Maternal Health: Inequalities facing BAME Women in Wales

Wednesday 5th August 2020, 10:30am – 12:00

Part of a forum series looking at impact of Covid-19 on BAME people in Wales.

Attendees: 65 participants attended the meeting with representation from a range of communities and organisations across Wales.

Speaker Panel: Vaughan Gething AM - Minister for Health and Social Services in Welsh Government, Laura Santana - Student Midwife and Co-Founder of Birth Partner Project, Antonia Ashaye - Founder of Obirin Africa and 5th year Medical Student, Dr Julie Bishop - Director of Health Improvement, Public Health Wales and Lucy Evans -Lecturer in Midwifery at Swansea University, and lead for admissions.

Chair's opening: Ginger Wiegand, Policy and Research lead on the All Wales BAME Engagement Program at EYST introduced the topic of Maternal Health and the inequalities in health outcomes for Black, Asian and Minority Ethnic Women in Wales.

1. **Vaughan Gething, Minister for Health and Social Services in Welsh Government**

Vaughan Gething spoke of the importance of focus on maternal health and differential outcomes, reflecting that this would have been important 12 months ago and that now in light of Covid-19 it is even more important as the pandemic has both highlighted and reinforced inequalities. There is a clear relationship between socio-economic inequalities and healthcare outcomes. People from BAME backgrounds are disproportionally living in less well-off communities and we know from research are more at risk of specific health issues than the white community.
The reality of the economic position of many BAME people plus COVID-19 has pushed health inequalities into sharp focus.

There is movement in Welsh Government to look at these issues with two groups focusing on WG response including one group led by Professor Keshav Singhal and the socio-economic sub-group of the Covid-19 task force chaired by Judge Ray Singh.

Welsh Government was also involved in research with Oxford University looking at maternal and perinatal mortality which found that BAME women made up over half of all women who died as a result of childbirth complications. It also found that Asian women were 4 times and Black women 8 x more likely to be admitted to hospital with Covid-19 than white women and that these admissions mostly happened in the third trimester. The Royal College of Midwives also were part of this research study.

Maternal mortality and differential outcomes for BAME women is an issue for the whole of our healthcare system. We are proud of our NHS but we recognise we still have more to do. We need to recognise we have a problem and by recognising we have a problem we will be able to take action to tackle the problem.

2. Laura Santana, Student Midwife and Co-Founder of Birth Partner Project

Laura has been asked to speak based on her experience as a 3rd year student midwife and co-founder of the Birth Partner Project in Cardiff which supports women seeking sanctuary and refugee women who face birth alone. The project supports women peri and post natal as well as during labour.

There are multiple barriers and difficulties that BAME women face. These barriers are complex and multi-faceted and include the impact of poor housing, benefits systems and language issues to name a few. Language is key because the pre-requisite of maternity care is informed consent. If interpreters are not being used, then we don't have informed consent and we can't find out about fundamental indicators of ill health such as reduced foetal movements.

There is both excellent and poor practice in maternity care in Wales. Access to interpreters should be an integral part of healthcare; it should be financed appropriately and not just be an add-on. We should be listening to women's experiences and hear them if they tell us they are experiencing poor standards of care. We must be able to scrutinise our practice, even if it makes us uncomfortable.

Health professionals need to recognise their unconscious bias, cultural and institutional racism. Witnessing racism as a student midwife is often difficult to challenge due to the hierarchy of the hospital environment. There are a lot of cultural attitudes and racial bias towards pain for example 'Traveller women never breastfeed', or 'Asian women always complain they are in pain' or 'Black women

don't need help with breastfeeding; they always just get on with it'. This type of racism fails to see the individual and their specific needs. Another example is with language, some babies are born with blue, black markings on their lower backs known in medical language as 'Mongolian blue spot'. Power is encoded in language and can terrorise and express so much.

3. Antonia Ashaye, Founder of Obirin Africa and 5th year Medical Student

Obirin is a non-profit organisation started at the beginning of 2020 focused on educating Black women about their reproductive and sexual health. Obirin means 'woman' in Yoruba.
WHO defines maternal mortality:

Maternal death *is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced: Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.*

This definition therefore includes death by suicide and domestic violence. The EMBRRACE Report https://www.npeu.ox.ac.uk/mbrrace-uk statistics show that Black women in the UK are five times more likely to die than white women (despite making up 20% of women giving birth in the UK) and Asian women twice as likely to die than white women as a result of maternal mortality. Why? What are some of the disparities and inequalities facing women from BAME backgrounds in the UK?

- Socio-economic inequality leading to lower health outcomes
- Poor housing
- Language - need for appropriate interpreter services
- Co-morbidities
- A perceived higher threshold for accessing services

Antonia offers 5 points to improve on to start to re-dress this inequality in maternal health:
1 – Communication. We need effective leaflets and diagrams to aid understanding.
2 – Professionals need to be advocates for women
3 – We need to encourage engagement with services
4 – We need to refrain from making assumptions
5 – Educate patients on risks and symptoms

4. Discussion and Questions – Part One

Patience Bentu from Race Council Cymru – there is great risk and ignorance in assuming all BAME women's maternal health issues are the same.

Ellen Nelson-Rowe from the African Caribbean Medical Association - What current training practices are in place across Welsh NHS workforce on unconscious bias and is it compulsory?

Karen Jewell, Lead Nurse and Midwife for Chief Nursing Office in Wales – NHS in Wales has linked in with the Royal College of Midwives who are looking at this (Unconscious bias training) as part of their leadership program. It should be being rolled out across all Health Boards (HB) in Wales within the next few months. https://gov.wales/sites/default/files/publications/2019-06/maternity-care-in-wales-a-five-year-vision-for-the-future-2019-2024.pdf

Claire Thomas from Bevan Foundation – what is being done to address translation/interpreter requirements? Is the expectation that all Health Boards provide translation as part of equity of service?

If there are specific health boards in Wales where translation/interpreting is not happening Karen Jewell would like to know about this.

Laura Santana notes that there is some good practice, for example use of skype.

Thanuja Hettiarachchi from EYST - When working as a peer researcher came across many stories where children were having to translate for their mothers. The research findings also showed how problematic this could be and the issues surrounding confidentiality.

Hannah Sabatia from Better Welcome to Swansea Project at SCVS – Pregnant Asylum Seekers face barriers getting to hospital to give birth as they do not receive sufficient financial support to get a taxi. Secondly the housing offered to asylum seekers is often sub-standard and cramped and not appropriate for new born babies.

5. Dr Julie Bishop, Director of Health Improvement, Public Health Wales

Being invited to the event was stimulus to look at something PHW have not given enough attention to in the past. The inequalities that arise from being BAME and the structural inequalities surrounding maternal outcomes are important to address. Thankfully, maternal death is rare. We need to look at the causes. Communication and structural racism to an extent but also poor health in these groups. Maternal morbidity and illness are a reality for 70% of Black women and 40% Pakistani women

in Wales/UK for example. In 2011 Black women were 2.5 times more likely to die in Childbirth and the current EMBRRACE report findings from 2015-17 show Black women are 5 times more likely to die than white women. The problem is getting worse. Again, when we look at causes, we can see for example that Anaemia can be an important indication of pregnancy problems, which is why communication is so important. Also, the issue of not accessing ante-natal care and general poor health which may affect certain groups such as refugees and asylum seekers (RAS).
Studies suggest women with African – Caribbean backgrounds are less likely to access ante-natal care. There is a tendency to blame the user. Of course, in fact, it is about how the services are run. Primary Care needs to be focused on changing to meet need not focusing on patients being 'wrong' for services.

Karen Jewell is leading on a piece of work looking at how we structure our services, access is crucial. It is very hard to find information and data on access statistics and in fact PHW doesn't actually report on data concerning ethnicity and attendance and maybe it should.

Our programme the first 1000 days focuses on reducing inequalities and improving outcomes from pregnancy to toddler age. http://www.wales.nhs.uk/sitesplus/documents/888/Parental%20insights%20E.pdf

6. **Lucy Evans, Lecturer in Midwifery at Swansea University, and lead for admissions.**

In addressing Maternal Mortality for Women of Colour the midwifery students are focused on learning about a range of issues including access barriers, infant mortality, breastfeeding support, post-natal education to name a few. It is important to focus on midwifery students because they are the future and we must not just have one module on cultural differences. It must be embedded into all taught modules.

We are teaching our students not to stereotype, to be open-minded to have an ongoing practice of educating yourself, to 'ooze' the notion that you have all the time in the world for that woman, to ask about preferences, to be aware of symptoms that may disproportionally affect women from specific ethnic minority backgrounds. We encourage our students to think about their conscious and unconscious bias, to challenge language in a professional way and to be part of a push for continuity of care (Maternity Strategy's 5-year vision).

Swansea University has a program focusing on decolonizing the curriculum and encouraging inclusivity https://www.swansea.ac.uk/inclusivity-academy/

What's next in teaching midwifery? There is lots of movement across the UK

- Looking to diversify the student cohort
- Mentorship – what is happening on the shop floor?
- We are re-writing our curriculum on the back of the Nursing Midwifery Council guidance in terms of cultural competency being threaded into every module and everyday care.
- The department has obtained a small grant from SAILS to do some widening access work to attract students from diverse backgrounds and make a step towards a more diverse workforce of the future. Targeting 6th forms and FE colleges.
- In Wales we are encouraged to focus on Welsh medium provision but what other 1st and 2nd languages could we be actively promoting in our recruitment?

7. Discussion and Questions – Part Two

- How are above initiatives measured in terms of their impact?

- Several people in the discussion and the chat expressed dismay and concern about generalising that Black women don't access ante-natal care.

- One woman shared her personal experience: AB experienced heart palpitations and repeatedly went to see doctor and midwife who brushed it off as usual morning sickness and vertigo. Finally, AB was referred to hospital and ended up having a blood transfusion and stayed in for a week. Impacted on AB's belief in medical professionals as was not listened to or taken seriously when she was describing her symptoms.

- Continuity of care is part of the new maternity vision for Wales. Women will see no more than 2 midwives throughout their outpatient pregnancy journey and all women will have a named midwife. It is now recognised how important it is to build up a relationship, despite the challenge's workforce wise.

- The maternity care workforce needs to be diverse – midwives, obstetricians – all of us need to step up and address this and have a targeted approach. The chief nursing officer has stated we need a focus on this.

- Karen Jewell, Lead Nurse and Midwife for Chief Nursing Office in Wales - the 'Train, Work, Live' initiative in Wales is aimed at encouraging a more diverse workforce.

- Participants in the forum expressed concern that we are not seeing career progression from BAME people and so BAME people choose to progress their careers elsewhere.

- Karen Jewell spoke of the RCM leadership campaign and the current recruitment for a BAME person in this associate role.

- Disclosure of Domestic Abuse an ongoing issue. Essential to have professional interpreters, confidentiality systems, continuity of carer and pathway and routine questioning used by all.

- Patience (RCC) notes that her biggest dream is to see racial diversity in recruitment of maternal health workers. It would go a long way. Also, what about looking specifically at health issues which disproportionately affect Black women for example Fibroids and NHS waiting lists.

- Karen Jewell will take this to policy leads and come back with a response. Dr Julie Bishop – this should be on basis on clinical need.

- Laura Santana – is there scope for specialist midwives (like we have a Refugee and Asylum Seeker specialist midwife in Cardiff) to look specifically at BAME women's health issues?

- Karen Jewell – PHE are currently looking specifically at this.

Notes from the Chat Substative comments

10:54:53 From F : Thank you so much Laura. I can resonate with all you said. I agree each woman should be treated as an individual rather than being stereotyped. Based on my own personal experiences with my two children, their pregnancies, birth and breast-feeding experiences were entirely different.

11:02:01 From EC : Several matters discussed resonate with me through experiences of friends and 'service users', other matters I was not aware of. I am surprised that there has not been much attention for this topic, considering there have been a number of reports about higher incidence of maternal deaths among BAME/migrant women in the UK since 2012.....

11:03:38 From EC (Newport) : Access to/provision of language support is vital; in my experience is that this needs to go hand in hand with the quality of interpreting and good practice issues!

11:05:11 From F: Thank you Antonia Ashaye, Language Barrier poses a major issue. Most times, Assumptions are being made and sometimes lead to wrong diagnosis.

11:06:44 From HS- Scvs : Works with Better Welcome project in Swansea - mentoring people seeking Asylum arriving in the city. As we speak 2 of our women participants are having their babies. The challenges has been immense , not just because it was Covid time, but also because of the limitations that asylum seekers have. Transport to hospital, language issues and all these things been spoken here. Just wanted to make aware that Asylum seeking women are and have an extra difficulty.

11:10:58 From EC : Having been a maternity nurse in a previous life, I agree with Laura that it is very important that a mother feels safe. If a woman feels safe, this usually has a positive impact on the birth process.

11:11:22 From RH: Postnatal depression is and iron deficiency is something very common and mostly taken as laziness of BAME Women even within family. Has there been any information in different language on postnatal depression and from where she can get confidential help??

11:12:12 From HS- Scvs : Also , without family near to help with childcare, the mothers worry about childcare of the older sibling.

11:12:13 From EC : Financial problems from people seeking asylum as well as migrants (especially those with NRPF) are a barrier to access health care

11:13:06 From MH: Many asylum seekers and refugees do not understand the letters sent to them by GPs and hospitals and some cases they miss important appointments and procedures

11:15:11 From EC: I know we are talking about maternal health, but I'd also like to draw attention to the reports of lower birthweights of babies from BAME women.

11:20:57 From RH : Experiences of young women coming from abroad after getting married to some one in UK and those mums to be from settled BAME Communities is very different for language and cultural differences of coming to this country and being with in laws something observed and talked about by new mums.

11:21:02 EC: I would be very interested in how researchers (or others) have come to the conclusion that black women don't access antenatal care because they are not/less aware of health services as mentioned by Julie.

11:23:04 From EYST Rights : MBRACE report: https://www.npeu.ox.ac.uk/mbrrace-uk/reports

11:23:18 From JewellK : Ginger I would be happy to give a quick overview of the maternity 5 year vision launched last year if there is time

11:24:17 From JewellK : https://gov.wales/sites/default/files/publications/2019-06/maternity-care-in-wales-a-five-year-vision-for-the-future-2019-2024.pdf

11:24:53 From AD : Black women do try to access antenatal care. whilst I was pregnant with my second baby, I repeated informed my midwife that I was sick and went to the doctors with my symptoms of dizziness, etc. was told I had vertigo when in fact I had severe

11:28:11 From RH: Domestic abuse including financial, emotional and psychological having huge impact on many BAME Women again many of those who are coming from abroad. sometimes family member to accompany those pregnant women so they don't get the opportunity to speak about what is going on behind the closed doors.

11:28:39 From julie bishop : Researchers have looked at data on attendance at ante-natal care and found that those from black african and caribbean backgrounds are more likely not to attend all appointments. There will of course be lots of reasons for this that we need to understand better. As people have said, when people do access care they may not be heard.

11:29:13 From EC: Experiences such as those of AD and others are having a negative impact on the trust and confidence in health care provision... :(

11:30:02 From D: Is there an way of understanding coercive control for women not attending ante natal clinics

11:30:21 From Laura Santana : diverse recruitment is essential

11:31:58 From PB : I agree @Laura Santana. I believe that ensuring racial diversity in recruitment will help provide the necessary support that ethnic minority women need.

11:32:32 EC: I am aware that midwives in Newport have found innovative ways to help women give a safe way of indicating that they experience domestic violence

and/or coercive control. I wonder whether this, or a similar approach, is also used on other hospitals?

11:32:44 From Rahila Hamid : Also those vulnerable mums to be taking asylum traumatic experience led them to come to the UK to be addressed with language and culturally appropriate sensitive support.

11:35:38 From AD : I saw the same midwife antenatally (in response to the public health officials statement on pledge that going forward women will see the same midwife throughout pregnancy).

11:37:06 From RH : AD sorry to hear that and I have heard a lot even GP saying to an Asain mum to be that you are wasting their time:(

11:37:29 From julie bishop : Our research has shown that women need to feel confident in the relationship with professionals to disclose abuse or other concerns, so very relevant to the continity of care comments

11:40:09 From SM : Again BAME people join the profession but see no progression and so they leave and move to other areas where they can experience social progression

11:42:30 From OA : Absolutely agree Selina; differential attainment, mentor ship and promotion and career progression is important in recruiting and retaining BAME staff (in medicine and midwifery)

11:47:01 From RH : For many BAME women often assumptions made that after being discharged they will have plenty of help especially as they see pool of people visiting them when they get back home with a little one where they may not have anyone so worth exploring to put something in place.

11:51:51 From RH : Ovarian Cyst is another issue BAME feels high risk of not conceiving any information provided to those trying to conceive??