

Pregnancy and childbirth

Headlines

There are more than 5,000 live births every year in Kirklees; around half of these are to new mothers.

A healthy pregnancy is more likely to lead to a healthy birth weight and better health in later life.

The birth rate amongst south Asian women is much higher than non-south Asian women. Over half of live births in Dewsbury and Batley are to women of south Asian origin.

Women in more deprived areas are more likely to have a baby, and are more likely to have a low birth weight baby.

Women are encouraged to book an appointment with a midwife as soon as they know they are pregnant so they can have a full health and social needs assessment as early as possible and any additional support, advice and information needed can be given in plenty of time before their baby is born. 1 in 10 women do not book an appointment before 13 weeks of pregnancy.

Why is this issue important?

The birth of a child is a major event for any family. Getting a good start in life is critical to lifelong development; the most serious damage can take place before birth and during the first 18 months of life when formation of the part of the brain governing emotional development is taking place. The antenatal period is as important as infancy to the outcome for a child, because maternal behaviour has such strong impacts on the developing foetus.

A healthy pregnancy – without smoking, with a healthy diet and with good mental health – is more likely to lead to a healthy birth weight, which in turn contributes to better health later in life.

Out of 6,120 pregnancies in 2010/11 there were 5,821 births to Kirklees women. The overall birth rate was 67 (per 1,000 women aged 15-44). The stillbirth rate was slightly higher than the national rate (5.1) at 5.3 per 1,000 births.

In August 2011 there were 55,180 families with dependent children (those claiming Child Benefit) . Of those nearly half (46%) had only one child, a third (37%) had two children and

a fifth (18%) had three or more. This provides a proxy for the proportion of births to first time mothers.

Low birth weight (less than 2,500g) is a risk factor for infant deaths¹. Locally more babies were born with a birth weight under 2,500g; than nationally (85 per 1,000 live births compared with 73 nationally).

Accessing antenatal care as early as possible can reduce the chance of having a low birth weight baby and factors such as diabetes and other diseases, smoking, drugs and alcohol use can be more effectively managed.

In 2011/12 there were 5,843 live births to Kirklees women. Out of the 6,120 pregnancies in Kirklees in 2010/11, 89% had their initial assessment before 13 weeks of gestation.

What significant factors are affecting this issue?

In order to focus on women and families who are more vulnerable to poorer outcomes for themselves and their babies, pregnancy care needs to be delivered through more community-based maternity services, using community midwives and skill mixing with Maternity Support Workers and volunteer-based peer supporters.

Investment in staffing resource and changing ways of working is vital. Whilst over 88% of women are booking into maternity services before 13 weeks of pregnancy there are still around 10-12% of women who book later than this. Although insight shows that some women do not know they are pregnant until well after 12 weeks and many others prefer to “conceal” it, a better understanding is required about the needs of the women and families who do not book into maternity services within 13 weeks. Many of these families may be from communities who are particularly vulnerable to poorer outcomes for their babies and themselves.

Which groups are most affected by this issue?

The number of live births and birth rates ranges from 1,028 births at a rate of 77 per 1,000 women aged 15-44 in Dewsbury and 629 births at a rate of 78 in Batley to 826 births at a rate of 50 in [Holme Valley](#) and 49 in [Denby Dale & Kirkburton](#).

The low birth weight rate is highest in Batley (119 per 1,000 live births), [Birstall & Birkenshaw](#) (116) and [Dewsbury](#) (101). North Kirklees has a higher rate of low birth weight

(95) than Greater Huddersfield (75) which is close to the national average. There is a higher rate of low birth weight amongst south Asians (120) than non-south Asians (85).

The live birth rate is closely linked to deprivation. The least deprived IMD quintile had a birth rate of 51 and this increases for each quintile with the most deprived quintile having a birth rate of 81. The pattern of low birth weight shows the opposite gradient with the least deprived quintile having a rate of 76 (per 1,000 live births) and the most deprived having a rate of 114.

There is a marked difference in birth rates between south Asian (100) and non-south Asian women (58). Within Batley and Dewsbury over half of live births (57% and 54%) were to women of south Asian origin, this is much lower in other areas.

[DN need data analysts to provide data to show any differences in booking between localities – i.e. are sig fewer women from e.g. lower SES booking by 13 weeks?]

Views of local people

Recent insight gained from women and maternity services staff in North Kirklees illustrates some of the issues around workforce capacity and capability. In general terms women reported being satisfied with the antenatal care they received, with the relationship with their midwife being the most critical factor.

Levels of satisfaction were higher with antenatal services compared with satisfaction with delivery and postnatal services:

“The trainee midwives are better than proper midwives 'cos they have time for you and they don't look down at you.” (White woman, aged 20 years, 1st baby)

“Auntie Pam's was really good. I got all the information there as my midwife didn't give me any.” (White woman, aged 20 years, 1st baby)

Asian women in particular reported high levels of satisfaction, though didn't give much detail as to why or what made their care good. In some examples the care had clearly not been good. For example, an Asian woman with diabetes who was 28 weeks pregnant was seen in the delivery suite as she was having complications.

“I was in a wheelchair for 2 hours on corridor as they had no beds. I told them I had baby pain but they were very busy. Two hours later when they checked me I had lost the baby.”

Despite this, the woman was extremely positive about the care she received in her previous pregnancy when she miscarried:

“They are all very busy” (37-year old south Asian female, speaking limited English, 5th pregnancy)

During discussions with service users the terms “good midwife” and “bad midwife” were frequently used. A “good midwife”, described by women who were happy with their care, was one who was seen as available and contactable, has time for the woman and is interested in them, not just the baby (e.g. discusses domestic abuse), offers the right information when needed, doesn’t just bombard the woman with loads of leaflets at booking in. Women feel they have a good relationship with these midwives, as they are pleased to see them and are reassuring.

Despite this, there was an apparent lack of knowledge regarding the problem of infant mortality in Kirklees. The majority of staff were not aware that infant mortality was a specific issue for Kirklees.

Experience on the postnatal ward was generally positive. Women reported they wanted a midwife who had time to sit with them and help with practical things like feeding, bathing etc.

The overriding concern of most women following delivery was feeding. Those wanting to breastfeed (particularly first time mums) felt they needed a lot more support than they actually received:

“I was discharged pretty much straight away but I would have liked more support with feeding.”

(White woman, aged 39 years, 1st baby)

All women who were asked were positive about the initial postnatal support received from the community midwives and then subsequently health visitors, but these staff sometimes feel they are “starting from scratch”.

“Sometimes we see women in the community after they have been discharged from the (postnatal) ward and they still don’t know how to take basic care of a baby. We are starting from scratch. It’s because they don’t have time on (the postnatal ward) now.”

What could commissioners and service planners consider?

- The two strategic service transformation reviews need to prioritise healthy pregnancy as part of a shared vision to give every child the best possible start in life.
- Service models need to be reviewed and agreed, putting service users and communities at the heart and engaging them in the process of transforming services.
- The transformation of maternity services needs to prioritise the “normalisation” of pregnancy and birth, putting women in control of their pregnancy, so that every woman feels in control over her choices and the need for “medical” interventions is reduced.
- Women need to be fully informed and involved in the decisions about their pregnancy and the birth of their child. Women and families need to have equitable access to high quality services centred around the woman, her baby and her family’s needs. This should enable her to have as normal a pregnancy and birth as possible and as appropriate, taking account of both her and her partner’s wishes.
- From the insight described above, further work is needed to look more closely into whether Asian women are genuinely satisfied with their pregnancy care or whether there are cultural barriers and differences which inhibit their feedback. Ideally this would be done using peers from inside the community to enable open feedback.
- The greater use of peers in the antenatal and postnatal process, including breastfeeding peer support, needs to be considered (e.g. service users supporting “parent craft” to talk about their experiences). This kind of peer support is offered through the volunteer led Auntie Pam’s and is working very well for the women who access that service.
- A women-centred, midwife led, less medical service model is required that supports women to plan their pregnancy and birth. These birth plans should be seen as the “default” option, but should include further options to allow for changed circumstances.
- Further work is needed to engage more Asian women in birth planning and preparation. Whilst considerable progress has been made over the last few years to improve the access of this group into maternity services (with huge success) it should be noted that they are not necessarily actively engaged with the birth

preparation process. “Parent craft” classes in their current form are unlikely to engage many of these women, therefore specific alternatives should be considered.

- Further engagement of minority groups (such as Asian women) in birth preparation and planning is needed. This should explore their ideas on how to better prepare for the birth experience and options such as specifically tailored approaches to parent craft.
- In order to support the “normalisation” of pregnancy and birth, and reduce the over-reliance on medical (and higher risk) interventions, the model of services needs to ensure that women have increased access to home births, midwife led units, home-from-home facilities and options such as birthing pools. These options should be available as standard and obstetric/medical care only required as the exception rather than the norm.
- This requires redirection of resources towards community models of care, women-centred and midwife led, workforce redesign and development, culture change and a “mixed economy” of capability and capacity, such as greater peer support, skill mixed teams, integrated with others providing psychological, social and economic support.

References

- i Child Benefit Statistics Geographical Analysis. HMRC; August 2011. Available from: <http://www.hmrc.gov.uk/statistics/child-benefit.htm#2>

Date this section was last reviewed

09/07/2013 (PL)