Antenatal Care Guidelines Review

June 2017

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6000 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the Antenatal Care Guidelines Review developed by the Australian Government Department of Health.

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DAA interest in this consultation

DAA is the peak professional body for dietitians in Australia. DAA acknowledges the importance of improving the health of women and babies through the antenatal period. DAA is interested in guidelines that support best practice Antenatal care in Australia.

The Accredited Practising Dietitian (APD) program is the foundation for self-regulation of the profession, and a public assurance of safety and quality. APDs play a key role in antenatal care as they have the training, skills and knowledge to provide evidence based interventions using Medical Nutrition Therapy. APDs work with other health professionals to provide nutrition advice to many during the antenatal period. This includes women who are either overweight or underweight, those with or at risk of pre-eclampsia, gestational diabetes and others requiring specific nutrition input. DAA recognise the essential nature of a multidisciplinary team, including an APD, in achieving better health outcomes for mothers and babies during the antenatal period.

Key Messages and Recommendations

DAA support routine weighing during pregnancy and the provision of nutrition and lifestyle advice by an APD for all pregnant women, but specifically those who are gaining inadequate or excessive weight (based on pre-pregnancy BMI) during their pregnancy.

Good nutrition is essential for all pregnant women as early life nutrition can play a role in subsequent adult chronic disease due to the 'developmental origins of health and disease'. Nutrition can also play a key role in addressing risk factors for fetal growth restriction, pre-eclampsia, preterm birth, diabetes and Vitamin D status. APDs are the experts in food and nutrition and provide Medical Nutrition Therapy for a variety of conditions. In all of these conditions where nutrition is identified as a modifiable risk factor the mother should be referred to an APD for evidence-based nutrition advice. As such, an APD should be included in the 'who' sections in the practice summary.

For a number of antenatal conditions such as pre-eclampsia and diabetes, DAA support that the APD would play an integral role in the multidisciplinary team to support the management as there is evidence for the role of nutrition in these conditions.

Overall DAA support the review and changes to the Antenatal Care Guidelines. Specific comments on the guidelines are below.

Discussion

Weight and Body Mass Index

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In the section on risks associated with low or high weight gain during pregnancy, DAA suggest changing 'low and high weight gain' to 'weight gain below or in excess of guidelines' to improve clarity and context of high and low weight gain.

DAA recommend that pre-pregnancy BMI should be calculated, where possible and BMI should not be recalculated on subsequent visits.

DAA are unaware of evidence to support the statement in the document that a calculation of BMI at the first antenatal visit is more accurate than a pre-pregnancy BMI. Evidence should be provided to support this statement. An Australian study[1] found that 10% of women had achieved or exceeded the gestational weight gain recommendations by the first antenatal visit and thus using this BMI could potentially promote excess gestational weight gain. Additionally there is evidence that supports that self-reported pre-pregnancy weight is valid and reliable[2].

Whilst there are limitations with BMI, which are addressed in the document, it would be beneficial to add that 'BMI is better than no measurement and is useful to guide and inform clinical judgements'.

DAA suggest changing the consensus-based recommendation to 'measure women's weight and height at the first antenatal visit and calculate their pre-pregnancy BMI to inform gestational weight gain goal'.

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IOM weight gain table- suggest rounding total weight gain figures to nearest 0.5kg to align with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Australian Dietary Guidelines recommendations.

Consensus-based recommendation III- recommend adding pre-pregnancy prior to BMI in this statement.

Recent evidence on routine weight monitoring- this section should outline initially that no systematic review about weight monitoring exists. There are numerous psychology studies that suggest routine weighing will be effective through goal setting and self-monitoring. There are a number of studies that show mixed results in this area, but this may be a result of poorly designed studies and lack of implementation evaluation. Other studies show different outcomes from routine weighing depending on the population group. Suggested additional studies in which routine weighing is part of the intervention are included in the reference list[3-6].

Consensus-based recommendation IV- women who are obese should also have their weight recorded and discussed at every antenatal visit. Suggest changing to 'f women are underweight, overweight or obese…'

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Recommend adding pre-pregnancy to all references to BMI.

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In the section about engaging women in discussions about weight gain, suggest adding 'advise on risks of inadequate and excessive gestational weight gain for all women, no matter their pre-pregnancy BMI'.

Pre-eclampsia

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High BMI should be identified in the risk factors for pre-eclampsia listed on this page.

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Screening for Pre-eclampsia Practice Point L. The comment "If a woman has a low dietary calcium intake, advise her to increase her intake of calcium-rich foods" is appropriate. However practical resources are needed for the practitioner to assess intake and to consolidate advice provided to the woman. The latter could be in a variety of formats, including pictorial for groups with low literacy. DAA would be pleased to help develop, or revise existing materials.

Diabetes

DAA support routine and accurate, reliable screening for diabetes during pregnancy.

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Within the section on diagnostic thresholds it's important to highlight the cons of using a Glucose Challenge Test particularly in women who are not detected as having diabetes. A paper published in Diabetes Care in 2013[7] provides a discussion and further references about some shortcomings of the Glucose Challenge test.

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In 4.2.4 birth defects and congenital abnormalities could also be added to the list of risks[8].

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Consider including in the points for discussion that breastfeeding for longer may reduce the risk of developing Type 2 Diabetes[9].

Practice summary-In the Who and referral sections this should state the correct title 'Accredited Practising Dietitian'

References

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