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Pregnancy as an ideal time for intervention to address the complex needs of black and minority ethnic women: Views of British midwives

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ABSTRACT

Introduction: maternal health inequalities exist across the world. In the United Kingdom, whilst there are variations within and between groups, Black and Minority Ethnic (BME) women tend to have worse maternal health outcomes than White British women. However, there is limited information about BME women's experience of maternity services. Midwives are central to the provision of safe maternity care but little is known about their perceptions of ethnically-based inequalities in maternal healthcare. Therefore, this study explored a cohort of midwives' experiences of providing care for BME women, focussing on their views on the relationship between maternal health inequalities and service delivery.

Methods: using a specifically-designed topic guide, 20 semi-structured interviews were conducted with qualified midwives in one National Health Service (NHS) Trust in the North West of England over a two-month period. Data were subsequently transcribed and thematically analysed.

Results: three main and seven sub-themes were identified. Firstly, *'language'* summarised difficulties midwives experienced in engaging with women whose English was limited. Secondly, *'expectations of maternity care'* outlined the mismatch between midwives and women's expectations of maternity care. Finally, '*complex needs extending beyond maternity care*' highlighted the necessity of inter-agency working to address women's care holistically when their needs transcend the scope of maternity services.

Discussion: Midwives' accounts indicated that they strive to provide equitable care but encountered numerous barriers in doing so. Paradoxically, this might contribute to inequalities in service delivery. In midwives' view, unrestricted access to interpretation and translation services is essential for provision of effective, holistic maternity care. Participants also advocated education for both women and midwives. For the former, this would improve BME women's understanding of health and care systems, potentially leading to more realistic expectations. Improving midwives' cultural competence would better equip them to respond to the needs of an ethnically diverse population. Finally, midwives highlighted that many minority women's complex care needs were identified during pregnancy. Hence, they regarded pregnancy as an ideal time for interventions to improve the health of women and their families and, as such, antenatal care cannot be treated as an isolated event. According to midwives in this study, delivering safe, effective maternity services in the 21st century requires greater collaboration with the women they care for and other health and care agencies (including independent sector providers).

Introduction

Inequality in health status and health outcomes is well documented across the world (Mackenbach et al., 2008; Graham, 2009). Reducing health inequalities has long been at the forefront of public health policy in many countries including the United Kingdom (UK) (Johnson et al., 2000; Department of Health: DH, 2012). Yet, the health of some groups in society is improving at a slower rate than other groups, and in some cases, has worsened (Smith et al., 2011). For

Abbreviations: UK, United Kingdom; NHS, National Health Service; BME, Black and Minority Ethnic; CMACE, Centre for Maternal and Child Enquiries; IMD, Indices of Multiple Deprivation; RCOG, Royal College of Obstetricians and Gynaecologists; RCM, Royal College of Midwives

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instance, in the UK, people from Black and Minority Ethnic (BME)[1] backgrounds remain more likely than their White British counterparts to experience poorer health outcomes and limited access to health-care services despite policy initiatives to tackle inequalities (DH, 2012). Ethnicity, a collective identity based on shared culture, religion, and/or language (Karlsen and Nazroo, 2006), is known to interact complexly with other key variables such as socio-economic position, age and gender (Black et al., 1982) and to contribute to the production and maintenance of health inequalities. Therefore, to deliver equitable services, it is important to understand health professionals' attitudes, beliefs, and behaviours in caring for an ethnically-diverse population (Smedley et al., 2003) as these factors are known to affect patients' health behaviours and outcomes (Karlsen and Nazroo, 2009).

The last two decades have seen a significant growth in the rates of migration from various countries to the UK. The 2011 UK Census reported a twofold increase in the number of people from BME backgrounds, in particular 'white other' from Eastern European Countries (Office of National Statistics: ONS, 2011a). Thus, the number of patients from BME backgrounds seeking care from the National Health Service (NHS) has increased. This is particularly evident in maternity services as migrants generally have higher birth rates than their White British counterparts (Office for National Statistics, 2012; Latif, 2014). Yet, BME women are known to experience the worse maternal health outcomes compared with the majority population (DH, 2007; The Marmot Review, 2010; Henderson et al., 2013). For example, the Centre for Maternal and Child Enquiries (CMACE) reported that Black African ($RR=3.85$) and Black Caribbean ($RR=3.75$) women had higher maternal mortality rates than White women in England (CMACE, 2011). Recent research has also found that BME women tended to access maternity services later than White British women, for reasons including difficulty accessing and/or maintaining engagement with maternal health services (CMACE, 2011), which increases mortality and morbidity (DH, 2004). Hence, it is crucial to reduce health inequalities and improve maternity care services for BME women. Better maternal and child health outcomes not only has the potential to positively impact the life course, it also benefits the UK economy through decreased NHS health and social care costs, and increased productivity (World Health Organisation: WHO, 2011; The Marmot Review, 2010).

Research consistently shows that BME women report more negative experiences of maternity care, such as poor communication and a lack of empathy from health-care professionals (Bharj and Salway, 2008; Raine et al., 2010; Edge, 2011). More recently, in a large study of women from different ethnic backgrounds, BME women reported poorer experiences of maternity care compared to White women, suggesting that little has changed over time, despite policy and practice initiatives to improve women's maternity experience and outcomes at local and national levels (Henderson et al., 2013).

Midwives are central to maternal health-care provision, and are involved throughout pregnancy and childbirth for the majority of women in the UK (Page, 2003; Sandall et al., 2010; Royal College of Obstetricians and Gynaecologists: RCOG, 2013). Research on midwives' perceptions of maternity care is limited (Lavender and Chapple, 2004; Bick et al., 2011), particularly on midwives' views of maternity care for BME women. An appreciation of midwives' views and experiences of providing care for BME women is essential for provision of more ethno-culturally appropriate, holistic care. Commissioning and provision of high quality maternity care services should consider the views of relevant stakeholders (Bick et al., 2011) including midwives. The current study explored midwives' experiences of providing maternity care for BME women with the aim of understanding the challenges of delivering equitable maternity care in a multicultural context, and the perceived role of the midwife in tackling health inequalities in maternity care. Therefore, the findings have potentially important policy and practice implications for provision of more culturally-appropriate maternal healthcare.

Methods

A purposeful sample of qualified midwives practising clinically was recruited in one NHS Trust in Greater Manchester, UK. Ethical approval was obtained from the University of Manchester Research Ethics Committee (UREC; Ref.: ethics/12393), and research access was gained via the Trust's Research and Development Department (Ref: RECNA01).

People living in Manchester suffer from worse health outcomes than the national average (DH, 2012). The research site was selected due to its ethnically-diverse patient population. One third (33.83%) of the population in the Trust's catchment area are from BME communities (ONS, 2011b). On the basis of the Indices of Multiple Deprivation (IMD) in 2010, the catchment area of the elected Trust was in the top 10% of most deprived areas in England (Manchester City Council, 2011).

A maximum variation (heterogeneity) sampling strategy was used, to identify commonalities across a range of midwives' experiences (Patton, 2002). Using an inductive approach to data analysis (Braun and Clarke, 2006) allowed the researchers to gain some insight into the experiences of midwives in providing care for BME women in one locality. Thus, midwives from different, areas of clinical practice and at differing stages of their career, were recruited to capture the diversity in the experience of care provision for BME women and highlight common experiences. To maintain the anonymity of the midwives, the demographic information collected was limited to their current practice area (e.g., community, postnatal ward) and years of experience. Qualified midwives not employed by the selected NHS trust, non-qualified staff (e.g. health-care assistants and students), and those unable to provide informed consent were excluded from the study. Research information was disseminated to reach all midwives (approximately 100 staff) in the elected NHS Trust via three routes and offer them the opportunity to participate in the study: (i) e-mails, accessible to all midwives, with study information were sent through senior midwifery staff via the Trust's intranet; (ii) 80 research study packs[2] containing a participant information sheet, self-addressed envelope to return to the research team and a form where midwives could provide their contact details; and (iii) attending team meetings (RA, DS) and shift handovers (RA) with support from senior midwives.

All midwives were recruited and interviewed by one researcher (RA) between May and June 2013. Participants were given verbal and written information about the study, time to consider participation (at least 24 hours) and opportunities to seek clarification. All midwives signed a consent form before participation. Semi-structured interviews were conducted at the hospital site using a topic guide developed by the research team based on existing literature and their knowledge of the research area. The topic guide (available on request) was pilot tested to establish confirmability (Lincoln and Guba, 1985) and covered four key areas: *information about the midwife*, *professional experience of providing care for BME women*, *views of health inequalities*, and *midwifery training*.

[1] Black and Minority Ethnic (BME) is a term frequently used in the UK to describe people of non-white descent (Institute of Race Relations, 2014).

[2] Eighty research packs were printed as opposed to 100 as this was not the sole recruitment route and were relied upon when the researcher (RA) was not present in the hospital (RA held the final 20 packs and used them when talking to the midwives).

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