AIMS For a better birth...

# MBRRACE and the disproportionate number of BAME deaths: Why is this happening and how can we tackle it?

**To read or download this Journal in a magazine format on ISSUU, please click**here

AIMS Journal, 2019, Vol 31, No 2

*By Gemma McKenzie*

In November 2018 MBRRACE-UK1 published a report on how many women had died in childbirth in the UK and Ireland between 2014 and 2016. It is a well-researched and important document that not only provides the statistics, but also short summaries on the circumstances in which some of these women died and recommendations for how maternity care can be improved. It is a harrowing read, not only because behind each statistic is a real woman and a motherless child, but also because there are patterns in the statistics that suggest endemic problems in our maternity system and wider society.

**What does the report say?**

In the two-year period included in the study there were 2,301,628 pregnancies that resulted in birth (described as 'maternities' in the report). Out of that total, 225 women died from either direct or indirect causes of pregnancy or childbirth within the first year of their baby's life.

The two main direct causes are medical in nature. The first is thrombosis (blood clots in the circulatory system) and thromboembolism (a blood clot that becomes dislodged and clogs another vessel in e.g. the brain or lungs), and the second is haemorrhage. However, the third most frequent cause of maternal death is suicide. Between 2014 and 2016, sixteen women committed suicide within the first year of their baby's life. This appalling statistic raises serious questions not only about mental health services, but also

about the support available for new mothers more generally in wider society.

The researchers also considered indirect causes of death and coincidental causes. Overwhelmingly, the main cause of indirect death was cardiac disease. Frighteningly, the main coincidental cause of death was cancer, of which 102 women died. The report notes that while some women with cancer received good care, there are still areas that need improvement. Women's cancer symptoms for example, were often mistakenly considered to be common pregnancy/lactation related issues, such as mastitis, meaning women did not always receive appropriate or timely care. A second issue highlighted in the report was that medical investigations that would be offered to non-pregnant people may have been withheld from pregnant women due to concerns about the unborn baby.

Equally disturbing is that between 2014 and 2016 ten women were murdered in the first six weeks after giving birth, with a total of 14 murdered in their baby's first year of life. All of these women were murdered by their partners. Again, this indicates potential failings not only in the maternity system for women experiencing domestic abuse, but also systemic failings in wider society. Continuity of Carer may enable midwives to become better attuned to domestic abuse in a woman's life and may encourage women to confide in their health carers in order to seek support. However, this has only limited impact if women are not appropriately supported to escape abusive relationships and the criminal justice system does not adequately deal with offenders.

**Women from Black and Minority Ethnic (BAME) communities**

As already noted, one of the main findings of MBRRACE was that women from BAME communities were more likely than white women to die during birth or within the first year of their baby's life. In comparison to white women, black women were almost five times more likely to die from pregnancy and childbirth related causes, and Asian women were nearly twice as likely.

Although AIMS welcomes the MBRRACE report, as an activist organisation campaigning for improvements in the maternity system, it is important that we understand***why*** the rates of maternal death for BAME women are higher than those for white women. Until that is pinpointed it becomes difficult to actively challenge the problem and improve BAME women's outcomes. While MBRRACE is thorough and provides a lot of useful information, the report also raises many questions for which there are no adequate answers provided.

**Racism**

Statistics suggesting rates of maternal deaths are higher in BAME women than their white counterparts raise one important subject: Racism. People do not like talking about racism; it is the elephant in the room. It can make people - especially white people - very uncomfortable. No one likes to think of themselves as racist or acknowledge that they may be unconsciously benefiting from a racist system. It is easier to believe that racism is something overt and direct - name calling or violence - than to believe it is something that can be structurally ingrained into an institution, a system or a society.

But when we see statistics like those provided by MBRRACE we cannot deny that this looks like evidence of racism. The questions that immediately arise therefore are: Who or what is responsible for this?

Where is it coming from? And how do we tackle it?

**What are the causes of death for BAME women?**

This is a crucial question if we are to understand exactly what is going on here. Unfortunately,MBRRACE does not provide us with enough information to adequately make links and to dig deep enough to root out the issues. This limitation means that we cannot pinpoint whether the problems lie within the maternity system, the society we live in – or both. Consequently, tackling the causes of disproportionate BAME deaths becomes a case of shadowboxing.

**Responsibility**

One argument that may be raised to explain the higher rates of BAME deaths is that there are physiological differences in BAME women's bodies that make their births more difficult or complicated. It is AIMS' position that this is extremely dangerous territory and it is not a view that we accept or advocate. This is explored further in this Journal by Beth Whitehead, in her article, "Diverse, not defective".

Although in the UK we use the term 'ethnic minority' to describe people who are not white, on a global level white people are in the minority. It therefore does not hold that there is some inherent physiological problem in BAME women's bodies that creates birthing complications. Further, to peddle the argument of physiological difference feeds the narrative that white bodies are the ideal and brown or black bodies are the defective version.

As highlighted in our article "Diverse, not defective", we know that there are examples of this presumption within the maternity system. This is something that we need to radically move away from. Acts, decisions, policies and guidelines that support the idea of racial hierarchies - even if these are unintentional and the person involved is acting with the best of intentions - need to be challenged and dismantled.

Even if after numerous robust scientific studies there could be proof that there was some pregnancy related problem that certain ethnic groups were prone to, this raises further questions. First, is that condition something which is caused or exacerbated by the way a person lives, for example, poor diet or stress? If so, we would then need to consider whether structural inequalities are playing a role in a particular ethnic group developing that condition. Second, even if a condition is found to be inherently physiological, we would have to ask whether BAME women were receiving appropriate and adequate care for that condition, and if not, why not?

**Accessing antenatal care**

The rates of BAME women who accessed antenatal care is not given in the report. Consequently, it cannot be presumed that BAME women were less likely to access this care and that this has contributed to their deaths. Even if the statistics were revealed and they showed that BAME women did not attend antenatal appointments, this is a potential oversimplification of what the reality may be.

While MBRRACE frequently critiques the services provided to all women and offers recommendations

for improvement, the emphasis of the report is often on the characteristics of the women themselves. There is less emphasis on the characteristics of the social world around them, and the staff, department, hospital, prison or other environment in which they died. Examples of relevant information would be the staffing levels within the departments in which the deaths occurred, or the experience of the attending health care practitioners.

Returning to the idea that a disproportionate number of BAME women may not be attending antenatal care, the same problem becomes apparent. There is no exploration of whether antenatal care was accessible to women based on the distance from their home to the clinic, their access to transport or the support services in place. There is also no exploration of whether antenatal services were home delivered, or whether appointments could be made to see healthcare providers outside of 9-5 working hours. A lack of this further exploration begins to shift blame away from the system and towards the women themselves. This is therefore an unfair presumption towards*all* of the women who died and does not adequately explain the higher rates of BAME deaths.

**Looking behind the statistics**

As already highlighted, MBRRACE provides detailed statistics on maternal deaths. But if we are to focus on the causes of BAME deaths in an attempt to tackle the disproportionate number, we begin to hit blind spots. This can be demonstrated by looking at some of the statistics.

The following table highlights the ethnicity of the women who died:[2]

| **Ethnicity** | **Number of women who died from direct causes of pregnancy and childbirth (out of 98)** | **Number of women who died from indirect causes of pregnancy and childbirth (out of 127)** | **Total (out of 225)** |
|---|---|---|---|
| White European | 63 (= 64%) | 83 (= 65%) | 146 (= 65%) |
| Indian | 3 (= 3%) | 7 (= 6%) | 10 (= 4%) |
| Pakistani | 6 (= 6%) | 8 (= 6%) | 14 (= 6%) |
| Bangladeshi | 1 (=1%) | 2 (= 2%) | 3 (= 1%) |
| Other Asian | 4 (= 4%) | 0 (= 0%) | 4 (= 2%) |

| | | | |
|---|---|---|---|
| Black Caribbean | 6 (= 6% ) | 2 (= 2%) | 8 (= 4%) |
| Black African | 6 (= 6%) | 17 (= 13%) | 23 (= 10%) |
| Others/Mixed | 5 (= 5%) | 6 (= 5%) | 11 (= 5%) |
| Missing | 4 (= 4%) | 2 (= 2%) | 6 (= 3%) |

*Table 1.*

A second table highlights where the women who died were born:

| **Women's region of birth** | **Number of women who died from direct causes of pregnancy and childbirth (out of 98)** | **Number of women who died from indirect causes of pregnancy and childbirth (out of 127)** | **Total (out of 225)** |
|---|---|---|---|
| UK | 59 (= 60%) | 83 (= 65%) | 142 (= 63%) |
| Eastern Europe | 7 (= 7%) | 2 (= 2%) | 9 (= 4%) |
| Western Europe | 1 (= 1%) | 1 (= 1%) | 2 (= 1%) |
| Asia | 9 (= 9%) | 9 (= 7%) | 18 (= 8%) |
| Africa | 4 (= 4%) | 17 (= 13%) | 21 (= 9%) |
| Australia and North America | 0 (= 0%) | 1 (= 0%) | 1 (= 0%) |
| Central and South America and Caribbean | 5 (= 5%) | 1 (= 1%) | 6 (= 3%) |

| | | | |
|---|---|---|---|
| Missing | 13 (= 13%) | 13 (= 10%) | 26 (= 12%) |

*Table 2.*

This data begins to paint a picture of the patterns and trends in BAME women's deaths. It is not possible to analyse all of the ethnic groups in this short article so just one group will be used to highlight the blind spots that become apparent. In Table 1 for example, the data tells us that 10% of all of the maternal deaths were of women who described their ethnicity as Black African. However, Black African people only make up just under 2% of the population of England and Wales.[3] The rates of maternal death are therefore much higher and totally disproportionate to what may be expected given the small percentage of Black African women living in this country.

We can also see that 21 out of the 23 Black African women who died were born in Africa. The report gives us a bit more detail on where some of these women came from. Seven were from Nigeria and three from Eritrea. However, we are not provided with information about the other eleven women.

Africa is a huge place - a whole continent - and each country has its own culture, language, ethnic groups and political and social history. Being born in a particular country only gives a snapshot of a person's connection to that place. A woman may have been born in Ghana but has spent her whole life until pregnancy living in London. In contrast, another woman may have only arrived in the UK from an African country a year before she gave birth. Her migrant status may also be relevant, for example if she was an asylum seeker. The point of this is that Black African women are not a homogenous group. In other words, they cannot all be bundled together and presumed to be the same. Doing so means that we cannot trace causes – simply knowing the rates of Black African women dying does not really explain very much at all.

On a similar note, all white people are grouped together even if they are recognised as a specific ethnic group in law, such as Gypsy and Travellers, who 20 years ago were believed to have "possibly the highest maternal death rate among all ethnic groups."[4] In 2012, the government considered Gypsies and Travellers to be "the most disadvantaged ethnic group in the UK" with a "shorter life expectancy than the rest of the population."[5] However, we cannot see them in the MBRRACE data. Perhaps this is because there were no maternal deaths in the Gypsy and Traveller community during this time. Or perhaps it is because they have been clumped together with white women or labelled 'other.' It is important that communities such as Gypsy and Travellers are not hidden within the datasets, or we may never be able to understand and dismantle structural inequalities or tackle racism.

**Cross-referencing ethnic background with other factors**

What MBRRACE also does not do is to cross reference how many BAME women died of which particular cause. Arguably this may be to maintain anonymity for the women and their families. However it becomes almost impossible to decipher whether the problems BAME women are facing lie within the maternity system, outside of it or in both. The exception to this is with regards to suicide. Data is

provided that tells us that 86% of the women who committed suicide were white (61 women), 10% were 'black or other minority ethnic group' (7 women) and there was missing data on 4% (3 women). Unfortunately, a group entitled 'black or other minority ethnic group' again bundles a potentially wide range of women together. It does not provide enough information for us to even start to consider what role the infrastructure of the health service and/or society may be playing in the overall disproportionate number of BAME deaths.

Similarly, the report tells us that women from the most deprived backgrounds were three times more likely to die than those from the wealthiest. But it does not provide details on which ethnic groups appeared more frequently in which socio-economic backgrounds. Just being from a particular ethnic group does not automatically signal someone's wealth, income or lifestyle. However, if there were more BAME deaths in the most deprived groups, it may be that the most influential factor in the disproportionate mortality rates does not lie within the maternity system, but in structural inequalities within our society. In other words, is it the fabric of society that puts BAME women at higher risk when they enter the maternity system or is it something that is happening within the maternity system itself?

As already mentioned, there is no information provided on ethnicity with regards to the various causes of death. The report tells us that 96% of the women who died could speak English (although the level of proficiency is not given). What this suggests is that when in the maternity setting, an inability to communicate in English does not seem to be a factor in women's deaths. However, as we do not know which ethnic groups featured in each particular cause of death, we do not know whether other factors connected to a person's ethnicity played a role in the care that they received. For example, if BAME women were more likely to die from post-operative haemorrhage, this might mean that institutionalised racism is playing a role, i.e. BAME women are being left alone, or their concerns and pain are not being taken seriously. This is not something that we can conclude as we do not have the relevant information. The problem therefore is that we cannot trace the root of the problem and begin to tackle it.

A similar issue is with regards the standard of care provided to the women who died. Notably MBRRACE provides data on the number of cases in which care was good, and the number of cases in which improved care could have made a difference to the outcome. Frustratingly, even given the conclusions that were found in relation to the rates of BAME women's deaths, this is not broken down into ethnic groups. Consequently, we have no idea whether the women whose care could have been better, included a disproportionate number of BAME women.

Another gap in the data is the geographical spread of the deaths. Do BAME women have worse outcomes in various areas of the country? What about in particular NHS trusts? Are the deaths all in urban places, or are they in rural areas, or is there no pattern at all? Again, this type of information could have helped shed some light on what exactly is going on.

**Conclusions – can we draw any?**

It was never the MBRRACE researchers' aim to just focus on BAME deaths, which explains the lack of further investigation, but their report has uncovered an important problem. Given that the death rates

for BAME women are shockingly high in comparison to white women, this is an issue that needs urgent attention. It is impossible to see those statistics and to not consider racism - in some form and somewhere, whether direct, structural or institutional - as playing a role in the poorer outcomes for BAME women. To think that this is all down to chance is unhelpful. And to think that this is all down to some fault of the women themselves is ignorant.

The MBRRACE team has the data that would put a better spotlight on what is happening to BAME women within the UK maternity system. AIMS would urge them to dig deeper into that data (e.g. coroners' reports, the birth place setting, medications and interventions used) so as to enable further causal connections to be made, and detailed conclusions to be drawn so that targeted action can be taken. One option would be to create a supplementary report that focuses specifically on the deaths of BAME women. This would enable organisations such as AIMS, those working in the maternity system and others in wider society to begin to tackle the root causes of what appears to be systemic inequality, disadvantage and racism.

---

References:

1. MBBRACE report: https://www.npeu.ox.ac.uk/mbrrace-uk/reports.
2. This information was taken from Table 2.9 of the report at page 16.
3. NOMIS Official Labour Market Statistics (2011) Country of birth by ethnic group by sex: 2011 Census. Available at: https://www.nomisweb.co.uk/census/2011/DC2205EW/view/2092957703?rows=c_ethpuk11&cols=c_sex [Accessed 6.6.19]
4. Lewis G. and Drife, J. (2001) Why mothers die 1997-1999: the confidential enquiries into maternal deaths in the United Kingdom. London: RCOG Press
5. Women and Equalities Committee (2017) Inequalities faced by Gypsy, Roma and Traveller Communities https://www.parliament.uk/business/committees/committees-a-z/commons-select/women-and-equalities-committee/inquiries/parliament-2015/inequalities-faced-by-gypsy-roma-and-traveller-communities-16-17/ [Accessed 13.6.19]