Public Health Association of Australia and Nutrition Australia submission on pregnancy care guidelines consultation

Contact for recipient:
Maternity Policy Team
Primary Care Division
Department of Health
E: maternity@health.gov.au

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au T: (02) 6285 2373
Contents

The Public Health Association of Australia ................................................................. 3
We believe ..................................................................................................................... 3
Our mission .................................................................................................................. 3
Our vision ..................................................................................................................... 3

PHAA Response to the pregnancy care guidelines consultation ...................... 4

About the Document .................................................................................................. 4
Lifestyle considerations: Nutrition and physical activity ......................................... 4
Clinical Assessments: Weight and body mass index ................................................ 6

Conclusion ................................................................................................................. 7

References ................................................................................................................ 8
Preamble

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia. The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of our Board, National Office, State and Territory Branches, Special Interest Groups and members.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

Our mission as the leading national organisation for public health representation, policy and advocacy, is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health. Members of the Association are committed to better health outcomes based on these principles.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health and wellbeing for all.

The reduction of social and health inequities should be an over-arching goal of national policy, and should be recognised as a key measure of our progress as a society. Public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.
PHAA Response to the pregnancy care guidelines consultation

About the Document

Is the language used in the consultation appropriate and easily understood? Yes

Does the document take into account socio-economic, cultural, and accessibility differences? No

Please provide any further comment/feedback on the consultation

The document may benefit from being more easily understood for those who are not specialists in pregnancy care, such as general practitioners.

While there is some mention of foods consumed by various ethnic communities, the inclusion of information to take into account cultural differences could be strengthened.

Under intended audience (p5), a statement says: “In addition, it is expected that policy makers will be able to draw on the Guidelines in the development of policy and the planning and delivery of health services”. In the nutrition background section (p6), a statement says: “Observations studies have found...limited dietary counselling by health professionals”. Given the broad health professional and policy maker audience including those who do not specialise in pregnancy care, these statements can only be achieved through a complementary plan with appropriate funding, to upskill health professionals and disseminate these guidelines widely. The document would benefit from clarifying this requirement.

For the section “Recent evidence on consumption of specific foods/good categories during pregnancy” (p9-11), a short interpretive summary for each nutrient/food group mentioned could increase usability for health professionals who do not specialise in pregnancy care. This could follow the evidence summaries and include whether the evidence is sufficient for a recommendation, and linking to the recommendations in the Australian Dietary Guidelines.

Lifestyle considerations: Nutrition and physical activity

Are there areas that have been overlooked in the lifestyle considerations section?

The absence of a recommendation regarding herbal preparations is notable given the high rate of use among pregnancy women (33.4%), and the associated rate of self-prescription (77.9%) (p17). A new recommendation based on the evidence is proposed below.

Under 1.1 Nutrition, the statement “requirements for some nutrients (eg iron, folic acid) may increase...” would benefit from being more specific by referencing the Australian Nutrient Reference Values published by the NHMRC.

Please outline any changes you consider should be made to the recommendations or practice summary within the lifestyle considerations section

We are very pleased to see the inclusion of evidence around sweetened foods and beverages and fast foods. The scientific understanding of the impact these foods have on health outcomes has increased substantially over the past 5 years, and specific inclusion in these new draft guidelines reflects this. It is particularly important to discuss these foods with pregnant women given the dual benefits to mother and baby immediately through limiting intake of these and other discretionary foods, as well as being a teachable moment for the mother to make changes to her nutritional intake in the longer term.
It is of note that the Australian Dietary Guidelines which underpin the nutrition recommendations for pregnancy were published in 2013 with the evidence review only considering evidence published up to April 2009. This was the first time in Australia that optimum diet in pregnancy and lactation was reviewed systematically.

Given this evidence is now well over a decade old, the Australian Dietary Guidelines urgently need to be reviewed to ensure the nutrition recommendations including those for pregnant women align with current evidence.

In section 1.2.1, recommendation #2 should be reworded to: *Advise women that, in the absence of confirmed nutritional insufficiency, taking vitamin A, C or E supplements is of little or no benefit in pregnancy and may cause harm.*

A recommendation regarding herbal preparations may be: *Advise women that the effectiveness of herbal preparations varies according to the herbal preparation and the condition being treated. Herbal preparations may present a pregnancy risk and should only be used following consultation with an appropriately trained health professional.*

In section 1.2.2 under iron, the reference Bokhari et al (2012) may not be the most appropriate supported evidence because the study has very small participant numbers and the intervention used iron rich bread not commonly consumed in Australia.

In section 1.2.2, if sufficient calcium is consumed through food, supplementation is not required. Recommendation #5 may be amended to: *Advise women with low dietary calcium intake or with hypertension to take calcium supplements.*

Recommendations on supplements may benefit from more specific wording such as a recommended dose where intake is below the recommended daily intake, and definitions of high-dose and low-dose.

In section 1.2.3, there is a recommendation for supplementation of Omega-3 fatty acids, food sources should be advised. The wording should clarify that for women seeking food sources of Omega-3, ensure advice to mercury in fish is provided.

Listeria can be very dangerous if you are pregnant, or for your unborn child or newborn baby. Cumulative qualitative evidence from Nutrition Australia Qld staff over the last 8 years demonstrates that those working with expectant mothers (GPs, nursing staff and other health professionals) have limited and varying levels of knowledge on foods which contain Listeria, and should be avoided during pregnancy. The Australian and New Zealand governments advise women not to consume alcohol during pregnancy, and mandatory pregnancy warning labels on alcoholic beverages are currently being confirmed, highlighting the importance of alcohol avoidance during pregnancy.

In the section 1.4 practice summary, it would be helpful to explain “eating a rainbow” as eating different colours of fruits and vegetables. An additional point should include foods to avoid during pregnancy such as those which include alcohol, fish with high mercury content (with a list of those fish attached or a link to [https://www.foodstandards.gov.au/consumer/chemicals/mercury/pages/default.aspx](https://www.foodstandards.gov.au/consumer/chemicals/mercury/pages/default.aspx)) and foods at risk of Listeria (with a list of high risk foods or a link to [https://www.foodstandards.gov.au/consumer/safety/listeria/Pages/default.aspx](https://www.foodstandards.gov.au/consumer/safety/listeria/Pages/default.aspx)).
In section 1.4 practice summary, provide advice – the text should be amended to include foods that are rich in calcium. It would be beneficial to include an appendix with additional comprehensive lists of foods:

- Iron containing foods
- Calcium containing foods
- Foods at risk of listeria
- Fish containing mercury
- Foods containing Omega-3 fatty acids

Clinical Assessments: Weight and body mass index

Are there areas that have been overlooked in the clinical assessments section?

This draft guideline does not address energy requirements in pregnancy. As estimated energy requirements vary through pregnancy and among women, and as a significant number of women are above a healthy weight at conception, guidance on energy intake would assist clinicians providing nutrition education. If the decision has been made by the expert working group to focus the guidelines on food group/nutrient intake rather than on energy intake, stating this decision in the guidelines would provide clarity.

The draft guidelines include the statement (p18) “An Australian cross-sectional study found that fewer women participated in exercise during pregnancy (61%) compared to before pregnancy (87%). It would be useful to provide interpretation on the NHMRC Nutrient Reference Value for dietary energy in pregnancy for women who reduce their physical activity throughout pregnancy or who are above a healthy weight.

Please outline any changes you consider should be made to the recommendations or practice summary within the clinical assessments section

A small study conducted by Nutrition Australia Qld in 2013 called ‘Healthy me Healthy baby’ included gauging expectant mothers and women’s knowledge on recommended weight gains during pregnancy. Consultations that occurred during the project revealed that approximately half of the 60 women surveyed were not aware that there were recommended weight gain targets for pregnancy. This information highlights the need for more education and resources in this area. Additionally, women identified that they needed practical tips such as meal plans and snack ideas that were web or app based.

The study also showed the use of pregnancy weight gain charts (PWGC) had a positive response. Many women reported that using the PWGC motivated or informed them about healthy lifestyles during pregnancy, with expectant mothers assisted in their ability to track their gestational weight gain. Most women reported positive experiences in using the PWGC to monitor and interpret their weight gain.

In section 2.4 Practice summary (p37), the importance of why recommended weight gain targets exist should be included, along with the use of a tracking mechanism (Pregnancy Weight Gain Charts) in addition to BMI, to assist with self-monitoring and educating on recommended weight gain during pregnancy. The focus should be on weight gain indicating that the growth of the infant is within expected guidelines, ensuring quality intake for the health of both mother and baby. Tailored advice should be provided by Accredited Practising Dietitians or be consistent with the Australian Dietary Guidelines.
Conclusion

PHAA supports the broad directions of the draft pregnancy care guidelines regarding nutrition, nutritional supplements, physical activity and weight assessment and monitoring. We are particularly keen that the following points are highlighted:

- The document should be easily accessible and understood by health professionals who do not specialise in pregnancy care
- An appendix should include lists of foods which are beneficial and to avoid during pregnancy
- Pregnancy Weight Gain Charts may be useful

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to improved pregnancy care for Australian women.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

Terry Slevin
Chief Executive Officer
Public Health Association of Australia

Malcolm Jull
President
Nutrition Australia

17 July 2020
References

2 https://naqld.org/projects/healthy-me-healthy-baby-2/