Promoting women's health and well-being for black women

Katie Jones

ORIGINAL

Background

Without proactively researching the history of black pregnant women and slavery the true extent of suffering endured may not be apparent. For example, slaveholding surgeon Francois Marie Prevost pioneered caesarean sections by experimenting on black enslaved women (Owens & Fett 2019). This is a small insight to demonstrate how the obstetric and gynaecological fields are indebted to black enslaved women. Furthermore, during the Windrush era in the 1940s and 1950s, men and women of African descent migrated to the United Kingdom (UK) to help rebuild the post-war economy, with a significant number of women being recruited into the health care sector (Nayar 2016). Despite the deep debt of gratitude, and reflecting on the cruelty and hardship women faced, a vast disparity between races is still ingrained in all areas of society today (Achiume 2018).

Following Windrush, the Race Relations Act (1965) was the first piece of legislation that protected against race discrimination. The Race Relations Act (1976) further stipulated preventing discrimination relating to race in areas of education, health care, employment and provision of goods and services. Although legal protection is in place, it is not enough to address the racism, prejudice and discrimination black women face today. A true understanding is imperative to further address vast disparities and make a change to the health care that women receive.

This article will focus on:

- the issues black women face relating to discrimination, education and institutionalised racism
- the relation of racism to socioeconomic status and mental health
- how midwives are better able to plan and implement the best holistic care as well as promoting sexual health for black, childbearing women.

What is institutional racism?

Institutional racism has been described as a:

'collective failure of organisations to provide suitable and professional services to people based on colour, ethnicity or culture. It exists in processes, attitudes and behaviours that accumulate into discrimination through prejudice, ignorance and racial stereotyping' (MacPherson 1999:42).

The NHS has an under-representation of black professionals, and those present face challenges such as racism, discrimination and invisibility through practices, policies and everyday acceptances that have somehow become the norm (Premji & Etowa 2014).

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 to support the NHS framework in highlighting inequalities between black and other ethnic minorities, in comparison to their white counterparts. Although the Equality Act (2010) is legislation provided to protect against discrimination within the workplace, the latest WRES (NHS England 2019) report highlights issues that still need addressing. For example, white applicants are 1.46 times more likely to be recruited and only 8.4 per cent of board members are from black and other ethnic minority groups. Rather than commenting on the increase in black ethnicity board members on previous years, what should be addressed is the ways in which representation of black ethnic members can be further improved.

Institutional racism within the NHS

Having an under-representation of black professionals within the workforce and in positions of power within the NHS is in conflict with the drive to improve overall health care services for black women (Maternity Action 2018). MBRRACE (Knight et al 2019) states that black women are five times more likely to face mortality in pregnancy and childbirth than their white counterparts, which raises the question of whether lack of representation of black health care professionals, along with institutional racism, is a contributing factor (Cobbinah & Lewis 2018, Knight et al 2019). Furthermore, an equal representation and presence of black health care professionals, including midwives, within the NHS would improve the ability to inform policy and enhance culturally sensitive care for black women, ultimately aiding engagement of women with their maternity care (Wren Serbin & Donnelly 2016).

Acknowledging health inequity within the health care sector, and listening to patients and colleagues about their experiences, is a remedial action required by each individual to begin to start to understand and implement change (World Health Organization (WHO) 2020). Using the Royal College of Midwives (RCM) as an authoritative platform would be a positive way to share the experiences of both black ethnicity midwives and service users, in a bid to speak out and stand up to racism and discrimination within midwifery.

Educating midwives about racism

Education and employment come hand in hand in the health sector. Midwives must complete higher education at university level in order to be registered with the Nursing and Midwifery Council (NMC), enabling them to practise. The NMC Standards Framework for Nursing and Midwifery Education (2018b), states students should have opportunities to learn from and work with a range of people to prepare them for providing care for women with diverse needs. Learning opportunities are structured to include cultural and ethnic beliefs, legislation, values and practice. However, there is no evidence that universities provide midwifery students in the UK with learning opportunities addressing racism — institutional racism, white privilege and unconscious bias — that would fully equip the future midwifery workforce with cultural competency. Furthermore, studies have shown that lecturers find conversations with students surrounding race and privilege stressful, and that they lack confidence discussing emotive and sensitive issues (Acosta & Ackerman-Barger 2017).

Including cultural competency within study programmes would assist the much-needed deconstruction of institutional racism. Midwives have a moral obligation to strive for beneficence for women in their care. Providing future midwives with cultural competency and understanding would help combat the health inequalities that black women face, while providing a safe and trusting environment enhancing overall holistic care (Gordon et al 2016).

In the UK, 13 per cent (992,000) of foreign-born people identified themselves with Black/African/Caribbean/Black British ethnicities (ONS 2011). Although the exact figure is unknown, a proportion will be female migrants with varying legal status, in need of maternity and sexual health care.

Maternity Action (2018) and Public Health England (PHE 2020) confirm that all maternity care is classed as 'immediate necessary treatment' and must not be delayed or refused for any reason; this includes family planning services, diagnosis and treatment for sexually transmitted infections (STI) and sexually transmitted diseases (STD), such as HIV. In addition, the Faculty of Sexual and Reproductive Healthcare (FSRH 2020) states that proof of residency is not required to access services, as obstacles are a deterrent for accessing health care. To restrict access to facilities migrant women need and deserve, would have safety implications for both women and their infants and would breach human rights (Human Rights Act 1998).

Black migrant women in the UK are less likely to attend cervical screening (RCOG 2019). Marlow et al (2015) found barriers to accessing cervical screening high due to perceived risk, fear and shame. Furthermore, women may not seek treatment or care for fear of having to pay, not knowing where to turn to access care or having a language barrier (Phillimore 2016). Midwives have a duty of care and ethical obligation to provide justice for women, in that all women should receive the same level of health care, regardless of circumstances. Midwives also have a responsibility to provide translation services in order to meet women's language and communication needs (Phillimore 2016). Women should be provided with literature and evidence-based information tailored to their individual requirements, taking into consideration format and preferred language (NMC 2018a).

Working in collaboration with charities, such as Sandwell African Women Association (SAWA 2014), midwives could identify and build trusting relationships with the migrant community, making for easier access to care for all black women (Knight et al 2016, NMC 2018a, Chief Nursing Officers 2020). Achieving presence in the community would aid the drive to reduce maternal mortality for migrant women, as migrant deaths are a contributing factor to overall maternal mortality (Knight et al 2016).

The impact of racism on mental health

Schouler-Ocak et al (2015) state that migration alone may lead to psychological disorders. The impact of socio-economic status relating to maternal outcomes is not only a factor for migrant women, it is even greater for all black women compared to the rest of the population and subsequently more likely to affect their mental health and physical well-being (Nazroo et al 2020). Furthermore, half of people with black ethnicity grow up in poverty (Department of Health (DH) 2013), with a resulting impact on mental health. A study has shown that women who live in more deprived areas are less likely to be asked about their mental health, receive treatment or offered support (National Perinatal Epidemiology Unit (NPEU) 2020).

The 'Whooley questions', is a tool currently used to identify poor mental health in women (Whooley et al 1997). However, only up to 50 per cent of cases of depression are detected antenatally using this tool (Littlewood et al 2016), possibly because its effectiveness relies on how the questions are asked, and women's acceptance of answering them (Williams et al 2016). In addition, women may not be asked the questions at all if a partner is present, highlighting inconsistencies. To increase effectiveness, midwives

should have some degree of training in perinatal mental health to boost understanding and confidence. Although the tool can be seen as a tick box exercise in an already time-restricted environment, its consistent use could contribute to identifying poor mental health in black women (Howard et al 2018).

Approaching mental health with sensitivity and empathy, while being non-judgmental, supports non-maleficence and crucial information can be extracted from women in a way that inflicts the least amount of stress. Furthermore, if all health care professionals adopted an attitude of racial sensitivity, rather than racial awareness, this could actively incorporate challenging racial injustices.

How midwives can combat racial inequalities

Midwives work in partnership with women. With consent, services, such as counselling and referral to a general practitioner (GP), can be made available for further assessment, along with support from the perinatal mental health team. This enables women to access most relevant health care, information and support when needed. However, the midwife is central to women's care. Following up on referrals, helping with transport to access additional help, and reviewing mental health at every contact is fundamental to providing the best, personalised care (National Maternity Review 2016).

Most black women are born in Britain and use English as their first language, and have varying levels of wealth, professions and education, as do white women (Whitehead 2019). Not all black women live in social deprivation: which begs the question, why are black women five times more likely to die in pregnancy and childbirth than white women? Although midwives as individuals can strive for equality and promote anti-racism, a system-wide approach is needed to achieve national equality (Halvorsrud et al 2018).

Black women are more likely to attend their booking appointment late, receive fewer antenatal appointments, fewer scans and less screening in comparison to white women (NPEU 2020). A reduction in overall maternity care contributes to an increased risk of maternal mortality and stillbirth rates. Although overall rates reduced in the UK for 2017 (to 3.74 per 1000 total births), for black women rates remain higher at 7.46 per 1000 births (Draper et al 2018). To combat this *Better births* (National Maternity Review 2016) introduced a continuity of carer (CoC) model which allocates women to a small number of midwives to provide personalised care during the antenatal, intrapartum and postnatal period in an attempt to reduce maternal mortality, pre-term and stillbirth. Positively, this is initially targeted towards black and other ethnic minority women.

A retrospective analysis conducted by Homer et al (2017) found that the CoC model led to positive outcomes for both women and their babies. However, to provide the most effective maternity care for black women, midwives must also seek education to increase cultural sensitivity. By considering women's individual cultural beliefs, behaviours, needs and spiritual needs, engagement with services will improve (Esegbona-Adeigbe 2018). Furthermore, flexibility with location and frequency of appointments is imperative. *Better births* (National Maternity Review 2016), states that each trust will have a maternity 'safety champion' providing safety education to the multi-disciplinary team (MDT). Factoring cultural sensitivity into the proposed role would further enhance the education of the wider MDT. This would lead to better antenatal care for black women, ultimately contributing to a reduction in maternal and infant mortality and pre-term birth.

During slavery, physicians believed that a 'black body' was biologically different to a 'white body' and black people were more resistant to pain and injury (Hoffman et al 2016). For black labouring women, the same racial bias seems to be apparent today, in that black women are less likely to be offered pain relief in comparison to white women (Whitehead 2019). Midwives can strive for equality and justice by providing the same pain relief opportunities for all women.

Pregnancy risk factors relating to black women, such as anaemia, sickle cell and thalassemia, gestational diabetes, hypertension and postpartum haemorrhage, are discussed with black women. However, identifying risk factors, and discussing care relating to these factors, loses significance without addressing the vast underlying issues relating to racism, education and institutional racism that are pivotal to black women's health care outcomes (Esegbona-Adeigbe 2018, Byrne et al 2020). In addition, highlighting differences based on colour of skin only, especially as *any* ethnicity can be predisposed to many of these risk factors, further highlights racial disparities and presents black women as being different to the 'white, western norm' (Whitehead 2019).

The way forward

Ideally, 'promoting women's health and well-being for black women' should not be a topic for discussion as all women should be treated equally and individually. However, there are disparities that urgently need addressing. With black women being five times more likely to face mortality during pregnancy and childbirth, evidence suggests the reasoning clearly goes beyond pre-disposing risk factors (Knight et al 2019).

A multifaceted approach to achieving racial equality needs to urgently commence. Improving representation of black professionals in the workforce, as well as introducing cultural competency into education, will not only begin to deconstruct institutional racism, it will improve the overall

quality of care black women receive and contribute to reducing rates of mortality. Moreover, the deconstruction of institutional racism will improve social and mental well-being, further contributing to improving maternal and fetal outcomes.

Not only should each individual strive for equality, anti-racism needs to be actively supported by all, until disparities and racism are no longer. The use of authoritative bodies, such as the RCM, changing existing national strategies and instigating anti-racism campaigns would be a pragmatic way to speak up and stand up to racism.

Author

Katie Jones is a student midwife at Staffordshire University. Email: j020491h@student.staffs.ac.uk.

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