MATERNAL HEALTH

Also see the JSNA sections on breastfeeding (www.hullpublichealth.org/jsna2017.html#c38) and early years (www.hullpublichealth.org/jsna2017.html#c36).

What’s the issue?

“Maternity services cover care for the women from when they become pregnant and access care until they are signed off by the midwife (around 10 days after the birth) and care formally handed over to health visitors” [154]. Good antenatal care and support can identify potential problems early, and provide information to aid informed choice. Poor care during the birth, as well as increasing the risk to mother and child, can have other implications such as post-natal depression. “Good maternity services should respond to the physical, psychological, emotional and social needs of women and their family in a structured and systematic way” [154].

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression, and having a poor relationship with a partner is also a risk factor for postnatal depression [155]. Infant mortality rates are higher among babies that are sole registered than for other registration types [156].

There is a higher risk of adverse events in pregnancy and during the birth for women who are teenagers, who are older, and who have unhealthier lifestyles. This increase in the proportion of ‘higher risk’ women, as well as the increasing number of births in recent years, has placed additional pressure on already stretched maternity services nationally.

There are a number of screening programmes in place in the UK relating to antenatal and newborn. “Tests in pregnancy and in the newborn after birth are designed to help make the pregnancy safer, check and assess the development and wellbeing of the women and her baby, and screen for particular conditions” [157-159]. Further information is given the JSNA section on screening (www.hullpublichealth.org/jsna2017.html#c38).

What’s our situation?

During the three year period 2013-15, there were 74 stillbirths in Hull giving a rate of 6.8 per 1,000 births which was higher than England (4.6) and whilst it had been higher in 2012-14 (5.8 v 4.7) it had been lower in Hull in 2011-13 (4.7 v 4.9) and 2012-14 (4.3 v 5.1) [26, 78, 82, 83, 160]. There were also 44 infant deaths (<1 year) giving a rate of 4.1 per 1,000 live births in Hull which was higher than England (3.9), although it had been lower in Hull for 2012-14 (3.9 versus 4.0) [26, 78, 82, 83, 160]. During the financial year 2016/17, at the time of their initial antenatal (booking) appointment, 1,153 (28%) were overweight (body mass index (BMI)¹ 25-29.9kg/m²), 617 (15%) had a BMI 30-34.9kg/m², 313 (8%) had a BMI 35-39.9kg/m² and 184 (4.5%) had a BMI 40+kg/m² (so 2,267 women out of 4,063 (56%) were overweight which included 27% who were obese and 4.5% who were morbidly obese) [161]. In 2016/17, 878 out of 3,834 women (22.9%) were known to be smokers at the time of delivery, compared with 10.5% for England [26, 95, 114]. Whilst the rate in Hull has fallen since 2005/06 when it was 29.6%, it has increased from 2014/15 when it was 20.9% due to the introduction of carbon monoxide (CO) testing at antenatal booking appointment (and at subsequent antenatal appointments if positive). The rate in Hull is currently second highest among the 209 CCGs. One in four babies born in Hull were delivered through a caesarean section in 2014/15, and the percentage was slightly lower than England (25.8% versus 24.4%) [160]. A lower percentage of births were multiple births in Hull (49 out of 3,553, 13.8%) compared to England (16.0%) in 2015, and there were a much lower percentage of births to mothers aged 35+ years in 2014/15 (10.2% versus 20.4%) [160]. Overall, 109 out of 3,306 babies (3.3%) were born to term (37+ weeks) and were of low birth weight (<2.5kg) in Hull for 2015 which was higher than England

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¹ BMI is calculated as height (in metres) divided by the square of weight (in kilograms).
(2.8%) although it has been lower than England for five of the last six years [26, 128, 160]. In 2013/14, it is estimated (using national prevalence data), that 10 women will have post partum psychosis, 10 chronic serious mental illness, 105 severe depressive illness, between 345 and 515 mild or moderate depressive illness or anxiety, 30 post traumatic stress disorder, and between 150 and 300 adjustment disorders and distress [162].

For more detailed information, see the JSNA Toolkit: Children and Young People, and Demography and Demographics reports.

What are the strategic needs?

With increasing numbers of older women having children and the high prevalence of smoking and obesity, there is a need to provide help and advice prior to pregnancy to attempt to reduce these risks (although recognising that not all pregnancies are planned). Identifying risks and intervening early to improve maternal health and wellbeing, improving birth preparation, promoting positive parenting skills, and creating an environment for children and young people that builds self-esteem and resilience, with good emotional health. Early help and intervention for all families should be timely, accessible and appropriate for their circumstances (see the JSNA section on early years, [www.hullpublichealth.org/jsna2017.html#c36]).

Hull’s Maternity Commissioning Strategy [163] has five key outcomes: an improvement in maternal health (including early access to midwifery, maternal obesity and smoking); reductions in maternal and stillbirths/infant mortality, and infant morbidity; and an improvement in maternity services experience. Improving mental health is also an important area of work.

References


