THE BLACK MATERNITY EXPERIENCES SURVEY

A NATIONWIDE STUDY OF BLACK WOMEN'S EXPERIENCES OF MATERNITY SERVICES IN THE UNITED KINGDOM

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FOREWORD

Inequalities in maternal death rates between Black women and White women in the UK have been documented for many years, and it is thanks to the work of Five X More and other advocates that tackling this disparity is now recognised as a priority.

It is important to remember that behind every statistic is an individual, a family, friends, and a community, and while the MBRRACE-UK reports can describe the care received by women who die or whose babies die, they cannot recount those women's experiences. The work that the Five X More campaign have undertaken, and which is described in this report, brings those experiences to the fore. It is only by listening to women that we can understand the full impact of the care we are providing and identify ways to improve. As noted in the conclusion to the report, remaining open to understanding Black women's experiences is essential.

When this survey was released, the fact that more than 500 responses were received within the space of little over 24 hours shows just how many Black and Black mixed women want to share their experiences and help drive change to maternity care. This report encompasses the views of more than 1300 Black and Black mixed women and provides a basis on which to make those changes.

The MBRRACE-UK reports have highlighted differences in maternal deaths between Black women, Black mixed women and White women, but nevertheless we know that maternal deaths are uncommon; in the UK three Black women die among every 10,000 who give birth. However, it is imperative to note that similar inequalities exist in severe pregnancy conditions, such that Black women are up to twice as likely to have a severe pregnancy complication compared with White women. Severe, or 'near-miss' complications are much more frequent than maternal deaths, affecting around one in 100 women, and this emphasises the importance of acting now to ensure that we are providing the best care for all pregnant and postnatal women.

The long-term impact of traumatic birth experiences for Black and Black mixed women is very clear from the experiences described in this report. Many women who contributed to the Five X More survey have highlighted ways in which services can improve to provide the maternity care they need. Each of us can read this report and identify different findings on which we need to act. We should all recognise where we as an individual, a healthcare professional, a service manager or a policy maker can make change. Together we can then strive to decrease the unacceptable disparity in maternity outcomes for Black women in the UK.

Marian Knight

Professor of Maternal and Child Population Health, University of Oxford
Lead for the MBRRACE-UK Confidential Enquiries into Maternal Deaths

A NOTE FROM THE PEER RESEARCHERS

Since the MBRRACE-UK 2018 report stating that Black women were 5 times more likely to die in pregnancy, childbirth and the six week postpartum period, the public has been inundated with headlines, documentaries, task forces, round tables and stakeholder groups trying to work out why this inequality exists and why it has done so for so long.

However, as Black women who have had various experiences within maternity systems, are in constant engagement with Black women, and started an organisation to change those very outcomes, we realised that the actual voices and daily experiences of Black women were missing from the narrative.

Even though the most recent figures show a slight decrease in the number of deaths, it must be noted that it wasn't statistically significant and the situation is still dire as the inequalities are still present. Some might view this as the situation is improving but the fact the disparity is still there is terrible.

We are Tinuke and Clo, the Co-founders of Five X More CIC. At Five X More, we aim to highlight and change Black women and birthing people's maternal outcomes in the UK in three different ways: first, by training healthcare professionals on the issues that Black women face within maternity services; second, by lobbying the Government to take action via our Black Maternal Health All Party Parliamentary Group and various Parliamentary evidence-giving sessions; and third, by empowering women with our free resources and information on their rights and what to expect through pregnancy and labour. Through speaking to thousands of Black women since starting Five X More in 2019, we quickly realised that we needed to find ways to amplify their voices and experiences through our platforms as we believe that you can learn from both good and bad experiences. However, it became clear that the actual data on Black women's maternity experiences was almost non-existent.

This was further highlighted on 19th April 2021 at the parliamentary debate to improve Black Maternal Healthcare and Mortality, following on from the successful petition launched by us at Five X More in March 2020. Nadine Dorries MP who, at the time, was the Minister for Patient Safety, Suicide Prevention and Mental Health explained that the Government were embarking on the first women's health strategy for England, and that the aim of the strategy was, first and foremost, to listen to the voices of women. Nadine then described a call for evidence launched to understand women's experiences of the health and care system stating that, "...by better understanding women's experiences, (they) can truly ensure that the health system truly meets the needs of women as they should be met". However, she later revealed that women from Black and other minority ethnic groups were underrepresented in the responses they had received.

This was a lightbulb moment for us at Five X More because we know that you are only as good as the data you have: One of our key campaign asks is that "Black women are involved at every level when it comes to making decisions about their care". We knew that gathering an all-Black expert panel of researchers, health professionals and organisational groups to conduct a national survey on Black women's maternity experiences was of the utmost importance, not only because it was timely, but because it had never been done on the scale that we were planning. So that is what we did.

On 21st April 2021, we launched the Black Maternity Experiences Survey asking Black women who had been pregnant in the last five years to tell us about their experiences. Within 24 hours of launching, we received over 500 responses, further solidifying that not only do Black researchers need to be front and centre when it comes to data collection on issues relating to the Black community, but that their input on providing solutions to the disparities we see is invaluable. We believe that you have to take a different approach if you want a different outcome, and we know that this pioneering piece of research will be the start of doing things differently.

We want to make clear that this study was completely self funded by Five X More. Whilst we are immensely proud of the huge amount of work that has gone into making this happen, we also want to take this opportunity to highlight that racial inequalities extend even into the commissioning of research. In 2020, we saw the funding agency, UKRI, give £0 of its £4.3m Covid pot to Black researchers even after making an equality pledge. The lack of funding awarded to Black researchers, academics and Black-led organisations like our own has a devastating effect on the wider society. Not only does this disproportionate distribution of resources mean that issues that affect us directly are not addressed, but it also means that opportunities for change are stifled.

We are hopeful that this study is the first of many, and that we can continue to amplify the voices of the Black women in the community that we serve. Their experiences have gone under the radar for far too long. There are real people behind the statistics and it is time to uncover the voices of Black women who have consistently had poorer maternal outcomes. Listening to them is vital for better understanding on how to dismantle the current systems and processes that maintain the status quo of racial inequality. Listening to them is how we work towards real, tangible change.

We are mindful of the importance of representing the views of all pregnant and birthing people and so the survey was open to anyone in the UK who identified as a Black or Black mixed woman, including people from LGBTQ+ or non-binary backgrounds. For consistency, we felt it important that the language used in this report reflects the language used in the survey. We, therefore, refer to “Black women” and “Black mixed women” throughout this report.

Please note that this report includes discussion of traumatic and uncomfortable birthing experiences which some readers may find distressing.

Tinuke

Clo

ACKNOWLEDGEMENTS

This work would not have been possible without the involvement of several Black healthcare professionals including doctors, midwives, policy advisors, researchers, as well as Black women's organisations and community groups based across the country who supported us in creating the questionnaire, recruiting the women to take part in the survey and sharing their expertise and insights with us across the whole process. We offer our sincere thanks to our researchers and report authors Michelle Peter and Reyss Wheeler whose contribution and pro bono support brought the data and report to life.

Particular thanks go to all the members of our expert panel whose contribution was vital in the making and distributing of the survey: Dr Adanna Okeahialam, Elaine Amoah, Black Ballad, Black Mothers Matter, Black Mums Upfront, Chat Her Box (Dr Remi Mogekwu and Dr Jennifer Owusu Adjei), Dr Christine Ekechi, Dr Adwoa Danso-Boamah, Mary Dehinbo, Jenny Douglas, Janet Fyle, Holding Her Space, Midwife Marley, Mum's Pride, Mummy's Day Out, Professional Aunty, Ruth Oshikanlu and Sisters in Business.

Many thanks goes to Eddie Morris, Kate Lancaster, Birte Harlev-Lam, Professor Marian Knight, Dame Lesley Regan and all the lawyers and trainees that supported us from Clifford Chance in particular David Boyd, Alice Darling, Yuli Adagun, Julia Kono and Maryam Khalifa.

Lastly, we would like to thank every single Black woman who took part in the survey and the in- depth interviews for trusting us and sharing their experiences. We know that for a long time Black women have felt that their concerns have been brushed aside or not taken seriously and that, in some cases, they did not know where to turn or were too exhausted to speak up. Your contributions have made this research stronger and our intention is that this report will highlight the experiences that have been missing from the narrative for so long. We hope that this work will be a major step towards positive changes to the future journey of maternity services for Black women in the UK.

EXECUTIVE SUMMARY

Maternal outcomes for Black women are significantly worse than for white women. Not only are Black women four times more likely to die during pregnancy, labour, or postpartum[1], but they are twice as likely to have their baby die in the womb or soon after birth[2] and are at an increased risk of readmission to hospital in the six weeks after giving birth[3] .

These racial inequalities are indisputable, and yet their cause remains unclear. Studies have highlighted that Black, Asian and minority ethnic women report negative interactions with healthcare professionals more often than white women, and that these interactions, often grounded in racial biases, negatively impact their experiences of care[4]. Little work, however, has explored these experiences from the perspective of Black women exclusively, even though the risk of adverse maternal outcomes is greatest for this community. The aim of this work was to address this urgent need: to better understand how Black women's maternity experiences in the UK shape their perception of care.

Using a survey designed with input from an expert panel of Black professionals, both quantitative and qualitative data was gathered from 1340 women and birthing people from around the UK who either identified as Black or of Black mixed heritage and had accessed NHS maternity services whilst pregnant between 2016 and 2021.

The findings raise cause for concern. Though both positive and negative experiences were reported, negative experiences far outweighed those in which women were happy with the care that they had received. These negative experiences were found to fit within a framework overarched by three interrelated constructs centred around the healthcare professional (HCP):

- *Attitudes* (e.g., using offensive and racially discriminatory language; being dismissive of concerns),
- *Knowledge* (e.g., poor understanding about the anatomy and physiology of Black women; poor understanding of the clinical presentation of conditions in babies of Black women), and
- *Assumptions* (e.g., racially based assumptions about the pain tolerance, education level, and relationship status of Black women).

These constructs were found to be a powerful influence over subsequent behaviour of the HCP and, in turn, often translated to a combination of clinical, emotional, and psychological outcomes, some of which were long-lasting, including anxiety, post-traumatic stress, and fear of having more children. Importantly, these consequences were pivotal in defining Black women's feelings around their maternal care. Positive experiences were those in which women described feeling valued and centred in decision-making; experienced empathy, compassion and able to relate to the HCPs involved in their care; and felt confident in their abilities to advocate for themselves.

Despite the stark disparities in maternal outcomes, Black women's voices and lived experiences have been notably absent from the literature. The findings in this report highlight the urgent work needed to ensure that rapid improvements are made – because a positive birthing experience is deserved not just by some, but by all.

INTRODUCTION

It is alarming, that after years of research highlighting the stark racial inequalities in health care, these disparities are as apparent today as they ever were, with people from Black, Asian, and minority ethnic backgrounds in the UK experiencing poorer health outcomes and lower quality of care[5],[6]. The inequalities seen in maternal health are just as historic and equally as appalling. Disparities in maternal mortality between Black and white women were identified as long as a decade ago[7], and yet maternal outcomes are, today, still substantially worse for Black women[8].

The release of the most recent MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK) 2016-18 report[9] received a great deal of attention and, for campaigners and advocates of maternal health, has been the catalyst for change that is long overdue. In the report, clear racial variations in maternal deaths were observed, showing that Black women are four times as likely to die as white women during pregnancy, delivery or postpartum. Similar patterns of disparity have been seen across other aspects of maternity care: Black women continue to be at a higher risk of their baby dying in the womb or soon after birth, with studies indicating stillbirth rates to be twice as high for Black women[10], [11], [12], [13]. The risks for Black women remain high even after even they have left the hospital setting: in a review of nine maternity services in the UK, Black women were found to have significantly higher rates of re-admission to hospital compared to white women in the six-week postnatal period (93 readmissions per 1,000 deliveries for Black women compared to 68 readmissions per 1,000 deliveries for white women during 2020)[14].

This striking disparity is deeply concerning and yet the reasons for the differences between Black and white women's maternal outcomes remain unclear. Factors associated with social disadvantage, such as low education level, low income, and living in areas of high deprivation, are often argued to be contributors[15], but studies exploring Black, Asian and minority ethnic women's maternity experiences have made it abundantly clear that these factors alone are not enough to explain the huge differences observed. These studies have revealed there to be other aspects at play that promote and perpetuate the inequality in the maternity care received by these women. In particular, they have highlighted that Black, Asian and minority ethnic women report negative interactions with healthcare professionals more often than white women, and that these interactions adversely impact their experiences of care. For instance, compared to white women, Black, Asian and minority ethnic women have been found to worry more about labour and delivery[16],[17]; to not feel treated with respect and report staff unhelpful and rude[18] ; to have been denied adequate pain relief and have less confidence in staff[19] ; and to report poorer experiences of maternity care in general[20] .

Most worryingly, the research highlights that these interactions can be related to racial biases embedded in the health system and predicated on negative racial stereotypes held by healthcare professionals[21], [22]. The discriminatory behaviour and attitudes that follow have been shown to negatively impact women's clinical outcomes and experiences of care including influencing the type and amount of information that women receive (which has implications for informed decision-making)[23], [24]; discouraging women from raising concerns[25]; and fostering a reticence to engage in maternity services in the future[26]. The significance of racial discrimination in the maternity setting has not gone unnoticed. In their 2020 Position Statement, the Royal College of Obstetricians and Gynaecologists (RCOG) acknowledged the impact of racial bias on maternal health disparities and proposed recommendations that include conducting clinical research that is inclusive of Black, Asian and minority ethnic women, and training medical students to understand how negative stereotypes and false beliefs about race affect the interactions with the women and families to whom they provide care[27]. Calls have also been made by grassroots campaigners and charities, such as Birthrights, Birth Companions and ourselves, for further investigation into racial injustice in the UK's maternity services.

The situation is, undeniably, complex. Socioeconomic factors partly explain the racial inequalities in maternal outcomes, but studies of Black, Asian and minority ethnic women's experiences have revealed the need to look beyond these as a way of explaining the differences observed. Racial discrimination is weaved into the fabric of our society and institutions, and racial bias has been recognised as a likely contributor to what is evidently a multifactorial issue. Nonetheless, it is still unclear why, of all the ethnic minority groups, the greatest risks of adverse outcomes are attributed to Black women.

A significant problem in trying to address this matter, is that Black women are underrepresented in maternal health research – a concern that was raised as long ago as thirty years by Jenny Douglas who describes the invisibility of Black women in research. To understand the experiences of Black women, studies must, she argues, *"incorporate an understanding of the relationship of these communities to the social organization of British society, where racial discrimination is central."*[28]. To date, there has been little done to resolve this historical underrepresentation and yet, in the absence of reliable research, guidelines that are driven by harmful ideas about differences between women of different ethnicities, continue to be made that will subject Black women to poorly evidenced care[29].

The issue is further complicated by the fact that, even when Black women are included in maternal health studies, researchers aggregate minority ethnic categories, assuming collective experiences across women from, what are in fact, culturally distinct groups[30], [31]. This generalisation has the potential to miss important nuances in the experiences that are specific to individual communities. The distinct lack of research into the maternity experiences of Black women specifically, means that we know little about why Black women in particular are disproportionately disadvantaged, and even less about how their maternity experiences shape their perception of care.

Aims

To address this issue, and to be able to develop recommendations that will accurately reflect the unique experiences of Black women, we believe the first step is to understand how maternity care is delivered from the perspective of women from the Black community. Our aim, therefore, was to gain insight into Black and Black mixed women's attitudes towards and experiences of maternity care in the UK. To do this, we used a survey to gather both quantitative and qualitative (open-text comments) data. Our overarching question was: What are Black and Black mixed women's experiences of UK maternity care across the antenatal, labour, and postnatal period? Our sub-questions were: a) Do Black women report different experiences of maternity care to Black mixed women?, b) Do experiences of maternity care differ between the antenatal, labour, and postnatal period?, and c) How do Black and Black mixed women's experiences influence their perception of care?

METHODOLOGY

Study design

This study is an experiential analysis of the antenatal, labour and birth, and postnatal lived experiences of Black women residing in the UK who were pregnant and accessed NHS maternity services between 2016 and 2021.

Survey development

In April 2021, a single survey was devised by Five X More with the support of doctors, midwives, health visitors, GPs and women's maternal organisations and community groups. During the development of survey questions, we discussed the use of correct terminology to describe ethnicity and the common issues faced by women across the various stages of pregnancy. We also considered the wording of questions to ensure that they could be understood clearly by all participants. The survey structure included three pathways depending on whether a respondent had a successful pregnancy and birth, a miscarriage or stillbirth. All respondents answered screening questions, provided demographic information and completed a prenatal survey section before being routed to a specific pathway based on the information they had provided about their pregnancy outcome. The maximum number of questions was 92, but the number of questions a participant could answer varied depending on the responses given. Respondents in the live survey were screened in or out depending on whether they identified as Black or Black mixed. Respondents were able to provide detailed feedback about their experiences in open-ended questions relating to their satisfaction with an area of care received. The average survey completion time was 28 minutes and 56 seconds with a drop off rate of 61%.

Participants and recruitment

The study was conducted using an online survey via purposive sampling (a non-probability sampling method for targeting specific sections of a population) to targeted Black and Black mixed women. The data set gathered 1340 Black and Black mixed women's individual experiences, obtained via an online survey hosted on Typeform from 21st April 2021 to 30th June 2021. Consent to take part in the study was sought at the start of the survey. The survey was disseminated across the social media platforms Instagram and Twitter, including @fivexmore, @MumsandTea and @_prosperitys. It was also shared with the Five X More Expert Panel, including organisations Black Ballad, Black Mothers Matter, Black Mums Upfront, Chat her Box, Holding Her Space, Mums Pride, Professional Aunty and Sisters in Business who distributed it to their target audience. Social media sites and specific handles were used because of their high engagement of Black women in the age ranges of 21 – 45. Users of these sites are often already engaged to varying degrees with the survey topics and have built relationships and trust with Five X More and other affiliated organisations looking at maternity care topics. The survey was also shared using Mail Chimp, WhatsApp and Mighty Networks. Following the survey, 10 women consented to be interviewed about the care they had received during pregnancy, giving birth and for up to one month after the baby was born. The current report describes the results from the survey only.

Data analysis

Quantitative analysis: The quantitative data included responses from 157 questions in total and was analysed as a whole population data set using measures of central tendency, and then as two populations sets with ethnicity as the independent variable; comparing the mean results for respondents who identified as Black with those who identified as Black mixed. Inferential analysis was employed to interpret the data and its meaning.

Qualitative analysis: The qualitative data comprised women's responses in the open-text boxes relating to questions about their maternity experiences in the antenatal, labour, and postnatal period. Responses were divided into those that were factual and those that were experiential, with only experiential responses being analysed. Responses were read and re-read to gain an overall sense of women's experiences. NVivo (Version 12)[32] was used to assist in the assignment of codes to the women's responses. Using an iterative process, themes were coded as they arose using a thematic content analytic approach.

FINDINGS
PARTICIPANT DEMOGRAPHICS AND CONTEXTUAL INSIGHT

Ethnicity, citizenship and religion

Three quarters of respondents identified as Black whilst a quarter identified as Black mixed.

Of those that identified as Black, 50% respondents were from the Black Caribbean diaspora, 45% were from the Black African diaspora and 5% identified as being both Black African and Caribbean or other Black. Of those that identified as Black mixed, 71% were Black Caribbean and white, 16% were Black African and white and 13% identified as Other mixed (Table 1).

Table 1. Ethnicity of survey respondents

Ethnicity	%
Black Total	76%
Black Caribbean	50%
Black African	45%
Black African & Caribbean	4%
Other Black	1%
Black mixed Total	24%
Black Caribbean & White	71%
Black African & White	16%
Other mixed	13%

The majority of respondents identified as being religious. The predominant religious identity was Christian (70%) whilst 20% of respondents said they had no religion (Table 2).

Table 2. Religion of survey respondents

Religion	%
Christian	70%
Muslim	5%
Buddhist	1%
Other	2%
No religion	20%

Almost all survey participants were British citizens and had lived in the UK their whole lives; only 4% of those surveyed had lived in the UK for less than 10 years (Table 3).

Ethnicity, citizenship and religion (continued)

Table 3. Citizenship status of survey respondents and time spent living in the UK

Citizenship Status	%
British Citizens	92%
EEA	3%
Non-EEA	3%

Time spent living in UK	%
Since birth	73%
10 years or more	22%
Less than 10 years	4%

Most women were either married or cohabiting at the time of their pregnancy; 14% of women were not in a relationship at the time of their pregnancy (Table 4).

Table 4. Relationship status of survey respondents

Relationship Status at time of Pregnancy	%
Married	51%
Cohabitating	31%
Not in a relationship	14%

Age and disability

The majority of respondents were of average child-bearing age. Only 1% of respondents were either under 18 or over 45 at the time of the pregnancy on which they reported.

Table 5. Age of survey respondents

Age	%
Under 18	<1%
18-25	19%
26-35	65%
36-45	15%
Over 45	<1%

Five percent of the population identified as having either a mental or physical disability; only 3% of the surveyed population believed they have or may have additional learning needs.

Education, occupation and income

Seventy-five percent of women were degree educated having achieved a Bachelors, Masters or PhD level education. Less than 1% of the surveyed population stated that they had no educational qualifications.

Table 6. Education, occupation and joint household income of survey respondents

Highest level of Education	%
Bachelor's Degree	52%
Postgraduate (MSc and PhD)	25%
A-Level & Post-16 Diploma	17%
GCSEs	4%
No educational qualifications	1%

Eighty-five percent of the surveyed population were employed or self-employed. Thirty-five per cent of respondents earned £39,999 or below, whilst more than half reported earning above £40,000.

Employment Status	%
Employed	74%
Self-employed	11%
Homemaker/Parent or Carer	9%
Unemployed	3%
Student	2%

Household Income	%
Under 20,000	11%
20,000-39,999	24%
40,000-59,999	21%
60,000-79,999	15%
80,000-99,999	12%
100,000 or more	12%

Pregnancy & Health

When answering the survey, the majority of respondents were referring to their first pregnancy (68%), whilst 20% were referring to their second pregnancy and 12% referred to their third or a later pregnancy. Of the pregnancies that respondents referred to, 93% resulted in a live birth. Seven percent of completed surveys referred to a miscarriage, still birth or non-viable pregnancy.

Over half of respondents said that they had received their care in the London area. A total of less than 3% received care in Scotland, Wales, Northern Ireland and the North East of England (Table 7).

A third of women reported not having any prior health conditions, 63% of women had a common health condition and 31% of women stated that they had a medically serious or life-threatening health condition, 31% of women had two or more conditions prior to pregnancy.

Table 7. Location of maternity care of survey respondents

Location of maternity care	%
London	53%
South East England	11%
West Midlands	9%
East Midlands	5%
North West England	5%
South West England	5%
East England	4%
North East England	1%
Yorkshire and Humberside	4%
Scotland, Wales and Northern Ireland	3%

The majority of women (85%) engaged with maternity services in the first trimester of their pregnancy, with 10% engaging in the second trimester and 5% engaging in the third trimester.

On average, 63% of women said they had no concerns about their pregnancy in the first, second or third trimester. Of the 37% of respondents who did have concerns during pregnancy, 91% of women shared that they reported those concerns to a healthcare professional. Only 3% of women reported missing a midwifery appointment and 1% or less missed an appointment with the doctor or a scan.

QUANTITATIVE SURVEY FINDINGS

Overview

The statistical data were analysed and organised thematically. The key themes that emerged from the quantitative data were: Information about maternal health; Care standards and complaints; and Satisfaction with antenatal, labour and birth, and postnatal care.

Information about maternal health

Overall women reported that midwives were likely to discuss physical health status and safeguarding and social risk factors. However, there was a lack of information, advice and support given around mental health, rights, choices and social support.

When respondents were asked about their initial antenatal meetings, they reported that midwives discussed the following at least 50% of the time: folic acid (74%), previous health history (70%), wider social issues and family history (61%), emergency medical contact (60%), smoking status (59%), mental health (51%). In contrast, women reported that midwives discussed the following issues less than 50% of the time: birth choices (49%), maternity rights (48%), reduced fetal movement (46%), antenatal issues (44%), domestic abuse (43%), foods to avoid (43%), medication and drug use (42%), vitamin D (35%), exercise in pregnancy (25%), pelvic floor (25%), female genital mutilation (19%), local maternity organisations (17%) and Maternity Voices Partnership (3%). Women also reported being uninformed about risk status with 40% of respondents reporting they were not informed of their pregnancy risk status or that it could change as the pregnancy progressed.

Thinking more widely about interactions with all health care professionals throughout pregnancy, 40% of respondents said health care professionals did not ask about previous or current emotional wellbeing and mental health. Of women who reported being asked about their mental health and wellbeing, 66% of respondents said that they were not signposted to any resources or provided with any additional support.

Women were most likely to use internet sites like the NHS website (60%) and Emma's Diary (53%) or family and friends (59%) to gain information they needed during pregnancy. Less than 2% of respondents identified using a book or a birthing support professional like a doula for pregnancy information. However, 13% of women said that they sought private professional support during pregnancy, outside of what was provided to them by the NHS.

Twenty-seven percent of women stated that they did not fully understand the information given to them by healthcare professionals postpartum and 28% were not confident with reading the information provided in English.

Care standards and complaints

Thinking about overall experience of healthcare professionals during pregnancy, 22% rated theirs as negative. On average, 27% of women surveyed felt that they received a poor or very poor standard of care during pregnancy, labour and postnatally. Of those that thought the standard of care was poor or very poor (16%) less than a quarter (23%) made a formal complaint. Women who identified as Black were 10% less likely than Black mixed women to make a formal complaint to the hospital or Trust providing their care.

More than half of women (54%) reported facing challenges with healthcare professions during their maternity care; 59% of mixed Black women reported facing challenges with healthcare professionals compared to 53% of Black women.

Furthermore, 43% of women reported feeling discriminated against during their maternity care, with the most common reasons being race (51%), ethnicity (18%), age (17%) and class (7%). Black women were 20% less likely than Black mixed women to report discrimination based on race or ethnicity.

Only 12% of women reported being informed about how to make a complaint, and 48% of women shared that despite not being satisfied with their care, they did not make a complaint. Ten percent shared that they complained informally and 8% complained in writing.

Women reporting on their first pregnancy were less likely to be satisfied that issues were identified quickly, whereas women experiencing a second or later pregnancy that had previously reported complications, shared that they were mostly satisfied that the issues were identified and dealt with quickly. For women referring to pregnancies and maternity care after March 2020 that was delivered virtually, 42% reported feeling very or somewhat dissatisfied with the service received.

Satisfaction with antenatal, labour and birth, and postnatal care

Antenatal care

Respondents were highly engaged with antenatal care. Of women surveyed, 96% reported engaging with maternity services in the first trimester of pregnancy and 95% of women reported engaging fully with midwifery, doctor and sonography appointments whilst pregnant.

Fifty-one percent of women reported having concerns about their pregnancy in the first trimester of which 97% said they had raised concerns with a healthcare professional (HCP). Concerns reduced in the second trimester with only 14% of women reporting any concerns and a subsequent 37% raising their concerns with a HCP.

For women who experienced miscarriage or pregnancy loss, 61% report that they were not offered any additional support to deal with the outcome of the pregnancy and 9% report accessing medical or wellbeing support outside of the NHS after their pregnancy loss.

Despite high levels of engagement with antenatal services and reporting of concerns to HCPs, 27% of women reported antenatal care as being unsatisfactory.

Satisfaction with antenatal, labour and birth, and postnatal care

Labour and birth

The surveyed population encompassed a range of birthing methods: 57% of women reported that their birth required further intervention from medical professionals; 43% of respondents had a vaginal birth without an instrument; 31% had an emergency caesarean; 27% had induced labour and 7% had a planned caesarean.

Thinking about women's overall labour and birth experience, 42% of women reported feeling the standard of care they received during childbirth was poor or very poor. Twenty-six percent of respondents reported dissatisfaction with the initial contact between them and their birthing centre, hospital or home birth team at the time of established labour. Moreover, 36% of respondents reported feeling dissatisfied with how their concerns during labour were addressed by professionals.

When women were asked about their experience of pain relief, 80% of Black women and 84% of Black mixed women felt that they required pain relief during labour. Forty-three percent of Black and Black mixed women reported that their pain relief options were not explained to them and 52% of women who did not receive their choice of pain relief shared there was no explanation as to why it was not given to them.

Additionally, women shared concerns around their safety, with 42% of respondents reporting feeling that their safety had been put at risk by professionals during labour or the recovery period, although Black mixed women were 6% more likely to report their safety being put at risk than Black women.

Satisfaction with antenatal, labour and birth, and postnatal care

Postnatal care

Women expressed concerns about postnatal interactions with and care from HCPs; 31% of respondents were concerned about the healthcare they received from their midwife during the birth recovery period; 24% were concerned about the care they received from their health visitor and 23% were concerned about the care they received from their GP during their recovery period.

However, 69% of respondents said they were somewhat or very satisfied with the postnatal health check-up performed by the health visitor however, satisfaction declined with only 57% of respondents feeling satisfied with the postnatal check-up with their GP. 27% of respondents report that they were not asked about their emotional wellbeing or mental health by a healthcare professional during postnatal interactions.

Thirty-four percent of respondents said they had concerns for their health after they gave birth and 78% of those with concerns said they raised their concerns with a HCP. Twenty-one percent of respondents said they were not confident or did not know which HCP to contact if they had concerns for themselves or their baby.

Women expressed a lack of confidence in interactions with HCPs postnatally; 36% of respondents said that they were not confident to ask for help on the postnatal ward, and a third were not confident in raising concerns about their postnatal maternal wellbeing with HCPs.

During the postnatal period, overall satisfaction levels were higher than those reported during labour; 15% of Black women and 21% of Black mixed women felt that the care they received postnatally was poor or very poor; 17% of Black women reporting a poor experience made a formal complaint with the relevant body, whilst 24% of Black mixed women pursued the complaints process.

QUALITATIVE SURVEY FINDINGS

Overview

Qualitative analysis of the free-text responses revealed there to be a complex interaction between a number of factors that contributed to Black and Black mixed women's maternal care experiences. Both positive and negative experiences were described. However, Black and Black mixed women's reports of adverse experiences and dissatisfaction with treatment throughout and following pregnancy, far outweighed the cases in which women stated that they were happy with the care that they received.

These negative experiences were found to fit within a framework overarched by three interrelated constructs centred around the healthcare professional (HCP): attitudes held by the HCP, knowledge held by the HCP, and assumptions made by the HCP. These constructs were found to be a powerful influence over the behaviour of the HCP which, in turn, often led to a combination of clinical, emotional, and psychological outcomes that defined Black women's feelings around and reflections on their maternal care. Importantly, this model was found to apply to experiences across the antenatal, labour and birth, and postnatal period.

Attitudes, knowledge and assumptions form the roots of Black women's maternity experiences

Attitudes

The reported attitudes of HCPs towards Black and Black mixed women contributed significantly to women's feelings about their care throughout and after their pregnancy. The attitude most frequently described by women was one of dismissiveness, with consistent reporting by many women of genuine concerns being ignored by professionals. For some, not being listened to made them feel "*scared*" about their pregnancy and as if their "thoughts and feelings do not matter". For others, concerns being ignored were felt to have led to emergency situations:

"I ended up having to go into surgery because my daughter's heartbeat had started to drop…I feel like we only got to this stage because the first midwife had dismissed me for hours when I was trying to…tell her that something is wrong." (Black woman)

Black and Black mixed women also expressed that, even when worries were acknowledged, they were often trivialised, with women frequently being made to feel that they were exaggerating their symptoms. One Black mixed woman was told that she was being "*dramatic*" during administration of an epidural which subsequently resulted in numbness in her leg for the following three months. Another woman who was in pain and walking with a stooped posture a day after delivering her baby by Caesarean section, overheard a nurse saying to a colleague that she would hit her back to make her walk straight. Women reported often that their symptoms were minimised and that their pain or worries about their baby were not taken seriously. For instance, one Black woman was told that she was *"being loud for no reason"*, whilst another described how the downplaying of her concerns about her baby's breathing had ended catastrophically:

"…she was struggling to breathe after birth. I was told that it was a normal thing for newborns. No checks were done to put my mind at ease. After about 20 mins, my baby stopped breathing. Efforts were made to resuscitate her, but she later died in NICU." (Black woman)

As well as adverse clinical outcomes in the neonatal setting, failing to act on concerns also negatively impacted maternal health, such as the case of a woman living with sickle cell anemia:

> ***"I had an episiotomy and the stitches fell out. I am at high risk from infection due to my sickle cell. They kept refusing to have a look…By the time a doctor looked the stitches had fallen out and it was infected. This then triggered a sickle cell crisis." (Black woman).***

Black and Black mixed women also spoke about HCPs making insensitive comments and using offensive language. For instance, one Black woman described how a midwife had commented on her daughter's complexion, noting that she was, "very fair for a mixed-race child, but at least she'll have a lovely tan when she grows up". Another woman stated that a midwife had made inappropriate comments about her future reproductive plans:

> ***"The midwife said in a mocking manner moments after I gave birth, "we will see you here next year anyway". Which I felt was implying that because I'm Somali I'll just end up giving birth every year." (Black woman)***

Further comments from Black and Black mixed women included HCPs making reference to physical features that are stereotypically categorised as Black *("I remember the sonographer kept saying my baby has big lips. I found it offensive."*), describing surnames as being *"difficult to pronounce"*, and making fun of how family members spoke: one woman recounted how her homebirth had been spoiled by the midwife mocking her partner's accent as he phoned family members with the news of their new baby.

Both Black and Black mixed women reported that HCPs displayed attitudes that were belittling and patronising, and that little empathy was shown towards them during a time when they were feeling most vulnerable. For instance, one Black woman stated that, when trying to explain her pain to the midwife, she was told *"not to be silly"* and that *"the pain isn't that bad"*, whilst another Black woman who requested the use of a wheelchair because of her multiple sclerosis, was told to *"just walk"* to see her baby who had been placed far away from her. Another example comes from a Black mixed woman who recounted telling the doctor in charge of her care that she felt no longer able to push and being told, *"I can't help you if you don't help yourself"*. It was soon discovered that the umbilical cord wrapped around her baby's neck was the cause of the difficulties she had experienced.

Attitudes, knowledge and assumptions form the roots of Black women's maternity experiences

Knowledge

Women's maternity experiences highlighted poor knowledge and understanding from some HCPs across a number of areas. Worthy of note is that these experiences were reported more often by Black than Black mixed women.

There was clear evidence of inaccurate knowledge about the anatomy and physiology of Black and Black mixed women and how this impacted pregnancy. For instance, one Black woman was told that her epidural had failed due to the anaesthetic having to *"work harder"* in Black women because *"we have a bigger curvature at the bottom of our spines"*. Being Black was also attributed to another woman's protracted cervical dilation:

> ***"One midwife when doing the sweep said that the reason for dilation taking so long for me was "probably due to an African pelvis" – even though I was on pain relief I was mortified that she actually believed there was such a thing as an African pelvis." (Black woman).***

Other factually inaccurate comments were reported, including one Black mixed woman being told that, "*black people are more stretchy"*, and being described as "*young"* and "*fit"* without her notes being consulted.

Some women were faced with situations in which the HCP dealing with their care had poor understanding of the clinical presentation of conditions in babies of non-European descent *("The lady was adamant that my mixed-race child had jaundice. She didn't listen or understand that mixed-race babies come in different shades"*) and in women with dark skin *("…I was told to look for redness in skin that does not show redness"*). Some women also experienced interactions with HCPs who they felt viewed their cultural practices as deviant:

"…in my culture screaming or making sounds while you're contracting is seen as wrong. This led to midwives not believing that I was truly having contractions". (Black woman)

There were also reports of failure to follow protocol with one example coming from a woman whose ethnicity was incorrectly recorded, subsequently impacting her care:

> ***"I was fobbed off by the phlebotomist who refused to take my ethnicity form which my midwife had given me as she said they didn't need it – as such, I was noted as white and my sickle cell test was not done." (Black woman).***

Attitudes, knowledge and assumptions form the roots of Black women's maternity experiences

Assumptions

The personal belief systems and opinions of HCPs were frequently highlighted during interactions with Black and Black mixed women. Many women were faced with situations where it was insinuated that they should be able to manage their pain. Crucially, overt comments relating to strength and coping tended to be towards Black women more often than Black mixed women. These comments were mostly made during the labour period with perceived strength often being a way of justifying the refusal of pain relief. One woman felt that she was expected to endure pain beyond a level that she was comfortable with. Another was told that she was *"big and strong so no need to worry"*, whilst another woman recounted being told, *"women like you should be able to take the pain"*.

When some women attended appointments alone, remarks grounded in negative racial assumptions were made, including those that implied the pregnancy was unplanned, such as being asked if the father was involved and assuming that the father of the current pregnancy was different to the father of previous pregnancies. Surprisal was also expressed at the relationship status of some women where it had been assumed by the HCP that the woman was either a single parent, unmarried or had doubts about paternity:

> ***"First visit a nurse said she was shocked I knew who the father was. As people like me usually don't know" (Black woman).***

Black women more often than Black mixed women described cases where assumptions were made about their immigration status and education levels. For example, when asking about breakfast on the postnatal ward, a Black woman was told, "this is not how we do things over here", despite her being from the UK. A Black mixed woman recounted her experience of attitudes towards her changing once HCPs learned of her profession:

"I'd turn up in a tracksuit and be spoken to in a certain (dismissive) way until they learnt I was a lawyer…and they would be more respectful overall in my experience." (Black mixed woman)

Similarly, although culturally based assumptions were reported, these were more often by Black than Black mixed women. One woman stated that the HCP refused to tell her the sex of her baby because she "*was Black and might get rid of it if it wasn't a boy*". Other comments included the ability to naturally conceive twins being linked to "*Black women eating a lot of yam*", how being Black should make childbirth and nursing "*easier*", and how slings to carry babies are "you *know, what you people use*".

Healthcare professional-centred constructs as drivers of behaviour

The attitudes, knowledge and assumptions held by HCPs (and the interplay between these constructs) translated to the subsequent behaviours of HCPs that were described by Black and Black mixed women.

A prominent feature of Black and Black mixed women's experiences was a reluctance or refusal from HCPs to provide adequate, if any, pain relief. This gatekeeping behaviour was evident during labour in particular, but also postnatally, with women often describing begging for assistance with pain management but being frequently told that it was "too late" or that they looked like they were "coping":

"I literally begged for an epidural, I stated repeatedly something was wrong, to which the midwife said I was fine, the obstetrician examined me and stated the baby was stuck." (Black woman)

Difficulty accessing pain relief from HCPs after giving birth meant that some women felt forced to make decisions that were unsafe or to deliver in unsanitary places:

> ***"There was a sense that the midwives felt I could handle the pain. I was left alone to give birth to my baby in the toilet. She fell into the loo on my last push. The midwives didn't check on me for hours." (Black woman).***

A number of Black and Black mixed women felt that there was blatant inequality in the support offered to them and the attitude and manner in which they were spoken to by HCPs compared to other white women or their own family members who were white. For instance, one Black woman described being treated with more courtesy when attending appointments with her husband who was white, than when she attended appointments alone, whilst another recalled that a nurse had been rude to her, but *"treated the white woman in our room completely different"*. Other comments described feeling that "white and Asian mums were spoken to in a softer manner" and that there was rule-bending concerning visitation time that favoured white women and their families.

Some Black and Black mixed women also noted behaviours from HCPs that demonstrated a disregard for their wishes and values about their care during labour. For instance, some women felt that they were not always provided with the opportunity to make informed decisions (*"I didn't request pethidine yet I was given it"*); that they were pressured into making decisions about treatment (*"…I found the attitude for an induction to be very forceful"*); that procedures were performed without consent (*"…She said she wanted to see how dilated I was, but also carried out a cervical stretch without my prior knowledge or permission*), and that medication was administered, sometimes by junior or student members of staff without permission:

"It wasn't until they were ready to do my spinal for the c-section that I realised it was a trainee putting the needle in my spine. She attempted to do it 3 times and because it was so uncomfortable for me a more experienced person took over. I wasn't asked if I minded that a student would be practicing on me." (Black woman)

These behaviours and lack of patient-centred approach were also reported during the immediate postnatal period with some HCPs failing to involve women in their care plans and conducting assessments on their babies without discussion or consent.

Positive experiences do exist for black and black mixed women

Not all Black and Black mixed women reported negative experiences. Some women were happy with their care and expressed praise and gratitude for the attentiveness that they were shown by HCPs throughout their birthing journey. Positive experiences were often those in which the woman described feeling informed and being treated with compassion. For instance, one Black woman stated that her midwife was "*lovely*" and that, *"she seemed to genuinely care about my well-being"*. Women also described positive experiences as those in which there was clear racial diversity in the workforce which provided them with a sense of reassurance and the feeling that they could relate to the professionals involved in their care. One Black woman described the *"all women of colour"* labour team as *"a team on a mission"* that made her feel *"well cared for and looked after"*, whilst another felt that the Black Caribbean midwives who looked after her understood her feelings and wishes. More practically, being cared for by members of the midwifery team from diverse backgrounds facilitated interactions and meant that women were able to voice their concerns:

"There was also a midwife on my ward who spoke my language (Portuguese) and she made a special effort to see to my needs." (Black mixed woman)

A patient-centred approach in which decisions were made jointly by HCPs and the woman was also central to experiences being defined as positive. One example comes from a Black woman who had wanted to have as natural a birth as possible, but ended up having to undergo an emergency Caesarean section. Though against her initial plans, she described feeling at ease with the decision because the doctor took her wishes into account *"as much as she could"*.

One caveat, however, is that some Black women reflected that being an HCP themselves (sometimes employed within the department in which they were receiving care), being familiar with members of staff in the hospital, making clear to HCPs their level of education, or feeling *"empowered to ask questions"* afforded a level of protection against negative treatment:

> ***"… as with all of my interactions with healthcare professionals, I made it clear that I am a research scientist and that I have more medical (specifically obstetric) knowledge than the average person. This type of behaviour is done deliberately on my part to ensure I am taken seriously and so (white) people don't slot me into one of their stereotypes." (Black woman).***

Important to note, however, is that some women had mixed reviews and talked about variable care that could depend on factors like care settings and HCP shift patterns. For instance, one Black woman described having poor antenatal care that only improved once a particular consultant took over, whilst another recounted how the care when she arrived on the antenatal ward was "next to none", but that when the new midwife arrived the following morning, "she was amazing". Some women also described a lack of continuity in care both within and across professions.

Clinical, emotional, and psychological consequences are long-lasting

It was evident that the behaviours, attitudes, knowledge, and assumptions centred around HCPs had consequences for Black and Black mixed women that heavily influenced their views of their maternity care.

Clinical consequences were described, with many women expressing that their treatment during labour escalated to emergency levels because their concerns had been dismissed and their symptoms downplayed by HCPs. Some of the adverse clinical situations mentioned included: giving birth in a disabled toilet; almost delivering in a triage room with a breech presentation; requiring an emergency blood transfusion despite persistent reporting of feeling faint and actual fainting; and needing emergency intervention even after trying to voice concerns during labour:

"I told the nurses to get a doctor as the baby was not coming out. They…kept telling me that I wasn't pushing…When they finally got the doctor, my baby was back-to-back with the cord around his neck and required a forceps delivery." (Black mixed woman)

Failure to provide pain relief, appropriate support, sensitive care, or involve women in decision-making impacted Black and Black mixed women emotionally. One Black woman who requested pain relief during active labour described being told to "hold on" so that a midwife could end her shift as "extremely stressful", whilst another woman attributed her unsuccessful breastfeeding journey to the negative interaction she had experienced with a breastfeeding nurse who turned the breastfeeding pump up to maximum and told her to "stop moaning and get on with it". Significantly, many women described feeling "traumatised" by their experiences, with a number of women feeling fearful of having more children:

"My whole birthing experience and aftercare has put me off having another child." (Black woman)

Psychological consequences were also reported. Some women disclosed long-term mental health issues and feelings of trauma that they attributed to the poor care that they received during labour. One Black woman described that she still has "several flashbacks" of her labour experience and that it brings her "to tears every time". Others reported that they were, "still suffering with PTSD", "have developed really bad anxiety" and are "seeking counsel" for trauma. There was also evidence that previous traumatic experiences had impacted later pregnancies:

"…during the c-section the epidural wore off and I informed the anaesthetist…The anaesthetist failed to tell the surgeons, so they carried on despite me screaming and crying in pain…It was extremely traumatic…I've since had another baby and the mental struggle to bring her earth side was horrendous."

For some, negative postnatal experiences impacted women's confidence and discouraged them from engaging with maternity services:

"When I was trying to latch my son after birth he latched immediately but I doubted myself and sought a second opinion. During her guidance she was very patronising and mocked me. She was so rude that it made me decide not want to ask another health professional for advice with my son."

Clinical, emotional, and psychological consequences are long-lasting (continued)

A number of Black and Black mixed women felt compelled to complain about the care they received but were often fearful that doing so would jeopardise their future care, or too traumatised and exhausted to raise a complaint so soon after having a new baby. One Black mixed woman stated that she *"should have complained"*, but that she just wanted to enjoy her baby, whilst a Black woman recounted that even though she wanted to complain, she did not because *"everything was a daze"*. Worryingly, some women refrained from complaining because of a resignation that their grievances would be disregarded:

> ***"I genuinely fear engaging with the NHS and wish I could afford to go private. There is simply no point in complaining, nothing will be done. If anything, I am likely to be victimised if I complain." (Black mixed woman).***

The recovery period: a mixed bag

In contrast to the experiences describing hospital-based care, which were largely negative, women's views on support provided once care had moved to the community were mixed. Whilst some women were grateful to be referred to mental health or physiotherapy services, just as many expressed ambivalence about the care during this time or reported not being asked about their mood or physical health during routine appointments with their health visitor (HV) or postnatal midwife. Worthy of note, is that some Black women actively chose not to disclose their feelings to HVs for fear of external agencies being alerted, being deemed unfit to care for their child, or because they had developed mistrust in HCPs from negative experiences earlier in their pregnancy:

"…much of the support I needed stemmed from the stress and trauma I received from the birth and aftercare and didn't feel I should raise with them after all they had done already." (Black woman).

In comparison, most Black mixed women reported interactions with their HV or postnatal midwife as negative and described receiving care from their GP that was lacking in knowledge of postnatal rehabilitation (both physical and mental), and that focused mainly on their baby or family planning.

Ensuring that black and black mixed women are given the care that all birthing women deserve

Black and Black mixed women highlighted a number of ways in which maternity care for Black and Black mixed women could be improved. An overwhelming number stated better communication as a priority, with many specifically reporting that HCPs should take concerns seriously (especially those related to pain) and that they should not belittle women or devalue their symptoms:

"When a woman expresses concern about her health or her baby's health…take your time to listen to her concerns and anxieties without making assumptions." (Black woman)

Education and training of HCPs was also felt to be fundamental. In particular, women expressed the need for training to correct misconceptions about the anatomy and physiology of Black and Black mixed women; to eradicate commonly held racial assumptions about Black and Black mixed women's tolerance of pain, their perceived education level, and their marital and immigration status; and to teach them about the presentation of symptoms and conditions in Black and Black mixed women and their babies:

"Staff need to be aware of unconscious biases and stereotypes that can influence their behaviour. This is not about people being malicious or intentional, but rather about how societal norms about racism have shaped us." (Black woman)

Women also expressed an urgency for investment into further research to better understand the disparities in maternal outcomes for Black and Black mixed women and their babies, and that the evidence-based findings from this research must be used to influence policy and guidelines about clinical practice:

"There needs to be more research based on black women and this used to train healthcare professionals rather than using research based on white women's bodies and birth experience and forcing us to fit those "norms". (Black woman)

Placing value in Black and Black mixed women's experiences by treating them with the same dignity, compassion and empathy as women from other backgrounds was also seen as crucial for ensuring the improvement of maternity care for this community.

Finally, the development of and signposting towards support groups and parent information aimed specifically at Black and Black mixed women (in an accessible format) was seen as an important way to improve engagement with maternity services; to help women to be more aware of ethnicity-related health risks during pregnancy; and to foster a sense of belonging.

DISCUSSION AND CONCLUSIONS

The data show discriminatory experiences continue to prevail for Black women. The stories told by Black women evidence the widespread and regular racialised interactions they have with healthcare professionals (HCPs) within their maternity care and highlight that current satisfaction ratings do not provide us with the full picture.

Whilst some interactions may leave women with the uncomfortable feeling of discrimination, others have undoubtedly contributed to harm. However, our findings of the relationship between Black and Black mixed women's reporting patterns has highlighted the hidden nature of racism in the maternity care of Black women.

This information may be especially difficult to digest; Black women and HCPs alike do not go into maternity care expecting to experience or perpetuate discrimination.

However, it is important that HCPs, service managers and leaders remain open to understanding Black women's experiences as the only way to positively change them.

Understandably, the NHS experiences constraints and, as such, considerations of the various financial, time and resource-related pressures experienced daily by the institution and its staff have been made.

Since 2010 the NHS has had a reduction in annual budget increases from 3.7% to only 1.4%, resulting in over half of NHS Trusts experiencing funding deficits between 2016-2021[33]. Recognition is given to the NHS Long Term Plan that has contributed to better outcomes for women[34]. Many maternity services are experiencing high staff turnover and increased rates of sickness[35] causing often unpredictable staffing shortages and increasing pressure to individual workers and departments. With that being noted, Black women are sharing negative interactions including racialised comments, ridiculing, cultural insensitivity and a lack of support from HCPs. These experiences coupled with overwhelming figures on poorer health outcomes and higher rates of maternal mortality for Black women evidence that there are significant disproportionate impacts for this group.

Black women's experiences of antenatal, labour and birth, and postnatal care have been collated and shared in amidst the backdrop of shocking statistics on the disproportionate maternal death rate and have revealed that Black and Black mixed women experience discriminatory practice throughout all stages of maternal care.

Worthy of note is that the majority of stories told by women referred to labour, birth and early postnatal experiences within inpatient maternity services. It is during these settings in which women most frequently described experiencing negative attitudes, assumptions and racialised knowledge-claims.

Reports such as that produced by MBRRACE-UK[36] and other studies that focus on clinical outcomes have been important for highlighting the ongoing racial disparities in maternal mortality, but we must not lose sight of the fact that these findings do not consider near-death experiences or the resulting physical and psychological co-morbidities that occur as a consequence of the poor treatment experienced by many Black women. As shown in this study, the psychological trauma experienced by Black women is real and needs to be viewed with as much significance as the disproportionate maternal death rate in this community.

The overall experience of Black women's maternity care is one of racial inequality perpetuated both by individual clinicians within maternity care services and systemically by the NHS maternity services. Overwhelmingly, women shared interactions with HCPs that were coloured by their ethnic heritage or race at moments where it was perceived to have little to do with the support they required. Studies into the psychology of implicit bias remind us of the power that unconscious bias has to impact attitudes and actions[37,38].

As a result, not only are women impacted clinically, causing more emergency outcomes, but Black and Black mixed women reported significant psychological impact, affecting their confidence, self-esteem and contributing to sadness and anxiety. The emotional impact of the many negative racialised interactions in maternity care has had more long term impacts on these women's experiences, including women having long term anxiety, disengaging from services and fearing future pregnancies.

Historically, experiential differences of Black women have been reduced to the impacts of multiple deprivation which we see reflected in research where intersectionality is considered[39], [40]. Yet, the findings of the current report suggest that Black and Black mixed women face racism, racial assumptions, stereotyping and micro-aggressions regardless of income, occupation, marital status or age, highlighting that the UK is not a *'relatively open society'*[41] for Black women, but rather a society in which racial discrimination, prejudice and the resulting harms, are systemic and commonplace for Black women accessing public maternity services. Continuing to ignore the stories repeatedly told by Black women contributes to the erasure of their lived experience.

As posited by the research questions, both the quantitative and qualitative data show that there are differences in the experiences of Black women and Black mixed women. Unexpectedly, Black women generally reported higher levels of satisfaction with care than Black mixed women and where Black women reported that they had concerns or negative experiences with HCPs, they were much less likely than Black mixed women to make a complaint via informal or formal channels.

However, when women's maternity care was explored in more depth, through open-text questions, Black women's responses reflected far more racial assumptions and negative racialised experiences, including assumptions of promiscuity that perpetuate the jezebel stereotype[42], an exaggeration of pain, and anatomy that deviates from perceived white norms. Views like these are steeped in a lengthy and painful history of racism[43], racialised medical experimentation, and the dehumanisation of Black people to justify mistreatment[44].

Thus, the data establishes that despite experiencing more negative racial experience than Black mixed women, Black women were less likely to pursue informal or formal reporting procedures and recorded better ratings of care. In explaining this we acknowledge recent political shifts since 2016 have further contributed to the delegitimization of Black experiences[45]. The socially pervasive hierarchy of race places Black people at the bottom. Paired with the intersectionality of gender, Black women have a dual burden of oppression even before considerations of socio-economic status are made[46]. As such, Black women may be desensitised to or normalise racism, resulting in apathy towards reporting it.

Similarly, Black women shared that they often felt their concerns were not taken seriously, speaking to the reoccurring 'strong Black woman' stereotype[47], in which Black women are perceived by others to be tough and able to endure physical and emotional pain, resulting in Black women internalising this thought process. This could account for an under-reporting of complaints from this group. Furthermore, this research has shown that typical measures of satisfaction used to understand NHS patient care conceal Black women's experience of racism within maternity service and the long term effects on their psychological wellbeing.

Additionally, Black mixed women experience a closer proximity to whiteness through European-like features and fairer skin – an experience termed colourism[48]. As such, in more diverse communities it is possible that Black mixed women may encounter fewer racial assumptions. Moreover, they may be used to better treatment and feel more confident that their experiences will be taken seriously, potentially explaining the higher complaint rate compared to Black women. However, even with this being considered, the conversion rate from issue to complaint for Black mixed women still remained low.

Some explanations for this provided by women included the difficulty or stress of the complaints process, not knowing who to complain to or how to do so, and wanting to move past the experience as they were happy that their child was 'alive and healthy'. In addition, there is a power dynamic between women and healthcare professionals, noted by Black women, many of whom felt the need to make HCPs aware of their level of education or professional occupation in order to obtain the standard of care they desired.

The offhand nature of remarks made to women about their bodies and the attitude that Black bodies differ from the baseline of white women's is indicative of a wider issue relating to the continuous process of 'othering'[49] and the problematic interaction between exclusionary Eurocentric health services and members of Black communities. The history of medical research has dehumanised Black women and alienated the skin and anatomy of darker skinned people. One such study reported that treatment recommendations of Black people were impacted by implicit bias held by persons with medical knowledge[50]. It is recognised that there are anatomical differences of women from different races. Acknowledgement of these differences is necessary for good and safe clinical care. However, it is evident that many of the comments Black and Black mixed women reported were grounded in racism and racial bias, with women facing personal blame, disregard, and unprofessional and non-medical terminology being used to describe their bodies and experiences. Current measures of satisfaction and complaints processes either ignore or make it harder for women to communicate their experiences and the types of racism faced in their care.

Another prevalent experience was dismissive or presumptuous treatment in relation to pain relief. Although medical reasons may partially explain why over half of Black women reported not receiving their preferred method of pain relief, there is no such reasoning for why an explanation and consultation about the decision that was made, was not provided. There is a historical pattern of medical professionals making decisions on behalf of Black people, lacking the person-centred approach championed by the NHS and eroding personal autonomy and the right to choose – concepts central to the medical profession. Many Black women reported that their pain was not taken seriously and despite requesting support to manage their pain, comments experienced by Black women in this study such as, "women like you…", "big and strong", "you don't look like you need it" evidence racist assumptions and a false belief of greater pain tolerance in Black people. The commonality of these experiences is supported by studies evidencing that treatment was impacted by a difficulty in clinicians recognising pain and emotions on Black faces[51]. Furthermore, research confirms racially related belief systems continue to be upheld by clinicians today. It is clear that there is a need to address the impact of implicit bias upon clinical outcomes[52].

Black culture has long been viewed through a comparative lens to normative white society and studies into various aspects of life including education, social class and criminality evidence a continuous portrayal of Black people as deviant and pathological in comparison to white peers, further contributing to socially ingrained racial bias and scapegoating[53]. It is accepted that racial bias can remain in the unconscious thought process and be enacted implicitly without the perpetrator being aware of the negative views they hold of a specific group[54].

However, years of literature have already advised on the need to disrupt unconscious thought processes to reduce discriminatory practice[55]. Furthermore, it is noted that members of a group, for example Black or Black mixed HCPs, may be influenced by stereotypical narratives or organisational cultures to unconsciously hold and act upon negative racialised views of their own or other racial groups[56], [57]. As such, there is a clear need to develop racial bias training that genuinely disrupts prejudicial and discriminatory practice for individual clinicians and medical institutions more widely. Learning can be taken from the positive patient-centred care some women reported experiencing, often from more diverse maternity teams, who displayed cultural understanding, empathy, compassion and communicated to women how their wishes were being considered.

In conclusion, the data illustrates that although Black and Black mixed women experience overt and covert racism throughout maternal services, their experiences are rarely captured or recorded by the institutions providing their care, due to a low complaint rate and the normalisation of racism as part of their everyday experience.

Although Black mixed women were more likely to make a complaint, helping to increase awareness of the issues faced by Black women as a whole, they were less likely to have experienced overt racial assumptions and attitudes, reducing the likelihood that patterns of racialised treatment will be reflected in complaints received.

Even though women reported negative racial experiences throughout their maternity care, by far the most common period for racial experiences was during labour and birth when women were continuously in contact with and being supported by HCPs. However, Black women's experiences continue to be erased by measures of satisfaction with services as seen in the *"Commission on Race and Ethnic Disparities: The Report"* ignoring the potential that racialised experiences have been normalised by Black women, resulting in apathetic reporting.

The immediate and long term harms shared by Black and Black mixed women, as a result of negative racialised experiences with HCPs must not continue to go understated or characterise their care experience.

If the UK is truly a society that has *"come a long way in the last 50 years"*[58], there must be zero-tolerance for racism and racial bias in all public services. There is a need to shine a light on practitioners and departments across maternity care providing interculturally competent, empathetic and compassionate care to women, in order to improve clinical and psychological outcomes for Black women and their children.

STRENGTHS AND LIMITATIONS

With input from Black professionals whose backgrounds include midwifery, obstetrics, general practitioners and health visitors as well as feedback from Black parents, and analysis conducted by Black researchers, a unique strength of this work is that it has truly been designed by Black women for Black women. A further strength is the scale of the data collected; as far as we are aware, this survey is the largest in the UK to have explored the maternity experiences of Black women exclusively. Of course, whilst this means that Black women's experiences are the focus, it also means that there is no direct comparator to our findings. As such, we must acknowledge that there may also be implicit biases at play that are to do with factors other than ethnicity. A further limitation is the possibility of self-selection bias, with women who have had a negative experience being more inclined to engage in the study.

Relatedly, we must also acknowledge the possibility of recall bias in women's accounts, though with the sheer number of Black and Black mixed women nationwide reporting similar experiences, we feel this is unlikely to significantly impact our findings.

RECOMMENDATIONS

1. An annual maternity survey targeted specifically at Black women

- Similar to the CQC maternity survey that takes place annually every February there must be an annual survey aimed specifically at collating/capturing the experiences of Black women to highlight positive experiences and key areas for improvement
- This suggested survey should be completed on a local and regional basis and the results used for the regulation, monitoring and inspection of all maternity units.
- The results from the surveys must inform and support public and parliamentary accountability, improve maternity services by NHS England, NHS Improvement and the Department for Health and Social Care.

Action: NHS England and NHS Improvement, Department of Health and Social Care

2. Increased knowledge on identifying and diagnosing conditions that are specific to and disproportionately affect Black women

- Health professionals, individuals that work in maternity and their patients should have training and information on the specific conditions that are more commonly seen in Black women for example:
  - Pre Existing medical conditions: Uterine Fibroids, Sickle Cell Anemia, Hypertension, Diabetes
  - Antenatal Conditions: Preeclampsia, Gestational diabetes and dietary advice specific to Black culture
  - Postnatal Conditions: Hypertrophic and Keloid Scarring, Perineal wound infection, mental health conditions
- Increased diversity in medical illustrations and textbooks that show accurate diagnosis of conditions in darker skin to help improve patient care

Action: NHS England and NHS Improvement

3. Improve the quality of Ethnic coding in health records

- NHS trusts must improve the quality and consistency of ethnic coding using the 2021 census categories within health datasets and record ethnicity correctly in hospital records
- Ethnicity should be self reported by the patient using a consistent set of codes from the updated 2021 census categories
- Staff recording data should avoid overusing the categories “other” or provide a text box to explain what “other” means

Action: NHS England and NHS Improvement, Integrated care system leaders and all NHS providers and commissioners

4. More community-based approaches must be used to improve maternal outcomes

- Funding agencies and institutions should remove barriers to accessing funding for Black researchers and community organisations to carry out more research
- Black led community groups supporting women and birthing people should be consulted about decisions affecting their care from conception of ideas through to implementation

Action: Funding agencies, NHS England and NHS Improvement, Department of Health and Social Care

5. An improved system for women to submit their feedback and/or complaints specifically for maternity

- To help maternity services improve there must be a more streamlined way of collecting feedback and/or complaints across all NHS trusts to ensure health professionals can better understand the experiences of women and adjust their care accordingly
- Data on ethnicity in line with the updated 2021 census categories needs to be added to all complaints procedures to capture better data on who is complaining
- To understand women's feedback in real time, an independent agency must be put in place. The Independent agency will:
  - Contact all women up to 6 months after giving birth to ask them of their experiences and rate the care given
  - Offer help to send more information on the complaint procedure
  - Monitor recurring complaints from each NHS trust, making suggestions to improve

Action: HSIB, NHS England and NHS Improvement

6. Ensure that individuals involved in training health care professionals are aware and have an appreciation of the disparities in maternity outcomes

- Health professionals who train and teach any students who will later work on a maternity ward e.g. midwifery students need to learn and have an awareness about the disparities and ways to improve outcomes for Black women
- Induction training for all maternity staff should include the disparities notes in the MBRRACE reports

Action: Heads of midwifery, university institutions, university lecturers, medical professionals

CALLS TO ACTION

Five X More's mission is to improve the maternal outcomes for Black and Black mixed women nationwide, but we cannot do this without your support. There are a number of ways that you can join us in our campaign to fight for change:

- Write to your local MP using our briefing pack and encourage them to sign the Black Maternal Health Pledge
- Take part in the annual Five X More Black maternal health awareness week in September 2022
- Use the hashtag #Blackmereport to continue discussion on social media
- Contact info@fivexmore.com if you are interested in booking our training
- Attend any upcoming and future public meetings for the Black Maternal Health APPG
- Sign up to our newsletter to stay updated with the campaign

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