



Dealing with pregnancy problems—why we all need to be part of the solution

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Better advice and support before and after pregnancy is needed from health and social care beyond maternity services

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Cite this as: *BMJMED* 2022;1:e000127. doi:10.1136/bmjmed-2022-000127

Received: 15 February 2022
Accepted: 4 March 2022

For almost two decades in the UK, it has been clear that the majority of deaths of women during pregnancy, or up to six weeks after the end of pregnancy, are due to medical and mental health conditions made worse by pregnancy, or the care received as a consequence of being pregnant.¹ Fewer than a third of these deaths are related directly to obstetric conditions. Yet, actions to prevent pregnancy problems still largely focus on childbirth care. At best, this work extends to antenatal and postnatal maternity services. Only with actions long before pregnancy, from health and social care services well beyond maternity, and for months and years after the end of pregnancy, can pregnancy problems truly be resolved. This effort is required from us all.

The findings are similar for other high resource settings such as the US² and Canada. Proportionately, deaths from medical and mental health conditions are increasing in low and middle income countries as efforts to provide skilled childbirth care take effect and deaths from obstetric conditions, such as postpartum haemorrhage and pre-eclampsia, are prevented. The imbalance is even greater when deaths between six weeks and a year after the end of pregnancy are considered, in which most women die from mental or physical health conditions that are not specific to pregnancy. Their outcomes, nevertheless, are adversely affected by the simple fact that they have recently been pregnant.¹

We have no comparable data for severe maternal morbidity solely due to non-obstetric conditions, although for every pregnant or postpartum woman that dies, a further hundred are estimated to have a severe morbidity.³ Between 10% and 20% of women are known to experience a mental health problem during or after pregnancy.⁴ Complications during pregnancy are known to have adverse outcomes many years after their occurrence.

In children's education, there is an important role for awareness of the need to optimise health before conception and pregnancy. Preventable conditions, such as obesity, contribute substantially to the risk of severe morbidity in pregnancy.⁵ Other environmental factors before pregnancy could influence pregnancy complications, such as housing quality, air pollution, occupation, and socioeconomic circumstances. Societal norms also play a part in the occurrence of pregnancy problems; the maternal age at first childbirth is rising globally and will inevitably lead to more women entering pregnancy with pre-existing

health conditions and to a consequent increase in pregnancy morbidity. These trends emphasise the importance of advice before pregnancy for women with comorbid conditions.⁶ That advice is required early, long before women are considering pregnancy, so that they are informed about how to optimise their health and drug treatments before pregnancy, and, importantly, are provided with contraceptive advice to enable them to delay pregnancy until a time of their choosing. A planned pregnancy will always be safer than an unplanned pregnancy in a woman with a pre-existing mental or physical health condition. Given the range of health conditions that women experience, provision of prepregnancy and contraceptive advice should be within the remit of any health professional who cares for women of reproductive age, from paediatric transition clinics onwards. Little research looks at women's perspectives on how best to provide that advice.

The UK Confidential Enquiries into Maternal Deaths repeatedly identify women with unplanned pregnancies who would not have died if they had been given appropriate contraceptive advice and had prevented their pregnancy.¹ Similarly, a consistent theme identified in reviews of the care of women who die is inappropriate withdrawal of drug treatment before or in early pregnancy by clinicians or women themselves.⁷ We must recognise the harm inherent in the pervasive risk messaging in relation to pregnancy drug treatment from the media,⁸ the actions of regulatory authorities, pharmaceutical companies, and insurers. The introduction of a programme designed to prevent in utero exposure to valproate, for example, has led to increased numbers of maternal deaths from sudden unexpected death in epilepsy among women taking no or inadequate drug treatment for their epilepsy.⁷ We must also recognise the culpability of researchers' acceptance to exclude pregnant women from clinical trials and act to ensure that inclusion in such research becomes the default.⁹ The guidance for ethical principles of the Pregnancy Research Ethics for Vaccines, Epidemics, and New Technologies (PREVENT) Working Group state that "Justice requires that pregnant women have fair access to research that offers the prospect of direct benefit."⁹ Pregnant women are frequently excluded by default from trials because of concerns about potential harm to the unborn child, despite a paucity of theoretical evidence to underlie such concerns, alongside real potential for maternal benefit. High proportions of vaccine hesitancy and preventable deaths of unvaccinated pregnant women from covid-19 is but one example of the impact of such exclusion.

During pregnancy, many women with physical and mental health comorbidities are still expected to attend multiple appointments with different teams, without thought to the near impossibility of such models of care for women with employment and childcare responsibilities. Holistic models of care are infrequent with clinicians tending to work in silos and without basic understanding of pregnancy medicine. The impacts of the woman's previous experiences of interactions with health and social care services, for example, with racial microaggressions and stereotyping, are rarely considered by healthcare providers.¹⁰

The effects of complications experienced during pregnancy can be life long, but many can be prevented by actions and care during the first postnatal year. Pregnancy events are a known cause of post-traumatic stress disorder for both women and their partners, and early intervention can prevent long term distress. Early postnatal blood pressure control can have long term benefits on future hypertension and cardiovascular events. Undiagnosed postnatal depression is recognised to have affected some women for several years, with associated impacts on their children and families. Postnatal care, however, is rarely prioritised.

These examples clearly show that pregnancy problems and their long term consequences can be prevented only by consideration of the needs of pregnant women throughout their life. The question arises as to why the consideration of these needs is not yet the case. Whatever our clinical specialty (be it paediatric, adult, or even geriatric medicine, when cardiovascular, urological, and mental health complications as a result of pregnancy conditions are still be evident), there will be examples of how the care we provide can prevent future pregnancy problems, or adverse consequences of pregnancy problems. As researchers, clinicians, service managers, and policy makers, we need to recognise this opportunity and ensure that women's voices are heard, and their needs recognised. We are all part of the solution—as individuals we need to take the first step and recognise this. Pregnancy must be an important focus for us all.

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Acknowledgements I thank Susanna Stanford for providing helpful comments from a personal experience perspective on a first draft of this editorial.

Contributors MK had sole responsibility for writing this article.

Funding MK is a UK National Institute for Health Research (NIHR) senior investigator. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care.

Competing interests I have read and understood the BMJ policy on declaration of interests and declare the following interests: grants from the NIHR, Healthcare Quality Improvement Partnership, Medical Research Council, and Wellbeing of Women in the previous three years.

Provenance and peer review Commissioned; not externally peer reviewed.

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