

Better
Health
Briefing

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**Addressing
ethnic
inequalities
in maternity
service
experiences
and outcomes:
responding
to women's
needs and
preferences**

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Key messages

- 1 Significant ethnic inequalities in maternity outcomes persist in the UK, with some minority ethnic groups experiencing particular disadvantage
- 2 Determinants of ethnic health inequalities are multifactorial. However, there is evidence that current service provision contributes importantly to adverse outcomes for minority women
- 3 A number of barriers can be identified that undermine timely access to high quality care for many black and minority ethnic women
- 4 Commissioners, managers and practitioners need to know their local population and consult and engage with service users in order to address inequalities.

Introduction

A number of studies over the years have examined the maternity experiences and outcomes of women from black and minority ethnic (BME) communities in the UK (Bharj, 2007; CHAI, 2007, 2008; Redshaw *et al.*, 2007). These studies note developments in midwifery service provision driven by health reforms and find that women report a mixture of positive and negative experiences in their encounters with maternity services. Nevertheless, they highlight persistent inequalities in both receipt of maternity services and reproductive outcomes between the majority White British population and women from minority backgrounds. Differentials also exist within and between ethnic groups, with some minority groups being particularly disadvantaged.

This briefing summarises the evidence available on the maternity experiences of women from BME communities in the UK, drawing on both qualitative and quantitative research. It sets out to identify barriers that may disadvantage minoritised women and offers suggestions for service improvement, while recognising the great heterogeneity that exists within and between minority ethnic 'groups' and the need, therefore, for flexible and nuanced responses.

Persistent ethnic inequalities in maternity outcomes and experiences

1

Maternity services are being driven by a radical agenda for change underpinned by targets for an enhanced role for midwives, continuity of care and care closer to home (DH and DfES, 2004). There is a renewed call to place women at the heart of services, giving them a real say in the way in which services are commissioned and delivered. This commitment to a 'woman-focused' and flexible service includes offering greater choice, higher standards and better quality of health care (DH and DfES, 2004). Furthermore, recent policy directives propose broadening the remit of maternity services, extending them beyond the production of healthy babies and satisfied mothers, to address broader family well-being. They strongly reiterate a commitment to address the needs of those who are vulnerable and disadvantaged (DH, 2007a).

The NHS's stated commitment to equality in maternity services has been reflected in a wealth of policy initiatives striving to redress the persistent ethnic inequalities in experiences and outcomes (Bhaji, 2007). In spite of this increasing policy commitment to reducing inequalities, evidence consistently demonstrates persistent inequalities in experiences and outcomes between ethnic groups, with some minority groups being particularly disadvantaged.

Although mortality rates have declined over time in all ethnic groups, there remain differentials in perinatal mortality (stillbirths plus deaths up to six completed days of life), infant mortality, maternal mortality and low birth weight (Lewis, 2004, 2007; DH, 2007b). Maternal and infant outcomes remain very poor for many women from BME groups, particularly among those women who have recently migrated to the UK (Lewis, 2007). Women from South Asian and Black African communities, women living in poverty, and women seeking refuge and asylum are significantly more likely to die in childbirth compared to their White British counterparts (Lewis, 2007). Recent analyses of data for 2005 illustrate that the infant mortality rates among babies born to women from the Pakistani and Caribbean groups were twice that of the White British group (CEMACH, 2006; ONS, 2007).

Ethnic disparities in access to and receipt of maternity services

2

Although the determinants of ethnic health disparities are clearly multifactorial (Randhawa, 2007), increasingly the NHS is called to account for its failure to mitigate inequalities in maternity outcomes (CHAI, 2007, 2008; King's Fund, 2008). Both qualitative and quantitative investigations find lower service satisfaction among minority women than among majority white women (Singh and Newburn, 2000; Redshaw *et al.*, 2007).

Resources 1

1 Good practice

Commission for Healthcare Audit and Inspection (2008)
Towards Better Births: A review of maternity services in England, London: Commission for Healthcare Audit and Inspection.

This is the most recently published review of maternity services and offers a checklist for commissioners and providers of maternity services, which should assist in improving maternity services.

Department of Health

Collecting ethnic category data – training materials and guidance

www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalCollection/DH_4049499

Guidance and training materials on ethnic category codes as well as some of the wider issues that prevent the collection of good quality ethnic information.

This practical guide, published by the Department of Health in 2005, further develops the guidance published in 2002. It draws on a range of good practice examples in its quest to promote the quality of ethnic monitoring in the NHS.

Resources 2

Making the Difference: The pacesetters beginner's guide to service improvement for equality and diversity in the NHS

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039

Published by the Department of Health in 2008, this offers guidance for service improvement approaches in the field of equality and diversity.

High Quality Care for All: NHS Next Stage Review final report

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

Also published in 2008 by the Department of Health, this is the final report of the NHS Next Stage Review by Professor the Lord Darzi of Denham KBE. It harnesses the ten SHA strategic visions and sets out a vision for an NHS with quality at its heart.

Furthermore, research has highlighted some important differences in the way that women from BME backgrounds may access and utilise maternity services compared to their white counterparts. Such differential receipt of services is identified as a factor contributing to adverse maternal and neonatal outcomes (Lewis, 2004, 2007). Notwithstanding important diversity within and between minority ethnic groups, national surveys indicate that, as a whole, women from BME groups are more likely to 'book late' (i.e. receive their first antenatal check-up beyond the recommended twelve weeks' gestation), are less likely to receive antenatal care regularly and therefore also tend to receive fewer antenatal check-ups (Redshaw *et al.*, 2007; CHAI, 2008). Overall, women from BME backgrounds are also less likely to have discussed breastfeeding with the midwife, although they are significantly more likely to initiate breastfeeding and are more likely to be exclusively breastfeeding following birth (Redshaw *et al.*, 2007). Evidence also suggests that some women from some minority groups are less likely than the majority White British to have dating or anomaly scans and to be offered or to undertake screening (Ahmed *et al.*, 2002; CHAI, 2008).

3

Barriers to high quality care and satisfaction with services

Findings from investigations identify a range of barriers to receipt of high quality care and satisfaction with services among minority women. More detailed information is urgently needed in order to better understand how patterns of receipt and barriers to care vary between and within different ethnic groups (e.g. according to levels of education, migration status, religion and other social factors). Nevertheless, four consistent and interrelated themes are evident: (i) inadequate provision of appropriate and accessible information; (ii) inadequate interpretation and translation support for non-English speakers; (iii) insufficient continuity of care and associated feelings of little support and control; and (iv) cultural insensitivity, disrespect and racism on the part of providers as well as the service more generally (Harper-Bulman and McCourt, 2002; Mclish, 2002; Richens, 2003; Bharj, 2007; CHAI, 2007, 2008). NHS organisations and health care professionals must take account of these barriers in order to restore trust and confidence in services among women from BME communities, to ensure that maternity services respond to the needs of women and their families.

All women have a desire for accurate and timely information about childbirth in a format they can understand; women from BME communities are no different. Consistently, however, evidence highlights the way in which many minority women do not enjoy access to information to the same level as their white counterparts, and that those who are less proficient in English are most disadvantaged (Bharj, 2007). Health care professionals are key players in information exchange, controlling not only the amount of information, but also to whom it is made available (Kirkham and Stapleton, 2001). Women's

knowledge of services has been found to correlate positively with education, English language competency and medical understanding (Bharj, 2007), so that those who are most in need of information tend to receive the least.

Communication is a key determinant in service access and utilisation (Katbamna, 2000). Many studies report widespread communication and linguistic difficulties between women who are less proficient in English and health care professionals (Harper-Bulman and McCourt, 2002; Mcleish, 2002; Davies and Bath, 2001). Many women report that interpreting services are inadequate and are often limited in the areas in which they are most needed. Use of relatives or friends as interpreters prevails (Katbamna, 2000; House of Commons Health Committee, 2003). Where interpreting services are available, it is the health care professionals who decide the need (Gerrish *et al.*, 2004; Bharj, 2007). This is unacceptable given that inadequate interpreting services feature persistently as a factor in maternal deaths (Lewis, 2004, 2007). High quality, accessible interpreting/advocacy services are essential to ensure that women fully understand the care options available and can effectively communicate their preferences to the providers caring for them. Indeed, NHS organisations must provide interpreting/advocacy services in order to comply with the requirements of the Race Relations (Amendment) Act 2000. At a local level, many initiatives have been developed to overcome communication barriers, often involving link workers or partnerships between NHS services and community-based organisations (D'Souza *et al.*, 2001-2002). However, these successful initiatives are too often dependent on short-term funding. Policy is not translated into practice uniformly, with economic imperatives driving provision and vastly different experiences of access to language support across different parts of the country. With increasing diversity of the population and a growing number of languages being spoken in many regions, there is a pressing need for NHS organisations to accurately assess the communication and language needs of their local population and develop innovative ways to respond to them. Approaches that warrant further development include: peer support, social support networks and doulas (Mir, 2007).

Minority women continue to voice concerns about a lack of adequate and appropriate information and a consequent inability to exercise their right to choice in relation to their care (Bharj, 2007; Redshaw *et al.*, 2007). For choice to become a reality, women's access to unbiased, evidence-based information in an appropriate format must be greatly increased.

Research suggests that many women from BME communities value support and continuity of care, but are less likely to receive such care than their White British counterparts, often because they are unaware of the services available or are unable to exercise their choice (Woollett *et al.*, 1995; Hemingway *et al.*, 1997; McCourt and Pearce, 2000). A further factor that undermines continuity of care for some minority women, particularly for Gypsy and Traveller women and those who are recent migrants to the UK, is residential mobility. These women may be forced to move home during pregnancy or shortly after

Resources 3

King's Fund

www.kingsfund.org.uk/health_topics/black_and.html

The King's Fund runs a programme of work that focuses on black and minority ethnic groups and includes evidence about inequities in access to health care.

MEDACT Reaching Out Project

www.medact.org/reaching_out_home.php

The Reaching Out Project aims to improve access to maternity services for highly marginalised black and minority ethnic women, including refugees, asylum seekers, women with little or no English and women with insecure immigration status. The project involves both campaigning and development of information resources. Training programmes for midwives and other health care workers are offered.

MIGHEALTHNET

www.mighealth.net/uk/index.php/Main_Page

The MIGHEALTHNET project aims to stimulate the exchange of knowledge on migrant and minority health through the development of interactive databases in each of the participating countries. This project aims to give professionals, policy makers (including health authorities), researchers, educators and representatives of migrant and minority groups easy access to a dynamically evolving body of knowledge and a virtual network of expertise.

Resources 4

NHS Connecting for Health programme

www.connectingforhealth.nhs.uk/about

This strives to assist the NHS with new computers and systems to improve patient care and safety. Maternity services should make more use of this programme.

Robinson, M. (2002) *Communication and Health in a Multi-ethnic Society*, Bristol: The Policy Press.

This text provides a review of recent research, with a particular focus on health communication interventions concerning service users who may lack fluency in English. The author highlights that meeting the needs of all health service users, including disadvantaged groups, depends on both structures and processes of communication.

Royal College of Midwives (2004) *Making Maternity Services Work for Black and Minority Ethnic Women: A resource guide for midwives*, Kent: The Royal College of Midwives Trust.

This resource pack offers guidance in mainstreaming of race equality into an organisation and delivery of maternity services.

delivery, with potentially serious implications for their own and their babies' health (see [Jenkins, 2006](#) in relation to Gypsies and Travellers). The constellation of NHS services is generally poorly designed to meet the needs of a mobile population. However, in some areas innovative approaches are allowing midwives to deliver care to asylum-seeking or highly vulnerable women regardless of their place of residence within the area ([NHS Sheffield, 2008](#), personal communication). Such flexible service responses must be expanded and further developed.

Many women acknowledge the importance of their relationship with midwives and the impact of this on their childbirth experiences, highly valuing those health care professionals who are ethnically sensitive, kind and sympathetic ([Bharj, 2007](#)). However, there are others who report negative and unsympathetic attitudes of staff, which have the effect of preventing them from engaging in decision making about their care. Research suggests that significant numbers of women from minority backgrounds feel ignored and that their needs and wishes have been dismissed by health care providers ([Mcleish, 2002](#); [Sivagnanam, 2004](#); [Redshaw et al., 2007](#)). Evidence also highlights the way in which some health care professionals racially stereotype some minority women, negatively affecting their maternity experience ([Bowes and Domokos, 2003](#); [Davies, 2007](#)). At the same time, research with health care providers continues to highlight the fact that many feel ill-equipped to meet the needs of their ethnically diverse patient population, that receipt of 'cultural competence' training is far from universal, and that where training is received it is often felt to be inadequate. It is suggested that a predominant focus on differences between ethnic groups and the acquisition of cultural knowledge, rather than on self-reflection on attitudes and developing generic skills, is unhelpful in preparing providers to deliver sensitive and supportive care ([Kai et al., 2001](#); [Kai, 2007](#)).

4

Effective utilisation of population profiling and patient consultation

Equity of access requires the timely availability of adequate maternity services. NHS organisations must have knowledge of their local populations and develop services appropriate to local needs. Although commissioners of maternity services should actively engage in undertaking health needs assessment, accessing adequate and appropriate data to inform decisions is a challenge. Ethnic monitoring data are often of poor quality, and where such data are available, they are commonly out of date ([Dixon-Woods et al., 2005](#); [CHAI, 2008](#)). Nonetheless, health needs assessment data are critical in forecasting demand as well as in identifying ethnicity-related gaps in services. Commissioners and providers of maternity services need to work together to ensure that data on ethnicity and other pertinent information (particularly language and interpretation needs) are collected robustly and routinely. They

must maximise the use of proposed frameworks as well as information technology programmes (DH, 2008) to commission and deliver world-class maternity services. Effective use should also be made of consultation with local providers (statutory and voluntary), health care professionals and, most importantly, women who use services, and their families.

Conclusion

Although many of the criticisms levelled at maternity services are experienced by women regardless of their ethnic identity, the persistence of wide variation in the quality of service provision to different ethnic groups is of serious concern. Further, there is convincing evidence that differential service receipt contributes to the poorer maternal and infant health outcomes evident among minority ethnic groups.

There is no place for discriminatory and oppressive service delivery. The Race Relations (Amendment) Act 2000 places a duty on service providers to ensure that discrimination does not take place. It is unlawful to refuse or deliberately fail to provide services, provide poorer services or treat people differently, or to set different terms and conditions for service users. Service delivery organisations clearly need to do much more to ensure that their maternity workforce is adequately prepared to confidently serve the needs of a diverse population and that effective structures and processes are in place to monitor service delivery and quickly address ethnic inequalities where they occur.

The NHS is committed on paper to reducing inequalities in health and service provision. However, despite the publication of numerous policies and guidance documents, it continues to fail to meet the maternity needs of its diverse patient populations. This failure reflects a number of factors including: (a) the pattern of service provision and delivery has not kept pace with changing population profiles; (b) maternity provision is, in the main, inflexible and based on the assumption of homogeneity; (c) maternity service providers have not been adequately prepared in terms of attitudes and generic skills, as well as cultural knowledge, to sensitively meet the needs of ethnically diverse populations; (d) innovative initiatives have tended to be small-scale and short-term and their learning has often not been mainstreamed; (e) the necessary data to monitor and address ethnic inequalities in maternity service receipt and outcomes have not been collected and acted on; (f) addressing the needs of diverse communities has not been consistently identified as a priority so that responding to other directives has impeded progress and change. Unless more is done to bridge the gap between policy and practice, women from BME communities will continue to have poorer maternity experiences and outcomes than the white majority.

Resources 5

2 Further reading

Bowles, C., Walters, R. and Jacobson, B. (2007) *Born Equal? Inequalities in infant mortality in London. A technical report*, www.lho.org.uk/Download/Public/12375/1/Infant_Mortality_FullReport.pdf

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