2024

The Motherhood Group: Southwark Maternity Commission Engagement Report

INSIGHTS FROM BLACK AND ETHNICALLY DIVERSE MOTHERS, PREGNANT WOMEN AND HEALTHCARE PRACTITIONERS

THE MOTHERHOOD GROUP

Contents

THE MOTHERHOOD GROUP

THU 06/06/24 11:45AM - 1PM

Maternity Care Professionals Virtual Lunch & Share

Calling all healthcare professionals who work at King's Hospital, Guy's and St Thomas' Hospital, Maudsley Hospital, or are residents in Southwark!

Join us for a virtual Lunch and Share workshop to discuss your experiences in providing maternity care and engaging with Black, Asian, and ethnic minority groups in Southwark. Your insights will help improve outcomes for mothers in our community.

By attending you can:

Share your experiences | Provide input | Contribute to improve | Network

Register via Eventbrite

Don't miss this opportunity to make a difference in Southwark's Maternity Care

THE MOTHERHOOD GROUP

Southwark Council

Virtual Lunch & Share Workshop for HCP

The Motherhood Group and Southwark Maternity Commission have partnered to make a difference in the lives of Black, Asian, and ethnic minority mothers in our community. We invite you to join our virtual Maternity Care Professionals Lunch and Learn Workshop on 6th June 2024 from 11:45am - 1pm. During this workshop, you'll have the opportunity to:

- Share your experiences, challenges, and successes in delivering maternity care 📢
- Provide valuable input on how to better engage with and support Black, Asian, and ethnic minority mothers 💡
- Contribute to the development of recommendations for improving maternity services in Southwark 🌍

Executive Summary

This report details findings from Black and Mixed-Black, Latin American, South Asian, Gypsy, Irish Traveller and Roma communities, and healthcare professionals in Southwark as part of the Southwark Maternity Commission. Approximately sixty-seven participants engaged in the work, twenty from Black or Mixed-Black backgrounds, thirteen from Latin American, ten from Gypsy, Irish Traveller and Roma, and less than five from South Asian backgrounds. The remaining nineteen were healthcare professionals. A qualitative approach was utilised to investigate maternal experiences during pregnancy, childbirth and in the postpartum period, centring the quality of care received, communication and understanding between service users and providers, and the support networks women used during this time. The report finds eight key thematic areas emerging across the groups, informing the recommendations. These are: Advocacy and Agency; Racism and Racialised Stereotyping; Listening; Stigma; Strengthening Relationships with Other Services; Continuity of Care; Cultural Competence and Sensitivity; and Intimate Network Involvement and Support. As such, this report makes the following recommendations:

1. **Strengthen community support**
    a. Provide tailored group care in the antenatal and postnatal period
    b. Chart existing organisations already providing support and advice for women from diverse ethnic backgrounds in the borough
    c. Ensure funding and space for social gatherings to promote advocacy and knowledge exchange between mothers, healthcare professionals and wider support networks (including friends and family)
    d. Devise stigma reduction strategies with community groups and organisations representing marginalised populations in Southwark
2. **Ensure availability of interpretation and translation services**
3. **Strengthen the capacity for healthcare professionals to advocate for service users**

    a. Strengthen healthcare professionals' capacity to communicate and advocate across other Southwark Council services, including housing, Universal Credit or financial services, and child support
    b. Ensure healthcare professionals have time to provide personalised care to service users, particularly those speak English as an additional language
    c. Ensure continuity of care is available to those who need or request it, particularly those who speak English as an additional language
    d. Implement mandatory anti-racism and cultural competency or sensitivity training for maternity staff across a range of departments (i.e perinatal mental health, obstetrics, midwifery, home visitation)
    e. Provide tailored training on kindness, empathy and respect learning from the accounts of those in the community emphasising tone, language and questioning
    f. Ensure information is provided sensitively and accurately to all service users, particularly when using remote communication devices such as telephones

4. **Ensure robust breastfeeding support for all service users after birth**
5. **Ensure robust mental health support at all stages of maternity care**
    a. Make sure signposting to services both in and outside of the NHS is clear and available

Introduction

The Motherhood Group (TMG) was tasked as part of the Southwark Maternity Commission with conducting qualitative research and writing a report outlining responses from a sample of Southwark's ethnically diverse population. The primary methods included focus groups and interviews, as well as a workshop and questionnaire, using cross-partnership projects with tailored community organisations to ensure representativeness.

Image of participants at the workshop.

This report focuses on the experiences and insights gleaned from Black, Mixed-Black, Latin American, Gypsy, Irish Traveller and Roma and South Asian women, as well as healthcare professionals living and working in Southwark. The methodology section details how interviews, a workshop, focus group, and a questionnaire were used, and the autonomy and independence given to other organisations better positioned to reach certain groups to support the project. The results section is split by group and topic area, offering a nuanced look at the qualitative accounts received. This section makes use of direct quotations from those spoken to, summarising the intersectional features emergent through their biographical data and narrative accounts. The results are presented this way to reflect the specificity of the accounts and give logic to the discussion. As a growing body of critique has indicated, those from a variety of minority ethnic backgrounds have differing challenges, positive experiences and concerns when it comes to engaging with any service, including maternal health. Whilst the discussion section brings the diverse perspectives together in order to tailor recommendations, TMG wanted to preserve the particularity of each experience.

Approximately[1] forty-four service users and nineteen healthcare professionals were engaged across the groups and methods, totalling approximately sixty-seven individuals. Sometimes, the concerns raised draw in themes much wider than ‘maternity care’ in hospitals or clinics. For example, healthcare professionals raised concerns about housing services in the borough, and expressed frustration at not being able to help service users promote their general health through supporting their wider living arrangements. People had difficulties with housing, social services, employment, finance, mental health, disability and child support that they tethered to their responses. TMG felt it was important to capture the scope of these entanglements to ensure an awareness of what people bring to healthcare settings, and what they take out.

All images presented in this report were taken with the consent and knowledge of participants at the workshop. They are not named anywhere in the report.

---

[1] The approximation refers to the totalling of South Asian participants to five to protect the anonymity of this smaller sample.

TMG would like to thank all of the participants who engaged in this process from a range of communities, including healthcare professionals, in Southwark, as well as the organisations who provided vital assistance in recruitment and listening to their stories.

Methodology

The Motherhood Group conducted a workshop, focus-groups, interviews and a questionnaire. A qualitative approach was applied to ensure participants felt they were listened to and capture nuance and specificity in response across each demographic.

The table below outlines who was involved in each method by demographic, and the number of Southwark participants who attended the workshop and focus groups, were interviewed or completed the questionnaire. We spoke with approximately forty-four service users and nineteen healthcare professionals. The total number of people engaged was approximately sixty-seven[2].

Method	Black or Mixed-Black	Latin American	Gypsy, Irish Traveller and Roma	South Asian	Healthcare Professionals
Workshop	17	-	-	-	-
Focus Group	-	13	-	-	19
Interview	3	-	-	-	-
Questionnaire	-	-	10[3]	<5	-

TMG engaged in cross-partnerships projects with organisations more strongly connected to specific ethnic groups, including Gypsy, Irish Traveller or Roma communities, Latin American and South Asian communities in the borough.

---

[2] The South Asian group is rounded to five to protect anonymity of the sample.

[3] Engagement from South Asian and Gypsy, Irish Traveller and Roma groups was facilitated by Southwark Travellers' Action Group (STAG) and The Rahman Group respectively. The Rahman Group directed their Southwark network to complete the questionnaire held by TMG. STAG composed of their own questionnaire, included in Appendix 1.

All mothers TMG engaged with were compensated for their time and contributions through vouchers and gift-bags. Those who attended the workshop were also given food or soft drinks during the day.

Each methodological approach centred the following set questions:

1. Have you ever lived or worked in Southwark?
2. Have you given birth at any of the following hospitals?
    a. King's College Hospital
    b. Guy's and St Thomas' Hospital
    c. South London and Maudsley
3. Reasons for choosing the specific hospital
    a. Overall experience at the hospital
    b. Comparison between different hospitals (if applicable)
4. How were you treated by NHS midwives and nurses during pregnancy and childbirth?
    a. Quality of care received
    b. Communication and empathy from healthcare professionals
    c. Cultural sensitivity and understanding
5. 4. How were you treated by healthcare professionals and community midwives after the birth of your child?
    a. Continuity of care post-birth
    b. Support for mental health and well-being
    c. Accessibility and responsiveness of healthcare professionals
6. Did you feel you could ask for help during and after pregnancy and childbirth?
    a. Where did you seek support?
    b. Comfort level in seeking assistance

   c. Availability of support networks (family, friends, professionals)
   d. Barriers to accessing support

7. Was there any support you felt you needed but did not receive?
   a. Identification of gaps in support services
   b. Impact of unmet needs on the mother's well-being
   c. Suggestions for improving support systems
8. Were there any unexpected forms of support during pregnancy, childbirth, and early motherhood?
   a. Positive surprises or experiences
   b. Innovative or non-traditional support methods
   c. Community-based initiatives or resources
9. Do you give consent for this information to be used, anonymously and confidentially, as part of The Motherhood Group's work on the Southwark Maternity Commission?
   a. Yes/No
10. Would you be willing to share your experience with the Southwark Maternity Commission in person (anonymously and confidentially)?[4]
    a. Yes/No

Sensitivity and discretion were central in shaping if and how the questions were asked. Through TMG coordinated events, we ensured distress protocols, including signposting to relevant organisations and the ability to withdraw consent or leave the engagement were communicated verbally to participants. Those who completed the questionnaire gave their consent via question nine, and participants at the Workshop were asked if they consented via the registration form. We

---

[4] This question was included to give an opportunity for those who only used the questionnaire to be contacted for an interview. The anonymity and confidentiality refers to the presentation and storage of the data following participation.

partnered with several organisations to signpost following participation including Melanin Mothers, Tommy's, Mums Aid and those who collaborated in Cross-Partnership Projects.

Ethnic Identification

In the questionnaire and in interviews participants were asked to self describe their ethnicity. Participants were also asked about their ethnicity when registering for the workshop. A free text box was available for participants to write down their ethnicity. In interviews, participants were asked: "how would you describe your ethnic background?".

TMG did not use a drop-down or option format to allow participants to self-describe as they wished. This was aggregated according to broader identifications, drawing from the Census data, to bring together broader groups such as 'Black' or 'South Asian'.

In the interviews and at the workshop, Black participants described themselves as 'Black African', 'Mixed Black', 'Mixed race', 'Black Caribbean', 'African', 'AfroCaribbean', and 'Black British'. These identifications have aggregated under the 'Black and Mixed-Black' category.

The South Asian group also used a variety of terms to describe their ethnicity or ethnic background, some making national affiliations, not mentioned here to protect their anonymity.

TMG is aware that Southwark aggregates the data for Gypsy, Irish Traveller or Roma groups in their council reporting, and that STAG, who were given autonomy in their work, works with all three groups. The Latin American group was recruited in collaboration with LAWRS and LOVO, and data is held by them as to the variety of identifications made by those present.

TMG acknowledges the diversity of identification can be masked or obscured when grouped together. TMG also acknowledges the growing critique of compiling all information about 'Black and Minority Ethnic' (BAME) groups together. In this report, TMG has endeavoured to draw out the specificity of experience in each case.

TMG-Led Recruitment

TMG used a variety of methods to recruit participants into TMG-led sessions, and to work with partnered organisations to consider the possibility of carrying out more diverse focus groups – 'women-only' (Appendix 2) – with mothers. TMG and the partner organisations agreed, however, that the sessions should be kept separate to ensure the spaces were safe and people could feel open to share and to avoid the assumption experiences across groups would be shared.

For TMG-led engagements, including with Black and Mixed-Black groups, healthcare professionals and the Latin American focus group, recruitment was carried out through emails, social media, in-person events (such as the Black Mums' Fest) and flyers. Some examples are included in Appendix 3.

Cross-Partnership Projects

TMG's strengths lie in engagement with women of Black and Mixed-Black heritage or identification, but strong ties exist with other organisations. To reach Gypsy, Irish Traveller and Roma, South Asian and Latin American women, TMG partnered with a number of specialised organisations, some recommended by the Southwark team. These included: Southwark Travellers' Action Group (STAG), Ladies of Virtue Outreach CIC (LOVO) (Latin American), Latin American Women's Rights Service (LAWRS) and Rahman Group (South Asian participants).

Except with LAWRS and LOVO, the aforementioned organisations were given independence in the method of engagement, though all were encouraged to refer participants to the questionnaire. As such, the information gathered from each group varies in degrees of depth and extrapolation. With STAG, we received a spreadsheet including responses from ten women, overall perceptions of care received and short statements of extrapolation, outlined in Gypsy, Irish Traveller and Roma Participants results.

LAWRS and LOVO supported recruitment and translation for the focus group with Latin American participants. As such, the quotations provided in this result section sometimes refer to the participant in the third person, reflecting the interpretation received. Participants in the group were keen to share their stories and were grateful for the safe space, particularly due to linguistic congruence of the participants. It indicated some crossover between the themes commonly identified in the experiences of Black and Mixed-Black women identified by TMG, including the feeling of not being listened to or overlooked, and the importance of culturally resonant research teams.

The Rahman Group shared the questionnaire with their networks, encouraging those who lived or had given birth in Southwark to participate. In the first round of circulation, only two participants responded. TMG followed-up with the Rahman group for further engagement, incentivised with shopping vouchers for those who give dedicated and detailed responses.

Interviews

Interviews with Black and Mixed-Black women were conducted by a research assistant at the Black Maternal Health Conference. Some of those interviewed in their capacity as mothers were also healthcare professionals. At times, this informs their experience and description of their care, however, they are featured here as mothers, rather than healthcare professionals, as this identity is what structured the interviews.

The researcher took detailed, typed notes during the interviews, using the questions above as a guide. The interviewee was able to see the researcher typing their responses, which in most cases prompted openness, as interviewees extended their descriptions of events or experiences for the interviewer to write down. The interview data was then compiled into a spreadsheet with the questionnaire data to facilitate the analysis.

Participants were informed verbally before the interview that any data would be made anonymous and kept confidential. They were then asked for their consent. Consent was recorded with each interview file by the researcher. Participants were told they could withdraw consent at any time through reaching out to The Motherhood Group via email or through social media.

Three in-depth interviews were carried out with Southwark residents. The interviews demonstrated the need to pay close attention to the individual behind the story, statistics and trends. Each case was unique and every participant wanted to talk and be listened to.

Focus Groups

Two focus groups were conducted online, one with women from the Latin American Community in Southwark, and the other with Healthcare Professionals and Practitioners working at Southwark hospitals including: King’s College, Guy’s and St Thomas’, or South London and Maudsley.

Latin American Community

The focus group with the Latin American community was attended by two facilitators and a research assistant at TMG. A Spanish-speaking interpreter was present to ensure all questions, answers and messages in the Zoom chat function were translated and accessible for those in attendance. The questions were spoken by the facilitators in English before being translated by the interpreter. Some participants were English speakers. We collaborated with Latin American Women's Rights Service (LAWRS) for recruitment and translation.

The focus group was recorded and transcribed. The research assistant listened back in line with the transcript to ensure the accuracy of the quotations. Because in most cases the interpreter was translating the responses from participants, the quotations presented in the Results section note the interpretation, and sometimes refer to 'her' or 'she', rather than 'I' or 'me', because of the interpreter's style.

Thirteen participants attended the online focus group and held a range of experiences and backgrounds clustered around the Latin American identity. For example, some of the participants did not speak any English, others had a good grasp of the language. This proved to be important in participants' reflections of the care they received at several Southwark hospitals. The youngest child born a participant in this group was two months and the oldest was five years. This provided a good range of responses over time and many of the participants' memories were vividly recalled.

As a translator was being employed during the session, the focus group unfolded through a series of stories or accounts narrativized by one participant at a time. As explored in the Results section, recollections were often highly emotively charged and the women in the group provided support to one another as it unfolded, affirming through shared experiences, active listening and responses through Zoom's various functions (reactions including applause or heart shapes and messages of solidarity in Spanish). The focus group lasted an hour and a half.

Healthcare Professionals

The focus group with healthcare professionals was attended by two facilitators and a researcher from TMG. The focus group was attended by a range of practitioners and professionals, including: bereavement nurses, perinatal mental health practitioners, midwives, nurses, therapists, obstetricians and community facing practitioners. The healthcare professionals consented to being identified by their profession in the report where relevant to ensure specificity of perspective. A list of the job titles or professions supplied by healthcare professionals when registering for the focus group can be found in Appendix 4.

A total of nineteen practitioners attended in total, each providing accounts in response to their professional position and understanding of effective care practices in Southwark and beyond, allowing tailored recommendations to be extracted from the accounts. The session had been scheduled to last an hour and fifteen minutes but was extended to an hour and a half because of the lively nature of the discussion. The session was recorded and transcribed. Some participants joined the online call in groups of two or three, sitting together to listen and engage in the focus group. The quotations presented in the Results section are directly drawn from the transcript and were double-checked through the audio file by the research assistant.

At the end of the focus group participants were asked to reflect on their experience. Many noted it had a positive effect to hear what others were doing from different roles and positions in hospitals and in the community.

The questions outlined above had to be altered for this focus group because of the positionalities of participants. Broadly, discussion centred the following questions, with participants encouraged to raise their thoughts on related topics and learning from within or outside of their place of practice. Questions were informed by what TMG had already gathered through interviews, the workshop, questionnaire responses and the focus group.

1. What barriers have you identified when providing maternity care with Black and ethnic minority service users?
    a. What barriers do you face in providing care?
    b. What barriers to Black and ethnic minority service users face when accessing maternity care?
2. How can we create inclusive and culturally resonant healthcare environments for diverse users?
    a. How might we foster and maintain trust?
3. How can we build effective community partnerships?
4. What are your recommendations or thoughts on ways to improve maternity care for Black and minority ethnic groups in Southwark?

The focus group with healthcare professionals was attended by a diverse group of people occupying a range of ethnic identities. Two of the nineteen participants were men.

The table below outlines the aggregated ethnic identifications of participants drawn from their descriptions during the focus group and information provided during registration. The term ‘British Asian’ is used to reflect how some of these practitioners described their ethnicity:

Ethnic Identification	Black or Mixed-Black	South Asian or British Asian	White or White British
Number of Participants	10	<5	6

Workshop

The workshop was conducted at the Black Mums Fest at an in-person event held at a Black-owned venue in Peckham, South London. Of those who attended, seventeen lived in Southwark. Attendants were asked to give their postcodes and the hospital at which they sought care at their discretion when registering for the event. Those in attendance were sometimes accompanied by children, family or friends. Like in the interviews, some of the participants in the workshop were both mothers and healthcare professionals. Though they may make reference to the intersection of these identities, they are considered here primarily in their capacity as mothers. A free meal was provided to those who came.

Participants spoke about their experiences to the group at large or in smaller break out sessions. Several activities were organised to ensure they felt supported through the day given the sensitive nature of the conversations taking place. For example, Rochelle Love, midwife and founded of Melanin Mothers, an organisation supporting Black and mixed-ethnicity women in their pregnancy, ran a session encouraging participants to write supportive letters to other Black and Mixed-Black women, encompassing what they had learnt and shared on the day. Rochelle Love is a Tommy's charity midwife, supporting women with experiences of miscarriage or baby loss. She has experience supporting mothers in pregnancy and beyond, particularly those who have struggled with traumatic experiences. Rochelle's present enabled participants to feel comfortable sharing as they were actively encouraged to speak to her about any of their concerns throughout the day.

The workshop could not be recorded due to the noise levels, participants were encouraged to bring children if they could not find childcare and the size of the room would have caused echoes. Instead, a researcher typed detailed notes whilst participants spoke, and another assistant was at hand to get involved in break out discussions.

Disability and Neurodiversity

One participant in the workshop lived with a physical disability. She was vague in her description of the disability, but alluded how the disability played a role in her care in hospital. Another participant in the workshop raised concerns about her child's educational support after he was diagnosed with severe learning difficulties in the early years. In the Latin American focus group, a mother spoke about hearing of a potential Down's Syndrome diagnosis over the telephone, which turned out to be false. She extrapolated on her son's autism. These cases are presented in the results section. TMG has included the mothers' concerns over their children's disabilities or neurodiversities to demonstrate the impact this can have on the overall maternal experience.

Questionnaire

A questionnaire was designed for use at the Workshop and at the Black Maternal Health Conference. The questions asked in the questionnaire were synonymous with those asked during interviews.

The questionnaire also acted as a format open for those TMG partnered with to share with networks. The South Asian respondents used this questionnaire, shared with them via the

Rahman Group. Participants could type as much or as little about their experience as they desired into a free text box. The questionnaire asked for postcode details, ethnicity, age and the hospital booked with during pregnancy or childbirth.

Image of a participant and her baby at the workshop.

Intersectionality

The American Black Feminist theorist and civil rights advocate Kimberly Crenshaw is largely cited as coining the term ‘intersectionality’. The concept has now entered everyday use with growing attention paid to the multiple sources of advantage and disadvantage tied to a person's social, structural, political and economic circumstances, among others. Crenshaw was initially concerned with the particular intersections of Black women's lives, in "the various ways in which race and gender intersect in shaping structural, political and representational aspects of violence against women of colour" (1991:1244). In doing so, Crenshaw acknowledges broader intersections, including "class, sexual orientation, age and colour" (1991:1244-1245n9). The origins of this theory are strongly linked to the political objectives of antiracism and feminism (1991:1243n4). Both of these objectives necessitate attention not only to intersectional disadvantage, but also to advantage and privilege: who holds power, and why. Intersectionality is now sometimes taken to refer only to the former – historical disadvantage – presenting and creating white identities as flat and without complexity.

In this report, intersectional positions participants hold are visible through their narratives, presented in quotations. These relate to, among others: age, religious disposition, migratory status, language, disability or neurodiversity, gender, ethnicity, class or economic status. It also becomes visible at times where a participant is detailing their perceptions of the intersectional position of another, often a caregiver, and how it impacted their care. In reading this report and recommendations, TMG suggests keeping in mind reflexivity. This involves thinking about who makes decisions based on the recommendations presented, how funds are allocated, how the teams of people responding, critiquing or implementing recommendations or policy are composed, and the embedded assumptions we might hold when reading about women of colour.

Sometimes, a person's or people's intersectional position is stated clearly in the presentation of the Results or Discussion. At others, quotations are used to demonstrate how the participant positioned themselves and the social or structural intersecting identities they find relevant to their care. This is part of our effort to reduce the impact of well-trodden assumptions about, as a primary and pertinent example, ‘the black, young, single mother’. Hearing participants describe their circumstances in their own voice is an effort to curb the perpetuation of harmful stereotypes or narratives built through years of deficit-based scholarship or research of minority populations.

Limitations

TMG aimed to involve fifty participants in the project. Although this number was exceeded with the inclusion of healthcare professionals, insights could have been strengthened through further engagement with service users. Additionally, the collaboration with STAG did not yield detailed insights about the experiences of Gypsy, Irish Traveller and Roma communities. Only one participant had a physical disability, and a further group specifically for those with disabilities would have been required to strengthen results at this intersection. Although some of the groups mentioned in the commission specification were not reached, TMG feels engaging across all of those expected with the agreed target of fifty participants may have provided thinner results in this report. Despite recruitment material emphasising the need for participants to be Southwark-specific, a greater number of participants than are recorded in this report attended the workshop who gave birth or lived in other, primarily South London, boroughs. Their presence at the workshop facilitated the range of topics discussed and added variety to the range of maternal experiences. They are excluded in this report to adhere to the commission's requirement for all participants to be Southwark residents.

Strengths

The strengths of this report lie in the nuanced and broad insights gleaned about the connectedness of maternity services to wider public services provided by the council – housing, mental health and financial support in particular. In the healthcare professional group, interviews, the workshop, and the focus group with Latin American participants, those in attendance were grateful for the opportunity to share and contribute to the commission. Their insights are nuanced and provide a picture of the difficulties and the effective strategies for providing or receiving good care. Because of the detail of data recording, either written or transcribed, the report offers valuable data in the direct quotations from those TMG engaged with.

Terminology

‘Healthcare Professionals’

The term healthcare professionals is used in this report to refer to all those who work in the maternal healthcare space. This includes midwives, specialised doctors, perinatal mental health specialists, health visitors, therapists and others. The term is sometimes used by mothers to encompass a range of positions. At others, they specify the professionals they are making reference to (i.e ‘midwife’).

‘Black and Mixed-Black’

As indicated in ‘ethnic identification’, the term ‘Black and Mixed-Black’ refers to those who identify as belonging to a range of Black backgrounds. This might include ‘African’, ‘AfroCaribbean’, ‘Black British’, 'Caribbean’, ‘Mixed-race’ among others.

‘South Asian’

As indicated in ‘ethnic identification’, the term South Asian refers to those who identify as belonging to a range of South Asian backgrounds. This can include ‘Indian’, ‘Bangladeshi’, ‘Pakistani’, ‘British Asian’, ‘Asian’, among others. To protect the anonymity of the small sample, the specific terms used in identification are not disclosed.

‘Gypsy, Irish Traveller and Roma’

Gypsy, Irish Traveller and Roma are separate communities. Learning from STAG, who work with each group, we use the encompassing term to reflect the range of those STAG engaged with to contribute to this report.

‘Latin American’

‘Latin American’ refers to those who identify with backgrounds from the South American continent. This could include a range of national identities as well as ethnic groups. As the specific information about each participant is held by LOVO and LAWRS, ‘Latin American’ is used in this report to refer to those who identified with this call.

Results

Image of participants and their children at the workshop.

Black and Mixed-Black Participants

The results presented in this section are drawn from the Workshop and the Interviews conducted with Black and Mixed-Black participants.

To give depths to the illustrative quotations in this section, a number of case studies are presented reflecting the broader context of the experience under consideration.

Treatment by NHS Midwives and Nurses in Pregnancy and Childbirth

Positive experiences centred attentive and empathetic care, allowing participants to feel empowered and knowledgeable. At the workshop, participants emphasised being treated with care and dignity. Advocacy, for oneself and others, was central to this experience, framed by an understanding of the likelihood of receiving inadequate care as a Black woman. The sense that care might be unsafe or not up to par was linked to previous experiences, the media or the sharing of stories in networks. Those who worked as healthcare professionals but were spoken to in their capacity as mothers made visible the way that a knowledge or understanding of health information and the healthcare system was used to to advocate for themselves.

A participant at the workshop, who occupied the positionality of healthcare professional (she was a mother and had given birth and worked at St Thomas' hospital), spoke about the support her husband provided during her labour:

> "My husband was there and was quite supportive. I gave him a long list of what he had to do and he was actually good at it"

Case Study: Advocacy and a Positive Birth Experience

A Black participant in the workshop gave birth at St Thomas' hospital. She is a doctor. She contextualised her profession to shed light on the intersection of class, ethnicity and gender, and how one's experience working in this field as a person of colour might work to improve care through the ability to advocate for oneself. She noted her midwife was

South Asian, which might have helped in communication, though she could not be sure. Having her husband there for support was described in the context of advocacy tools, as they had prepared, together, a list of requests and expectations whilst giving birth in the labour ward. This participant felt she was listened to by staff, for example, in delaying cord clamping or cutting and being given time with her family for an hour after birth. She did not tell her midwife she was a doctor because she did not want to be treated differently or have assumptions made about her.

(Participant from the Workshop)

One interviewee had anticipated being told what to do and ensured she was able to make her own decisions through self-advocacy. She noted about her experience giving birth at Kings':

> "It was nice to bring the baby up myself and bring him up to my chest. That is what motherhood feels and looks like. I didn't allow things to just happen to me, you can't trust the NHS to do everything for you. As a Black woman, you should know what you might experience and be sensitive and heightened to it if it doesn't feel right, then do something about it"

Case Study: 'Knowing the NHS'

Giving birth to her second child at King's College Hospital, a participant spoke of the relief of being allowed time to bond with her child and bring the child up to her chest after birth. It made her feel like a true mother. However, this was not easily given. This participant emphasised that she had to advocate and ensure her choices were respected. She did not just allow things to happen to her as she didn't trust the NHS because of what she knows about Black women's experiences with the institution.

In her first birth, this participant had taken the advice of a supportive Black midwife after meconium was found in her waters. The midwife suggested she have an epidural to focus on labour. The midwife told her, "don't be a hero, get an epidural". The interviewee describes: "I was like, right on sister!".

Her uneasiness with her second birth, about not letting things happen to her, was a result of the MBRRACE UK five times more statistics. This participant knew she would have to advocate for herself to ensure she was treated with dignity and respect.

For support before and after birth, she drew on family networks, including her mother, husband and friends, as well as a friend who is a midwife.

(Participant in an Interview)

A common theme among negative experiences was being told to do things by professionals with little direction or explanation. As one interviewee described:

> "I was told I'd be induced and go to the labour ward, but I didn't know where it was. The midwife came four hours later and told me to get changed into a gown, no one had told me to do this. They broke my waters. I asked for an epidural but I knew it could cause paralysis, so then I asked for gas and air. I didn't understand how my midwife couldn't advocate for me, to give me pain relief and stuff. I was a nurse, so I knew there were options"

Case Study: Being ‘Told’ What to Do

In an interview, a participant spoke of not being given choices when she was giving birth at Kings’ College Hospital. In the birth of her first child, she was “told” she was going to have a number of procedures, or to do certain things. This related to her induction of labour, changing into a gown, and having her waters broken. This participant was a nurse and had a good understanding of available pain medications and protocols for receiving them. Occupying this position allowed her to navigate her request for alternative relief, aside from an epidural. This participant gave birth to her first three children at the hospital where she worked. Despite her familiarity with the location, she felt she often had to chase staff to understand what was going on.

Because of her intimate connection with the hospital, having birthed and worked there, this participant described the care she received in the community positively. She felt they were empathetic and understanding of the struggles of new motherhood in particular a lack of sleep, and constant concern for the child.

This participant, being a healthcare professional, did not access any of the other available resources (except health visitation) following the births of her children. In part, she feels this was because she was not referred.

She sought support from her family and a best friend who is a midwife.

(Participant in an interview)

Another participant who had given birth at St Thomas' hospital at the age of twenty-one felt her age and background impacted the quality of care received during pregnancy and childbirth, leading to a stillbirth:

> "I didn't feel I was heard when I had problems or questions. It was brushed off a lot. [...] I was twenty-one and perhaps because of age they brushed off concerns I had and didn't want to listen because I'm a young Black mum. I did have a stillbirth due to negligence of the hospital. [...] When I did go to hospital or midwife appointments most people were older than me and stuff so when I asked it was not like an eye roll, but just brushing off. [...] As a young woman, I believed everything and put my trust in them"

Case Study: A 'Young' Mother

A young Black woman who gave birth at St Thomas' hospital shared in the workshop that she felt brushed off by the practitioners, that they didn't listen to her primarily due to her age. She ended up having a stillbirth at the hospital caused by their negligence. After this experience, she feels she should not have trusted the practitioners so blindly.

The participant reflected on asking for further assistance from the midwives, but felt each time that they would reassure her everything was okay, without taking care to listen to her concerns. This is where she identified the negligence, as she felt further checks could have been taken at her request to avoid the loss of her child. Rather than being handed over to a doctor, she was often sent to triage by midwives where she received 'standard checks' without being asked for further details about her appearance there.

This participant was seen by a number of student midwives and felt happy to support their training. However, it was whilst she was being seen by a student midwife that she remembers “key times” where things were missed. She felt qualified practitioners did not look over the students’ work accurately.

Image of participant sharing at the workshop.

Treatment by Healthcare Professionals and Community Midwives After Childbirth

In one interview, a participant had a good experience with her health visitor after she moved home following the birth of her child:

> “With the community I’m in now it was brilliant. The health visitors were on the ball, they knew I wouldn’t be sleeping”

Support

Participants sought support from family networks, mothers, godmothers, partners, friends, lawyers, and online groups. They felt further support could include being with other women that could relate to their circumstances or perspective. As one interviewee notes:

> "We need more groups for Black mothers, who a lot of the time feel alienated, with no one to talk to, no midwife to call you and check up on you. We need more information because often it depends who you know. It would also be good to have antenatal sessions with a group, speaking to a midwife with others. Group sessions are very limited"

Case Study: The Significance of Signposting

In an interview, a participant noted her reliance upon and desire for more groups for Black mothers who are overlooked in the community. Despite having a good experience of pregnancy and childbirth, having a sense of empowerment in the birth of her second child after a miscarriage, she felt she did not know what support was available after the birth. This participant felt much of the support depended on who you know and who could refer you to relevant services, groups or applications. Building these connections was seen to be tied to meeting people in person.

This participant sought support primarily from her mother before, during and after giving birth.

(Participant in an Interview)

At the workshop, a participant described seeking support online as unexpectedly helpful:

> "I found unexpected support on online spaces and I did not envision going online for support but there were times when I was Googling heavily about everything and was surprised by how many mothers had gone through a similar journey"

Others chose to seek support from family and friends instead of healthcare professionals during pregnancy or after the birth of a child. This was usually because they felt they were not listened to by professionals, or had previous negative experiences. A participant in the workshop noted:

> "Postpartum, with my first, I had moments of struggle and I don't think the doctor I spoke with was listening to me. [...] It was not useful to go to the doctor because in my pregnancy I had issues and they didn't take it seriously and so that put me off. My Trust was tainted from the beginning"


Image of participant sharing at the workshop.

Case Study: Understanding Conditions

A participant in the workshop, who sought support from friends and family rather than healthcare professionals, linked this to her child's diagnosis of colic. The participant did not know what it was and felt the explanation from the doctor was not sufficient. She ended up crying to the doctor because she did not know what was wrong with her baby.

This participant works as a therapist, and felt that her professional background allowed her to notice the doctor's avoidance of her questions. She was also surprised that the doctor did not endeavour to check on her mental health, not even providing her with the questionnaire she knows general practitioners use to survey a patient's mental health.

In her second pregnancy, this participant felt nervous to go to the doctor and ask about her struggles, leading her to note: "My Trust was tainted from the beginning".

This participant lived in Southwark but did not want to disclose the Trust where these experiences took place.

(Participant in the Workshop)

South Asian Participants

South Asian participants were recruited through The Rahman Group, they shared long form responses using the questionnaire. Because of the small sample size, recommendations informed by this group's insights are tentative, made through their correlation or relevance to those drawn from all other groups.

Treatment by NHS Midwives and Nurses in Pregnancy and Childbirth

From less than five responses, participants felt midwives were competent and were grateful for the birth of a healthy child as a result of their care. One participant noted she was treated "with respect", and another was "happy with the service". However, sometimes this was seen as dependent on who the midwife was due to a lack of continuity of care. Additionally, one respondent was specific about how she was treated by those in different roles and areas – between birth centre, labour ward and sonography.

> "The midwives that I encountered with my second pregnancy were a mixed bunch. Those in the birthing suit I found listened a bit more and I could talk to them a little bit about my concerns. But those in the labour ward were very abrupt and somewhat impatient and I definitely couldn't speak with them about my concerns. For me, the sonographers were most impatient and one even referred to me as a 'fat cow'"

There seemed to be a desire for more empathy and support. This emerged from being stereotyped based on one's ethnic background. Intersectionality plays a part here, where medical or clinical professionals might hold stereotyped views of people depending on their age, gender and ethnicity. Sometimes, this can lead to false diagnoses, or mishaps, leading the person seeking care to feel overlooked and ignored. As one participant mentioned:

> “I was also told your baby is big, you must have diabetes, everyone in your race has it and in the borough most people have it. Even though I did the test three times”

Treatment by Healthcare Professionals and Community Midwives After Childbirth

Some participants felt they received good information and signposting after the birth of the child from those who visited them at home. They received the support they needed. One participant noted she was treated “very well” and had the opportunity to ask questions.

> “Just as good, and no problems. And I got information for children’s health”

In one case, there did seem to be a sense of miscommunication, or lack of understanding, after the birth of a child. In the questionnaire, a participant wrote:

> “After the gift of my second child I had to stay in hospital for five days as he was early. I was very emotional as it had been a long and hard pregnancy. Due to my being emotional – overjoyed and relieved we were both safe – I was addressed by two midwives and a doctor who said they found my behaviour concerning and said I was showing signs of postnatal depression. This, to me, was a massive shock. I literally had given birth and three hours after they said this to me. They requested a psychiatric specialist to come see me the next day. [...] When the team saw me the next day they soon discovered this was not the case and that quite understandably I was exhausted and in need of rest”

The same participant did not feel there was enough breastfeeding support and “felt like [..] a bother” when asking for support.

Support

Overall, participants felt they could ask for support during pregnancy and after childbirth. They sought support from hospital and community midwives, hospitals and public health centres and some made complaints. Participants felt they could have been listened to with greater attention. None of the participants who filled out the questionnaire could identify unexpected forms of support.

Gypsy, Irish Traveller and Roma Participants

Southwark Travellers' Action Group (STAG) were given autonomy in conducting engagement for this commission. Unlike other groups, we received shorter form responses, outlined in this section. We received responses from ten participants.

For antenatal care: "Six participants experienced positive care during antenatal care, with two describing their care as "very positive". Two felt their care was neutral. One participant felt their care was negative."

For care during childbirth: "Eight participants felt their experience of care during childbirth was positive, with two describing their care as "very positive". Two described their experience as neutral. There were no negative experiences reported."

For postnatal care: "Six participants described their experience of postnatal care as positive, with one describing the care as "very positive". Three described their care as neutral and one as negative."

Further responses and the full table are outlined in Appendix 1.

Latin American Participants

Engagement with Latin American women in Southwark was supported by Ladies of Virtue Outreach (LOVO) and the Latin American Women's Rights Service (LAWRS). Participants shared their experiences and perspectives of the transformative impact of motherhood, childbirth and engagement with healthcare services in their lives. They discussed the challenges of balancing work and motherhood and the importance of support networks, as well as the impact of motherhood on their identities and sense of self. Participants explored their personal experiences of discrimination in healthcare settings in part due to language barriers. They emphasised the need for better maternity care and mental health support centring empathy, understanding and access to robust care for new mothers, including those with children with disabilities. Due to the centrality of language and communication, this part includes a dedicated section addressing this theme.

Language and Communication

> "We are not treated equally, we cannot speak to the doctors and the nurses on the ward. They don't know anything and you are undermined because they think you can't speak the language. So I had my baby at St. Thomas' and the experience was terrible, and I have heard of many cases of mothers coming to have their baby there and they don't pay them attention. [...] In my case, when I went there they didn't pay me any attention and that broke my heart, and I was not feeling well and they sent me home. When I came back I had to have an emergency Caesarean, these things shouldn't happen, they should hear you, and even more when you speak a second language"

This mother's experience encompasses a central issue raised by the women in the Latin American group: of not being listened to, being dismissed and treated unfairly because they either do not speak English or spoke English as a second language. This is a very important intersection to consider, which ties in migratory status, gender and ethnicity.

A participant noted her mother was told to ‘shut up’ when asking questions to a midwife during birth. Familial connections were important to this participant's story, having her mother there allowed for greater support during her pain. She told the midwife not to treat her mother like that because she didn’t speak the language:

> “They asked me to translate, but I was in pain. I couldn’t focus on translation. So what I felt at the time was a lot of frustration”

A woman who gave birth in King’s College found her daughter had rubella after birth. They went to hospital for a week and when the mother asked for medication for pain resulting from her Caesarean to a nurse, explaining she was at the hospital because of her daughter, she felt disrespected by the nurse. It was only when a Spanish speaking midwife arrived that she was given medication.

> “She explained that it was her daughter in the hospital, not her, so she couldn’t give her anything. And when she insisted, even though she was speaking English the nurse said she didn’t understand. Then another nurse again came and ended up giving her the paracetamol”
>
> (Translation by interpreter during focus group)

Another participant also gave birth at King’s College and felt ignored. She pinned this to her language.

> "She was at King's College hospital, she said they never told her who her midwife was, there was a different midwife every time and she said she felt ignored because of the language. They told her she was going to receive the confirmation of an appointment by letter but it was two times that although she received the letter when she went there they told her the appointment was cancelled or she was not on the system. She had to show her passport to show she was on the system. [...] She even had to cry and they made her wait all day for a check-up."
>
> (Translation by interpreter during focus group)

This woman lost her child and felt if she had not been ignored and received check-ups on time she would not have lost her child. The gravity of this story was reflected in the focus group, where the woman cried as she recounted the events.

During one woman's birth, expressions of emotion through tears seemed the only way to communicate with practitioners. She described:

> "The birth was okay, but she didn't know what was going on because they didn't provide interpreters so she spent a lot of time crying for not understanding. So although she didn't have any health complication she couldn't understand what was going on"
>
> (Translation by interpreter during focus group)

Another mother whose child was born in St. Thomas' and has good comprehension of English noted that she knows others in her community struggle to receive care as practitioners are not patient.

> "She says she's seen other mothers struggling with the language. She says the staff at the hospital are not patient. They don't take into account that the mothers are going through a very difficult experience because they are pregnant. She says she did notice the staff paying more attention to her because she

> was able to communicate in English than with other women. She thinks they need more empathy with people that don't speak the language"
>
> (Translation by interpreter during focus group)

Seeing others being treated differently because they did not speak the language was reflective of unempathetic care and seen as negative, even though this mother felt she had been taken care of. This is demonstrative of how witnessing disrespect of those in one's community can shape perceptions of the service as a whole. It demonstrates an important aspect of intersectionality – that the experiences of a minority are influenced in part by the actions and ideas held by the majority community.

One participant noted that even though her English is not fluent she was still able to communicate. However, communication with the midwife in terms of empathy and understanding was still difficult:

> "She was having problems with breastfeeding. So she asked the midwife for advice and the midwife was very rude. She never treated her kindly, she was treating her like she should already know everything she was supposed to do. This was difficult as she was already in pain due to the Caesarean section."
>
> (Translation by interpreter during focus group)

Overall, the need for competent interpreters or translation services came through strongly in the focus group with Latin American women. Additionally, there was a general sense that care was not empathetic enough to the wider circumstances and challenges they were navigating, as well as the particularity of their cases, explored in the following sections.

Treatment by NHS Midwives or Nurses During Pregnancy and Childbirth

Linked to Language and Communication, many of the participants in this group did not feel they were listened to or had their choices respected during childbirth. This often led them to carry these feelings for a long time. As one participant noted:

> "It has been five years since I had my baby and I'm still very upset about what happened there"

Sometimes, negative experiences were tied directly to neglectful care or being ignored in care choices. Even when participants had understood childbirth might be 'complicated' following advice by professionals, there was a sense of frustration related to a lack of agency when giving birth in the hospital. A participant explained:

> "I felt at that time a lot of frustration. My pregnancy got complicated. I have seven centimetres dilated and the baby had a rope around it. I asked for a C-section and they didn't allow it. They ended up taking the baby out with forceps and it was a horrible experience."

As Language and Communication indicates, there were also problems in midwife allocation and continuity leading to difficulties with understanding and increased stress when women had to describe time and time again what they had already been through.

Treatment by Healthcare Professionals and Community Midwives after Childbirth

One participant described unkind behaviour by health visitors who visited them at home after the birth of their child. After a difficult experience with her child's sickness and access to pain relief, outlined in Language and Communication, this participant went on to describe the health visitor's behaviour at her home:

> “The health visitor visited her at her house. When she said she was a single mother, she asked if she was working. She replied, ‘yes’. And then the health visitor started questioning her: how was she going to take care of the child if she was working? And she started to scream at her. In the end she realised she was not behaving well and apologised, but after all of that…”
>
> (Translation by interpreter during focus group)

Being asked about work by a health visitor in an insensitive way was shared by another participant:

> “She said that the health visitor went to her house after the birth and it was also the case that she was asking about working, and what she was going to do after maternity leave. She said she works full time and was planning to return to work and the health visitor questioned her about how much money she had and how she was going to work and have children. She was alone, alone with the baby, so she started on her own to seek support. She said the health visitor never gave her information about organisation, where she could find clothes for the baby, she didn’t even tell her about universal credit”
>
> (Translation by interpreter during focus group)

The participant above highlighted positive care when she went to the hospital because of her child’s allergies. She also noted she was treated well after the loss of a baby.

Breastfeeding advice was raised as important, and one participant noted the midwife was rude after the birth of her child when requesting breastfeeding assistance:

> “She said the hardest part was after she had him, after a C-section. She was having problems breastfeeding and so she asked the midwife for advice. She said the midwife was very rude, she never

> treated her kindly. She was treating her like she should already know everything she was supposed to do. This didn't suit her and she was also already in pain from the C-section so very vulnerable"
>
> (Translation by interpreter during focus group)

Support

For many, community groups and friendship provided pivotal support throughout maternity. Support from those who did not work in healthcare was seen as more empathetic and detail oriented, as one participant expressed:

> "Being part of motherhood and witnessing it has changed how I recognise how much women need to support other women. Because there are so many things from healthcare that they just don't get. The details in the support, the empathy, in healthcare it's professionals. They're doing their work, they're doing the best they can. But there are certain things, like looking after a mums' emotions and helping her with little things in her life to make it easier."

One participant linked this to single motherhood, and the 24/7 nature of care. She felt providers would be able to give better support if they heard directly from mothers about their experiences.

> "Your life changes in every sense. Up and down, your mood. Everything. And I think for the NHS, or maternity, it is very good to share and join with other mothers to share their experiences, whether their not good or fine"

Single motherhood was difficult when people did not have their family in the country, another participant noted:

> “I am a single mother and motherhood has allowed me to discover a new phase of myself. Even though it can be very hard because I don’t have a family that is here, it is also very rewarding”

In one case, a participant was assisted by a stranger she met at the park. This was the woman who received no information about organisations, baby clothes or Universal Credit from her health visitor:

> “After, thanks to a person she met in the park when she was in the playground with her kid, she got to know different organisations that support mothers and parents. After that, everything became easier. But, she felt she didn’t have support from the health visitor and it is very important that the health visitor is informed about support available and can signpost mothers”
>
> (Translation by interpreter during focus group)

Another participant wondered whether certain information was only given to wealthy people. Another noted:

> “First of all, the NHS needs to give more information to mothers and treat them with respect”
>
> (Translation by interpreter during focus group)

Healthcare Professionals

Participants discussed various strategies for improving maternity care, including personalisation, cultural sensitivity and community engagement. Overall, the discussion centred on personalised care – primarily through confidentiality and anonymity – and robust systems of emotional and practical support provided by healthcare professionals and community networks. Participants shared their own experiences of providing culturally competent care.

Time and Communication

Importantly, healthcare professionals were aware of the structural and systemic constraints facing those working in the NHS. The biggest barrier to providing a high standard of care was time. Time was felt to be short more acutely in instances where service users did not speak English with fluency. Not only did they have to try to find interpreters, there was also a sense that ideas, symptoms or beliefs might be missed due to an incongruence in language.

> “Sometimes language is a barrier. We all speak English, but even the language I’m using and the dialect of the person I’m speaking to at a certain time can be hard. And I think we all come from areas with different health beliefs and trying to see everyone’s side of the story… Does that make sense? In a day to day basis that’s what I see when seeing mums and families”

When asked to expand on cultural beliefs posing a challenge in the provision of healthcare, the same practitioner, an obstetrician, noted:

> “I think it sometimes comes up where birthing people, mums, really don’t want a Caesarean section for various reasons. And discussions about what would happen if that did happen, or was necessary. So

> those things come up a little. And challenges around abnormal antenatal scans, when does your baby become too small or too big?"

Related to the question of language, 'health literacy' was raised as another potential barrier to the provision of care to black and minority ethnic groups in the borough.

> "I think health literacy is a big component here in terms of the challenges we face. Sometimes their understanding of medical conditions and recommendations of treatment can sometimes pose a challenge. But again I think sometimes it does come down to cultural beliefs as well and really trying to unpick that with them. But it's trying to have that time as well, to sort of, sit with women and actually unpick the things in a lot more detail and understand where they're coming from and then sort of explain it, explain it in a way that they can also understand"

As this community midwife indicates, questions of understanding and communication in clinical or medical settings are made difficult by time constraints alongside language and "health literacy". Health literacy is usually used to refer to an understanding of specific health terms or issues.

One practitioner expanded on the connection between time and communication through connecting the people she sees to wider services.

> "For me it is usually around engagement with other services before they get to us. So big things being communicated, how messages are being put across, and judgement. It's often things we can't really help with which is really frustrating"

For this healthcare professional, who works with a community facing organisation supporting mothers in Southwark, barriers of communication were interlocked with the maternity services relationship to other support in the wider community, discussed further in the next section.

Despite many of the healthcare professionals speaking of "cultural beliefs", there was little extrapolation as to what they encompass. However, one midwife did specify an example from the ward about communication and dialect:

> "We had a mum who was talking loud, and people thought she was being aggressive, she was being loud. But I understood it's not loud, it's just her way of talking. When she talks to us, we could reassure her and remind her she's on a ward [..] So she said she could relate to me because I understand her. This is not a mum that's being aggressive or agitated, it's just her presentation, the way she speaks and expresses herself"

Another practitioner noted it is important to have a diversity of culture working with all people to develop an understanding.

Relationships with Services Outside of the NHS

Healthcare professionals felt connections with broader services, including social services and housing, were inadequate. Many of them noted the connection between physical and mental wellbeing and quality of life outside of the immediate clinical encounter. Sometimes, they felt they were not equipped to ensure a service user's total wellbeing due to circumstances outside of their control and outside of the hospital.

A community-facing healthcare professional, mentioned in the previous section, expanded on difficulties of communication between different services, not always seen to be connected to maternity care. She explained:

> "They may be having issues with, for example, housing, which is not our area. But you'll hear about how they're not properly being treated and it always shows there's lots connected and lots that we really can't do anything about and it's really quite awful"

There was a shared feeling among participants that these wider issues – particularly of housing and mental health – were out of the remit of healthcare professionals. Although they cared about the wider lives of the service users, it was difficult to enact change or improve a person's circumstances or experience of maternity services when they were perceived to be deeply connected to a much larger structural and political dilemmas in the community.

This "wider sense" of constraint in connection with other services was noted by this healthcare professional as pervasive across a number of South London and Southwark hospital districts. She explained:

> "If you think of housing and the council and everything else, in my opinion working in different areas of South London is a difficult thing to do. The council doesn't seem to be responsive or do things that garner that conversation as there are a lot of issues with a lot of people when it comes to housing, which obviously has been the main issue for a long time and is getting worse. So to have those platforms where you can have people from the general public come and have conversations where they can express stresses and grievances, I've just never heard of something like that being done. [...] Just if they could hear the among of women and birthing people that were coming through with these issues around housing"

Whilst conversations about housing and wider constraints in the council might seem to be outside of the scope of the maternity commission, it is vital to note the centrality of the 'wider world' in many of the narratives emerging from healthcare professionals and minority ethnic groups in TMGs research.

The most people felt they could do to support people with housing, finance or domestic violence – make a broad range of appeals to the council – was to write a letter of support.

A neonatal psychologist related the housing issue to single mothers from Black or Asian groups. She explained:

> "This is just an observation, but a lot of the women I've seen, who are Black or Asian, are single mums, and they're in temporary housing and moved around [...]. Often they're living in hotel rooms with no cooking facilities with small children. Some of them want to work, they're capable of doing it, but they can't contribute because they're living situation is unstable. So it is bound to have an impact on their mental health"

Alongside mental health, the impact of wider structural issues was said to affect physical health also. She expanded:

> "I mean, there are things that maybe you wouldn't even think of, like hydration, diet, sleeping properly. They all have an impact. And some people also have comorbid health conditions or they develop physical conditions as a result of maybe poverty and, you know, years of stress. It is complex"

Another participant, who works with Black mothers in the community providing self-help support through the organisation of pop-up events where women can speak about their wider struggles also noted the impact of structural issues on maternal health more widely. She also noted housing as a key problem facing many of the mothers and pregnant women she engages with in Southwark. She is quoted a length for the particularity and specificity of her example, demonstrating the feeling of being stuck and its effect on maternity, particularly soon after the birth of a child:

> “Some of the things I’ve been told is mostly to do with housing, the issue with housing is that they claim they have less housing, but some of them have even tried to get help from their MP and councillors and all of that. Even when they offer letters of support the council does not take that into consideration they just say ‘we’re sorry’, ‘we’re trying our best’, and they'll say we have a high volume of people and they ‘understand’ but there’s ‘nothing they can do at present’. And that is actually making some women really ill. To go back to the example, imagine having just given birth, and you know, being put in a box. You can’t even take care of yourself. You’re being moved, and there’s a lack of stability, and that affects your work. Most of these women actually work, they’re not on benefits, you know. They’re not receiving help from the government. However, all they want is the opportunity but they’re always put in a box.
>
> One particular lady, after having a child, was not given notice by her landlord. She was not prepared and these things can really affect you. So her mental health became very severe. She went to the council with the letters stating that and then on the day of her appointment nobody told her no one would see her. She was waiting and was never seen. At the end she was told they were short staffed. She had to return to the same condition, without anything being changed. Being a mum is already stressful, but adding something on top of it, it does not help at all. I just feel certain communities are marginalised in my opinion”

A senior midwife suggested that some of the structural constraints related to housing, finance and mental health were often dependent on the maternity unit itself, and what services were available.

> “Depending if there are other factors which are, or make them eligible for one of our specialist teams, they’ll have more tailored care, longer appointments, and be referred to specialist services that are then able to sort of, link in with other community-based services. I know at King’s we have our maternal

> medicines team, so they work with people who are high risk and have medical complexities in their pregnancy. They're already linked into a lot of sort of MDT [?] work with medical and healthcare professionals. We have the lotus team, so if someone's been diagnosed with a severe mental illness they'll be referred to the lotus team who work closely with other mental health services and other community services. Once maternity care has ended, they're already sort of plugged in with services to support their mental health and long term sort of, help in life"

This midwives understanding of the available services was closely linked to her role at King's. She was proud to share the work King's is doing, but it is worth considering who might fall through the net when services are tailored to particular expressions of mental ill health or medical complications. As explored in the next section, Stigma, it is not always possible for people to share their mental health concerns.

In addition to housing, a maternal mental health specialised raised the significance of fears of social services:

> "I have worked with mums before who haven't wanted to disclose certain things because they're worried they're baby might be taken away, or other consequences. So in assessment, I might ask it as bluntly as that: 'do you have any worries about being linked in with services?', 'do you have any concerns about working with me'. That can be a good starting point where I can say 'yes, maybe we will have to bring other services in but I will always have that discussion with you first'. [...] I can't just assume someone is going to trust me, because that's not helpful for anyone"

The comments above tie in questions of trust and fear of punitive action by maternal healthcare services if connecting with social services.

Stigma

For some, stigma was a key issue affecting the delivery of maternity care, particularly in conversations around mental health.

> "Just from a mental health point of view, I think that stigma is kind of central to engagement with services. And trauma, people who have been through traumatic events are the people we see most commonly. The combination of stigma and trauma can be quite debilitating and often people don't feel they have support from their communities or families because of the stigma, they don't feel they can feel how they should feel. And that can be culturally informed as well"

When asked to expand on the specificity of the stigmas this cognitive behaviour therapist who has worked with mothers and pregnant women had seen in the community, she explained:

> "King of having, feeling depressed and postnatal depression, feeling like they can't cope or struggling just with being a new mum or having you know, a lot of people with housing difficulties, financial difficulties, domestic violence. All of those can be really stigmatising especially in certain communities and certain groups. It's quite broad but there's a lot of 'I shouldn't be feeling like this', 'I'm a bad mum', 'I must be crazy'. So a lot of the work we do is around that"

Importantly, the cognitive behavioural therapist links the issues she is facing in providing maternity care from a mental health approach to wider structural issues, some of which are mentioned in the previous section. Housing, previously noted, was an important connection to mental health and maternal support in the perinatal period.

Here, understandings of cultural practices were raised in specific terms. Though the example was not addressing 'stigma', it spoke to this theme through noting how perceptions of cultural practices seen as 'disruptive' or 'unreasonable' by healthcare professionals might derive from a misunderstanding of their context. A midwife explained in relation to Pentecostal Christian expression:

> "Okay, so this person was a religious Christian, and the way she was worshipping, I call it worshipping, they deemed it as something she was doing because she was paranoid or whatever. And I said no, I understand where she is coming from because I am a Pentecostal Christian, so I understand what she is doing, I get what she is doing, and it is nothing that should be taken out of context. So by advocating for that mother she was allowed to express openly. And I could see changes in other Christians, who were able to come and completely worship, free to do what they wanted in terms of reading the scripture and all of that."

To address stigma, the cognitive behavioural therapist suggested 'normalising' mental illness, particularly trauma, in the community, a sentiment shared by a number of healthcare professionals. This is also related to the expression of certain cultural practices explored earlier, where characteristics of behavioural, emotional or linguistic expression can contribute to how a person is perceived by those working in healthcare.

Creating Inclusive Healthcare Environments

As this section indicates, creating inclusive healthcare environments requires more than a focus on 'maternity'. It means expanding the connections between maternity services and wider community support – whether with housing, employment, finance or mental health.

A midwife at King's who also works with family hubs noted the importance of early outreach and engaging the wider family or network of support.

> "Including birthing partners from the beginning and inviting them to any classes and to all appointments. I guess if you're in work, thinking about when your appointments are so that other birthing people can come knowing that … obviously as the mum you can get time off work. But many of the birthing partners can't get time of work so feel less involved"

Her comment contributes to the discussion of Time and Communication. However, it also highlights how valuable support from lay-networks – friends, family, birthing partners – can be for birthing women and people.

Another midwife at King's noted they do specific antenatal classes specifically for Black and Mixed-Black heritage groups. This is delivered through a sign-up scheme marketed through signposting initiatives and posters with QR codes around the clinic. A college a community midwife offered an evaluation of the specific antenatal classes:

> "I think there could be better attendance, but that's on our side in terms of advertising it and ensuring we have regular classes to become part of our normal scheduled parent education. It is not only those classes that have been effective, we're also just trying to promote uptake of our parent ed classes in general. With the Black and Black mixed we offer that in person. And it's not just about labour cases it's also about health advice, we go through stuff like the MBRRACE report and the stats. Just educate them about accessing care, a healthy pregnancy, diet and exercise. Partners are included in the classes that we run."

Further, suggestions for promoting inclusive care were linked to Relationships with Services Outside of the NHS. The same community midwife at King's centred children's centres as key points of outreach and engagement:

> "We are looking to go back into our children's centres a lot more. Being based in the local communities. We did sort of move away from it over the years and be centrally based in the hospital but our plan is to go back out into the children's centres so that we can actually link them very easily into other services that run from the children's centres, which we know are excellent. There are a lot of classes and mental health support there. So, we're trying to get back into that. And I know that family hubs are also moving back into Southwark as well. That will be another great space for maternity staff linking with mental health services and other community based services to provide holistic care for women accessing our service."

To address mental health needs, a perinatal mental health nurse emphasised the significance of personalised relationships with each service user. When asked about potential strategies to address the unique mental health needs of black, Asian and other minority ethnic mothers or pregnant women, he explained:

> "The key thing is asking. That for me would be important for all our patients. The key thing, and I think people have talked about time, so it depends if people have time for it also. But I think with a lot of the efforts that people are making, to make the maternity service more inclusive, is that its about asking people about what they want and how they can be supported, it can be about asking on their perspective of mental health. Personally, I'm often quite wary of generalising too much. [...] Just because somebody comes from a particular culture or has a particular ethnicity doesn't mean, from my perspective, that they have a particular perspective on mental health. [...] So for me, it is just about trying to provide as individualised care as possible. So there needs to be a rigorous assessment of people's mental health experiences. And, I guess, there needs to be an understanding about how different people might communicate that. People from different communities might be more or less likely to communicate in

> various ways. But it is really about trying to raise awareness of difference, that's probably the most important thing. [...] I think it is important to note that people's engagement with services is often based on the service's engagement with people."

There is a tension between the NHS efforts to provide personalised care and also be culturally competent that seems to emerge in this practitioners account. However, it is also interesting to note his challenge to the idea that it is the burden of the service user to engage with the service.

In response, a bereavement nurse stressed the importance of an intersectional approach.

> "Always try to hold in mind intersectionality. We're thinking about race, but maybe we're also thinking about class, language, ability. And actually, all of those things are really important."

When speaking about building trust, a maternal mental health practitioner noted trust cannot be assumed. This was linked to Time and Communication. She noted:

> "I think it is about time and not pushing too hard. It is also empowering someone to say, 'you know what, I don't want to talk about that right now'. I think that can be quite nice. Because it sets up something where they might need to bring it up in a week or two, but if it doesn't feel safe right now that's okay. There might be things to push more on if there are safety concerns but it is about deconstructing the power as much as possible. Of course, the power dynamic is always there."

A participant working in family hubs and midwifery noted how this dual role gave a perspective on the challenges "on both sides". Addressing creating more trustworthy and inclusive healthcare environments, she spoke about how healthcare professionals change roles frequently and how this might affect trust:

> “When we look at health professionals, they change roles quite frequently. And actually, sometimes that can lead to distrust. But when you look at community leaders, it tends to embody who they are. So they tend to have really good, long lasting relationships with their communities. So obviously there has been a lot of talk around the commission with regards to us as healthcare professionals going into spaces that the community feels safe. Because actually, we’re asking them to come to us and they’re seeing a lot of different faces each time. They don’t want to have to retell their whole story over and over again, hoping that you will understand where they come from, where they are coming from.”

She noted a lack of capacity and funding, linked to structural issues explored in Relationships with Services Outside of the NHS, mean the NHS cannot always help those seeking wider care. In response, she suggested working more closely with community organisations “who actually know what they’re doing”.

A community based support worker expanded the point through suggesting promoting inclusive healthcare environments would require better staff training.

> “We need to think about training the staff. [...] When you’re seeing women and birthing people and supporting birthing people, you need to be able to pick up on where people are coming from. You know when someone is talking to you because they really care, and when you know they’re like ‘okay, I just need to get, you know, I have another patient to see”

This was linked to questions of recruitment by the same practitioner, feeding into the notion that people do not get to see the same staff – the lack of continuity of care – might affect trust and openness from Black and minority ethnic communities. Working in the community was seen as potentially promoting better services:

> "This goes into recruitment. Because, what X was saying around inconsistencies and people changing [...] in the community it is a different picture. [...] There is definitely a different kind of energy that comes with that and people will want to engage. I used to work with SureStart Centres and people really liked that, they could come there and talk to all types of professionals"

Related to recruitment, community and employment in creating inclusive healthcare environments was racial or ethnic congruence with practitioners. A perinatal nurse spoke about Black staff in nursing teams and the effect this has on openness and engagement with services:

> "When I first started in the community we had only just one Black staff member on the nursing team. Now that seems to be changing. We had a discussion the other day and someone on my team, a senior nurse, we were talking about the benefits of having a more ethnically diverse team. Quite unintentionally, when we decide who is going to take on which mum, I think it is unintentional that I would more likely gravitate towards Black mums, and decide I was to take those on my caseload. I think that I can, you know, relate to them as well. It makes you feel good when you walk into these homes and see that Black mother. It makes you feel like you have a relationship with them as well, they understand your background and you understand where they're coming from"

This might also feed into questions of staff training, as well as some of the constraints outlined by healthcare professionals in relation to Stigma. However, the idea that racial or ethnic congruence builds trust was contested by some practitioners. Another community facing midwife who has worked inpatient noted in response to the above:

> "Can I also say I've worked with mums in the inpatient setting that didn't want to work with someone that looks like them. And I suppose you have to think about every person as an individual, because this mum had a really negative experience with her own mother and so she didn't want anyone who looked like her mum"

The comments are somewhat reflective of those given by the perinatal mental health nurse, weighing out the tension between personalised and culturally competent care.

Many of the community facing healthcare professionals felt people felt more comfortable in their own homes, particularly when there is continuity of care.

> "I think that the element of trust when you come into their home builds a really trusting relationship with them. And it does make them look forward to seeing you"

This was sometimes likened to feelings of friendship creating a sense of safety.

Overall, a perinatal mental health nurse wrapped up some of the key takeaways for creating inclusive healthcare environments drawn from the focus group. He noted:

> "I find once people have an awareness, and once you give people that awareness of what's happening to people and what people are up against… I just feel people innately have the tools to make that count. It is just about how we make all of this count. So that it actually matters"

Disability and Neurodiversity

At the workshop, one attendee from the Black and Mixed-Black group required the use of a walking stick, visibly indicating her disability and accommodations were made to ensure her comfort in participation. When speaking, she referred to her “condition” without explicitly naming it. The participant’s story related to the loss of a child at term. At 40 weeks and 10 days, the participant went to hospital after feeling she was about to go into labour. The midwives sent her home because she was not dilated enough and requested she come back the following day. She was required to pay for a taxi home, “despite [her] condition”:

> “By the time I came back it was too late. I lost the heartbeat”

In the Latin American Focus Group, receiving information about health results during pregnancy was noted to have been delivered insensitively, without considering the kind of support a person might need when making crucial decisions. One participant offered the following specific example:

> “During her third pregnancy, they made a blood test, and they called her to give her results. When they called her they didn’t ask if she was with any family members. They just called her over the phone and told her her son had Down’s Syndrome. Then they asked her whether she wanted to continue with the pregnancy or not. They said all of this over the phone, not making sure there was any family around”
>
> (Translation by interpreter during focus group)

To make this situation more complicated, the participant decided to continue the pregnancy. After the birth of her child, she found he did not have Down’s Syndrome but was diagnosed with autism. This is an important consideration in relation to disability and neurodiversity, and the way testing results are delivered. After the child was born, and later diagnosed with autism, the participant felt those she sought care from at King’s College Hospital did not pay enough attention to her concerns. This was partly related to the need for interpreters, but the speaker also emphasised the need for people seeking care from the NHS to know their rights and what is available to them.

When the participant who received a false Down’s Syndrome diagnosis over the phone had given birth to her child, he needed to be checked up. This participant went into the hospital for tests”

> “She feels that they treated her baby poorly. They couldn’t find the vein, and she saw them being rude to the baby. This was in King’s College Hospital. When they wanted to do a blood test on the baby they were not treating the baby properly. There is no support for parents with children with disabilities, none for therapists or special schools. She said all the doors were closed to them and the family suffers in these circumstances because they don’t know where to go. And she says then mothers tend to isolate themselves”
>
> (Translation by interpreter during focus group)

It is important to stress that disability or neurodiversity of a child can affect the maternal experience. In the Black and Mixed-Black workshop, a mother shared that after finding out her child had severe learning difficulties in his early years she started independently researching the social impact of neurodiversity on black children. She described being led to do this research after hearing about “disparities and the long history of black women in medical care in general, the disparity of black men and mental health …”. This mother found that children with special educational needs and disabilities were more likely to face barriers at schools, or as she put it:

> “Are not care for as much when they’re black and at school”

This mother felt wider social inequalities affecting black children were likely to affect her child, causing anxiety about how best to advocate for his needs.

Discussion

This section summarises the findings from across the demographics reached and through each methodological approach. A thematic approach is taken to draw together the varied experiences of each participant group. The eight themes explored include: Advocacy and Agency; Racism and Racialised Stereotyping; Listening; Stigma; Strengthening Relationships with Other Services; Continuity of Care; Cultural Competence and Sensitivity; and Intimate Network Involvement and Support.

Advocacy and Agency

Through all groups, advocacy emerged as a central theme defining experiences, desires and understandings of the role of maternity services. This is sometimes configured around receiving support centring individual and collective experiences, including concerns about personalisation of care and patient advocacy needs.

Service Users

In the Black and Mixed-Black groups, having a midwife who was attentive to the birthing or mothering person's desires and emotions was highlighted as enabling positive experiences of care. Friends and family could also act as advocates in labour when the birthing person had devised a plan or list of expectations for how the process would unfold, and intimate support could ensure practitioners were reminded of the significance of the person’s choices. Some of the Black and Mixed-Black participants noted the ethnicity of their midwife as having a potential impact on the quality of the care and communication received. To increase an ability to advocate for oneself, a participant in the Black and Mixed-Black group suggested the organisation of specific and tailored groups could empower people to form connections and share information that was relevant to their shared and individual experiences. This is noted in the case study on the significance of signposting, where a participant reflects on a feeling that many services, organisations or networks remain unknown. Advocacy for oneself was also emphasised in the Black and Mixed-Black results, where an awareness of racial inequalities in maternal healthcare impacted how participants prepared for their interactions with healthcare professionals. Sometimes, this was linked to an intersectional experience drawing in one's profession, as in the case of those who occupied positions as both mothers *and* healthcare professionals. These participants sometimes had a better understanding of the resources available to them, whether pharmaceutical or therapeutic. However, self advocacy was not always an effective tool, as the case study of the 'young' mother indicates. Despite revisiting the hospital numerous times with concerns, she felt she was "brushed off", overlooked and did receive adequate attention from a variety of practitioners working in different departments.

In the South Asian group, advocacy was shown to be supported through precise information about a child's health, contrasting with the Black mother who wished she could have received more information and attentiveness when her child was diagnosed with colic.

In the Latin American group, the shock of hearing of a child's potential Down's Syndrome diagnosis without consideration for how this information was communicated seems to echo how an inattentiveness to needs of the person receiving this information can lead to feelings of disempowerment and disrespect. Friends and family, alongside those in the wider community, were highlighted too by the Latin American group as able to advocate for a mother or birthing person. The Latin American group also felt language was a barrier to effective advocacy and desired better interpretation or translation skills to ensure someone was physically present to advocate for their needs. The Latin American group emphasised the need for better breastfeeding support in the postpartum period.

Some of the participants from the Gypsy, Irish Traveller and Roma group noted communication could have been better. A positive experience noted it was framed by an understanding of what was taking place.

Healthcare Professionals

One healthcare professional also expressed a desire to see public forums for people to talk about their stresses and grievances with the council as a whole – linking this their concern with housing and the difficulty of advocating for service users trying to appeal to housing services for a safe, comfortable and dignified place to live.

Racism and Racialised Stereotyping

Service Users

Across the Black and Mixed-Black, South Asian and Latin American groups a variety of experiences of racism or racialised stereotyping were made visible. A South Asian woman noted an assumption that she would have diabetes because of her background, a Black mother noted her age and ethnicity might have impacted her care when she was overlooked by numerous practitioners, and many of the Latin American women detailed being ignored, underestimated or treated differently to those around them because they did not speak English fluently.

Participants described rude behaviour or offensive comments from healthcare professionals – a South Asian participant was called a “fat cow”, a Latin American woman’s mother was told to “shut up”, and a Black mothers mental health was overlooked by her general practitioner after giving birth. This demonstrates the need for more awareness around the kind of language used to communicate with those from ethnic minority backgrounds and how microaggressions can reflect and effect a perception of the racial inequalities in maternal healthcare.

Healthcare Professionals

Among healthcare professionals, cultural and religious modes of expression were raised as frequently misunderstood or pathologized by practitioners, whether praying or speaking at a certain volume. Some of the Black participants in the healthcare professional group felt their ethnic or cultural congruence with a person seeking care made them more attentive to the variations in cultural practices that might make themselves visible in healthcare settings.

Listening

Service Users

A lack of clear communication, being overlooked, or not being listened to, or being told what to do were highlighted as common themes among the groups. In the Black and Mixed-Black group, a participant lists a number of things that happened to her without being given choice nor explanation, despite being a healthcare practitioner herself. The young mother in the Black and Mixed-Black group had an experience defined by not being listened to in multiple instances, her concerns were overlooked and she characterises this as negligence. This participant wanted referrals to be made and more communication between doctors and midwives. It was also central that doctors and midwives ensured those they were speaking to understood what was being communicated, as some women indicated feeling unsure or not knowing what was taking place.

The mode of communication, of listening, speaking and being heard, was seen as an important factor in the experience of a South Asian participant. She felt her midwives spoke to her abruptly and impatiently, leading her to feel she could share her own concerns. Another participant in this group described being "addressed" by two midwives and a doctor about her emotional response to the birth of her child. Despite not feeling depression, she was referred to a specialist in this area, causing a "massive shock". This draws out the importance of asking and listening attentively, and understanding responses to any event in the reproductive experience might not always look the same.

In the Latin American focus group, the confusion and lack of attentiveness around appointment confirmations was raised by one participant. She struggled to know whether her appointments were being upheld, and when she went to check she found they had been cancelled, or was asked to show identity documents to confirm she was on their systems. Her child passed away, which she pinned to, like the 'young' mother in the Black and Mixed-Black group, negligence by hospital staff, who did not listen to her concerns.

It is important to emphasise modes of listening that are attentive to emotional expression, rather than only listening to the words a person says. In the Latin American groups, crying was a central mode of emotional expression through which participants reflected fear, uncertainty, or a lack of understanding where translators were not available. A participant in the Black and Mixed-Black group also described crying to her doctor when a clear description of colic's effects on her child was not given.

Healthcare Professionals

For healthcare professionals, listening was linked to structural and systemic constraints facing those working in the NHS. One of their central concerns in terms of *being listened to* was in their efforts to mobilise other council services in support of service users, as explored thematically in advocacy and strengthening relationships with other services. In the focus group, this demonstrated that healthcare professionals are listening to the concerns raised by service users and understand the shared responsibility of public services to address their needs.

Healthcare professionals also emphasised the difficulty of communicating with those who speak English as an additional language or ensuring a shared understanding even when there was linguistic congruence. This broadens listening to include communication, encompassing the experiences of providing advice and ensuring understanding. For example, the obstetrician noted that providing information about the necessity of certain procedures, in this case a Caesarean section, could be difficult when the birthing person did not want to undergo the procedure. In expressing this concern, the professional linked listening to advocacy, highlighting the competing expectations of service users and professionals. A potential mode of ensuring effective listening and communication was having time to gather details about a service user and understanding the source of their concerns. This could aid professionals when providing explanation and reduce ambiguity around whether a concept has been understood.

Listening involved moving beyond spoken language and into other modes of communication for healthcare professionals also. Some were conscious of the variety of cultural expressions that could be easily misinterpreted on the wards. This could be related to religious expression or even the volume of the voice.

Stigma

Service Users

Few participants in these groups mentioned stigma by name, but they did allude to its presence in their treatment. For example, in the case study from the Black and Mixed-Black group on ‘knowing the NHS’, the participant noted how the midwife’s comment about the epidural made her feel more comfortable accepting this form of pain relief. This was linked in her narrative to the midwife herself being Black, as the participant evokes a ‘sisterhood’ in the midwife’s concern for her pain and experience. Moreover, the ‘young’ mother felt practitioners saw her in a certain light influenced by her age, gender and ethnicity. The idea that everyone was older than her impacted how she was listened to demonstrates her feeling of being judged, or stigmatised, because of her pregnancy at the age of twenty-one.

The Latin American group highlighted feeling stigmatised about going to work after giving birth during home visitations. Two participants felt the mode of questioning by their visitors was judgemental or rude, undermining their ability to be employed and care for their child. One of the participants felt better information about organisations or services to support new mothers, including Universal Credit, would have been beneficial.

Healthcare Professionals

In the focus group with healthcare professionals, stigma surrounding postpartum mental health emerged as a central concern. This was seen to have a far-reaching effect on communities and families, leading to feelings of debilitation caused by a lack of information. Stigma could also emerge through wider factors in the maternal experience, linked to the next theme of ‘strengthening relationships with other services’ where issues with housing, finances or violence are perceived to make it more difficult for service users to seek care from healthcare professionals.

Strengthening Relationships with Other Services

Service Users

Strengthening relationships with other services was raised primarily in the healthcare professional group, but was also apparent in the Latin American and Black and Mixed-Black groups.

The Latin American group centred the need for more robust support networks outside of hospital settings – such as knowing where they can find resources to look after their children, or financial and housing assistance.

In the Black and Mixed-Black group, participants alluded to the need for support in paediatric services (such as the child's colic diagnosis) and mental health. It was also found that the relationships and experiences of Black people with a range of healthcare services affected how a person expected they might be treated in maternal healthcare services, whether it be schools, mental health support for Black men, or a wider history of negligence or discrimination against Black women in medicine. It was positive when community-facing professionals were attentive to Black women's needs.

Healthcare Professionals

The healthcare professionals emphasised housing as an area of concern and a sense of helplessness. They felt the council was not responsible to practitioners' requests to make available safe, dignified housing for the service users struggling to find a comfortable place to live. They also noted empathy for those who are living in temporary housing or hotel rooms where they cannot cook for their children. Temporary housing for new or expectant mothers was additionally seen as a barrier to gaining employment because of the uncertainty and instability of this condition.

As indicated through the theme of stigma, some participants felt healthcare professionals could have been better at signposting them to relevant services, including Universal Credit, to support them after giving birth.

Continuity of Care

Service Users

Particularly in the Latin American group, continuity of care emerged as a possible tool to ensure women felt cared for and treated with respect and dignity where language barriers were a concern.

This theme also emerged in the Black and Mixed-Black group, as in the story from the ‘young’ mother who saw many different healthcare professionals, all of whom seemed to overlook her needs. Continuity of care could be most pivotal for those who occupy intersecting positions of structural disadvantage.

Healthcare Professionals

This theme also made itself visible both in the accepted meaning of the term – seeing the same person each time – and in the more expansive definition – ensuring robust care is provided once a person has given birth, ‘the care continues’. For healthcare professionals, this meant looking at how negatively health-impacting factors such as poor housing, lack of cooking provisions or financial difficulty can be strengthened for those service users who need it most.

Service Users

Across the service user groups a need for greater attention to cultural competence and sensitivity from healthcare professionals emerged. This was indicated in the Latin American women's descriptions of how they noticed or felt others were treated better than them due to a range of factors centring language. In one case, when a participant's mother was told to 'shut up', the need for this competency and sensitivity to be extended to the service user's family, friends of other intimate networks was emphasised.

In the South Asian group, as explored in the section on racism and racialised stereotyping, the idea that diabetes was most common amongst this "race" demonstrates the need for more robust anti-racist and cultural sensitivity or competency training. If comorbidities are found to have a high prevalence among certain ethnic groups, work should be done to ensure the communication of this likelihood is delivered sensitivity and with respect for the dignity of the service user and their own understanding of their healthcare conditions.

Moreover, in the Black and Mixed-Black group, where some of the respondents worked in healthcare themselves, their ability to advocate for themselves was not always bolstered by this position – at times they felt more wary about how they would be treated, and thus paid more attention to the tools of advocacy – because of their knowledge of healthcare cultures. In the extreme case of the young mother whose child was stillborn, she ties her treatment to healthcare professionals' perception of her as a young black mother, and the societal tropes and stereotypes surrounding this intersection.

Healthcare Professionals

Healthcare professionals touched on the theme of cultural competence in reference to the beliefs or expressions of service users. They also found certain conditions, medical and otherwise, might be more stigmatised in certain ethnic groups, where approaching NHS services for assistance might be made difficult because of how they think they will be perceived. This was indicated in the cognitive behavioural therapist's insights.

Intimate Network Involvement and Support

Service Users

Many of the participants spoke about the role of their intimate network in providing support during their maternal experience. Whether this was one's husband, friend, or mother, or even a friend who was a midwife or a stranger in a park, participants utilised a range of social support networks in and outside of hospital settings. This highlights the need to be attentive to the role wider intimate networks play, and include them in efforts to address maternal health inequalities.

Supporting Equity and Justice

Significantly, this report provides vital information in supporting Southwark's goal to become a borough of equity and justice. First, the report highlights the connections between maternity care and other social provisions and support in the area including housing, mental health support, community groups and networks, language and interpretation services, social services, children's services, and health and cultural education. Listening attentively to the voices of those who participated places Southwark in a strong position to affect local police and ensure trust, accountability and openness in the borough.

To promote justice, it is central to consider the competing interests of those in a position to affect change and ensure equitable delivery. For example, as much as some of the participants in the Latin American group felt wider structural constraints affected their care and treatment, healthcare professionals sometimes felt immobile in addressing their key concerns. Many healthcare professionals take it upon themselves to learn how best to navigate the difficulties of working in the NHS in a context of short appointments, limited resources and wider social challenges. However, the healthcare professionals noted they cannot be solely responsible for ensuring good health and equitable treatment, when attempts to improve the overall health-impacting conditions of those they serve can be difficult or feel inadequate – such as writing a letter to no effect. Thus, in addressing the findings of this report, it is important to consider these connections and strive to empower each group through robust systems of support across the board.

Recommendations

6. **Strengthen community support**
    a. Provide tailored group care in the antenatal and postnatal period
    b. Chart existing organisations already providing support and advice for women from diverse ethnic backgrounds in the borough
    c. Ensure funding and space for social gatherings to promote advocacy and knowledge exchange between mothers, healthcare professionals and wider support networks (including friends and family)
    d. Devise stigma reduction strategies with community groups and organisations representing marginalised populations in Southwark
7. **Ensure availability of interpretation and translation services**
8. **Strengthen the capacity for healthcare professionals to advocate for service users**
    a. Strengthen healthcare professionals' capacity to communicate and advocate across other Southwark Council services, including housing, Universal Credit or financial services, and child support
    b. Ensure healthcare professionals have time to provide personalised care to service users, particularly those speak English as an additional language
    c. Ensure continuity of care is available to those who need or request it, particularly those who speak English as an additional language
    d. Implement mandatory anti-racism and cultural competency or sensitivity training for maternity staff across a range of departments (i.e perinatal mental health, obstetrics, midwifery, home visitation)
    e. Provide tailored training on kindness, empathy and respect learning from the accounts of those in the community emphasising tone, language and questioning

   f. Ensure information is provided sensitively and accurately to all service users, particularly when using remote communication devices such as telephones

9. **Ensure robust breastfeeding support for all service users after birth**
10. **Ensure robust mental health support at all stages of maternity care**
    a. Make sure signposting to services both in and outside of the NHS is clear and available

Appendix

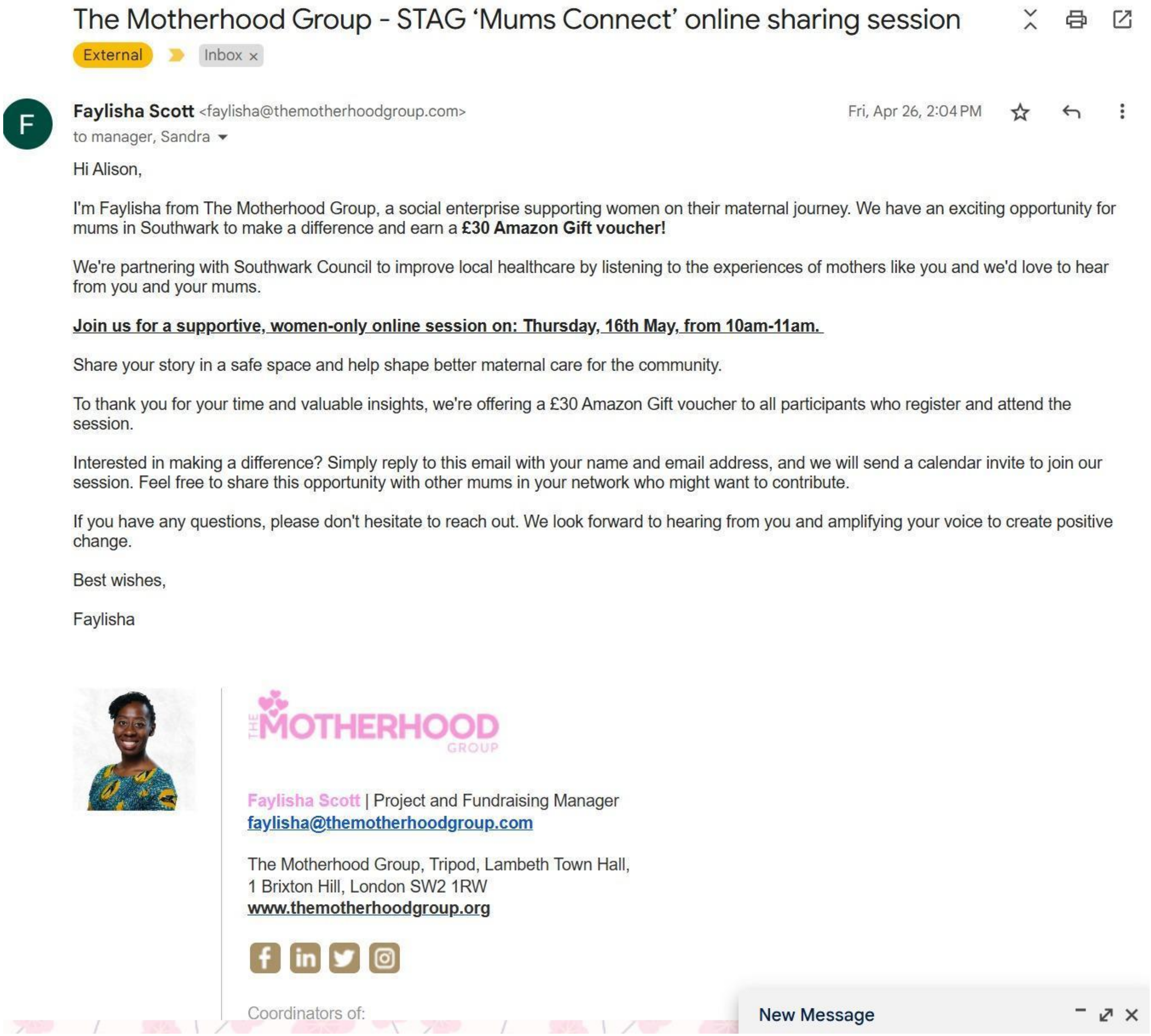
Appendix 1: STAG Reponses Table

Where did you receive maternity care?	When was your last experience of maternity care?	How was your experience of ante-natal care?	How was your experience of care during childbirth?	How was your experience of postnatal care?	Please share any comments or feedback about your experience of maternity care here	What happened to you and your baby, how easy were services to use and what was your experience of maternity care?	Had you experienced poor mental health after your baby was born?	If yes, was it easy to get support for your mental health after your baby was born?
Bromley University Hospital	6-12 months ago	Very positive	Very positive	Very positive	I had great care.	They did contact me all the time.	No	N/A
St Thomas' Hospital	2-5 years ago	Very positive	Very positive	Positive	Some great views	We were contacted at all times	No	N/A
St Thomas' Hospital	6-12 months ago	Neutral	Neutral	Neutral	They weren't the best but I did receive after care	I had to ring them.	No, I don’t think so.	N/A

St Thomas' Hospital	2-5 years ago	Positive	Positive	Positive	All good.	All good.	No	N/A
Lewisham	6-12 months ago	Negative	Negative	Negative	Not so good.	Not the best service	Yes	No
St Thomas' Hospital	1-2 years ago	Positive	Positive	Positive	I had some great experience and understanding	We were looked after	No	N/A
Bromley University Hospital	6-12 months ago	Neutral	Neutral	Neutral	It was OK	Fine	No	N/A
St Thomas' Hospital	1-2 years ago	Positive	Positive	Positive	It was fine.	We were looked after	No	N/A
Kings College Hospital	2-5 years ago	Positive	Positive	Neutral	I did think they could do better with our community Explained things better	Not too easy to use	Yes, some?	No, not really
St Thomas' Hospital	More than 5	Positive	Positive	Positive	It was fine, as expected	It was fine	No	N/A

	years ago							

Appendix 2



The Motherhood Group - STAG 'Mums Connect' online sharing session

Faylisha Scott <faylisha@themotherhoodgroup.com>
to manager, Sandra
Fri, Apr 26, 2:04 PM

Hi Alison,

I'm Faylisha from The Motherhood Group, a social enterprise supporting women on their maternal journey. We have an exciting opportunity for mums in Southwark to make a difference and earn a **£30 Amazon Gift voucher!**

We're partnering with Southwark Council to improve local healthcare by listening to the experiences of mothers like you and we'd love to hear from you and your mums.

Join us for a supportive, women-only online session on: Thursday, 16th May, from 10am-11am.

Share your story in a safe space and help shape better maternal care for the community.

To thank you for your time and valuable insights, we're offering a £30 Amazon Gift voucher to all participants who register and attend the session.

Interested in making a difference? Simply reply to this email with your name and email address, and we will send a calendar invite to join our session. Feel free to share this opportunity with other mums in your network who might want to contribute.

If you have any questions, please don't hesitate to reach out. We look forward to hearing from you and amplifying your voice to create positive change.

Best wishes,

Faylisha

THE MOTHERHOOD GROUP

Faylisha Scott | Project and Fundraising Manager
faylisha@themotherhoodgroup.com

The Motherhood Group, Tripod, Lambeth Town Hall,
1 Brixton Hill, London SW2 1RW
www.themotherhoodgroup.org

Coordinators of:

Appendix 3

THU 06/06/24 11:45AM - 1PM

Maternity Care Professionals Virtual Lunch & Share

Calling all healthcare professionals who work at King's Hospital, Guy's and St Thomas' Hospital, Maudsley Hospital, or are residents in Southwark!

Join us for a virtual Lunch and Share workshop to discuss your experiences in providing maternity care and engaging with Black, Asian, and ethnic minority groups in Southwark. Your insights will help improve outcomes for mothers in our community.

By attending you can:

Share your experiences | Provide input | Contribute to improve | Network

Register via Eventbrite

Don't miss this opportunity to make a difference in Southwark's Maternity Care

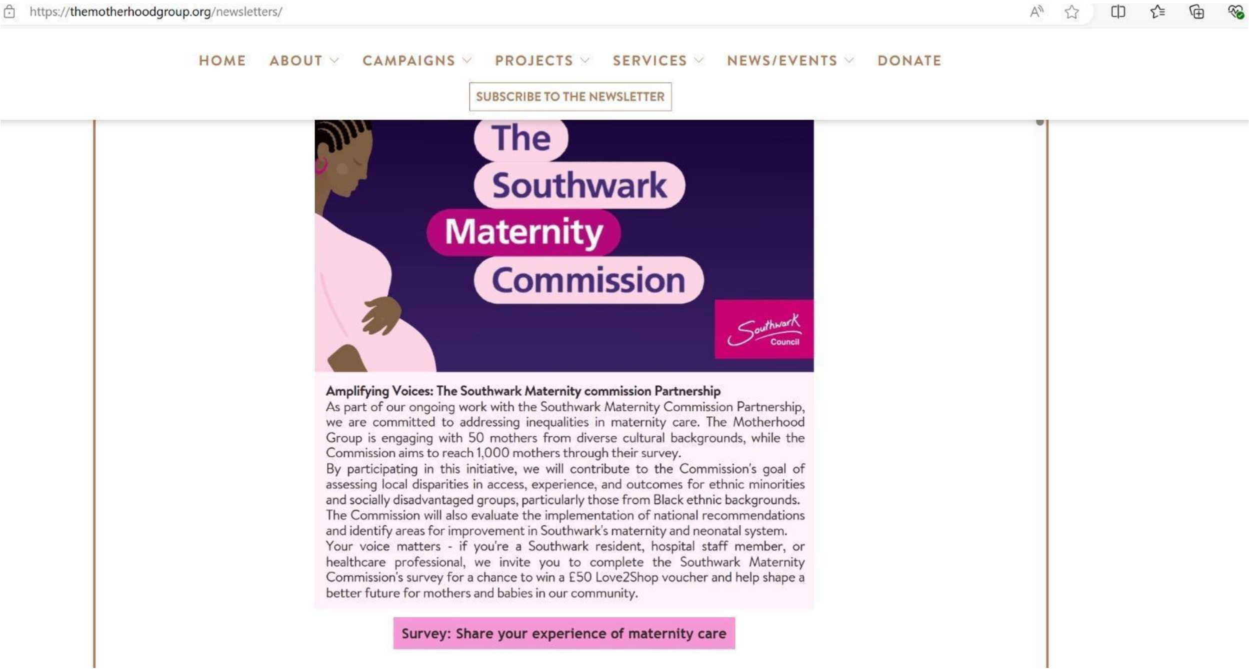
THE MOTHERHOOD GROUP

Southwark Council

Virtual Lunch & Share Workshop for HCP

The Motherhood Group and Southwark Maternity Commission have partnered to make a difference in the lives of Black, Asian, and ethnic minority mothers in our community. We invite you to join our virtual Maternity Care Professionals Lunch and Learn Workshop on 6th June 2024 from 11:45am - 1pm. During this workshop, you'll have the opportunity to:

- Share your experiences, challenges, and successes in delivering maternity care 📢
- Provide valuable input on how to better engage with and support Black, Asian, and ethnic minority mothers 💡
- Contribute to the development of recommendations for improving maternity services in Southwark 🌍



Amplifying Voices: The Southwark Maternity commission Partnership

As part of our ongoing work with the Southwark Maternity Commission Partnership, we are committed to addressing inequalities in maternity care. The Motherhood Group is engaging with 50 mothers from diverse cultural backgrounds, while the Commission aims to reach 1,000 mothers through their survey.

By participating in this initiative, we will contribute to the Commission's goal of assessing local disparities in access, experience, and outcomes for ethnic minorities and socially disadvantaged groups, particularly those from Black ethnic backgrounds.

The Commission will also evaluate the implementation of national recommendations and identify areas for improvement in Southwark's maternity and neonatal system.

Your voice matters - if you're a Southwark resident, hospital staff member, or healthcare professional, we invite you to complete the Southwark Maternity Commission's survey for a chance to win a £50 Love2Shop voucher and help shape a better future for mothers and babies in our community.

THE MOTHERHOOD GROUP

The Southwark Maternity Commission

Southwark Council

Would you like to share your maternal experience to improve maternal health outcomes for Black Women?

We are looking for:

Black and Black Mixed Heritage mothers
Who have given birth in Kings College or Guy's St Thomas Hospital
Given birth in the last 5 years

Thursday, 11th June 2024
12pm- 14:30pm
@ Peckham Library, 122 Peckham Hill Street, SE15 5JR

Childcare is available upon request

All participants will receive a £50 Love2Shop voucher

Email to register : faylisha@themotherhoodgroup.com

The Motherhood Group: Southwark Maternity Commission

The Motherhood Group has partnered with the Southwark Maternity Commission to conduct an engagement piece around the experiences of Black, Black Mixed Heritage and other ethnic community groups.

rahamproject Your Voice Matters! 🌟

The Motherhood Group is proud to back the Maternity Commission's engagement questionnaire.

This initiative is vital in understanding and enhancing maternity care for Black, Brown, and mixed ethnicity women and families. We encourage our community to share their experiences and help shape the future of maternity services.

Your insights are invaluable!

To express their gratitude, the first 5 mums to complete the survey with in-depth answers will receive a £25 Amazon voucher.

Don't miss out—fill in the survey today: https://docs.google.com/forms/d/e/1FAIpQLScgrcsA0xi6xSEvkxw0EuMpbPDAiZoS59IBDfWshb6A1dIFEg/viewform

For more information or any questions, please contact info@themotherhoodgroup.com

Together, with your help and the support of Raham Project, we can make a significant impact. Thank you for your participation and for helping us advocate for better maternity care. 🤱

#motherhood #mumssupportingmums #mumslife #parentshelpingparents #community #newmums #parenting #parenthood #midwife #midwifery #peterborough #peterboroughmidwives #peterboroughcommunity

9 w

Appendix 4

The job titles or professions provided by the healthcare professionals who participated in the focus group included, excluding repetitions:

- 'Specialist Cognitive Behavioural Psychotherapist'
- 'SLP Perinatal Improvement Workstream – Health Inequalities (South London and Maudsley)'
- 'Engagement – South East London Integrated System (Partnership Southwark)'
- 'Healthcare Professional NHS'
- 'Clinical Service Lead, South London and Maudsley'
- Community Learning and Disability Nurse, Guys and St Thomas' NHS Trust'
- 'Consultant Obstetrician'
- 'Portfolio Manager – Impact on Urban Health'

- ‘Nurse – South London and Maudsley’
- ‘Perinatal Equity Lead’
- ‘Advisory Specialist’
- ‘Nurse’
- ‘Specialist Health Visitor’
- ‘Doula and Birth Support’
- ‘Bank Midwife – Kings’ College London’

Citations and Resources

APPG Birth Trauma. (2024). *Listening to Mums: Ending the Postcode Lottery on Perinatal Care.* APPG. Available at: https://www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf. Accessed: 4/6/24.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Colour. *Stanford Law Review*, 43(6). Pp.2141-1299.

Birthrights. (2022). *Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care. Executive Summary*. Birthrights. Available at: https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf. Accessed: 21/2/24.

The Breastfeeding Network. (2023). *Black Breastfeeding Week: Facing up to power and privilege*. TBN (online). Available at: https://www.breastfeedingnetwork.org.uk/black-breastfeeding-week-facing-up-to-power-and-privilege/. Accessed: 5/6/24

Peter, M. and **Wheeler**, R. (2022). T*he Black Maternal Experience Survey: A Nationwide Study of Black Women's Experiences of Maternity Services in the United Kingdom*. FIVEXMORE. Available at: https://fivexmore.org/embargoed-report. Accessed: 2/1/23.

Southwark Public Health Division Children's and Adult's Services. (2023). *Census 2021 Results: Ethnicity, National Identity, Language and Religion*. Southwark Council. Available at:

https://www.southwark.gov.uk/health-and-wellbeing/public-health/southwark-health-data/our-population/census-and-demographics?chapter=2#:~:text=In%20Southwark%2C%20just%20over%20half,one%2Dquarter%20of%20Southwark%20residents.. Accessed: 1/7/24.