Protecting human rights in childbirth

Systemic racism, not broken bodies

An inquiry into racial injustice and human rights in UK maternity care

Executive summary

birthrights

Introduction

"One of the things that's really embedded in this system is the blame that's put on Black bodies and that this is somehow our fault because our bodies don't work in the correct way."

— Midwife, healthcare professional focus group

The 2018 MBRRACE report gave us the stark findings that Black women were five times and Asian women two times more likely to die in the perinatal period than white women[1]. Research has shown similar trends for decades, with Black, Asian and Mixed ethnicity women also more likely to experience baby loss, become seriously ill and have worse experiences of care in pregnancy and childbirth, compared to white women. But for too long, explanations for racial inequities in maternal outcomes have focussed on Black and Brown bodies as the problem – regarding them as 'defective', 'other', and a risk to be managed.

The starting point for our year-long inquiry was that systemic racism exists in the UK and in public services. We set out to understand how it manifests within maternity care and to drive action to end it. This report uncovers the stories behind the statistics and demonstrates that it is racism, not broken bodies, that is at the root of many inequities in maternity outcomes and experiences. We believe this is an urgent human rights issue and urgent action must be taken to address it.

The inquiry heard testimony from women, birthing people, healthcare professionals and lawyers outlining how systemic racism within maternity care – from individual interactions and workforce culture through to curriculums and policies – can have a deep and devastating impact on basic rights in childbirth. This jeopardises Black and Brown women and birthing people's safety, dignity, choice, autonomy and equality.

Led by an expert panel bringing together lived experience with maternity care and legal knowledge, the inquiry reviewed in-depth testimony from over 300 people via an online call for evidence, focus groups and interviews. We heard oral evidence from professional and clinical bodies, experts in maternal mortality and anti-racism, and other charities who work with LGBTQ+ birthing people of colour and refugee, asylum-seeking and migrant women.

[1] MBRRACE-UK, 2018, Saving Lives, Improving Mothers' Care 2018: Lay Summary

Common themes emerged from across the evidence. They are:

- Lack of physical and psychological safety
- Being ignored and disbelieved
- Racism by caregivers
- Dehumanisation
- Lack of choice, consent and coercion
- Structural barriers
- Workforce representation and culture

It is clear that we need urgent action at all levels. We welcome the recent focus on maternal health disparities and the impact on the human rights of Black and ethnic minority groups, as highlighted in the Joint Committee on Human Rights report *Black people, Racism and Human Rights*,[2] but Government and NHS initiatives must recognise the role that racism plays in the worst outcomes and experiences for Black, Brown and Mixed ethnicity women and birthing people.

Our report sets out five calls to action to drive forward concrete change.

We call on all parts of the maternity system to:

- Commit to be an anti-racist organisation
- Decolonise maternity curriculums and guidance
- Make Black and Brown women and birthing people decision-makers in their care and the wider maternity system
- Create safe, inclusive workforce cultures
- Dismantle structural barriers to racial equity through national policy change

[2] Joint Committee on Human Rights, 2020, Black people, racism and human rights

Systemic racism in maternity care

Based on the evidence heard in the inquiry, we break systemic racism down into the following four categories, which highlight both the structural and interpersonal ways they manifest, and map onto the inquiry's calls to action.

Nature of racism	Examples	Calls to action
Individual interactions	• Being ignored and disbelieved • Racist stereotypes and microaggressions • Dehumanisation • Denial of pain relief	Commit to be an anti-racist organisation Make Black and Brown women and birthing people decision-makers in their care and in the wider maternity system
Education and training	• White bodies as the 'norm' or default • Failure to recognise conditions e.g. jaundice, sepsis • Lack of cultural understanding	Commit to be an anti-racist organisation Decolonise maternity curriculums and guidance
Policies and frameworks	• Ethnicity as grounds for induction within policies • 'High risk' pathways based on ethnicity alone • Lack of representation in clinical evidence and committees • NHS charging regime and failure to provide interpreting services	Decolonise maternity curriculums and guidance Make Black and Brown women and birthing people decision-makers in their care and in the wider maternity system Dismantle structural barriers to racial equity through national policy change
Workforce	• Lack of senior representation • Higher rates of disciplinary action • Bullying and toxic culture	Commit to be an anti-racist organisation Create safe, inclusive workforce cultures

Human rights in maternity care

Article 2 protects the right to life.

Providing safe maternity care is one of the ways that the state guarantees respect for this right. If a person dies during pregnancy or childbirth, the state may have violated Article 2 if systemic issues, rather than negligence by an individual clinician, contributed to their death.

Article 3 prohibits inhuman and degrading treatment.

The courts have defined this as treatment which causes intense physical or mental suffering (inhuman) or is extremely humiliating and undignified (degrading). In healthcare, Article 3 can be infringed by deliberate infliction of ill-treatment, negligence, or inadequate standards of care. Performing procedures without a person's consent, physical abuse, racist abuse or behaviour, failure to provide pain relief, or neglect in hospital wards, could all violate Article 3 if they caused intense suffering or humiliation.

Article 8 protects the right to private and family life.

This includes "physical and psychological integrity", so hospitals must respect people's autonomy and decisions about maternity care. The European Court of Human Rights has said that Article 8 covers "the circumstances of giving birth", including choices about where, how and with whom to give birth. Informed consent is a core aspect of Article 8 and lack of informed consent to any aspect of maternity care will violate this right. Article 8 is a limited right and interferences with it can be justified if they pursue a legitimate aim and they are necessary and proportionate.

Article 9 protects the right to freedom of thought, conscience and religion.

This protects a person's religious beliefs, customs and choices, including religiously-motivated choices about healthcare. Like Article 8, the right to religion is a limited right and interferences with it can be justified if they pursue a legitimate aim and they are necessary and proportionate.

Article 14 prohibits discrimination.

This entitles people to equal treatment in their enjoyment of all other rights and means it is unlawful for public bodies to discriminate against people on grounds including race, colour, language, religion, and national or social background.

Inquiry process

The inquiry heard directly from **over 300 people** with lived and professional experience of racial injustice in maternity care:

244 responses to the written call for evidence

11 focus groups – reaching 50 women and 5 midwives

14 in-depth interviews – with 3 LGBTQ+ birthing people/partners, 2 women, 1 midwife and 8 clinical negligence solicitors/barristers

We commissioned a poll with Survation to compare the experiences of **1,069 women** who gave birth in the last 5 years – 556 white and 513 Black, Asian and Mixed ethnicity.

Oral evidence sessions

The expert panel held three oral evidence sessions with decision-makers and experts in June, July and September 2021.

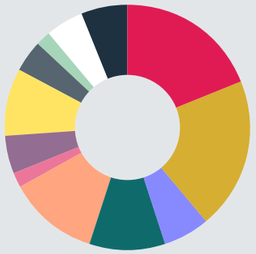
June 2021
Lived experience and intersectionality, with Maternity Action (migrant women and NHS charging) and Black Beetle Health (LGBTQ+ people of colour);

July 2021
Healthcare professionals' experiences, with the Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, and Nursing and Midwifery Council;

September 2021
Policy and systems change, with the National Institute for Health and Clinical Excellence and MBRRACE-UK.

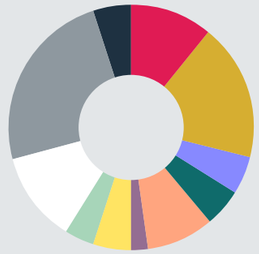
Birthrights call for evidence

187 women and birthing people



Black African	19%	36
Black Caribbean	20%	37
Other Black background	6%	11
Indian	10%	19
Pakistani	12%	22
Bangladeshi	2%	3
Chinese	0%	0
Other Asian background	5%	10
White and Black Caribbean	9%	17
White and Black African	4%	7
White and Asian	2%	4
Any other mixed background	5%	10
Arab	0%	0
Not disclosed	6%	11
Total	100%	187

57 healthcare professionals



Black African	11%	6
Black Caribbean	18%	10
Other Black background	5%	3
Indian	5%	3
Pakistani	9%	5
Bangladeshi	0%	0
Chinese	0%	0
Other Asian background	2%	1
White and Black Caribbean	5%	3
White and Black African	0%	0
White and Asian	4%	2
Any other mixed background	12%	7
White	24%	14
Not disclosed	5%	3
Total	100%	57

Focus groups

- African Community Centre
- Swansea Women's Asylum seeker and Refugee Group
- Raham Project
- Latin American Association
- Happy Baby Community - Kurdish
- Happy Baby Community - Arabic
- Happy Baby Community - Yoruba/English
- Happy Baby Community - Urdu
- Happy Baby Community - Mandarin
- Leeds NHS Maternity Voices Partnership
- Healthcare professionals

Interviews

- LGBTQ+ birthing people and partners
- Women
- Midwife
- Clinical negligence solicitors and barriers

Survation poll

Ethnicity

556	White
145	Black or Black British
227	Asian or Asian British
141	Mixed
1,069	Total

Language

Is English your first language?

	White	Black and Brown
Yes	90%	73%
No	10%	26%
Prefer not to say		1%

Gender identity

Is your gender identity the same as the sex you were assigned at birth?

	White	Black and Brown
Yes	97%	95%
No	3%	5%
Prefer not to say		1%

Sexuality

How would you describe your sexuality?

	White	Black and Brown
Straight/heterosexual	93%	88%
Gay	1%	1%
Bisexual	4%	8%
Queer	0%	1%
Other	1%	0%
Prefer not to say	0%	3%

Findings and evidence
Safety

Finding

Feeling unsafe during maternity care was the most prominent theme in the testimonies we received, with two thirds of people who shared their stories describing not feeling safe some or all of the time. Participants in our inquiry told us that racism and racial discrimination had a direct impact on their sense of safety.

Human rights law protects the fundamental right to access safe, appropriate maternity care, which encompasses both physical and psychological safety. Yet existing research shows that Black, Asian and mixed ethnicity women experience far higher rates of unsafe outcomes, including death. Our evidence supports this research, showing that many Black and Brown people do not feel safe during their care, regardless of clinical outcome.

"They were panicking, and I thought I was going to die."

— Participant, Yoruba speaking focus group

Case study:
jaundice not recognised in a Black baby

"For my second child I had good birth care, he was premature. After we went home he developed jaundice. My health visitor was not convinced but my whole family could see it. She said she'd test his levels just to put my mind at ease. He tested super high and the HV was alarmed but she kept insisting the machine must be broken. She agreed to inform her superior though, still insisting there was nothing wrong but "mum wants some reassurance", and the superior agreed to refer us to the hospital.

"At the hospital the doctor admitted the reading was very high but insisted from the look of him there is nothing to suggest he was severely jaundiced, just a "slight" yellowing of his eyes. By then he looked neon to me. They did another reading and sent his bloods off, it was even higher than the last. My baby was immediately hospitalised for several weeks. The white staff did not recognise jaundice in a Black baby."

Case study:
Ghanaian person with life-threatening blood clot overlooked postnatally

One interviewee described their experience when being discharged home from the postnatal ward after repeatedly raising concerns about pain in their chest and feeling breathless. It was later discovered they had a pulmonary embolism, a life-threatening blood clot in the lungs. They describe the dismissal of their own and other Black women's voices, and in this case, the clear and direct impact on their safety.

"I was literally about to go home, there was a genuine 10 minute period between me going home with a potential embolism [and] it was just so weird, like the day before I remember constantly saying 'my chest feels really tight, I can't breathe, I can't stand, I can't walk, I can't do anything'. I had to get a bed pan to pee in because I couldn't stand for long without losing my breath and I'm like, you know I get it, I was anxious. But also, I genuinely couldn't breathe, you know, and that's the moment that always scares me because you hear so many of these stories, especially from Black women where their pain hasn't been taken seriously during this crucial moment. [...] My pain wasn't taken seriously and I was dismissed to the point that could have actually, you know, cost me my life."

Case study:
African woman with sepsis dismissed during birth

One written testimony described a "horrible" birth experience where the midwife repeatedly minimised her concerns, continued with her paperwork and did not recognise the symptoms of sepsis, in this case paleness and loss of colour in the skin, due to her being a Black woman.

"I shivered so badly for quite a while that I thought I would die. When my husband asked for blankets, the nurse said it was a natural reaction and it would die down, eventually my husband searched all the room and found some blankets then covered me up."

She repeatedly raised concerns that she could feel severe pain despite the epidural. It was only when a South Asian doctor doing her rounds for the night finally noticed her skin was pale that swift action followed: *"She took one look at me and asked if I felt well. I answered "not really, I feel like I have the flu" then she asked the nurse if she was checking my temperature which she replied "yes". The doctor was still concerned, she said the patient looks pale (I think she noticed this because she was South Asian) and asked the nurse to check my temperature again, it had soared!"*

After being put on antibiotics and with an assisted delivery, she gave birth to a baby girl.

"I later learnt that I had suspected septicaemia and it was captured just in time with the antibiotics drip. I believe that doctor saved my life and my baby's life. I think if I were a white woman, my constant request to check my pain relief (epidural) would have been validated. I felt like [the nurse] thought I was either strong enough or I was exaggerating."

Finding

We received numerous accounts from people who felt their voices were not heard during their maternity care. In particular, people reported that their pain was dismissed or minimised. There was evidence that the failure to listen to Black and Brown women and birthing people was at least in part a consequence of racism.

Failing to listen to people, disbelieving and dismissing their concerns, constitute serious failures to meet the legal standards set out in the Montgomery case and under the Human Rights Act. It is essential that caregivers establish respectful relationships with the people in their care and respond appropriately to their concerns.

"I kept asking them to give me strong painkillers because my stitches were not dissolvable and they had to remove them after five days and it's the c-section stitches that got really infected and my wound started bleeding. So I was in a lot of pain, but they were completely refusing to give me strong painkillers."

Case study: pain and contractions not being believed

A Chinese woman attended hospital a day before her due date with some bleeding, but was discharged and told to stay at home even after contractions started. The pain was so severe she took a taxi to the hospital and had to resist the urge to push. When she arrived the staff were angry that she had come back. She was told to wait where she was even though she could barely stand. When she was examined, she was 8-9cm dilated.

Case study: dismissing concerns about jaundice leading to harm

A clinical negligence solicitor shared how a Black woman's concerns over her baby having jaundice and looking yellow were overlooked and "totally dismissed", resulting in the baby becoming brain damaged.

"The baby started being extremely poorly and so by the third day she'd had no support and no help, [she was] really worried about her. And you know, the damage had been done. She had hyperbilirubinemia and she's got cerebral palsy."

The solicitor expressed frustration about the failure to listen to her client's concerns and prevent avoidable harm.

"Like check the baby, the mum's saying she's worried about her being yellow, why are you not all over that? And she's a beautiful little girl, but she's got a lot of complex needs now and that [was] totally avoidable..."

Finding

We found that racist attitudes and behaviours by caregivers - manifesting as stereotypes, microaggressions and assumptions about risk based on race - are having a serious detrimental effect on people's maternity experiences. Two thirds of respondents to our written call for evidence felt that their race, ethnicity or religion impacted on their care. In the Survation poll, 31% of Black, Asian and Mixed ethnicity respondents who said they were treated poorly by their midwife or doctor felt that this was because of their race or ethnicity.

Racism is a fundamental violation of the right to be treated without discrimination, protected by both the Human Rights Act and the Equality Act 2010. As well as being unlawful, our evidence suggests that racism plays a part in the inequalities in health outcomes for mothers and infants. Crucially, it is the persistent and prolonged exposure to microaggressions that causes harm.

Throughout the written testimonies, focus groups and interviews, there were a multitude of accounts where women and staff had heard Asian women being referred to as 'princesses' or 'precious' and Black women as 'aggressive' or 'angry'.

Case studies: lack of respect for cultural needs

An Asian woman told staff that the milk provided was not suitable for her baby and her husband would be bringing Halal milk – she then overheard staff saying "*'people like me' have made issues like this in the past*", which was deeply upsetting.

A woman of Chinese descent spoke of how staff appeared shocked and made her feel embarrassed about not showering immediately after delivery, due to wanting to follow traditional Chinese post-partum customs.

Healthcare professionals described colleagues saying that Black women and babies have "thick, tough skin", that a ward "smells of curry" when South Asian families were being cared for, and that Chinese people are "dirty". They also observed Black and Brown women and birthing people experiencing differential treatment compared to their white counterparts – such as white women being allowed visitors out of hours, receiving more responsive care, being granted time for multiple questions and given more patience listening to concerns.

"I wore my hijab and abaya during my stay at hospital. Staff in the special care unit were very patronising [until] I disclosed that I was a pharmacist, [when] the whole team's behaviour changed."

"There was one point in my labour right near the end where I remember looking at [my Partner] and saying, I'm going to be a Black statistic."

Finding

Black, Brown and Mixed ethnicity people are subject to dehumanisation in maternity care, manifested by disrespect, rudeness and lack of empathy that breaches basic human rights principles of dignity and respect.

The feeling of not being seen as an individual, or even as human, can act as a significant barrier to accessing maternity care, further entrenching the inequalities seen in outcomes and patient experience, and causing long-lasting trauma.

A majority of responses to the written call for evidence described a lack of basic dignity, disrespect or rudeness. Stories shared in focus groups and by lawyers demonstrated a pervasive lack of curiosity or empathy, harsh or rough treatment, and even shouting and threats.

One midwife commented on how the entrenched view of Black and Brown bodies being deemed as 'other', often leads to them being dehumanised and pathologized.

"One of the things that's really embedded in this system is the blame that's put on Black bodies and that, you know this is somehow our fault because our bodies don't work in the correct way. I was taught as a midwifery student about the African pelvis and the problems that it causes that African women, Black women are more likely to have diabetes, that we're going to have high blood pressure, this is our fault, it's the food that we eat, it's the weight that we carry. Everything works against us that Black bodies and Brown bodies are basically flawed in some kind of a way and so that anything, any care that we're given, we should be grateful for."

Case study: lack of respect and empathy

One interviewee reported two incidents, firstly where they attended hospital for an induction of labour to be left waiting for hours without any explanation –

*"When I came in for my induction, there wasn't a bed ready. So, I was basically sat in this empty bay. Just waiting and then they forgot about me, for like four hours, so then some random person was like [...] 'what are you doing here?' And I was like 'we were told to wait here four hours ago. But my name is {name}, I was booked in for an induction' and she was like, 'oh sh*t, I'm so sorry'. So, then they finally got me a bed. We paid for a private room because I've got agoraphobia, didn't get the private room...and then I went, and the private room was empty, so annoying. So, I was like the room was empty and I paid for it and I'm still not getting it, what is that about? But yes, it was very, very traumatic."*

After having had their baby, this person then developed a blood clot. When returning from a CT scan they were met with a midwife refusing to accept them into their bay –

"I went to have this CT and then I came back, and I was being put back into my bay and then a woman was like, no she can't come here. I'm full, so basically they had moved my bed. And then it was like, okay this porter didn't really know where to take me so took me to another bay, they were like, no, no, no, I'm done, I don't want anymore. And it was really horrible, I literally just found out that I had a clot in my lung, and I was just being moved around from bay to bay with people saying, no, I don't have enough beds, I'm trying to get all my people discharged. And that felt quite cold and it was quite upsetting."

"As a Black woman I felt less than human. I was dictated to, not asked."

Finding

We found serious and routine violations of the right to informed consent for Black, Brown and Mixed ethnicity people. The evidence showed that consent was not always sought for medical procedures, caregivers sometimes used coercion and obstetric violence, and there was a lack of choice about their maternity care.

These findings reveal a maternity service struggling to serve women, birthing people and families, or to support its staff. They are not unique to Black, Brown and Mixed ethnicity people's experience, as we have seen from the Ockenden report.[3] However, they are even more dangerous when combined with systemic racism, as they reinforce inequalities and cement feelings amongst Black, Brown and Mixed ethnicity women and birthing people that they are unsafe within the maternity system.

"All the stories were very, very similar, they're not listening to us, they told me I had to do this, I didn't know I could say no."

— Black LGBTQ+ interview participant

[3] NHS England and Improvement, 2022, Ockenden final report letter to NHS Trusts

Case study: pressure to be induced

One woman spoke of her request for a homebirth being dismissed, as she was told she would need an induction of labour. She tried to arrange a discussion to weigh up the risks and benefits of an induction and look at other options to better understand and make an informed decision. Despite these requests for a discussion, which she repeatedly made from early on in her pregnancy, it did not happen until she was 37 weeks pregnant and even after making her decision to have a homebirth, she received daily phone calls asking her to come in for an induction.

"They didn't give me any other options, not once did they tell me any of the risks of doing something or not doing something."

There were many examples of women with limited or no English who had no access to an interpreter or adequate translation services, leading to them having procedures where they were not clear of the risks or benefits, or even why they were having it all.

Case study: failure to provide interpreter jeopardising consent

In one legal case, a solicitor described the experience of a woman whose request for no male staff and to have female interpreters was denied. They instead allowed her sister-in-law to translate, who was not a trained interpreter, which led to a lack of informed consent for vaginal birth after caesarean. The internal investigation found if her wishes had been listened to and she was allowed to have someone translating for her, the hospital would have known she didn't understand or didn't have enough information to give consent.

Finding

There are two main structural barriers to safe, respectful and non-discriminatory maternity care: lack of access to interpreting services and the impact of NHS charging. These structural barriers disproportionately affect Black, Brown, and Mixed ethnicity women, particularly those who speak English as a second language or who have refugee, migrant, or asylum seeker status. They pose serious risks to people's safety and dignity in maternity care.

"People are traumatised, they are frightened already, they don't need to go to hospital and be frightened more."

"'If you are not going to pay the money then probably you will be in trouble. Maybe the Home Office will come to know about this and you will have some problems, they will send you back', these kinds of things they have started telling to me."

Case study: lack of interpreting leading to infant brain injury

In one tragic case shared by a lawyer, a baby suffered a catastrophic brain injury due to hypoglycaemia caused by lack of feeding support, which she was unable to receive as no interpretation services were provided either antenatally or postnatally. The NHS Trust lost the case and had to pay out a significant sum in damages to the family.

"At the beginning of the antenatal notes, it said on page one of the records, 'Does she need an interpreter?' And the answer was, 'Yes' and [in subsequent entries] the little tick box section of the form had been ticked in [and someone] had written in capitals with stars all round it, 'This woman speaks no English. She must have an interpreter', and an interpreter was never provided. […] [It states] in the NICE guidance [that there are two appointments] at which advice should be given on how to breastfeed. On the first, there was rather an elusive entry in the midwife record saying, 'Unable to give advice, no interpreter.' "

Case study: refusal to provide care due to NHS charging

One woman experienced bleeding in early pregnancy so attended a GP where she was not registered and was told she would have to pay £220 for an ultrasound scan upfront. She said did not have money then and asked them to scan her and provide an invoice so she could pay later. She was denied an ultrasound unless she paid upfront, so she did not have it. She bled two further times after that but didn't bother seeking assistance as she had no money to pay for any investigations and was not told how to go about accessing any health care provision.

Findings and evidence
Workforce representation and culture

Finding

Racism and discrimination deeply affects the maternity workforce on a personal and professional level, which has serious consequences for equitable and non-discriminatory provision of care to women and birthing people.

Our call for evidence captured the voices not just of women and birthing people, but of those working within the maternity system, so we could understand how racism can impact on the workforce, examining how it affects healthcare professionals and their ability to give good care. More than two thirds (70%) of healthcare professionals who submitted written evidence identified as Black, Asian or Mixed ethnicity, a quarter (24%) as white and the majority were midwives. Almost all of these responses stated that systemic racism and/or racial discrimination is contributing to maternity outcomes and experiences.

"The NMC is being used as a bullying tool. How many midwives have been threatened having their PINs revoked, have been threatened to be reported to the NMC, they're used as a tool to bully, they're used as a tool to stop midwives from standing up and speaking out when they see something wrong."

"Yes, I'm still a student midwife. I'm in my second year now and I've experienced quite a lot of overtly racist comments in the short time I've been in my Trust. And I'm finding it really challenging because it seems to always be me who reports it and often it's, because I'm a student, I'm obviously the lowest of the low in the hierarchical structure."

"It makes me reluctant to continue in this profession where I feel completely othered and have to bear witness to abhorrent behaviours yet feel the power imbalance and consequences of speaking out make it difficult as a student."

Finding

Positive accounts of maternity care focused on good communication, person-centred and culturally sensitive care. This emphasises the critical importance of upholding the principles of respectful individualised care and dialogue enshrined in the Montgomery judgement and human rights law.

"Respect, bodily autonomy and just being heard."

— Participant, Leeds MVP Focus group

"They were just incredible and listened [...] they just kept me safe but at the same time really respected what I needed."

A midwife's response to call for evidence summed up what good care looks like:

"It means listening to people in our care. Respecting their choices as theirs to make. Always giving evidence instead of just assuming Western ideas are the best and other choices are inferior. It means having a diverse staff body so that the culture changes from within too. [...] It means proper training and real consequences for racist behaviours. It means being able to report our colleagues without fear. It means treating people like they are actually human, not just a skin colour or a name we haven't heard before. It means practising someone's name and getting it right and not stopping until we can say it. It means asking people about their cultural practices."

"My experience was brilliant; it was really good... the midwife explained everything clearly and she made me feel at ease, to the point that I wasn't scared to give birth... Even the interpreters, they were brilliant."

"The midwife during childbirth was amazing, she was really nice and caring, even though her shift finished, I was in labour, but she didn't leave and she stayed with me until the end."

Calls to action

Based on the evidence gathered through the inquiry and analysis of the legal context, together with our expert panel we have identified five universal calls to action to achieve racial equity in maternity care.

We call on all parts of the maternity system to:

- Commit to be an anti-racist organisation
- Decolonise maternity curriculums and guidance
- Make Black and Brown women and birthing people decision-makers in their care and the wider maternity system
- Create safe, inclusive workforce cultures
- Dismantle structural barriers to racial equity through national policy change

We outline on the following pages concrete steps to achieve these goals. Birthrights commits to apply these to our own organisation and work with partners to identify their own action plans.

Calls to action	Legal basis
1. Commit to be an anti-racist organisation • Robust mandatory training on anti-racism and cultural safety for all staff, run at least annually • Clear standards on what constitutes racism and discrimination in the workplace and service provision • A clear pathway for reporting that ensures the safety of the person experiencing racism and encourages learning • Foster a feedback culture that does not blame the person experiencing racism and delivers a timely, proportionate response to the perpetrator that encourages accountability • Follow up on all reports of racism, ensuring some form of resolution has been achieved or action has been taken within a specific time frame to avoid unnecessary prolonged harm (4 weeks) • Organisation-wide racial equity action plan, with named people accountable for delivery at every level and annual tracking to monitor the impact of training and other actions on both workforce and care provision [metrics could include staff wellbeing and retention, improved outcomes and fewer complaints]	Article 14 HRA – equity Equality Act – public sector duty
2. Decolonise maternity curriculums and guidance • Robust mandatory anti-racism training for all educators, run at least annually • Embed anti-racism and cultural safety as explicit principles within codes of practice and guidelines • Wholesale review of education, examinations, training and clinical guidance to ensure the white body is not centred as the norm and that variations within specific ethnic groups are understood and addressed, without pathologizing Black and Brown bodies • Recruit more diverse and inclusive representatives for guideline groups, advisory committees and lay-examiners using positive action in the Equality Act – set and monitor specific targets • Ensure assessments address scenarios such as the impact of racial stereotyping and microaggressions, cultural awareness and the ability to give individualised care for all women and birthing people	Article 2 HRA – safety Article 14 HRA – equity Equality Act – positive action

Calls to action

Calls to action	Legal basis
3. Make Black and Brown women and birthing people decision-makers in their care and the wider system	Montgomery – informed decision-making Article 3 HRA – dignity Article 8 HRA – choice
• Put Black and Brown women and birthing people in control of their care and respect their dignity, choices and concerns • Implement tested, proven interventions and mechanisms that aid communication between minority groups and care providers, initiate regular check-ins and gather frequent feedback, especially for those at risk of racial discrimination or where harm has been caused, to re-build trust in communities facing disproportionate health outcomes • Deliver existing Better Births commitments e.g. continuity of carer if appropriate, choice and personalised care, the right to change caregiver • Invest in meaningful co-production throughout policy-making, led by Black and Brown people and with a well-supported pipeline and equitable processes for involvement • Set targets for inclusive participation e.g. in Maternity Voices Partnerships to reflect local communities • Accountability mechanism with community representatives, Maternity Voices Partnerships and volunteer peer links to track effectiveness of co-production and impact on quality of care	

Calls to action	Legal basis
4. Create safe, inclusive workforce cultures	Equality Act – direct and indirect discrimination
• Build a culture of care, wellbeing, support and mentorship so Black and Brown leaders can thrive • Set specific targets and use positive action to achieve increased representation of Black and Brown staff, especially within senior leadership • All institutions to establish trauma-informed teams of 'Link Lecturers' for Black and Brown students who are responsible for their wellbeing and safety whilst at university and in clinical placements • Mandatory training on trauma-informed practice and ongoing therapeutic supervision for all frontline staff • Address toxic organisational culture and HR practices which allow bullying and racism to thrive unchecked, with named paid roles external to maternity units to promote and protect emotional wellbeing for staff • National incentives set by NHS England and its counterparts for Trusts and Health Boards to track and positively address stress-related sickness • Positive workforce culture initiatives and staff satisfaction within NHS Trusts and Health Boards to be measured by the Care Quality Commision and its counterparts	
5. Dismantle structural barriers to racial equity through national policy change	Article 2 HRA Article 3 HRA + Montgomery – informed-decision making Article 2 and 14 HRA Equality Act – direct and indirect discrimination
• End NHS charging for maternity care • Ring-fenced investment in NHS interpreting services with clear targets for local delivery • Political commitment and target to end the ethnicity gap in maternal deaths – to achieve no difference in the rates of death for Black, Asian, Mixed and white ethnic groups by 2030 • Review the Maternity Incentive Scheme (CNST) to routinely capture ethnicity data at booking and address ethnic inequalities in maternity outcomes as core safety actions • Revise the Birthrate Plus tool to include ethnic and social need data in calculations for staffing need e.g. to allow for potential extra time due to language barriers and cultural and social needs	

birthrights