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**Midwives experiences of
caring for high risk
women from Black Asian
Ethnic Minority groups**

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Sarah Chitongo
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EXECUTIVE SUMMARY

This qualitative study explores midwives' experiences of caring for high risk Black Asian Minority Ethnic Groups in order to identify how improvements can be made to the care and outcomes of this group. The study was also undertaken against the backdrop of research findings suggesting that Black Asian Minority Ethnic (BAME) women had significantly higher maternal and perinatal mortality rates for minority ethnic (55 per cent higher combined) compared to their white British counterparts (9.8 percent) MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK 2018).

BAME women also report lower maternity care satisfaction, and UK health professionals report more difficulty in providing services to these clients. Several factors have been identified: poor communication between practitioners and patients, stereotyping and inaccurate cultural assumptions held by some practitioners, and a general lack of research and sensitivity concerning the cultural and linguistic needs of patients from minority groups (McFadden et al., 2013; Reitmanova and Gustafson, 2008; Maternity Alliance, 2004). Other contributory risk factors, such as socioeconomic status, including education status and income, and living in areas of high deprivation are frequently cited as distal determinants of poorer health outcomes (Garcia et al., 2015).

Semi- structured interviews were undertaken with twenty midwives who had recent experience of caring for women from BAME groups who were high risk. This is the first study to investigate the impact on midwives of caring for BAME women within an advocate role of the struggles they see for these women. This study aimed to understand how midwives perceive the consequences of high risk pregnancies on BAME women and their challenges they face to give optimal care to BAME women in pregnancy. Thematic analysis was undertaken for data analysis. Findings were viewed through a lens of critical social theory (CST) and drew on critical race theory principles to provide a deeper understanding of the emergent themes. Findings indicated that midwives wanted more cultural awareness and

safety training within their mandatory training. Reasons explaining what midwives' barriers to caring for these women were grouped into themes; 'continuity of carer' 'difficulty accessing translation services', 'listening to women', 'too afraid to seek NHS care' "cultural safety training".

An existing body of literature highlights the importance of midwife-woman relationships in care satisfaction and pregnancy outcomes. The implications for institutions, midwifery practice and further research are outlined. The study provides a valuable and unique insight from midwives' perspectives that continuity of care and carer is important to improve outcomes and acculturation of the midwifery workforce is essential.

Translation services within the National Health Service (NHS) require an overhaul to ensure that they are accessible. Language disparities in the United Kingdom (UK) mean that non-English speakers are known to have more negative experiences than those for whom English is their first language (Attanasio and Kozhimannil, 2015). The use of interpreters to mitigate these to an extent however there remains concerns as highlighted by the midwives in the quality and availability of appropriate interpreters and the lack of training for midwifery staff in communicating with translators.

This study was undertaken at just one NHS Trust and will not represent all midwives, however the themes and recommendations made by the midwives are reflective of the majority of practising midwives. The midwives are voices and advocates to these women who are rarely heard by mainstream services. The insightful experiences of the midwives will assist in enhancing care, providing individualised care and ultimately improve the outcomes and experiences of BAME high risk women.

Keywords: Cultural Competency, Maternity, Midwifery, Experiences, BAME.

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CHAPTER 1: INTRODUCTION

Globalisation and other forces worldwide have also been responsible for mass population movement resulting in diversity in various societies (Benza and Liamputtong, 2014). The Black Asian Minority Ethnic (BAME) communities now make up 14% of the UK population (Sunak and Rajeswaran, 2014). Net migration for the United Kingdom has substantially risen in the past 3 years (Office for National Statistics 2018), and in the year ending September 2018, 627,000 more individuals entered the UK than left (Office for National Statistics 2018). As a result, non-UK-born communities continue to grow within the United Kingdom, increasing the ethnic diversity of the general population.

In 2017, there were 486,417 live births to women born in the UK and 192,651 live births to women born outside the UK (ONS 2018). Worldwide an estimated 190 million people are now living outside their countries of birth or citizenship, and the rate of this migration is expected to remain high (Jentsch 2007). The resulting growing cultural and ethnic diversity in societies creates specific challenges for those delivering public services such as health care. Immigration may bring with it many problems, including racism, negative stereotypes and inequality in health care provision (Sword et al 2006).

Globally, approximately half of the migrant population are women (Jentsch 2007). In the UK itself, 53 per cent of foreign nationals are women (Research Development and Statistics Directorate 2001) and maternal and reproductive health is thus of major importance. As shown later in this discussion, pregnancy outcomes of women from Black Asian Ethnic Minority groups are known to be poor, showing significant disparities when compared with those of indigenous populations (Macfarlane 2000). This highlights the need for investigation in this area particularly in areas such as London with data from 2013 suggesting that 39% of inner London's population were born abroad (Rienzo and Vargas-Silva 2016).

Evidence suggests that women from ethnic minority groups in the UK have poorer pregnancy outcomes, experience poorer maternity care, are at higher risk of adverse perinatal outcomes and have significantly higher severe maternal morbidity than the white British women (Puthussery, 2016; Henderson et al., 2013; Puthussery et al., 2010; 2009; Pollock, 2005; Maternity Alliance, 2004; Bulman and McCourt, 2002; Ellis, 2004). Although UK policies explicitly urge a woman-centred approach that is accessible, efficient and responsive to changing needs, ensuring choice, access and continuity of care, evidence of the impact of such policies in addressing inequalities in maternal health outcomes is relatively thin (Puthussery, 2016). Medical care has been estimated to play a role in only 10% of the variation of health outcomes, whilst genetic and behavioural factors have been estimated at 30% and 40% respectively (McGinnis et al., 2002).

This highlights as a cause for concern and indicates that the maternity services in the UK are still struggling to provide appropriate care that meets the needs of women from diverse populations (Henderson et al., 2013; Puthussery et al., 2010; , 2009; Pollock, 2005; Maternity Alliance, 2004). Katbamna (2000), Laird et al and Puthussery et al. (2008) argue that this is mostly due to a lack of awareness of ethnic minority groups and their needs, due to limited research. The little research there is, suggests that more could be done from a service provision's perspective to support BAME women, as they make the life changing transition to motherhood. Therefore, it is important to have competent healthcare services and professionals for the future development of maternity services.

RATIONALE FOR THE STUDY

Health disparities in the UK exist among and within ethnic communities. Maternity care providers have a duty to provide high quality care that is safe and responsive to the needs of mothers, babies and families (Department of Health, 2004; Department of Health and Partnerships for Children Families and Maternity, 2007; NHS England, 2016a). Social class affects the degree of these variations in levels of health among these groups (Randhawa 2007). Thus, providing a common model of maternity care may not meet the needs of all the different groups that are present in a multicultural society (Henley and Schott, 1999). This argument is supported by a report released by the Department of Health on Tackling Health Inequalities. There are wide geographical variations in health status, reflecting the multiple problems of material disadvantage facing some communities. These differences begin at conception and continue throughout life. Babies born to poorer families are more likely to be born prematurely, are at greater risk of infant mortality and have a greater likelihood of poverty, impaired development and chronic disease in later life. This sets up an inter-generational cycle of health inequalities which the Department of Health is keen to eradicate (DOH,2002).

The National Maternity review (2015) highlights that quality services must be personalised. The review set out recommendations for how maternity services should be developed to meet the changing needs of women and babies, highlighting a framework that includes seven key priorities;

- 1- Personalised care (centred on the woman, her baby and her family)
- 2- Continuity of carer (based on a relationship of mutual trust and respect in line with the woman's decisions)
- 3- Better postnatal and perinatal mental health care

- 4- A payment system (that fairly compensates providers for delivering different types of care to all women, while supporting commissioners to commission for personalisation, safety and choice)
- 5- Safer care (professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place)
- 6- Multi-professional working (breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care), and finally
- 7- Working across boundaries (providing and commissioning maternity services to support personalisation, safety and choice, with access to specialist care whenever needed).

Overall, despite the increase in the number of births and the increased complexity of cases in women giving birth later, the quality and outcomes of maternity services have improved significantly over the last decade (National Maternity review, 2015). However, there is still a considerable variation across the country in the quality, safety and effectiveness of maternity care, which indicates the scope for improvement (National Maternity review, 2015).

Research has indicated that women from ethnic minority groups have experienced poorer maternity care and maternity outcomes than the white population (Garcia et al., 2015; Puthussery et al., 2010; Maternity Alliance, 2004; Bulman and McCourt, 2002; Ellis, 2004). This body of research indicates that the maternity services in the UK are still struggling to provide culturally appropriate care that meets the needs of women from diverse populations. Exploring and challenging racism in health services is essential to the development of effective strategies to decrease health inequalities among ethnic populations. There is growing evidence that institutional racism has contributed to ethnic inequalities in health (Nazroo, 2003). Further to this there is also considerable body of evidence on health inequalities in ethnic minority communities in the UK, including studies concerned with minority women's

access to and views of maternity care (McCourt and Pearce 2000, Davies and Bath 2002, Richens 2003, Ali and Burchet 2004).

Communication barriers have been identified as one of the obstacles to providing high quality health care for many BAME women (Bharj and Salway, 2008). A study by Ellis (2004) exploring the birth experience of South Asian Muslim women highlights that communication problems often exist between midwives and BAME women even without major language problems. The Maternity Alliance report (2004) also identified poor communication between BAME women and health professionals and a lack of appropriate information provided during pregnancy, childbirth and postnatal periods, especially for women for whom English is a second language.

In a study by Crowther (2019), indicate that poor communication may result in women not receiving important information and as a result feel alienated. This has a subsequent impact to nutritional problems and inadequate access to maternity service for regular antenatal check-ups (Balaam, et al., 2013). The CEMACH report (2011) emphasized that poor communication is one of the risk factors associated with increased morbidity and mortality among black and ethnic minority women. Balaam (2013) further went to add that ethnic minority women tend to avoid using health services if they are unfamiliar with the health system as certain attitudes on the part of healthcare professionals may be seen as disrespectful.

Cultural practices and beliefs about pregnancy and childbirth have often been blamed for the poor uptake of maternity services, but it is also important to recognise that many women from minority ethnic communities are prevented from making effective use of maternity services due to language and communication problems, intrusive examinations, lack of explanation, negative stereotyping and the racist attitudes of health professionals (Katbamna 2000). This demonstrates the importance of cultural awareness in helping healthcare professionals understand and recognize individual cultural difference and remove any

barriers that are unconsciously created due to unawareness of the importance of culture for a childbearing woman (Esegbona-Adeigbe, 2011).

Understanding cultural difference extends far beyond language needs, it includes beliefs regarding health, illness, healing and health systems; cultural behaviour in seeking healthcare and attitudes toward healthcare providers; and views and values of those delivering the care (Szczepura, 2005). Esegbona-Adeigbe (2011) suggests that midwives should use culture as a first point of assessment for women when planning care; allowing for consideration and acknowledgment of cultural norms and respect for any taboos, while facilitating women's needs by removing barriers that may compromise their culture.

BACKGROUND

Women from South Asian and Black African communities and women seeking refuge and asylum are significantly more likely to die in childbirth (Lewis 2007). Women from BAME groups are more likely to 'book late' (i.e. receive their first antenatal check-up beyond the recommended twelve weeks gestation) and are less likely to receive antenatal care regularly. There is research evident that healthcare providers feel inadequately prepared to meet the needs of their ethnically diverse patient population. It is the need for the appropriate management of these complications which have brought the development of this specialist care to the forefront.

The purpose of the midwifery high dependency unit is to provide care to women who develop complications during the antenatal, intrapartum or immediate postpartum period. This area of care is becoming increasingly important as health demographics of women who have a pre-existing medical condition especially more prevalent in the ethnic minority groups. Under the Race Relations (Amendment) Act 2000, it is unlawful to refuse or deliberately fail to provide services, provide poorer services or treat people differently. Organisations need to ensure that their maternity workforce is adequately prepared to confidently serve the needs of a diverse population (DOH 2004).

Confidential Enquiries into Maternal and Child Health (CEMACH) for women who died between 2009 and 2014 focuses on lessons about cardiovascular disease, caring for women with hypertensive disorders of pregnancy, and messages for early pregnancy and critical care. Black Caribbean patients have an increased prevalence of left ventricular hypertrophy whilst diabetes was markedly higher in Bangladeshi, Pakistani, Indian and Black Caribbean patients. The high levels of cardiovascular mortality and morbidity in ethnic minority groups has been the focus of several studies. The Black Asian Minority Ethnic (BAME) population has increased significantly over the course of the last three decades (Office of National Statistics (ONS),

2011). This trend is set to continue. Delivering high quality safe maternity care is the responsibility of every midwife.

The NHS Constitution in England core values includes respect; compassion; commitment to quality of care; and working together for patients. The last report from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) (2011) in which cardiovascular disease has been highlighted as a cause for concern amongst the BAME maternity group of patients highlights the importance on revalidation of the educational curriculum to enable each student to qualify with the high dependency skills and knowledge to care for a critically ill BAME patient and seems to now more than ever be a priority.

The traditional view that a midwife is concerned with normal childbirth can no longer be seen as feasible. The purpose of midwifery training is to ensure that minimum level of competence is achieved to ensure safety of the woman and child. Competence is a concept that was explored by Benner (1982) who identified levels of competence from novice to expert. Expert practice is an essential aspect in practice especially now given the complexity of the health problems that come with this group of patients. Most importantly most healthcare trusts have relied significantly on nurse trained colleagues in caring for this diverse complex group whom they would have cared for within the nursing profession. Direct entry midwives are disadvantaged as Vaughan (2010) noted as the midwifery training allows for little experience within the general nursing environment or an understanding of the disease process.

While maternity services have guidance on working with women with individual presenting factors, no current framework for understanding and meeting the needs of high risk BAME women (Randhawa,2007). This undoubtedly makes sense for the midwifery curriculum to be adapted to address the increasing number of black minority ethnic groups who have very complicated pre-existing medical conditions. To ensure that midwifery education remains fit for purpose it is essential that the patients are not put at risk as well as place the midwives in

difficult compromising positions from a professional position. While some universities have admitted midwives onto general intensive courses it does not cover the pregnant ill woman. As the diverse population increase within maternity services, we need to be proactive to ensure that appropriate high dependency care is available, and this includes training staff to have a unique set of skills. I would like to influence formal guideline with the essential competencies to make provision to this high-risk group of patients within the National Health Service and the Nursing and Midwifery Council.

MATERNITY SERVICES AND ETHNICITY

The World Health Organization (WHO) proposes that maternal health may best be understood as a state of physical, mental and social well-being (Mooney et al 2008). In the human reproductive process, which includes pregnancy, childbirth and puerperium, the physiological process is the same for females around the world (Braithwaite et al 2004). As a result of differences in social circumstances, as well as culture, religion and values, prenatal, childbirth and postnatal care practices vary greatly in different societies and cultures. Moreover, the experiences arising from migration such as isolation, absence of kinship and support networks, together with poor English skills, create social disadvantages in accessing maternal health care services for this group, which have been linked to numerous poor maternal health outcomes (Alcorse and Schofield, 1992).

This is supported by a study conducted on Somali refugee women in an area of west London, which indicated unequal access to maternity services by this group of women due to lack of interpreter services, stereotyping and racism from health service staff, and a lack of understanding by staff of cultural differences (Harper-Bulman and McCourt 2002). Mackinnon and Howard (2000) assert that lack of language skills and up rootedness were the two issues causing most emotional distress. They further highlighted the importance of social support in providing protection from mental and physical illness, especially during stressful events like immigration.

A national survey of women's experiences of maternity care found that there was disparity in the way care was provided to, or experienced by, women, particularly in those from minority ethnic groups (Redshaw et al 2007). The Healthcare Commission's investigations into the maternal deaths of ten women at North West London Hospitals Trust indicated that nine of the ten women were from a minority ethnic background (Health Care Commission 2007). The report "Saving Mothers Lives: reviewing maternal deaths to make motherhood safer 2003-2005", released by The Confidential Enquiries into Maternal Health (CEMACH), indicated that women from some ethnic minority groups are at three times more risk of maternal death

compared to white women (Lewis 2007). Furthermore 25 per cent of women from ethnic minority populations access maternity services when they are five months pregnant or more or they miss four or more routine antenatal visits during their pregnancy (House of Commons 2003). The NHS Plan published in 2000 asserted that the health of mother and baby during childbirth will build the foundation of the baby's health throughout its life and gave evidence that the mortality rate of Pakistani female children in their first year of life was twice that of children of women born in the UK (Department of Health Public Services Agreement 2000).

ETHNICITY AND ETHNIC GROUP

Ethnicity has been defined as “a set of descent-based cultural identifiers used to assign persons to groupings that expand and contract in inverse relation to the scale of inclusiveness and exclusiveness of the membership” (Cohen 1978 p 387). Ethnicity is characterised by the common denominators of culture, language, heritage, and ancestry. Ethnicity is not a static quality that individuals possess but it is a relationship under continuous negotiation between interactants of a culture (Skutnabb-Kangas 1994). Ethnicity can therefore reside in cultural practices of a group of individuals. An individual's ethnicity can change over the course of a lifetime. According to Zenner (1996) ethnicity refers to a common heritage shared by a particular group. Heritage includes similar histories, languages, rituals and preferences for music and foods.

Minority ethnic groups encapsulate the experience of social differentiation on the grounds of race, cultural difference and religion and refer to groups in the minority. Culley and Dyson (2001) assert that ethnicity is socially constructed and socially grounded in culture and is used to refer to people who share the same ancestry, religion, heritage and geography. In fact, we all have ethnicity; we are all ethnic.

ETHNICITY AND MATERNITY SERVICES

The 2001 the UK census indicated that minority ethnic groups form around 7.9 per cent of the total UK population (4,694,681 out of a total population of 58, 84, 8579). The Office of National Statistics records indicate that 50 per cent of the minority ethnic community in the UK gave their ethnic origin as Asian or Asian British, 25 per cent black or black British and a further 15 per cent as mixed race (ONS 2001a). The 2001 Census data show that the ethnic minority population is growing more rapidly than the indigenous population: approximately 73 per cent of Britain's overall population growth was due to a high birth rate and to migration.

In February 2016, the National Maternity Review Better Births set out the Five Year Forward View for the NHS maternity services in England. NHS England established a Maternity Transformation Board to oversee the delivery of the policy and recommendations. The board recognised the vital role of local leadership and action in making sure its vision is achieved. It formed Local Maternity Systems that bring together commissioners, providers and service users to plan and deliver maternity services. The review did not however include any specific findings in relation to maternal mortality rates by ethnicity.

General Health Inequality

Health 'inequality' is the term used to describe the variation in health outcomes for distinct populations; including mortality/morbidity rates, disease prevalence, and treatment outcomes. The scale of health inequality varies greatly across countries (Crombie et al. 2005), with cross global comparisons showing the United Kingdom to have one of the largest gaps in health status between high- and low-income groups when compared to countries of similar economic and social background (OECD 2015). Data from 2013 suggests that whilst 88% of the top 20% of earners report good or very good health, only 68% of the bottom 20% of earners report this same positive health status (OECD 2015). Despite the subjective nature of

self-reported health, such measures have been found to be a good predictor of people's future health care use, and are therefore seen as a good indicator of health status (OECD 2015).

In response to persisting health inequalities, the United Kingdom has become a world leader in policy development and practical action to tackle these inequalities (Health Inequalities Unit 2008). In November 2008, Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010 (Marmot et al. 2010).

Since 2012 health bodies in England have had legal duties to address health inequalities (NHS England et al. 2015) and are assessed on their performance of these duties on an annual basis by the Secretary of State for Health (NHS England et al. 2015). Furthermore, the British government holds full and continuing engagement with the social determinants and health inequalities agenda of the World Health Organisation and European Union (Health Inequalities Unit 2008).

ETHNIC INEQUALITIES IN UK PREGNANCY EXPERIENCES AND OUTCOMES

In the UK, minority ethnic women consistently report lower maternity care satisfaction (Singh and Newburn 2000; Bowes and Domokos 2003; Richens 2003; Redshaw et al. 2007), and less choice in their maternity care (Redshaw et al. 2007; Redshaw and Heikkila 2011) than their white British counterparts. Similar findings are shown globally; with minority ethnic and migrant women reporting less positivity about their maternity care (Small et al. 2014).

In addition to poor experiences of maternity care in the UK, a wealth of research details poor pregnancy outcomes for minority ethnic women; including an increased risk of complications

during pregnancy (Nair et al. 2015), unplanned caesarean section (Essex et al. 2013), and having their baby cared for in a neonatal unit (Raleigh et al., 2010). Furthermore, despite a significant decrease in maternal mortality rates since the 1930s (Chamberlain 2006); (Ibison et al. 1996); (Knight et al. 2015), substantial differences in mortality rates can be observed between ethnic groups (Knight et al. 2015). For example, between 2011 and 2013, the estimated mortality rate for white women in England was 7.8 deaths per 100,000 maternities (Knight et al. 2015). In Black African women this rate was more than tripled at 28.3 (Knight et al. 2015) and was also significantly higher for both Pakistani and Bangladeshi women; 15.9 and 14.7 respectively (Knight et al. 2015). Overall 40% (5 times higher than in white British) MMBRACE report 2018 of all direct maternal deaths occurred in women from black and ethnic minority groups (Knight et al. 2018). An extremely worrying statistic given that data from the Office for National Statistics (ONS) suggest that individuals from these ethnic groups accounted for less than 20% of residents in England and Wales during the same time period (Office for National Statistics 2016).

Over-representation in maternal mortality rates is not only seen for minority ethnic populations but also, more specifically, for foreign-born women (Knight et al. 2015). Indeed, the most recent report on maternal mortality in England suggests that a quarter of women who died in 2014-16 were born outside of the UK (Knight et al. 2018); with 70% of these women being born in either Asia or Africa (Knight et al. 2018). Although the overall relative risk of maternal mortality for non-UK-born women slightly decreased between 2011-13 (Knight et al. 2015), in-depth study of the data shows that this risk actually increased for certain groups of migrant women over this time period. For example, the relative risk of maternal mortality for Pakistan-born women living in the UK increased from 1.53 to 1.8 (Knight et al. 2015) – suggesting almost twice the risk of mortality for these women compared to their UK-born counterparts. This increase was reflected in ethnicity data; the relative risk of maternal mortality for Pakistani women rose from 1.29 to 2.12 in the same time period (Knight et al. 2015). The authors therefore acknowledged that the observed decrease in maternal mortality rates for migrant women was largely driven by the large number of EU

migrants included in the second report (Knight et al. 2015) and had potentially masked increases in risk for non-EU migrant women.

Along with increased risk of maternal mortality, data consistently suggest that minority ethnic women are at an increased risk of perinatal mortality. For example, in 2013 mothers of black ethnic origin were twice as likely to have a stillbirth than mothers of white ethnic origin (Draper et al. 2015), and babies of Asian or Asian British ethnic origin were also at significantly increased risk, with up to 64% higher stillbirth rates than their white counterparts (Manktelow et al. 2015).

GENETIC DIFFERENCES

Genetic susceptibility has also been suggested as a factor contributing towards the ethnic inequalities seen in incidence rates of perineal tears and obstetric anal sphincter injuries in the UK (Balaam, 2013; Shah et al. 2011). For example, a study by Shah et al. (2011) found that Chinese women were significantly more likely to experience perineal tears from childbirth, when compared to white British women. Similar findings were found by Balaam (2013) when comparing women of Indian and African origin to their white counterparts. As perineal tears often lead to health complications extending further than the immediate physical birth outcomes (Williams et al. 2007) it has been suggested that these physiological risks may play a part in explaining inequalities in other pregnancy outcomes (Williams et al. 2007).

Despite these findings, many authors acknowledge that the underlying genetic mechanisms of susceptibility are often poorly understood (Cantwell et al. 2011) and should therefore be interpreted with caution. Indeed, such genetic differences are unable to explain the differences in outcome observed between UK- and foreign-born women of the same ethnicity. Furthermore, delivery factors such as slowing down the delivery of the head by

instructing women to not push at this point (thus relying solely on the uterine expulsive efforts) has been shown to decrease the incidence of perineal tears by 50% to 70% (Harvey et al. 2015). Such findings suggest that incidents of tearing may, in fact, be largely influenced by communication between woman and health providers at this stage of labour.

In a study by Knight et al (2014), the analysis from their study suggests that several factors, including unplanned pregnancy, no antenatal care or late engagement with antenatal services, transfer during labour, higher caesarean section delivery rates and poor communication and care from health professionals, may collectively contribute towards poorer maternal outcomes among women from the lowest socio-economic group in the UK.

Health research suggests that genetic predispositions do exist for some health risks - for example the physiological susceptibilities for obesity, diabetes and cardiovascular disease found in the South Asian population (Abate et al. 2003; Naran et al. 2008; Misra and Khurana 2011). Although US researchers often link pre-existing medical conditions, such as hypertension and diabetes, to ethnic disparities in severe maternal morbidity (Fiscella 1996; Varner and Esplin 2005; French et al. 2006; Puthussery 2016) these links have not been identified in UK data (Knight et al. 2009; Puthussery 2016). Indeed, evidence on the role of biological factors in ethnic inequalities in neonatal and infant outcomes in the UK is restricted to a limited number of conditions and outcomes.

MIDWIFERY EDUCATION AND TRAINING AND HIGH RISK CARE

The need for education and training for midwives to provide high dependency care is undisputed given the specialist knowledge and skills that may be required for invasive monitoring and neurological assessment (Gaunt, Yentis & Holdcroft, 2002; Hardy, 2013). Expert opinion suggests varying approaches may be adopted to ensure qualified midwives

receive the necessary post registration education and training to equip them to provide HDU care competently (Goebel, 2004; Hardy, 2013; Simpson & Barker, 2008).

To develop the necessary 'practical' skills midwives required for HDU care, midwives may need to rotate into a critical care unit or general HDU or receive training either from midwives specialising in HDU, consultant obstetricians and anaesthetists and / or intensive care nurses (Billington & Stevenson, 2007; Martin & Hutchon, 2008; Saunders et al., 2013; Yeadon et al., 2001). External 'courses' are available that may equip midwives to deal with some, but not all facets of HDU (e.g. Advanced Life Support Group, 2011; ALERT, 2015; ALSO UK; Resuscitation Council UK, 2015) but have significant financial implications and may not be feasible on the study budgets available in some obstetric units (Martin & Hutchon, 2008).

Practical training is likely to be 'competency' based and examples of competencies include airway management, care of women with invasive monitoring (e.g. arterial and central venous pressure (CVP) lines), electrocardiogram (ECG) interpretation and the recognition of common dysrhythmias (Billington & Stevenson, 2007; Hardy, 2013). However, there is limited published research nor high-level evidence to suggest this is the most effective way for midwives to develop the knowledge and skills required to provide HDU care.

Recently the development of draft competencies for the care of the acutely ill woman in the delivery suite setting have been devised by the Intercollegiate Maternal Critical Care Subcommittee of the Obstetric Anaesthetists Association (2015). The competencies are grouped into three categories (R, C and SES) using a body systems approach and it is the SES skills that relate specifically to aspects of HDU provision:

Category R. Those that midwives should possess at the point of entry to the NMC register (e.g. protect the airway, recognise cardiovascular shock). Category C. Core competencies that

midwives working on the labour ward will use on a continuous basis (e.g. attach a patient to a cardiac monitor and identify bradycardia, tachycardia, ectopic beats). Category SES. Specialist enhanced skills (SES) that are required by a minimum of one midwife or nurse per shift when acutely ill women receive care in the obstetric unit (e.g. assist with the insertion of a central line, prime a transducer, set appropriate alarm limits) (Intercollegiate Maternal Critical Care Sub-Committee of the Obstetric Anaesthetist Association, 2015).

These competencies offer a pragmatic solution to the competencies required by midwives providing HDU care in maternity but are not evidence based. In addition to gaining the necessary HDU competencies, midwives face the challenge of needing to maintain their competencies, which may be difficult if they are not encountering women requiring HDU care on the delivery suite on a regular basis (Billington & Stevenson, 2007; Hardy, 2013). The regularity with which midwives encounter women requiring HDU may be influenced by the annual birth rate of the Obstetric Unit, the acuity of the local case mix and the local guidelines specifying the care pathways for ill women and indications for transfer to Intensive Care Unit.

An audit completed by midwives in charge of 16 Delivery Suites in the Yorkshire region fifteen years ago identified that only n= 2 of the Obstetric Units had HDU training courses and n= 6 provided a HDU / ITU experience day (Quinn et al., 2000). Half of the midwives completing the audit identified a need for increased training in HDU care with more teaching from anaesthetists. Midwives who had received HDU training were more confident caring for women with obstetric complications but less confident with basic and invasive monitoring (Quinn et al., 2000). Whilst this data is fifteen years old, Bench's qualitative study (2007) identified that midwives felt anxious when caring for critically ill women, did not consistently understand the instructions they received from doctors, and some stated they 'felt out of their depth' when asked to provide HDU care.

A survey conducted by Cockerill et al. (2011) involving midwives working on the Delivery Suite of a tertiary centre (n=60) identified that 64% felt they did not have adequate knowledge to care for women receiving high dependency care. Another survey of n= 137 Obstetric Units highlighted that 71% of all HDU care was undertaken by midwives and only 76% of these had received some formal training (Saunders et al., 2013). This highlights that a quarter of the midwives did not have any MHDC training and all members of the multi-disciplinary team providing MHDC must maintain and update their knowledge and skills (CEMACH, 2011; Lewis, 2007).

The increase of midwives who have undertaken direct entry midwifery programmes which requires no previous professional nursing qualification, has been raised as a concern when for provision of HDU care (Cockerill et al., 2011; Martin & Hutchon, 2008; Vercueil & Hopkins, 2015; Wheatly, 2010). At present, the pre-registration midwifery education curriculum is intended to develop newly qualified midwives who are skilled in providing normal midwifery care with the ability to detect deviations from normal progress throughout the childbearing continuum (Nursing and Midwifery Council, 2009).

However, the Midwives in Teaching (MINT) study commissioned by the Nursing and Midwifery Council (NMC) identified that newly qualified midwives would have preferred educational input regarding the care of women with high risk pregnancies and those requiring high dependency care during their training (Fraser et al., 2010). This finding is replicated in a recent survey of midwives working in two Obstetric Units with annual birth rates of > 5500 (Rangarajan et al., 2014). Of the 101 midwives who completed a questionnaire asking them about different facets of HDU provision, 85% agreed that 'critical care skill' should be included in the pre-registration curriculum. It is acknowledged that the midwives taking part in this audit worked in large Obstetric units providing HDU care and may therefore may not be typical of all midwives, especially those working in smaller Obstetric Units

CHAPTER 2: SYNTHESIS OF THE LITERATURE

The literature reviewed prior to developing this study identified a paucity of empirical evidence exploring midwives' experiences of caring for BAME women in HDU. No literature explored midwives' experiences of caring for BAME women in HDU, either directly through questioning midwives, or indirectly through relating data collected to HDU care. Most studies investigated isolated aspects BAME women's experiences rather than employing holistic approaches to explore what works well and doesn't work well in providing care to these women in this area of caregiving. Literature highlighted that people from ethnic minority groups are likely to experience many difficulties in their contact with health services in the UK (Ali and Burchett, 2004; Harper-Bulman and McCourt, 2002; Katbamna, 2000 ;) and elsewhere (Ny et al, 2007; Rolls and Chamberlain, 2004; Liamputtong, 2001; Wiklund et al, 2000).

Jenny McLeish, Social Policy Officer at Maternity Alliance indicated two forms of inequality in accessing maternity services. The first concerned inequalities in physical access and knowledge of the services available. The second occurred through ethnic minorities receiving poorer quality care (House of Commons Health Committee 2003). McLeish also argued that women from south Asian backgrounds are late in accessing maternity services and make fewer antenatal visits. Moreover, Asian women received 70 per cent fewer antenatal screening tests such as those for hemoglobin disorders and Down's syndrome compared with white women.

One study undertaken with migrant women in Australia reported migrant women did not take an active part in decision making regarding their care in labour and birth because of the communication problems they experienced (Small et al 1999). Jayaweera et al (2005) found that childbearing Bangladeshi women who were more fluent in English felt they received higher quality care in the UK maternity services. This was supported by the findings of Richens (2003). In this study one woman who learnt to speak English between her first and second

pregnancy, felt that the attitude and behaviour of midwives was more positive in her second pregnancy. However, this could also have been linked to her familiarisation with the maternity services available.

In 2003 a qualitative study was conducted into Muslim parents' experiences of maternity services in England. The study found that there was poor communication between healthcare providers and Muslim parents and linked this to a shortage of interpreters for those who did not speak English (Ali and Burchett 2004). This confirmed the findings of an earlier study which compared the experience and satisfaction of Asian and non-Asian patients with non-clinical aspects of their hospital care (Madhok et al 1992). This study highlighted how Asian patients in England were at risk due to poor access to trained interpreters. Ali and Burchett (2004) also criticised the over-reliance of NHS staff on family members or friends acting as interpreters and highlighted the lack of accessible and easily comprehensible information during childbirth for Muslim women. The UK government promised free translation and interpretation services for all NHS trusts by 2003 through NHS Direct (DOH, 2000). However, the availability of interpreters remains patchy (Aspinall and Jacobson 2004).

The literature dealing with minority ethnic populations and maternity services has been discussed. There is limited research relating specifically to BAME women's experiences or midwives' experiences within a HDU setting, supporting the need to investigate the midwives experiences to be explored in detail.

MIGRATION

In the UK, the term migrants or immigrants is used loosely to refer to individuals who have come from another country to live in the UK. This includes those individuals who have been in the country for both short and long periods of time, as well as permanent and temporary

residents. Migrants are a very diverse group of people who come to the UK for a variety of reasons including socioeconomic factors, for education, to seek asylum from political persecution and as refugees (Glover et al 2001).

Migration: is a word which originates from the Latin word "migratio" (the verb to move). Zohry (2005) defined migration as a movement that changes the residence of individuals over a considerable distance. International migration is the shifting of residents outside the perimeter of their home country (Zohry 2005). The expression "migrant" is connected with movement; one can leave one's country of origin and move to other countries in the world, and one might also go back to one's country of origin. Measurements of migration could therefore include individuals moving out of or returning to a country. In the context of this study the term migration will be used and is defined as individuals who have moved to the UK to live as temporary or permanent residents.

Migration presents many problems including racism, inequality in health care services and loss of such protective support factors as family support and cultural orientation, which may be associated with increased physical and psychological illness. Therefore, consideration needs to be given to exploring the concept of culture and its effect on health and wellbeing in migrant populations.

CULTURE

Understanding the concept of culture is a key to understanding human behaviour. Anthropologists describe culture as a system of shared meanings. People who identify themselves with a racial or ethnic group are assumed to share the same culture. This assumption is over-generalised, however, because not all members of society will share the same culture, and they may identify themselves with different social groups to which they feel a stronger cultural tie, for instance being Catholic, teenage, gay or lesbian (Henley and Schott 1999).

CULTURALLY COMPETENT CARE

Many definitions of “cultural competence” exist in the literature, but there is no consensus on what the term means. Leininger (1999), the founder of Culture Care Diversity and Universality Theory, simply defined culturally competent care as "to provide care that is meaningful and fits with cultural beliefs and lifeways" (Leininger 1999 p9). Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs (Betancourt et al 2002). As British society becomes more heterogeneous healthcare professionals need to bear many things in mind when providing culturally competent care. These include valuing diversity, maintaining an orientation towards the values and beliefs of the society being served, and the adaptation of care based on the cultural norms and traditions of individual clients and families (Kettering General Hospital NHS Trust 2008).

Cultural competence is developmental, a continuous dynamic process of learning and sharing. It will not come only by reading books or attending workshops. In order to provide culturally competent care, it is important to know about the cultures of the client group and to ask respectful non-judgemental questions rather than making assumptions. Meleis (1999) argued that a culturally competent person is a person who is able to recognise differences and balance his or her own caring actions, avoid stereotyping, and identify the pattern of responses.

Cultural competence is a process born of a commitment to provide quality care by being respectful of and responsive to the cultural factors that may influence patients' attitudes and behaviours at the institutional level. This will be achieved by supporting policies for employing people from different cultures. At the individual level cultural competence is achieved by respecting the cultural background, values, beliefs and practices of clients, families, communities and the population. It has been found that patients tend to seek care, follow the health care plans and are more satisfied when receiving care from healthcare professionals

who demonstrate culturally competent care (College of Registered Nurses of Nova Scotia, 2006).

It is suggested that the initial step to being culturally competent is self-awareness and cultural sensitivity. On one hand self-awareness means being knowledgeable regarding one`s own culture and being honest in facing and dealing with personal prejudices (Orlando Regional Healthcare, Education and Development 2004). On the other hand Garity (2000) asserts that being sensitive toward different cultural groups includes being aware of the effect of factors such as immigration, stress, a perceived lack of harmony in a person`s life, family influences, poverty, language barriers, retaining face, myths, taboos, praying and spirituality and the potential for these factors to enhance or inhibit professional practice.

Ultimately, culturally competent care is about acknowledgment of differences, advocacy for the marginalised and intolerance of inequity and stereotyping (Meleis 1999). The provision of culturally competent health care is a contemporary international issue that warrants further attention. Midwives must respect the health consumer`s culture, value systems and ways of thinking, which is necessary to protect the consumer`s rights in every aspect of care delivery.

INSTITUTIONAL RACISM

This phrase was first coined in 1967 in the USA by Stokely Carmichael. He defined the term as “the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin” (Carmichael, 1967). It represents the systematic and covert forms of racism perpetuated by institutions, dominant groups and social systems (Anachebe et al., 2003). However, it was used before this in the UK. It was not

until its use in the Macpherson Inquiry into the death of black teenager Stephen Lawrence that it came to prominence.

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 chronic stress of experiencing racism or discrimination may be an underlying social determinant of persistent ethnic disparities in pregnancy outcomes (Narayansamy 2004). Therefore, it is important to investigate racism in institutions. The three aspects of addressing institutional racism are: the processes and auditing systems of an organisation; changing to a more inclusive organisational culture and challenging individual behaviour and attitudes (King, 1996).

UK policies explicitly urge a woman-centred approach that is accessible, efficient and responsive to changing needs, ensuring choice, access and continuity of care, evidence of the impact of such policies in addressing inequalities in maternal health outcomes is relatively thin (Puthussery, 2016). After a series of published national policy documents and local initiatives (Henderson et al., 2013) there is a body of research that highlights this as a cause for concern and indicates that the maternity services in the UK are still struggling to provide appropriate care that meets the needs of women from diverse populations (Henderson et al., 2013; Puthussery et al., 2010). 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 (King's Fund, 2008).

ACCESSING SERVICES

The Immigration Act (2014) restricted access to free at the point of use care to those with indefinite leave to remain. In 2015, an accompanying regulation was published which provided for anyone who was ineligible for care to be billed for secondary healthcare, at 150% of the cost according to the NHS Tariff. Since October 2017, these arrangements apply not only to secondary care but to all community services including midwifery and mental health services. They were aware that maternity and child healthcare services are free as are the prescriptions and dental care during pregnancy and one year after delivery.

Women from minority ethnic backgrounds were less likely to attend antenatal classes or use written material. Generally, the pregnancy book is considered the main source of information. A study by Singh et al (2002) did not investigate the most-preferred method of delivering the information for women. In a qualitative study of Bangladeshi women, they claimed that their ability to access information related to benefits and other resources was limited due to language barriers and the absence of written information in their language (Jayaweera, 2005). Some women report their lack of knowledge regarding maternity services, such as maternity benefits for the first baby. Some women express that their rights and entitlements were discovered later on. The lack of knowledge regarding the healthcare services, especially maternal and child health services, of BAME women that have recently settled in the UK is particularly noticeable when women recount their experience of having their first baby in the UK.

GPs are considered as a key element when using the healthcare services in the UK, and then the GP refers the patient to other healthcare services such as midwifery, hospital and other services. The main barrier to accessing GP services in this study confirms other previous studies (Ahmed et al., 2010; Aung et al., 2010; O'Donnell et al., 2007). These can be summarised as the lack of previous experience abroad, self-medication, language barriers, long waiting and referral times and problems in getting appointments.

Late bookings are of potential concern in terms of antenatal care, especially for women with special health needs. NICE antenatal care guidelines (2003) endorsed that 'booking' with the maternity services should be made before 12 weeks of pregnancy. In by studies (Ali et al., 2004; Bawadi, 2009; Rassin et al., 2009) women did not use antenatal or exercise classes due to the presence of both sexes and the need to arrange childcare for older children, so they sacrificed themselves. Continuity of care emerged as a key element; most of the BAME women in the studies would have preferred to have been cared for by the same midwife through antenatal care and, if possible, during birth and post-partum. This helps the women to feel comfortable; her midwife knows her case well and follows up her condition.

Assessing maternity care of Pakistani and white British women conducted in a northern UK NHS region demonstrated negative comments about postnatal periods at hospital (Hirst & Hewison, 2001). However, in the same study, groups of both Pakistani and white British women provided positive comments on postnatal community care (Hirst & Hewison, 2001). The main reasons for dissatisfaction in Bawadi's (2009) study were that Arab Muslim women felt uncomfortable with shared rooms, toilets and food

SOCIO ECONOMIC STATUS

Socioeconomic status and ethnic background of women are known to increase the risk of maternal death in the UK. A quarter of women that died were born outside the UK. 42% of the women were not UK citizens. 13% were refugees and asylum seekers and 16% were known to social services. The Fourth National Survey of Ethnic Minorities suggest that socio-economic factors account for differences in morbidity and health-related behaviours according to ethnic group membership (Smith et al., 2000), whereas Cooper's study shows that socio-economic inequality can account for the health disadvantage experienced by minority ethnic men and women (Cooper, 2002). The direct factors, such as socio-economic disadvantage, and socio-cultural factors, such as lifestyle and genetics, have the responsibility

to explain the differences in health among minority ethnic groups. The accessibility and quality of healthcare is another determinant of health.

Smith et al. (2000) summarise the effect of racism and discrimination on health in three ways. First, as an indirect effect on health because of consequent socio-economic disadvantage; second, minority ethnic people will have a clear recognition of the relative disadvantage they face as a result of the obvious inequalities, discrimination and racism that they experience in virtually all spheres of their lives; third, a direct detrimental effect on health related to the experience of racial discrimination and harassment (Smith et al., 2000). Marmot (2010) emphasises this point claiming that income and wealth have a direct effect on health inequalities.

STEREOTYPING

Allport (1954) defined stereotyping as making imprecise judgements about a person based upon the presumed features of the group to which that person belongs. Cross-Sudworth (2007) explored the concept of stereotyping by seeking the opinions of midwives regarding women of foreign ethnicities: they expressed the view that such women were 'difficult', that they needed a large amount of time to deal with and that they were a further drain on an already over-taxed service. These inaccurate assumptions not only affect communication, they also lead to a poor standard of maternity care.

Stereotyping and inaccurate assumptions by healthcare professionals were also identified as other issues that BAME women experience. The Maternity Alliance Report (2004) reported that BAME women experienced stereotypical comments during their maternity care. Women from minority ethnic groups are also more likely to be labelled as 'high risk', even in the absence of specific risk factors (McFadden et al., 2013). Balaam et al. (2013) highlighted that ethnic minority women tend to avoid using health services if they are unfamiliar with the

health system as certain attitudes on the part of healthcare professionals may be seen as disrespectful.

McFadden et al. (2013) emphasised that stereotyping and inaccurate assumptions expressed by healthcare practitioners are barriers to women making informed decisions about their own care and having their individual needs met. Other studies indicate that migrant women may lack the confidence to discuss their concerns and are sometimes reluctant to ask midwives questions (Berggren et al, 2006; McLeish, 2005). Specific behavioural expectations and unconscious stereotypical views held by health professionals also have the potential to affect their clinical decision-making and practice. These attitudes may also reduce client satisfaction, adherence to compliance levels, and can cause disparities in access to services (Puthussery et al., 2008).

Despite these assumptions, a number of studies challenge the role of stereotyping and discrimination in poor maternity care and pregnancy outcomes. For example, during discussions of their maternity care experiences with McCourt and Pearce (2000), minority ethnic women attributed poor care to systemic factors, and rejected any suggestions of racism and/or discrimination. Similar findings were shown by Cross-Sudworth et al. (2011), who found that maternity care experiences for Pakistani women seemed to be influenced by their level of education and social support, rather than perceived racism or discrimination from healthcare professionals. Such findings suggest the existence of factors contributing to poor outcomes for minority ethnic women which are over and above that of racism and discrimination.

CHAPTER 3: METHODOLOGY OF RESEARCH

In contrast to quantitative approaches, qualitative approaches are able to uncover the unquantifiable dimensions of experience (the whys, how's, contexts and experience) to gain a more comprehensive understanding of the object of study, and to make sense of it in terms of individual meaning-making (Marshall & Rossman, 2011). Given the limited understanding regarding midwives' experiences and perceptions of supporting and caring for high risk BAME women on delivery suite, qualitative methodology was chosen for this study. It will help develop a comprehensive understanding of midwives' experiences. Qualitative enquiry does not confirm a hypothesis, it helps to see the world through the participants' eyes and explore how each participant makes sense of the world around them (Rees, 2003). Qualitative methodology helps capture a more authentic awareness of each participants' interpretations of a situation or phenomenon (McLeod, 2008). It provides opportunities to probe deeper into participants' answers, where appropriate, thus move beyond their initial responses and answers in order for the complexity of a phenomenon to be realised (Green, 2017).

The aim of this study is to gain ontological insights into the experience of midwives caring for high risk BAME women in the HDU. As this study aims to explore those aspects of that affect or influence the experience of maternity care from the midwives, as well as the personal experiences of participants, a qualitative approach is most appropriate. "Qualitative research attempts to increase our understanding of why things are the way they are in our social world, and why people act the ways they do" (Hancock 1998 p1).

GENERIC RESEARCH

The aim of this study is to explore midwives experiences of caring for high risk BAME women. The researcher concluded that generic qualitative research was the most suitable for this study. In many applied fields such as education and healthcare, the popularity of generic research has increased over recent years (Percy et al., 2015). Qualitative researchers employ methods such as interviews to explore experiences, attitudes and behaviours of individuals.

Not all qualitative studies are about culture, as in the ethnographic approach, or improving practice, as in action research, or a thorough study of a small group of individuals' lived experiences, as in phenomenological research, nor are they about the development of theory, as in the grounded approach. In those cases, generic research is considered by many researchers in the field of education and health-related research to be an appropriate alternative (Merriam, 1998). Terms such as 'non-categorical qualitative research' (Thorne et al., 1997), 'fundamental qualitative research' (Sandelowski, 2000), and 'generic qualitative research' are sometimes used (Merriam, 1998), but to avoid any confusion the study will use the term given by Merriam of 'generic research'.

Generic research does not follow a set of philosophical foundations like those of an established qualitative research approach. Rather this approach exhibits some or all of the characteristics of other established qualitative research approaches without making claim to any particular approach. Merriam (1998) states it is an approach that 'simply seeks to discover and understand a phenomenon, a process or the perspectives and worldviews of the people involved' (p11). In other words, it aims to explore individuals' accounts of their personal opinions, attitudes, beliefs, or reflections on their experiences of particular things in the outer world.

Generic research uses data collection methods and analytical methods that best suit the study's questions, instead of fitting the study's questions to a certain philosophical viewpoint

(Smith, et al., 2008). It uses methodologies that provoke participants to report on their thoughts about their real-life experiences (Percy et al., 2015). For example, generic research will use semi- or full structured interviews, instead of unstructured data collection methods such as the ones used in phenomenology (open-ended interviews) or ethnography (participant and/or researcher's observation).

Generic research was appropriate for this study as it enabled the researcher to explore midwives' experiences, thoughts, attitudes and beliefs regarding caring for high dependency women from BAME. This approach gave room for the study to use a wider variety of midwives who care for high risk women when they cared for them antenatally or postnatal. Semi-structured interviews were used as this gave the researcher the opportunity to ask questions such as 'can you tell me more' when wanting to explore further (Percy et al., 2015). Smith et al. (2008) state that generic research is essential if healthcare policy is to be met in relation to valuing and understanding carers' perspectives of healthcare provision.

ETHICS

Even though developing knowledge is important in qualitative research, maintaining research ethics is also essential throughout the research process. Like any research method that involve face-to-face interactions with participants, this research needed to undergo ethical consideration. The research will be conducted in such a way that goes beyond merely adopting the most appropriate research methodology, but conducting it in a responsible and morally defensible way. Clinicians base their ethical principles on beneficence, non-maleficence, autonomy and Justice (Hendrick, 2000).

The main purpose of research ethics is ensuring that the research does good and avoids harm. Orb et al. (2000) highlight that the application of appropriate ethical principles helps to

prevent or reduce harm. Therefore, it was the researcher's responsibility to consider and address all the possible ethical issues that might accrue in the process of this research. This includes confidentiality, data protection, potential harm and relations between researcher and participants. Ethical approval for the study was obtained from the University Ethics Committee first and then local approval at NHS Trust level, in the Clinical Effective Team as this was deemed a Clinical Audit (refer to appendix 1).

This study sought informed consent and had an information sheet (refer to appendix 3) and consent form that were presented to participants before they took part in the research (refer to appendix 4). Before obtaining informed consent, the researcher ensured that all participants were fully aware of the purpose of the study and clearly understood their role in this study. Participant information sheets highlighted the overall aim of the study, the specific objectives of that particular research phase, the role of the participants, the data collection methods, and how the data would be used. It also highlighted the importance of the participants' rights, explaining that all participants had the right to withdraw at any point without repercussions. Each participant was given the chance to read the information sheet and discuss further with the researcher.

Once participants were confident that they understood the aim of the research and what it involves, a consent form stating the following was presented:

- Participant's right to withdraw and terminate their participation at any point without repercussions.
- How data would be obtained (audio recording)
- Confidentiality and anonymity

The researcher used an audio recorder for each interview, all participants were informed of this and consent was obtained. Audio recordings transcribed ensured participants remained

anonymised. Throughout this process, pseudonyms and numbers were used throughout to protect all participants' identities.

All the research documents were stored in a secure locker in the research office of the university that only the researcher had access to. All transcripts were anonymised before being subjected to analysis; and all documents (audio files and anonymised transcripts) were stored on a password protected secure server.

RECRUITMENT AND SAMPLE

This study used a purposive sample of midwives. These midwives were recruited via emails to all midwives working on the delivery suite who regularly care for high risk women. Snowballing was then used to recruit other midwives eligible for participation. The snowballing approach was much more successful with midwives as number of midwives passed on my contact details to colleagues and encouraged them to take part. I designed a flyer for staff, specifying that midwives who worked on delivery suite and cared for BAME women to kindly get in touch. Prior to gaining full commitment from participants, there were some lengthy time lapses, due both to participants workload whilst on shift on the delivery suite.

INCLUSION CRITERIA AND PARTICIPANT PROFILE

- Registered midwives with over a year's working experience
- Regularly works within high dependency unit
- No age gender limit
- No ethnic exclusion
- Working as at Band 6

EXCLUSION CRITERIA

- Less than one-year experience
- Other allied healthcare staff such as midwifery support workers, obstetricians, domestic staff
- Midwives that are still on return to practice

Profile of sample recruited to participate in the study

Less than 10 years registration	More than 10 years registration	Ethnic Background	Dual Qualification	MIDWIFERY QUALIFICATION
8	12	7 White British 3 Asian 7 Black African 3 Black Caribbean	6	14

Table 2

DATA COLLECTION

Prior to tape recording the interviews, the aims and objectives of the project was reiterated, thereby enabling participants to voice any queries or concerns before giving consent. The participants were requested to read through the consent form and to sign as confirmation of understanding the project and agreeing to take part. There was added reassurance that

withdrawal was permitted at any stage in the process. Tape recordings were transcribed verbatim from a dicta phone following a USB device was stored in a locked safe and password protected. Personal information was not detailed enough to elicit individual participants' profile i.e. individuals were assigned coded identification by their initials, gender and age. Steps were taken to maintain confidentiality and anonymise names of individuals and institutions participating in the study and to securely store and archive hard copies of data. The interviews took place in a side room on the delivery suite. The interviews took place in delivery room. All interviews were digitally recorded and professionally transcribed.

DATA ANALYSIS

Qualitative data consists of mainly words, not numbers, which will have order and understanding once analysed. This is why it is important that the researcher approaches the data using a systematic process that will help in generating an understanding of the participants' experiences. There are many data analysis approaches, but the overall aim of any approach is always to provide an understanding through the researcher's interpretation of the data. This study used an approach known as thematic analysis; Braun & Clark (2006) describe this particular approach to thematic analysis as a process that aids the researcher to identify, analyse and report patterns (themes) within data sets.

The fact that thematic analysis is not specific in representing a research design makes it an approach that is compatible with many research designs and theoretically flexible in the process of analysing qualitative research (Percy et al., 2015; Cooper and Endacott, 2007). The compatibility and flexibility in this approach enabled the research to go beyond counting of words or phrases and focus on recognizing and describing both hidden and explicit themes within the data set. Percy et al. (2015) consider thematic analysis as a generic approach that

is able to both reflect reality and unravel the surface of reality as reported by participants and create the basis for various qualitative interpretations.

The process took the format of close reading of the text, listening to voice becoming immersed in the experience, re-reading, reading. I noted when themes were common in the participants as nodes in Nvivo and as notes in my research diary in an iterative and cyclical process (Strauss, 2014). Notes and summaries for each interview were made which included initial thoughts and reflections. Data obtained during the interviews were then entered into NVivo 10 for ease of data management. It was through the process of familiarisation of the data that themes started to emerge from the interviews

The coding was undertaken systematically and after each interview a printed copy of the transcript read, and a surface level analysis was undertaken using pen and paper. This was achieved by using a constant comparison line-by-line analysis of the interviews. Preliminary analysis occurred concurrently with ongoing data collection and enabled further exploration of different concepts in the following interviews.

CHAPTER 4: FINDINGS

In this section, the key findings from the research project point and the themes identified are presented. The themes emerged from analysing experiences of the midwives caring for high risk patients from BAME background, outlined in figure 2 gave insight into their experiences and facilitators and barriers to providing care for this group of clients' perceptions.

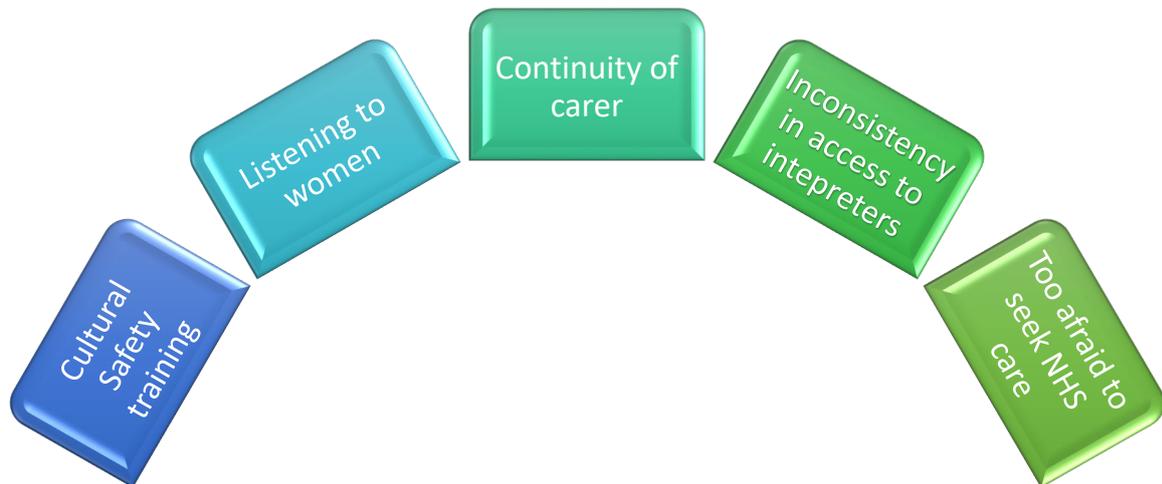


FIGURE 2: THEMES FROM THE FINDINGS

DISCUSSION OF THEMES

This study set out to explore the experiences of midwives in caring for high risk women from BAME groups on delivery suite. The view was one where women were not blamed but for the midwives to give account of how things need to improve for BAME women and also examined areas might be developed to improve individual experiences of these women. What has transpired from listening and re-listening, reading and re-reading the interviews, is the challenges and complexities of that midwives are experiencing in providing individualised care to BAME women as well as how maternity services need to reconfigure the services to have better outcomes for BAME women.

THEME ONE: LISTENING TO WOMEN

Participants stated the failure of some staff members in listening to BAME women. Black women often appeared not to feel empowered enough to say how they feel and were often not taken seriously.

“..... I looked after a black woman. When I took over the shift the woman said that she had been telling staff she was not feeling well and she felt they didn't believe her. The lady ended up with an eclamptic seizure. Thankfully she was fine in the end but if she would have been listened to earlier things could have been different”

Participant 13.

A study by Henderson (2018) indicated that women born outside the UK report a poorer experience of maternity care than UK-born women. Overall, women who came to the UK more recently, including more women from Accession countries, had a more negative perception of their care than women who had been in the UK for longer, more of whom came

from outside Europe. This might explain why some of the similar findings noted here are also apparent.

Women often request for staff to “believe them.” Participant 17

Further forms of unconscious bias has been observed in some colleagues

“.....there is a lot of stereotyping that black women do not want to take their health seriously, but we are not looking beyond that, why is it that they are not actually coming for the appointments, and what more should we be doing for them”

Participant 2

Participants stated the importance of

“listen... to understand, rather than listening to answer”

Participant 4

This concept most participants found it critical to be able to tune in with the women.

THEME 2: CONTINUITY OF THE CARER

When given the opportunity to discuss how they feel about caring for high risk BAME women, most participants were very honest about the impact the women’s experiences were previously negative and how they could benefit from having continuity of carer.

“I think the biggest barrier is the fact that you can’t have – I suppose you could do, depending on what you’re looking at – but not having a continuity of care is a big barrier, because you don’t form that relationship with the women.....”

Participant 5

Some participants as much as they would have the responsibility for facilitating continuity of carer, there was great apprehension about how it would affect their working pattern

“The continuity of care model is very expensive and it’s probably not one that’s sustainable in the long term but it’s very important to try for women especially the disadvantaged and BAME women”

Participant 16

The participants in this study clearly enjoyed caring for BAME women and are keen to see an improvement in their outcomes.

“Continuity of carer improves outcomes and policies identifying that all pregnant women should receive midwifery continuity of carer throughout the continuum of pregnancy, birth and new motherhood.”

Participant 17

CULTURAL AWARENESS

The participants talked about their lack of training around caring for women from diverse cultural backgrounds. Most participants stated that they

“Learn on the job and from other colleagues”

Most participants recollect that within their midwifery training they did not have specific training

“no, I wouldn’t say there is any education I received in cultural awareness on this group in particular, no I didn’t.”

Participant 15

The participants felt that they would have benefitted from education in cultural awareness and as they sometimes felt they were out of their depth of knowledge

“so, understanding the cultural aspects; to having training; to understanding, especially when it’s a large proportion of our population – I think it’s about 60-70% of our population here, and considering we don’t have any formal training on that”

Participants expressed need for all midwives to have access to drop in training sessions so that they could provide holistic care and treat women as individuals and understand some of the needs they have from a cultural perspective

“I sometimes feel like BAME women have their own, mannerisms, cultures and traditions which I would like to get education and training on in order to provide holistic individualised care.”

Participant 18

This was further confirmed in an interview with a different participant

“.....understand their culture, understand how we will be able to give them proper care, and that is how, whoever’s going to be specialised, needs to understand the culture and be able to give them care”.

Participant 3

Time was identified as a barrier to learning some of the different cultures whilst on the job: this was compounded by staffing levels and the workload

“We don’t want black and Asian women who are coming to our maternity units to die’. But how can we prevent that; it’s more of awareness, understanding their education background; going back to the curriculum to allow our students to have cultural awareness training and training identifying the kind of conditions that affect these women.....and also let management in the different Trusts make sure we have time allocated to special ongoing cultural training as CPD”

Participant 13

The findings of the study are extremely valuable and contribute to understanding of experiences and the support that midwives need to provide culturally safe care to women from BAME backgrounds. They will be discussed on the bearing they have for education and policy.

THEME 3: INTERPRETING SERVICES

One of the key challenges participants expressed they experienced was accessing interpreting services. They reported that a lack of a process during emergency treatment and found they were challenged to explain procedures to the women. Midwives have expressed the challenge in this:

“....where it’s difficult to obtain, like a proper history from the patient, even though, you know, we do use the interpreters, but it’s a phone call, isn’t it, so I don’t know whether it is idea, because you don’t know what the other person is saying to the woman and with limited time the call is very rushed especially when it’s an emergency;....it’s difficult to ascertain if its full consent you just don’t know”

Participant 1

Participants acknowledged the usefulness of interpretation services in dealing with language barriers and the provision of safe care to patients with was also highlighted. Participants went on further to explain that they heavily rely on their colleagues on shift to help with the interpreting or if they are lucky to directly translate if they speak the same language as the woman

“.....sometimes their English is very limited, so I have been lucky to care for people from my own country, so when the doctors talk, I translate it to their language. I realise that if they understand what you are telling them, they cooperate with you, but if they don’t, they don’t really and they will complain”

Participant 4.

Another participant went on to state that

“When I speak to my patients in their own language, they feel more comfortable, secure and confident”

Participant 19

Participants that spoke the same language as some of the women stated that provision of language concordant care improves patients experience, increases their comfort, make them feel listened to and enhances their satisfaction with the health care service they receive.

“it is such an added benefit when I care for women that speak the same language as myself. I have full confidence that they there is full informed consent and that they are in control of their labour or delivery”

Participant 17

The midwives went on to further explain that they face the challenges of not knowing if information is being communicated effectively

“but we did have the Language Line, but you never know how this information that we were transferring to the women, how it was communicated, because when you speak to the person on the Language Line, then they translate in their language, of which you wouldn’t be knowing whether, what they’re now speaking is actually what you’ve actually conveyed for them to explain to the women”

Participant 6

In order to overcome communication barriers, participants also described other approaches used in practice, including friendly body language, adjusted style of speaking, innovatively creating picture cards and using language apps on digital devices - even taking time to learn the patient’s language:

“.....I have tried to use the google app but without much training it became very difficult as I found I couldn’t find some of the medical words.....it made everything far more difficult”

Participant 11

Participants considered that interpreters and apps do not always understand the midwifery and obstetric medical terminology and this results in misinterpretation resulting in miscommunication of the information, which is neither cost effective nor efficient.

However, participants considered that, due to an absence of clear and supportive policies and lack of appropriate recognition of their skills, their ability to speak multiple languages results in extra pressure on them, especially when they have to act as interpreter for patients not in their direct care and have to be called from providing one to one care for women they are looking after to assist:

“Sometimes it is hard to finish other jobs if you are going to interpret for another colleague. If you have a woman in active labour then it is not possible”

Participant 13

Some participants considered that ability to speak multiple languages adds to their workload and makes them accountable for things not clearly articulated in their job description or organisational policies and the midwives also recognise that this ability can be a source of extra work that may not be very useful for their career progression.

“I speak 4 languages and this sometimes is such a disadvantage to me as it puts such extra added workload and responsibility. It is also frustrating as it's not officially recognised and I don't know if it adds anything to when I apply for promotions”

Participant 15

THEME 4: TOO AFRAID TO SEEK NHS CARE

Numerous participants expressed their concern about how some of the women, particularly the asylum seekers and disadvantaged groups were too scared to seek NHS care. Some would be requested to move home or to pay for their care if they had no immigration status:

“we have a high proportion of women here who are charged for their care and I do think that impacts women's engagement, especially with ante-natal care, because they get frightened, they get bills, a tariff of 150% which can affect their immigration status. So I think that's one area in amongst a big issue that I think we need to seriously work towards”

Participant 19

Participants stated that they are facing some dilemmas which are beyond their remit of practice and care

“...the system should not make us feel like cops but give all women good care regardless of where they come from. As midwives there is too much pressure in assessing and referring women to payments teams and takes me away from looking after the mother and baby.... It makes me feel physically sick doing it.”

Participant 10.

This does sometimes change the attitude of some of the midwifery workforce

“...I have seen some of the negative attitudes midwives towards women who are not eligible to free care.....”

Participant 18

Although participants did not talk in detail about the impact this has on the way they practice, they did demonstrate immense empathy for these women.

Midwives also stated that there are several cases where pregnant women have been moved against medical advice and close to their due date:

“.....it makes it so difficult for the women.....a new home, new surroundings...it is pretty overwhelming for these women and isn't right”

Participant 13

Most participants state that the fear is quite apparent in asylum women. Midwives are not always informed when their patients are moved and spent time searching for them. And when they do arrive in the new area, they have had gaps within their antenatal care which would have missed some arising complications. Asylum seeking women in can have high risk pregnancies due to serious physical health conditions having fled torture, sexual violence, or even female genital mutilation in their own countries. Participants stated that educating and supporting women with understanding their needs sometimes posed as a challenge as it required time

“the Government could please, irrespective of what status, they should make it open, because these women are afraid, that is the bottom line; they think once they are caught, they will be repatriated back to wherever they come from, so if the Government could make it clear to them that, irrespective of whatever status, if they are pregnant, they should please attend their ante-natal clinic”

Participant 20

THEME 5: DIFFICULTY FOR WOMEN TO ACCESS SERVICES

Midwives stated that some BAME women experienced difficulties to access care due to a variety of reasons. One was religious and the second common reason was the challenge high risk women face when they have to attend numerous antenatal appointments. This hugely impacts on their engagement and ability to manage their medical conditions effectively

“the woman is in hospital; she’s admitted to bed rest because of her blood pressure; the man has got to go to work – again, you can see where he’s coming from - if he doesn’t work, he doesn’t get paid; most of them are on zero contract hours; so they bring the toddlers to come and stay with the mother in hospital. How is she going to get any rest if she’s looking

after the toddler, because he's got to go to work. They struggle with childcare and this affects the number of times they come into the hospital"

Participant 5

The midwives showed great sympathy for the women and this sentiment was widely shared by all participants

"the lack of support, especially with their other children, they tend not to comply. They will be in a rush to go home, because there's nobody that will look after the other kids and, as a mother, they get caught in between, you understand – 'which, is what I do if I were in her situation as well?"

Participant 15

Participants reported that several women fail to engage safely with services as they have minimal family support around here in the UK. The frustration this causes for participants is apparent. They want to do more.

In addition, white British participants commented on how they rely on their BAME colleagues to help them understand the family challenges and support that can affect women which can lead them to understand the direct impact on how it affects their engagement and accessing medical treatment. Diversity brings richness and provides staff with a wealth of experience:

".....my colleagues from the Nigerian community have helped me understand how some women have very little support with family and childcare.....it has immensely made me feel more empathetic to these women and we as maternity services need to do more for them."

CHALLENGES AND LIMITATIONS

The present study explored an important issue affecting midwives in caring for high risk women from BAME backgrounds in delivery suite. The qualitative nature of the study helped to explore perspective of midwives and their experiences. The study provided a voice for midwives experiences whose opinions remains unheard. The findings of the study will help improve care provision by midwives and highlight the struggles they are facing and also highlight what is working well. There has also been an identification of a mismatch between policies and practices and its impact on the midwives confidence and ability to deliver appropriate services.

One limitation of this study is that due to its qualitative nature, the results cannot be generalised. However, it could be replicated with other participant groups in pursuit of wider understandings in this area. It was not possible to explore the perspective of service managers/leads due to time constraints.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

The findings from this study suggest that women from BAME backgrounds experience challenges during pregnancy, birth and the postnatal period. This is mainly attributed to lack of continuity of carer, stereotyping of women, ineffective translation services, difficulty for women to access services and lack of cultural competency training for staff. Although the information was elicited from a small group of participant midwives, these findings are important in an ethnically diverse population in ensuring that services are culturally competent and tailored to meet the individual health needs of BAME women, their babies and their families (DH, 2007, Midwifery 2020).

TRANSLATION SERVICES

In the UK, approximately 10% of babies are born to non-English-speaking women (ONS, 2018). Availability and quality of interpreting services was one of the most frequently mentioned barriers to maternity care. This often then deters BAME women from engaging with services leaving them vulnerable in terms of exercising rights and entitlements (Phillimore, 2018). Communication errors occur when the message becomes distorted; this can be due to the 'sender' and 'receiver' speaking a different language (Crowther, 2019).

Poor communication between staff and pregnant women has been suggested as being one of the most pervasive threats to patient safety (Paul and Schyve, 2007) and CEMACH suggests that language barriers may have had an influence on the death of 26 women between 2006–2008 (CEMACH, 2011). These women were not able to provide a full medical history, which resulted in inappropriate clinical decision-making (CEMACH, 2011). In addition, adequate communication is essential for acquiring informed consent from a woman when performing any examination or intervention; without this consent, the midwife could be accused of

undertaking a physical assault (Dimond, 2006). Inability to communicate effectively was identified by midwives, in this research, as a barrier to the formation of a good midwife-woman relationship. This finding is supported by a number of previous studies, where ineffective communication has been cited as a major contributing factor to strained cross-cultural relationships, and for maternity care relationships in general (Binder et al. 2012; Degni et al. 2012; Boyle 2013). Participants in my study identified the potential for language barriers to directly influence maternity outcomes; many expressing fears that miscommunication between woman and midwife could compromise safety and wellbeing.

A study by Haith-Cooper (2014) highlighted frequent problems with the availability of interpreters and their translation accuracy. Concerns around substandard care as well as adverse impact on the ability to build a trusting relationship with the woman, overcome cultural barriers and obtain informed consent were also shared by these authors. Consequently, this particular publication suggests utilising a fresh and contemporary method of communication such as google translate and pre load the app with maternity terminology harnessing the rapidly developing world of technology to find solutions to these needs. The findings here seemingly also would support the development of similar provision.

POLITICS AND MIDWIFERY AND FUTURE ACCESS OF CARE

The implications of Brexit are unclear but leaving the EU will have an impact on women moving to the UK depending on reasons for migration and country of origin. Under such changing circumstances it is important to continue to assess whether women's access to and experience of maternity care is adequate, equal and fair.

The current levels of staffing in the NHS are inadequate. If a 'hard' Brexit is to be followed with no access to the single market and limits to immigration, as recommended by the Prime

Minister, this may negatively impact the numbers of staff. While the recent White Paper does aim to ‘protect and enhance the rights people have at work’, there is no guarantee as to whether the EU workers currently resident will be allowed to stay.

STEREOTYPING WOMEN

To avoid stereotyping, an awareness of unconscious bias is important to avoid rapid judgements about BAME women without having time to process in detail everything about the individual and context. This unconscious process may have an impact on the quality of care we provide (Sporek, 2015).

As midwives we have a privilege to be with women and families during the most intimate times of their lives (Crisp 2012). The findings presented here suggest that being aware of unconscious bias and how midwives backgrounds and personal experiences may affect an interaction with women and their families may be the first step to providing well- balanced and unconditional maternity care that is equitable to all women and also assists in tailoring person centred care.

ACCESS TO HEALTHCARE

In the UK, asylum seekers are entitled to free maternity and NHS care, although do not have the right to work nor an entitlement to state benefits (Maternity Action, 2017). Home Office statistics show that the number of asylum applications in the UK has risen from 17 916 in 2010 to 32 414 in 2015 (Home Office, 2016). Aspinall and Watters (2010) argue that the asylum system does not consider the specific health and social needs of women. This point was also evident in research conducted by Reynolds and White (2010), who state that women face gender-specific issues that make them particularly vulnerable when seeking asylum— especially if they are pregnant. The result of Home Office dispersal policy which relocates women across the UK (UK Visas and Immigration, 2016) can move them from all their social networks to accommodation in new cities where they knew no-one.

Like most of the participants in this study, the women they have cared for suffer a lot from social and community support and ultimately social isolation. A study by Bryant (2011), which documents midwives having little understanding of the asylum system and a lack of confidence in their ability to advocate for women. The midwives in this study did state their desire to provide continuity of carer which Kirkham (2010) that care is an ongoing and cumulative process, in which trusting and meaningful relationships are created between midwife and mother has greater ability to help tackle acute isolation. The argument for relational continuity is key in the recent National Maternity Review (2016) and seems fundamental in providing quality care for women who are seeking asylum and are often isolated.

A crackdown on “health tourism” based on notions that some migrants come for health gain (Williams, 2005) is part of the Home Office's strategy to increase the discomforts associated with living illegally in the UK, encourage irregular migrants to leave and prospective migrants to go elsewhere. The crackdown includes charging migrants with no recourse to public funds and failed asylum seekers for maternity care. The UK Government held a consultation on the extension of charging overseas visitors and migrants using the NHS in England. In 2017 it concluded:

“Having considered the views put forward, we intend to proceed with the extension of charging overseas visitors for most NHS services they can currently access for free, although this will be taken in a staged approach”.

Midwives in this study talked about how difficult they found negotiating the charging regime as well as how it has a deterrent effect on migrant women accessing maternity care. It also highlights the notion that midwives need to not fear highlighted by (Caplice, 2014: Refugee Action 2018), that they need to continue being advocates for women. The findings illustrate

that the voices of women BAME women are left out of this decision-making. This, in turn, could mean that their needs are not taken into consideration when services are designed. The Long-Term Plan sets a new target of March 2021 for BAME women to receive continuity of carer will be particularly, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes (Asif, 2015) .

Indeed, a recent UK national case-control study conducted by Nair et al. (2015) found that inadequate use of antenatal care was significantly, and independently, associated with maternal death from direct pregnancy complications. Indeed, these findings suggest that it is essential that midwives do not just accept non-attendance as part of a stereotype, but instead find ways to explore and work around the individual barriers to care. As noted by Tyler (2012), it is responsibility of the service to identify high risk women and to ensure the provision of regular antenatal care.

Some participants explained that the asylum seekers and immigrants appeared to trust the quality of the maternity care they receive, however they reported that they were unfamiliar with the role of the midwife. It is therefore important to ensure that there is a robust orientation to maternity services for asylum seekers to ensure that the barrier to accessing care is overcome (Phillimore et al, 2018).

CONTINUITY OF CARER

There is good quality evidence that a midwifery continuity of carer model has better outcomes for women and babies (Homer et al., 2017; Sandall et al., 2016). Continuity of carer enables a woman to receive safer, dignified, equal and respectful care that is responsive to her needs and supports her as an informed decision-maker. As stated by Renfrew (2014), this model of care promotes good quality midwifery which is underpinned by a philosophy of

holistic care that optimises bio-psychosocial and cultural processes and strengthens women's capabilities. Most of the participants within the current study were advocating for women to receive continuity of carer. However, there were fears of how this would be coordinated. Therefore, any service reorganisation should monitor closely the feedback from both the midwives and women in the continuity of the carer model if it is to be adopted effectively (Fenwick et al, 2017).

Most of the participants within the current study were also advocating for this model for BAME women however there were worries about how this would be implemented and what it meant for their jobs in rotation. Evidence from the UK and other countries indicates that successful implementation of the continuity of the carer model requires initial funding and support (Dawson et al., 2016; Stevens and McCourt, 2002). It also further requires involvement and negotiation between midwives and management (Burau and Overgaard, 2015), and having midwives who are interested and available to work in the model (Dawson et al., 2016). In a study by Sandall et al (2017), the women that received caseload care had enhanced emotional social support through a continuity of the carer model. It also enabled them to feel safe, relaxed and able to confide about problems within a trusting relationship (Beake et al. 2013). This is vital particularly to socially disadvantaged and BAME groups with complex high-risk pregnancies.

A Cochrane Review of midwife-led continuity models (Sandall et al. 2016) indicated this form of care benefits women and their babies in regard of improved safety, clinical outcomes and positive childbirth experiences. Having relational continuity with a known midwife engendered a sense of comfort, confidence and ease amongst women (Allen et al. 2017). This is really needed in order for women to have confidence in the service and improve the level of engagement. In order for the Continuity of the carer model to be effective, significant service reorganisation is required to successfully implement and sustain it. The model will also require staff involvement and on-going evaluation of progress and impact. The midwives

should also be skilled and competent and prepared for emotional investment in the health and wellbeing of the women (McDowell, 2019).

CULTURAL SAFETY TRAINING

It is clear from the participants experiences here, that rather than adopting an approach whereby professionals possess cultural knowledge about ethnic groups, an approach which is simply not feasible in an era of super diversity and has been argued to result in essentialism (Jayaweera et al., 2005; Bhopal, 2012). It is therefore perhaps better to focus on development of intercultural competence and cultural safety. In order to address inequalities, the inclusion of cultural competency in education is imperative and must be comprehensive. This enables professionals to communicate effectively, empathetically and appropriately with people as individuals rather than as groups (Warmington, 2012).

Cultural safety focuses on recognising the uniqueness of the individual, acknowledging that each person carries their own cultural identity. McPherson, Harwood and McNaughton (2003) suggest that cultural safety

"goes further than learning factual information regarding dietary or religious needs of different ethnic groups: it means engaging with the sociopolitical context of beliefs ... "

This incorporates recognition of the range of cultural influences including but not limited to ethnicity, gender, age, sexual orientation, lifestyle choices, beliefs. Cultural safety has allowed for a more reflective, critical understanding of the actions of health care professionals. Most participants within this study shared the same sentiments. The integration of cultural safety into midwifery practice will provide for the formal recognition of power relations within health care interactions. By adopting cultural safety, it becomes not only possible but

inevitable that an exploration of the assumptions underlying practice, brought by both individuals and the profession will occur.

If the semantics were changed, for example to refer to cultural awareness or sensitivity, this would signal a shift in the locus of power away from the patient and on to the practitioner. The term 'cultural safety' encompasses the idea that the recipients of care need to 'feel safe' in accessing health care services, and that these need to be provided in a non-judgmental and non-threatening environment (Gordon, 2016). Healthcare policy and service development currently acknowledge and uphold basic patient rights, including respect, informed consent and dignity. However, the individual's cultural safety must also be upheld. Failure to do so risks disempowerment, alienation from health services, and potentially places the patient at risk of a less than optimal outcome.

Van Cleemput (2012) argues that culturally safe health care requires more than awareness of cultural beliefs. It can be insensitive to claim such knowledge, as claiming knowledge of a group one is not part of can lead to incorrect assumptions and stereotypes that do not represent the nuanced and complex nature of identity. As such, cultural safety focuses on the practitioner having good levels of self-awareness and reflexivity regarding their position and aims to avoid stereotypical assumptions by seeking to understand and respect each person as an individual. In light of this theory, reflection becomes a fundamental process for investigating one's own preconceptions and providing care that promotes equality

Cultural safety training has been proposed as a strategy for eliminating racial inequalities and ensuring culturally appropriate services (George et al., 2015). Incorporating in-depth exploration of impacts of racism, power, and privilege as social determinants of health is a challenging but necessary component of cultural competency training for all health practitioners (Gordon, 2016). If continuity of carer is going to be effective, the core theme of

person-centered care which enables the professional to progress from a concept of “cultural competence” towards one of cultural safety. If the midwives get to know the women and respond to their cultural needs in a way that reduces fragmentation of care, it will be a clear demonstration of how cultural safety will be adopted in the continuity of carer model and help overcome barriers to care (Beake et al 2013).

CHAPTER 6: CONCLUSION

This study highlights the need to reconsider the way existing maternity services provision are configured, planned and delivered in order to address health disparities. If services are to improve care and experiences for BAME women, there also needs to be an improvement in the morale of the staff who deliver care to BAME women. Participants here particularly perceived organisational constraints as a factor in their ability to deliver quality care.

Investing in cultural safety training and having culturally competent Continuity of Carer teams will enable midwives to care for all BAME women. This may address some of the issues the women have such as fear and distrust of services. The proximity of hospital antenatal clinics and access to transport also may need to be safely delivered in community settings, as there is a tendency to concentrate maternity care in hospitals, despite the fact that such a policy excludes many.

The Maternity Safety Training Fund was commissioned by the government for NHS Trusts to upskill their workforce. There were clear developed pathways for sustaining the learning through extending mandatory training programmes and creating champions. The “champions” need to incorporate cultural competency and safety training in these otherwise it will remain as a blinkered approach to address the diverse population.

It is the hope of this research team that the recommendations from this report will act as a catalyst for action in devising a strategy of positive change to improve the experiences of both women and staff and contribute to further Policy Development for care for high risk BAME women. It is hoped that this will also inform the curriculum for the training and development of future midwives as stated in the NHS Long-term Plan (NHS, 2019). The NHS Long Term Plan

is promising to improve care for BAME women and babies. This report highlights how crucial the advocate role played by midwives is important to facilitate this.

CHAPTER 7: RECOMMENDATIONS

The findings of this study have implications for midwifery practice, organisations, education and research.

Implications for midwifery practice

- Provision should be made for effective and continuous training programs on the basis of religion, culture and ethnicity for all care providers, including receptionists, allowing a reflexive approach to developing cultural competence.
- Care should be culturally competent and emphasise the importance of recognising differences as well as creating trusting relationships. At the same time, midwives should be aware of the dangers of labelling women because of their cultural and religious beliefs. Midwives should also be aware of the importance of seeing beyond the contexts of religion, cultural and ethnic background to focus on the individual woman.
- Midwives need to be competent in caring for high risk women in delivery suite. All midwives need to remember that they are required to act in a family's best interest, as required by the Code of Professional Conduct (Nursing and Midwifery Council, 2015).
- Midwives need to be proactive in identifying ways to provide effective high dependency care to BAME women, therefore it is important to be involved in policy making.
- Maternity teams should receive mandatory training in order to understand and better meet the needs of women with multiple complex social and cultural needs. This could include the women giving their birth expectations according to their culture and religion.

- Midwives caring for high risk BAME women should be supported with opportunities to debrief and share experiences. Working in designated high-risk teams can assist the facilitation of this.
- A HDU protocol easily accessible on an app including information, services, policies and key translation statements pertaining to interpretation of a wide range of challenges would be useful.

Implications for organisations

- *Consider setting up community “hubs”/ one stop shops* for women and their families to deliver antenatal care to women, there is evidence that such hubs has the potential to attract BAME and vulnerable women. It will give them the opportunity to meet and learn from other women; it is also an opportunity to do health promotion interventions and give a much more holistic care to families at reduce cost and improve outcomes. The Hubs could bring together antenatal care, birth facilities, postnatal care, mental health services, other specialist services and health visiting services. This will significantly address the issue of continuity of carer and accessibility for women which have been highlighted as an issue of engagement for BAME women. Hubs were recommended in the *Better Births* report but progress in getting them up and running has been slow or at worst non-existent.

The priority under Better Births to improve antenatal and postnatal care is particularly critical to improving outcomes for women from BAME community.

- Better Births (National Maternity Review, 2016) on the importance of continuity of carer for Black Asian Ethnic Minority Women is a priority approach on making the greatest impact on improving outcomes.
- The additional workload that BAME women can pose on for midwives who provide interpreting services and language skills should be valued, recognised and remunerated. A register of midwives that are bilingual who are confident and willing to use their language skills should be developed and kept within the delivery suite.

This will be helpful in identifying appropriate people with a specific language in out of hours or when arranging an interpreter is not possible or difficult.

- A dedicated team of midwives is recommended to ensure that additional time is available for midwives to provide continuity of carer for identified high risk women at the first antenatal appointment. It well known that some BAME women present late or have little antenatal care which then leads them to become HDU patients. This means organisations need to be more flexible to adapt to these issues in order to enable provision of woman centered care.
- Midwives should not be penalised for using their own language skills. Neither should they be pressurised to act as interpreters for patients for whom they are not responsible for especially when they have ongoing one to one care.
- Care is being delivered closer women`s homes through community “Hubs”. Women will report better access to care and greater decision-making and feelings of being control of their care, fewer missed appointments which will be positively highlighted in the CQC surveys.

Implications for education

- Unconscious Bias training and cultural safety training should form part of the induction programme for all staff who provide maternity care and those who commission maternity services and be mandatory across the maternity services. This is relevant in helping the workforce to avoid stereotyping women.
- An affordable education programme needs to be available for qualified midwives to enhance their skills in caring for HDU care. The current working environment of many midwives does not allow them to have study leave or expenses paid for studying.
- Ensure midwifery education incorporates cultural safety training. Maternity safety training courses need to be delivered in specific contexts relating to BAME

communities. These courses need to be redesigned to create more bespoke training to increase staff awareness of the cultural context and poor outcomes in the diverse populations. The maternity “champions” need to have had extensive cultural competence training in order to understand why certain groups of women may not see antenatal care as relevant because of; a) where these sessions are delivered b) the fact that many of these women do not consider pregnancy as risky.

- Midwifery academics need to honour and recognise the importance of culturally safe teaching and learning environments for all students irrespective of their background. Recognition of the importance of family, community and cultural commitments are important elements of cultural safety awareness.

Implications for research

- The government should support the Policy Research Unit in Maternal and Neonatal Health and Care at Oxford University to undertake research in 2019-20 to investigate the factors associated with increased perinatal and maternal mortality in BAME groups, implement the findings and support further research for women and families to record their lived experiences.
- The richness of data produced by this study has allowed a detailed understanding of midwives’ experiences for caring for BAME women. It is important to conduct ethnographic research exploring the potential challenges that BAME women face in maternity care, how their family structures and traditional cultures impact on their experiences and what they feel the services need to do more for them. As the UK is considered to be a multicultural country, such research would enable midwives to deliver culturally competent care and would help in developing multicultural maternity care models.

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Appendices

MIDWIFERY RESEARCH STUDY



STUDY TITLE: An exploration of midwives experiences in caring for women from Black Asian Minority Ethnic Groups on delivery suite high dependency unit.

Looking for participants to interview the study above.

- If you are a midwife on delivery suite and provide care in HDU, I am interested to hear about your experiences in caring for women from Black Asian Minority Ethnic Groups.
- Interviews will last 30-45 mins within the hospital setting.
- This information will be anonymous
- Can be added to your revalidation hours

FOR MORE INFORMATION PLEASE CONTACT

Sarah Chitongo 07578140822/S.Chitongo@mdx.ac.uk

APPENDIX 2

Clinical Effectiveness Department
1st Floor, Estates Building
University Hospital Lewisham
Tel: 020 8333 3000 ext. 8380/8382
Fax: 020 8333 3384
E-mail: lh.clinicalaudit@nhs.net

25th January 2019

Project Number: 6110

Dear Sarah Chitongo

Project Title: An exploration of midwives experiences of caring for women from Black Asian Ethnic Minority Groups on delivery suite high dependency units

Thank you for sending the above Clinical Audit to the Clinical Effectiveness Department, received on the 23rd December 2018.

Your project has been reviewed by the Clinical Audit Review Panel on the 25th January 2019. The purpose of the review is to ensure that all relevant principles of Information and Audit Governance that are applicable to your project are being followed.

We are pleased to inform you that your project has been approved by the Clinical Audit Review Panel and we can confirm that you may now commence this clinical audit.

We would like to take this opportunity to remind you that on completion of your audit, it is mandatory to supply the Clinical Effectiveness Department with a copy of the final report using the Trust Reporting Form which is available on the Trust Intranet.

If you have any questions, please do not hesitate to contact extension 6355 or email Clinical Effectiveness Department at lh.clinicalaudit@nhs.net.

We look forward to hearing from you.

Yours sincerely,

Kathryn Chapman
Clinical Effectiveness Facilitator

APPENDIX 3

Participant Consent form
Chief Investigator: Sarah Chitongo
Middlesex University
|

Ethics ref: 4782

Version/Date: 8.9.18



Participant Identification Number:.....

CONSENT FORM

Title of Project:

An exploration of midwives experiences for caring for high dependency women from Black Minority Ethnic Groups on delivery suite

Name of Researcher: Sarah Chitongo

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that relevant data collected during the study may be looked at by individuals from Middlesex University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to data collected as part of the study.
4. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers.
5. I agree to being audio recorded for the purposes of this study
6. I agree to take part in the above study

Name of Participant Date Signature

Name of Person Date Signature

1 copy for participant; 1 copy for researcher;



VERSION 5- 29/01/2019

MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET (PIS)

Sheet Study title: An exploration of midwives experiences for caring for high dependency women from Black Minority Ethnic Groups on delivery suite

Dear Midwife

I am undertaking the study of exploring midwives experiences in caring for high risk patients from the Black Asian Minority Ethnic Groups. You are warmly invited to take part in this study. Please take time to read the following information carefully and discuss it with others if you wish. Also, please feel free to ask me if there is anything that is not clear or if you would like more information before agreeing to be in the study. Thank you.

1. What is the background and purpose of the study?

This project aims to explore midwives experiences of caring for women from Black Asian Minority Ethnic groups (BAME) groups on delivery suite. The United Kingdom is a diverse society with 7.9% (4.6 million) of the population from (BAME).

Women from this population group present with complex co-morbidities which means that perinatal care including birth is frequently more complex generally. This subsequently means they have a higher risk of admission as a high risk patient on delivery suite.

Midwives experiences of the care they provide to these women admitted with pre-existing medical conditions and conditions unique to pregnancy has not yet been explored .

The project will aim to engage with and elicit the views of qualified midwives to gain an insight into their experiences in caring for this population group. The hope is also your views, challenges and experiences could facilitate to encourage care that is planned around the needs of women and their families more effectively from these diverse cultural backgrounds.

This project will ascertain whether insight gained can contribute to highlighting professional development needs. UK legislation from the 1902 Midwives Act onwards protects the public, promotes high quality care through standards for practice and education, and enshrines the profession's purpose and identity. It resonates with the NHS Constitution in England (Department of Health 2017). Similar principles enshrined in legislation and policy in Scotland, Wales and Northern Ireland. The core values of the NHS include respect; compassion; commitment to quality of care; and working together for patients.

2. Why have I been invited?

You have been invited to take part in this study because you are recognised as a midwife that provides care regularly within the delivery suite and have cared for a high risk women from the Black Asian Minority Ethnic Group. Your views are important for the study because your experience of this topic can help encourage provision of equitable services. Most importantly your experiences are heard. It will also lead to further training needs as required.

3. Do I have to take part?

Taking part in this study is voluntary. It is up to you to decide whether or not to take part. You can ask me any questions you want to in order to understand what is involved in the study and what this would mean for you.

If you would prefer not to take part, you do not have to give any reason and no one will mind. If you agree to take part you will be asked to sign the consent form to say that you are taking part voluntarily and that you

4. What will happen if I take part?

I will invite you to talk about your experiences in caring for high risk women from Black Asian Ethnic Minority backgrounds within the delivery suite. This is a semi structured interview and will be held in a private room allocated within the hospital and at a time which is convenient to you. With your permission, I will record the interview with a small digital audio recorder. The interview will last about 30-45 minutes.

Please be mindful of the NMC code www.nmc-uk.org/Nurses-and-midwives/The-code/ states that as nurses and midwives 'you must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practicing'.

5. What are the possible benefits of taking part?

Taking part in this research project will give you opportunity to see how qualitative methods research is undertaken. You will also be able to record in your Personal and Professional Development Portfolio (PPDF) that you have participated in a research project as part of your on-going development.

As a result of participating in this study, you may also develop a more heightened awareness of high dependency care provision within your organisation. Also, the research outcomes will also inform the revalidation of the midwifery curriculum for the pre-registration midwifery course. If you wish, you may receive a copy of the summary report of the study.

6. Will my taking part in this study be kept confidential?

All information collected during the study will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be identified from it.

The data for this study will be collected using a digital audio recorder during the interview. Once the interview has ended, the recorder will be kept in a lockable briefcase and transported from the interview venue to

my locked office at Hendon Campus. The recording will then be transcribed and a written record of your discussions will be created. The data will be stored on the Middlesex University secure OneDrive Folder. These documents will be anonymised and marked by a unique identified code allocated to you by me. This will not be seen by anyone else.

The research data generated from the interviews will be kept securely on a password protected computer and in a locked cabinet, accessible only to me. There is onsite security and alarms are fitted to the building. All digital recordings will be deleted and any paper based information will be shredded seven years after the study is completed according to the university Data Protection policy, which is based on Data Protection Act 1998 and Freedom of Information Act 2000.

7. If I take part, can I withdraw from the study at a later date?

You can withdraw from the study at any time. Simply contact me that you would like to withdraw. All data collected from you will be destroyed as confidential waste unless you agreed to use the data up until the date and point of withdrawal. The data can be withdrawn up to one month after data collection, after which time the data will have been amalgamated into the study analysis. My contact details are at the end of this information sheet.

8. Who has reviewed this study?

The proposed study has received ethical approval from the School of Health and Social Care Ethics Subcommittee at Middlesex University where I registered for doctoral studies, the Clinical Effectiveness Department at the Local Trust where the study is to take place.

9. What are the disadvantages and risks of taking part

There is a small to moderate risk involved in discussing sensitive experiences you have had whilst caring for a particular patient. Your time in taking part in this research could be viewed as a disadvantage. You are free to withdraw at any point. It is my duty as the researcher to ensure, to best of my ability, the well-being and security of all participants is safeguarded.

10.What will happen to the results of the research study?

A detailed research report will be written as part of my doctoral thesis and will be shared with the Pre-registration Midwifery Programs at Faculty of Health and Education at Middlesex University. You can receive a copy of the summary report as requested by email to the researcher. The results will also be published in education and health care journals and conferences. With your permission, anonymous quotes may be used to illustrate the study's findings. You will not be identified in any report or publication arising from the study. If you wish, you may receive a copy of the summary report of the study.

11.What if I have questions or concerns after reading this sheet?

In case of any further questions about any aspect of this study, please do not hesitate to contact me in the first instance, and I will do my best to clarify or address these. If you have any concerns about this study, please contact my supervisor.

12.What should I do now?

If you think that you would like to take part in the study, please sign and return the attached invitation sheet to my office at Ms Sarah Chitongo, c/o Middlesex University, Building 10, Hendon, London, NW4 4BT or send through email to SC2083@live.mdx.ac.uk and Professor Helen Allan as my supervisor . On receipt of the return sheet/email, I will contact you to arrange the interview at mutually convenient time at a mutual convenient place.

Thank you very much for taking the time to consider taking part in the study.

Sarah Chitongo
Email: S.Chitongo@mdx.ac.uk

Supervisor

APPENDIX 5



VERSION 6- 1.8.18

Appendix 4

Topics for discussion at face-to-face interviews with Delivery suite midwives

An exploration of midwives experiences for caring for high risk women from Black Minority Ethnic Groups on delivery suite

Introductory Statement

I would like to thank you for agreeing to take part in this interview and for sharing your views on the above study. My name is Sarah Chitongo and I am a midwifery educator from Middlesex University. Just to let you know that there are no right or wrong answers and whatever you say will be helpful to the audit. The discussion should last no longer than an hour.

In conducting this interview a digital recorder will be used to enable me to capture your views. I hope you don't mind me using this equipment. I would like to reassure you that anything said will remain confidential and you do not need to answer anything you do not wish to, so please try to feel at ease during this interview. In conducting this

interview please try to avoid identifying any hospitals or organisations or persons during the interview process. Before we begin, are there any questions you would like to ask?

Biographical Data

Age.....

Gender.....

Ethnicity.....

Qualification.....

Length of Qualification.....

1. Tell me about your experiences you have had with caring for a patient from Black Asian Minority Ethnic group whom you believe is considered to a high risk individual?
2. Can you tell me about a situation where things went well or when things didn't go as well as you would have liked?

3.Are there any barriers or challenges to providing individualized care to these group of patients within the unit ? How?

4.Do you find you have to adopt different ways of working with this client group in the HDU setting? If yes, can you expand on this?

5.What is your understanding of cultural competency? Prompts will be included here

6.Tell me about the support and education you have received for caring for these women?

7.How could the service better support you to care for these women?

8.Is there anything else you would like to add that I haven't asked you but which you think is important, or anything else you think I have missed?

Thank you very much for sharing your experiences with me.

APPENDIX 6

32nd ICM Triennial Congress
Indonesia 21-25 June 2020
Midwives of the World: delivering the future



Dear Ms. Sarah Chitongo,

Thank you for contacting us. Your abstract has been re-moderated by reviewers which has resulted in a slightly higher score that has now put it in the admissible category.

As a result, your abstract ICMBALI-0198 *Midwives experiences of caring for high risk women from Black Asian Ethnic Minority groups on delivery suite* has been accepted as a poster presentation at the 32nd ICM Triennial Congress, which is being held in Bali, Indonesia, 21 – 25 June 2020.

Posters will be displayed for one Congress day, poster viewing sessions will be held each day. We will send you further instructions in a future email. We expect to publish the detailed program during January 2020.

REGISTRATION

Please take advantage of early bird conference rates by **registering online by 1 November 2019**, at <https://www.midwives2020.org/registration>. **Presenting authors must be registered for the Congress by that day.** If you do not register by this date, your presentation opportunity will be offered to another author.