

Description

Racialised Women's Use of Midwifery Units: Barriers and Facilitators

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Summary

Midwifery units (MUs) offer a bio-psycho-social model of care that supports safe physiological birth and good outcomes, yet racialised women are less likely to access these settings. Structural racism, risk-averse practices and cultural assumptions about safety contribute to unequal uptake. Disproportionate exclusion through risk assessment, limited information provision and biases about who MUs are for further restrict access. Evidence suggests MUs can be safe and beneficial for women with intermediate risk factors who are often excluded. We discuss strategies to improve equitable access.



The benefits of midwifery units

MUs embody the bio-psycho-social philosophy of care at the heart of midwifery.[1] They provide an environment that enables physiological labour and birth, mediated by neuro-endocrine processes.[2] One-to-one midwifery care alongside facilities that support movement and promote calm, aids straightforward progress. Safety is maintained by non-intrusive maternal and fetal monitoring and escalation to medical care if required.

Racialised women suffer structural racism often reflected in encounters with public institutions.[3] This may adversely affect their physical and mental health, reduce trust in health services and heighten anxiety within an institutional birth-space. However, MUs can provide privacy, dignity and cultural safety for women and their families.

Women from communities who value care from female healthcare professionals are more likely to have this need met in MUs, due to predominantly female midwives, less doctor contact, and greater continuity of care.[4,5] MUs can be located within community settings, offering ease of access, familiarity and local staff.

Despite these benefits research shows that racialised women are less likely to give birth in midwifery units than white women.[5,6,7] Rather than being encouraged to access this gold-standard service, there are various barriers beholden on midwifery services to overcome.[8]

> “Research shows that racialised women are less likely to give birth in midwifery units than white women.[5,6,7]”

Risk assessment

Racialised women may be more likely to be recommended obstetric-led care pathways.[9] Black women, for instance, are more likely to develop hypertensive disorders or have pre-existing diabetes. South Asian women are more likely to have small for gestational age babies or develop gestational diabetes.[10] The option of a MU birth is removed if continuous electronic fetal monitoring is recommended. However, there is increasing evidence that care in the MU for women with intermediate risk factors – such as a raised BMI or gestational diabetes – is a safe option.[11,12] Local guidelines do not always reflect this evidence, resulting in groups of women being disqualified from care that might particularly benefit them.

Beliefs about birth

As a result of a risk-averse medical culture and media influences, both midwives and women can perceive MUs as ‘risky’ despite strong evidence to the contrary, deterring midwives from offering it as a genuine choice.[6,13,14,15] Assumptions by midwives about ‘types’ of women who want MUs can lead to racialised women not being offered options. Continuity of carer can reduce bias and help midwives offer personalised information and support individual choice about birthplace options.8 Many women find out about these options via informal networks, social media and

private antenatal classes, further excluding communities with less historical take-up.[5]

In many communities there is a persistent belief that safety equates with doctor-led care in hospital, leading to a mistrust of MUs.[4,5] Women from these communities can find themselves going against the cultural norm and face criticism from family members if they choose an MU, but they may also choose a midwife-led setting for reasons of cultural safety.[5]

Good practice example: By Fedwa Harrak

During an antenatal appointment, a woman of Nigerian descent expressed concern about giving birth in hospital, detailing a past experience in which she felt disregarded and over-medicalised. I enquired about her preferences and provided culturally appropriate, evidence-based information about birth places available to her, including the AMU. In an open, non-judgmental conversation, I discussed how AMUs enable privacy, continuity and a setting that encourages physiological birth while preserving safety through established escalation procedures. I used visual resources and provided a unit tour to help her decide.

This experience encouraged me to focus on my professional responsibilities to promote autonomy and uphold equality and inclusiveness. By offering balanced information and addressing myths, I boosted her confidence and decision-making. Her feedback, that she felt 'respected and empowered', emphasised the necessity of compassionate, customised care and proactive communication in improving racialised women's access to midwife-led care.

Recommendations for services

To increase access to MUs for racialised women, services need to ensure availability, and midwives need to give full and equal information and support.

An 'opt-out' model for women without biomedical risks could remove biases in care choices. Community outreach and diverse representation in publicity materials can normalise MUs and address assumptions about who they are for – women who have positive experiences tell others. Strengthening midwife-women relationships, providing group antenatal care or antenatal education that meets the needs of different communities and integrating MUs within community settings could further increase access. Continuity of carer may improve access by increasing the chances of addressing both midwives' and women's assumptions. Finally, MUs need to regularly evaluate the demographics of their users and question whether they offer an equitable service for all. **TPM**

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