AIMS For a better birth...

Black Trust Within Maternity

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By Mars Lord

The NHS is made up of hundreds of different organisations of differing sizes at central, national, regional and local levels, each with different roles and responsibilities. The NHS Maternity system in the UK provides care throughout pregnancy, birth and early parenthood. It starts with antenatal check-ups and continues through labour, birth and postnatal care. Women and birthing people can choose where to give birth, at home, in a midwife-led unit or in the labour ward. Care is typically provided by midwives for low-risk pregnancies, with doctors involved for high-risk cases. The system aims to offer continuous care from a known midwife or team, integrating community and hospital services, though we know, currently, that this is not always the case. Women and birthing people are encouraged to make informed choices about their care, with support available for various aspects of pregnancy, birth and early parenting. Giving birth in the UK is, for the greater part, safe. Maternal mortality rates are not something that most people want to think about even though our maternal mortality rates are low. To date we have no figures

on the maternal morbidity rate: morbidity is defined by the World Health Organisation as*'any health condition attributed to and/or complicating pregnancy, and childbirth that has a negative impact on the woman's well-being and or functioning"*[1]

It is important to understand the makeup of maternity services in order to see the points of intersection for trust and also to look at the available statistics. In 2022 according to theOffice for National Statistics there were 605,479 live births in England and Wales. Data fromSands and Tommy's show that there were at least 100,000 miscarriages in England in 2021/22. There were 13.41 maternal deaths per 100,000 pregnancies between 2020 and 2022, according to figures published by theMBRRACE-UK investigation into maternal deaths in the UK.

Trust, therefore, is an important part of parents' interaction with maternity services. They trust that both they and their babies will be kept safe within the system that is 'designed' to care for them. This is one of the most vulnerable times in their lives and one which society, the healthcare system and the media tells them is the riskiest time for them. Trust is a firm belief in the reliability, truth or ability of someone or something, in this case the healthcare professionals and system which includes midwives and doctors. This begins from the moment engagement starts. What is expected is that there will be effective communication so that medical advice can be accurately weighed when making informed decisions. When the healthcare professionals and the system within which they work are trusted, there is higher satisfaction with the services provided, even when the outcome is not what was expected. What this article looks at are the specific challenges and disparities faced by Black bodied women in the UK maternity system. There is a huge erosion of trust amongst Black bodied women in the maternity system due to systemic issues and individual experiences of discrimination and anti Black racism, and we have a ways to go to change all of that.

There are many racial disparities in healthcare here in the UK.[2] These include but are not exclusive to, maternal mortality, fertility treatment, miscarriage, mental health, COVID-19 outcomes, cancer screening, diabetes, cardiovascular disease, access to GP services, access to pain management, organ donation and transplants, representation in medical professionals and language barriers.

When we look at historical causes for the disparities in Black maternal health, we remember the gynaecologic experiments in the 19th century of Dr J Marion Sims, who until recently was, and in some circles is still, called the "father of modern gynaecology".[3] As a quick sidenote, there are still medical instruments named after him in current use. He conducted experiments on enslaved Black women without anaesthesia and he performed surgeries to develop techniques for treating vesicovaginal fistulas which often caused great pain and suffering. In the early to mid 20th century, eugenics programmes in countries which included the UK disproportionately targeted Black bodied women for sterilisation, and they were based on racist ideologies about population control and "racial improvement".[4, 5] In the 1950s, early contraceptive pill trials were conducted on Puerto Rican women who were not fully informed about the risks or the fact that they were a part of an experiment. At least 8 women died. In the US there were efforts to eliminate traditional Black midwives in favour of hospital births ignoring the cultural importance and community role of those midwives, which led to poorer care for Black bodied

women.[6] Whilst not about midwifery and birth, another example of the disregard for Black bodies, their health and informed consent, is the Tuskegee Syphilis Study (1932-1972).[7]

There is an underrepresentation and exclusion of Black bodied women in research studies which leads to gaps in understanding, and there is also an underrepresentation of Black bodied researchers. Racialised medicine is where there is a false belief in the biological racial differences which leads to misdiagnosis and inappropriate treatment for Black patients. This belief accounts for the historical belief that Black bodied people have thicker skin and a higher tolerance to pain.[8]

It's not just within the US that Black bodied midwives have been discriminated against and mistreated. Whilst here in the UK there was no strong tradition of Black community midwives, the discrimination was just as rife. Post World War II, Black women were recruited from across the Caribbean to work in the NHS but they often faced discrimination, being relegated to lower paying jobs, less desirable roles and facing barriers to career progression despite their qualifications and experience.[9] Today they are most likely to be complained about by both service users and their colleagues. There are fewer opportunities for access to training and professional development for them and they face higher instances of workplace bullying and harassment and cultural biases and discrimination.[10], [11], [12], [13]

When we recognise the attitudes towards Black bodied midwives, it can come as no surprise that Black bodied women and people don't fare well within our maternity system. Through the 1960s-1980s there were reports of Black bodied women facing discrimination in maternity wards which included being placed in separate wards and/or receiving less attention from medical staff.[14] In the 1990-2000s studies began to emerge highlighting disparities in maternal care and outcomes for Black bodied women. We see the evidence of this with the reports by CEMACH (Confidential Enquiry into Maternal and Child Health) showing higher maternal mortality rates amongst Black bodied women.[2] In 2017 we saw the story of Serena Williams when she gave birth to her firstborn, Olympia, which is a clear example of Black women not being listened to. Despite telling her healthcare professionals the symptoms that she was experiencing, and her own recognition of the fact that she was prone to pulmonary embolism, she was ignored by different nurses and doctors before finally getting the CT scan and heparin drip she had asked for.

A 2019 study by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) showed that Black bodied women were five times more likely to die during childbirth than white bodied women. Black bodied women experience a 43% higher rate of miscarriage compared to white bodied women. The COVID-19 pandemic highlighted and exacerbated the existing disparities. Black pregnant women were more likely to be hospitalised with COVID -19. In 2021 Birthrights found that 43% of Black or Black British respondents said they were not treated with respect during pregnancy or childbirth. In 2020 Nicole Thea, a popular YouTuber, who'd documented her pregnancy journey, suffered a cardiac arrest caused by an undiagnosed condition called hypertrophic cardiomyopathy (HCM). Nicole went to the hospital with breathing difficulties. Despite guidance issued by the Royal College of Midwifery saying that Black bodied women presenting with breathing difficulties should be fully examined, she was sent home by a midwife who told her that difficulty breathing was

common in pregnancy. No checks etc were ever made. Nicole Thea was 24 years old. Just recently in 2024 Laxmi Thapa's son was born with a blue spot (Dermal melanocytosis) - blue-grey markings common on babies with brown or black skin. After being referred to hospital in Basingstoke she was arrested when medical staff and police followed procedures for suspected child abuse. Despite being a breastfeeding mother, Laxmi was kept apart from her son for over 20 hours.

The Ockenden report (2022) provides an extensive overview of findings, including the failings identified within antenatal care, intrapartum care, postnatal care, maternal deaths, obstetric anaesthesia, and neonatal care, which each helped to inform the subsequent recommendations they outline. On 19 October 2022 Dr Kirkup's report Reading the Signals was published by the Government. The report from the independent investigation found that women, babies and their families had suffered significant harm because of poor care in our maternity and new-born services, between 2009 and 2020. To date, no such highly publicised report on the scale of the Ockenden Report has been commissioned or published into the disparities in the maternal mortality rate for Black and brown bodied women. The most recent report from the Government, Black Maternal Health: Third Report of Session 2022-2023 shies away from directly naming structural and systemic racism, focusing more on pre-existing conditions without talking about their root causes.

And so we come to the issue of trust.

We have increased reporting about Black maternal health, with the emphasis being on the "trauma porn" aspect. People want to hear the stories, stories which *deserve* to be told and heard, but they do not wish to look beyond the stories and move towards action. What we have instead is a generation of Black bodied women who are increasingly scared of birth and a health system that continues to pathologize Black birth. When there is no trust in a system or trust in the people perpetuating harm and working within said system, broken trust is a given.

The implications of this are that Black bodied women are withdrawing themselves from maternity care. They are not, however, withdrawing without fully investigating all of their options. They are making informed decisions about what they want for their care and who they wish to provide it. There are no figures and statistics at this moment, but anecdotal evidence speaks to increasing numbers of freebirths. After all, why give birth where it is riskiest for you - within a racist system that has much to do to change and repair trust. Perhaps a reason for the lack of numbers is the prevalence of some outside agencies and health care professionals who disregard the fact that freebirth is a legal option, and threaten as well as report women, particularly those who are from marginalised communities, to social services and the police.[15]

When the data points to higher rates of complications and maternal mortality, there will also be an increased risk of poorer mental health. Increased stress and anxiety leads to higher levels of cortisol, cardiac and respiratory problems, all of which play their part in the poorer outcomes and increased disparities. The MBRRACE-UK report shows that Black bodied women are dying of the same issues as their white counterparts, but at much greater levels. Research shows that poor treatment and ineffective

communication in healthcare settings often leads to women avoiding seeking necessary care.[16]

It is important to look beyond the medical sphere to recognise how the societal narrative is mirrored within the maternity system. Black bodied women and birthing people do not suddenly develop the health predispositions on presentation to their healthcare providers. The continual micro and macro aggressions, the racial biological weathering begins before birth, continuing the cycle of discrimination and resulting in the disparities. Consider this. When the body is under stress it produces cortisol. An effect of cortisol is the overproduction of insulin. An overproduction of insulin can lead to diabetes. What this suggests and demands is a wider look at the anti Black racism and discrimination throughout society. Whilst this is an enormous task, that will not be resolved in my lifetime, indeed within the lifetime of my grandchildren, it is imperative that we recognise the mirroring of society within the healthcare system and most especially, in this instance, within the maternity system.

It is said that a good birth heals both seven generations forwards and backwards. We begin to understand more and more about epigenetics and how DNA is affected and how trauma travels through generations.[17] So how as healthcare professionals, birthworkers, doulas, activists and campaigners can we begin to change what is, and begin to influence the health of generations?

First comes the rebuilding of trust. Once trust is broken it is hard to rebuild and it can take many years. There is no quick fix, but it is possible for us to create short term goals that lead to long term goals and outcomes. This requires honesty and less 'clutching of pearls' and knee jerk defensive responses. Taking time to consider what is being presented and slowing down our initial responses is a good place. Two questions that I often ask of my clients (both in birth work and as a Life Coach) are:

1. What has caused you to respond defensively? Take time with this one and be honest with yourself. There is no one judging you. This may take a little more time than you realise, but taking time may well be the thing that brings about change.

2. What if it were true? I ask this question because people can sometimes have fixed beliefs and instantly reject what is put in front of them. To further extend the question.. And if it were true, then what?

Once time has been spent reflecting on those questions (and any others that come to mind), it is time to plan forward and move to the next questions:

1. What can you do now, personally?

2. How do you take ownership of your thoughts and beliefs to make change in your life, allowing you to *then* begin to work to build trust amongst the different communities that you serve?

When we look to the most marginalised in our communities, when we lift up Black bodied women, the

rest of society follows. The other marginalised groups are seen and recognised too. This isn't about 'whataboutisms'; the different groups will have similar issues and problems, but the solutions for them will be different. Today we are looking at the trust of Black bodied people and the maternity system. This is where I invite you to start. For far too long when Black bodied women are the centre of the conversation there is a shouting, shoving and bustling to bring in the 'whatabouts', therefore relegating Black bodied women to the bottom of the pile, again and again. So pause. A way to build back trust is to honestly look at and focus on Black bodied women and people birthing within the maternity system. For when we treat the most disadvantaged in society well,*everyone* benefits.

How does your medical curriculum look? Who is it based on and how can it be adapted and expanded to *include* the marginalised? What can you as an individual do to begin rebuilding trust?

There are many questions that are continually being asked and there are questions that still need to be asked individually as well as collectively. Imagine what would happen if we were to look at Black bodied people and support them to thrive. How can we throw off the societal and historical narrative that speaks of them as less than and blames them for the disparities in maternal mortality and morbidity outcomes? How do we treat them as people rather than pathologizing their Blackness? Let's stop calling for Black bodied women and people to speak up, and take a moment to actually listen.

The disparities in maternal health outcomes for Black bodied women and people in the UK are not just statistics—they represent real lives, families, and communities. These inequities stem from deeply rooted historical injustices and persist due to systemic racism within healthcare and society at large. Rebuilding trust between the maternity system and Black communities is crucial, but it requires honest self-reflection, sustained effort, and meaningful action at both individual and institutional levels.

As healthcare professionals, policymakers, and members of society, we must confront uncomfortable truths about bias and discrimination. We need to critically examine our practices, policies, and educational curricula to ensure they serve all birthing people equitably. This means centering the voices and experiences of Black women and birthing people, and actively working to dismantle the structures that have led to their marginalisation.

The path forward demands more than performative gestures or temporary solutions. It requires a fundamental shift in how we approach maternal care, medical education, and healthcare policy. By focusing on improving outcomes for Black birthing people, we have the opportunity to elevate care for all marginalised groups and, by extension, the entire population.

The questions posed throughout this piece are not rhetorical—they are calls to action. Each of us has a role to play in this transformation. Whether it's through personal education, advocating for policy changes, or reimagining healthcare practices, the time for change is now. The health and lives of Black mothers, parents and babies depend on our collective commitment to creating a just and equitable maternity care system.

As we move forward, let us remember that trust is earned through consistent, compassionate action. It's

time to move beyond acknowledgment and into the realm of tangible, systemic change. The journey may be long, but with dedicated effort and unwavering resolve, we can work towards a future where every birthing person receives the respectful, high-quality care they deserve, regardless of the colour of their skin.

We have a long journey ahead of us, and my hope is that, perhaps inspired by the recentWorkforce Race Equality Standard report, you identify and take your personal first steps.

Author Bio: Mars is a Certified Life Coach and birth activist. She is the Leading Voice in Black Maternal Health and Cultural Competency. A multi award-winning doula, mentor, and educator, she is on the RCOG Race Equality Taskforce and on the Birthrights Legal inquiry into Black Maternal Health panel. With 20 years experience. Mars is in high demand, both in the UK and across the world, as a speaker and trainer. Mars created Abuela Doulas, a doula preparation course primarily, but not exclusively, for Black and brown bodied people.

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