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Australian Longitudinal Study on Women's Health (ALSWH) Submission 2 of 2: Preconception, Pregnancy and Postpartum Care

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Coordinating Authors:
Professor Gita Mishra AO: g.mishra@uq.edu.au
Professor Deborah Loxton: deborah.loxton@newcastle.edu.au

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

THE UNIVERSITY OF QUEENSLAND AUSTRALIA

Submission summary

This submission was prepared by Natalie Townsend and Prof Deborah Loxton and is made on behalf of the Australian Longitudinal Study on Women's Health (ALSWH).

This submission focuses on findings from ALSWH, a long-established national study that takes a comprehensive view of health, and the factors that affect health, across a woman's lifespan. Since 1996, ALSWH has collected data from over 57,000 women in four age cohorts using regular surveys and individual record linkage to administrative health databases, including Medicare (MBS, PBS), hospitals, and perinatal data. ALSWH provides evidence to inform policy development and the provision of health services, and to support new and revised clinical guidelines for health professionals.

This submission outlines findings from ALSWH in relation to preconception, pregnancy and postpartum care for women, with a focus on mental health. Recommendations to improve care for women during preconception, pregnancy and the postnatal period are also included.

The findings presented inform the following Inquiry terms of reference:

a) best practice approaches to postpartum healthcare, including the delivery of physical and mental health support and services for mothers and their partners including those who have experienced infant loss;
b) women's experiences in the postpartum period, including the physical, psychological, emotional and economic impacts of birth;
c) best practice pregnancy and postpartum care models to support long-term maternal physical and mental health;
d) the cost and accessibility of postpartum healthcare, including: infant feeding supports, mental health supports and services, physiotherapy services, including pelvic health services, and related allied health services;
e) antenatal and postpartum reproductive health support and education, including contraceptive care;
l) best practice approaches to assisted reproduction treatments; and
m) access and affordability issues relating to fertility and assisted reproduction treatments.

Submission contacts

Natalie Townsend (Natalie.Townsend@newcastle.edu.au)

Professor Deborah Loxton (Deborah.Loxton@newcastle.edu.au)

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Women's mental health: From preconception to the postpartum period

Depression and anxiety during the preconception period and pregnancy

A history of poor mental health prior to pregnancy is linked to further mental health issues during pregnancy [1]:

- For women born 1973-78, 26% of women with preconception depression reported perinatal depression, compared to 10% of women who did not have preconception depression
- For women born 1973-78, 24% of women with preconception anxiety reported perinatal anxiety, compared to 7% of women who did not have preconception anxiety
- For women born 1989-95, 41% of women with preconception depression reported perinatal depression, compared to 12% of women who did not have preconception depression
- For women born 1989-95, 43% of women with preconception anxiety reported perinatal anxiety, compared to 18% of women who did not have preconception anxiety

Recommendation: Given the high rates of perinatal recurrence in women with preconception anxiety and/or depression, it is important to address mental health problems as part of preconception care, and to screen women for mental health problems during and after pregnancy.

Symptoms of depression and anxiety and social support during pregnancy

A high proportion of pregnant women experience symptoms of depression and anxiety [2]:

- 25% of pregnant women born 1973-78 had depressive symptoms when they were aged 34-39
- 21% of pregnant women born 1973-78 had anxiety symptoms when they were aged 34-39

Low social support is experienced by pregnant women in Australia [3]:

- 7% of pregnant women born 1973-78 reported low social support when they were aged 34-39

Social support may play a role in antenatal symptoms of depression and anxiety [2]:

- Among women born 1973-78, the odds of antenatal depressive symptoms was approximately three times higher among pregnant women who reported low social support compared to those with high social support
- Among women born 1973-78, the odds of antenatal anxiety symptoms was seven times higher among pregnant women who reported low affectionate support/positive social interaction than those who reported high affectionate support/positive social interaction

Social support plays a direct and mediating role in improving the health-related quality of life of pregnant Australian women [4]:

- Among women born 1973-78, emotional/informational support, tangible support, and affectionate support/positive social interaction played a significant mediating role in the relationship between perceived stress and mental health-related quality of life

Recommendation: Pregnant women should be screened to determine their level of social support during routine antenatal care. Programs which target improving social support and mental health for pregnant women should be developed and implemented.

Psychological and emotional impacts of birth

Traumatic birth experiences are common among Australian women [5]:

- 46% of women born 1989-95 experienced a traumatic birth the first time they gave birth
- 37% of women born 1973-78 experienced a traumatic birth the first time they gave birth

Australian women also commonly experience multiple traumatic birth experiences:

- Among women born 1989-95 and 1973-78 reporting traumatic birth experiences, more than one in four experienced two types of birth trauma [5]

Among Australian women, emotional distress during labour is associated with other traumatic birth experiences, including [6]:

- Labour interventions (induction, episiotomy, forceps or vacuum, emergency caesarean)
- Excess blood loss
- Long labour
- Premature birth
- Stillbirth

Traumatic birth experiences are associated with an increased risk of poor mental health in the postnatal period [5]:

- Among women born 1989-95, those who had experienced a traumatic birth were 74% more likely to be diagnosed with postnatal depression and anxiety, compared to those who had not experienced a traumatic birth
- Among women born 1973-78, those who had experienced a traumatic birth were 63% more likely to be diagnosed with postnatal depression and anxiety, compared to those who had not experienced a traumatic birth

Recommendation: The strong association between traumatic birth experiences and poor perinatal mental health underscores the need to include past traumatic birth experiences in psychosocial risk assessment during subsequent pregnancies. There is also a need to integrate evidence-based recommendations for the prevention and management of physical and psychological birth trauma into maternity-related policies, clinical practice guidelines and training and professional development packages.

Postpartum depression

There is evidence of generational differences in postpartum depression [7]:

- The prevalence of postpartum depression diagnoses at age 22-27 has doubled in the generation born 1989-95 compared to the generation born 1973-78
- The prevalence of postpartum depression symptoms at age 22-27 has increased by 60% in the generation born 1989-95 compared to the generation born 1973-78
- The higher prevalence of postpartum depression in the 1989-95 cohort was mainly due to the high prevalence of pre-pregnancy depression

Recommendation: Postpartum depression has increased for the current generation of young women compared to the previous generation. The drivers behind this increase should be examined in future research. Strategies that manage pre-existing depression may benefit the prevention of postpartum depression for the current generation of young women and warrant further investigation.

Mental health service use after birth

There is an increase in uptake of government-subsidised mental health services among women who have given birth:

- Use of government-subsidised mental health items increased 2.7-fold among perinatal women born 1973-78 in NSW between 2009 and 2015 (4% versus 11%, respectively), compared to a 1.3-fold increase among non-perinatal women (6% versus 8%, respectively) [8]

Recommendation: The findings suggest that women are increasingly accessing mental health services after giving birth. While an increase in uptake may indicate improvements in accessibility of mental health services, there is a need to understand the drivers behind a possible increased need.

Health behaviours during and after pregnancy

There is evidence that women change their diet during pregnancy [9]:

- Women born 1973-78 appear to improve the consumption of healthy diets during the pregnancy period
- Changes in health dietary patterns from preconception to during pregnancy are associated with:
    - Education
    - Marital status
    - Income
    - Area of residence

Some dietary habits are linked with physical health outcomes:

- Frequent artificially sweetened beverage consumption during pregnancy was associated with a higher risk of gestational diabetes mellitus among women born 1989-95 and 1973-78 [10]

Physical activity during pregnancy has been linked with better mental health:

- Antenatal anxiety was less prevalent in women born 1973-78 who reported low or moderate physical activity during pregnancy than in those who reported no activity [11]

Among women born 1973-78, having children is associated with [12]:

- Increased weight and energy intake
- Decreased physical activity
- Increased diet quality
- Decreased sitting time

Recommendation: Strengthening advice in antenatal and postnatal care could be important to improve women's awareness and attitudes towards the role of healthy lifestyle choices before, during and after pregnancy.

Fertility and treatments for infertility

Diet and fertility

There is a relationship between diet and fertility [13]:

- A diet with greater inflammatory potential was associated with higher odds of self-reported fertility problems among women born 1973-78
- Higher dietary quality was associated with lower odds of self-reported fertility problems among women born 1973-78
- Consumption of a Mediterranean-style dietary pattern was associated with lower odds of self-reported fertility problems among women born 1973-78

Recommendation: A healthy diet may support female fertility and warrants further investigation.

Fertility issues and mental health services

Women with fertility issues access mental health services:

- Women born 1973-78 who were childless due to fertility issues had higher odds of using government-subsidised mental health services and attending mental health treatment sessions compared to women who had given birth in a calendar year [14]

Recommendation: These findings suggest that routine mental health screening should be integrated into fertility care.

Experiences of violence and fertility

Experiences of intimate partner violence have been linked with poor reproductive outcomes. Among women born 1989-95 and 1973-78, exposure to intimate partner violence significantly increases the likelihood of [15, 16]:

- Infertility
- Miscarriage
- Pregnancy termination

Recommendation: Guidelines and protocols for managing intimate partner violence and the associated reproductive health risks among women should be in place and support services must be available for practitioners to refer to.

Assisted Reproduction Treatment

There is some evidence on the use of Assisted Reproduction Treatment (ART) and the associated costs [17]:

- There has been an increase in total out of pocket cost for ART between 2006 and 2012 among women born 1973-78
- In 2012, the maximum amount paid in out-of-pocket costs among women born 1973-78 was $12,916 compared to $2,778 in 2006
- Despite this increase in out-of-pocket costs, the use of ART became less inequitable after a policy change in 2010
- Low and decreased bulk-billing rates were found for ART items from 2006 to 2012

Recommendation: The cost of ART may act as a significant barrier to uptake of ART. A review of costs and available subsidies should be undertaken.

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