU. Also notes that Perinatal Mental Health Clinics previously offered in the WAU have resumed and lists contact details for this service.	Government of South Australia: SA Health.	A6 One side	One colour photograph used as header. Yellow background, Black and grey text. Small map of the hospital (cropped version of Large Map, see above). Black arrow used to indicate the movement of the WAU from its former site to its current location.
6. Healthy Eating During Pregnancy and Lactation.	Brochure providing nutritional health advice for women during pregnancy and post-birth. Includes information about supplements such as folate, important nutrients during pregnancy, weight gain during pregnancy, and the impact of consuming alcohol, caffeine and artificial sweetners during pregnancy. Describes Listeria and provides a list of foods which should be avoided during pregnancy because of the risk of Listeria bacteria. Also provides information about the benefits of breast feeding and lists the dangers of using drugs, smoking and drinking alcohol when breast feeding.	Unclear – appears to have been compiled by the Nutrition and Dietetics Department at the LMH. Lists a number of original sources where it appears information has been adapted from including: • 'Nutrition During Pregnancy': Noarlunga Health Services Dietician-Nutritionists. • 'Food for Health': Dietary Guidelines for Australian Adults (2003). • 'Listeria and Food: Advice for People at Risk': Food Standards Australia New Zealand (2005) • And the Pharmacy Department of the Lyell McEwin Health Service, although this information is cut off.	A6 Half fold. 12 pages.	This brochure is a black and white photocopy. Some of the information at the bottom of page has been lost in the process.
7. Exercise in Pregnancy	Provides advice regarding the type and amount of exercise that can safely be performed during pregnancy. Describes the benefits of exercise during pregnancy and uses illustrations to demonstrate how to safely perform certain actions while pregnant (e.g. bending). States that women should stop exercising and contact their doctor if they experience particular symptoms (list provided).	Government of South Australia: SA Health.	A4 Double sided (2 pages).	Black and white, photocopy.

8. LMH Values Your Opinion.	Comments and complaints form. Describes how people can provide feedback about the healthcare that they receive. Also has a small text box on the bottom of the form that discusses car parking.	Government of South Australia: SA Health.	A4 One sided (1 page)	Black and white, photocopy.
9. YANA Groups: Perinatal Mental Health Services Lyell McEwin Hospital.	Describes the group programs provided by the Perinatal Mental Health Services including session days and times and contact details.	Government of South Australia: SA Health.	DL Double sided (2 pages)	White background, black and grey text. Small abstract colour photograph. Brochure has been cut out by hand very roughly.
10. Your Rights and Responsibilities: A Charter for Consumers of the South Australian Public Health System	A booklet that describes people's rights as healthcare consumers including the right to be involved in decisions about the care that they receive and the right to be treated with 'respect, dignity and courtesy regardless of your age, gender, sexuality, religion or culture' (p. 7). Also discusses fees and financial assistance that may be available to LMH clients, and the responsibilities of clients (e.g. to provide medical histories, to report changes in conditions, to treat staff and other patients in a considerate manner).	Government of South Australia: SA Health.	A6 One fold, 21 pages (including front and back covers).	Bright blue front and back cover. Inside – white background with black text and blue headings/accents.
11. Emotional Health During Pregnancy and Early Parenthood (includes a separate flier which lists support services and contact numbers for South Australia residents)	A guide which helps women and their greater networks understand what to expect during pregnancy, how to identify if they are not coping and what to do if they experience depression or anxiety. Includes a copy of the EPDS questions which women can take themselves. If they receive a score above 10 it is recommended that they contact a healthcare professional.	Beyond Blue.	A6 One fold, 28 (including front and back covers).	Front and back covers: raspberry/pink background, blue accents, colour photographs. Inside – white background, black text, raspberry/pink accents.
12. Drug Information Centre: Women's and Children's Hospital.	Small business card with a phone number and opening hours of the Drug Information Centre at the WCH. This centre provides information about the safe use of drugs during pregnancy and lactation.	Women's and Children's Hospital.	Business Card, Double sided.	White background, black text, blue WCH logo.

13. Breastfeeding	Describes the benefits of breast feeding and provides contact details for the Australian Breastfeeding Association including a website and Breastfeeding helpline.	Australian Breastfeeding Association	Custom size (smaller than A6) One fold, four pages.	Uses muted tones (black and white photographs, peach background. Cursive text stating 'What you should know' is behind the main body of text which makes it more difficult to read.
14. National Cervical Screening Program	Brochure reminds women to have a Pap Smear every two years, describes what the test involves and provides information about what to do if the test is abnormal. Also lists where women can go to have a Pap Smear.	Government of South Australia: SA Health.	A4 Tri-Fold 6 pages	White background, raspberry headings, blue text. Includes diagram of the female reproductive system.
15. The Inside Story: Your Pregnancy Diary.	An extensive booklet that provides information on the following topics: pre-pregnancy planning, prenatal touch and massage, sex during pregnancy, health tips for pregnant women, antenatal screening, week by week guide to pregnancy, until the birth, breast feeding, the birth plan, check list for hospital bag, glossary of terms. The aspect of this booklet that Midwives focus on in triage appointments is the week by week guide to pregnancy. The booklet is produced by Johnson and Johnson and it contains a list of their products.	Johnson and Johnson.	Smaller than A6. One fold,. 48 pages (including front and back covers).	Booklet utilises pale yellow highlights. Is predominantly, black text on white background with some blue headings. Also includes diagrams that show the babies development and list common discomfits that may be felt in this gestational period.
16. Breast Awareness for All Women	Provides advice about mammograms and breast self-examinations. Uses diagrams to depict how to examine your breasts and the types of changes that should be reported to a health professional.	Cancer Council SA	A4 Tri Fold	White background, black text, blue heading. Extensive use of yellow and blue (Cancer Council logo colours).