
ALL4MATERNITY
E-BOOK
Safer Together:
Unpacking racism in maternity care

ADVERT

About this e-book
Welcome to your learning journey on culture, race and bias in maternity practice and healthcare.

This is an interactive learning e-book with articles and worksheets to aid you in your learning and consideration of culture, race and bias in relation to maternity practice and healthcare. Contained within the e-book are articles and worksheets with interactive links providing you with a bank of resources to demonstrate and explore the challenges and best practice solutions for individual and collective action towards more equitable and culturally safe environments of care.

Worksheets
Throughout the e-book there are seven worksheets for you to explore, make note and reflect on your learning. Each of the worksheets start with a summary reflection on the articles you have just read. You are invited to note your main 'take away' from the readings, what have you noticed yourself thinking and feeling, are there key points made by the authors that resonate with you or challenge you in some way? You are then invited to explore if you felt 'comfortable or uncomfortable' as you read and reflected on the article theme. This leads on to offer you the opportunity to make note of an action that you can commit to in your own learning and practice to address the theme of the article in your own context/practice.

Following the reflection questions, you are provided with three further questions on each worksheet to aid you in deepening your learning on the specific themes and topics presented in the articles. You can use these to document how the themes inform your practice and engagement with people in your teams and care. Throughout the workbook you will find interactive links that take you through to additional examples and activities for a more in depth look at unpacking racism and developing cultural safety.

Use of Language
The language used to describe culture, race and people from ethnic minority groups is ever changing. We have included articles as they were written by the authors. We are aware that at points these articles include acronyms and language that may have progressed and changed since the point of publication. We have made the decision to keep the articles as their original format as it allows us to reflect on progress, challenges and developments in our collective communication on disparities, racism and inequity. If you identify language within the articles that evokes a sense of discomfort with you, use that as a learning tool to document why you feel this way and what adaptations you would bring into your own practice and use of language.

Use our glossary of terms (*Figure 1:* Interactive link to glossary of terms) to support you throughout your learning. For further resources and recommended reading use our further reading recommendations. (*Figure 2:* Interactive link to further reading resources)

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SAFER TOGETHER: UNPACKING RACISM IN MATERNITY CARE

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Chapter 5 Esegbona-Adeigbe S. Cultural safety in midwifery practice-protecting the cultural identity of the woman. The Practising Midwife. 2020; 23(11):9-11.

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Chapter 7 Sibanda S, Ezzahra Ghaouch F. We have a dream: Midwives making change. The Practising Midwife. 2021;24(1):14-17.

Chapter 8 Burnett A. This hurts us much more than it hurts you: the lived experiences of Black, Asian and multi-racial student midwives. The Practising Midwife. 2021;24(2):12-16.

Chapter 9 Raynor M, Essat Z, Menage D, Chapman M, Gregor B. Decolonising midwifery education part one: how colour aware are you when assessing women with darker skin tones in midwifery practice? The Practising Midwife. 2021;24(6):36-43.

Chapter 10 Menage D, Chapman M, Raynor M, Essat Z, Wells W. Decolonising midwifery education part two: neonatal assessment. The Practising Midwife. 2021;24(6):44-49.

FOREWORD

I first became aware of the UK's Black maternal mortality crisis halfway through my midwifery training. The jarring discovery came in the form of a singular slide about the 2019 MBRRACE report and the harrowing finding that Black women were five times more likely to die during the perinatal period than their white counterparts. Thankfully (and rightfully so), the crisis and the health inequalities affecting women and birthing people from marginalised ethnic groups are receiving increasing attention. The Black Maternity Scandal Dispatches documentary aired on Channel 4 March 2021,[1] Black maternal healthcare and mortality was debated in parliament April 2021,[2] and key campaigners for Black perinatal health such as Mars Lord, Sandra Igwe and FivexMore have amplified their calls for change through national press coverage. These repeated calls for reproductive justice are becoming louder and ever more pervasive and can no longer be ignored.

Whilst there is no government target to address the health disparities affecting the UK's Black childbearing population, several birthworkers and midwives have been working to achieve change. The disparate pregnancy outcomes of Black, Asian and multi-ethnic women have led to the establishment of culturally safe midwifery care providers such as Mimosa Midwives and the My Midwives Initiative developed by My Midwives UK.[3] All4Maternity has also made efforts to raise awareness about the health inequalities affecting marginalised communities and the work being done to combat them: The Student Midwife has featured a powerful anti-racism pledge for midwives, and discussed how to recognise and address white privilege in maternity settings while making a concerted effort to increase ethnic and geographical diversity amongst its editorial board and authors. The Practising Midwife's ***Racism Matters*** series, which has been collated by this e-book, ran from September 2020 to February 2021 and featured Black and Brown midwives and birth workers challenging readers to **listen to** Black, Asian and multi-ethnic women; **tell the truth** about why Black and Brown birthing people experience poorer perinatal outcomes and **restructure maternity services** so that they better meet diverse populations' needs.

Eurocentrism within midwifery education also comes under criticism in this book. Student midwife Chelsea Beckford-Procyk makes a compelling case for decolonising midwifery education, whilst I present the impact of Eurocentric curricula and ethnic homogeneity amongst midwifery educators and student cohorts upon ethnically diverse student midwives. There is also a call for change in midwifery practice from senior midwifery lecturer Sarah Esegbona-Adeigbe, who advocates for cultural safety when caring for women and birthing people, and midwifery lecturers from De Montfort University who address profession-wide failings to detect clinical signs in women and neonates with darker skin tones.

All4Maternity's efforts to highlight and address ongoing maternal health inequalities have also culminated in the production of two open-access eLearn modules. The Safer Together eLearn modules serve as an introduction to culture, race and bias in midwifery practice for any professional involved in caring for women and birthing people and are designed to support learners to reflect upon how they can improve pregnancy outcomes for Black and Brown women. The group of professionals involved in developing the modules are representative of the beneficiary group and welcome feedback pertaining to the content of the modules via info@all4maternity.com.

It is my hope that this e-book will appear on the essential reading list of every pre-registration and post-registration midwifery training course in the UK, in recognition of the continued need to raise awareness of the UK's ongoing maternal health disparities, and the urgent need to take meaningful action to combat them.

Alicia Burnett

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CHAPTER 1

‘WHEN PEOPLE SHOW YOU WHO THEY ARE, BELIEVE THEM’: WHY BLACK WOMEN MISTRUST MATERNITY SERVICES

Anna Horn

THE DREAM

This moment in time didn’t arrive without careful thought, consideration, grit and a call to greet the unknown and what-ifs with open arms. You’ve dreamt about this moment for years and finally you’re pregnant. You and your partner are on your way to building the life you imagined for yourselves over many nights of pillow talk. Immediately your mind goes to tiny booties, baby names and how you plan to share the news with family and friends.

Now imagine you’re a Black woman.

THE NIGHTMARE

Only a quick Google search highlights British media coverage of high-profile Black women, such as singer Beyoncé and tennis star Serena Williams, famously opening up about the difficulties that Black women face around pregnancy and soon after childbirth.[1] As a Black woman in the UK, you may be falsely assured that the increased risk of death that Black women face in pregnancy and around childbirth are unique to our sisters across the pond.[2] However, latest national reports show that Black women in the UK are the most likely to die from pregnancy and childbirth-related complications compared with white women.[3] The guards go up, the fear creeps in and you’re suddenly in survival mode, desperate to protect yourself, your unborn baby and the family you’ve worked hard to create.

THE FEAR AND MISTRUST

To understand why Black women mistrust maternity services, we must also consider the wider context of the institutional racism which infiltrates our education, justice, housing and employment systems. Why should we, as Black women, believe the healthcare system has been excluded from systematic strategies crafted to innately benefit the middle class and very wealthy white people?

Fear and mistrust of maternity services doesn’t start at conception and amplify in our expanding wombs. We carry the fear and mistrust of our mothers, our grandmothers, the wider African diaspora and our shared ancestors. In western society, people have shown us who they are for generations and thus, we believe them. Our concerns about our lives, the lives of our children and our communities are steeped in the direct consequences of the lack of equity, diversity and inclusion.

From slave breeding farms,[4] to forced wet nursing[5] and the inhumane treatment of enslaved Black women to perfect the surgical techniques of J Marion Sims,[6] known as the father of gynaecology, there’s a longstanding history of the dehumanisation of Black women’s bodies that still rings in the ears of Black women today. Not only are our bodies still under attack, but also like many mothers, we fear for the health and safety of our children. Of the neonatal deaths that occur in England and Wales, white babies continue to have the lowest occurrences.[7] Those of us who are lucky enough to take our babies home from the hospital then have the added responsibility of teaching our young people about how to get safely back home to us. Unfortunately the fear of violence, injustice and discrimination against our children is as a part of Black motherhood as daily school runs. Take, for example, mothers Doreen Lawrence and Sybrina Fulton, who both lost their sons to racist attacks. On 22 April 1993, Doreen’s 18-year-old son, Stephen Lawrence, was stabbed to death by a racist group while simply waiting at a London bus stop.[8] Nineteen years later, on 26 February 2012, Sybrina’s 17-year-old child, Trayvon Martin, was shot to death in Florida by a self-appointed neighbourhood watchman.[9] Both mothers continue to fight a system and a culture that did not see their children as victims, or even as human beings.[10,11,12]

THE SILENCING

Therefore, many Black women are not surprised by the ethnic disparity in maternal deaths. There is a shared historical, political and social lived experience that Black people have endured for generations, which makes this horrific disparity a reality. We are also not shocked by the discomfort race brings when the topic is raised in the birth world. Very publicly, there have been attempts to silence Black women who bravely share their experiences as mothers. Social media influencer Candice Brathwaite (@candicebrathwaite on Instagram), was accused of ‘playing the race card’ when raising the lack of diversity in the white majority online world of ‘mum influencers’.[13]

On the ground, organisations that are built to provide support to mothers and ensure that their voices are included in the implementation of maternity services are often absent of women of colour. I’ve also experienced, first hand, healthcare workers questioning the validity of ethnic disparities and reports of bias treatment by Black women. In turn, as a Black woman, I was expected to provide evidence, education and an explanation for the race disparities within maternity services. I’ve also witnessed on two occasions Black women being scrutinised for requesting pain medication. Is it because healthcare professionals didn’t believe their pain? Given the stressors and racial discrimination that many people of colour often face, one experiencing this situation can’t help but wonder. Most midwives may protest in disbelief that such an event ever occurred. After all, the heart of midwifery philosophy is to put the woman at the centre of care. Many midwives would even say that it would never happen in their practice or the practice of their colleagues. If we can’t listen to each other, then how can we make a positive change?

The truth is there are complexities to improving maternity services, including inequalities. Like many other minority voices, Black women need to be believed. We need to be included, and not superficially, to give an illusion that an organisation is diverse. We need to be on the frontlines of maternity care, on boards and committees at the local and national levels.

THE CALL TO ACTION

Very famously, American poet and civil rights activist Maya Angelou said: ‘When people show you who they are, believe them.’ Many Black women feel as though we are set up to fail and our experiences in maternity services are no exception. After all, a white patriarchal society has shown us who they are – and we believe them. There is an on-going effort to make maternity services better for women, babies and their families. Many people of all races, ethnic backgrounds, national origins, genders and social backgrounds are working hard to ensure that every voice is heard and policies, practices and work culture in maternity services enable people to have the best experiences and health outcomes. I challenge those who are working in the birth world to show us who you are by addressing inequalities, discussing race and being open to the experiences of people who are different to you – no matter how difficult or unpleasant. Show us who you are and we will believe you. **TPM**

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WORKSHEET 1

'Show us who you are!' Exploring personal and professional identity

REFLECTIONS:

My main 'take away'

My comforts and discomforts

My action/commitment:

Question 1: Use the identity wheel (*Figure 3:* interactive pop out to an identity wheel) to describe your identity in relation to your visible and permanent characteristics and those that change over time.

Question 2: Have there been times when your identities have been ignored? What was this experience like for you?

Question 3: In your work or study environment what challenges do you have to navigate in relation to identity? What are your peers and colleagues doing to overcome inequalities? (*Figure 4:* Interactive pop out to scenarios of inequity)

CHAPTER 2

DISPARITIES IN COVID-19 OUTCOMES

Rebecca Gilbert

INTRODUCTION

It has been a tough few months for everyone worldwide because of the COVID-19 pandemic and, for me, May was even harder. The news from America of the death of George Floyd was only a harsh reminder that sadly we continue to live in a world where structural and systemic racism still exists. We started off 2020 disheartened from The Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE)[1] report, which once again showed that Black women in the UK are five times more likely to die in pregnancy than white women, and now recent statistics show a similar pattern in relation to deaths from COVID-19.

COVID-19

Up until 5 June 2020, there had been 40,465 deaths from COVID-19 in the UK.[2] After adjustments are made for age and other socio-demographic characteristics, both women and men from all ethnic minority groups are at a greater risk of dying from COVID-19.[3] What is even more concerning is that, if you are a Black woman, you are 4.3 times more likely to die than a white woman, while Black men are 4.2 times more likely to die.[3]

So, what does this mean if you are pregnant? As we are still currently amid this pandemic, the guidance and management around COVID-19 and pregnancy is continually evolving and being modified as we learn more about the virus.

Researchers in Oxford have recently released preliminary findings of COVID-19 and its impact on pregnant women in the UK.[4] The UK Obstetric Surveillance System (UKOSS) is a national system that looks at rare disorders of pregnancy. The study collected data from 194 consultant-led obstetric units in the UK, and found that between 1 March and 14 April 2020, 427 pregnant women were admitted to hospital with a positive COVID-19 result.[4] The most common symptoms upon presentation were reported to be pyrexia, cough or breathlessness. Of the 427 women in this study: 247 delivered their babies or had a pregnancy loss; 40 needed level 3 critical care; four women received extracorporeal membrane oxygenation (ECMO); and tragically five women died during this period.[4] The report does not disclose the ethnicity origins of the women who died, although we do know from media reports from the BBC that one of these women was Mary Agyeiwaa Agyapong. A Black NHS nurse originally from Ghana – just 28 years old – she was admitted to hospital at 35 weeks' pregnant with COVID-19 symptoms.[5] Her death, due to complications from the virus and an emergency caesarean, evoked an outpouring of sympathy from NHS staff and the general public across the country.

Fortunately, Mary's daughter survived,[5] and the UK Obstetric Surveillance System (UKOSS) report observed that outcomes for infants were 'largely reassuring'.[4(p12)] There were 64 infants who needed to be admitted to a Neonatal Intensive Care Unit (NICU); 46 of these infants were preterm, and 19 were born before 32 weeks' gestation. The data from the study shows that 12% of women were delivered preterm because of 'maternal respiratory compromise'.[4(p10)] The mortality for infants was of a similar figure to mothers. Sadly, three babies were stillborn and two died in the neonatal period, although the study discloses that three of these deaths were not related to COVID-19, while the remaining two are unclear.[4]

The main aim of the report was to identify risk factors in pregnancy around COVID-19. Unsurprisingly, women from a BAME background were considered to be the most at risk of developing severe symptoms from COVID-19, as well as women with a higher maternal age, obese or with pre-existing medical conditions. The authors acknowledged: 'The strong association between admission with infection and Black or minority ethnicity requires urgent investigation and explanation.'[4(p2)]

This message echoes that of the MBRRACE report, 'Saving Lives, Improving Mothers' Care' for maternal deaths between 2015-2017,[1] which did not show any change in the higher number of maternal deaths for BAME women, from the previous report in 2018. The authors commented in the report that, although 44% of the women who had died had received good care, 29% of the cases may have had better outcomes if care had been improved.

HEALTH INEQUALITIES

As well as higher mortality rates, Black women in Britain are also more subject to poorer perinatal outcomes including preterm deliveries, morbidities and mortalities. The stillbirth rate for Black or Black British women was 7.46 per 1,000 births in 2017 – almost double the UK stillbirth rate of 3.74 per 1,000 births.[6] Neonatal mortality rates for Black babies was 2.77 per 1,000 births, compared with the UK rate of 1.67 per 1,000 births.

Health inequalities continue to be a recurring theme in maternity, with subtle or unconscious racism often cited as a factor. Poor communication, language barriers and a lack of cultural awareness were some of the points raised by women in two different studies around BAME women's experiences using maternity services.[7,8] Health providers assuming stereotypes or displaying prejudices can be detrimental in providing care that is safe and can also create barriers in women seeking help or support that they need. This can lead to poor antenatal care, which, as we know, can often have poor outcomes.[1,6]

WHAT CAN MIDWIVES DO NOW AND MOVING FORWARD?

Before COVID-19 there were already national strategies in place to tackle health inequalities following the publication of the Better Birth report in 2016.[9] With Professor Jacqueline Dunkley-Bent OBE as the frontrunner of the Maternity Transformation Programme, work is now being done on reducing inequalities in outcomes for BAME women on the principle of proportionate universalism.

Continuity of Carer (COC) is currently being implemented nationwide, with an aim that 75% of women from a BAME background will have this level of care by 2024.[10] COC is the best way to build relationships with women and helps to reduce any stereotypes or prejudice.
As Hindley stated in 2005: 'The process of getting to know someone as an individual diminishes perceived differences.'[11(p.34)]

On a more local level, healthcare professionals working in maternity services need to ensure that they have an awareness of how culture can impact the way they interact with their patients and build a relationship. Staff should be culturally competent so that they understand the birthing people they look after. This starts with education and collaboration with, for example, members of the community or religious leaders. Maternity Voices Partnerships are always a good way to improve services and you can actively recruit BAME women to find out what needs improving from their perspective.

The antenatal period is the time for information sharing and health promotion, and midwives need to ensure that women understand the information they are receiving whether it is verbal or written.[9] Translation services should always be used, and women should be able to access written information such as screening tests in pregnancy.
In relation to COVID-19, the Royal College of Obstetricians and Gynaecologists (RCOG)[12] has produced guidelines for health professionals acknowledging the UKOSS study. They advise clinicians to be aware of the increased risk and have a lower threshold with BAME women who present with any symptoms. As already advised before this pandemic, all pregnant women, particularly those from a BAME background, should be advised to take a vitamin D supplement. Vitamin D has found to be beneficial in reducing respiratory tract infections.[12]

CONCLUSION

In 2020 there can no longer be excuses for health inequalities, particularly in maternity care. Midwives have a role to play in ensuring that they are advocates for all the women in their care, especially during this time of pandemic when so many women will be invisible because of reduced services. It is all our responsibility to ensure that we are educating ourselves on cultural differences, as well as making sure women are aware of how to seek help or advice when they have concerns. COC will ensure that safe care is provided, by building trusting relationships and breaking down barriers. Now is the time to leave prejudices at the door and start to call others out on their behaviours. **TPM**

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WORKSHEET 2

'No more excuses!' Exploring disparities and inequity in healthcare

REFLECTIONS:

My main 'take away'

My comforts and discomforts

My action/commitment:

Question 1: What are some of the disparities faced by people in relation to their culture and/or race in your learning or practice context? (*Figure 5:* Interactive pop out to vignettes on disparities)

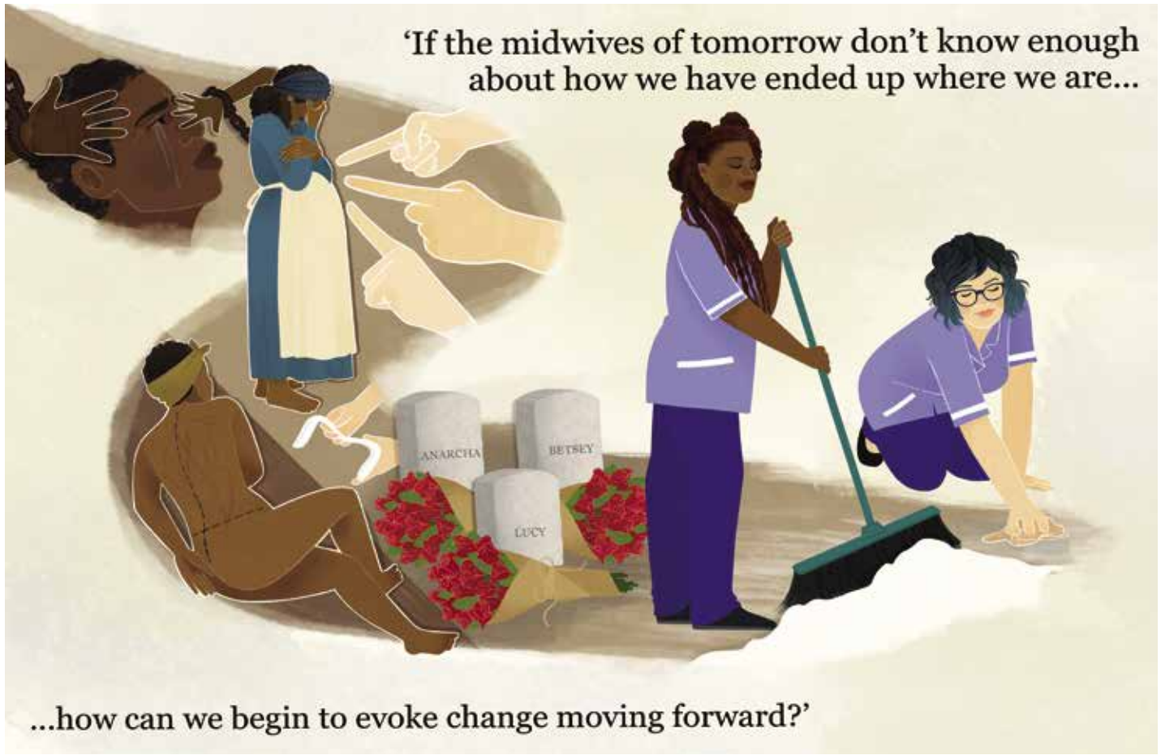
Question 2: What strategies, techniques and behaviours can you deliver or work on to ensure that these disparities do not exist in your workplace? What behaviours and actions are currently working well? (Figure 6: Interactive pop out to vignettes on successful behaviour and actions in practice)

Question 3: What are some of the challenges that you might face in implementing new behaviour and action toward equitable environments of care?

CHAPTER 3

SHOULD WE DECOLONISE MIDWIFERY EDUCATION?

Chelsea Beckford-Procyk



INTRODUCTION

Every qualified midwife is expected to deliver universal care to all women, birthing people and their newborn babies. Combining clinical knowledge and communication skills to deliver person-centred care, midwives are also required to promote cultural sensitivity and competence. In doing so, they actively advocate for the human rights of birthing people in their care. This awareness is highlighted in the Nursing and Midwifery Council's updated competencies for midwives.[1] Student midwives all over the UK are writing assignments, undertaking wider reading and completing practice hours in anticipation of becoming the best midwives they can be. Considering these hopes and aspirations, it is important that we acknowledge and resolve the gaps in our education that stand in the way of fully achieving these required proficiencies.
These gaps can not only go some way to explaining the disparities in maternal mortality seen in the UK, but also shine a light on the need for university curricula to address deficits in midwifery programmes. It should be noted that deficits are not only confined to midwifery education, because primary and secondary education are also under scrutiny.[2] With this in mind, it would be a forward-thinking move if midwifery education led the way in decolonising education. The chasms in our curriculum did not happen overnight – they are a result of ingrained colonialism within midwifery education, which sustains an institutionally racist healthcare system. These are the very systems that must be dismantled for the benefit of student midwives, those in our care and society as a whole.

Racism, underrepresentation and inequality should not be words associated with midwifery practice or healthcare in general, but the sad truth is, the result of these very things have a direct impact on the lives of Black, Asian and ethnic minority women and birthing people, which was highlighted in the 2019 MBRRACE-UK[3] report. In the UK between 2015 and 2017, Black women were five times more likely to die because of complications during pregnancy and the perinatal period than their white counterparts. Asian women were twice as likely to die.[3] This statistic not only raises questions as to why this is happening, but also the importance of addressing the multifaceted causes. I believe a key factor in making positive changes to these alarming statistics lies in how and what student midwives are taught and more importantly, what we're not taught.

WE SHOULD ACKNOWLEDGE THE PAST AND ITS IMPACT ON THE PRESENT

Throughout history we have seen the idea of race and connotations of differences equalling inferiority used in the field of medicine. It was used to justify James Marion Sims' repeated experimentation on enslaved women without the use of analgesia to advance gynaecological and obstetric procedures.[4] To this day he has medical instruments and the Sims Position named after him, but what do we know of the women whose bodies were used? With more historical context, student midwives can gain insight into how colonisation has impacted what we have been taught thus far and examine how it impacts the lives of people today. Let us not forget that behind the MBRRACE-UK[3] report statistics, real lives have been lost.

Our current curricula and healthcare system continue to reflect a longstanding colonial legacy.[5] Although this may not be intended, it evidently reflects and seeks to serve what is thought to be the dominant culture, which in this case is the white population. Such standardisation of midwifery education may perpetuate a lack of awareness, and in turn lead to failures in highlighting differences in the women and birthing people we care for. For example, when discussing the appearance of a newborn baby's skin, words like 'pink' and 'pale' are often the standard descriptors used. But we're not told what to look for or how to describe a Black or Brown baby's skin. The models used in skills lab are usually white, and when learning about the maternal pelvis we concentrate on the gynaecoid type. This is despite white people being the minority in global terms and the fact that pelvic shapes vary between geographical regions and also within the same populations.[6] The focus of the 'ideal' gynecoid pelvic shape has been the case for many years in midwifery education. Maybe now is the time to challenge this tradition in favour of more inclusive learning.

Eurocentric learning continues the reinforcement of white and western dominance and privilege, and the standardisation of education in healthcare does little to prevent Black and Brown bodies being othered. The same could be said for the use of the term BAME (Black, Asian, and minority ethnic), which is a blanket descriptor used to group an extremely wide range of ethnicities and essentially means anyone who isn't white. If this wasn't the case, why would medical student Malone Mukende see the need to create a handbook of clinical signs on Black and Brown skin?[7] Once again, this highlights the issue of racism in education not being confined to midwifery.

COLOUR IS NOT A RISK-FACTOR, RACISM IS

It is important for student midwives to have an awareness of how Black and Brown people have been, and still are, othered. Time and again we hear that Black and Brown birthing people are predisposed to underlying health conditions that may be behind the high mortality rates. Their diets, high blood pressure and BMI (which was devised with European men in mind) are all scrutinised as the causes of complications that arise during pregnancy and childbirth. Even the often-revered Ina May Gaskin infamously pointed the finger back at Black birthing bodies at a Texas Birth Networks Event held in 2017, citing drug use and unhealthy diets as causes of maternal mortality in Black women.[8] Black and Brown bodies are seen as the issue and not the systemic racism in healthcare, which largely goes unchecked. This draws chilling similarities to physicians blaming enslaved birthing women and their midwives for the high death rates of their infants, citing their lack of hygiene and superstitious beliefs as opposed to the horrific conditions they were forced to live in or the amount of forced labour they had to carry out each day.[9]

The belief that Black and Brown bodies are physiologically so dissimilar to their white counterparts may seem outrageous today, but in 2016 a study showed almost half of white medical students and residents held the hugely problematic and dangerous belief that black people feel less pain than white people, which lead to less appropriate care recommendations.[10] This is a clear indication of the prevalence of conscious and unconscious bias in healthcare today and the urgent need to tackle such beliefs before they become a part of how we practise as professionals. It is imperative that history is not whitewashed but confronted head on. If the midwives of tomorrow don't know enough about how we have ended up where we are, how can we begin to evoke change moving forward?

STUDENTS NEED A SAFE SPACE TO GROW

Having access to a safe space to openly reflect on or acknowledge our own bias or prejudiced views would provide students with an invaluable opportunity to not only challenge their own beliefs but also present a chance to learn how to challenge the language or behaviour of others.[11] As a student on placement, it's often easier to accept that some people will not change their behaviour or promise ourselves that we will not be the same, which only perpetuates current cultures. This is not enough for the women and birthing people in our care. As student midwives, our education should provide us with a safe learning culture that respects diversity and enables us to feel empowered through learning opportunities.[12] As a Black student midwife, to feel supported in the process of finding my voice and speaking up to challenge the status quo without the fear of being perceived as aggressive, penalised by practice assessors or not being taken seriously should be a given. It would be a great shame for students to feel they may as well give up before they even qualify, and an even greater shame to think this contributes to the attainment gap for Black, Asian and ethnic minority students.[13]

CONCLUSION

Decolonising midwifery education is not a simple tick-box exercise. Challenging such deep-rooted systems will need a sustained effort – the voices and actions from not only students but lecturers, deans and practicing midwives we work with. It will take more than reading lists that include literature from Black, Asian and ethnic minority authors or learning about cultural competence from ethnic minority birth workers, despite these being welcome interventions. To make a perceptible impact, there must be a combined effort to be the change we wish to see. Our learning culture must reflect the diversity of both the students and people in our care. With the veil around racism in healthcare falling, we can no longer claim ignorance. There is much work to do, and we must all play a part to ensure it is done. **TPM**

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WORKSHEET 3

'Students need a safe space to grow!' Exploring the role of education in overcoming racism in practice

REFLECTIONS:

My main 'take away'

My comforts and discomforts

My action/commitment:

Question 1: Reflect on your training and education experience. How was your education informed by privilege, considerations of identity and equity? (*Figure 7:* Interactive pop out to examples from student midwives)

Question 2: Can you name some examples of your own privilege, considerations and awareness in relation to racial equalities?

Question 3: What is your understanding of the term 'decolonising'? Can you give examples of how your training/education was informed by colonial systems and ideas? (*Figure 8:* Interactive pop out to a resource on understanding decolonisation)

CHAPTER 4

RETHINKING VULNERABILITY: LABELLING OF THE SO-CALLED 'VULNERABLE MIGRANT WOMAN'

Esther Sharma

The term 'vulnerable' has become increasingly used by midwives as well as widely across the health sector to describe various groups of the population. It is recognised that midwives play an important role in reducing health inequalities and inequities and there is an emphasis on providing targeted midwifery care to those who are considered to be within vulnerable groups in order to achieve this. One such group is the so-called 'vulnerable migrant woman'.

VULNERABILITY LABELLING AS PROBLEMATIC

In this context the term 'vulnerable migrant women' is often used collectively in the literature to describe any combination of women who are refugees, asylum seekers, undocumented migrants or recent immigrants, ignoring other categories of migrants. Among some categories of migrants (refugees and asylum seekers) there is evidence of poorer perinatal mental health[1-3] and difficulties in accessing maternity care, which can result in late booking and fewer antenatal appointments.[4-6] However, the evidence for the impact on obstetric outcomes is unclear, largely because of the fact that studies include varying categories of migrants and in varying contexts, rendering direct comparison problematic. Nonetheless there can be a tendency to assume that outcomes are worsened. This assumption is compounded by ethnicity sometimes being used as a proxy measure for migrant status.

Vulnerability in relation to pregnancy, childbirth and the postnatal period is poorly defined in the literature.[7] This vagueness not only reinforces 'othering' but can lead to a 'filling in of the blanks' or multiple interpretations of its meaning.[8] Such gaps or interpretations may be filled or informed by the stereotypical portrayal of migrants in the media – migrants stranded in boats eliciting pity or, paradoxically, the angry rhetoric of migrants adding pressure to already-stretched public services – creating unhelpful narratives. Additionally, the hegemonic migrant-trauma discourse often portrays women through a lens of despair and loss; as passive and dependent victims. This, in turn, can result in performative interactions with health professionals, resulting in service users enacting stereotypes of being docile victims rather than resilient individuals, capable of expressing agency[9] (an individual's ability to act on their choices).

UNDERSTANDING AND RESPONDING TO VULNERABILITY

Seeking to address the ambiguity of vulnerability around the time of childbearing, a concept analysis identified two categories from the existing literature that contributes to vulnerability: threats and barriers.[10] The authors found that threats could be physical, such as age or having a pre-existing medical condition; psychological, such as anxiety or confusion; and sociological, including deprivation or forced marriage. Barriers that were identified related to difficulties in accessing maternity care or the barriers created by health professionals when failing to engage appropriately with women. However, barriers that create vulnerability are far wider than this. Structural barriers are those political, economic, social and organisational power relations that can exacerbate vulnerability. Restrictive access to free NHS maternity care; dispersal policies resulting in women being rehoused with their newborns upon discharge from hospital[11]; the organisation of maternity care (access to interpreters[5] or clinic locations that women have difficulties physically getting to[6]); and austerity measures resulting in cuts to specialist services are all structural barriers that affect migrant women's ability to access or use maternity care.

The provision of respectful and dignified, individualised and person-centred care is important in addressing some of these threats and barriers, through, for example, the use of interpreters, culturally sensitive and empathetic care, appropriate multi-disciplinary referrals and relevant information. However, it is vital that structural barriers are addressed. Doing so will involve challenging discrimination and racism. Additionally, although working with community-based organisations and those whose activities include national-level advocacy may not be within the remit of most midwives' roles, supporting such organisations through awareness raising on social media, signing campaigns or fundraising can contribute to reshaping the structural barriers in order to reduce inequities for migrant women.

THE ROLE OF RESILIENCE IN SHIFTING AWAY FROM VULNERABILITY

In spite of this, there is a growing body of evidence demonstrating resilience in countering vulnerability. It has been found that women who experienced vulnerability through adversity were able to shift away from this vulnerability using resilience.[10] Rather than the misplaced notion of resilience being the ability to bounce back from difficulties, resilience here can be thought of as an adaptive behaviour that enables flourishing under adversity.[12] Vulnerability and resilience are not dichotomies, but are dynamic and overlapping. Indeed, migrant women may feel vulnerable in some aspects of life, while concurrently being resilient and expressing agency in others.[13]

Social support and networks, religious beliefs and personal characteristics such as optimism have been identified as factors that support resilience for migrant women.[14,15] Social support includes formal support, such as that provided by midwives. The importance of women having a midwife with whom a trusting relationship can be built can play an important part in enabling women to shift towards resilience from vulnerability,[10] as can vital signposting to community support groups and activities, especially if migrant women find themselves separated from family and kinship networks. Specifically, models of midwifery care that provide continuity of carer (CoC) can provide this vital social support, enable cultural understanding and safety and are positively experienced by women.[6,16]

CONCLUSION

By very virtue of being human beings, everyone has the potential to become vulnerable at some point.[17] The labelling of migrant women as vulnerable can be stigmatising and disempowering.[15] That is not to say it should be a term that is abandoned, because it is acknowledged that its use can legitimise additional support that midwives provide for women as well as access to funds and resources.[9] Nonetheless, it must be used with care and caution, recognising that *'these women are not simply victims to be coddled and pitied, but instead they build a framework to exercise their immense agency in meeting needs'*.[18(p.151)] The use of woman-centred language is powerful[19] and midwives have a unique opportunity in recognising the agency that women express and supporting their resilience through individualised care that meets their unique needs in their specific context, as well as challenging structural barriers. Further research is needed to understand the perspectives and lived experiences of those in so-called vulnerable groups on their perceived vulnerability, as well as the specific role that midwives play in increasing reliance through interactions with migrant women. **TPM**

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WORKSHEET 4

'Filling in the blanks!' Exploring the role of language in informing views and bias in healthcare

REFLECTIONS:

My main 'take away'

My comforts and discomforts

My action/commitment:

Question 1: How had language informed the way in which we understand the people we are caring for? (Use the Interactive glossary to access some of examples of words that impact how we group and categorise people)

Question 2: Write a summary critical review of this article, taking into consideration any examples of the role of limiting or restrictive language in your own practice/ context. (*Figure 9:* Interactive pop out on how to write a critical review)

Question 3: Choosing either the word vulnerable, minority or marginalised -think about an example of where the word has informed your interactions with a person in your care. What happened and how could your learning from this chapter inform more equitable care if you were faced with the same situation again?

CHAPTER 5

CULTURAL SAFETY IN MIDWIFERY PRACTICE-PROTECTING THE CULTURAL IDENTITY OF THE WOMAN

Sarah Esegbona-Adeigbe

THE CONCEPT OF CULTURAL SAFETY

The concept of cultural safety has been around since the 1980s and was developed in New Zealand to cater for the needs of the indigenous Maori population.[5] Williams states the concept of cultural safety as an *'environment that is spiritually, socially and emotionally safe, as well as physically safe for people; there is no assault, challenge or denial of their identity, of who they are and what they need'*.[6,(p213)] In contrast to cultural competency, the focus of cultural safety moves to the culture of the clinician or the clinical environment rather than the culture of the woman.[3] Women should be valued as cultural beings who have a personal view of how they wished to be cared for during pregnancy. Cultural safety stipulates that midwives should not focus on learning cultural customs of different ethnic groups but focus on being aware of differences, consider power relationships, implement reflective practice, and allow the woman to determine whether a clinical encounter is safe.[7,8,3] Unsafe cultural practice comprises any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual or does not recognise the cultural identities of individuals.[9,10] Cultural safety is needed in midwifery practice and should be a basic human right for all pregnant women.

MIDWIVES' PROFESSIONAL CULTURE

The midwifery profession has developed a culture with norms and beliefs guided by the statutory framework of the NMC that may impact on the achievement of cultural safety. Midwifery culture may also be internalised by individuals entering the profession created by training and teaching methods, which individuals adopt in order to become part of the profession.[11] The professional code of conduct specifies how a midwife should behave in order to maintain the integrity of the profession.[12] The midwifery professional culture may be conformed to despite the individual midwife's own cultural beliefs. It is alleged that healthcare professionals tend to lean towards ethnocentrism, whereby a person judges the culture of other people from the point of view of their own culture.[13,14] Any ethnocentrism in midwifery practice may result in a disregard of other cultures and lead to dominance of one's cultural beliefs over others, which conflicts with the concept of cultural safety. Unfortunately, midwives have been socialised into assuming control as part of their autonomous role, resulting in failure to identify and legitimise the cultural identity of the women they care for.[2]

WORKPLACE CULTURE

The workplace environment also has influence on the individual midwife's behaviour and views. A workplace environment can influence how things are done, who does what, and defines the hierarchical structure of an organisation.[15] Workplace culture is comprised of behavioural norms and practices that are expected and 'allowed' within a workplace.[16] If there are particular ways of performing or behaving in a workplace, this may become an integral part of a midwife's beliefs and attitudes. There may also be conflict between the midwife's beliefs and workplace practices that impacts on the quality of care that is provided to women. Some maternity units may have adapted practices that embrace women's cultural needs or this could be the opposite. The woman's cultural needs may fall to the bottom of the agenda when there is overwhelming pressure on maternity services such as during the COVID-19 pandemic. Cultural safety acts as a buffer against factors that impact on service provision which in turn may affect the quality of care.

INTEGRATING CULTURAL SAFETY INTO MIDWIFERY PRACTICE

Using critical consciousness

It is essential for midwives to recognise the assumptions and beliefs behind their thoughts and actions; they should recognise that the way they practice midwifery is influenced by their beliefs.[17] There is a call for midwives to understand the bicultural nature of the patient-practitioner relationship, beginning with themselves, their own race, culture and imprinted stereotypes.[18] Midwives need to be engaged in working towards cultural safety during midwifery practice by using critical consciousness. To do this, midwives must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture and the cultural systems in which they provide midwifery care.[3] This challenge of the midwife's own culture should be a subconsciousness process on a daily basis when caring for any woman, something that is always 'at the back' of the midwife's mind.

Involving women in decision making

Midwives should regard cultural competence as representation of good clinical practice and should regard each woman in the context of her own culture, as well as from the perspective of their own cultural values and prejudices.[19] Taking this approach inadvertently sets a basis for a culturally safe interaction where the woman is able to verbalise her views and foster a trusting relationship. Culturally safe midwifery practice can be achieved when there is no unintentional disempowering of women: indeed, where women are involved in the decision making and become part of a team effort to maximise the effectiveness of their care.[8] This should be a requisite for all midwife-client interactions; asking the woman to discuss her care needs at every stage during pregnancy opens up the opportunity for such interactions to occur.

Midwives need to be made aware and educated on the tools that can be used to develop cultural safety. Developing critical subconsciousness of cultural views is required by a midwife when caring for women and understanding that involving women in decisions made about their care is crucial for cultural safety. In particular, acknowledging that it is the woman who states that she has received culturally safe care is relevant. Organisations should be aware of any workplace cultures that can impact on the midwife placing the woman's culture at the centre of her care and allowing her to be involved in decisions about her care. Adopting these approaches can achieve cultural safety and effective midwifery practice that places the woman in a culturally safe environment and protects her cultural identity. **TPM**

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CHAPTER 6

IT'S TIME TO TELL THE TRUTH: ACTION NEEDED TO SUPPORT BLACK PEOPLE IN MATERNITY

Mars Lord

BLACK MATERNAL MORTALITY

By now, most of us are aware of the disparities in the maternal mortality rates for Black and white women – Black women are currently five times more likely than white women to die within the perinatal period.[1] Quite rightly, there has been a lot of focus on raising awareness of this fact. I should know, I'm one of the leading voices in that conversation. We continue to hear about how shocked people are at the statistic and how dreadful it all is. This is swiftly followed by the questions 'why?' and 'what is wrong with Black bodies?'. The outrage moves then to a small nod towards actions: 'We need to do more research.' And yet these worsening statistics haven't been hidden, they've just been steadily ignored while the disparity grows.

SMOKING AND SUDDEN INFANT DEATH SYNDROME (SIDS)

Let us look at smoking in pregnancy and also at SIDs. When we discovered that smoking caused smaller birth weight babies (and let's remember that doctors used to prescribe smoking to pregnant mothers for that same reason), we began to campaign and educate midwives, doctors, parents and communities about this.[2] We saw concerted efforts by people to reduce smoking in pregnancy. When we discovered that laying babies on their backs reduced the risk of SIDs (or cot death as it was known at the time), a national campaign was undertaken. I remember it so well, as my first child was born just 17 months after TV presenter Anne Diamond's son, Sebastian, died in July 1991. It was found that both smoking and laying babies on their fronts caused increased risk of SIDS.[2]

WHAT HAPPENS TO THE WHISTLE-BLOWER

Meanwhile, with all this playing out, Black midwives were talking about their treatment within the NHS; Elsie Gayle became known as 'the whistle-blower midwife'. Returning to work in the UK in 2002, Elsie was appalled at the way mothers and babies were being treated, particularly women of African descent. The response to her complaint was sustained bullying that took her to the point of suicide and bailiffs at her door, courtesy of Sandwell and West Birmingham hospitals.[3] At this time, women of African descent were found to have an 80-83% higher risk of unexplained severe maternal morbidity when compared with white European counterparts; were 50% more likely to suffer a stillbirth when compared with white mothers; and at higher risk of preterm birth than their white contemporaries. As you can see, things have got worse.

WHEN RACISM MEETS DEFENSIVENESS

The systemic and structural racism of the NHS has been called into question. Defensive responses have sprung from doctors and midwives decrying the accusation of racism. Instead of turning their faces and eyes to the rot within the NHS, they have called instead on white fragility and discomfort and all but screamed 'be kind' as they take the accusations of racism personally. It would appear that being called racist, even though what is being pointed out is that the system and structure are racist, is worse than actually *being* racist. The fact that Black and Brown women and birthing people are dying at higher rates is not, somehow, as offensive. At a recent conference,[4] organised by Elsie Gayle and a team of incredible women, where the topic of the day was Black maternal mortality, a senior NHS midwife interrupted two sessions to interject her opinion. This included taking the microphone during question time, when she hadn't been called on to speak, to state: 'What about white women?' The de-centring and erasure of Black women is not lost here. At a time when the conversation was all about them, defensiveness and white centring raised its head. The wonderful Jennie Joseph, NHS trained and the founder of the first-ever Black certified Midwifery school in America, continues to exhort us with the words: 'It's time to tell the truth.'[5]

THE RESEARCH LENS

And so we come back to the call for research. Elsie Gayle put in her complaints back in the early 2000s. The MMBRACE study shows year in and year out that the rates for the disparity continues to rise.[1] The statistics and the figures are there. The calls drawing attention to racism, implicit and explicit bias have been there for decades. Nothing changes. Just yet more calls for research. I have an inbox full of requests, and sometimes demands, that I break down the MMBRACE study, give reasons for, and assist in information garnering about the disparities, from white midwives who wish to 'know about' and 'write about' this awful tragedy, so that their PhDs can be published and put up on shelves. More research, as Black women continue to die. The lens remains a white lens. Where are our Black researchers? Where is their funding?[6] The funding goes to white researchers and so again, in a crucial area, Black voices are erased. There are countless articles where my words have been used, but the article written by white women. Articles that are sent to me to proofread or make comment on. There is nothing new under the sun. Within the Black community, we know it isn't racism until the nice, white lady says it is.

A GLOBAL SHIFT?

After the video recorded murder of George Floyd on 25 May 2020, there came a groundswell of noise and Black lives were once again news. This is not to say that their murders and the implicit and explicit racism has ever been hidden, just that white eyes were beginning to turn towards it. Eight minutes and forty-six seconds caused a global shift in attention to the brutal racism experienced by Black people, particularly in America. For some, it was the first time they had been truly confronted with it. The video recording made national and international news. White people demanded examples of racism and here in the UK, many assumed that the problem was 'an American problem' but how many of you know about Cynthia Jarrett, Cherry Groce, Joy Gardner and Mark Duggan?[7] Perhaps you have fleeting memories of the brutal, unprovoked murder of Stephen Lawrence.[8] The demanding of examples of racism points clearly to the lack of belief when Black people speak and we verge into Black trauma porn when we continue to search through and watch and relay stories we've heard of racist brutality. 'If all we ever do is react to racial violence, then all we literally ever do is react to racial violence.' Ravideep Kaur, Instagram September 2020.

It's time to move from reaction to ACTION.

TEARS, SELF-FLAGELLATION AND INACTION

This is where tears begin to flow and fear of making mistakes rears its head. This fear of making a mistake leads to inaction and silence. The words that rise are 'I'm not one for public conversation about this'; 'Just because I'm not speaking about it, doesn't mean I'm unconcerned'; and 'Why do people expect me to speak up just because I have a large platform?' It's funny how so many of the 'silent' warriors can rant and rage about feminism (white centred), plastic, climate change and COVID-19, but cannot speak up for Black women dying in front of their eyes. This is a time for action. Yes, mistakes will be made. Of *course* mistakes will be made. That's where most of our learning comes from. Our mistakes. The only true mistake is to hide behind defensiveness when we discover we've spoken or acted out of turn. Much simpler, but for many not easier, is to hold our hands up and say: 'I did that wrong. I made a mistake.' No need for long-winded explanations as to why that wasn't your intention and that truly your heart is good and that you have a Black friend, lover, partner, child. This is a time to pause before action. Pause, *not* stop. This is a time to look at ourselves and where implicit bias shows up in our lives, in our homes, in our workplaces, in our education, within our families. We need to stop turning to oppressed people to ask them how we can stop oppressing them.

EDUCATION AND CHANGE

It's time to call out bad practice. We need to root it out of the systems and structures. We need to decolonise (an oh-so-trendy word at the moment that detracts for the actual need to decolonise) our medical curriculum, our systems of training and supervision. We need to ask why Black midwives are far more likely than their white counterparts to be referred to the Nursing and Midwifery Council (NMC).[9] We need to ask why they are silenced and forced into narrow paths of operation where they dare not speak up against injustice for fear of loss of career. We need to re-educate ourselves. Strip back the eurocentric learning and embrace the cultural differences of the people around us, and their different cultural needs. No more complaining that 'they' won't come in to us.[10] We need to find ways to go out to those communities, and not just to impose our 'superior' education and ways, but to listen and to learn.[10] To change one small thing within our own practice. To demand one action of change within our hospitals and our beloved NHS.

CONCLUSION

It's time to update our own personal education, so that we can make changes within ourselves, our communities and our workplaces. Midwives like Illiyan Morrison, of Mixing Up Motherhood, are creating and running workshops around advocacy. Within *The Practising Midwife* we are beginning to see more articles and information written by Black and Brown contributors. *The Student Midwife* has a Black editor, which ensures the Black voice isn't muted and made palatable to white readers. We're beginning to see the colouring in of the landscape of birth. Each of us needs to take personal responsibility for our work and our learning. This is not the time to follow trending accounts and refuse to look beyond the pretty imagery. Black women are dying. We are rapidly approaching the time when the latest figures are released by MMBRACE. It's time to stop procrastinating and hiding behind discomfort. It's time to elevate and join Black and Brown voices as they cry out for reproductive justice. In the words of one of my favourite beings, Angela Davies: 'It's time to change the unacceptable.' **TPM**

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CHAPTER 7

WE HAVE A DREAM: MIDWIVES MAKING CHANGE

Samukeliso Sibanda and Fatima Ezzahra Ghaouch

BACKGROUND

The increased disparity in maternity in the UK has been a cause for concern for a while. It is well evidenced that Black, Asian and minority ethnic (BAME) women in the UK have been known to have an increased risk of dying in childbirth or in the first year following the birth of their child compared to other ethnic groups.[1] In fact, the 2018 report by MBBRACE-UK[1] and others studies show that BAME women are more likely than white women to die during childbirth. Black women are five times more likely to die as a result of complications in their pregnancy than white women.[1] For women of mixed ethnicity, the risk is threefold and for Asian women it is double.[1] Significant ethnic inequalities in maternity outcomes persist in the UK and the determinants of these ethnic health disparities are clearly multifactorial.[1]

The Better Births review made a few recommendations to address some of the issues that were highlighted.[2] One of the recommendations was that women should be cared for in a continuity of carer[2] (CoC) model. This means women should have CoC from a small number of midwives, where each woman should have a named midwife who will provide most of the woman's care, antenatal intra partum and postnatally. Following the publication of Better Births in 2016,[2] the NHS is undergoing a National Maternity Transformation Programme[3] aiming to implement a vision of more personalised and safer care across England. The current aims are: to reduce the rates of still births, maternal mortality and neonatal mortality and brain injury by 2025.[4] As part of these recommendations, Northampton General Hospital in November 2019 launched two CoC teams. The Sapphire team was launched to look after women from BAME backgrounds, geographically identified from a GP practice, as well as women from an area of social deprivation, which is the focus of this article.

WHY BAME; WHY US?

Our Sapphire team consisted of seven midwives. Samukeliso was the CoC champion and Fatima worked as part of the team. We identify ourselves as part of ethnic minorities, we both went through the migration process and we are passionate midwives. We have a passion for providing women and their families centred, holistic care. We are mindful of our journeys and how they have impacted on who we are today. We share the same work ethics and have worked hard to understand deeply the disparities and the health inequalities faced by people from ethnic minority backgrounds. Working in a multi-ethnic, multicultural NHS, we are keen to be part of the transformation plan and deliver CoC to the women in our society. We look forward to seeing the improvement in outcomes for all women cared for in this model of care.

BEING A MOTHER IN FOREIGN LAND

A key focus of our work is to support women who have migrated to the UK. As diversity and migrations are part of modern societies, and as societies become more multicultural, it also influences the health system. The migration flow is determined by the international scenario that involves conflicts, economic crisis, wars, political and ethnic persecutions or humanitarian catastrophes.[5] This brings a series of difficult and complicated changes for the person involved that is considered migratory trauma.[5] These situations can be more critical for women, and being a mother in a foreign land may increases vulnerabilities.[6] Migration requires psychic work, where encultured ideals of belonging can be in contradiction to the new and unknown context with different medical, cultural and social ways of thinking.[6,7] This is further complicated by constraints imposed by migration: acculturation, solitude and individualism.[6] These mothers experience birth as a state of insecurity and suffering that can involve the whole family. They find themselves deprived of a family support network, dealing with solitude and social exclusion.[6]

Migrant women are more likely to access care later in their pregnancy due to several factors[7,8,9]:

1. Lack of understanding of services available and how to access to them
2. Different cultural beliefs about the importance of healthcare
3. Poverty and domestic abuse
4. Fear of attending hospital
5. Fear of being charged
6. Poor administration between different health and social care services
7. Difficulty registering for services and misinformation about entitlements to healthcare
8. Language and cultural barriers
9. Racism and discrimination.

The UK can be classed as a multi-ethnic society, where cultures from all over the world are found. It is therefore essential for healthcare professionals to be aware of all the factors that may contribute to adverse outcomes for women from other ethnic minorities in our care, and recognise that the lack of accompaniment, support and understanding means loneliness can become a threat for these women. Such awareness is what drives our work within the CoC model, to attempt to mitigate against these factors so that women are supported to achieve positive outcomes.

PROVIDING CULTURALLY SENSITIVE CARE

While the physiology of birth is universally the same, there are different ways of managing pregnancy, birth and postpartum. For this reason, from an anthropological point of view, childbirth is an enigma.[12] It is a cultural object surrounded by social and moral rules rooted in culture, influenced by the social environment and social structure.[12] When it comes to cultural consideration, it is not purely down to language differences, but all aspects of different expectations that are based on the different background.[12] A cultural and ritual vision of birth also involves the interpersonal relationship between the woman and the midwife, including the gaze, the position of the body, the touch and tone of the voice.[12] The rituality is concentrated in the gestures, in the procedures, in the words, which on one side channels the collective emotion and on the other accompanies this mysterious and significant event.[12] It is important to recognise for second-generation women that, despite being born in the UK, their ancestral birth knowledge is a point of reconnection that may deviate from the UK expected cultural norms.

If the providers, organisations and systems are not working together to provide culturally competent care, patients are at higher risk of having negative health consequences, receiving poor-quality care, or being dissatisfied with their care. To obtain a change in health services, training of health personnel is required, which is often scarce and incomplete. A collective work of reflection, research, asking questions and confronting ourselves is important, even by critically observing our own cultural elements. We can conclude that our attitudes must be dictated first by respect beyond tolerance for differences, by an interest in cultural diversity, which helps to think about the world. We need to find a balance between the selfless search for cross-cultural work and our medical responsibility. This is a key advantage of working in a continuity model, where the primary intention is to build a relationship of trust with those in our care,[10] as evidenced by the improvement of outcomes (*see Box 1*), which means we are able to offer culturally-sensitive care, respond to women's needs and improve outcomes.

***BOX 1:* MIDWIFE-LED CONTINUITY MODELS OF CARE COMPARED WITH OTHER MODELS OF CARE FOR WOMEN DURING PREGNANCY, BIRTH AND EARLY PARENTING[10]**

16% less likely to suffer pregnancy loss;

19% less likely to lose their baby before 24 weeks;

24% less likely to experience pre-term birth;

15% less likely to require regional analgesia;

16% less likely to have an episiotomy;

THE FUTURE

A reorientation of services is necessary to meet the needs currently identified. Our goal is to take care of the birth path, to support the women who carry in their wombs the future of our societies. Therefore, we have an important role to stop this multigenerational circle of disadvantages. As such, CoC is our opportunity to:

1. Create spaces for welcoming, attending and taking care of patients through multidisciplinary work to identify treatment and support strategies. With our role as midwives it allows us to create a harmonious and balanced therapeutic relationship based on trust that allows us to identify needs, problems and any fears, anxieties and stress.
2. Reduce health inequalities through the work of proportional universalism as identified by Marmot[11]
3. Encourage language mediation when it is necessary to cope with language barriers
4. Provide anthropological and psycho-social training of personnel for adequate cultural competence
5. Challenge racial and cultural bias within the system.

CONCLUSION

Understanding diverse cultures can only but enrich midwifery and make it the great caring profession it is. It cannot be echoed enough that in providing CoC in midwifery, we will begin to see the improvement of outcomes for the women in our care. It is more about being conscious of our unconscious bias, it is taking action to overcome the structural disadvantages many women face. COVID-19 has magnified the disparities of care faced by BAME women. We at Northampton General Hospital are in the process of setting up a further two BAME teams post COVID-19. Watch this space. **TPM**

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CHAPTER 8

THIS HURTS US MUCH MORE THAN IT HURTS YOU: THE LIVED EXPERIENCES OF BLACK, ASIAN AND MULTI-RACIAL STUDENT MIDWIVES

Alicia Burnett

HARD TO REACH?

When the Office for Fair Access (OFFA) challenged universities in England to increase the participation of under-represented ethnic groups in higher education (HE),[3] they ostensibly tackled this challenge with vigour.[4] As recently as 2019, 44.5% of applicants who obtained a place at university were Black, 35.5% of successful candidates were multi-racial, and 50.3% of HE applicants were Asian.[5] Indeed, non-white students are now attending university at higher rates than their white counterparts and, in 2019, only 30.3% of university entrants in England were white.[4] Outwardly, it appeared that English HEIs had succeeded at widening Black and Brown applicants access to their universities.[7] However, OFFA also gave universities the task of increasing ethnically diverse candidates' access to Oxbridge and Russell Group universities, yet some ethnic groups remain under-represented at these higher-tariff institutions,[6] which include universities that offer undergraduate midwifery study.

HARD FACTS

Attrition rates among almost all non-white ethnic groups remain persistently high when compared with that of their white peers. Asian students are 3%-17% less likely to be awarded a first or 2:1 degree classification than white students, whereas Black students are 6%-28% less likely than white students to get a first or 2:1 degree.[7] These racial disparities within HEIs have been attributed to numerous factors, including the increased likelihood of students from marginalised ethnicities coming from areas with low HE participation and lower-income families.[2-4] Previously, racism and racial discrimination were often overlooked as contributing

factors to attainment gaps between white and non-white ethnic groups in undergraduate education. This is because HEIs consider conversations about race too uncomfortable to broach, refuse to acknowledge that racism exists in HE, or are unaware of racial or ethnic attainment gaps within their own institutions.[2,7] It is widely accepted that discussions about race and racism are uncomfortable conversations to have, but discomfort does not absolve vice-chancellors, senior leaders and academics from their responsibility to address racial inequities within the academy.[2,8]

HARD LESSONS

While there has been considerable focus on HE access, attainment and retention among ethnically diverse students,[2,3] there is a lack of data about how racial disparities influence the learning experiences of non-white student midwives. We already know that race and ethnicity can significantly impair degree outcomes,[2] but we also have limited insight into the emotional burden associated with being a Black, Asian or multi-racial trainee midwife in the UK. Oxford Brookes University has commissioned research into the experiences of current and prospective midwifery students from marginalised ethnic communities,[9] but until this research is published, anecdotal insights from student midwives across the UK provide a valuable knowledge base.

Despite UK universities improving access for ethnically diverse students, midwifery trainees have disclosed that their cohorts do not reflect this inclusivity. Black and Brown students have described feeling as though they 'stick out like a sore thumb' in practice and at university, with multi-racial and white-presenting students in particular being repeatedly asked to reaffirm their racial identities, because their physical appearance or name are indicative of 'otherness'.[10,12] Since a sense of 'belonging' is a determinant of student engagement, well-being and outcomes,[2,11] universities must prioritise making their midwifery intakes diverse as a strategy to promote the well-being and attainment of Black and Brown student midwives. The lack of diversity among midwifery academics – fewer than 1% of UK-domiciled professors are Black[2] – is also cited as an issue that undermines non-white students' sense of belonging, and makes them less likely to report racial harassment, which, ultimately, impairs HEIs ability to detect and address racial abuse.[2,7] Further experiences that exacerbate Black and Brown midwifery students' feelings of vulnerability and isolation include educators, peers and clients being surprised by their presence on a midwifery programme,[2,7,10] as well as racial harassment from students, academics and practice supervisors.[8,10] On the other hand, working alongside ethnically diverse midwives can *heighten* feelings of belonging. Some learners even express 'joy' when they encounter midwives from similar cultural backgrounds, because they provide real-life examples of what Black and Brown students can achieve,[2] particularly if they have overcome perceived cultural barriers to success, such as speaking English as a second language.[10]

HARD TO BEAR

Sixty-six per cent of students affected by racial abuse do not report it to their universities;[8] this worrying statistic can be explained by the negative consequences described by non-white student midwives, such as being disbelieved, having racial harassment dismissed as harmless jokes, and being 'frozen out' by lecturers, practice supervisors and other students.[8–10] Senior leaders must support their universities to develop effective, institution-wide mechanisms for responding to racial discrimination, which are simple, anonymous where possible and informed by the experiences of students from diverse ethnic backgrounds.[8] The failure of universities and practice learning partners to adequately respond to microaggressions or overt racism gives rise to a deeply disturbing question: if midwifery students, educators and midwives are able to racially abuse non-white student midwives with impunity, are Black and Brown women, birthing people and babies safe? This is a particularly pertinent question when the UK's disproportionate maternal morbidity and mortality rates for Black, Asian and multi-racial women are considered.[14] All universities offering midwifery programmes must modify their recruitment processes to include screening for implicit and explicit racial bias, to prevent bigoted applicants from becoming student midwives, thereby mitigating ethnically diverse women and birthing people's exposure to racial discrimination and promoting healthy outcomes. The mental health of Black and Brown students would also benefit from racist candidates being disbarred from midwifery training, because students report that racial harassment has precipitated anxiety,[10] depression and suicidal ideation.[8]

HARD WORK

The influence of intersectionality upon the racial inequities faced by Black and Brown student populations cannot be underestimated.[4,13] Some non-white Muslim student midwives have reported racism compounded by Islamophobia, whereby women and birthing people respond adversely or with curiosity to their presence in maternity settings.[10] Students from Black, Asian and multi-ethnic backgrounds also describe feeling pressure to work harder than their white counterparts, because being one of so few non-white students places them under more intense scrutiny than their less conspicuous white colleagues.[10]

The ubiquity of Eurocentric language, simulation body parts and imagery in midwifery learning materials centres on white birthing people and infants, while erasing and marginalising their non-white counterparts.[10] Eurocentric midwifery curricula also suggest the safety of Black and Brown parents and babies is not a priority in the UK, as students and midwives do not learn how cyanosis and other clinical signs of deterioration manifest in non-white individuals, or even how to assess for visible signs of jaundice in babies with darker skin tones. Midwifery education must be decolonised as a matter of public safety, for example, citing localised 'redness' as an indicator of mastitis or phlebitis, irrespective of a woman's ethnicity, increases the risk of misdiagnoses. Some midwives are modelling care that perpetuates systemic racism and poor pregnancy outcomes by withholding analgesia from 'strong Black women' and 'Indian princesses', and only screening non-white women for sickle cell disease, thalassaemia and female genital cutting, because these complications 'don't affect white people' – this is untrue.[10] Practice learning partners must embed comprehensive anti-racism and allyship education into annual mandatory training, as part of wider strategies to make maternity services more inclusive educational spaces, while supporting midwives to become culturally safe practice supervisors.

CONCLUSION

The racial harassment of students from ethnically diverse backgrounds must be addressed through the integration of modified recruitment and complaints processes, as well as the strategies outlined by the Universities UK (UUK) report *Tackling racial harassment in higher education*.[8] Key stakeholders in the HE community, student advocacy groups and the National Union of Students need to hold UK universities accountable for responding to racial discrimination experienced by non-white student midwives. The experiences presented in this article are real and they may make you uncomfortable, but remember, this hurts us much more than it hurts you. Protect Black and Brown student midwives. **TPM**

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WORKSHEET 5

'Who you are and what you need!' Exploring the meaning of cultural safety

REFLECTIONS:

My main 'take away'

My comforts and discomforts

My action/commitment:

Question 1: Describe your education or practice environment culture in relation to people's varying characteristics and identities? (Use the interactive identity wheel to consider a range of identities that differ from your own)

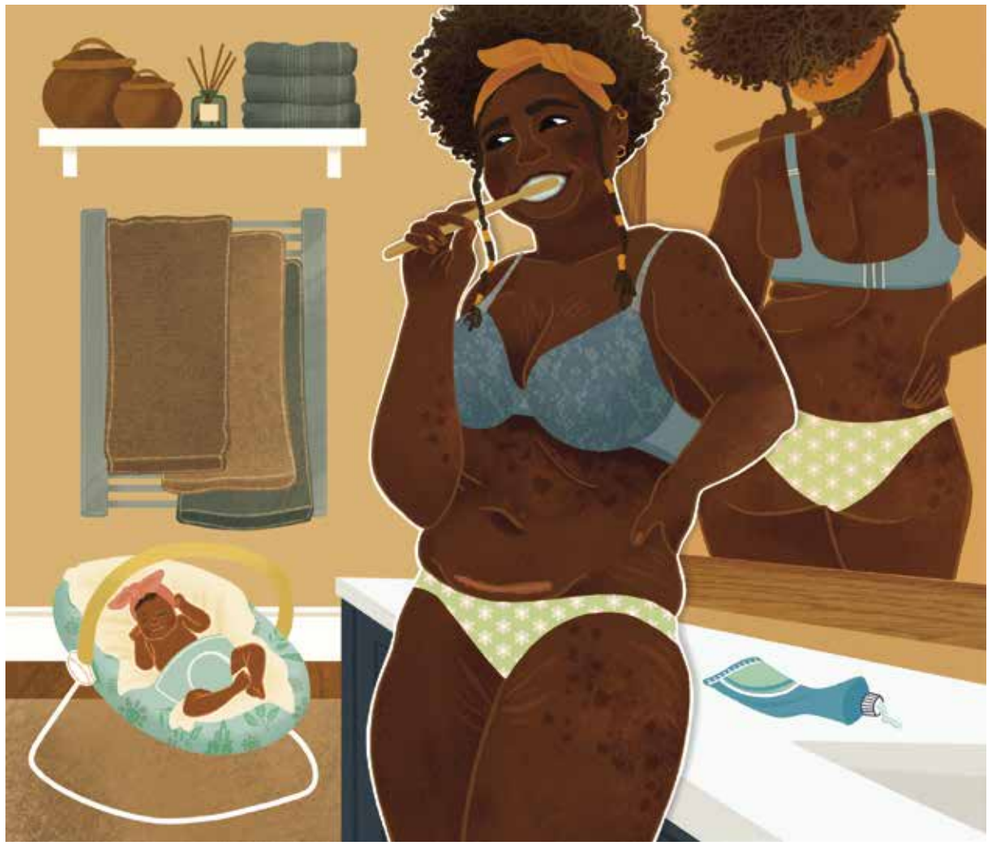
Question 2: Define cultural safety in your own words. (*Figure 10:* Interactive pop out to a list of resources on expanding definitions and understandings of cultural safety)

Question 3: Give some examples of environments of which are culturally safe. How can you act to integrate cultural safety in your work or study environment?

CHAPTER 9

DECOLONISING MIDWIFERY EDUCATION PART ONE: HOW COLOUR AWARE ARE YOU WHEN ASSESSING WOMEN WITH DARKER SKIN TONES IN MIDWIFERY PRACTICE?

Maureen Raynor, Zaheera Essat, Diane Ménage, Maxine Chapman, Bernadette Gregor



INTRODUCTION

There is a dearth of literature regarding the nuanced presentation of clinical features in mothers and babies with darker skin tones. Yet skin examination is a vital component of any physical assessment of maternal and neonatal wellbeing, not least because it plays a crucial part in determining physiological parameters alongside blood pressure, temperature, respirations and pulse, and aids in the timely recognition of developing complications that may lead to poor outcomes.

A recent MBRRACE report[1] on maternal morbidity and mortality in the UK highlighted the stark health disparities between women from Black, Asian and Minority Ethnicities (BAME) compared with those who identify as white. The COVID-19 pandemic has also magnified the problem. Therefore the specific risk to women with darkly pigmented skin should no longer be overlooked. It might be possible that lack of understanding on how deviations from the norm may manifest in individuals with Brown and dark skin could mean that early developing morbidity is missed.[2] Against this background, the drive towards decolonisation in midwifery theory and practice is helpful in building momentum in terms of midwives being colour aware instead of colour blind. This will close the gaps, reduce health inequalities and rebalance the Eurocentric perspective of the language used to communicate assessment and documentation of skin changes in women with darker skin tones. Furthermore, the lack of resources showing a balance between how critical illness may manifest in dark-skinned women compared with their white-skinned counterpart is of concern, as it reinforces colour blindness and whiteness as the norm.

The skin is the largest organ in the body; as alluded to earlier, it can be readily observed in an unobtrusive way to provide a gauge of perfusion, body temperature and oxygen saturation levels. A full and thorough skin assessment should include a detailed history taking, listening to women and effective communication, both verbal and written. Commonly, midwives are educated to recognise certain changes in skin colour that signal deviations from normality. Much of this knowledge is based on the care of women with light skin tones. It is much more challenging to determine these visual cues in women with darker skin. It is imperative therefore that midwives are educated to assess and recognise skin changes in all skin tones in order that they can care for women with confidence using clinical judgement. This article is the first in the series of two that places the spotlight on the subtleties involved when assessing the skin of women with darker skin tones. The second article will explore the neonatal context.

COLOUR AWARENESS VS COLOUR BLINDNESS

In acknowledging the diversity in skin tones, it is important to remind midwives that skin pigmentation relies on four main factors: the variety of carotene pigments in the subcutaneous layer of the skin; the amount of haemoglobin and general oxygenation; the degree of melanin present in the epidermis; and the presence of other essential pigments such as bile.[3] Melanin is the dark natural pigment that gives skin, hair and eyes their colour.[3] The amount of melanin present in a person's skin is primarily determined by their genetic inheritance. The levels of melanin are also influenced by lifestyle and behaviours that result in frequent exposure to the sun. More melanin is produced with repeated sun exposure.[4] Therefore, melanin plays an important role in protecting the skin from the harmful effects of UV radiation, filtering sunlight before it damages the cells of the skin. Hence the close association between an individual's skin tone and their (or their parents) place of origin.[4] Clearly, individuals with dark skin tones have more melanin than those with lighter skin tones. Melanin is synthesised by a specialised group of cells known as melanocytes and sunlight promotes the synthesis of melanin, leading to darkening of previously synthesised melanin.[4] The variations and differences in skin pigmentation across the racial spectrum are due to the amount of melanin produced rather than the number of melanocytes per se.[4]

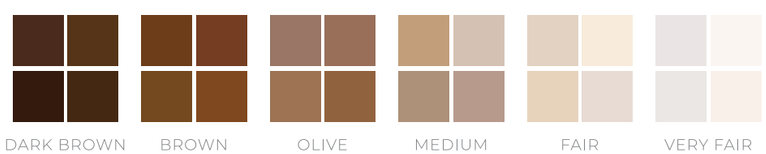
CLASSIFICATION OF SKIN TYPES

There are a number of nomenclature used in determining skin type when assessing individuals. The popularised Fitzpatrick[5] system (*see Table 1*) of classification lists six gradations. However, it is argued that this spectrum is quite limited and biased towards Caucasians as only one category is used to depict the myriad of individuals with variations of darker skin tones, therefore *see Picture 1* for greater variation.

***Table 1* Fitzpatrick system of classification**

The Fitzpatrick[5] system of classifying skin type		
Type 1	*Very fair skin tone: burns and never tans*	
Type 2	*Fair skin tone: burns and sometimes tans*	
Type 3	*Medium skin tone: burns sometimes and always tans*	
Type 4	*Olive skin tone: rarely burns and always tans*	
Type 5	*Moderately pigmented brown skin tone: never burns and always tans*	
Type 6	*Darkly pigmented/ black skin: never burns, always tans*	

***Picture 1* – Diverse skin tones**



ANTEPARTUM PERIOD: SKIN CONDITIONS OF SIGNIFICANCE

The pregnant woman will experience a number of changes and this includes vicissitudes to the skin. Some changes to the skin may be aesthetic in complication and resolve after birth but, as in the case of melasma, the dermatoses are more prominent in skin of darker tones and the characteristic dark patches to the woman's face can create significant distress and may not fade immediately after birth. Treatment measures are complex and often contraindicated in pregnancy and with breastfeeding.[6] Polymorphic eruption of pregnancy is a rash that can present across the body and create significant discomfort; namely pruritus, burning and stinging. The presentation of the lesions in lighter skin tones is pink or red[6] but in darker skin tones will be the tone of the skin or darker, which may not be immediately noticeable and thus requires a review of symptoms experienced by the woman (*see Picture 2*). Atopic eruption of pregnancy is suggested to be benign,[6] however, it causes chronic eczema with dry, thickened and itchy areas. In darker skin tones, it can cause complications like dark spots or hyperpigmentation in the presence of acne or other skin irritations. Early treatment, particularly with acne, is therefore suggested but many pharmacological preparations are contraindicated in pregnancy.[7] Pemphigoid gestationis is a rare autoimmune disorder that can occur in pregnancy and after birth.[8] It presents as inflammatory skin lesions and severe pruritus. Although it is more common in fairer skin tones, the presentation in darker skin tones will be a darker-toned rash that develops into blisters rather than a pink rash.

***Picture 2* – Skin rash**

BRUISING

Bruises, irrespective of skin tone, will develop in the same way in antepartum women. The expected redness to the skin, however, will not initially present in darker skin tones (*see Pictures 3-5*). This is significant as trauma, including cases of domestic abuse, have the potential of being missed. In darker skin tones the affected area, as the bruise develops, will become darker in colour.[9] The anticipated bluish or purple colour will be seen on lighter skin tones. The palpation of the skin where obvious bruising is not seen may identify a swelling, which will warrant further investigation.

***Pictures 3-5* – bruising**

PALLOR AND CYANOSIS

Skin colour is often used as a predictor for morbidity in antepartum women. Although this may be a useful indicator of compromise, the presentation will differ depending on the skin tone of the woman. Cyanosis is often indicated by a woman's skin colour and in lighter skin tones the bluish tint of the skin and mucous membranes is evident.[2] In darker skin tones, however, it will be recognised as a greyish or white colour, which will be seen to the skin in the region of the mouth and conjunctivae. Pallor, too, which may indicate anaemia, in darker skin tones is assessed by examining any paleness to the conjunctivae[2] and mucosa rather than the limbs.

ADMISSION TO HOSPITAL AND/OR STAY IN HOSPITAL

During labour in a hospital setting, each NHS hospital has clinical guidelines and risk assessment proforma such as the Braden scale (reported to be the most validated and reliable risk assessment tool) to identify women at risk in order to prevent pressure ulcer formation.[10] Regardless of skin colour, an initial risk assessment of the skin must be carried out within two hours of the admission

process for all women who present with known risk factors, such as altered level of consciousness/sensory impairment and impaired mobility. For the majority of women who do not have any identifiable risk factors, the risk assessment must be performed within six hours of admission.[10] For women who are immobile and/or at greater risk, for example, those with major disability, especially where mobility is affected, there must be re-evaluation of the skin at intervals. This is particularly important if there is any change in the woman's condition, such as epidural in situ or delay in the second stage of labour; following obstetrical interventions such as an instrumental birth or episiotomy; handover of care/change of shift; if the woman is transferred to a postnatal ward and on discharge from the hospital setting[10] (how to assess for ulcers is provided in the postnatal section). While we were unable to source an appropriate image for this article, there are numerous pictures of pressure ulcers in darker skin tones that can be accessed via Google.

Intrapartum period

Many midwives use their skills of observations to identify visual cues during labour when assessing progress in women who present in spontaneous physiological labour.[11,12] These visual cues are commonly referred to as the purple line and rhombus of Michaelis, recognised as less intrusive means of assessment compared to digital vaginal examinations. The purple line is described as a reddish/purplish or even brown line that arises from the anal cleft/margin, which extends between the buttocks as labour advances.[11,12] It is easier to identify on women who are light-skinned but is less useful in women with dark skin tones.[11,12,13] However, the rhombus of Michaelis might be a more helpful sign in women with dark skin tone.[13] This is where a kite-shaped area between the sacrum and ilea can be observed, regardless of skin colour. It is noticeable towards the commencement of the second stage of labour when the fetal head is deep within the pelvis and the wings of the ilea push outwards to increase the pelvic diameter.[11,12] Creating an environment that is conducive to a spontaneous physiological birth often means dim lighting will be a challenge when observing the skin of women with darker skin tones. A torch in this instance can be invaluable, as well as actively listening to women and noting any changes to symptomatology they report. The parameters outlined previously to assess the skin during the antepartum period will also apply in labour.

Postpartum assessment

As midwives, it is urgent that we address the continued racial inequities that exist in healthcare including the fact that women categorised as BAME are more likely to die during the six-week postnatal period than white women.[1] The midwife's confidence, therefore, in the holistic assessment of women postnatally, including women of varied skin tones, is essential to ensure anomalies and potential complications are recognised and referred appropriately. Below we offer information of how to carry out a postnatal assessment that is inclusive to women with Black/Brown skin colours.

Breasts

An inspection of the breasts is important where nipple trauma, for instance, may present. Skin lesions to the nipple is considered to be pink or red in colour and during inspection the trauma is clearly visualised but in darker skin tones these typical colour representations will not be evident and will require a consideration of features other than colour.[14] These include listening to the woman and asking her about the signs and symptoms she is experiencing. Women who experience breastfeeding complications such as mastitis are often asked to observe for indications like redness to the breast, but in darker skin tones this will not be evident. However, changes to the skin colour, like hyperpigmentation, may be seen. In addition, bruising, is a potential complication of breastfeeding and may also be present. Although the process of bruising, irrespective of skin pigmentation, is mainly consistent, the presentation will vary. In darker skin tones, the trauma may not initially be detected because the reddening of the skin will not be seen, but the skin will appear darker in shade and a swelling might be evident and palpable at the site. Unfortunately, there is a dearth of images related to breastfeeding complications and we hope to update this article at a later date.

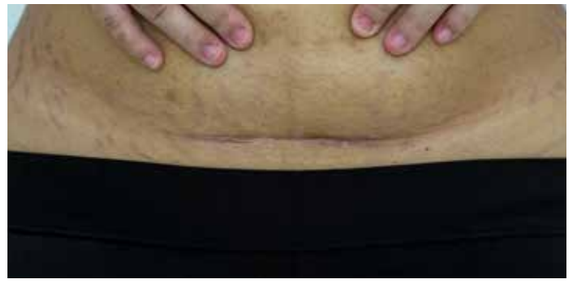
Perineal assessment

The skin is assessed to ensure wound healing[15,16] during the examination of the perineum; the abdominal wound for signs of infection; and wound breakdown as part of the postnatal examination. Injury to the genitalia of darker skin tones, however, is often not visualised and more likely to be missed and not treated. It is questionable therefore, how effectively perineal trauma, after birth, is recorded for women of darker skin tones. Furthermore, the UK and Ireland Confidential Enquiry into Maternal Deaths identifies that mortality related to genital tract sepsis was largely contributed to delayed diagnosis and incomplete assessment.[1] It is suggested that the rate of wound healing varies and scars will eventually fade.[16] Yet, in skin of a darker pigmentation, we know that keloid scarring (over granulation/an overgrowth of scar tissue extending beyond the original wound) is more common, which can lead to pain and discomfort. The additional aesthetic complication of wound healing where dyspigmentation results can also have a negative psychological impact.[17]

ABDOMINAL WOUND ASSESSMENT

The skin is also assessed following a caesarean section to ensure effective wound healing. Although in lighter skin tones some redness to the scar may be seen and the scar is expected to fade, in darker skin tones a white or brown discolouration to the scar tissue is likely (*see Picture 6*). Keloid (*see Picture 7*) and hypertrophic (raised at the wound only) scarring, following caesarean section, are also more likely in darker skin tones and excessive scarring can impact on the mother's physical and psychological health.[18]

***Picture 6* – Healing caesarean wound**



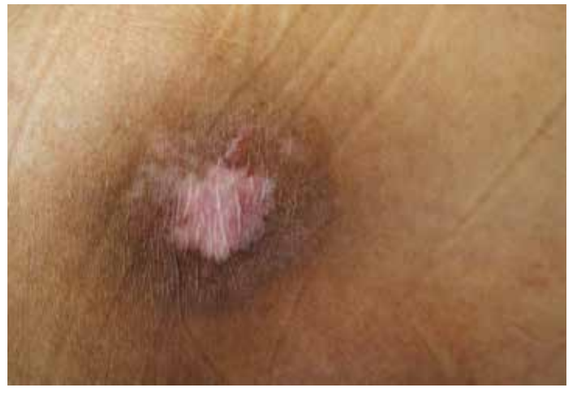
***Picture 7* – Keloid scarring from vertical incision**

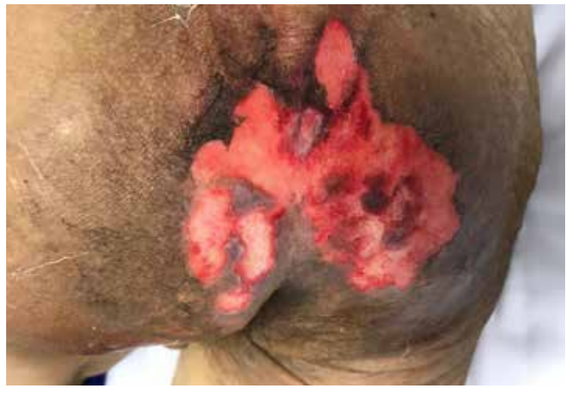
Pressure ulceration, which is not given enough consideration, is an avoidable injury to the mother.[19] For women who are immobile for any length of time, it is imperative to assess for ulceration.[10] Early changes in the skin are noted through the use of inspection and tangible signs like non-blanching erythema response, but this will not be visualised with darker skin tones.[20,21] Furthermore, the dependence on redness as an indicator of inflammation is not suitable for all skin tones. Other cues that establish tissue perfusion need to be considered. These include:

- applying light pressure and assessing for any pain or discomfort
- when observing for pallor, the mucous membrane must be examined in darker skin tones as abnormal lightening of the skin will not be seen as would be the case in lighter skin tones
- changes in skin colour other than redness:
  - like darker tones that is suggestive of hypoxia
  - increased warmth in comparison to surrounding skin
  - the skin may appear oedematous, indurated, taut and shiny.[19]

An assessment by touch, therefore, will be as invaluable as visualisation – *see Picture 8 and 9* for advanced pressure sores – to be avoided.

***Picture 8 and 9* – advanced stages of pressure sores**





Legs

The maternal legs are examined to identify complications like thromboembolism, in particular deep vein thrombosis. Not all typical signs like redness to the affected area[22] will be seen in darker skin tones and will require a review of maternal concerns and an assessment of signs and symptoms of deep vein thrombosis that include:

- Skin changes: oedema, warmth and discolouration (although typically red, the affected area should be compared to a non-affected area to identify any changes in skin tone).
- Unilateral calf pain or tenderness.

CONCLUSION

Maternal skin colour, including the assessment of varied skin tones, plays a substantial role in the assessment of wellbeing. Colour awareness, therefore, is an important consideration when conducting examination of maternal skin in midwifery practice. This is a necessary step in order to reduce health disparities and be thorough and inclusive in our approach of all women, regardless of their ethnicity and skin colour. This is a good example of how midwives can help close the gap and prevent inequalities in care. Additionally, real change in midwifery theory and practice requires vision and courage to confront uncomfortable truths and identify areas where care can be improved. To achieve this, midwives require safe spaces where they can come together and allow enlightening conversations to flow. Finally, to aid personal reflection, readers are asked to review the accompanying case vignette as well as the recommendations for practice and the related questions pertinent to the assessment of skin colour. **TPM**

Case vignette (postnatal period):

A primigravid woman, Layla, had a spontaneous vaginal birth using epidural anaesthesia. You complete her postnatal examination the day after birth. She informs you that her buttocks are sore and she is unsure if it is because she was in the same position for a lengthy period of her labour. She is unable to sit for long periods, making it difficult to breastfeed.

You examine the affected area with consent but you are unable to clearly visualise the skin. You note that Layla's skin tone is of a darker pigmentation.

1. *What measures will you take to enable you to complete a thorough assessment of the skin integrity?*
2. *You suspect Layla has a pressure ulcer. What are the likely signs, symptoms and presentations of pressure ulcers within diverse skin pigmentations?*

Signs and symptoms of pressure ulcers	Presentation in darker skin tones

Practice points

- **Enhancing your learning:** explore wound images to identify pressure ulcers of a diversity of skin tones as well as at various stages of injury.
- **Inspection:**
  - Ensure you have ambient lighting during the assessment process. Where possible use natural light or a halogen light source, to minimise changes in the skin's usual colour.
  - When examining the skin integrity or wound changes, compare the affected site to a non-affected area and make a note of the appearance of the affected area.
  - Ensure you complete a thorough examination, especially when the typical representations of compromise to skin integrity is not evident.
- **Palpation:**
  - Gently feel for warmth and induration as the blanch test may not be indicative of compromise in darker skin tones.
- **Listen to the mother:**
  - Pain and discomfort are suggestive of the development of a potential complication and so take time to listen to the woman.

Reflective questions

- How will you ensure the correct utilisation of skin colour in your assessment of maternal wellbeing in order to reduce maternal morbidity plus prevent and arrest potential complications?
- Using maternal skin colour as an indicator of maternal wellbeing, what technology can midwives use as an adjunct to ensure a thorough assessment of darker skin tones?

Recommendations for practice

- Ensure teaching aids and resources are available that depict a variety of skin pigmentation to enhance an awareness of skin colour in the assessment of maternal wellbeing.
- Ensure there are no barriers, including language, that compromise the quality of communication with the mother and the potential for complications to be recognised and referred appropriately.

RECOMMENDED FURTHER READING

Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2020.

This recent report continues to shine the light on disparities in health outcomes for women from minority ethnic groups, highlighting further inequalities brought about by the coronavirus pandemic and placing emphasis on actions needed to address systemic biases.

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WORKSHEET 6

'It's time to update our own personal education!' Exploring our responsibility to continued learning and 'unlearning'

REFLECTIONS:

My main 'take away'

My comforts and discomforts

My action/commitment:

Question 1: How are you or could you action updating your education to ensure that you are culturally safe? (*Figure 11:* List of courses, groups, associations or other that support this further learning- vignettes of good practice continued learning)

Question 2: What role can you play in ensuring that lesser heard voices are not erased in your education or practice environment?

Question 3: How could you work alongside colleagues or peers to ensure that this learning is shared and active in your context?

CHAPTER 10

DECOLONISING MIDWIFERY EDUCATION PART TWO: NEONATAL ASSESSMENT

Dr Diane Ménage, Maxine Chapman, Maureen Raynor, Zaheera Essat, Rachel Wells

INTRODUCTION

Midwives have an important role in the assessment of neonates to confirm normality, detect deviations from the norm and arrange appropriate referral. Midwives examine neonates at birth, at postnatal examinations and when performing the Newborn Infant Physical Examination (NIPE). Historically, very little attention has been paid to the significance of skin colour when teaching midwives examination skills and there is a knowledge gap around the detection of clinical signs on darker skins. There has been a lack of awareness that many skin conditions can be more difficult to recognise on darker skins, and almost all clinical textbooks use examples and illustrations of people with pale skins. Generations of clinicians have been educated in this way and it is only very recently that this gap in clinical education has been recognised and is now being addressed.[1] Neonatal skin conditions are no exception to this knowledge gap. This is the second of two articles on skin assessment in maternity care, which seek to kickstart the discussion and begin to fill that knowledge gap, plus raise awareness of some of the clinical signs and features that present differently, on darker skin tones. The first article, also published in this issue, focused on enhancing knowledge and comprehension of the nuances involved in assessing women with dark skin tones, while this article discusses the nature of neonatal skin colour, assessment of the baby at birth, signs of cyanosis, skin conditions, birthmarks and neonatal jaundice. A clinical vignette and critical questions are intended to encourage readers to consider this example and reflect on their own experiences when assessing the health and wellbeing of babies with skin tones other than white.

SKIN COLOUR

Skin colour in the neonate is influenced by a number of physiological factors: the density and distribution of melanin (a dark pigment which provides protection from ultra-violet rays in sunlight); haemoglobin; bilirubin and skin thickness.[2] Therefore, ethnicity, general health and gestational age will all be significant factors. Although we may think of ethnicity as the main determinant of skin colour, studies have shown that skin tone and ethnicity do not always correlate precisely.[3] Skin tone varies among individuals from any given ethnic group. Therefore, it is not necessarily accurate or useful to talk about African skin or Asian skin. In fact, there is huge variety in skin colour and yet clinical textbooks on assessment of the skin are almost exclusively focused

on pale skin tones. Few studies have explored this topic, although there have been recent attempts to classify neonatal skin colour.[3] However, neonatal skin is relatively dynamic as babies are often born slightly paler than their parents; their skin colour developing in their first weeks or months and beyond as their skin is exposed to the natural light.[3] Neonates also have areas that contain less pigment – for example, the palms of the hands – while other areas may be more pigmented – for example, the genitals, with a deeply pigmented scrotum being a common incidental finding in Black, Asian and Middle Eastern baby boys.[4]

GENERAL ASSESSMENT OF THE BABY AT BIRTH

Visual assessment of the skin is an important part of neonatal clinical examination and any assessment must be made in relation to individual skin tone in order to confirm normality and identify abnormalities. For the midwife, examining the baby following birth using the APGAR score provides a system for rapidly assessing newborn health using five criteria: heart rate, respiratory effort, tone, reflex and skin colour.[5,6] The newborn is scored (out of two) for each criterion, usually at one minute and at five minutes, allowing a maximum score of 10. However, assessment of colour is known to be the most problematic and least reliable field, because to score two the baby needs to be 'pink all over'. As a screening tool for detecting babies who are compromised, this description is particularly problematic. Some babies with darker skin tones may be well perfused but will not look particularly pink, making it practically impossible for them to gain maximum score in this field. This is of concern because it means that darker-skinned babies may be given inaccurate APGAR scores, which could lead to unnecessary surveillance and interventions for the baby and increased anxiety for the parents. Similarly, it may be harder to assess 'blueness' in the skin of a Black or Brown-skinned baby and this could lead to inadequate detection of those babies who are compromised. Therefore, there is a strong argument for reviewing and developing the APGAR scoring system to ensure that it is fit for purpose for all neonates.

ASSESSING FOR CYANOSIS IN THE NEONATE

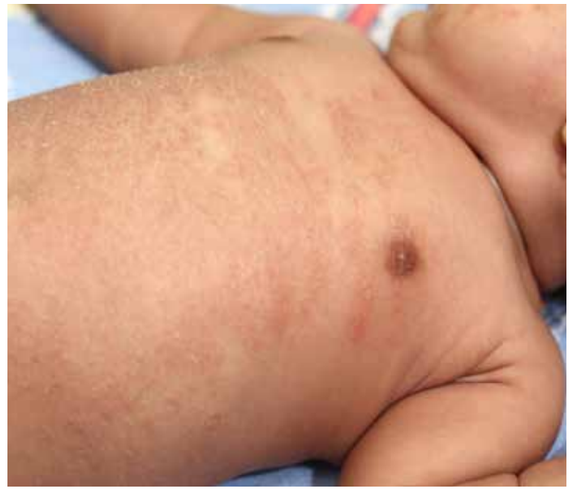
Cyanosis is the blue discolouration of the skin and mucous membranes caused by deoxygenated haemoglobin.[7] In neonates peripheral cyanosis is common in the first 24 hours of life and is not considered pathological if the baby is generally well.[8] Central cyanosis is associated with pathology and can indicate respiratory, cardiovascular or haematological abnormalities.[9] Therefore, it is essential that midwives are able to detect signs of cyanosis in neonates. As a fundamental skill in midwifery practice, teaching has been impaired by language and assumptions about skin colour. It has been the norm to talk of skin looking blue, white or 'pinking up' and, although this may reflect what is seen in paler-skinned neonates, it may not describe what happens in babies with darker skin tones. For this reason, we would strongly advocate moving away from this language and emphasise that the assessment of cyanosis should assess for any grey or blue discolouration of the skin (*see Picture 1*). It should always involve examination of the lips and mucous membrane in the mouth and tongue because these are areas where there is thin epidermis and a good blood supply in all skin colours and therefore sites that are reliable indicators of central cyanosis.[1,7] Assessment of the nail beds is not useful for detecting central cyanosis in neonates under 24 hours of age, given that non-pathological, peripheral cyanosis may complicate the assessment.[8] While it is essential that midwives hone their observation and examination skills for babies of all skin colours, pulse oximetry provides an important objective measurement where there are concerns. Moreover, in many maternity units this is now offered routinely as part of newborn screening.[10]

***Picture 1* – Cyanotic newborn**

NEONATAL SKIN CONDITIONS

Rashes are common in neonates and therefore midwives need to be skilled at recognising normal, harmless conditions and those that may need to be referred. Erythema Toxicum Neonatorum (commonly called Newborn Rash) can look alarming but it is an insignificant, transient rash present in approximately half of babies in the first few weeks of life – *see Pictures 2 and 3*.[11] It can be more difficult to assess on darker skins as erythema (redness) may be less obvious.

***Pictures 2 and 3* - Erythema Toxicum Neonatorum**



Neonatal pustular melanosis is uncommon in white babies but is thought to affect around 5-15% of babies with Black parents.[12] It resolves spontaneously but similarly it can be very concerning for parents, particularly as the small pustules develop and then turn into flat, brown lesions (S*ee Picture 4)*. Careful and comprehensive inspection is key and listening to parents is important because they will often be the ones to notice subtle marks and blemishes.

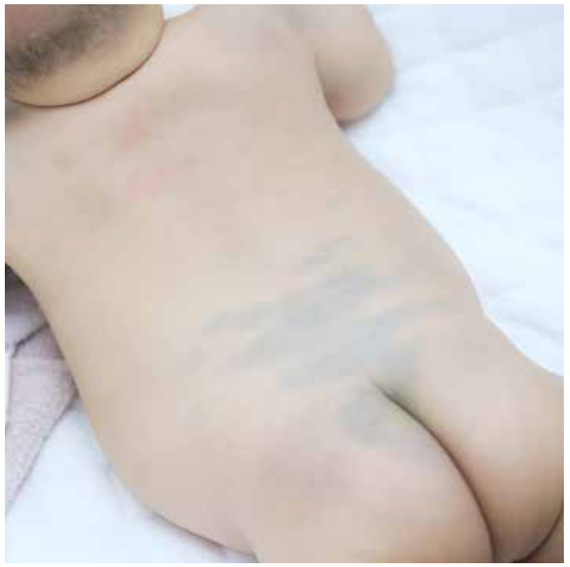
Picture 4 – Neonatal pustular melanosis

BIRTH MARKS

Dermal melanocytosis (also slate grey nevus or blue spot) are blue/grey or brown patches found on newborn babies. They are a type of birth mark seen on babies of all skin tones, although they are very common in dark-skinned babies and present in up to 90% of babies from Black and Asian ethnicities.[11] They are usually present from birth and found on the buttocks or lower back and they generally disappear in the first few years of life.[11] *See Pictures 5 and 6* overleaf. Although often referred to as *Mongolian blue spot*, this description is an inaccurate and outdated term based on discredited race theories.[13] For this reason we strongly recommend using the correct name: *dermal melanocytosis* or simply *blue spot*. Inability to accurately recognise blue spot has led to this being

confused with bruising. Sadly, this has sometimes resulted in inappropriate child protection referrals, causing unnecessary distress to families.[14] It is important that midwives record all birth marks and skin lesions on the body map and in all neonatal records as soon as it is noticed and continue to observe and document any changes. While remaining vigilant to the possibility of bruising from birth trauma or inflicted harm, midwives can differentiate between bruising and blue spot if they understand the distinguishing features of each. Blue spot predominantly appears at typical sites (buttocks and back), they are patches of skin that may look blue/grey or, on dark-skinned babies, they may just look darker than the surrounding skin. They are more uniform in colour and they do not change colour.[1] They are always non-tender with no associated swelling or redness. Bruises may be tender with associated inflammation. They can be blue/grey but they are less uniform in colour and the colour also changes as the bruise ages; sometimes purple and yellow tones can be seen.[15] The head-to-toe examination following birth and during each neonatal examination plays a vital role in detecting bruising.

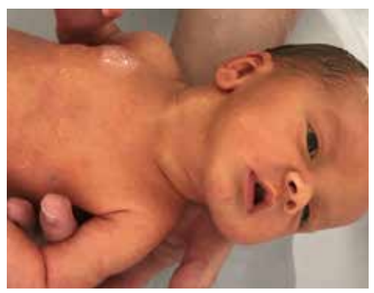
***Pictures 5 and 6* – Blue spot**



JAUNDICE

Jaundice is the yellow colouration of skin and sclera caused by raised bilirubin (a bile pigment) in the circulation.[16] Neonatal jaundice affects 60% of term babies and 80% of preterm babies in the first week of life.[16,17] In most cases, this is a physiological jaundice that spontaneously resolves without treatment. Less commonly, jaundice is pathological and can be life-threatening. Observation and examination of newborn babies to detect those babies who may have pathogenic jaundice and require referral is an important part of neonatal care.[17] Measurement using a transcutaneous bilirubinometer is recommended practice in the UK, in babies with suspected or obvious jaundice,[16,17] although it is not always available, particularly in community settings. Therefore, visual assessment is still a key aspect of assessing the degree of neonatal jaundice. This can be more difficult in babies with dark skin tones – *see Pictures 7-9*.[18] A full visual assessment should be made in good light and particular attention should be paid to inspecting the whites of the eyes (sclera), gums, palms of the hands and small areas of skin temporarily 'blanched' by light digital pressure.[17,19]

***Pictures 7-9* – Neonatal jaundice**



Again, listening to the parents is also key. They may notice changes in skin colour that are not evident to a midwife who has not seen the baby before or who lacks knowledge and experience in assessing babies with darker skins. In the vignette below, a midwife reflects on a neonatal examination of a baby with white and Afro-Caribbean heritage in relation to detection of jaundice. After reading this, use the critical questions to reflect on current practice.

CONCLUSION

The teaching of clinical assessment of the newborn must be relevant and fit for purpose for *all* newborns, whatever their skin tones. Images of newborn babies with dark skin tones should be included in textbooks and other educational materials. Resources, such as clinical manikins, should reflect a range of skin tones. Those working in midwifery education have a responsibility to ensure that what is taught is relevant and appropriate for mothers and babies of all skin tones. **TPM**

A REFLECTION ON JAUNDICE ASSESSMENT OF A NEWBORN WITH WHITE AND AFRO-CARIBBEAN HERITAGE

As a community midwife, I attended a primary home visit with a final-year student midwife, to a mother who had given birth to her third baby on the previous day following an uncomplicated pregnancy and birth. The parents' ethnicities were that of white and Afro-Caribbean heritage, the student was white and my heritage is white and Afro-Black Caribbean. During the assessment of the newborn, the student had asked me if I agreed that the newborn appeared to be jaundiced. I reassured her that the newborn was not jaundiced based on a full assessment. A discussion followed wherein the mother shared her experiences with us of the care and assessment of her first two babies when they were considered to be jaundiced during the initial postnatal period. The mother expressed that she considered the additional surveillance visits undertaken by the midwives to be unnecessary because results of the investigations were found to be within the normal ranges. Care provided with her first newborn included a referral to the hospital because there was not a transcutaneous bilirubinometer (TCB) available for the community midwife to use during the visit. The findings of the TCB were within the normal range and therefore no further intervention was necessary. The mother expressed her frustration as she felt that her newborns were healthy and that perhaps the midwives and other healthcare professionals involved were not familiar with the healthy skin tones for babies with white and Afro-Black Caribbean heritage. I felt that the commonality that we shared in our heritage enabled the mother to be open with me about her experiences. The discussion we had highlighted limitations of individualised assessment of jaundice in the newborn, because of a lack of knowledge around jaundice in neonates with skin tones that were other than white. Reassurance was given to the mother and advice provided on monitoring the health and wellbeing of her newborn. Following the visit, the student midwife expressed her concern that she had limited knowledge and experience of the assessment of babies with skin tones that were not white, which she felt would lead her to undertake a TCB or make a referral to be 'safe'.

PRACTICE POINTS

Jaundice in assessment of the neonate
Enhancing your learning: explore images of jaundice in a diversity of skin tones.

History
- Is an interpreter required?
- Listen to the mother: are there any concerns with the colour of the skin, feeding, activity or any other concerns?

Observation
- Ensure you have ambient lighting during the assessment process. Where possible use natural light or a halogen light source, as estimation of the degree of jaundice can be inaccurate due to the type of lighting and the reflective ability of surrounding objects.
- Ensure you have fully undressed the newborn for the assessment to fully visualise the colour of the skin – face, abdomen, back and limbs and palms of the hands.
- Ensure 'top to toe' examination is performed with a specific focus on:
  - General behaviour
  - Eyes – assessing the colour of the sclera
  - Mouth – assessing the colour of the gums
  - Nappies – observe for yellow or darker-stained urine.

Investigation
- Ensure full explanation to parents and gain consent if further investigation is required
- Where jaundice is suspected, ensure investigations are implemented, results followed up and referrals made as appropriate.

Documentation
- Ensure findings of the assessment are accurately documented.

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WORKSHEET 7

'We have a dream!' Exploring representation, inclusion and belonging in healthcare practice

REFLECTIONS:

My main 'take away'

My comforts and discomforts

My action/commitment:

Question 1: Describe what having a sense of belonging means to you.

Question 2: What action is needed to ensure that everybody can feel a sense of belonging in your education or practice environment?

Question 3: Reflect on the whole e-book- what have your learnt? List 3 top actions that you are committed to making within the next 6 months. Who else would benefit from this workbook? How and with who are you going to share this resource? (*Figure 12:* Interactive link allowing people to email access to the workbook to a colleague or friend with an auto message that say's I have just read and completed this workbook and I think you would also find it useful and insightful)