EARLY TAKE UP OF ANTE NATAL CARE

Report of a Conference held at the King's Fund Centre
on Friday 30 November 1979

Report by Pat Young

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The King's Fund Centre
126 Albert Street
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King Edward's Hospital Fund for London

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Chairman: Miss N M Hickey SRN SCM MTD, Area Nursing Officer, Coventry Area Health Authority

PROGRAMME

10.00 a.m.	Coffee and Registration
10.30	Welcome to the King's Fund Centre Mr W G Cannon, Director
10.35	Introduction by the Chairman
10.40	Nurse, I think I'm pregnant'. Ms Judy Weaver, Family Planning Nurse, Camden and Islington Area Health Authority (T)
11.00	Questions
11.05	Why see the doctor anyway? Dr Christopher Donovan, Temple Fortune Health Centre
11.25	Questions
11.30	Not typical but topical - two recent pregnancies Miss R O Craven, Senior Nursing Officer (Midwifery) Royal Shrewsbury Hospital
11.50	Questions
11.55	Women's views and experiences of ante natal care Mr Christopher Smith, Research Officer, Institute for Social Studies in Medical Care
12.15 p.m.	Questions
12.30	Briefing for Group Work
12.45	Lunch
14.00	Discussion Groups
15.00	Tea
15.15	Reporting back
16.15	Summing up by the Chairman
16.30	Conference Ends

EARLY TAKE-UP OF ANTE-NATAL CARE

The many disciplines concerned in ante-natal care are anxious that the services available should reach all young mothers and young children, where the reduction of perinatal mortality begins. "Early booking of ante-natal care means more precise timing of when your baby is due, the earlier detection of any problems which need correction in pregnancy, more chance to get to know members of the team who help to deliver you, a better chance of discussing your share of social and welfare benefits in pregnancy." The Chairman, Miss N.M. Hickey, SRN? SCM, MTD, Area Nursing Officer, Coventry AHA, quoted these words from the recently published Children's Committee Report, to set the scene for this conference.

The first speaker was Judy Weaver, a Family Planning Nurse and health visitor, at present Health Education Officer in Barnet, whose title was "Nurse, I think I'm pregnant." She was pleased that the conference began with family planning because so many people thought of family planning clinics as "stopping places" rather than as bases for promoting family welfare, helping people to have - or not to have - children, she said.

Doing two clinics a week, one in a middle-class area at a GP run health centre, the other in a working-class area of London in a local authority clinic with little contact with GPs, she saw between two and three pregnancy tests a week, which represented on average quite a large number of tests. The three types of pregnancy she saw most frequently were:

(1) The unplanned and unwanted, when the girl did not want the baby and came to the clinic for verification of her pregnancy and advice regarding an abortion:

(2) The planned and wanted - girls who wanted a baby, had missed a period, and wanted to know if they were pregnant:

(3) The "don't knows" - mainly unplanned pregnancies where the baby might be wanted or unwanted. The decision whether or not to have the baby often was influenced by the nurse's advice, and here, Miss Weaver stressed, the family planning nurse had an important role as she could help her client greatly with good counselling.

The family planning clinic had many advantages over other referral agencies, Miss Weaver continued: first, the pregnancy testing was free; second, clinics were held in the evening which made it easier for working girls and young mothers with other children to attend; third, usually no appointment was needed, for all clients were seen even if it meant a period of waiting; and fourth, girls could see staff who didn't know them personally, rather than the family doctor who would know their family background and might disclose the girl's condition or visit to the relatives. For instance, a girl separated from her husband and wishing to conceal her pregnancy from him would be afraid her family doctor might talk to her husband

about it. Equally, if a girl felt she could talk freely and with confidence to the family planning clinic staff, she could come back to see people she knew and trusted.

The main disadvantage in a family planning clinic, Miss Weaver continued, was that the staff got very little feedback about their clients' progress, as many clinic staff worked part-time and there was inevitably a communication difficulty between them. And if a girl decided not to keep her baby, the staff would lose touch with her unless she came back for further advice after either having had the baby or a termination of her pregnancy. There was no continuity of care in which contact with the clinic could be maintained.

Miss Weaver illustrated her points with two case histories: the first concerning a planned baby. The girl concerned was aged 28, a teacher, who had visited the clinic quite regularly, coming first in January, when everything was found on examination to be normal, and again in June, when the staff discussed with her the possibility of her having a baby, and the need for rubella screening, what to expect after coming off the contraceptive pill, and all the other aspects normally discussed with intelligent, well-motivated girls.

Miss Weaver said she was always amazed at how little most girls know about the risks of smoking, drinking, and using drugs in the vital first few months of pregnancy when the foetus was being formed, and she always stressed to them how great these risks were. Too much emphasis, she commented, was given to the later stages of pregnancy and not enough to the early stages, and recommended the Health Education Council's booklet What You Need to Know as particularly useful at the beginning of pregnancy.

The majority of cases she saw were not so straightforward, Miss Weaver continued; they were usually complicated cases where the pregnancy was unplanned and unwanted, and had occurred through ignorance or misinformation about contraception, or through belief in popular myths about avoiding pregnancy. As an example she quoted the case of a very nice girl aged 20, a nursery nurse, who was very worried at the prospect of pregnancy and badly needed help. She was advised to think her situation out carefully and to come back in a couple of weeks when she had made her decision, to discuss matters, particularly if she had decided to keep the baby, so that she could be advised about the risks to avoid during early pregnancy. Fortunately she had a supportive boy friend and no problems about caring for the infant - but this was the exception rather than the rule, Miss Weaver said.

Recapitulating, she remarked that the disadvantages in her work were that she was isolated from her colleagues and lacked feedback about her clients. She could only hope that by getting at them early, she and all other family planning nurses were doing their bit towards reducing the risks during early pregnancy.

During question time one delegate suggested that the midwife was the person to be contacted when a girl was found to be pregnant; but it was pointed out that a midwife in uniform might not be as

acceptable to a young unmarried mother as someone in mufti.

The second speaker was Dr. Christopher Donovan, a GP based at Temple Fortune Health Centre in London, and also a part-time senior teacher at the Royal Free Hospital, vice-chairman of a working party on prevention at the Royal College of General Practitioners, and Chairman of a GP working party for the Health Education Council. The title of his talk was: "Why see the doctor anyway?"

Although he was preaching to the converted he began, he hoped to bring out two points: the first, why see the doctor anyway? Doctors were still regarded as authority figures, particularly by the young and those whom they would like to attend for ante-natal care as early as possible, but who were not attending clinics: these were the social groups 4 and 5, or those less well read than their contemporaries. Why not see the nurse, the midwife, the receptionist, anyone in the community who could direct them to the proper medical care? While it was difficult for doctors to divest themselves of the image of authority, however much they wished to, it was for the other health care disciplines to help the frightened patients where they could not.

Dr. Donovan's second, and more important, point was that in spite of the variety of professions represented at this conference, one group was missing: the patients themselves who don't attend ante-natal clinics, or who come too late. The problem was to get through to these people, while they were still young and at school, the importance of seeking early ante-natal care, so that they could answer the question, "Why see the doctor anyway?" for themselves.

Dr. Donovan illustrated this point with an anecdote about a man who had phoned his surgery at about 9 a.m. saying that he had just come to live in the area, his wife was having a baby, and could the doctor come round to see her. The receptionist explained that he would first have to come to the surgery to register with the practice, and then his wife could be seen. An hour or so later, when surgery was nearly over, the receptionist told Dr. Donovan the man had rung again to say his wife had now had the baby, and could the doctor come round to see her now. He rushed round to their house to find what he described as "an idyllic situation." The wife was sitting up in bed with her baby in her arms, reading an American paperback on how to have your baby without the help of doctors!

The husband was rather distracted, because he had come to this country to take part in a major cello competition, and went into the next room to practise. To the strains of cello music Dr. Donovan began to examine the wife, to find that all was far from idyllic. The baby's cord had not been tied, and it was obvious the mother was having a post-partum haemhorrage, and had virtually a third-degree tear. The cord was still bleeding, so Dr. Donovan could take a cord blood test; the mother had had a previous abortion, her blood group was Rhesus positive, and the Coomb's test proved positive. She was running all number of risks - yet she got away with it. This exemplified the need to get across to the public the risks they could be running by not seeking ante-natal care, in order to educate them and encourage them to attend clinics early.

The objectives of those involved in ante-natal care, Dr. Donovan continued, were:

(1) To ensure that the mother's health was not impaired, and that she enjoyed her pregnancy;

(2) That she had a healthy baby at the end of it;

(3) To inform her of what services were.available to her and the baby.

Taking the mother's health first, Dr. Donovan said it was generally believed that mothers did not now die in pregnancy, but only three months ago a mother had died from loss of blood in a big London teaching hospital. Such tragedies do still happen, and the 1970-72 inquiry into maternal deaths had revealed the third most common cause of death to be pre-eclamptic toxaemia. The report had stated: "In two-thirds of cases avoidable factors were present: commonly, failure of patients to attend for ante-natal care or to accept advice" Dr. Donovan added that failure to attend for medical help early was also probably a factor in the loss of these mothers.

Dr. Donovan then showed slides of figures relating to the three common causes of neonatal mortality: immaturity, congenital abnormality, and birth asphyxia. On immaturity, he commented that the type of patient could be predicted who was likely to have a premature or small-for-dates baby. Figures had been produced to help those running ante-natal clinics to pick out these mothers and refer them to a hospital with a good premature baby unit.

He then showed a table of risk factors, which included age less than 18, previously induced abortion, unmarried, moderate to severe pre-eclamptic toxaemia, history of renal disorders, previous sterility, first trimester bleeding, and smoking. These factors helped to create a picture of the type of mother likely to have a premature or small-for-dates baby. The problem was to translate this information into meaningful statements for young schoolgirls, to encourage them to come early for ante-natal care.

On congenital abnormality, Dr. Donovan commented that it was important to get patients to come early for the various screening processes now available, such as amniocentesis, and emphasised that health education on the dangers of radiation from X-rays, taking drugs, smoking, and so on, was vital.

Regarding birth asphxia, he said again the doctor had an interest in picking up factors in the mother which might affect the foetus. He emphasised the complexity of the information which would have to be simplified sufficiently to enable women to understand and avoid the risk factors, or at least seek early advice.

Before concluding, Dr. Donovan made two further points. Was there a danger, he asked, that we were being straitjacketed by the domination of specialist thinking? For instance, ante-natal care came within obstetrics, yet this conference had begun with a discussion of unwanted pregnancies, and termination of pregnancy was not part of obstetric practice. Should GPs not be thinking on a much wider scale? The Chairman had already pointed out that care of the foetus started much earlier than conception, and young women must be encouraged to build up a good relationship not only with their GPs but also with all other members of the health-care team, so that when pregnant they already knew what services were available, whom she could consult, and what risks lay in smoking, drinking, and drugs - not only those prescribed, but also those bought across the counter. She should be aware of the dangers of X-ray to the foetus, and of the need for immunisation against rubella. Finally, she should accept the responsibility for choosing the right time for her pregnancy - in financial and housing terms, for example, when the best conditions would be available for her child.

Dr. Donovan urged the conference to think in terms of "non-medicalisation of motherhood." It was not for the health-care team to take the responsibility for the health of the foetus away from their patients; it was for them to help mothers to carry responsibility for their own health and that of their foetus. To do that they must be given the right information early on in their lives. They must be helped to answer the question, "Why see the doctor anyway?" What responsibilities do I have for my own health?" The responsibility must be passed back to the patients, and if they are properly taught, they will accept it.

During question time the points were made that boys as well as girls should be included in the proposed health education programme, as prospective fathers; that all GPs should be trained to refer pregnant mothers early to ante-natal clinics; that more facilities for ante-natal care should be available at places of work; and that more emphasis should be laid on preventive medicine in the NHS, so that it became a true National Health Service, rather than, as at present, a National Sickness Service.

The third speaker was Miss Ruth Craven, Senior Nursing Officer (Midwifery) at Shrewsbury, an area with a completely integrated midwifery division. Miss Craven's responsibilities are for the GP Unit (Community), with a strong liaison with the consultant unit. The title she took was: "Not typical but topical - two recent pregnancies".

Her first case history was of Mrs. Jones, 28 years old, in her first pregnancy. She first visited her GP when she was 8 months pregnant (June 4) - to make sure someone would come and deliver her baby. She had left it so late because she was determined to have her baby at home and didn't wish to be persuaded otherwise. Although she and her family had lived in the locality

for some time, she had not consulted her doctor before because none of them had been ill, and minor disorders were treated at home.

On examination, Mrs. Jones was found to be perfectly normal and healthy; she had had rubella, and there was no relevant family history. She had been married for about nine months, and had not used any contraceptives, and was happy to be pregnant. Her last period had been in September, and her expected date of confinement was July 2. She was of normal height and weight, and not obese. All tests were normal, except for traces of sugar in the urine, and nothing abnormal was revealed by abdominal examination. The doctor told Mrs. Jones he could only recommend hospital confinement, in view of the lack of ante-natal care, and the fact that she lived in a remote area, seven miles from the GP unit, and sixteen miles from the consultant unit, and two miles up a lane. However, Mrs. Jones was determined to have a home confinement, and the GP eventually agreed. She attended the midwives' clinic at the GP unit five days later, when the findings were again all normal, including the urinalysis.

Mrs. Jones told the midwives that she had stopped smoking at four months, as well as horse riding, of which she was very fond. She had eaten well, drunk plenty of milk, didn't rest unless she felt she needed to, and had remained very active. This information was extracted with difficulty, as she was by nature reticent. She refused an offer to join the parentcraft classes, but agreed to tour the Unit and see the babies. She was given an information booklet, and arrangements were made for a home visit the following week: this was carried out on June 15. Again all was normal on examination, abdominal palpation showing the head in the brim of the pelvis.

Mrs. Jones's home was an old cottage with indoor bathroom and toilet, open coal fires, not very clean but she promised to clean it up. She said her husband would be available to help at the birth, and her mother also if needed. Her husband had no strong views on where the baby should be delivered. Mrs. Jones's family history was that she had three younger brothers, there being a ten-year gap between her and the oldest one. She had gone to secondary school, had had no sex or parentcraft education, would have liked to become a vet but had to leave school at 15 as her father had told her to get out and start earning. She had worked first in a factory, then in a nursery for six years, not enjoying either job. For the past six years she had been head groom and gardener at the local manor house, which she liked very much. During this time she had learned to drive.

Mrs. Jones and one of her brothers had been born at home, but she said this fact had not influenced her decision. Her nearest neighbours and the nearest telephone were two miles away.

On June 27 at 5.15am the husband telephoned the midwife to say his wife was in labour. The midwife arrived at 5.45am and a normal baby was delivered at 10.50am, but when the uterus was palpated a second baby was evident. The husband sent for the doctor, who arrived quickly, and because there was bleeding and uterine inertia the obstetric emergency squad was summoned. A dextrose drip was set up, contractions started, and a breech delivery, forceps assisted, was carried out at 1.15pm. The child did not try to breathe, and resuscitation was unsuccessful. When the emergency squad arrived it too failed to resuscitate the infant. The mother and babies were taken to hospital. The mother did not mention the stillborn child, appearing to be quite happy with the one child she wanted; neither she nor the husband wanted to think of the dead baby.

Mrs. Jones cared for the live baby well, and though it developed jaundice on the third day after birth she discharged herself against medical advice. Home care was satisfactory; she breast fed until the 28th day and then stopped, for no apparent reason. She attended for post-natal examination, but mainly for contraceptive advice. She agreed to the baby being immunised for diptheria and tetanus, but not for whooping-cough, because the husband objected. She accepted that for any further pregnancy she would have to go into hospital, and said she would consult her doctor much earlier next time.

The question remained, Miss Craven pointed out, how this type of lady could be helped: although she had behaved sensibly in some ways during early pregnancy, by giving up smoking and horse-riding, she didn't appreciate the necessity for ante-natal care.

The second case history was of Mrs. Davis, a girl aged 26, in her third pregnancy. She had first visited her GP after 28 weeks, the lateness relating to the birth of her other children. Her first baby had been born with spina bifida and hydrocephaly, and had died at three days old. She then had twins, which had to stay in the special care unit for a short period after she was discharged, but she had visited and looked after them. At 4 months' old one of the twins was admitted to hospital with multiple injuries, and the second child was also noted to have extensive bruising, both later being confirmed as cases of non-accidental injury. The husband admitted to being quick tempered and heavy-handed, though it was not clear who had actually injured the children. Both children were placed in foster care.

When Mrs. Davis became pregnant for the third time she seemed to pretend it wasn't happening. She was apathetic and not very bright, but did want the baby, though she realised she couldn't cope with more than one. She knew she could be screened for congenital abnormality; and because her twins had been put into care, she was afraid she wouldn't be allowed to continue with this new pregnancy. There were financial problems also, as her husband had recently been charged with theft, and she was worried how he would react.

Mrs. Davis went to her GP and was referred immediately to the consultant unit; she did not keep this appointment, but after the midwife visited her at home she did attend the unit. Her ante-natal care was normal, though she missed one consultant and one GP appointment. Home visits by the midwife were helpful. At a case conference it was decided to keep the twins in long-term care, to encourage her and her husband to attend, and that she could keep the new baby though it would be subject to a court order. It was also decided to introduce a family care worker to support her, and the health visitor was advised to remain in contact with her after the birth.

Mrs. Davis was advised to stay in hospital for 10 days after the birth, for instruction in caring for her baby, and this she did. She appeared to accept advice regarding diet, rest, smoking, etcetera, but it was not subsequently acted upon. A baby boy was born at 39 weeks, the husband not being present, and she cared for the baby fairly well. But she remained very apathetic, and her attitude could be summed up by the term "non-compliant". Miss Craven ended.

At question time one delegate, representing a community health council, raised the issue for later discussion of the degree of intervention by health-care staff which is acceptable in cases such as this.

The final speaker was Mr. Christopher Smith, Research Officer at the Institute for Social Studies in Medical Care, who discussed two surveys in which he had been involved, into women's views and experience of ante-natal care.

The first of the two surveys was about the childbearing experiences of married women, and was based on a random sample of legitimate live births registered in 24 areas of England and Wales during July and August 1975. The mothers had been approached when the babies were three to five months old, and 91% were successfully interviewed. The second and more recent study was of teenage mothers and their partners, based on a probability sample of live births to women aged under 20 in 26 areas of England and Wales, the babies being born in July, 1979. The mothers were approached when the babies were $2\frac{1}{2}$ to 4 months old, and 86% were successfully interviewed.

Mr. Smith began by summarising the main findings from the 1975 survey. These fell into three main areas: the time an ante-natal visit takes; the problems of going to ante-natal clinics; and women's views of their care. It had been found that the average time spent on an ante-natal visit, from leaving home or work until returning there, was 110 minutes. However, the time spent on a hospital visit was far higher than on a visit to a GP - the average times being 156 and 69 minutes respectively. Part of this difference was accounted by the longer journeys that had to be made to hospitals, but there was a greater difference in waiting times: mothers were kept waiting for 62 minutes on average at a hospital, and 22 minutes at a GPs surgery. It was not surprising, therefore, that only 55% of the women receiving hospital care, compared with 87% being

cared for at a GP surgery, felt the period of waiting time was "reasonable".

More problems associated with attending for ante-natal care were reported relating to hospital visits than to GP surgery visits. For example, 11% complained about the awkward times of hospital clinics, compared with 5% in GP care. 13% of hospital patients had difficulty in arranging for care of other children, compared with 7% of GP patients.

When the women were asked for their views on the ante-natal care they had received, there was most criticism about the way, or the extent to which, things had been explained to them. Nearly half the mothers (46%) were "less than enthusiastic" about this. Overall, hospital care was rated as less satisfactory than GP care, apparently due to the more personal care given at GP clinics, the on-going relationship with one or two professionals, and the feeling that more time was available for questions and discussion. The research team therefore suggested that it should not be impossible to organise hospital clinics and bookings to allow women to see the same doctors and midwives at each visit, and thus develop a more personal and continuous relationship with them.

Mr. Smith then discussed the "non-attenders": four women in each survey sample had received no ante-natal care, and the circumstances were as follows:- Of the four women in the 1975 survey, the first was married to a building worker and had had one previous pregnancy. She first went to her doctor when she was between 16 and 20 weeks pregnant, saying there was no reason for not going before. Her doctor arranged ante-natal care for her at hospital, but she had the baby the day before her first ante-natal appointment. The baby died soon after birth.

The other three women made comments suggesting that the health services were at least partly responsible for their not having ante-natal care. A tractor driver's wife with one other child had said she first saw the doctor in the eighth week of pregnancy, but then, she said "Nobody came to see me until the day he should have been born".

The third woman was married to a cinema doorman, with no other children. She first saw the doctor when she was between 16 and 20 weeks pregnant: her reason for going so late was that she had only recently moved into the district. She had had no ante-natal care because: "The doctors weren't bothered. They didn't seem interested. We'd moved and I couldn't get registered, but even when I did the doctor didn't seem interested in my pregnancy"

The fourth woman had three other small children and a husband who was unemployed. She had not wanted the baby and had him adopted as soon as he was born. She was 7

months pregnant when she first saw a doctor, and said "With us moving there was not point as things would have to be altered. I knew what was going to happen with having the other three. I knew I should have gone, but I didn't seem to have time" Even after she saw the doctor, no ante-natal visits were arranged for her: "He didn't make any arrangements for it. He's no couch or anything down there, he's just got an office and a back room where he keeps his tablets".

Moving on to the 1979 survey, Mr. Smith said that the four non-attenders in this study were all single. The first, 19 years old, first saw the doctor in the tenth week of pregnancy. She said: "I knew I was pregnant at 2 months, but thought at $2\frac{1}{2}$ that I'd better have it confirmed". Her reason for having no ante-natal care was that she had been looking after her sick mother until she was 4 or 5 months pregnant - "and I thought it was too late then".

The second woman, another 19 year-old, but having her fourth child, was $5\frac{1}{2}$ to 6 months pregnant when she first saw a doctor. She said: "I just never bothered. I never bothered with none of them. I was always all right. I didn't see the point of going". She hadn't been for ante-natal because - "I knew how to do it from before". The remaining two women, both of whom had seen a doctor at 2 months pregnant, gave no reason for not going for ante-natal care. One was just $14\frac{1}{2}$ when her baby was born.

These eight women were, happily, examples of a rare occurrence, Mr. Smith continued. The vast majority go for ante-natal care, but not all receive the same amount of care, some beginning care later than others. In both surveys the respondents were asked: "When did you go for your first ante-natal visit? How many weeks were you pregnant then?" The distribution of answers is shown in Table 1.

In identifying the late-comers for care, Mr. Smith pointed out that the picture from post-war surveys was remarkably constant. A report in the late 1940's noted that expectant mothers who were "well-to-do came markedly earlier for ante-natal supervision, and that only "33% of agricultural and 37 of manual workers' wives are supervised during the first term". A later survey, conducted in the 1960's, showed that high-parity social class 5 women were the least likely to attend for ante-natal care before the 17th week of pregnancy; and that during the period 1951-66 young women having their first child had become late-comers for care.

Table 2a gives details of the late-comers for care in Mr. Smith's 1975 survey, and shows that young women, those of high parity, women with husbands in unskilled jobs, women born in Ireland, India, Pakistan, or Bangladesh are likely to be late-comers. Table 2b gives similar details of the 1979 survey, identifying two additional groups: women aged under 16, and single women.

To throw some light on why women go late for care, Mr. Smith said they had asked the women interviewed in the second survey

who first attended after the 16th week of pregnancy: "Could you tell me why you didn't go before then?" Although the women's response had not yet been analysed, Mr. Smith showed in his last slide some quotations which gave some idea of the range of their reasons (Table 3).

He ended by pointing out the most constructive and the most disappointing findings from his data. The most constructive was that all the non-attenders for care had made an initial contact with the health services, and Mr. Smith wondered if they would have been non-attenders if this contact had been followed up by a health-care professional. The most disappointing finding, in his view, was that the "hard core" of his late-comers for care - the unskilled, working-class women, young women, and those of high parity - had been perpetuated into the late 1970's.

Following established practice at King's Fund Centre conferences, the afternoon was given over to group discussion of listed questions, and reports from the groups. The questions for discussion were:

Failure in early take up of ante natal care may be attributed to many factors, would the groups discuss the following possibilities:

a. Lack of effective communication between nursing/midwifery staff, professionals, volunteers and ancillary workers.

b. Inappropriate facilities may sometimes cause embarrassment and anxiety: lack of creche facilities may also discourage young expectant mothers.

c. Pharmacists may be the first point of referral. How can this factor be used to encourage early take up care?

d. How may staff be helped to identify gaps in their systems of communication - can training help? Have the groups any recommendations regarding this arising from their own training practices?

e. Could further means of improving early contact with expectant mothers be established through the Occupational Health Service?

The first group to report thought that in order to meet clients' needs and expectations it was important to keep up with research findings, such as the studies described by Mr. Smith, as clients' needs might well differ from the professions' ideas of them. More personal care could be achieved by decentralising care from hospital into the community; continuity of care by increasing shared care with community midwives and GPs and shorter waiting periods by establishing evening clinics which could be manned by part-timers. This group also thought employers should be encouraged to allow paid time off to female staff to attend ante-natal clinics. More sustained effort was needed in conducting health education campaigns, and while midwives had their part to play by visiting schools to talk to the children about ante-natal care and parentcraft, the problem of finding time for this in the school curriculum would have to be overcome.

This group also suggested that creches should be set up at both hospital and community clinics, so that pregnant mothers could bring other children with them; food parcels might be an added incentive to attend for socially deprived mothers.

The second group approached their discussion in three parts: before pregnancy, during pregnancy, and communications. They considered that before pregnancy there should be closer liaison between family planning clinics and the ante-natal care services, so that patients were referred to other agencies and not left to fend for themselves. "Well-woman" clinics should be set up in socially deprived areas to offer health education and advice, and possibly also family planning, as well as screening. Druing pregnancy, it would encourage better take-up of ante-natal care if midwives' clinics were re-established, to avoid multiple visits to GPs surgeries and consultants' clinics. Midwives' clinics could be held from 8 am. to 8pm., and patients might be given 10 minutes listening time. Regarding communications, the group thought that information leaflets about ante-natal care could be given to pregnant women by occupational health nurses and by pharmacists. It recommended that efforts should be made to avoid several disciplines giving conflicting advice to patients, and that closer integration between hospital and community staff should be fostered, perhaps through lectures and seminars.

To this the third group added the thought that mothers should be considered as people, and that team spirit should be strengthened. The media should be encouraged to present more programmes of the "Cathy Come Home" type to get over the need for early ante-natal care; and a "health education bus" could tour districts as a propanganda vehicle. Ante-natal advice centres could also be set up. Clinics could have facilities for play groups, with voluntary helpers to look after the children, and a midwife counsellor always available.

To improve interprofessional communications, the fourth group suggested a questionnaire which could be passed from one discipline to another. Family planning clinics should be able to give patients an appointment to attend the local hospital ante-natal clinic. Where a patient was not referred by her GP, an "open house" system should be instituted, on the lines of the accident and emergency department. To solve the waiting-time problem, this group suggested more employment of married women doctors on a part-time basis. Audio-visual aids could be used to convey information to waiting patients at clinics; and an information booklet on responsibility for health could be given to every school-leaver, emphasising the responsibilities of parenthood.

The fifth group considered that access to ante-natal care should not only be through GP referall: other disciplines should be able to refer patients, and there should also be direct access to clinics. They thought the medical associations should be asked, in the interests of the patient, to consider the

possibility of making GP referral in this instance desirable rather than mandatory. This group thought there was need for research and experiment into how ante-natal clinics were conducted. Mothers should be allowed to keep and read their case notes, which should include instructional material. In order to get the message across to the public, the DHSS should employ an advertising agency to sell ante-natal care in the same way as any other commodity, making it really attractive to the client. Trade unions could put pressure on employers to encourage employees to attend ante-natal clinics.

Careful placing of health education posters, and their distribution in public places such as buses and the underground, were receommended by the sixth and last group. Preparation for parenthood should be part of the school curriculum, as already suggested, but it should be taught by the teaching staff, with midwives playing an advisory role.

A film on conception and development of the foetus had proved a great attraction, to young men as well as women, at a local flower show, and could be an effective method of health education. Educative and communication skills should be taught during training, to aid relationships with both patients and colleagues. One group member had reported that a drop in perinatal mortality rates in her area had been achieved through integrated maternity services, integrated services between consultants and GPs, and by taking ante-natal care to the patient. This group emphasised the importance of updating knowledge, and recommended that GPs should attend statutory refresher courses, or as an alternative every practice partner should have to do at least two years' continual obstetric practice. On waiting time, this group suggested more explanation to papients of why clinics were running late; and advocated that patients should be allowed to keep and read their case notes and ask relevant questions - though there was some objection to this in the discussion that followed. They also described a system of categorisation of risk factors which could be identified in pregnant mothers, an aggregate of which would point to the possibility of a premature or small-for-dates baby. The risk factors could be listed on a form which would be passed from one discipline to another, each of whom would fill it in, so that a clear picture of the patient at risk would emerge.

In summing up, the Chairman said that perhaps all staff involved in ante-natal care needed to be more sensitive to the patients they serve. Personal care, continuity of care, and communications had been emphasised throughout the day; there was a need to break down barriers in order to get information accepted; and to share the caring between the different branches of the service in the interests of the patient. She ended with another quotation from the Report of the Children's Committee;

> "Preparation for parenthood should start with children of both sexes early in life. It should be maintained and much more effort made to attract potential mothers and fathers to acceptable guidance and advice before, during, and after pregnancy."

TABLE 1 - WEEK OF FIRST ANTE-NATAL VISIT

Number of weeks pregnant	Married Women 1975 %	Teenage Women 1979 %
Less than 8	5	4
8 to 12	25	25
12 to 16	46	35
16 to 20	14	18
20 to 24	6	11
24 or more	4	7
Number of women (=100%)	2120	527

TABLE 2 - LATECOMERS FOR ANTE-NATAL CARE
(a) Married Women 1975

	Proportion attending after 16th week	Proportion attending after 20th week	Number of Women (=100%)
Women aged under 20	39%	19%	140
Women of parity 4 or more	44%	33%	45
Women with husbands in unskilled jobs	35%	18%	111
Women born in Ireland	39%	20%	56
Women born in India, Pakistan and Bangladesh	35%	18%	72
All Women	24%	10%	2120

TABLE 2 - LATECOMERS FOR ANTE-NATAL CARE
(b) Teenage Women 1979

	Proportion attending after 16th week	Proportion attending after 20th week	Number of Women (=100%)
Women aged 16 and under	57%	38%	47
Single women	50%	27%	169
All Women	36%	18%	527

TABLE 3.

Some reasons for not attending ante-natal care earlier

" I didn't know I was pregnant until then"

" I didn't have a ring on my finger"

" I was booked into a local hospital here, but I was working a long way away, and so it wasn't convenient"

" I moved from London to here, and by the time I was sorted out it was April before I went"

" I didn't think it was necessary. I was feeling alright"

" Because I went every two weeks with the first. Funny how you go with the first and not the second"

" I had to wait for a letter to come and it didn't come until I was 7 months"