The importance of antenatal care in early pregnancy

We support the Government priority for all pregnant women to have started their antenatal care by 12 weeks. Women who start their antenatal care late or regularly miss appointments are much more likely to be vulnerable or socially excluded. These women and their babies are also much more likely to experience serious health problems and higher death rates, including the mothers being at higher risk of committing suicide. It makes such a difference if vulnerable women can make a relationship with one or two midwives, and see them throughout their pregnancy, during birth and afterwards, so that they feel understood, safe and valued as a person. We back the Royal College of Midwives’ call for an additional 5,000 midwives to be recruited, since having enough midwives is fundamental to delivering consistently high quality care from the start of antenatal care through to the end of the postnatal period.

The additional funding for maternity services in England announced in 2007 was not ring-fenced and consequently seems to have vanished into a black hole in some PCTs. Additional funding is needed to invest in employing more midwives, funding out-reach clinics and providing additional support services. It is important not to move resources into improving early pregnant care, at the expense of one-to-one midwifery care during labour and postnatal support.

Background information

17% of all maternal deaths in the UK between 2003-05 were of women who booked for maternity care after 22 weeks gestation, missed over four routine antenatal appointments, or did not seek care at all (CEMACH Saving Mothers’ Lives 2007).

An overview of the evidence on Social Inequality in Maternal and Perinatal Mortality (New Digest 44) found that:

- Women with a partner who was unemployed or in an unclassified occupation had the highest maternal mortality rate and were over seven times more likely to die than women with partners in employment.
- Women without a partner (irrespective of social class) were three times more likely to die than women with a partner.
- Perinatal mortality was considerably higher for babies with fathers in ‘routine’ occupations than for babies with fathers working for ‘large employers and (in) higher managerial occupations’.
- Perinatal mortality was highest for solely registered births, followed by births registered jointly by unmarried parents and lowest for births registered by married parents. For births registered jointly by unmarried parents perinatal mortality was lower when parents lived at the same address.
- Black African women had the highest maternal mortality rate of all ethnic groups. The high proportion of refugees and asylum seekers in this group contributed to this.
Women born in the ‘Rest of Africa’ country group (predominantly West African countries) had the highest perinatal mortality rate; over twice the rate for UK-born women. The incidence of very preterm birth and very low birthweight is high amongst babies of African ethnicity.

- Mothers living in the most deprived areas quintile were about five times more likely to die than those in the least deprived quintile.
- Babies born to mothers living in the most deprived areas quintile were 1.8 times more likely to die stillborn or in the first week of life than those in the least deprived quintile.
- Perinatal mortality was higher for babies of teenage mothers and for those born to women aged 40 and over.
- Women from socially disadvantaged groups were more likely to have complex needs yet were less likely to access and receive the care they required.
- Seventeen percent of all direct or indirect deaths were of women who booked late, were irregular attenders for care, or did not seek care at all.

Women need to know that they will have one-to-one care in labour, a time when they may feel very vulnerable and afraid. This is especially important for women with a history of sexual abuse, and for those experiencing domestic violence or heightened anxiety. The postnatal period is also a time when parents need plenty of support and practical help, particularly if they are first-time mums or dads, teenage parents, homeless or vulnerable in other ways.

Caseload midwifery is a system for organising midwives so that they work in pairs or small partnerships and each care for around 28 women (if working full-time), or fewer if their families have additional needs (this ratio is supported by the Royal College of Midwives, The Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health). They get to know the family, providing care at each antenatal appointment. They go to the mother’s home when she is in labour and go with her into hospital if she chooses not to stay at home for the birth. They also provide postnatal care once the family come home. The system is highly flexible and requires midwives to be on-call regularly, though they can provide cover within the partnership. The way of working is very rewarding for families and for those midwives who opt to work that way.