“Where did it start for you?” Understanding the pre-pregnancy experiences of BAME women

CREATE Health Foundation

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Foreword

BAME women are more likely to die in childbirth than white women.[1] Each year, the national audit programme Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) has continued to report this shocking fact, but maternal deaths are just one tragic outcome of a much broader context of inequality. For every reported death, there are multiple other stories of 'near misses' and poor experiences.

We are looking beyond 'survival' as the marker of a good outcome in pregnancy. Our aim with this research is to understand the longer journey that women have towards childbirth, including before conception. We can only expect outcomes to become truly equitable when all women, irrespective of race and social background, are supported and respected to make informed choices about their bodies and pregnancy at every step of the way.

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[1] MBRRACE-UK (2022). 'Saving Lives, Improving Mothers' Care 2022: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2018-20'. Retrieved from: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf

Executive Summary

There is no "one size fits all" journey to becoming a mother. Each person's journey is full of personal decisions. Women may be able to choose when they want to become pregnant; how to tell their family, friends and colleagues about their pregnancy; how they want their baby to be delivered; and what kind of perinatal support they would like. People using healthcare services are rarely faced with so many choices and decisions. For a safe and satisfactory experience and outcome to be possible, women must be sufficiently supported in making these choices with the right information and care.

But we know from the "Women's Health – Let's Talk About It" survey launched by Department for Health and Social Care in 2021 that only 59% of women feel that they can access enough information on **how to prepare** for or prevent a pregnancy.[2] There is a **lack of consensus and understanding of what good care should look like**, particularly during early phases leading up to pregnancy.

Meanwhile, the landmark MBRRACE report from 2022 highlights one of the most pervasive **racial health inequalities** of our time, which is poorer maternal outcomes for BAME women in the UK. Higher rates of maternal death and poor maternal outcomes for Black, Asian, and Mixed Ethnicity women in the UK were reported. Black women were found to be 3.7 times more likely to die during or up to 6 weeks after pregnancy compared to White women.[3] The report also found that by the same metric, Asian women were 1.8 times more likely to die than White women.

While there have been several studies analysing BAME women's end-to-end pregnancy journeys from their perspective, in this report we sought to understand whether these racial inequalities would also exist in pre-pregnancy care, information and preparation and whether these would show differences which would affect the outcome of the pregnancy. Our research also investigates the extent to which women were empowered to make choices, and how far their choices were respected. This report shares two stories from BAME women. They share their experiences of the beginning of their journeys towards motherhood and how this affected their wider experience of motherhood and outcome of their pregnancy. We focus on three key themes:

[2] GOV.UK (2022). 'Results of the 'Women's Health – Let's talk about it' survey'. Retrieved from: https://www.gov.uk/government/consultations/womens-health-strategy-call-for-evidence/outcome/results-of-the-womens-health-lets-talk-about-it-survey; Contraception and pregnancy prevention are outside of the scope of this research.

[3] MBRRACE-UK (2022). 'Saving Lives, Improving Mothers' Care 2022: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2018-20'. Retrieved from: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf

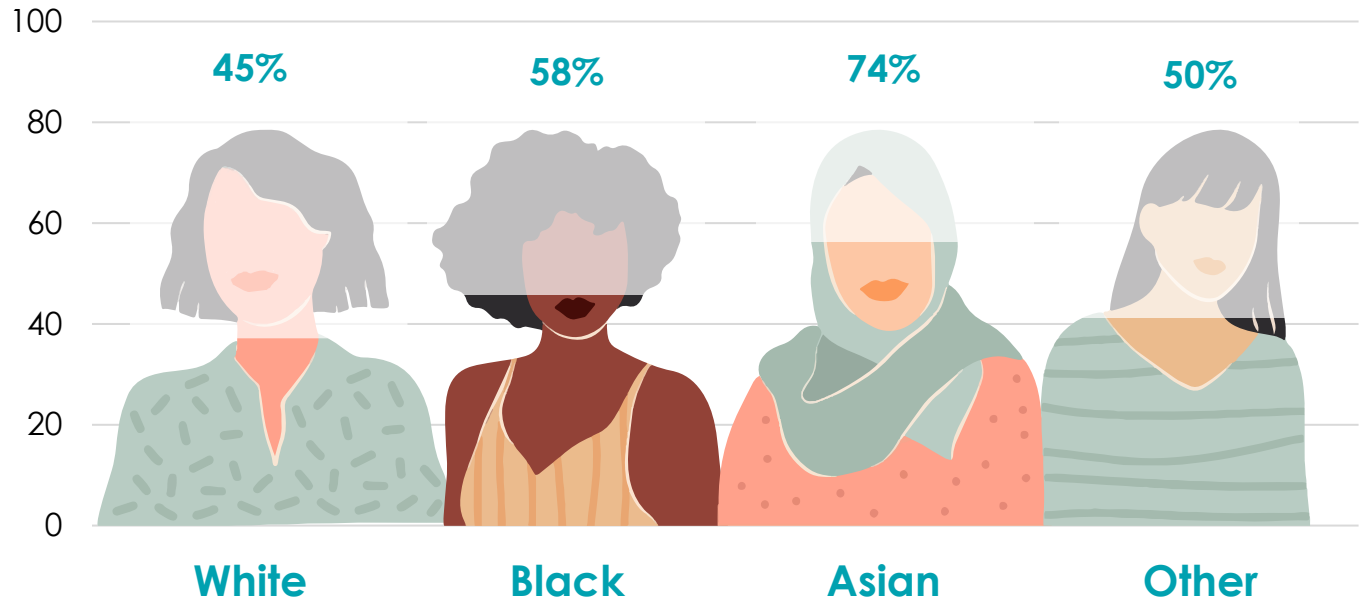
1. Awareness	2. Access	3. Care
What women know about maximising the chances of a healthy pregnancy, and how to get support in doing so	The extent to which **information and services are open and easy to use** for all women	**How women are treated** when using pre-pregnancy and maternity services

Many of the barriers to awareness, access and care exist before pregnancy. We have looked at 'pre-pregnancy' as the period before conceiving a child, where women either received or would have liked to receive advice or support about becoming pregnant, having a healthy pregnancy, or otherwise preparing for child rearing. Pre-pregnancy advice and support can include NHS advice and services (including obstetric medicine clinics); advice from friends and families; private or third sector services, or media sources in general.

'Pre-pregnancy' services lack consistent language and signposting in the NHS service directory, through GPs, and online sources more widely. This stage of pregnancy is not well defined, with a lack of agreed and shared language to help women find the advice and support they need. This can create an unmet need that leaves women less prepared, informed, and confident for their pregnancy journey.

"Having more knowledge of pre-pregnancy services would have helped me have a better pregnancy"

% Strongly agree or agree



**Unless otherwise stated, all statistics represent our survey findings*

Importantly, pre-pregnancy can also vary dramatically in terms of length. Women plan and try to become pregnant for different amounts of time and some have unplanned pregnancies. We have therefore allowed women to determine the length of their own pre-pregnancy period.

We believe that the ideal future state of pre-pregnancy provision must be designed based on the following core principles, linked to the three key themes of our research:

1. Awareness	2. Access	3. Care
• When women are looking for advice and support, including for pre-existing health conditions, it is available and easy to find. • Women can be signposted appropriately to advice or support with accessibility in mind. • Women are clear on what needs are a must-have or a recommendation, and where they may have choice to exercise.	• There are multiple routes to access information and support, including: digital and non-digital, formal and informal routes, with cultural sensitivity and accessible language, maximising community assets.	• All women are treated equally well with compassion and non-judgmentally, with their choices around pregnancy respected. • Care-related conversations are collaborative and non-paternalistic.

For this report, we conducted a survey of over 300 women in the UK who have been, or tried to become, pregnant within the last 10 years to identify the broader pre-pregnancy experience of women in the UK. We then conducted in-depth interviews with 15 women to explore some of these key themes and to reveal the nuance behind each individual's maternity journey.

Within our survey respondents there was a slightly higher representation of women with a medium to higher socioeconomic status, residing in London, and over 30 years of age. The sample from our surveys and interviews are not wholly representative of all pregnancy journeys in the UK. There is a skew towards planned pregnancies and women residing in areas with lower levels of deprivation. Our findings do, however, highlight key areas of concern, and prompt further conversation and research. To ensure equity of access, awareness, availability and care for pre-pregnancy provision regardless of ethnicity, recommendations have been proposed following our key actionable research findings:

Awareness

Despite similar levels of self-reported access to pre-pregnancy information, BAME women voiced a greater need than White women for information earlier on and felt unable to navigate maternity care. Our survey demonstrates that women across all ethnic groups generally reported similar levels of confidence and knowledge in finding useful pre-pregnancy health advice and service information, but Asian (74%) and Black (58%) women more strongly believe than White women (45%) that having more knowledge of pre-pregnancy services would have helped them have a better pregnancy.[4] Given the increased prevalence of comorbidities and health complexities in pregnancy such as sickle cell disease and hypertension in BAME communities, there is a growing demand for personalised health information and advice.

"I realised early on that I'd need to inform myself. They can catch you off guard in the appointments so you have to go in knowing what's within your rights."

Asian woman, age 36-40

Our interviews indicate that those with personal ties to the healthcare system knew more about 'the right words to say' and what to ask for in a healthcare setting in order to ensure they would receive high quality treatment. Those that were less connected to 'insider knowledge' felt a strong impetus to arm themselves with knowledge to try and advocate for themselves.

Our interviews also revealed that women perceive a significant gap in information and guidance specifically tailored to pre-existing conditions and comorbidities, such as mental health conditions and gestational diabetes. While some women were able to access personalised and high quality information, this was not universal. Throughout the interviews conducted, BAME women reported an unmet need for information tailored to their health and demographic circumstances, noting that their personal health histories were not adequately addressed during pregnancy.

Recommendations

- **Unify terminology around pre-pregnancy services** and undertake an educational campaign to increase awareness of service provisions
- Encourage **primary care staff** including, but not limited to, GPs to build higher awareness of **trusted online and offline community groups** (e.g. FivexMore, Black Mothers Matter, The Motherhood Group) to **signpost patients and promote greater education**
- Support services to deliver **ethnically specific and culturally sensitive pre-pregnancy advice**, e.g. via Maternity Voices Partnerships (MVPs), local maternity systems, GPs and other community groups as an accessible choice

[4] A chi-square test of independence demonstrated statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements differed by ethnicity group, X^2, (2, N=297)=15.97, p<0.001.

- Create an **educational campaign to boost awareness of guidelines and services** via community and faith groups, with different language options
- Increase investment for **midwifery teams** to provide **community engagement and outreach** starting from pre-pregnancy
- Consider piloting a **digital one-stop-shop** resource providing pre-pregnancy support for target groups

Access

Access to pre-pregnancy support is inconsistent amongst ethnic groups, and different women also seek support through different avenues.

> **"I had to email again and again to get help. It felt like I'd been failed everywhere, and it's only because of my job that I knew to keep chasing"**
>
> **Asian woman, age 36-40**

Amongst BAME women, community and social groups were better trusted and more often used sources of pre-pregnancy information and support than for White women. In our survey, overall, **White women reported trust in the overall health services in the UK at a higher rate (78%) than Asian women (61%) and Black women (63%).**[5] There need to be further efforts to strengthen trust in healthcare for all if our healthcare system is to be able to address current inequalities. BAME women reported significant barriers and gaps in communicating their options and needs when using healthcare services. They remarked on both perceived and internalised feelings of stigma when approaching healthcare services, especially professional mental health support.

Yet, BAME women also reported a greater desire for more NHS pre-pregnancy support. The patterns in access suggest an area of unmet need for BAME women. As they perceive barriers to getting what they need via standardised healthcare routes, they may make more frequent visits in an effort to try and get what they need or otherwise turn to family, friends, or community to fill gaps. While frequent use may be driven by concerns over pre-existing health, our interviews revealed the need for more tailored services. BAME women consistently voiced a desire for more information to help them navigate the healthcare system and make sense of services or advice.

Access challenges can accumulate over time. An absence of open dialogue in pre-pregnancy or early pregnancy about the options available can set a precedent for a lack of consultation and collaborative decision-making closer to birth.

Recommendations

- Provide pre-pregnancy advice and support **through sources that BAME women trust**, with more accessible language and communication styles

[5] A chi-square test of independence demonstrated statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements differed by ethnicity group, X^2, (2, N=194)=40.75, p<0.001.

- Improve education for healthcare professionals (GP, midwives) on how to provide culturally unbiased conversations and choices for pre-pregnancy and wider maternity care
- Improve **access to perinatal mental health teams** for BAME women
- Strengthen links between antenatal care and **digital pregnancy interventions and programmes** (e.g. NHS Digital Redbook) to support women to more effectively navigate services and select the provider best for them from pre-pregnancy
- Engage in **government lobbying for improved funding for pre-pregnancy services** for all women
- Increase pre-pregnancy provision through **neighbourhood-level and PCN-led (Primary Care Network) service developments** to enable tailored service designs, accommodating local needs
- **Target areas of high deprivation** to ensure MVPs have a strong community voice and lobbying power for local pre-pregnancy and end-to-end maternity services

Care

"It's always a fight"

Black African woman, age 31-35

Our interviews demonstrated how BAME women can feel discriminated against, judged, or otherwise treated differently than White women. These women were often forced to advocate for their own care. They felt their feelings of pain were dismissed; felt they were placed in a situation where they must fight for their healthcare rights; or felt that they were not offered empathetic care. These stories highlighted how the pregnancy experience for BAME women is multifaceted and emotionally exhausting for many who are mindful of cultural stigmas and stereotypes. Whether women had a supportive or disruptive relationship with a healthcare provider could often make all the difference in their journey.

Our interviews show that this lack in high-quality personalised care was also evident for women who had previously been pregnant and endured a traumatic birth or pregnancy. Here, inter-pregnancy care, which could have offered women support to process their previous experiences and prepare for another pregnancy, was often withheld due to the assumption that only first-time mothers require support before a birth.

Beyond tragic maternal outcomes, little data is recorded and scrutinised to capture the complicated and stigmatised reality of BAME women's pregnancy journeys. While this report explores the maternity journey for BAME women, there needs to be further intersectional research on how socioeconomic factors, age, or other characteristics impact with or separately from race to alter the quality of maternity experiences throughout the UK.

Recommendations

- **Improve education and the medical school curriculum** on what it takes to offer holistic, high quality care throughout the whole pregnancy journey
- Support NHS, National Childbirth Trusts and community groups to offer **more accessible and ethnically representative groups**, with options for women to **join in their pre-pregnancy stages**
- Develop **NICE guidelines** for pre-pregnancy advice and support specifically for women from BAME backgrounds, taking into account their higher risk status
- Provide **inter-pregnancy advice**, with sensitivity to previous **birth traumas or miscarriages**
- **Improve data collection at national level to capture the holistic pregnancy experience** to link with maternity outcomes e.g. pre-pregnancy service use, birthing plans
- Conduct **regular local audits of pregnancy care** including data on ethnicity
- Investigate and address barriers to **providing adequate and equitable pain management and birth interventions** across ethnicities
- Review **diversity and sensitivity training**, and recruitment and onboarding strategies to ensure **staff makeup is ethnically representative of the population**

Overall, we see this piece of research as the first step in addressing an understudied and under-served area. Whilst more work is needed to define best practice, design services, and measure the impact of better pre-pregnancy support for BAME women, we believe we have presented compelling evidence as a starting point to further explore how to meet the needs expressed by the women in this report.

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About this report – Introduction and context

Poorer maternal outcomes for BAME women in the UK has emerged as one of the most pervasive health inequalities of our time, and is deeply rooted in the pre-existing racial inequalities. In its annual 2022 report on maternal deaths, MBRRACE detailed higher rates of maternal death and poor maternal outcomes for Black, Asian, and Mixed Ethnicity women in the UK. Its key finding that Black women were 3.7 times more likely to die during or up to 6 weeks after pregnancy compared to White women has sparked outrage and became a battle cry to correct the disparities and trauma underpinning the BAME maternity experience.[6] In addition to higher mortality rates, poor antenatal and postnatal health, and experiences of racism or discrimination by healthcare professionals serve as all too familiar narratives of the BAME maternity experience and merit further attention.

A range of efforts and taskforces in response to MBRRACE's work, including the Ockenden report and the Race Equality Taskforce under Royal College of Obstetricians and Gynaecologists, have prompted discussions on best practices and new maternity care guidelines.[7] Current guidelines now champion the importance of collaboration between providers, commissioners, and their communities to meet various needs. Underpinning guidance for pre-pregnancy services, antenatal care, and postnatal care is the expectation that commissioners and providers ensure that all relevant health information and appropriate maternity services are clear, accessible, and proactively offered to all patients. This aligns with the three-year delivery plan for maternity and neonatal services published by NHS England (NHSE) in March 2023, as well as the Black maternal health report by the House of Commons in April 2023 which stresses that equity of care will only be achieved by offering patients compassion and personalised care to address all aspects of their health and social complexities.[8]

6 MBRRACE-UK (2022). 'Saving Lives, Improving Mothers' Care 2022: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2018-20'. Retrieved from: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf

7 Department of Health and Social Care (2022). 'Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services'. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064303/Final-Ockenden-Report-print-ready.pdf

8 NHS England (2023). '3-Year delivery plan for maternity and neonatal service'. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf; House of Commons (2023). 'Black maternal health'. Retrieved from: https://committees.parliament.uk/publications/38989/documents/191706/default/

The framework for maternity service standards put forward by the Royal College of Obstetricians and Gynaecologists (RCOG) highlights the timelines and types of services that patients should access at various stages of pregnancy.[9] If a patienst has no medical disorders, a low-risk pregnancy, and an uncomplicated birth, they should therefore have the following experience and services offered during their pregnancy:

Pre-pregnancy	Antenatal	Birth	Postnatal
Prior to pregnancy Given key public messaging and tailored advice	**Pregnancy** Antenatal care accessed prior to 10 weeks gestation Given a named midwife for the duration of pregnancy Offered screenings, referred to specialist services, and given counselling especially if the patient has complex social needs of a medical disorder	**Intrapartum Care** Provided unbiased information for each birth option, and is able to access all options **OR Elective Birth** Given an open discussion with a provider who determines to induce labour or provide a caesarean section based on an individual approach	**Up to 6-8 weeks after birth** Individual needs are immediately addressed, usually by midwife Follow up appointments arranged before discharge Physical, emotional, and mental health continually assessed and reviewed again at 6-7 weeks after birth Breastfeeding support and instruction Provided information and contact details to discuss their baby's health, and their emotional wellbeing

The reality, however, is that many BAME women do not uniformly experience a pregnancy according to these 'best practices'. While RCOG's maternity care recommendations outline the evolving needs of patients at each stage of pregnancy (from pre-pregnancy to postnatal care), there is no shared understanding of what inequality looks like in pre-pregnancy care, as compared to antenatal care where microaggressions and inequitable treatment are widely documented by the BAME community. In the pursuit of equitable and compassionate healthcare, an individual's ability to receive high quality care rests on their awareness of these services, their ability to physically reach services, if the services are accessible, and whether the service is itself of high quality. When in their journey do BAME women start experiencing disparity in the pregnancy experience? Can we stop poorer outcomes for BAME women early into pregnancy or even before pregnancy?

9 Royal College of Obstetricians & Gynaecologists (2016). 'Providing Quality Care: A Framework for Maternity Service Standards'. Retrieved from: https://www.rcog.org.uk/media/xt2fqcw0/maternitystandards.pdf

Taking a life course approach throughout a BAME woman's pregnancy journey, there are 3 keys gaps within known barriers that need to be addressed:

Limited accessible information and health literacy: **AWARENESS**

BAME women, particularly migrant women, lack information or knowledge of existing healthcare services, their entitlements, or pregnancy related health advice. While it is up to providers to support access and offer information, there is the assumption that birthing people have some level of pre-existing knowledge of maternity health advice and services, such as to not drink alcohol and that a midwife is a pregnancy specialist. Yet, studies have consistently highlighted that migrant women may not know of these services, and aren't actively given this information. Ultimately, limited antenatal education has been identified as a barrier to care and support, and contributes to anxiety around intrapartum care and labour.

OUTSTANDING QUESTIONS:

What barriers prevent BAME women from being able to seek out accurate information throughout and prior to their pregnancy journey?

Do BAME women get sufficient information and advice they need from various sources?

Digital exclusion: Does digital exclusion influence how BAME women build their awareness?

Formal education: Are BAME women disadvantaged by barriers to formal education?

[10]

[10] Higginbottom, G. M. A, & et al. (2019). 'Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review.' BMJ open, 9(12): e029478; Womersley, K., Ripullone, K., & Hirst, J. E. (2021). 'Tackling inequality in maternal health: Beyond the postpartum.' Future Healthcare Journal, 8(1): 31; Henderson, J., & Redshaw, M. (2017). 'Sociodemographic differences in women's experience of early labour care: a mixed methods study'. BMJ open, 7(7), e016351.

Cultural and social barriers: **ACCESS**

Cultural barriers, including religious and language barriers, have been pointed out by both midwives and pregnant BAME women as an obstacle to getting quality care. Cultural and social barriers can consist of providers' lack of awareness of or insensitivity towards religious values or cultural norms, competing cultural expectations on the role of healthcare professionals during pregnancy, and fractured communication between patients, providers, and their family or interpreters. These barriers are largely noted by migrant women, who are disproportionately BAME, and the healthcare staff treating them. Cultural barriers can even encompass the differing terms BAME women may use to describe their symptoms, delaying diagnosis and treatment.

OUTSTANDING QUESTIONS:

What are the cultural barriers facing BAME women who were born in the UK or deeply familiar with British culture and the NHS?

Are BAME individuals fearful of mental health services, and do they experience cultural stigma and internalised stigma in accessing care?

[11]

[11] Roozbeh, N., Nahidi, F., Hajiyan, S. (2016). 'Barriers related to prenatal care utilization among women'. Saudi Medical Journal, 37(12): 1319–1327.; Boerleider, A.W., Wiegers, T.A., Manniën, J. & et al. (2013). 'Factors affecting the use of prenatal care by non-western women in industrialized western countries: a systematic review.' BMC Pregnancy Childbirth, 13(81): https://doi.org/10.1186/1471-2393-13-81; Hassan, S. M., et al. (2020). 'A qualitative study of healthcare professionals' experiences of providing maternity care for Muslim women in the UK.' BMC Pregnancy and Childbirth, 20(1): 1-10; Konje, J.K., & Konje, J.C. (2021). 'Experiences of accessing maternity care in the UK: Perspectives from Somali migrant women in Leicester'. European Journal of Midwifery, 13(5): 56; Khan, Z. (2021). 'Ethnic health inequalities in the UK's maternity services: a systematic literature review.' British Journal of Midwifery, 29(2): 100-107; Garcia, R., Ali, N., Papadopoulos, C. & et al. (2015). 'Specific antenatal interventions for Black, Asian and Minority Ethnic (BAME) pregnant women at high risk of poor birth outcomes in the United Kingdom: a scoping review'. BMC Pregnancy Childbirth, 15(226): DOI 10.1186/s12884-015-0657-2; Toh, R. K. C., & Shorey, S. (2023). 'Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation.' Women and Birth, 36(1): 30-38; Jomeen, J., & Redshaw, M. (2013). 'Ethnic minority women's experience of maternity services in England.' Ethnicity & health, 18(3): 280–296.; Heys, S., Downe, S., & Thomson, G. (2021) ''I know my place'; a meta-ethnographic synthesis of disadvantaged and vulnerable women's negative experiences of maternity care in high-income countries.'Midwifery, 103 (2021): 103123.

Poor relations with healthcare staff: **CARE**

Poor relationships with healthcare professionals is a prominent narrative within advocacy pieces and studies on BAME people's experience with health services, culminating in a justified reluctance to use maternity services. Poor previous experiences and perceptions of discriminatory or stigmatised care create a pervasive sense of distrust and unmet expectations, influencing mental health and willingness to engage with healthcare services. BAME women report discrimination, feeling disrespected, or not adequately and equitably treated by providers, perpetuating a mutual sense of distrust and increasing their anxiety surrounding pregnancy-related care. Feelings of 'stereotyping' or not being believed, especially regarding pain management or symptoms, are aptly highlighted in studies that focus on the BAME birthing experience and often reflect the final point in a fraught pregnancy journey.

OUTSTANDING QUESTIONS:

Systemic discrimination: Are BAME women impacted by systemic racism at earlier points in the pregnancy journey?

Fractured relationships: Do previous discriminatory experiences and intergenerational trauma therefore cause BAME women to mistrust maternity care providers, and how can maternity health care workers solidify a bond with their BAME patients?

[12]

[12] BirthRights (2022). 'Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care'. Retrieved from: https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf; House of Commons (2023). 'Black maternal health'. Retrieved from: https://committees.parliament.uk/publications/38989/documents/191706/default/.

Our approach

a. Taking a life course approach

For this research, we took a life course approach to mapping and understanding how barriers and health inequalities manifest for BAME women at different stages of pregnancy. Acknowledging that health and social inequalities are linked to intergenerational experiences and persist throughout one's life, this approach highlights how early health care experiences and inequalities fundamentally inform later ones.[13]

This approach builds upon existing research that argues that earlier lifestyle factors and good health during pregnancy strongly influence a child's wellbeing and educational outcomes.[14] National health guidance has thus come to reflect this approach by attempting to address early experience of health inequalities before they adversely influence long term health outcomes.[15] Emphasising the potential for early intervention, the Maternity Disparities Taskforce highlights pre-conception care and health awareness as a key area for improvement in its mission to improve pregnancy outcomes and its related health inequalities.[16] Pre-pregnancy, pregnancy, and inter-pregnancy will each be shown to be part of a continuum of one's overall health, each playing a substantial part in a woman's wellbeing.

For this piece of research, our key research question was:

> In the context of poorer maternal outcomes and higher mortality, and considering life-course and early preventative measures, how can **awareness**, **accessibility**, and **care** be improved for BAME women across the UK, leading to better maternity outcomes?

Contraception and pregnancy prevention were determined to be outside of the scope of this research.

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[13] This assumption is supported through related research on socioeconomic inequalities and their correlation to long term health inequalities. See: Hurst, L., Stafford, M., Cooper, R., Hardy, R., Richards, M., & Kuh, D. (2013). 'Lifetime socioeconomic inequalities in physical and cognitive ageing.' American Journal of Public Health, 103(9):1641-1648.

14 NHS England (2021). 'Equity and equality Guidance for local maternity systems'. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

15 Public Health England and the Marmot report, amongst others, have reported that social and environmental factors influence a person's mental and physical health over time, placing an emphasis on prenatal and neonatal care as a key opportunity area to address lifelong health and social inequalities. See: Institute of Health Equity (2010). 'Fair Society, Health Lives (The Marmot Review)'. Retrieved from: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review; Public Health England (2019). 'Health matter: Prevention – a life course approach'. Retrieved from: https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach

16 Department of Health and Social Care (2022). 'Maternity Disparities Taskforce: Terms of Reference'. Retrieved from: https://www.gov.uk/government/publications/maternity-disparities-taskforce-terms-of-reference/maternity-disparities-taskforce-terms-of-reference

b. Research methodology

To identify where service provision or other preventative measures do not meet the healthcare needs for BAME women, we analysed health inequalities and experiences of maternal care across each pregnancy stage. The stages were defined as:

Pre-pregnancy	Antenatal	Birth	Postnatal
Undefined period prior to pregnancy, or when planning to become pregnant	Starts at 10 weeks gestation	Birth and transfer of care	Up to 6-8 weeks after birth

The life stages used here are adapted from the Framework for Maternity Service Standards by the Royal College of Obstetricians and Gynaecologists (RCOG).[17] Importantly, pre-pregnancy can vary dramatically in terms of length as some women plan and try to become pregnant for different amounts of time, while some have unplanned pregnancies. We have therefore allowed women to determine the length of their own pre-pregnancy stage, defining it as the period before conceiving, where they received or would have liked to receive maternity care or advice to become pregnant, have a healthy pregnancy, or otherwise prepare for child rearing.

This research was conducted in April and May 2023 through the following methodology, supported by The Public Service Consultants (The PSC):

- **A landscape review** was conducted to determine the scope and existing knowledge of barriers and health inequalities of the BAME maternity experience in the UK. Including in this review were 35 academic peer-reviewed original research articles, 13 scholarly literature review articles, and 5 advocacy research papers.
- **A survey** regarding pre-pregnancy and pre-pregnancy health experiences and services was released and completed by 310 respondents. The composition of the sample is detailed in Appendix B.[18]
- **15 semi-structured interviews** were conducted with primarily BAME women to relay their experiences of pregnancy, pre-pregnancy and to understand what shaped their experiences

[17] Royal College of Obstetricians & Gynaecologists (2016). 'Providing Quality Care: A Framework for Maternity Service Standards'. Retrieved from: https://www.rcog.org.uk/media/xt2fqcw0/maternitystandards.pdf

[18] See 'Appendix B: Research participant breakdown' for more details on research participants and their demographic characteristics.

c. Terminology

Throughout our research and this report we use the term BAME (Black, Asian and minority ethnic) to refer to individuals of non-white ethnicity. This term is used to align with the terminology of existing academic research and is therefore able to be reached by a widespread audience accustomed to using the terms BAME to find relevant literature on the experiences of individuals of varying ethnicities.

Our breakdown of each ethnic grouping is based on the ethnic groupings of the 2021 census as shown below:

Asian or Asian British
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background (for example: Filippino, Korean, etc)

Black, Black British, Caribbean or African
- Caribbean
- African
- Any other Black, Black British, or Caribbean background

Mixed or multiple ethnic groups
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed or multiple ethnic background

White
- English, Welsh, Scottish, Northern Irish or British
- Irish
- Gypsy or Irish Traveller
- Roma
- Any other White background (for example: Persian, Polish, etc)

Other ethnic group
- Arab
- Any other ethnic group

We also use the term 'women' throughout this report to refer to those who are planning to become pregnant, are pregnant, and give birth. We acknowledge that not all birthing people identify as women and that maternity and pre-pregnancy related services must be inclusive.

Key findings: Awareness, Access and Care

Awareness of pre-pregnancy support

Section summary

Women across all ethnic groups generally reported similar levels of confidence and knowledge in finding useful pre-pregnancy health advice and service information, but in our survey, Asian (74%) and Black (58%) women more likely to believe than White women (45%) that having more knowledge of pre-pregnancy services would have helped them have a better pregnancy. For one Black woman interviewed, 'it's always a fight' to get the services and information she needs.

Those with personal ties to the healthcare system knew more about 'the right words to say' and what to ask for in a healthcare setting in order to ensure they would receive high quality treatment. Those that were less connected to 'insider knowledge' felt a strong impetus to arm themselves with knowledge to try and advocate for themselves.

There was also a significant gap in information and guidance specifically tailored to pre-existing conditions and comorbidities. While some women were able to access personalised and high-quality information, this was not universal. BAME women reported an unmet need for information tailored to their health and demographic circumstances.

BAME women and White women report similar levels of confidence in their knowledge about how to maximise their chances of having a healthy pregnancy.

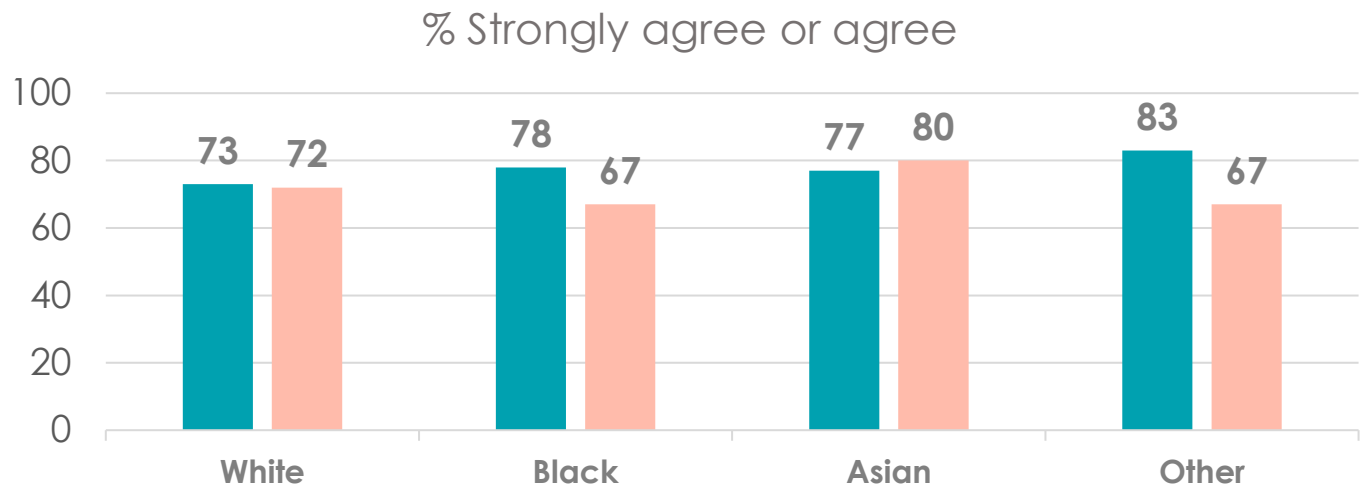
Our survey results reveal that across all ethnicity groups, women have similarly high levels of confidence in their pre-pregnancy knowledge. Overall, 73% of White women, 69% of Black women and 80% of Asian women stated that they agreed or strongly agreed to the statement 'I felt confident in my knowledge about how to maximise the chances of having a healthy pregnancy'. [19]

[19] A chi-square test of independence demonstrated a lack of statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements did not differ by ethnicity group, X^2, (2, N=293)=3.25, p=0.20.

A similar pattern was found regarding their ability to find pre-pregnancy related services in their area. All ethnicity groups had similar proportions of women who strongly agreed or agreed to the statement 'I was able to find useful information about how to have a healthy pregnancy during pre-pregnancy'. [20]

"I was able to find useful information about how to have a health pregnancy during pre-pregnancy"

"I felt confident in my knowledge about how to maximise the chances of having a healthy pregnancy"



Women in pre-pregnancy 'don't know what they don't know', and express a demand for more advice and help in these early stages

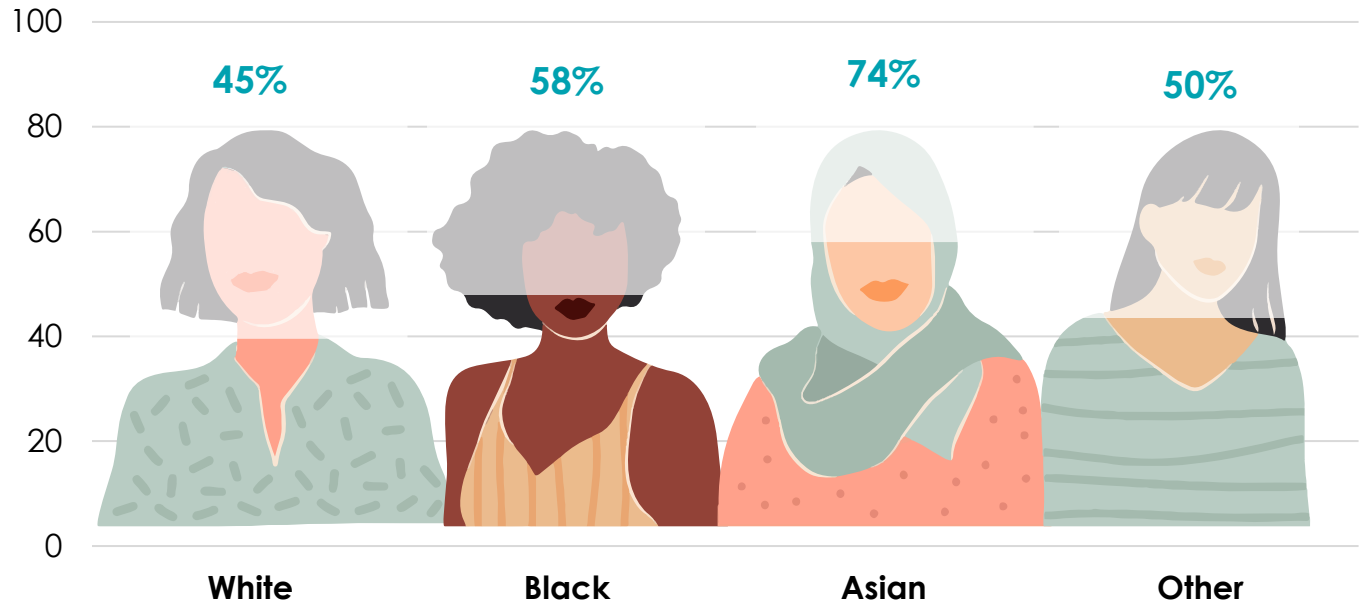
Despite the fairly high confidence levels reported regarding knowledge of how to have a healthy pregnancy, women expressed a need for more awareness of what services or help to search for or ask about in the early stages.

20 A chi-square test of independence demonstrated a lack of statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements did not differ by ethnicity group, X2, (2, N=293)=0.90, p=0.64.

In our survey, Asian and Black women in particular were more likely to report having a strong belief that having **more knowledge of pre-pregnancy services would have helped them have a better pregnancy**. Approximately 74% of Asian women and 58% of Black women strongly agreed or agreed to the statement compared to 45% of White women.[21] This was one of the greatest areas of variation in the survey, **strongly indicating an unmet need** in pre-pregnancy services that affects the experience of BAME women.

"Having more knowledge of pre-pregnancy services would have helped me have a better pregnancy"

% Strongly agree or agree



Women's ability to get high quality information during pre-pregnancy stages can depend on the how close the woman's personal network is to the healthcare system

Our interviews reveal a more nuanced picture, with variation in levels of awareness depending on their individual context. Some women we interviewed noted that they were able to access highly accurate and personalised pre-pregnancy information, but these women were often either a healthcare professional themselves or closely related to a healthcare professional.

For Melika, her husband was able to rely on his medical background to offer her pre-pregnancy advice and ensure that she would have all the correct vitamins and supplements to prepare for her last pregnancy at age 40.[22] Her husband saw to it that all

21 A chi-square test of independence demonstrated statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements differed by ethnicity group, X2, (2, N=297)=15.97, p<0.001.

22 Pseudonyms are used throughout to protect the identities of those interviewed.

tests were conducted and that Melika was well prepared for a higher risk pregnancy due to her age. He gave Melika a clear understanding of the necessary vitamins and other steps she could take to have the best pregnancy experience possible. This support continued into the delivery room, where Melika's husband made a personal request to his colleagues to take great care of his wife as she gave birth.

"It's always a fight"

– Alicia (Black woman, age 31-35)

Yet, despite also being able to access a great deal of pre-pregnancy knowledge before deciding to become pregnant, Alicia found healthcare staff less receptive to her exercising agency over her pre-pregnancy and pregnancy journey. Alicia is herself a sexual health nurse, and was confident in her own knowledge on how to have a healthy pregnancy. She felt like she knew how to advocate for herself and how to ask for the support she needed before and during pregnancy, but therein lies the problem – she always had to advocate as 'it's always a fight'.

As a Black woman, Alicia felt that there was an assumption that Black women 'don't research' and are generally less informed on healthcare and pregnancy matters. Alicia's experience therefore showcases an assumption that women are responsible for conducting thorough research of the pre-pregnancy and pregnancy journey.

Navigating the system and understanding or identifying services is therefore a daunting task. The lack of available advice and services for the pre-pregnancy stage appears to inhibit women's ability to become assured and prepared for the choices and risks they may face during pregnancy. The NHS service directory does not currently include list services that are specific to offering pre-pregnancy support or provide pre-pregnancy advice, although some clinics and hospital maternity units offer pre-conception related services. **Without unified and intelligible language and signposting for pre-pregnancy services, pre-pregnancy services remain inconsistent and obscured.** Pre-pregnancy advice can be buried within a plethora of services such as obstetric medicine clinics that women might not be actively encouraged to reach out to during pre-pregnancy, demonstrating a need to better define and promote these services. Placing the onus entirely on women to understand services and options available to them can exaggerate potential inequalities due to differing levels of digital literacy and education. It can also diminish the role of providers to effectively signpost women to trusted sources of information, and ensure information is accessible and clear if women are able to be largely aware of the services they want and need.

Pre-pregnancy guidance is too generic and not tailored to specific circumstances and needs

Every person who gives birth in the UK is different. Their needs, their health history, their worries, and their concerns are all a reflection of their own thoughts, opinions and experiences. However, our interviews revealed **a perceived lack of pre-pregnancy advice tailored to individual health concerns or circumstances**. This lack of specific advice left one of our interviewees without adequate mental health care provision for her

entire pregnancy. While there are some key steps the NHS recommends women with specific pre-existing conditions and comorbidities need to take during pre-pregnancy, such as to see a diabetes specialist if they are already living with diabetes or to manage one's weight if overweight or obese, most advice hinges on the principle of simply being healthy. For many of our interviewees, this message did not offer enough guidance or reassurance for their needs.

> ***"There really isn't a lot available. I was naïve the first time round; in the second time you're more confident. But even then, there wasn't anything there – nothing on how to support my mental health or look after two children. It might be different now, but there was very limited info on the NHS website. If there is anything, it's hidden or you have to pay for it, or an e-guide, or tips that are super generic."***
>
> *– Shanaya (South Asian woman, age 36-40)*

Brianna felt that, when preparing for her second pregnancy, she could not find any relevant advice. After scouring the internet and going to her local library, she could only find a recommendation to take folic acid and otherwise just stay healthy. Reflecting on her experience she said, "If someone came to me now, and asked for pre-pregnancy advice, I have nothing to tell them because **I couldn't find any useful information for myself**….[On the advice to get tested for STIs before pregnancy, this] is normal adult behaviour".

For women with pre-existing medical conditions, and those on medication, an awareness of the possible impact of some medications would have better helped them prepare on how to manage their health during pregnancy. For Boudica, she found herself taken off certain medications without clear warning or an alternative, taking a big toll on her health. After finding success with an antidepressant in managing her mental health symptoms, she was taken off the medication once she became pregnant, but was not aware of any support or was given any replacement medication to manage her symptoms. Health care professionals took "[her medication] away for the whole 9 months. They just took [me] off it and made me get on with it… when I didn't take [my medication] my mood dropped. It was a big change to me – I had to deal with it, along with the hormones. It was a lot at once". Tailored advice, addressing existing comorbidities such as obesity, sickle cell disease, hypertension, or diabetes, is ultimately both reassuring and empowering for those hoping to become pregnant.

> ***"[Being taken off antidepressants] was a big change to me – I had to deal with it, along with the hormones. It was a lot at once"***
>
> *– Boudica, (Mixed White and Black Caribbean woman, age 21-25)*

Knowing where to find tailored and culturally sensitive advice, and the role of providers and organisations in offering outreach support to communities and effectively signposting women in need of personalised advice, can be crucial to ensuring women feel prepared for their pregnancy.

Case study: Vivienne

Vivienne is a woman in her 40s from Mauritius, who has been in the UK for most of her adult life. Vivienne gave birth after seeking specialist fertility support, and while grateful to have become a mother, she felt like she could not share and discuss her struggles due to the cultural stigma surrounding fertility treatment.

In her pre-pregnancy phase, Vivienne recalls that she wanted to find out what she could do if her attempts at getting pregnant weren't working. She struggled to find helpful information or support offered publicly by the NHS. Her experience with her GP at the time left a negative impression on her, as she was told that her success of having a baby was in the "hands of God". She didn't receive any options for testing or advice, and believes that the GP fixated on her weight in denying her any assistance.

Although she felt heavily discouraged by who she describes as a very pessimistic doctor, Vivienne continued to try conceiving and eventually went to see a specialist fertility doctor in her third year of trying. She felt that this experience was significantly more positive, where she felt that the doctor was working with her "in partnership".

Despite her success with fertility treatment and her praise for her fertility doctor, she has never discussed her journey with friends or family beyond her mother and husband. She fears that her children would be labelled as 'test tube babies', noting the persistent stigma around fertility treatment in her culture. The belief that conception should be natural meant that Vivienne has not been able to share her experience and utilise a wider support network.

Access to pre-pregnancy support

Section summary

Access to pre-pregnancy support is inconsistent amongst ethnic groups, and different women also seek support through different avenues.

BAME women interviewed reported significant barriers and gaps in communicating their options and needs when using healthcare services, and also reported a greater desire for more NHS pre-pregnancy support. The patterns in access suggest an area of unmet need for BAME women. As they perceive barriers to getting what they need via standardised healthcare routes, they may have more frequent visits in a bid to try and get what they need or otherwise turn to family, friends, or community to fill gaps.

Amongst BAME women, community and social groups were better trusted and more often used sources of pre-pregnancy information and support than for White women. Overall, White women reported trust in the overall health services in the UK at a higher rate (78%) than Asian women (61%) and Black women (63%).

Access challenges can also accumulate over time, when an absence of open dialogue in pre-pregnancy or early pregnancy about the options available can set a precedent for a lack of consultation and collaborative decision-making closer to birth.

Some BAME women struggle to acknowledge and express their needs to healthcare staff because of cultural expectations and norms, driving them to seek support from alternate sources and express a desire for community support

Cultural norms and stigma around pregnancy and family were revealed to have a huge impact on women's perception of their own needs, especially for Asian women. For example, Dara recalled being embarrassed to show the shape and size of her belly as she progressed in her pregnancy, crediting "traditional values and beliefs" for the desire to hide her baby bump.

> ***"We're not culturally allowed to talk about our experiences"***
>
> *– Shanaya (South Asian woman, age 36-40)*

Shanaya, a woman of South Asian heritage, recognised this desire and has taken this as a call to action by setting up many community groups to allow Asian women to share their needs with other members of their community. Noting that many support groups were organised by White women, and largely attended by White women, Shanaya has proactively opened more space for Asian women.

Women like Erica and Courtney, both of mixed ethnic background, would have valued access to these support groups. While able to rely on an aunt for emotional support during pregnancy, Erica believes "community is an important aspect of any person" and wished that she was informed of and could reach mum groups to have that peer support.

During Courtney's pregnancy, COVID kept groups closed and unable to meet, leaving her with an unmet desire for community-based support.

Case study: Marianne

Marianne is in her late 30s and from an East Asian background.

Marianne had a positive pregnancy experience for both her children, but was anxious about becoming pregnant again after she suffered from a miscarriage between her first and second child. She felt that she was supported and treated compassionately by healthcare staff when first learning about the miscarriage and discussing her options, but did not receive professional support in the aftermath. Her friends and family, both in the UK and elsewhere, gave her a large amount of support which she credits to helping her during her mourning period.

When Marianne decided that she wanted to try for a baby again, she felt anxious and turned to online resources and her midwife for advice. Despite learning that there weren't extra precautionary measures to avoid miscarriage, and otherwise taking all pre-pregnancy related health advice, Marianne was still anxious. For her, her real support came from a strong network of friends, also going through pregnancies at a similar time, that could offer her the empathy she needed.

Given difficulties in accessing support, BAME women rely on and trust family, friends, and community groups for pre-pregnancy information at a greater rate than White women

Although information related to pre-pregnancy support is reported to be inconsistent with major gaps, the sources through which it is made available is very broad. It is therefore important to understand where women access pre-pregnancy information and advice, and how this may vary by ethnic groups.

In our survey, Asian women generally reported having the lowest access to pre-pregnancy services in their local areas, with 26% of respondents rating strongly disagreeing or disagreeing with the statement "I could access pre-pregnancy services in my area" compared to 18% of White women and 15% of Black women.[23]

23 A chi-square test of independence demonstrated statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements differed by ethnicity group, X2, (2, N=194)=40.02, p<0.001.

However, BAME women generally sought out pre-pregnancy related advice or information more frequently than White women, and across a wider range of sources as well. BAME women were far more likely to see their friends, family and community groups to seek pre-pregnancy information compared to White women, with Asian women accessing this source most frequently. This is echoed by the finding that **Asian and Black women expressed a greater desire for more pre-pregnancy services from local community groups** than White women. Approximately 62% of Black women, and 75% of Asian women strongly agreed or agreed to the statement "I would have liked to access more pre-pregnancy services from local community groups", compared to 51% of White women.[24]

In the 6 months before becoming pregnant, the following proportion of women in each ethnic category consulted these sources for pre-pregnancy related advice or information more than once…

	White	Black	Asian	Other
Family members	58.3%	69.6%	80.5%	50.0%
General health websites	50.0%	62.6%	67.1%	66.7%
Friends	57.3%	68.4%	79.3%	33.3%
Books	40.6%	53.5%	58.5%	83.3%
Healthcare professional	44.3%	52.2%	67.5%	66.7%
NHS/government funded websites	49.5%	58.8%	76.8%	33.3%
Internet formus	45.4%	55.7%	65.4%	50.0%
Social media	44.8%	65.8%	62.2%	16.7%
Charity websites	32.3%	32.5%	32.9%	50.0%

24 A chi-square test of independence demonstrated statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements differed by ethnicity group, X2, (2, N=296)=8.64, p=0.01.

	 White	 Black	 Asian	 Other
Medical association websites	25.8%	34.8%	45.1%	33.3%
Community groups	21.6%	37.4%	40.7%	16.7%

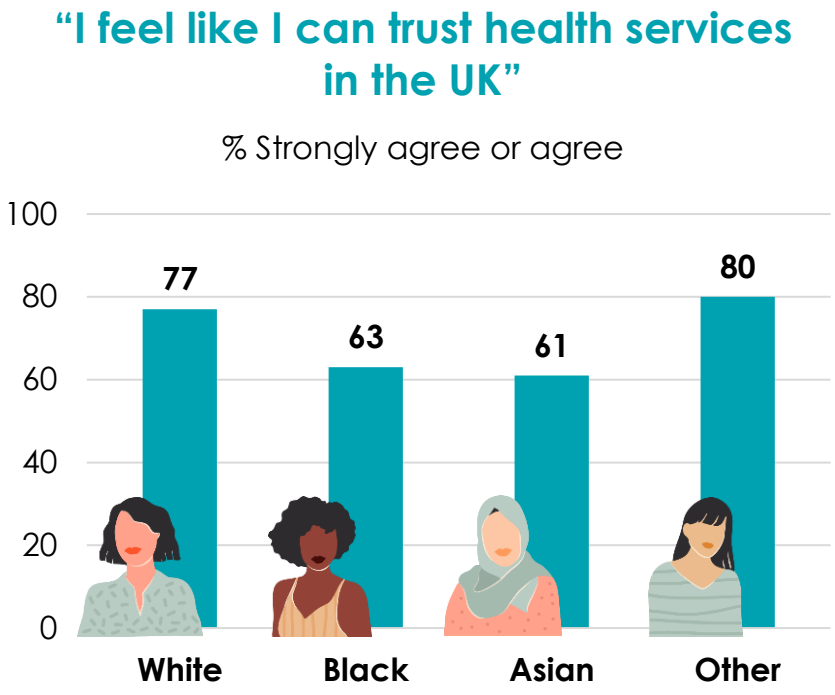
☐ 0-24.9% ☐ 25-49.9% ☐ 50.74.9% ☐ 75-100%

Our interviews revealed a similar theme as our survey findings. For Asha, having a strong relationship with her sisters helped her navigate pregnancy and inter-pregnancy, and now that two of her sisters are currently pregnant, her family unit has continued to showcase their support for one another. Marianne's support network after her miscarriage was also predominantly made up of friends and family, and she credits their compassion to her being able to mourn her pregnancy loss and prepare to try for another baby. The role of informal and community networks in Asian women's pre-pregnancy experience therefore reveal another important element to the accessibility and affordability of their pre-pregnancy care, and remarks on how the makeup of a supportive environment may differ for different groups of women.

Finally, the survey revealed patterns about the usage of other media sources – nearly 66% of Black women reported turning to social media for advice, compared to approximately 45% of White women. This resonated with the story of one woman who followed pregnancy vlogs of a local woman as one of her main information sources, feeling that her experiences would be most relevant and representative to her own upcoming journey. This highlights the opportunity for 'official' sources of guidance such as the NHS to work with or refer to content creators to make culturally and socially relevant resources online, when local community options aren't available or feasible.

BAME women rate lower trust for health services in the UK than White women, but are more likely to express that they would like greater access to NHS services for pre-pregnancy support

Interestingly, while BAME women reported higher usage of health care professionals during their pre-pregnancy period, **White women were more likely to report trust in health services in the UK than BAME women**. Approximately 78% of white women agreed or strongly agreed to the statement 'I feel like I can trust health services in the UK' compared to about 61% of Asian women, and 63% of Black women.[25]



However, BAME women also consistently voiced a **greater desire for more NHS pre-pregnancy services** than White women. Approximately 68% of Black women and 70% of Asian women agree or strongly agreed to the statement "I would have liked to access more NHS pre-pregnancy services", compared to 54% of White women.[26]

Our surveys suggest a pattern where, despite accessing healthcare professionals and public websites during pre-pregnancy at a greater frequency than White women, BAME women do not trust these services to the same extent and would like greater access to NHS services. Though this higher usage may stem from greater concerns for pre-existing comorbidities, our interviews revealed that several women felt that they continually needed more information to navigate the system or receive tailored advice. This raises the question of whether BAME women are receiving what they need when they go to health services during pre-pregnancy, or if their higher use and desire for further use is possibly being driven by not being offered the services and care they need.

25 A chi-square test of independence demonstrated statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements differed by ethnicity group, $X2$, (2, $N=194$)=40.75, $p<0.001$.

26 A chi-square test of independence demonstrated statistical significance, where the proportion of respondents strongly agreeing or agreeing to the statements differed by ethnicity group, $X2$, (2, $N=296$)=6.62, $p=0.04$.

Choices that can be made to support a healthy pregnancy are not consistently communicated

When women are able to reach pre-pregnancy healthcare services, the degree to which they receive effective communication and accurate personalised advice for their pre-pregnancy plays a huge role in their overall wellbeing. Not every solution or medication will work for every person – this is the cornerstone of personalised care.

However, the women we interviewed often found that they were rarely presented with choices and alternatives when trying to support a healthy pregnancy or treating an ongoing health concern. Dara suffered from low iron and was given iron tablets to alleviate her symptoms. However, she found any kind of medication difficult, often vomiting it back up. Yet, "they couldn't prescribe anything besides iron tablets", leaving Dara stuck and confused without any alternatives, and unsure if she could even ask for more options.

For Erica, she experienced strong pelvic pain with her second pregnancy but when she approached her doctor for help, she felt that there weren't any personalised solutions. Instead she was given a leaflet with some pelvic floor exercises but didn't find them particularly helpful and would've valued someone taking the time to give her personal advice or offer an explanation along the lines of 'try this [approach] because of this'.

Collaborative discussion with health care providers and clearly presenting health advice as needed emerged as valuable tools to creating a supportive environment. Where there was a specific health need that was supported by healthcare staff, such as coming off a very potent medication to prepare for pregnancy, regular communication with a consultant was seen as essential. Knowing that she had to continue to manage her pre-existing health condition, Shanaya was advised that it was only safe to try for a baby after she had been off her medication for a certain period. This meant that Shanaya had to rely on her consultant to navigate her options. While NHS websites offer medical advice, she found that speaking with a consultant who knew her particular concerns offered her the reassurance and guidance she needed – "I don't think I would've listened to anyone else at the time".

Other women, however, felt that cultural bias coloured their pre-pregnancy and pregnancy discussions. For Asha, she found it difficult to have unbiased and culturally sensitive conversations about pregnancy with her GP and midwife, noting that they assumed she must want many children and 'only boys' due to her cultural background.

As most BAME women indicated they would have liked more NHS pre-pregnancy services, there is growing scope to **proactively and constructively engage with women during pre-pregnancy so their options and available services are clearly communicated.** For some women, however, communication in pregnancy care was spotty. There were also instances where women felt that they were not in the right frame of mind to have certain aspects of pregnancy or postnatal care communicated with them, again emphasising the importance of both early clear communication and follow up. For Anna, by the time she had been induced, the gas she had been given made her light-headed. Only then was she given her anaesthesia options. This caused Anna only further distress as she had never previously been told or given time to consider what she might want to have happen in this scenario.

After Courtney gave birth, the doctors found that her baby had a birthmark. Nothing noteworthy was mentioned and Courtney, still foggy from her anaesthetic, was told that there were no concerns. After she took her baby home, the birthmark started regularly bleeding and causing her baby a great deal of discomfort and pain. This prompted her return to hospital where doctors noted that her child should have never left hospital without seeing the paediatrician. Courtney reflects that if "someone could have waited for me to actually process what happened and give me time to ask questions", she might have gotten to address the issue sooner.

This lack of clear communication often left women feeling at fault for any pregnancy-related complications they experienced, and pointed to their desire for reassurance and empathy. The effects of this distrust and anxiety after pregnancy complications can leave women vulnerable during their pregnancy and beyond, showcasing the benefits of further mental health and compassionate professional support.

There are gaps in how birthing options and preferences are communicated during pre-pregnancy and early pregnancy

Planning one's pregnancy, and ensuring that one has the information needed to make informed decisions at every key milestone, can be an emotionally daunting task and can see women lean on the support of caring professionals to know they're in safe hands. Yet, some women voiced that there wasn't a clear distinction between a birthing plan and a preference, making it difficult to understand when to advocate for themselves and the extent to which women are able to make an informed choice on how they give birth.

For women like Melika, whose husband is a doctor, she was firm in her birthing choice, deciding that if she was not going to be offered a planned caesarean section by the NHS, she "would choose another country [to give birth in] or go private". However, several women noted that they could not exercise this same level of control over their birthing plans. For Anna, she had made plans for a water birth but during labour, was induced and given an epidural at the advice of the doctor attending. She found her midwife was supportive of her, and explained that things can't always go to plan, but it left Anna with a critical question – while she adhered to the doctor's advice, would they have adhered to her plan if she didn't need to be induced?

Several women also explained that they were not adequately informed about the possibility of an emergency procedure, its possible consequences, and critically why an emergency procedure would be deemed necessary. Without this clear and pre-emptive communication prior to pregnancy or birth, women such as Asha were left unprepared and panicked when it came time to give birth and recover. Asha was given an emergency caesarean section after initially wanting a natural birth. While she said that she understands doctors need to make quick decisions, and she trusts them to make the right choice if any woman warrants an emergency procedure, she felt rushed into an emergency procedure and despite having two more children afterwards, has never been told why she was given a caesarean. "They send you home with those questions. I never got a chance to find out why certain things happened".

A lack of communication or reassurance also coloured Dara's experience during birth. For Dara, she needed an emergency procedure after her baby was born at a birthing clinic. Once staff realised that Dara needed emergency surgery, they only said that "they couldn't do anything, or have anything available. Even before I held the baby." She was transferred to a hospital and rushed into the theatre where doctors performed emergency procedures. Dara recounted losing consciousness due to blood loss.

The BAME women interviewed here were often barred from a clear explanation of the choices they could make before, during, and after pregnancy, limiting their agency and causing anxiety. Beyond their basic entitlements to healthcare, few women here felt that they possessed the power and ability to choose a service or provider best suited to their needs and concerns at every stage of their journey.

Quality of care

Section summary

BAME women we interviewed in our research reported how high quality personalised care could often be beyond reach.

10 out of the 15 women interviewed reported feeling discriminated against, judged, or otherwise treated differently by healthcare staff due in part to their ethnicity at some point in their pregnancy journey. Whether their feelings of pain are dismissed, they are placed in a situation where they must fight for their healthcare rights, or they are not offered empathetic care, many BAME women find the experience of pregnancy complex and emotionally exhausting. Having a supportive or disruptive relationship with a healthcare provider could often make all the difference.

This perceived lack in quality personalised care was also strongly expressed amongst women who had previously been pregnant and endured a traumatic birth or pregnancy. Here, inter-pregnancy care, rather than offering women support to process their previous experiences and prepare for another pregnancy, was often withheld due to the assumption that only first-time mothers require support.

Black and Asian women, including those with mixed ethnicities, were more likely to report having felt discriminated against by healthcare professionals, with many Black and Asian women recounting stories of being treated differently by healthcare staff because of stigma, stereotypes, and cultural differences

The quality of care received by the BAME women in our survey and interviews highlight some key discrepancies in how BAME women are treated as compared to White women. Overall, the BAME women surveyed were 1.5 times more likely to report having had an experience of feeling discriminated against by healthcare professionals than White women. The universality of discriminatory experiences points to how experiences of stigma are often driven by intersectional factors including and beyond ethnicity. However our interviews reveal an unsettling snapshot particularly for BAME women, where **10 of 15 interviewees shared that they had an experience of being treated differently by healthcare professionals, most likely because of their ethnicity or race**. Of the women who shared an experience of being discriminated against, cultural stereotypes could play a significant role in how they were treated.

There were multiple incidents of BAME women feeling that their experience of pain was dismissed by various types of healthcare staff. Often these experiences were associated with the actual birthing experience, or during pre-pregnancy and early pregnancy stages when it was women's second time or more in being pregnant. For instance, Brianna recounted a story where she felt her concerns for her baby were 'fobbed off' by her midwife team in her second pregnancy. Asha recalls describing her pain to her midwife who stated, "you shouldn't find it that painful", leaving Asha to feel like "they think I'm a lunatic". These experiences echo other research findings that state Black women are more likely to experience birth without intervention, while rates of emergency caesarean

births were higher compared to White and South Asian women.[27] These findings suggest that BAME women are not being offered adequate birth interventions until it becomes clear they need an emergency procedure, while our interviews showcase how BAME women are also not receiving sufficient pain management. The extent of this issue, and the number of women affected across the UK, however, remains unknown without a comprehensive record of birth interventions by ethnicity.

> ***"There's a belief that Black women are strong, and that they don't need pain relief (...) the Planned C-section gave me a sense of control given back to me"***
>
> *– Jada (Black African woman, age 31-35)*

In some cases, women felt as though they had to advocate for themselves, but found that staff were unreceptive to their concerns or judgemental. Jada also shared experiences of how she felt she had to unreasonably justify her decision for wanting a planned C-section for her second baby, given the traumatic experiences she had the first time round. Shanaya, a woman with difficult health complications, in her case gestational diabetes, shared that she had been blamed blatantly by healthcare staff for her diet, although her condition was genetically determined. She was struck by the fact that other White women in the same ward with the same conditions were being treated with much more compassion and less blame. Shanaya was surprised by how frequently she experienced discrimination from staff with BAME backgrounds. While some studies have revealed that poor outcomes and the mortality rates for Black infants improve when Black infants are cared for by doctors of the same race, it is crucial that staff makeup reflects the population and that all staff are adequately trained to offer equitable and ethnically sensitive care.[28]

Some women felt affected by similar treatment from healthcare professionals outside of maternity care as well – for example, Boudica, a White/Black Caribbean mixed-race woman felt that her "loudness" was often misinterpreted as aggression by her social care worker, who as a result didn't listen to or believe her accounts of being in an abusive relationship. Boudica was particularly vulnerable with complex psychological and emotional needs given her long history of suffering multiple adverse childhood experiences. Her already low levels of confidence and trust in the healthcare system appeared to have been exacerbated by the challenging experience with her social care worker.

27 National Maternity and Perinatal Audit (2021). 'Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies: Assessing care using data from births between 1 April 2015 and 31 March 2018 across England, Scotland and Wales'. Retrieved from: https://maternityaudit.org.uk/FilesUploaded/Ref%20308%20Inequalities%20Sprint%20Audit%20Report%202021_FINAL.pdf

28 Russell, T. (2021). 'Mortality rate for Black babies is cut dramatically when Black doctors care for them after birth, researchers say'. Washington Post. Retrieved from: https://www.washingtonpost.com/health/black-baby-death-rate-cut-by-black-doctors/2021/01/08/e9f0f850-238a-11eb-952e-0c475972cfc0_story.html

"What's the point of talking about yourself if they don't listen?"

– Boudica (Mixed White and Black Caribbean woman, age 21-25)

Case study: Boudica

Boudica is a White/Black Caribbean mixed race woman who grew up in foster care, where she experienced abuse from only two years of age. She repeatedly felt dismissed by her social workers despite being in the care of her abuser. Boudica became pregnant at 16 years old, and felt that the foster care or social care system did not provide her information on how to become a good parent.

Her pregnancies have been complicated, with health risks that have left her to use crutches throughout pregnancy and perinatal depression. She also has pre-existing mental and physical health conditions (e.g. PTSD, perinatal anxiety) that have warranted additional support during her pregnancies. However her mental health concerns were not always addressed. In her most recent pregnancy, she was taken off an antidepressant medication she had used since adolescence, with no alternative or additional support offered in lieu of this medication.

While she feels that healthcare workers have generally supported her throughout life, social care workers have not. She feels that she is often dismissed and treated differently from her ex-partner who she was in an abusive relationship with – and thinks it has to do with her race and stereotypes around being aggressive, even when she is not.

Nevertheless, Boudica turned to family members and a neighbour who have supported her throughout her pregnancy. They helped her access her health appointments and informed her about childcare in a helpful way. Positive interactions with charity-based mental health support groups for mums and the police have encouraged Boudica to speak more honestly and openly about her life experiences, allowing her to overcome her belief that her issues were not worth speaking about.

For other BAME groups, stereotypes specific to their ethnicities frequently played out in their experiences of care. For instance, a Pakistani woman felt that professionals asked judgemental questions on whether or not she had desires to have many children, purely based on traditional stereotypes. Another felt patriarchal stereotypes enforced upon her, with one staff member 'looking past' her and asking her husband if she spoke English, despite being British-born.

"The doctor asked my husband all the questions. It seemed like he wanted a man to man conversation… about my body being cut open or not"

– Irhaa (South Asian woman, age 36-40)

A singular relationship can have a major impact on how women perceive their overall experience, and of the wider healthcare system

Many of these women reflect that a single negative experience can be enough to diminish their trust in the system and shape their subsequent choices. Shanaya shared that if she received adequate support in the first pregnancy, she would have chosen a natural birth for the second baby but she simply didn't trust that she would be cared for if something went wrong again. Another mixed-race woman, Vivienne, in her 40s vividly recalled her negative experience of her GP who told her that having a baby would be 'in the hands of God' and refused to support her attempts at conceiving. These interactions with the GP shaped her view of her first pregnancy where she felt inadequately supported by the healthcare system.

On the other hand however, many women also strongly recalled one or two consistently positive relationships with healthcare staff throughout their end to end pregnancy journey that defined the positivity of their pregnancy experiences. Shanaya recalls her midwife team who were consistent throughout her pregnancy made the biggest difference. She felt understood and found it very positive when she didn't have to explain herself repeatedly. She felt extremely grateful when one of the team members went the extra mile to come see her at her house and make sure she and her baby were okay. Courtney gave her midwife a lot of credit in making her pregnancy experience highly pleasant, as she made herself always available to answer questions, and presented herself as very approachable. The midwife also had an existing relationship with the family from beforehand, as she had provided midwifery care to Courtney's sister during her sister's pregnancy, so "the bond was already there".

Positive relationships beyond midwifery play a meaningful role in women's pregnancy journey. Ayesha and her husband reflected that the Doula service – to which they were referred to through their community midwife during their early pregnancy phase – made a decisive difference in their experience between their first and second pregnancies. The Doula has offered face-to-face contact, advice on how to work towards a normal delivery, lifestyle advice on diet and exercise, as well as hands-on housework support during perinatal stages.

Many women have traumatic birthing experiences in the past that affect their decisions around subsequent pregnancies: the significance of 'intra-partum' care.

Considering an individual's health history and helping them consider their options going forward is a fundamental asset of personalised care. The women interviewed in this study, however, often noted that their pregnancy histories were often disregarded or ignored, leaving them unsupported as they tried to navigate another pregnancy and demonstrating how personalised care is yet to become the norm for women in the UK.

There is a key role for providers to serve as a caring source of guidance and information during a women's inter-pregnancy period as she navigates her choices and may need ongoing support for her previous experiences. **Previous healthcare experiences fundamentally inform later ones. The inter-pregnancy period thus emerged as a vulnerable time for women to access both postpartum support and explore pre-pregnancy services and support available to them**. While a short inter-pregnancy period has been noted to lead to an increased risk for pregnancy complications, and there is an

emphasis on ensuring access to contraceptives shortly after birth to reduce this risk, there is no substantive conversation around the care women need during inter-pregnancy in the UK.[29]

For many women who experienced a difficult pregnancy, miscarriage, or traumatic birthing experience, the decision to try to have another child has been or continues to be incredibly difficult. But despite knowing what could go wrong, and the kind of support and services they need in order to prevent their experiences from repeating, many women seeking advice for a subsequent pregnancy were denied this support under the assumption that 'your body has already been through it' and 'you know what you're doing'. Rather than simply another pre-pregnancy period, there is a critical time during women's inter-pregnancy period where they could both properly reflect upon their previous experience and utilise their knowledge to prepare for another pregnancy.

Case study: Brianna

Brianna is in her mid-30s and from a Black Caribbean background.

Brianna felt that she was met with judgement for having children. Commenting on her economic status, she felt that people questioned how she was going to cope with having children, a judgement she felt that her White friends did not have to endure.

When Brianna did become pregnant, her journey was marked by unsupportive staff and a continuous feeling that she was being dismissed or ignored, making for a difficult pregnancy.

This culminated in a 4-day long labour, where Brianna was not given proper pain relief, believing that staff assumed she could simply handle the pain.

This experience made Brianna incredibly anxious about becoming pregnant again, but she felt that her anxiety was not taken seriously by healthcare staff, leaving her to turn to family members for comfort, support, or reassurance instead. For her second pregnancy, she was adamant that she wanted a planned caesarean section but was told that she didn't need anything because 'your body can do it'. When she went into labour for her second child, she was told to stay home without being assessed because her first labour had taken 4 days. She persisted and went to hospital, where she almost immediately gave birth. She's grateful she made this decision, and feels that had she listened to the professionals' advice, based on their telephone conversation, her and her child could have been in jeopardy.

29 Gebremedhin, A.T., Regan, A. K., Malacova, E., et al. (2018). 'Effects of interpregnancy interval on pregnancy complications: protocol for systematic review and meta-analysis'. BMJ Open, 8(8): 1-4.

The reduced support levels for second pregnancies are especially troubling when women experienced trauma in their previous pregnancies. When recovering from a difficult or traumatic pregnancy, a fundamental issue of not being heard by health services and the absence of a reciprocal sense of trust between patient and provider emerged for some BAME women during inter-pregnancy.

Brianna had an extremely difficult labour that lasted 4 days, making her adamant that she wanted to prepare and discuss all options before another pregnancy. When she decided she wanted a second child, she knew she didn't want to risk another prolonged labour so proactively asked for a planned caesarean section. She recalled that "they immediately said 'you don't need it'". Brianna, a Black woman, felt that she was expected to have another 'natural' birth, and that there was no clear communication or justification given as to why a woman who previously endured 4 days of labour would be categorically told 'no' to her desired birthing option without any assessment or clear reason.

Past trauma also informs the decision to have another child at all. Asha is currently considering whether or not she would like another child. However, she's concerned that after three caesarean sections, each with a difficult recovery period, her "body can't handle it". She has unanswered questions about the tissue damage she may have endured from her emergency procedures and wants to speak to a medical professional to get reassurance and understand how another pregnancy and birth might unfold. Whether she decides to try for another child, or not, will be difficult, making clear and compassionate advice and guidance from trustworthy sources especially valuable as she navigates her options. These experiences, however, were not adequately captured in patient records or carefully considered by providers in signposting these patients to much needed further support.

Recommendations

We believe that the ideal future state of pre-pregnancy provision must be designed based on the following core principles:

- **Awareness:** When women are looking for advice and support, including for pre-existing health conditions, it is available and easy to find. Women can be signposted appropriately to advice or support with accessibility in mind. Women are clear on which aspects of their journey are a must-have or a recommendation.
- **Access:** There are multiple routes to access information and support, including: digital and non-digital, formal and informal routes, with cultural sensitivity and accessible language, maximising community assets.
- **Care:** All women are treated equally well with compassion and non-judgmentally, with their choices around pregnancy respected. Care-related conversations are collaborative and non-paternalistic.

To contribute towards this ideal future state, recommendations have been proposed following our key research findings:

Awareness

- **Unify terminology around pre-pregnancy services** and undertake an educational campaign to increase awareness of service provisions
- Encourage **primary care staff** including, but not limited to, GPs to build higher awareness of **trusted online and offline community groups** (e.g. FivexMore, Black Mothers Matter, The Motherhood Group) to **signpost patients and promote greater education**
- Support services to deliver **ethnically specific and culturally sensitive pre-pregnancy advice**, e.g. via Maternity Voices Partnerships (MVPs), local maternity systems, GPs and other community groups as an accessible choice
- Create an **educational campaign to boost awareness of guidelines and services** via community and faith groups, with different language options
- Increase investment for **midwifery teams** to provide **community engagement and outreach** starting from pre-pregnancy
- Consider piloting a **digital one-stop-shop** resource providing pre-pregnancy support for target groups

Access

- Provide pre-pregnancy advice and support **through sources that BAME women trust**, with more accessible language and communication styles
- Improve **education for healthcare professionals** (GP, midwives) on how to provide **culturally unbiased conversations and choices** for pre-pregnancy and wider maternity care
- Improve **access to perinatal mental health teams** for BAME women
- Strengthen links between antenatal care and **digital pregnancy interventions and programmes** (e.g. NHS Digital Redbook) to support women to more effectively navigate services and select the provider best for them from pre-pregnancy
- Engage in **government lobbying for improved funding for pre-pregnancy services** for all women
- Increase pre-pregnancy provision through **neighbourhood-level and PCN-led (Primary Care Network) service developments** to enable tailored service designs, accommodating local needs
- **Target areas of high deprivation** to ensure MVPs have a strong community voice and lobbying power for local pre-pregnancy and end-to-end maternity services

Care

- **Improve education and the medical school curriculum** on what it takes to offer holistic, high quality care throughout the whole pregnancy journey
- Support NHS, National Childbirth Trusts and community groups to offer **more accessible and ethnically representative groups**, with options for women to **join in their pre-pregnancy stages**
- Develop **NICE guidelines** for pre-pregnancy advice and support specifically for women from BAME backgrounds, taking into account their higher risk status
- Provide **inter-pregnancy advice**, with sensitivity to previous **birth traumas or miscarriages**
- **Improve data collection at national level to capture the holistic pregnancy experience** to link with maternity outcomes e.g. pre-pregnancy service use, birthing plans
- Conduct **regular local audits of pregnancy care** including data on ethnicity
- Investigate and address barriers to **providing adequate and equitable pain management and birth interventions** across ethnicities
- Review **diversity and sensitivity training**, and recruitment and onboarding strategies to ensure **staff makeup is ethnically representative of the population**

Limitations and areas for further research

The topics of maternity care, and BAME people's experience of health and healthcare are increasingly expanding in academic literature and advocacy research. This report therefore contributes to the ever-growing awareness around health and social inequalities, but it by no means exhaustive of the issues facing BAME women, and the broader influence health inequalities have on one's quality of life.

There are several limitations to note from this research. Firstly, findings in this report are based on our survey and interview results gathered from respondents with a disproportionately high representation of:

- Medium to higher socioeconomic status as indicated by their current professions
- Planned pregnancies
- 36-40 age groups
- Women residing in London.

Secondly, our sample size of 15 for interviews is fairly limited and may represent only a small proportion of perspectives and experiences. Survey responses were analysed without controlling for confounding variables to maximise the sample size, which does not eliminate the potential influence of demographic and socioeconomic factors beyond ethnicity, even when differences across ethnic groups are reported.

Further work and research, leading to actionable and clear steps for healthcare providers and the bodies overseeing healthcare, is still needed as health inequalities persist and take on new forms. Suggested outstanding questions for exploration are as follows:

- How does birth literacy differ across ethnicity and other demographic characteristics in the population, and what interventions are needed to improve this?
- What factors in pre-pregnancy care directly impact maternity outcomes most?
- How effective are holistic, culturally unbiased, choice-based pre-pregnancy care in improving experience of care and maternity outcomes for BAME women?

A thorough understanding, and willingness to openly discuss these inequalities, how they present themselves, and how to address them will be crucial to achieving equitable and personalised care in maternity services and beyond.

Relevant resources

An overview of some of the existing work on the issues discussed here can be found below.

Advocacy research on BAME maternity outcomes

The following reports have highlighted the key disparities in maternity outcomes for BAME women in the UK, forming the basis for this work. These works have each highlighted how systemic racism in healthcare services had negatively affected BAME women, sometimes with tragic outcomes, and informed new taskforces and efforts to identify and address these underlying inequalities.

- MBRRACE-UK (2022). 'Saving Lives, Improving Mothers' Care 2022: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2018-20'. Retrieved from: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_v10.pdf
- FIVEXMORE (2022). 'The Black Maternity Experiences Survey: A Nationwide Study Of Black Women's Experiences Of Maternity Services In The United Kingdom'. Retrieved from: https://www.fivexmore.com/blackmereport
- BirthRights (2022). 'Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care'. Retrieved from: https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf

Related health inequalities in the UK

Expanding on the known link between health and social inequalities, the following studies highlight how social inequalities are linked to adverse pregnancy outcomes or pregnancy related health conditions.

- Devonport, T.J., & et al. (2022) 'A systematic review of inequalities in the mental health experiences of Black African, Black Caribbean and Black-mixed UK populations: Implications for action.' Journal of Racial and Ethnic Health Disparities, https://doi.org/10.1007/s40615-022-01352-0.
- McLeish, J., & Redshaw, M. (2019). 'Maternity experiences of mothers with multiple disadvantages in England: A qualitative study.' Women Birth. 32(2):178-184.
- Jardine, J., & et. al. (2021). 'Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study.' The Lancet, 398(10314): 1905-1912.

The BAME pregnancy experience and risks

Our study ultimately highlights only a small fraction of BAME women's experiences of pregnancy and how it may differ from White women in the UK. The following studies elucidate some of the other areas of increased risk for BAME women, as well as the difficulties they may face in addressing their concerns or receiving equitable treatment.

- Garcia, R. et al. (2021). 'Analysis of routinely collected data: Determining associations of maternal risk factors and infant outcomes with gestational diabetes, in Pakistani, Indian, Bangladeshi and white British pregnant women in Luton, England.' Midwifery, 94: 102899.
- Amoah, E. (2021). 'Predicting Perinatal Low Mood and Depression for BAME Women-The Role of Treatment, Perceived Public, and Internalised Stigma.' Diversity and Equality in Health and Care, 18(7): 387-397.
- Redshaw, M., & Heikkilä, K. (2011). 'Ethnic differences in women's worries about labour and birth.' Ethnicity & health, 16(3), 213–223.
- Kramer, M. R., & Hogue, C. R. (2009). 'What causes racial disparities in very preterm birth? A biosocial perspective.' Epidemiologic reviews 31(1): 84-98.

Provider perspectives

We have championed the viewpoint of women receiving pregnancy related care throughout this study. However, it is important to note that providers and healthcare workers' perspectives offer unparalleled insights into the realities of healthcare in the UK and the effectiveness of work to improve maternity care to date. While there is not yet a plethora of research on how providers adapt to and address the unique challenges of BAME or socioeconomically disadvantaged women in the UK seeking maternity care, there are some key sources.

- Chitongo, S., & et al. (2022). 'Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk' pregnancies: A qualitative study.' Women and Birth, 35(2): 152-159.
- Homer, C. S. E, & et al. (2017). 'Midwifery continuity of care in an area of high socio-economic disadvantage in London: a retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009).' Midwifery, 48: 1-10.

Appendix A: Full landscape review

Poorer maternal outcomes for BAME women in the UK has emerged as one of the most pervasive health inequalities of our time, and is deeply rooted in the pre-existing racial inequalities.

In 2018, MBRRACE released its report detailing higher rates of maternal death and poor maternal outcomes for Black, Asian, and Mixed Ethnicity women in the UK. Its key finding, that Black women were 5 times more likely to die during or up to 6 weeks after pregnancy compared to White women, has sparked outrage and became a battle cry to correct the disparities and trauma underpinning the BAME maternity experience. While there has been some improvement from the original 2018 maternal death report, the most recent report from MBRRACE still notes that Black women are 3.7 times more likely to die during or up to 6 weeks after pregnancy, and Asian women are 1.8 times more likely to die, than White women.[30]

Tragic maternal outcomes are not the only result of racial inequalities and systemic discrimination experienced by BAME women. Rather, these inequalities foster poor antenatal and postnatal health, with experiences of racism or discrimination by healthcare professionals serve as all too familiar narratives of the BAME maternity experience and merit further attention.

Additionally, when BAME women experience anxiety around aspects of pregnancy and labour, there is a disparity in the support they receive, and it remains unclear where these concerns begin to manifest.[31] These difficulties, however, are not captured by metrics on poor maternal outcomes but serve as an important glimpse into the inequalities that affect the entirety of the BAME maternity experience from before pregnancy to well after birth.

30 MBRRACE-UK (2022). 'Saving Lives, Improving Mothers' Care 2022: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2018-20'. Retrieved from: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_v10.pdf

31 Womersley, K., Ripullone, K., & Hirst, J. E. (2021). 'Tackling inequality in maternal health: Beyond the postpartum.' Future Healthcare Journal, 8(1): 31; Henderson, J., & Redshaw, M. (2017). 'Sociodemographic differences in women's experience of early labour care: a mixed methods study'. BMJ open, 7(7), e016351.

Current state of national efforts and guidance

The MBRRACE finding has elicited responses from the NHS and UKHSA (formerly Public Health England), and has led to the development of new grassroot efforts, charitable foundations, and taskforces to address maternal inequalities and correct this disparity. Part of a chorus of new voices and research on maternity care, such as the Ockenden report, there is growing sentiment that NHS maternity services are failing mothers.[32] In 2020 the Royal College of Obstetricians and Gynaecologists launched their Race Equality Taskforce to address racism and racial inequalities in maternity care, while in 2022, the government launched their own Maternity Disparities Taskforce to identify barriers to maternity services, and inform how the government could improve care for ethnic minorities and those in deprived areas.[33] This effort is part of a larger turn towards improving perinatal inequalities, as outlined in NHSE's Equity and equality: Guidance for local maternity systems.[34]

These efforts and taskforces have ultimately prompted discussions on best practices and new maternity care guidelines. Current guidelines champion the importance of collaboration between providers, commissioners, and their communities to meet various needs. Underpinning guidance for pre-pregnancy services, antenatal care, and postnatal care is the expectation that commissioners and providers ensure that all relevant health information and appropriate maternity services are clear, accessible, and proactively offered to all patients.

RCOG's framework for maternity service standards highlights the timelines and types of services patients should access at various stages of pregnancy.[35] If a patient has no medical disorders, a low-risk pregnancy, and an uncomplicated birth, they should therefore have the following experience and services offered during their pregnancy:

32 Department of Health and Social Care (2022). 'Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services'. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064303/Final-Ockenden-Report-print-ready.pdf

33 GOV.UK (2022). 'New Taskforce to level-up maternity care and tackle disparities'. Retrieved from: https://www.gov.uk/government/news/new-taskforce-to-level-up-maternity-care-and-tackle-disparities

34 NHS (2021). 'Equity and equality: Guidance for local maternity systems'. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

35 Royal College of Obstetricians & Gynaecologists (2016). 'Providing Quality Care: A Framework for Maternity Service Standards'. Retrieved from: https://www.rcog.org.uk/media/xt2fqcw0/maternitystandards.pdf

Pre-pregnancy	Antenatal	Birth	Postnatal
Prior to pregnancy Given key public messaging and tailored advice	**Pregnancy** Antenatal care accessed prior to 10 weeks gestation Given a named midwife for the duration of pregnancy Offered screenings, referred to specialist services, and given counselling especially if the patient has complex social needs of a medical disorder	**Intrapartum Care** Provided unbiased information for each birth option, and is able to access all options **OR Elective Birth** Given an open discussion with a provider who determines to induce labour or provide a caesarean section based on an individual approach	**Up to 6-8 weeks after birth** Individual needs are immediately addressed, usually by midwife Follow up appointments arranged before discharge Physical, emotional, and mental health continually assessed and reviewed again at 6-7 weeks after birth Breastfeeding support and instruction Provided information and contact details to discuss their baby's health, and their emotional wellbeing

In reality, we know that many women do have complicated pregnancy journeys, and that BAME women are disproportionately affected by health and social concerns throughout pregnancy. Yet tailored advice, for either BAME communities, higher risk pregnancies, and generally low-risk pregnancies is sparse and difficult to find. NICE guidance stresses that to address health disparities, commissioners must cooperate and identify areas of need.[36]

Identifying needs and offering services to match ultimately rests on the idea of personalised care. NHSE's three-year delivery plan for maternity and neonatal services, published in March 2023, stresses that equity of care will only be achieved by offering patients compassion and personalised care to address all aspects of their health and social complexities.[37] Personalised care is also discussed at length in the April 2023 Black maternal health report by the House of Commons. The report, however, notes that while personalised respectful care and continuity of care are the cornerstone of current recommendations, staff shortages inhibit the NHS's ability to offer this care safely and

36 NICE (2010). 'Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors'. Retrieved from: https://www.nice.org.uk/guidance/cg110/resources/pregnancy-and-complex-social-factors-a-model-for-service-provision-for-pregnant-women-with-complex-social-factors-pdf-35109382718149

37 NHS England (2023). '3-Year delivery plan for maternity and neonatal service'. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf

uniformly.[38] This remarks on only one barrier to ensuring all women can enjoy the pregnancy experience outlined by the RCOG.

Overview of known inequalities in maternal experiences and outcomes

Given the context of poorer outcomes, it is clear that many BAME women do not uniformly experience a pregnancy according to the 'best practices' outlined in national guidance. What do we know is preventing this?

The known barriers preventing BAME women from accessing maternal care in the UK can be divided into four main categories:

Cultural and social barriers

Cultural barriers, including religious and language barriers, have been pointed out by both midwives and pregnant BAME women as an obstacle to getting quality care. Cultural and social barriers can consist of providers' lack of awareness of or insensitivity towards religious values or cultural norms, competing cultural expectations on the role of healthcare professionals during pregnancy, and fractured communication between patients, providers, and their family or interpreters.[39] These barriers are largely noted by migrant women, who are disproportionately BAME, and the healthcare staff treating them. Cultural barriers can even encompass the differing terms BAME women may use to describe their symptoms, delaying diagnosis and treatment.[40]

Lack of information

Studies have cited that BAME women, particularly migrant women, lack information or knowledge of existing healthcare services, their entitlements, or pregnancy-related health advice.[41] While it is up to providers to support access and offer information, there is likely to be a public assumption that women have some level of pre-existing knowledge of maternity health advice and services, such as to not drink alcohol and that a midwife is a pregnancy specialist. Yet, studies have consistently highlighted that migrant women may not know of these services, and aren't actively given this information. Ultimately, limited antenatal education has been identified as a barrier to care and support, and contributes to anxiety around intrapartum care and labour.[42]

38 House of Commons (2023). 'Black maternal health'. Retrieved from: https://committees.parliament.uk/publications/38989/documents/191706/default/

39 Hassan, S. M., et al. (2020). 'A qualitative study of healthcare professionals' experiences of providing maternity care for Muslim women in the UK.' BMC Pregnancy and Childbirth, 20(1): 1-10; Konje, J.K., & Konje, J.C. (2021). 'Experiences of accessing maternity care in the UK: Perspectives from Somali migrant women in Leicester'. European Journal of Midwifery, 13(5): 56.

40 Khan, Z. (2021). 'Ethnic health inequalities in the UK's maternity services: a systematic literature review.' British Journal of Midwifery, 29(2): 100-107.

41 Higginbottom, G. M. A, & et al. (2019). 'Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review.' BMJ open, 9(12): e029478.

42 Womersley, K., Ripullone, K., & Hirst, J. E. (2021). 'Tackling inequality in maternal health: Beyond the postpartum.' Future Healthcare Journal, 8(1): 31; Henderson, J., & Redshaw, M. (2017). 'Sociodemographic differences in women's experience of early labour care: a mixed methods study'. BMJ open, 7(7), e016351.

Poor relations with healthcare staff

Poor relationships with healthcare professionals is a prominent narrative within advocacy pieces and studies on BAME people's experience with health services, culminating in a justified reluctance to use maternity services. Poor previous experiences and perceptions of discriminatory or stigmatised care create a pervasive sense of distrust and unmet expectations, influencing mental health and willingness to engage with healthcare services.[43] BAME women report discrimination, feeling disrespected, or not adequately and equitably treated by providers, perpetuating a sense of mutual distrust and increasing their anxiety surrounding pregnancy related care.[44] Feelings of 'being stereotyped' or not being believed, especially regarding pain management or symptoms, are aptly highlighted in studies that focus on the BAME birthing experience and often reflect the final point in a fraught pregnancy journey.[45]

Physical and geographical barriers

There is a postcode lottery in maternity services, and where women live can greatly determine their access to care. Physical barriers, namely proximity to pregnancy services and related socio-economic barriers such as limited access to transportation services, are also a key obstacle to accessing care.[46]

Key gaps in knowledge

While the barriers named here are already monumental, they unfortunately do not encompass all of the many factors driving BAME women's negative experiences of advice and support during pre-pregnancy and pregnancy. Currently, there are key gaps in our understanding of the BAME woman and birthing person's pregnancy journey, and where further intervention or support could make all the difference.

The barriers mentioned here often are often focused on the challenges facing migrant women who recently immigrated to the UK. How some of these barriers differ, or not, for BAME women who were either born in the UK or have been resident in the UK for many years is unclear. In 2021, 28.8% of live births were to non-UK-born women, making it clear that limiting the discussion of barriers facing migrant women limits our full understanding of the difficulties underpinning the BAME maternity experience.[47]

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43 Garcia, R., Ali, N., Papadopoulos, C. & et al. (2015). 'Specific antenatal interventions for Black, Asian and Minority Ethnic (BAME) pregnant women at high risk of poor birth outcomes in the United Kingdom: a scoping review'. BMC Pregnancy Childbirth, 15(226): DOI 10.1186/s12884-015-0657-2

44 Toh, R. K. C., & Shorey, S. (2023). 'Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation.' Women and Birth, 36(1): 30-38.

45 Jomeen, J., & Redshaw, M. (2013). 'Ethnic minority women's experience of maternity services in England'. Ethnicity & health, 18(3): 280–296.; Heys, S., Downe, S., & Thomson, G. (2021) ''I know my place'; a meta-ethnographic synthesis of disadvantaged and vulnerable women's negative experiences of maternity care in high-income countries.' Midwifery, 103 (2021): 103123.

46 Amoah, E. (2021). 'Predicting Perinatal Low Mood and Depression for BAME Women-The Role of Treatment, Perceived Public, and Internalised Stigma.' Diversity and Equality in Health and Care, 18(7): 387-397.

47 Office for National Statistics (2022). 'Birth by parents' country of birth, England and Wales: 2021'. Retrieved from:

While RCOG's maternity care recommendations outline the evolving needs of patients at each stage of pregnancy (from pre-pregnancy to postnatal care), there is no shared understanding of what inequality looks like in pre-pregnancy care, as compared to antenatal care where microaggressions and inequitable treatment are widely documented by the BAME community. When do BAME women start experiencing disparity in the pregnancy experience? Can we stop poorer outcomes for BAME women early into pregnancy or even before pregnancy?

Looking across the entirety of a BAME woman's pregnancy journey, there are 4 keys gaps within known barriers that need to be addressed:

Limited accessible information and health literacy: Awareness

While studies on pregnancy disparities acknowledge that recently immigrated BAME women often do not possess the information necessary to access the right pregnancy sources for them, how limited information or knowledge of services affects pregnancy for UK-born or long term migrant BAME women is not widely understood. How BAME women seek out, or are barred from seeking out, accurate health information throughout and prior to their pregnancy journey is a missing piece in our understanding of what is informing the BAME pregnancy experience in the UK.

While there is some pregnancy-related health advice that is widely known, such as to not consume alcohol or smoke, the baseline knowledge for more specific pregnancy health advice is unclear. When to start taking folic acid, how to manage pre-existing diabetes, what mental health medications are safe, or what to do if you're anaemic are all examples of more specific questions that a pregnant person could easily have, and need answered.

We know today's patients seek out information from many sources, whether it's online, through family or friends, their GP, or anywhere else. Are BAME women getting, or somehow stopped from getting, the information they need from these sources?

Digital exclusion

Digital sources, both trustworthy platforms created by medical professionals and perhaps inaccurate platforms like online forums, have become critical information sources for health throughout the world.[48] Given the amount of misinformation online, it's striking that we don't know how women view these sites and whether they rely on them, or how much they trust the information given. Also, given that issues with digital exclusion are particularly prevalent Black and South Asian communities in the UK, does this influence whether BAME women are getting information or making appointments online?[49]

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https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/parentscountryofbirthenglandandwales/2021

48 Vogels-Broeke, M., Daemers, D., Budé, L., de Vries, R., & Nieuwenhuijze, M. (2022). 'Sources of information used by women during pregnancy and the perceived quality.' BMC Pregnancy Childbirth, 22(109): https://doi.org/10.1186/s12884-022-04422-7

49 Sounderajah, V, & et al. (2020). 'Bridging the Digital Divide: A National Survey Assessing Public Readiness for Digital Health Strategies Against COVID-19 within the United Kingdom.' Scientific Reports, 11(5958):

Social circles

With all the competing resources online, social circles, namely friends and family, can provide a key role in offering a pregnant person comfort, reassurance, and support.[50] However, what else are these networks providing that women are otherwise lacking from their healthcare services? Scholars have noted that migrant and BAME women in particular seek out pregnancy-related information and health advice from their family and friends, but it's still unclear what questions they're asking, and what care informal social networks provide to support the BAME pregnancy journey.[51]

Education and knowledge-sharing

There is an identifiable link between a mother's education to the risk of preterm birth in the UK. This is thought to be due to poorer overall health and lower access to prenatal screenings.[52] Lower levels of education are therefore just another example of how social equalities and health inequalities are deeply intertwined. Within the UK, BAME groups reported lower sexual health knowledge than their White British peers.[53] Does one's formal education impact their awareness of pre-pregnancy and pregnancy-related advice or services? How is pre-pregnancy and pregnancy related knowledge disseminated to and amongst BAME communities in the UK?

Cultural and social barriers: Access

There are clear cultural, social, and language barriers between UK health providers and migrant women, especially for those women who have recently immigrated to the UK. But what about cultural barriers facing BAME women who were born in the UK or are deeply familiar with British culture and the NHS? The cultural differences between providers and UK-born or fluent English speaking BAME women have therefore not yet been captured. When faced with an obvious language barrier, the NHS is required to provide interpreter services for patients, though this still presents practical difficulties regarding scheduling appointments around patients, doctors, and available interpreters. However, the idea of miscommunication, diverging vocabulary to describe symptoms, and misinterpreted non-verbal communication are all examples of communication barriers that could face

https://doi.org/10.1038/s41598-021-85514-w; Litchfield, I., Shukla, D. & Greenfield, S. (2021). 'Impact of COVID-19 on the digital divide: a rapid review.' BMJ open, 11(10) e053440.

50 Bjelke, M., & et al. (2016). 'Using the Internet as a source of information during pregnancy—A descriptive cross-sectional study in Sweden.' Midwifery, 40: 187-191.; Blaylock, R., & et al. (2022). 'WRISK voices: A mixed-methods study of women's experiences of pregnancy-related public health advice and risk messages in the UK.' Midwifery, 113: 103433.

51 Stacey, T., Haith-Cooper, M., Almas, N. & et al. (2021). 'An exploration of migrant women's perceptions of public health messages to reduce stillbirth in the UK: a qualitative study.' BMC Pregnancy Childbirth, 21(394): https://doi.org/10.1186/s12884-021-03879-2; Etowa, J. B. (2012). 'Black women's perceptions of supportive care during childbirth.' International Journal of Childbirth Education, 27(1): (2012): 27-32.

52 Ruiz, M., & et al. (2015). 'Mother's education and the risk of preterm and small for gestational age birth: a DRIVERS meta-analysis of 12 European cohorts.' Journal of epidemiology and community health, 69(9): 826–833.

53 Coleman, L., & Testa, A. (2007). 'Sexual health knowledge, attitudes and behaviours among an ethnically diverse sample of young people in the UK.' Health Education Journal, 66(1): 68-81.

patients regardless of their time in Britain. Fluency in English is ultimately only one tool needed to effectively communicate with healthcare staff.

Given the ethnic and cultural diversity of the UK, it would be impossible to assume that all women possess or experience the same cultural practices, stigma, or barriers to accessing maternity care. It has been established that BAME individuals may be fearful of mental health services and experience both cultural stigma and internalised stigma in accessing care. Is this also true of maternity services?[54] Understanding that socioeconomic factors and wider social determinants of health greatly affect maternal outcomes, it becomes imperative to understand how or if these social and cultural factors inhibit access to early maternity care if we are to address poor outcomes.

Distrust between patients and healthcare providers: Care

Systemic discrimination

There is growing recognition that there is structural racism embedded within the NHS as an institution, demonstrated through outcomes around inequitable care.[55] The systemic discrimination and structural racism of health care organisations ultimately hinder an individual patient's ability to ensure equitable care on their own.[56] How individuals are perceived by healthcare workers, and any preconceived assumptions healthcare workers bring into the patient's appointment, unfortunately can greatly affect the quality of that patient's care.

It is widely understood that Black women are perceived as 'difficult' or 'strong' by health care practitioners, with this perception serving as an obstacle to Black women being given adequate pain management during pregnancy.[57] Being denied adequate and appropriate medication is an all too common narrative of the Black birthing experience. But are there other, and earlier, instances where systemic racism serves as a destructive force in the BAME pregnancy and pre-pregnancy journey?

54 Amoah, E. (2021). 'Predicting Perinatal Low Mood and Depression for BAME Women-The Role of Treatment, Perceived Public, and Internalised Stigma.' Diversity and Equality in Health and Care, 18(7): 387-397.

55 House of Commons (2023). 'Black maternal health'. Retrieved from: https://committees.parliament.uk/publications/38989/documents/191706/default/

56 BirthRights (2022). 'Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care'. Retrieved from: https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf; House of Commons (2023). 'Black maternal health'. Retrieved from: https://committees.parliament.uk/publications/38989/documents/191706/default/.

57 FIVEXMORE (2022). 'The Black Maternity Experiences Survey: A Nationwide Study Of Black Women's Experiences Of Maternity Services In The United Kingdom'. Retrieved from: https://www.fivexmore.com/blackmereport

Fractured relationships with healthcare providers

Discriminatory experiences and distrust are common themes to emerge from BAME communities' descriptions of their relationships with healthcare providers. These poor relationships with healthcare providers seem to emerge over time, and through repeated incidents where a patient feels potentially ignored, discriminated against, or offered inequitable care. Do previous discriminatory experiences and intergenerational trauma therefore cause BAME women to distrust maternity care providers, and how can maternity health care workers solidify a bond with their BAME patients?

The reality that BAME communities may not automatically trust health care services is not a new finding. It is well understood that an effect of this distrust is poor uptake of health services, as demonstrated by BAME women's lower uptake of cancer screening services, and BAME communities' underutilisation of free testing services during the Covid-19 pandemic.[58] For maternity services, it therefore becomes crucial to create a supportive environment where patients can trust, and feel trusted by, their maternity care workers from the start of their journey.

58 Marlow, L. A. V., Wardle, J., & Waller, J. (2015). 'Understanding cervical screening non-attendance among ethnic minority women in England.' British journal of cancer, 113(5): 833-839.; Public Health England (2020). 'Beyond the data: Understanding the impact of COVID-19 on BAME groups'. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

Appendix B: Research participant breakdown

Survey participants

Survey responses were gathered from people self-identifying as women who have reported having been pregnant, or having tried to get pregnant in the past 10 years. All ethnic groups are generally well-represented, however with a larger proportion of Black individuals compared to the distribution of residents across England according to the 2021 Census data.

Survey participants by ethnicity group

Survey participants (310)	
Ethnic group	**Number (% total) of participants**
Black	**98 (31.6%)**
• Black, Black British, Caribbean or African: African	53 (17.1%)
• Black, Black British, Caribbean or African: Caribbean	40 (12.9%)
• Other Black, Black British, Caribbean or African background	5 (1.6%)
Asian	**75 (24.2%)**
• Asian or Asian British: Bangladeshi	5 (1.6%)
• Asian or Asian British: Chinese	12 (3.9%)
• Asian or Asian British: Indian	24 (7.7%)
• Asian or Asian British: Pakistani	18 (5.8%)
• Other Asian background	16 (5.2%)
Mixed	**37 (11.9%)**
• Mixed or multiple ethnic groups: White and Asian	11 (3.5%)
• Mixed or multiple ethnic groups: White and Black African	4 (1.3%)
• Mixed or multiple ethnic groups: White and Black Caribbean	17 (5.5%)
Other	**1 (0.003%)**
• Other ethnic group: Arab	1 (0.3%)
• Other mixed or multiple ethnic background	5 (1.6%)

Survey participants (310)	
Ethnic group	**Number (% total) of participants**
White	**99 (31.9%)**
• White: English, Welsh, Scottish, Northern Irish or British	81 (26.1%)
• White: Irish	3 (1.0%)
• White: Roma	1 (0.3%)
• Other White background	14 (4.5%)

Majority of survey respondents were born in the UK. Of those born abroad, there were a comparable number of people who have been in the UK for less than 7 years and for longer than 7 years.

Survey participants by age group and time in the UK

Survey participants (310)					
Age group	**Number (% total) of participants by length of residency in the UK**				
	Born in the UK	**7+ years**	**Less than 7 years**	**Unknown**	**Total**
Under 20	4 (1.3%)	0	1 (0.3%)	0	**5 (1.6%)**
21-25	21 (6.8%)	5 (1.6%)	10 (3.2%)	1 (0.3%)	**37 (11.9%)**
26-30	22 (7.1%)	1 (0.3%)	19 (6.1%)	1 (0.3%)	**43 (13.9%)**
31-35	34 (11.0%)	18 (5.8%)	27 (8.7%)	2 (0.6%)	**81 (26.1%)**
36-40	34 (11.0%)	22 (7.1%)	14 (4.5%)	0	**70 (22.6%)**
41-45	24 (7.7%)	12 (3.9%)	6 (1.9%)	0	**42 (13.5%)**
46-50	12 (3.9%)	5 (1.6%)	1 (0.3%)	0	**18 (5.8%)**
51+	11 (3.5%)	2 (0.6%)	1 (0.3%)	0	**14 (4.5%)**
Total	**162 (52.3%)**	**65 (21.0%)**	**79 (25.5%)**	**4 (1.3%)**	

The majority of the survey respondents were either in higher managerial, lower managerial and intermediate occupations at an aggregate 62.3%. There is a relatively lower representation of categories representing lower socioeconomic status.

Survey participants by type of occupation as proxy for socioeconomic status

Survey participants (310)	
Managerial occupation	**Number (% total) of participants**
Higher managerial, administrative and professional occupations (eg. Lawyer, Architect, Medical doctor, Chief executive, economist)	42 (13.6%)
Lower managerial, administrative and professional occupations (eg. Social workers, nurses, journalists, retail managers, teachers)	97 (31.3%)
Intermediate occupations (eg. Armed forces up to sergeant, paramedic, nursery nurse, police up to sergeant, bank staff)	54 (17.4%)
Small employers and own account workers (eg. Farmers, shopkeepers, taxi drivers, driving instructors, window cleaners)	10 (3.2%)
Lower supervisory and technical occupations (eg. Mechanics, chefs, train drivers, plumbers, electricians)	11 (3.6%)
Semi-routine occupations (eg. Traffic wardens, receptionists, shelf-stackers, care workers, telephone salespersons)	24 (7.8%)
Routine occupations (eg. Bar staff, cleaners, labourers, bus drivers, lorry drivers)	7 (2.3%)
Never worked/long-term unemployed	40 (12.9%)
Full-time students	8 (2.6%)
Not sure	17 (5.5%)

Interview participants

Interviews were conducted for a total of 15 women.

Interview participants (15)	
Ethnic group	**Number (% total) of participants**
Black	**3 (20.0%)**
• Black, Black British, Caribbean or African: African	2 (13.3%)
• Black, Black British, Caribbean or African: Caribbean	0
• Other Black, Black British, Caribbean or African background	1 (6.7)
Asian	**7 (46.7%)**
• Asian or Asian British: Bangladeshi	1 (6.7%)
• Asian or Asian British: Chinese	1 (6.7%)
• Asian or Asian British: Indian	2 (13.3%)
• Asian or Asian British: Pakistani	3 (20.0%)
• Other Asian background	
Mixed	**4 (26.7%)**
• Mixed or multiple ethnic groups: White and Asian	1 (6.7%)
• Mixed or multiple ethnic groups: White and Black African	0
• Mixed or multiple ethnic groups: White and Black Caribbean	2 (13.3%)
• Mixed or multiple ethnic groups: Other	1 (6.7%)
White	**1 (6.7%)**
• White: English, Welsh, Scottish, Northern Irish or British	0
• White: Irish	0
• White: Roma	0
• Other White background	1 (6.7%)

The largest cohort of interviewees were in the 36-40 age group. The majority of our interviewees were UK born.

Interview participants by age group and time in the UK

Survey participants (310)				
Age group	Number (% total) of participants by length of residency in the UK			
	Born in the UK	7+ years	Less than 7 years	Total
21-25	3 (20%)	0	0	**3 (20.0%)**
26-30	1 (6.7%)	0	0	**1 (6.7%)**
31-35	1 (6.7%)	1 (6.7%)	1 (6.7%)	**3 (20.0%)**
36-40	4 (26.7%)	2 (13.3%)	1 (6.7%)	**7 (46.7%)**
41-45	0	0	0	**0**
46-50	1 (6.7%)	0	0	**1 (6.7%)**
51+	0	0	0	**0**
Total	**10 (66.7%)**	**3 (20.0%)**	**2 (13.3%)**	

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Thank You