Reducing Antenatal Health Inequalities

Outcome Focused Evidence into Action Guidance

January 2011

healthier scotland
SCOTTISH GOVERNMENT

Reducing Antenatal Health Inequalities

Outcome Focused Evidence into Action Guidance

The Scottish Government, Edinburgh 2010

ISBN: 978-0-7559-9885-2

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS11081 (01/11)

Published by the Scottish Government, January 2011

The text pages of this document are printed on recycled paper and are 100% recyclable

Ministerial Foreword

I am delighted that this evidence into action guidance has been developed in response to the recommendation in the Equally Well Task Force report that *'NHS Boards should improve the capacity of antenatal services to reach higher risk groups and identify and manage risks during pregnancy'*. I am launching this guidance alongside the refreshed Framework for Maternity Care in Scotland as a key component of the Framework's implementation.

High quality healthcare during pregnancy makes a crucially important contribution to the reduction of health inequalities at birth, in infancy, throughout childhood and across the whole of an individual's life course. We now know that the antecedents of many lifelong conditions and illnesses in the middle and later years have their roots in the antenatal period.

Improving universal antenatal healthcare *and* supporting women with multiple and complex health and social care needs will help improve the health of newborns and pressures on neonatal services as well as improve later outcomes. Crucially these improved outcomes will not only be health outcomes but will include educational, social and economic outcomes as well.

We know from the work of the child and maternal confidential enquiries, and other key evidence reviews, that some women and their babies are at higher risk of poor and unequal health outcomes. We also know that often it is those 'high risk' women who do not access and or benefit from antenatal healthcare. Equity in the quality of care provided is a key component of NHSScotland's healthcare Quality Strategy. Improving access to antenatal care and the quality of the care received amongst high risk groups must therefore be seen as a vital NHS contribution to wider early years work.

This guidance is based on the evidence gathered for the Early Years Framework, Equally Well and a recent rapid review of the evidence carried out by NHS Health Scotland to specifically inform this guidance. The actions detailed are specific to the NHS and lie within the remit and direct sphere of influence of NHS Boards. The Scottish Government will ensure the national actions detailed in the guidance are carried out to ensure NHS Boards have the support they need.

I am grateful to the antenatal working group and NHS Health Scotland for their work in developing this guidance. I know from the group's engagement with maternity services and other key stakeholders that this guidance is welcome. I am aware that staff involved in providing antenatal healthcare have a real enthusiasm to raise the profile of the important role of antenatal care so as to ensure that all women receive the information, care and support they need before their babies are born. I am therefore delighted to commend this guidance to NHS Boards and all services providing maternity care.

Shona Robison, Minister for Public Health and Sport

RATIONALE FOR THIS GUIDANCE

'The medical and obstetric consequences of social risks, requires them to be managed by clinical services as robustly as they manage, for example, diabetes or epilepsy'

Dr Harry Burns, Chief Medical Officer, Scottish Government

This guidance details the specific actions needed to strengthen antenatal healthcare at NHS Board and national level. **It requires action across each NHS Board's corporate functions**, including specialist public health, planning and performance management. It is intended to support improvements in antenatal care for women, including care provided by Primary Care Services, Substance Misuse, Mental Health and Sexual and Reproductive Health Services.

The guidance has been developed by an Antenatal Inequalities Working Group – a sub group of the Maternity Services Action Group (MSAG)[1] in response to recommendation 4 of the Equally Well Implementation Plan[2] that NHS Boards need to ***'improve the capacity of ante natal services to reach higher risk groups[3] and identify and manage risks during pregnancy'***. Its specific actions are based on a review of what the evidence says needs to happen to:

- **Improve access to antenatal healthcare services** **(see page 10)**
- **Improve the assessment of health and social need** **(see pages 11-12)**
- **Ensure *equity in the quality of care*** (see pages 13-14)

Poor and unequal access to antenatal healthcare *contributes* to inequalities in maternal and infant mortality and morbidity[4]. We know that **those women and babies who are at the greatest risk of poor health outcomes are the least likely to access and/or benefit from the antenatal healthcare that they need.**

There is a compelling body of evidence that early intervention and preventative spending ***before*** **babies are born** is vital for improved outcomes for mothers, babies and families in Scotland. Indeed, **the future financial constraints, rather than being a barrier to action, provide an imperative to take the action identified in this guidance.** The evidence is strong that investing in early intervention, prevention and support as early as possible leads to significant savings across public services.

---

[1] MSAG is the Scottish Government convened group that brings together key stakeholders from Maternity Services, the Royal Colleges, and the Scottish Health Council with the Scottish Government. The key aim of MSAG is to provide national leadership, guidance and support in the formulation and implementation of Scottish Government policy as it relates to maternity care.

[2] Equally Well Implementation Plan 2008- http://www.scotland.gov.uk/Publications/2008/12/10094101/0

[3] The term high risk cannot be prescriptive and will depend on individual circumstances. NICE have highlighted teenagers, women with addiction problems, women from BME communities, women experiencing domestic abuse, other groups would be women with learning disabilities or women involved in prostitution. Poverty is usually an underlying key feature within all of these groups and is in itself a risk factor for poorer outcomes.

[4] NICE Socially Complex Pregnancies- http://guidance.nice.org.uk/CG110/NICEGuidance/pdf/English
WHO maternal and infant mortality observatory
http://www.chimat.org.uk/default.aspx?QN=CHIMAT_DATADIR_MI

'A wide range of economic studies suggest that returns to early investment in children during the pre-birth period and first few months of life, up to the age of eight years old are high, but reduce the later the investment is initiated. Investment in early and effective interventions translates into substantial savings to the public sector'. [5]

Reaching and managing higher risk groups in the antenatal period will help strengthen NHS capacity to both promote healthier pregnancies *and* effectively manage the co morbidities which often lead to premature births and poorer maternal and infant health outcomes- in turn this should reduce demand on neonatal and paediatric services in the short term and a range of public services in the medium to long term.

Improving access to, and the quality of antenatal healthcare, will strengthen NHS capacity to respond to the needs of women in high risk groups. It will strengthen its contribution to improving maternal and infant nutrition including breast feeding; promotion of smoking cessation, reduced alcohol use and the uptake of welfare support and income maximisation services.

Many of these improved outcomes are measureable and deliverable in the short term- they can be measured during pregnancy and in the first few weeks of a baby's life. We know that improving outcomes in the short term will also have a positive impact on a wide range of outcomes across the life course of mothers and babies and contribute to the implementation of the Early Years Framework.

There is substantial work already underway within NHS Boards to strengthen the contribution that antenatal health care makes to reducing health inequalities. In addition we know that maternity staff are committed and passionate about providing high quality antenatal health care. The guidance should therefore be used in conjunction with and/or with reference to:

- The Refreshed Framework for Maternity Care Services in Scotland – www.maternityservices.scot.nhs.uk
- The Maternal and Infant Nutrition Framework – www.maternityservices.scot.nhs.uk
- NHS QIS Vulnerable Families Pathways – http://www.nhshealthquality.org
- Getting it Right for Every Child CEL and implementation guidance http://www.scotland.gov.uk/Publications
- Gender Based Violence CEL – www.sehd.scot.nhs.uk/mels/CEL2008_41.pdf
- Hall 4 revised guidance – www.scotland.gov.uk
- Future Health Promoting Health Service requirements in relation to contraception services, in particular the promotion of longer acting reversible contraception.

[5]Tackling Child Poverty in Scotland- A Discussion Paper http://www.scotland.gov.uk/Publications/2010/11/15103604/11

A SNAPSHOT OF INEQUALITIES IN MATERNAL AND INFANT HEALTH OUTCOMES

- **Women aged less than 20 are at risk of higher rates of stillbirth (5.6 per 1000 total births), higher rated perinatal deaths (8.9 per 1000 total births) and higher rates of neonatal deaths (4.4 per 1000 live births) than women aged 20-34** http://www.cemach.org.uk/Publications-Press-Releases/Report-Publications/Maternal-Mortality.aspx

- **Children born to women from more vulnerable groups experience a higher risk of morbidity and face problems with pre-term labour, intrauterine growth restriction, low birth weight and higher levels of neonatal complications.** http://www.cemach.org.uk/Publications-Press-Releases/Report-Publications/Maternal-Mortality.aspx

- **81% of women who died of direct or indirect causes and who were in abusive relationships found it difficult to access or maintain contact with maternity services**http://www.cemach.org.uk/Publications-Press-Releases/Report-Publications/Maternal-Mortality.aspx

- **In over 50% of domestic abuse cases, children were also directly abused**http://www.cemach.org.uk/Publications-Press-Releases/Report-Publications/Maternal-Mortality.aspx

- **Socio-economic deprivation remains one of the factors associated with poor perinatal outcomes in Scotland: the perinatal mortality rate among the most deprived in 2007-2008 was 8.8/1000 births compared with 6.5/1000 births in the least deprived. A similar gradient was recorded for prematurity , low birth weight and small for gestational age babies (ISD 2009** http://www.isdscotland.org/isd/1018.html

- **Women from BME communities are 7 times more likely to die in childbirth than other groups**http://www.cemach.org.uk/Publications-Press-Releases/Report-Publications/Maternal-Mortality.aspx

- **20% of women who died either first booked for antenatal care after 20 weeks gestation, missed over four routine antenatal appointments, or did not seek care at all** http://www.cemach.org.uk/Publications-Press-Releases/Report-Publications/Maternal-Mortality.aspx

- **High risk factors during pregnancy –substance misuse, domestic abuse, smoking as well as diet and maternal nutrition impact on a child's subsequent health and development outcomes (Early Years Framework Evidence Briefing http://www.scotland.gov.uk/Topics/People/Young-People/Early-years-framework/background/evidence**

SUMMARY OF KEY MESSAGES FROM THE EVIDENCE

Antenatal health care has a **unique and vital contribution** to make to **improving maternal and infant health outcomes and reducing health inequalities, ensuring that every child has the best start in life and is ready to succeed**

The role of **universal antenatal healthcare** in **assessing women's health and social needs** is pivotal to ensuring appropriate pathways of care, including multiagency and multidisciplinary pathways of care are in place

The medical and obstetric clinical consequences of social risk requires **them to be managed by clinical services as robustly as the management of medical risk, for example diabetes or epilepsy**

The **development of workforce skills** for the **assessment** of individual women's assets[6] for health ***and*** health and social needs to be addressed as a **priority**

The development of workforce **communication skills should be addressed as a priority**- prioritising women who do not have English as their first language; women who have sensory disabilities and/or women with poor health literacy[7]

Continuity of carer(s) and the development of trusted relationships should be provided for all women and **ensured for the safe care of women with complex health and social care needs**

The **collection and analysis of data** particularly **data relating to healthcare equity should be improved as a priority**

Integration of planning and service provision among **antenatal care services, other key NHS services and local authority services** should be **strengthened**

Staff should have the support, supervision, time and resources needed to enable them to work effectively with women who have multiple and complex health and social care needs

Regular and systematic clinical audit of **short term maternal and infant outcomes** should be carried out

[6]Health assets are strengths within an individuals' possession. They embrace both internal and external strengths. Internal strengths include positive relationships with others, the motivation to control or change individual circumstances, and the presence of protective personal characteristics such as for example a resilient personality and/or a sense of optimism. External characteristics include social support networks, expectations of others, and physical and environmental elements. The antecedents of health assets are genes, values, beliefs, and life experiences. Health assets mobilise an individual to engage in risk assessment, decision making, and change. The consequences of health assets are positive health behaviours that can lead to control, self-efficacy and improved health outcomes. Health asset based approaches recognise that traditional approaches to health improvement generally concentrate on the problem or deficit smoking, obesity etc, rather than starting with what is working in a person's life and what people care about.

[7] The World Health Organisation's definition of Health Literacy is 'the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health'

THE NEXT SECTION LOOKS AT KEY ACTIONS FOR NHS BOARDS
NHS BOARDS-TAKING MEASURABLE ACTIONS

ACTION	MEASURING IMPROVEMENT
Public Health Department's work with CHPs, primary care and maternity services to carry out a rapid health needs profile of *women of reproductive age* for benchmarking and service planning purposes	Data required for the SWHMR is effectively and efficiently recorded, collected and systematically used for national and local audit and health profile purposes All data required for national purposes to be returned within the agreed timescales
Boards should work towards all women accessing antenatal care services by 12 weeks of pregnancy	Audit the numbers of women booking for antenatal care by the 12th week of gestation , including uptake by women under 20 and women living in the most deprived quintiles; high risk groups ensuring the collection of all data required by Equalities Legislation
The GIRFEC national practice model and inequalities sensitive practice is integral to assessment of need and care responses within antenatal services	Benchmark and measure whether staff have the time, knowledge and skills to work in partnership with women to assess their needs including enquiry into and collection of sensitive social data- (e.g. domestic abuse, substance misuse, poverty etc) Benchmark and audit continuity of care and carer
A risk assessment of communication, liaison and referral processes between maternity services, primary care and other key NHS services including mental health and substance misuse services and Local Authority services is carried out	Benchmark and measure staff have the necessary skills to work in partnership with women to support them make key lifestyle changes Ensure communication, language and translation plans are in place.
Short term (conception – postnatal phase) health outcomes of antenatal care for women and their babies in high risk groups are routinely measured	Ensure that effective audit cycles are in place to drive clinical improvement for high risk women in the antenatal phase Benchmark and systematically measure key short term outcomes including maternal and infant mortality and morbidity data, premature birth, smoking cessation rates, breast feeding rates, drugs and alcohol use amongst high risk groups
Primary Care and other key NHS and Local Authority services ensure that women's preconceptual general health is cared for particularly those women in high risk groups The promotion of long lasting reversible contraceptives are promoted particularly to teenagers, women with addiction problems and sex workers prior to discharge from postnatal care	Primary Care Disease register data, QOF data

THE NEXT SECTION LOOKS AT KEY NATIONAL ACTIONS

NATIONAL ACTION

THE Scottish Government will ensure that an implementation plan is developed for the Refreshed Framework for Maternity Care Services focussing on Information/data, workforce development and risk analysis of care pathways between primary care, maternity services and public health nursing
The Scottish Health Council's report regarding strengthening service user involvement with practical recommendations for capturing the experience of women from seldom heard groups will be available for NHS Boards
The Scottish Government will commission NHS QIS to update the SWHMR ensuring that it is fit for purpose
A proposal for a HEAT target measuring improvements in access to antenatal care by the 12th week gestation for all women, including those under 20 and those living in the poorest SIMD quintiles is being developed for 2012
NHS Education for Scotland will produce a workforce development plan and knowledge and skills framework in order to support Health Boards to address antenatal inequalities
NHS QIS will develop a Vulnerable Families Pathways as a practical tool for antenatal staff working with women in high risk groups
NHS Health Scotland- is undertaking an EQIA of early years resources and will review and maintain all publications and websites for antenatal services. They will provide support for cross sector work and special interest groups via the early years network[8]
NES, QIS and Health Scotland are developing a national syllabus, training and resources for antenatal education

[8] Maternal and Early years Website- **www.maternal-and-early-years.org.uk**

THE NEXT SECTION GIVES AN OVERVIEW OF WHAT WE MEAN BY ANTENATAL HEALTH INEQUALITIES

HEALTH INEQUALITIES- AN OVERVIEW

WHAT DO WE MEAN BY ANTENATAL HEALTH INEQUALITIES?

- Inequalities appearing at pregnancy, birth and the early years often have a significant bearing on maternal health and the subsequent development of the child, its' health, happiness and productivity in society
- **Largely socially determined variations** in health outcomes for women and their babies that are determined pre conceptually ***and*** during pregnancy.
- Although largely socially determined they have **clinical manifestations that require effective clinical responses**
- They result in poor ***comparative*** **health outcomes** at birth for women and their babies –and are especially significant where for example any or some of the following ***circumstances interlock****:* poverty, age (teenage/older), ethnicity, domestic abuse, learning disability, substance misuse problems, alcohol +tobacco use.

WHAT DO WE KNOW?

- They are a **strong indicator of social injustice**
- **They result in poor health, social, educational and economic outcomes** across the **whole of the life course** for **women and their babies**
- **They are result in significant reactive public spending** across health, social care, education and criminal justice departments
- They **significantly hamper** Scotland realising its ambition of **becoming a more successful country, with opportunities for all of to flourish.**

WHAT CAN NHS ANTENATAL HEALTHCARE DO?

Health inequalities arising in the antenatal period need to be tackled through all areas of public policy and all public services **they cannot be tackled by health policy and health care alone. However** those who are at the greatest risk of poor pregnancy outcomes are the least likely to access and/or benefit from the healthcare that they need. **Antenatal healthcare has a unique and vital contribution** to make to reducing health inequalities **by taking action across three main themes:**

1. **Improving access to antenatal healthcare services**
2. **Improving the assessment of health and social need**
3. **Ensuring *equity in the quality of care* for women and their babies**

THE NEXT SECTION GIVES AN OVERVIEW OF WHAT WE KNOW AND KEY MESSAGES FROM THE EVIDENCE IN RELATION TO THE 3 MAIN THEMES.

THEME 1-ACCESS TO ANTENATAL CARE SERVICES

WHAT DO WE MEAN BY ACCESS?

Early access to antenatal care is important however access is **not just about physical access to antenatal booking at a particular point in time** – it is about the quality and impact of ***ongoing access*** to, and **engagement** with, antenatal healthcare.

WHAT DO WE KNOW

- **Women under 20 and women living in areas of deprivation tend to 'book' for antenatal care later than other groups of women**
- **Some 'high risk' women *do not book later* but their engagement with and experience of antenatal care is sub optimal**

BARRIERS TO ACCESS

- **Womens' perceptions and fears of how they will be treated**
- **Womens' fear that their baby will be 'taken away' if they disclose for example- substance misuse or domestic abuse**
- **Treatment by and attitudes of staff**
- **Poor continuity of individual care and lack of Integrated care by local service providers**
- **Lack of staff knowledge and sensitivity about the impact of social inequalities on women's lives**
- **Poor communication between staff and women**

KEY MESSAGES FOR IMPROVED ACCESS

- **Communication and promotion of antenatal healthcare to high risk groups of women is a multi agency responsibility**
- **Integrated planning and provision of antenatal services between NHS specialist services and Local Authority services, for example–addiction services, mental health services, homelessness services, asylum and refugee services**
- **Known barriers to access are addressed and where possible services are co-located**

THEME 2- ASSESSMENT OF HEALTH AND SOCIAL NEED

WHAT DO WE MEAN BY 'HIGH RISK'?

For the purposes of this guidance, high risk is intended to refer to women who have complex health ***and*** social care needs. In other words those women whose social circumstances have a ***clinical impact-*** either physically, psychologically or both, which in turn may have an obstetric impact. As a result of this interlocking risk, any or all of the following outcomes may occur:

- The woman or baby is more likely than usual to become ill or die
- Complications before or after delivery are more likely than usual.
- Longer term child and maternal health and other social outcomes (educational, economic etc) are poorer when compared to other groups

IDENTIFYING AND MANAGING RISK

NHS antenatal health care has a unique role to play- as the only universal public service for women and infants in the pre birth phase. Health inequalities follow closely the social gradient[9], affecting all groups to a greater or lesser degree[10]. This means that action to reduce health inequalities in the antenatal period needs to be based on assessment of needs and assets for every woman across social groups including those at the 'high need' end who may already be 'known' to public services.

Antenatal care needs to be tailored and *progressively intensive* depending on *individual need*.

GIRFEC Practice Model –Key Questions
What is getting in the way of this woman or baby's wellbeing?
Do I have all the information I need to help this woman or baby?
What can I do now to help this woman or baby?
What can my service do to help this woman or baby?
What help, if any, may be needed from others?

The Getting it Right for Every Child (GIRFEC) approach enables assessment across the spectrum of need, whether there are early indications of additional needs within universal antenatal care or in higher risk situations involving the need for more complex interagency plans. It enables staff providing antenatal healthcare to ask the same key questions of themselves about a woman and her baby.

WHAT DO WE KNOW?

Staff who provide antenatal healthcare need to have the skills to assess individual women's risks and assets/strengths in partnership with the woman. This means taking into account the woman's communication needs and levels of health literacy. Effective assessment should be a mutual process carried out between the practitioner and the individual woman. Women are highly motivated to do what's best for their babies. However working in strengths or assets based way requires a shift

[9], Equally Well Task Force- http://www.scotland.gov.uk/Publications/2008/06/25104032/0
[10] Marmot review Reference- http://www.marmot-review.org.uk/

from traditional practice - staff will need learning and development inputs and ongoing supervision in order to make this shift.

Developing and supporting the workforce will enable antenatal care services to harness the opportunity to support women make behavioral changes particularly in relation to smoking, use of alcohol and drugs and improved nutrition. Effective assessment will also improve the capacity to identify where other services or supports are needed. Management of risk and/or support for behaviour change is more likely to be effective if it there is also support for complex and challenging social circumstances. Identifying and responding to social risk factors is as important as addressing physical factors such as diabetes or pre-eclampsia.

KEY MESSAGES

- Effective assessment of health and social care needs is highly dependant on a partnership between the woman and a named practitioner *and* the continuity of that relationship.
- Assessment should look for assets/resources for health as well as identification of need and risk
- Continuity of carer(S) and the development of trusted relationships should be provided for all women but is critical to the effective and safe care of women who may have complex health and social care needs
- The GIRFEC approach helps assessment across a wide spectrum of need
- Assessment of health and social need should be a dynamic process throughout the woman's journey through antenatal care and beyond
- Supporting behavioural change should use person centred asset based approaches and happen alongside any collaborative support needed in relation to a woman and her families social circumstances
- Effective collaboration across services and professions with clear pathways of care is essential
- Workforce development, support and supervision is needed to shift practice

THEME 3. EQUITY IN THE QUALITY OF CARE

WHAT DO WE MEAN BY EQUITY IN THE QUALITY OF CARE?

The NHSScotland Healthcare Quality Strategy[11], recognises that healthcare quality is *'built from the ground up and is dependant on the effects of millions of individual care encounters'*. Care encounters that are consistently person centred, clinically effective and safe for every person, every time. The strategy has been built around what people in Scotland have said they want from healthcare services. They said they wanted:

Caring and compassionate staff and services
Clear communications and explanation about conditions and treatment
Effective collaboration between clinicians, patients and others
A clean and safe environment
Continuity of care
Clinical excellence

Delivering this quality of care is at the heart of clinical values and the motivation for all healthcare staff, including staff providing antenatal care. Three high level Quality Ambitions have been developed to incorporate these aspects and the internationally recognised six dimensions of healthcare quality-person centred, safe and effective, efficient, **equitable** and timely into the Quality Strategy.

WHAT DO WE KNOW?

The quality of care experience reported by women using maternity care services is strongly socially patterned, declining in satisfaction with social status[12],[13].

Women with complex social problems report that they experience discrimination and judgemental behaviour and that this impacts on their ongoing engagement with services[14]. Women from disadvantaged groups report that they are not given the information they need or communicated with in a way that meets their needs.

[11] NHS Scotland Health Care Quality Strategy http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality
[12] Framework for maternity services 2001 http://www.sehd.scot.nhs.uk/publications/ffmsshow/ffms-00.htm
[13] Record Delivery National Perinatal Epidemiology Unit- https://www.npeu.ox.ac.uk/recorded-delivery
[14] Inequalities Sensitive Practice Initiative- Maternity user Survey http://www.equalitiesinhealth.org/publications.html; NICE Socially complex pregnancies http://guidance.nice.org.uk/CG110

Ongoing engagement with antenatal healthcare is critical for the effective management of risk and to improvements in maternal and infant health outcomes.

KEY MESSAGES

- Staff need to have knowledge and understanding of how social inequalities impact on women's health and health behaviours
- Staff need to understand and be aware of the impact their behaviours and attitudes have on women's engagement with services and women's concordance with advice and treatment
- Continuity of care and carer(s) is particularly important for women at risk of poorer outcomes
- Staff need appropriate training and ongoing supervisory support to safely and effectively manage the care of women and babies in high risk groups

THE NEXT SECTION PROVIDES INFORMATION AND LINKS TO THE SUBSTANTIAL EVIDENCE USED TO DEVELOP THIS ACTION GUIDANCE.

THE EVIDENCE BASE

The Antenatal Health Inequalities Working Group commissioned Health Scotland to carry out a rapid analysis of the evidence. The full Health Scotland report- '***Antenatal health inequalities: A rapid review of the evidence'*** can be accessed at **www.healthscotland.com.**

Health Scotland's review included the recently published NICE guidelines relating to socially complex pregnancies and the National Perinatal epidemiology report regarding infant mortality.

In addition the actions and key messages in this guidance are based on an extrapolation of evidence from the following sources:

- Background Information relating to Inequalities in Antenatal Care: http://www.isdscotland.org/isd/servlet/FileBuffer?namedFile=Information%20on%20Inequalities%20in%20Antenatal%20Care.doc&pContentDispositionType=attachment
- UK Child and Maternal Confidential Enquiries, to which Scotland contributes data; http://www.cmace.org.uk/
- Equally Well: http://www.scotland.gov.uk/Publications/2008/12/10094101/0
- The Early years Framework: http://www.scotland.gov.uk/Topics/People/Young-People/Early-years-framework
- Getting it Right for Every Child: http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec
- Achieving our Potential:http://www.scotland.gov.uk/Publications/2008/11/20103815/0

Membership of Antenatal Inequalities Working Group

Dr Catriona McDonald (Chair)	Independent Public Health Consultant
Dr Claire Alexander	Consultant Obstetrician, RIE
Sally Beautyman	Health Improvement Project Officer, NES
Dr Catherine Calderwood	Senior Medical Officer, Women and Children's Health, Scottish Government
Dr James Chalmers	Consultant in Public Health Medicine, Information Services Division (ISD)
Pauline Craig	Public Health Programme Manager, Glasgow Centre of Population Health
Wayne Duffy	Policy Officer, Maternal and Infant Health, Scottish Government
Christine Duncan	Change Manager, Maternal and Infant Health, Scottish Government
Ann Holmes	Consultant Midwife
Rosemary Hill	Participation Network Manager, Scottish Health Council
Ann Kerr	Team Head, Health Living, NHS Health Scotland
Leslie Marr	Reproductive Health Programme Co-ordinator, NHS QIS
Vicky Milne	Senior Research Officer, Health Analytical Services, Scottish Government
Anncris Roberts	Early Education and Childcare, Scottish Government
Gail Trotter	Family Nurse Partnership Implementation Lead, Early Years, Scottish Government
Sylvia Shearer	Branch Head/Policy Analyst, Maternal and Infant Health, Scottish Government
Andy Bruce	Health Improvement and Health Inequalities, Scottish Government
Dr Sara Twaddle	Health Improvement and Inequalities, Scottish Government
Carolyn Wilson	Branch Manager, Early Years, Scottish Government
Maria Wilson	Head of Midwifery, NHS Lothian

ISBN: 978-0-7559-9885-2

This document is also available on the Scottish Government website:
www.scotland.gov.uk

APS Group Scotland
DPPAS11081 (01/11)