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ANTENATAL CARE: STILL WAITING FOR ACTION

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INTRODUCTION

In 1949 the Obstetrics and Gynaecology section of the Royal Society of Medicine called for antenatal care to be made as easy and attractive as possible with the rights of the woman being respected. In 1961 a Standing Committee of the then Ministry of Health summarized widespread complaints made about antenatal care relating to long waiting times, overcrowding, lack of privacy, hurried consultations and a lack of information and explanation. In 1980 the Short Committee reported in very similar terms to the House of Commons and in 1982 the Government established a Maternity Services Advisory Committee whose first major task was to consider the provision of antenatal care.

The publication of "Maternity Care in Action (Part 1: Antenatal Care)" in 1982 and the recommendations to Health Authorities contained therein form the starting point for this review of the work done by Community Health Councils. CHCs as part of their statutory functions regularly make visits to hospitals and clinics and conduct patient satisfaction surveys to evaluate aspects of the health service. They are therefore well placed to monitor the extent to which Health Authorities have taken on board the important recommendations of the Maternity Services Advisory Committee.

This paper drawing on work done by fourteen CHCs since the publication of Maternity Care in Action, attempts to evaluate the extent to which antenatal services have improved since that report.

THE IMPORTANCE OF GOOD ANTENATAL CARE

It has long been recognized that high standards of antenatal care contribute significantly to lower rates of perinatal and neonatal mortality, and indeed the Maternity Services Advisory Committee report indicates that much of the credit for the lowering of maternal and infant deaths in the 1960's and 1970's was due to the high level of specialist antenatal care available.

However, pregnancy and childbirth bring not only physical but also psychological and social changes for those involved, and good antenatal care should aim to guide and support prospective parents through this exciting but often nerve-racking time. Women having babies need to be treated as people engaged in a normal and natural process. If the process of visiting antenatal clinics itself produces additional stress and worry, much of the benefit of regular medical checks will be undermined. Even more worrying is the association between bad experiences of antenatal care and non-attendance by women, leaving them outside the system of professional care.

Antenatal care can be provided by GPs, midwives and health visitors running small local clinics, or by obstetric departments in large general hospitals operating larger clinics with a comprehensive range of technical screening and testing services. Whilst some women attend only one type of clinic throughout their pregnancy,many experience both, in a system of "shared care"; whereby the majority of their care is undertaken by the GP, with less frequent visits to the hospital for more detailed tests. A shared care system is not only advantageous in that it is more economical, but such systems may also be more satisfactory for the women involved, offering local services, provided by professionals who are already familiar and trusted, and avoiding many of the problems associated with hospital-based care of transportation, continuity of care and long waiting times.

MATERNITY CARE IN ACTION - ANTENATAL CARE. First report of the Maternity Services Advisory Committee

From the outset the Maternity Services Advisory Committee acknowledged that there is often severe pressure on antenatal clinics because of the large numbers of women to be seen and shortages of staff and facilities. This often means that only routine physical examinations are carried out, at the expense of providing women with practical information, guidance and help. The theme running through the whole of the Committee's report is that a more flexible approach to women and their antenatal needs would not only reduce stress and anxiety but would also help to make more effective use of the resources available.

The Committee's report was circulated to all health districts as a model for good practice and is intended as a plan for action, strongly urging Health Authorities to reassess the way that antenatal care is provided.

To assist Health Authorities, each chapter in the report ends with a checklist of recommendations which the Committee encourage Authorities to use in a critical appraisal of their own services. Whilst the report acknowledges financial constraints, many of the recommendations and improvements are aimed at changing attitudes and procedures which would not involve additional expenditure. In total 57 points, recommendations and guidelines are laid down in the report covering all aspects of antenatal care, including confirmation of pregnancy and initiation of care, the initial assessment of the needs of the expectant mother, the subsequent antenatal care and the organization of hospital antenatal clinics.

COMMUNITY HEALTH COUNCIL SURVEYS OF THE STANDARDS OF ANTENATAL CARE PROVIDED

This review highlights seven general areas of concern which the results of CHC surveys have shown to be the most problematic.

These are:

(i)LACK OF INFORMATION: this includes the availability of health information and health education particularly in relation to the importance of antenatal care; local guidance on where to obtain antenatal care; information on the content of antenatal care, including the types of tests to expect etc; and advice on diet, drinking, smoking etc.

(ii)TRANSPORTATION DIFFICULTIES: this includes analysis of the difficulties experienced by women in attending clinics, particularly travel methods and costs; but also includes problems associated with childminding arrangements, time off work etc.

(iii)LACK OF CONTINUITY OF CARE: this includes examination of the number of different professionals seen by women and how this affects women's perception of their care; effective use of midwives and women's ability to identify staff.

(iv)FAILURE TO MEET INDIVIDUAL NEEDS: this includes measurement of the quality and quantity of information given; the opportunities women are given to ask questions and express opinions; the sensitivity with which women's views are received, respected and followed through.

(v)PROVIDING SERVICES TO MEET THE NEEDS OF ETHNIC MINORITIES: this includes the translation of signs and labels, the availability of interpreters and the acknowledgement of differing health needs and problems.

(vi)PROBLEMS ASSOCIATED WITH WAITING TIMES: this includes waiting times for initial appointments; waiting times in the clinic and problems associated with block bookings etc.

(vii)THE ENVIRONMENT OF CLINICS: this includes provision and standard of facilities in the waiting and examination rooms, for example, seating, play areas, refreshments, toilets, privacy and security.

INFORMATION

"Now I realise I was given hardly any information in the way of leaflets and booklets. Any information I got was through having to ask." "If they could explain all the things on the co-op card and as they are doing the examinations, I feel that this would put a lot of women at their ease." (Two mothers from Kidderminster)

The provision of clear and unambiguous information on all aspects of antenatal care is essential. This is important for three reasons: first, it helps ensure that women make full use of the services available; second it helps women to feel part of and

understand the care being offered; and third it assists women to make effective choices about the type of care they receive and the manner in which they wish their pregnancy to proceed.

Oldham CHC in a survey of antenatal care at its district general hospital in 1984 found that 53% of pregnant women interviewed had not been given advice on diet, smoking, alcohol or drugs by the hospital although many reported having been given such information by their G.P. Furthermore, 54% of women had received no information on the types of welfare benefits and support to which they may have been entitled.

In a survey of its antenatal services in 1984 West Birmingham CHC found that 25% of first time mothers and 19% of multiparas (i.e women having already experienced at least one pregnancy) felt that they had not been given enough information on their pregnancy generally. Dissatisfaction levels rose dramatically when expectant mothers were asked their views on the guidance they received on delivery methods, with 60% of primaparas (i.e women experiencing their first pregnancy) and 43% of multiparas feeling that they were given insufficient information. Women particularly expressed a desire for more information on labour, delivery, epidurals and birth positions. Only 55% of women had discussed diet with a health professional, 21% welfare benefits, 17% antenatal tests (what to expect and why they are done), and 5% post natal depression. These figures were all significantly lower amongst Asian women. 87% of women had not been asked whether they would like to look around the maternity unit prior to admission and the CHC found many women ignorant about inductions, pain relief and delivery care, due to insufficient information from the professionals.

East Dorset CHC's investigation into the local maternity services in 1986 found a high level of general satisfaction with the amount and quality of information received during pregnancy. However many women complained of insufficient explanation of tests and examinations being carried out and 40% of women reported being given no advice on diet, smoking, drinking or welfare benefits.

Following the publication of this survey and pressure from the CHC, major efforts are now being taken by health visitors, midwives and health education staff to tackle the problem of smoking amoungst pregnant women.

In a study of expectant mothers in the district in 1986 Kidderminster CHC found that on average 80% of women were satisfied with the amount of information that they had been given on general health care during pregnancy. However, at the hospital clinics, provision of advice was found to be less satisfactory, only 49% of women received written information on what to expect during labour, 37% on the maternity unit itself, 29% on the different methods of delivery and 29% on the role of fathers or partners during pregnancy. Only 2% of women received written information on the emergency "flying squad" facilities offered by the hospital.

Most of the women in this survey, although generally content with the amount of information received, expressed a wish for more choice in the progression of their pregnancy, particularly in relation to delivery methods and care during childbirth. In many cases women reported feeling inhibited about asking for further information and the CHC recommended that pregnancy information packs should be prepared by the hospital to ensure that all women received written advice.

Liverpool Southern/Central and Liverpool Eastern, Aylesbury Vale and South West Hertfordshire CHCs also found similiar problems of a lack of information for pregnant women. South West Herts recommended that more public advice particularly on pregnancy testing services in the area should be made available.

TRANSPORTATION

"The buses to hospital are irregular and very awkward when eight months pregnant, especially with another child." (Mother from Portsmouth)

Problems in getting to and from antenatal clinics are likely to affect the willingness of women to continue to attend and receive antenatal care. Travelling costs, times and child care facilities all need to be borne in mind by the service providers at the planning stage if women are not to be discouraged from attending. Long travelling distances are problems more usually associated with rural areas. However the same problems are now becoming more common in urban areas, particularly where hospital services are being "rationalized" (often being situated on the outskirts of towns and cities). Cuts in public transport have compounded the problems.

Kidderminster CHC found that 35% of mothers travelled over 5 miles to get to consultant clinics and 30% spent over £2 on each visit. The CHC concluded from its research that cost of travelling was a significant factor for women in deciding whether to attend clinics. 13% of the Kidderminster women reported difficulties in arranging child care services to cover visits, 19% had transport problems and 9% had difficulties actually getting time off work.

In 1985 Portsmouth and South Hampshire CHC conducted a survey of womens' experiences of antenatal care and found that over 30% of women travelled for over 30 minutes to get to the consultant clinic, although most women could travel easily to their local G.P. or midwife clinic and only needed to use public transport for the trips to the consultant clinic. A common complaint amongst the women in the survey was the irregular and infrequent buses to the hospitals and the difficulties of travelling by bus

when pregnant, especially when accompanied by additional children.

Plymouth CHC in 1982 undertook a study of the antenatal facilities at the district general hospital and found 42% of women had to spend over 30 minutes travelling to get to the clinic and 24% reported difficulties in using public transport.

A follow-up survey in 1984 found 36% of women travelling for over half an hour and 17% expressing particular problems with public transport. The improvement in these figures was due largely to the alteration of bus routes giving more direct access to the hospital. The CHC remained convinced that good public transport was a key factor in the availability to patients of health care services.

The survey by West Birmingham CHC found that the majority of women attending consultant clinics at hospitals used buses, whilst they could easily walk to their local G.P. clinic. Some women reported journeys of an hour each way to get to the hospital, but only a small proportion found travelling particularly difficult and none reported cost of travelling to be prohibitive. As an interesting aside, the Birmingham survey found that Bangladeshi women were far more likely than any others to use taxis to get to and from clinics.

Aylesbury Vale and East Dorset CHCs also found a significant number of women who found transportation to hospital clinics particularly difficult and frustrating. Women in Aylesbury cited domestic problems such as arranging child minding etc as particularly stressful.

CONTINUITY OF CARE

"Nobody ever introduced themselves. Consistency - seeing the same person at the hospital would have helped a lot - lack of personal interest or courtesy." (Mother from Mid-Staffordshire)

"Maternity Care in Action" states that: "It is important that the woman should be able to build up a relationship of trust with the staff she meets, and efforts should be made to involve the same group of staff at each visit. Staff should be easily identifiable." The importance of continuity of care lies mostly in putting women at their ease so that they feel confident about asking questions or expressing fears. It also cuts down the risks of irritation due to duplication or worry due to conflicting advice being given. From the professionals' point of view unnecessarily repeated questions and tests are a waste of time and valuable resources.

Kidderminster CHC, as a result of their survey of consumer satisfaction with antenatal care, expressed concern to the local

Health Authority about duplication by the consultant and consultant teams, especially in respect of the standard tests etc carried out by GPs. The women in the survey complained about seeing different doctors on different occasions, so being required to explain their whole medical background etc on each visit. The CHC reiterated the advice in Maternity Care in Action that clinics should aim to minimize the number of professionals dealing with each woman making it easier for her to relate to her carers. This could be achieved by a planned policy of referrals consistent with the approach of shared care by consultants, GPs and midwives.

In the study by Portsmouth and South Hampshire CHC only half of all respondants said they had always seen the same staff: 19% said that they had never seen the same staff. The situation was considerably worse in the hospital-based clinics, where only 17% of those attending reported seeing the same staff on every visit.

Similiarly, the 1982 Plymouth CHC survey found that 80% of women did not see the same consultant on each visit to the clinic and 73% did not see the same midwife. However, 77% of women reported that they would have liked to have seen the same staff.

Plymouth CHC's follow up survey two years later found higher levels of continuity of care, with 65% of women saying that they had seen a different doctor on each occasion and 63% a different midwife. These levels whilst still in themselves poor do show that continuity of care is possible with increased effort by the service providers. The CHC hoped that with the additional pressure of their second survey, levels of continuity of care could be further raised.

As part of their survey West Birmingham CHC asked women how they thought that continuity would affect their care. The women reported that they felt that the quality of care would be improved by doctors becoming familiar with individual cases and having an overview of the development of the pregnancy. The women expressed irritation that the consultants often appeared reliant on notes made by other doctors and often repeated questions. The women also said that if they could get to know their consultants a little they would feel less inhibited about asking questions. In this survey only 13% of women had seen the same consultant and 32% the same midwife at every visit.

Oldham CHC found that 80% of women claimed to see a different midwife on each visit to the clinic, 71% had seen a different doctor on every visit and 3% had never seen a consultant at all.

INDIVIDUAL NEEDS

"I didn't know what the blood tests were for - I presume they knew what they were doing." "It would be nice to be made to feel

a bit more special by antenatal clinic staff, rather than run of the mill daily routine." (Two mothers from East Dorset)

As part of its overall policy statement "Maternity Care in Action" lays down that "each woman needs to discuss the pattern of antenatal care most suitable to her".
If women are to feel involved and important during antenatal care, rather than merely "processed" as has been alleged in the past, they must feel able to ask questions and venture their own opinions. From the professionals' point of view this means that consultants, midwives and GPs should not only encourage and give time for women to express their opinions and then respect and treat sympathetically such views; but should also take time to discuss and plan with women when, how, why and by whom tests and examinations should be carried out. Furthermore, preparation for labour, childbirth and perinatal care should be discussed during the antenatal period.

In their report of antenatal services in the area in 1984, South West Hertfordshire CHC linked poor communication between consultants and expectant mothers to a lack of continuity of care, finding that women often complained of being unable to ask questions, of being confused or not satisfied with answers given. In this survey 75% of women reported that they were given no choice about their delivery position.

Portsmouth and South Hampshire CHC's study found that, although most women felt that they had been given sufficient time to discuss their worries with the professional staff, some felt inhibited about asking too many questions. Again, differences between the hospital based clinics and the community based clinics were identified: 25% of those attending hospital clinics felt that they did not have enough time to discuss their pregnancies with staff, and many found the attitude of staff at these clinics to be more impersonal and less friendly than that of staff at their local clinic.

The Oldham CHC study found that 42% of women said that they had received different advice from different doctors and 31% complained that the doctors tended to talk to one another rather than to the woman during examinations etc. 32% felt that they were not encouraged to talk about their fears and 32% reported having received no information on how their pregnancy was progressing. More worrying was that 79% of women said that no one had discussed the birth with them, 84% were not asked if they had any preferences in respect of the manner in which they gave birth and 80% were given no information on the use of pain killing drugs.

In the Kidderminster CHC survey, 24% of women said that the place where they were booked to have their delivery was not the hospital of their choice. Many women complained that the explanations given for this were unacceptable and others felt uninvolved in the decision making process. Only 27% of women reported having discussed their preferences for care and delivery with a midwife, 39% with a consultant and 55% with a GP. In many

cases women did not meet the team responsible for the delivery until they were actually in labour and this exacerbated communication problems. The biggest area of complaint was the failure of professionals to consider parental wishes. The CHC recommended that clinical staff receive continuing training in communications to encourage women to discuss their preferences and to ensure that full explanations are given where necessary.

In the West Birmingham CHC survey, 73% of women said that they had been given no choice about where they went for their antenatal care or the pattern of care they received. Furthermore 53% of women felt that they had been given no choice as to the place where they were to have their baby and 20% were positively unhappy about the choice of hospital for delivery which had been made for them. Whereas 86% of women at local GP clinics felt that they could ask all the questions they wanted only 59% of women at hospital clinics felt similiarly. Only 39% of women at hospital clinics and 58% of women at local clinics were completely satisfied with the answers to their questions.

Plymouth and Camberwell CHCs also reported finding women discontented with the staff responses to their questions, citing overwork and lack of interest as the perceived reasons.

ETHNIC MINORITIES

"They think I am not a human being. I can't speak English - they think I cannot understand anything and they talk and laugh between themselves." "If the interpreter is not there I have to sit and wait until she comes or they find someone else who can speak Punjabi and that takes an hour sometimes... without her I cannot see the doctor." (Two women from West Birmingham)

In addition to the problems and frustrations confronting women using antenatal facilities already covered , many women from ethnic minority communities face other problems resulting from cultural and especially language differences. The unique problems of women from ethnic minorities are not specifically dealt with in Maternity Care in Action, although there is a general acknowledgement that special arrangements may be necessary to cater for groups with special needs. The report also recommends that midwives and health visitors should make links with ethnic minority groups in order to build confidence and understanding. However, it does not give guidance on how antenatal clinics can be organized to be of more assistance to women with special needs. It is in this area that those CHCs

with high ethnic minority populations have attempted to evalute customer satisfaction.

Paddington and North Kensington CHC undertook in 1983 a study of the provision of antenatal services for women whose first language was not English. They found that at none of the

hospital based clinics was there any systematic arrangement for the use of interpreters, rather there was a reliance on other nursing staff who happened to know other languages. This haphazard method caused particular problems when staff needed for interpreting were busy with other work. No mention was made in letters to women of ethnic minority communities that they could if they wished bring along an escort or interpreter to the clinic. However even where these arrangements were made the clinic staff reported difficulties because of not knowing if translations were accurate, women being embarrassed to relay problems through (often male) interpreters and particularly not knowing if the opinions being expressed were really that of the women.

The CHC recommended as a result of this study that midwives' clinics with continuity of care and staff able to speak other languages would significantly raise the standard of antenatal care given to such women.

In its study of antenatal services at the local district general hospital, Oldham CHC found that the majority of signs on the exterior and interior of the building were in English, Urdu, Hindi and Bengali. However, only 4% of the women from ethnic minorities interviewed understood fully all the information they had been given by the clinical staff. Only 23% of the women had brought someone along to interpret for them and of the remainder only 19% were aware that they could bring along an interpreter.

West Birmingham CHC found that a large proportion of women attending the antenatal clinic at the district hospital did not speak English as their first language and for such women one full time interpreter was available. Despite this there was a strong reliance on husbands and relatives as interpreters. The widespread use of children as interpreters was held to be particularly unsatisfactory by the CHC.

Aylesbury Vale CHC also found no interpreting facilities available at clinics. Asian women attending tended in the main to use their husbands as interpreters.

WAITING TIMES

"Had to wait two to three hours for a five minute examination." (Woman from West Norfolk) "We all had to turn up at 11.00 and it was sometimes 12.00 before we were seen. I found it hard to take that much time off work." (Mother from Portsmouth)

Not only is the length of time women are made to wait before appointments a source of much frustration, anger and worry, but many of the CHC surveys also show that it is a major factor in determining whether women continue to attend clinics. This is of particular concern in the light of evidence submitted to the Maternity Services Advisory Committee showing a strong

association between lack of antenatal care and perinatal mortality.

"Maternity Care in Action" is quite specific in its recommendations to Health Authorities that women should not be subject to unnecessary stress caused by long waiting periods. Paragraph 5.3 states that the organizers of antenatal clinics "need to recognize that time is valuable to the women attending as well as the staff, and waiting times before and between procedures should be kept to a minimum. The timing of appointments should have regard to her (the woman's) travel arrangements and should be realistic in estimating the likely duration of each consultation. Appointment systems should be substituted where block bookings cause long waiting periods."

The two Liverpool CHCs were prompted by many complaints about the length of time spent waiting at the City's hospital antenatal clinics to undertake a comprehensive survey of waiting times. The two hospitals in the survey ran different appointment systems, the first operating a block booking system and the other an appointments system. The survey found that not only did the women attending the first hospital wait longer after their appointed time (only 22% were seen within half an hour compared with 51% at the hospital that ran the appointments system; but also many more women at the first hospital tended to arrive early for their appointments in the hope that they might be seen quicker. In addition, the hospital running the block booking system had an absenteeism rate of 18% whilst at the hospital running the appointments system absenteeism was only 4%.

At the hospital running the appointments system 47% of women were through the clinc in under half an hour, whereas at the hospital running the block booking system only 12% were through the clinic in under an hour. The CHCs concluded from this survey that the block booking system was not working efficiently or effectively and that an appointments system should be substituted.

In the survey by Kidderminster CHC only 3% of women reported spending less than 30 minutes at the antenatal clinic, 25% spent between 30 minutes and an hour, 35% spent between one and two hours and 15% spent more than two hours. The survey found many women discontented with the amount of time spent waiting at the clinic and frustrated when after a long wait they spent only a few minutes with the consultant. As a result of this survey the CHC recommended that the Health Authority introduce an appointments system.

Portsmouth & South Hampshire CHC found in their survey that waiting times, especially at the first visit, were a strong factor in shaping women's overall satisfaction with their antenatal care. 17% of women who had attended a hospital clinic, had to wait over an hour for their first appointment, whereas far fewer women had long waits at the GP or midwife clinics. For subsequent visits, women attending hospital clinics continued to suffer much longer waits; 22% waited over an hour compared with only 3% at GP clinics and none at the midwife's. 59% of women at

the hospital clinics felt that their wait had been unreasonable, compared to 16% at GP and 7% at midwife clinics.

The 1982 Plymouth CHC survey found that 84% of women were not seen at their appointed time, of these 48% reported that this had seriously inconvenienced them. Many were worried about children returning home from school, husbands having taken time off work to attend the clinic, bus connections home, and restless children also brought along to the clinic etc. 32% felt discouraged from attending again. 41% of the women complained to the CHC interviewers that waiting times were too long and 29% complained specifically about block bookings. Other areas highlighted by the mothers were doctors and consultants being late for appointments, overcrowded waiting rooms, too short a time with the consultant and impersonal and hurried attitude of staff.

The 1984 Plymouth survey showed that due to CHC pressure and the publication of the 1982 report, alterations to the block booking system had been made. However, 69% of women still reported that they had not been seen at their alloted time. Furthermore 75% of women said that the long waiting times discouraged them from attending the clinic again. The CHC concluded that even after alterations the blockbooking system was clearly not working effectively and should therefore be replaced by an appointments system.

West Birmingham CHC in their survey found that only 27% of women waited less than half an hour to be seen at the hospital clinics compared with 65% at the GP clinics. Only 44% of women felt that their wait had been reasonable and many even qualified this by remarking on the number of people waiting to be seen. 17% said that the long wait had caused them particular problems in relation to children left with minders, children to be collected from school etc. The CHC concluded that the tension, worry, boredom and frustration associated with long waits at the hospital clinic was against the best interests of the pregnant women.

As well as long waiting times, Dewsbury CHC in their survey found that in some of the clinics, up to 50% of the women waited for over 30 minutes undressed before seeing a nurse.

Aylesbury Vale, Oldham, South West Herts, West Norfolk, South Cumbria, East Dorset and Camberwell CHCs all found high levels of dissatisfaction caused by waiting times (ranging from 1-3 hours) at hospital clinics. Many of these delays were attributed to block booking systems. In all cases, waiting times at local GP clinics were substantially less.

ENVIRONMENT OF CLINICS

"There should be a creche in the clinic - it's difficult to find baby sitters." (Mother from East Dorset) "I think more discretion should be exercised with regard to unnecessary

undressing. Just because we're pregnant doesn't mean we get used to being poked and prodded by all and sundry" (Woman from Portsmouth)

The environment of clinics and waiting areas is important if women are to feel at ease. Not only should adequate standards of cleanliness, temperature and lighting be observed but also the special needs of pregnant women recognised. There should be ample comfortable seating, toilet and refreshment facilities and arrangements made for the many women who take other children with them to the clinic. As women may have to wait some time before appointments, suitable magazines and literature could be made available (this would seem a good opportunity to make general health education information available to women). Adequate arrangements also need to be made for changing and examination, so that privacy is respected and the security of belongings is ensured if these need to be left unattended. CHC surveys have shown that the environment of the clinic and waiting area is another very important factor in shaping womens' overall impression of the antenatal care they receive.

Whilst the majority of women interviewed by Aylesbury Vale CHC found the waiting area comfortable, many complained that insufficient arrangements had been made for young children, in particular there was no one to look after the children whilst the women were being examined by the doctor.

Plymouth CHC in their first survey found that 78% of women who had taken their young children with them to the clinic were dissatisfied with the facilities available in the waiting room and 69% with the facilities for the child's care during the mother's examination. 45% of all the women found the waiting area unsatisfactory and 32% complained about the changing facilitities. Specific criticisms were: 22% felt that the waiting area was overcrowded; 20% made adverse comments about dirty and smelly gowns used for examination (many women added that the gowns were too small for the pregnant shape); 17% said that the changing cubicles were inadequate and 12% complained of uncomfortable seats. 34% of the women reported that they had been unable to get any refreshments during their wait.

By the time of the 1984 survey, due to CHC pressure the health authority had taken steps to improve the environment of the clinics. In particular, improvements had been made to the changing accomodation to give women more privacy and to remove the need for women to get completely undressed. Facilities for accompanying children had also been improved. However, women remained unhappy about the overcrowded waiting area.

Oldham CHC in a visit to the antenatal clinic at the local general hospital found a pleasantly furnished waiting room with a small refreshment stall. The informal arrangement of chairs and tables meant that women could talk easily and there were plenty of health promotion leaflets for the women to read. However, the CHC also found that the waiting room was too small and easily

became overcrowded and that the play area for children was not supervised.

The survey by West Birmingham CHC found a children's play area supervised by a volunteer. Only 15% of the women with other children felt that the arrangements for other children were inadequate. Although the clinic usually offered a snack bar service this was out of use at the time of the CHC's visit due to a shortage of staff. 25% of the women interviewed found the changing facilities and clothing arrangements unsatisfactory. Particular problems were caused by small changing areas, gowns being dirty and ill-fitting and not enough privacy for and after changing. Many women had seen no reading material in the waiting room and, of those who had, only 20% thought that it was any good. During the period of the survey hard plastic chairs were being replaced with semi-cushioned high back chairs and only 21% of women felt that these were inadequate.

Portsmouth and South Hampshire CHC found that many women were concerned by the lack of privacy at the antenatal clinics. Other areas of improvement suggested by the women were: better facilities for children, provision of more information in the waiting areas and somewhere to get refreshments.

The majority of women in the Dewsbury CHC survey reported that they found the waiting area comfortable although many complained that it was hot and stuffy. However, some of the women were unhappy about the changing facilities which were cramped and that there was nowhere to leave clothes and that they had to return to the waiting area in examination gowns.

Aylesbury Vale, South Cumbria, and East Dorset CHCs all cited examples of clinics with poor facilities for waiting, changing and examination etc. Although, following the publication of East Dorset's report consideration is now being given to the provision of creche facilities at the hospital clinic.

MATERNITY SERVICES LIAISON COMMITTEES

As well as the specific recommendations in "Maternity Care in Action", the Maternity Services Advisory Committee also made one other major recommendation to Health Authorities aimed at raising the standards of antenatal care generally. That was the establishment of Maternity Services Liaison Committees (MSLC). These are recommended as a way of bringing together all those interested in the provision of maternity care to ensure integration between the specialist and community services.

"Each Committee should have two functions, the agreement of generally applicable procedures and the monitoring of the effectiveness of these procedures as they apply to the individual women." The report goes on to say that whilst it may not be appropriate for lay members to be involved in clinical

discussions, their inclusion in the more general discussions would be "**desirable**". It is on such Committees that CHCs would be able to make a very important contribution in representing the consumer's views to the service providers.

From figures collected by the DHSS it would seem that there are very few DHAs which have not yet established a MSLC. In London 24 of the 30 CHCs are on their local MSLC, although some report that their representation is only token. For example, Hampstead CHC report in GLACHC's "The Maternity Crisis" that their MSLC operates on a two tier system. Four meetings a year are held which the CHC is not eligible to attend, and two open meetings are held to which a CHC member is invited. It is felt that in practice this means that all serious discussion and decision making is done in the closed sessions.

ACHCEW has undertaken a survey of all the 216 CHCs in England and Wales and has found that 80 (37%) CHCs are not represented on their local MSLC. Of these 18 (23%) report that the reason is positive opposition from the DHA and/or the consultants, most of these CHCs are currently engaged in the process of trying to persuade the DHA to give them representation. Only 6 (2%) CHCs said that they had no wish to be represented. Of those CHCs which do have representation 10 (7%) were not invited to attend the committee but had to argue strongly with the DHA that the presence of the CHC was in the best interests of the committee. Further, 20 (14%) of those CHCs with representation reported that they did not find the committee useful, in many cases additional professional-only committees were also established on which the CHC's voice was not heard. Many of these CHCs feared that most of the discussion and decision making went on in these closed groups. Amongst the CHCs with representation 13 (9%) only had observer status at the meetings. This leaves only 93 (43%) of CHCs who are satisfied with the way that the MSLC in their area works and the way in which the health authority has sought the CHCs' participation.

CONCLUSIONS

From the evidence provided by Community Health Councils in the form of their visits and surveys it has become clear that many Health Authorities have not yet taken on board the recommendations of the Government's Maternity Services Advisory Committee and indeed in many areas the standards of antenatal care have not risen at all in the thirty-odd years since the Ministry of Health's review. The areas of concern highlighted in "Maternity Care in Action" waiting times, impersonal attitude of staff, provision of information etc are still those which irritate, frustrate and confuse the users of antenatal services. On the specific areas highlighted in this report, CHCs have found that:

(1)The provision of information on diet, smoking,alcohol, drugs etc is piecemeal and inadequate; as is guidance on what to expect

during pregnancy and childbirth and what options are available for women in the way of antenatal care.

(2)The length of time and costs incurred by women in travelling to antenatal clinics are significant factors in determining whether they continue with antenatal care. Policies of shared care, with women receiving most of their care at local clinics are not in force in all areas and are not effective in others despite evidence from CHCs that women find locally based care far more convenient and satisfying.

(3)Women continue to be confused and frustrated by the lack of continuity in care, especially in hospital clinics. This often leads to duplication or omission of information and often inhibits women from asking questions and expressing their fears.

(4)The way in which antenatal care is provided continues to pay little attention to the individual needs of women. There is a lack of choice relating to how care is administered and a lack of opportunities for women to make their views known.

(5)Antenatal services are rarely organized with the problems of women from ethnic minorities in mind. Signs are usually in English only, interpreters are rarely available and the culture of women from ethnic minority groups is little understood.

(6)Waiting times in antenatal clinics appear to give rise to more dissatisfaction than any other matter and it is clearly unsatisfactory that women can wait up to 3 hours for appointments. In particular, block booking systems have not shown themselves to be a succesful method for organizing clinics; by and large appointments systems are better.

(7)Womens' impressions of the lay-out and facilities at clinics are important factors in determining overall satisfaction with care received. Many clinics do not have adequate heating, lighting or seating arrangements, do not provide suitable play areas for children and have changing and examining rooms which are dirty, unsecure and offer no privacy.

(8)CHCs are by no means represented on all Maternity Services Liaison Committees and often they have only observer status. Yet, properly constituted MSLCs could provide Health Authorites with an excellent opportunity to hear all points of view, including the consumers, on how antenatal services should be provided.

RECOMMENDATIONS

For the most part the following recommendations would cost very little to implement. Indeed the biggest improvements in antenatal care could be made by changes in administrative and management procedures and the adoption of a more sympathetic and considerate attitude by clinical staff and service providers.

(1)Well prepared written broadsheets or information packs should be available for women, providing detailed guidance on all aspects of pregnancy and childbirth. These should also be available in ethnic minority languages.

(2)A more co-ordinated approach to shared care should be introduced to avoid unnecessary visits to hospital clinics when care from a GP or midwife would be more appropriate. Evening clinics should be introduced for the convenience of working women and women with small children. Service planners should take note of transportation problems etc when deciding on the location of clinics.

(3)Hospitals, in particular, should make more effort to ensure that, wherever possible, women see the same professionals on each visit. To help women identify them, all staff should wear name tags.

(4)The professionals involved in antenatal care should make greater efforts to ensure that care reflects women's wishes. Primarily this involves encouraging women to discuss their doubts, anxieties and preferences. As far as is possible women should have choice in relation to where and how they give birth, including the use of drugs, attendance of partners and delivery positions.

(5)Health Authorities should address themselves to the needs of ethnic minority consumers. In particular it is most unsatisfactory for husbands or children to act as interpreters. Not only should clinics encourage women to bring friends or community workers as advocates to help with interpreting and explaining; but where demand is obvious clinics should themselves provide interpreting services using representatives from ethnic minority cultures.

(6)Where block booking systems have been shown to have broken down they should be replaced by well organized appointments systems. In all normal situations women should not be expected to wait more than 30 minutes for an appointment.

(7)Health Authorities should take note of the good practices highlighted by CHCs. Some clinics do provide supervised play areas for children, easy chairs for waiting rooms, plenty of informative literature and clean, secure and private changing and examining rooms. These should be the norm rather than the exception.

(8)All Health Authorities should establish Maternity Services Liaison Committees and invite CHCs to take an active role in their work. Above all else, service providers should recognize that the consumers of antenatal services should have an equal voice in the way that care is administered.

BIBLIOGRAPHY

CHC Sources

"Report of a survey into Ante-natal clinics in Liverpool" (June 1983)
by Liverpool Central/Southern and Liverpool Eastern CHCs

"A pregnant pause? - Communication between women whose first language is not English and antenatal clinics in Paddington and North Kensington" (February 1983)
by Paddington and North Kensington CHC

"Women waiting - Antenatal Services in West Birmingham" (1984)
by West Birmingham CHC

"Antenatal care - A study" (December 1986)
by Kidderminster CHC

"Patient satisfaction survey - Antenatal clinics" (October 1984)
by Aylesbury Vale CHC

"Antenatal services in South West Hertfordshire" (June 1984)
by South West Hertfordshire CHC

"Report of the survey of the antenatal department at Oldham and District General Hospital" (September1984)
by Oldham CHC

"Survey on the antenatal facilities at Freedom Fields Hospital" (May 1982)
by Plymouth and District CHC

"Women's experience of antenatal care - A report of research conducted in collaboration with Portsmouth and South-East Hampshire Community Health Council" (November 1985)
by Portsmouth and South-East Hampshire CHC

"Results of outpatient survey at Staincliffe Maternity Unit"
by Dewsbury CHC

"Report of survey on maternity services at Risedale Maternity Hospital, Barrow in Furness" (1984)
by South Cumbria CHC

"Maternity Services" (1986)
by West Norfolk and Wisbech CHC

"Report on district maternity services" (1986)
by East Dorset CHC

"Maternity patients survey" (January 1987)
by Camberwell CHC

Other material

"Consumer reaction to present day antenatal services" by Sally McIntyre from "Pregnancy care for the 1980s"

"The maternity crisis" by Christine Hogg for GLACHC

"Maternity Care in Action, Part 1 Antenatal Care" by Alison Munroe report of the Maternity Services Advisory Committee

"Report of the R.C.O.G. working party on antenatal and interpartum care" by The Royal College of Obstetricians and Gynaecologists