
| RESEARCH ARTICLE

The Experiences of Black, Asian and Minority Ethnic Women of Maternity Services in the UK

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| ABSTRACT

There is little research into Black, Asian and Minority Ethnic (BAME) women's experiences of maternity care in the United Kingdom. However, with 28.2% of live births in England and Wales and almost 50% of live births in Birmingham being to non-UK born women in 2016, it is an important area to investigate as maternity care is such a crucial part of pregnancy and labour. The aim of this review is to assess these experiences and determine if they can be improved. A literature search took place for guidelines, systematic reviews, and primary evidence that were conducted in the UK, including women of ethnic minorities. Guideline searches were conducted through NICE, GMC, and SIGN, systematic reviews through NICE, Cochrane, and MEDLINE, and primary evidence through EMBASE, BMJ, MEDLINE, and PLoS. Each finding was then appraised using the appropriate AGREE II, CASP, and AXIS appraisal tools. We summarised the literature findings in Table 4 of this review. One guideline was found detailing advice on the needs of refugee and asylum-seeking women, as well as those with difficulty reading and speaking English. Searches also found 36 systematic reviews, of which one was included, and 1,091 primary studies were found, of which four were included (two qualitative and two cross-sectional). Both the systematic review and the four primary evidence studies showed that BAME women's experiences were generally more negative and engagement with maternity services was poor. Some of the themes which emerged were poor communication, lack of respect for the culture, and lack of support. One study, however, did show that more recent migrants described their overall experiences as much more positive than migrants who had been in the UK longer. This review suggests that BAME women generally perceive their maternity care more negatively than White women. Specific areas that were highlighted for requiring improvement include poor communication and cultural insensitivity despite current guidelines. However, these guidelines do not sufficiently target the BAME group; with more research, these guidelines could be improved and adhered to so BAME women can experience the same level of care as White women in the UK.

| KEYWORDS

BAME, Minority ground, Maternal experience, Maternity care, Patient experience

| ARTICLE INFORMATION

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1. Introduction

Maternity care is the provision of services throughout the antenatal, labour, and the postnatal period up to 8 weeks after birth. (Excellence) It is important because pregnancy is the most common reason for hospital admission in the UK, with 657,076 babies born in England and Wales in 2018 (Office for National Statistics). Additionally, pregnancy is a significant social and personal event, and considering patient experience is a key component of quality care (The Stationary Office, 2008). Indeed, it is one of 5 domains of the NHS outcomes framework (National Health Service Digital). Acknowledging patient experience is essential for reducing stress during maternity and is also positively associated with patient safety and clinical effectiveness (Doyle, Lennox, & Bell, 2013). Furthermore, poor care and negative experiences are remembered for the rest of a patient's life (Forssén, 2012).

BAME women have been shown in a national survey on maternity care to be more likely to access services late and experience more complications, contributing to a poorer experience of care in comparison to Caucasian women (Raleigh, Hussey, Seccombe, & Hallt, 2010). The standard definition of BAME includes Black, Asian, and Minority ethnic groups (Institute of Race Relations, 2020). For the purposes of this review, we have chosen to include white minority ethnic women, for example, Polish and Roma women, within this category.

For many BAME women, the experience of maternal care is compounded by the stress of understanding a foreign healthcare system and potentially a foreign language. Overall this may result in a breakdown of communication between the patient and the healthcare professionals (HCPs), creating an atmosphere of 'fear and uncertainty' (McLeish & Redshaw, 2019). Consequently, patients may struggle to trust HCPs, and this can lead to non-compliance or dishonesty (Institute of Race Relations, 2020; Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). They may not feel comfortable reporting sensitive issues regarding health, malpractice, or racial bias, further contributing to poor experience (Jacobs et al., 2006). In order to alleviate such realities, we must understand the source of this issue which this review aims to address.

2. Methodology

We used the SPIDER framework to define our review question and searched for guidelines, systematic reviews (SR), and primary research studies. (Cooke, Smith, & Booth, 2012)

Sample	Black and Minority Ethnic women using UK maternity services
Phenomenon of Interest	Experience of Maternity care
Design	Interviews, focus groups, questionnaires, surveys & observations
Evaluation	View of healthcare received and how they were treated
Research Type	Peer-reviewed studies using qualitative and mixed-method research

Table 1: SPIDER framework used for this review

Initially, we searched NICE, GMC, and SIGN for guidelines. The search terms used for all searches can be seen in Table 3. The search terms here were broader following a scoping search which found few guidelines for BAME women. The results were screened independently by two researchers for title and source and summary of guidelines to determine if they met the criteria. If any disagreements could not be resolved, a third-party researcher was brought in to make a final decision. This was the process used for subsequent searches. Any guidelines found were then appraised using the AGREE II tool (Agree Trust, 2009).

We searched for SRs through MEDLINE, Cochrane, and NICE databases. Two independent researchers screened the reviews by title, abstract and full paper. The same process for guidelines was used if there was disagreement. Any SRs retrieved were then appraised using the CASP SR framework (Critical Appraisal Skills Programme, 2018).

The search for primary evidence was conducted through MEDLINE, EMBASE, BMJ, and PLoS databases. The papers were screened by title, abstracts, and then the final paper by two independent researchers with any disagreements resolved as previously stated. Any papers retrieved were appraised using CASP qualitative framework and our own checklist based on the AXIS study for cross-sectional designs (Critical Appraisal Skills Programme). (Downes, Brennan, Williams, & Dean, 2016) Once screening had been completed, the final results were narrowed down by applying the limit of 2015 onwards for systematic reviews and 2012 onwards for primary evidence. The results of the studies were summarised and combined into themes, as seen in Table 4.

In all searches conducted, the inclusion and exclusion criteria in Table 2 were adhered to. This ensured our searches were focused on the review question, allowing us to achieve our aim.

2.2 Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Written in English Language • Participants used are women of ethnic minority • Patients' experiences were measured 	<ul style="list-style-type: none"> • Not solely in UK • Duplicates • Paternal Experience • Staff experience measured

Table 2: Inclusion and exclusion criteria used to acquire guidelines, systematic reviews, and primary research studies which were relevant to our review question.

2.3 Search Terms Used

Search	Database	Search Terms	Limits Applied
Guidelines	NICE Evidence Search	(Pregnancy) AND (Migrants)	Guidance 01/01/2010 - 02/12/2019
	GMC	(Ethnic minority maternity care. BAME maternity care. BME maternity care. (Note: Can't Boolean)	
	SIGN	BME AND maternitv care	
Systematic Reviews	MEDLINE	(Prenatal care OR Delivery, Obstetric OR Midwifery OR Maternal Health Services OR Postnatal care) AND (Patient satisfaction OR Quality of healthcare) AND (Ethnic groups OR Minority groups OR African continental ancestry group OR Asian continental ancestry group OR Continental population groups OR Roma OR Transients, migrants OR Emigrants, immigrants) AND (United Kingdom OR England OR Scotland OR Wales OR Northern Ireland)	Systematic Reviews
	Cochrane	(Ethnic group OR Minority group) AND (Patient satisfaction) AND (Maternal care)	
	NICE Evidence Search	(BAME OR BME OR Ethnic group OR Minority group OR Race OR Ethnicity OR South Asian OR Black Person OR Bangladeshi OR Indian OR Pakistani OR Migrant OR Immigrant OR Romani) AND (United Kingdom) AND (Maternal care OR Prenatal care OR postnatal care OR Maternal health services OR Obstetric)	Systematic Reviews From 01/01/15 - 04/12/12
Primary Research Studies	EMBASE	(Maternal care OR Midwife OR Prenatal Care OR Postnatal care OR Obstetrics) AND (Patient satisfaction) AND (Ethnic group OR Minority group OR Race OR Ethnicity OR South Asian OR Black person OR Bangladeshi OR Indian OR Pakistani OR Migrant OR Immigrant OR Romani (people))	
	MEDLINE	(Prenatal care OR Delivery, Obstetric OR Midwifery OR Maternal Health Services OR Postnatal care AND Patient satisfaction OR Quality of healthcare) AND (Ethnic groups OR Minority groups OR African continental ancestry group OR Asian continental ancestry group OR Continental population groups OR Roma OR Transients, migrants OR Emigrants, immigrants) AND (United kingdom OR England OR Scotland OR Wales OR Northern Ireland)	
	BMJ	(BAME OR BME OR Ethnic minority) AND (UK OR United Kingdom) AND (Maternity care) AND (Patient experience)	01/01/2015 - 02/12/2019
	PLoS	(BAME OR BME OR Ethnic Minority OR Ethnic group OR Race OR Ethnicity OR South Asian OR Black person OR Bangladeshi OR Indian OR Pakistani OR Romani) AND (United Kingdom) AND (Maternal care OR Midwife OR Prenatal OR Postnatal OR Obstetrics OR Maternal Health Services) AND (Patient Satisfaction OR Quality of healthcare)	01/01/2015 - 02/12/2019 Research articles PLoS One PLoS Medicine

Table 3: Keywords and limits applied to each search for guidelines, systematic reviews, and primary research studies

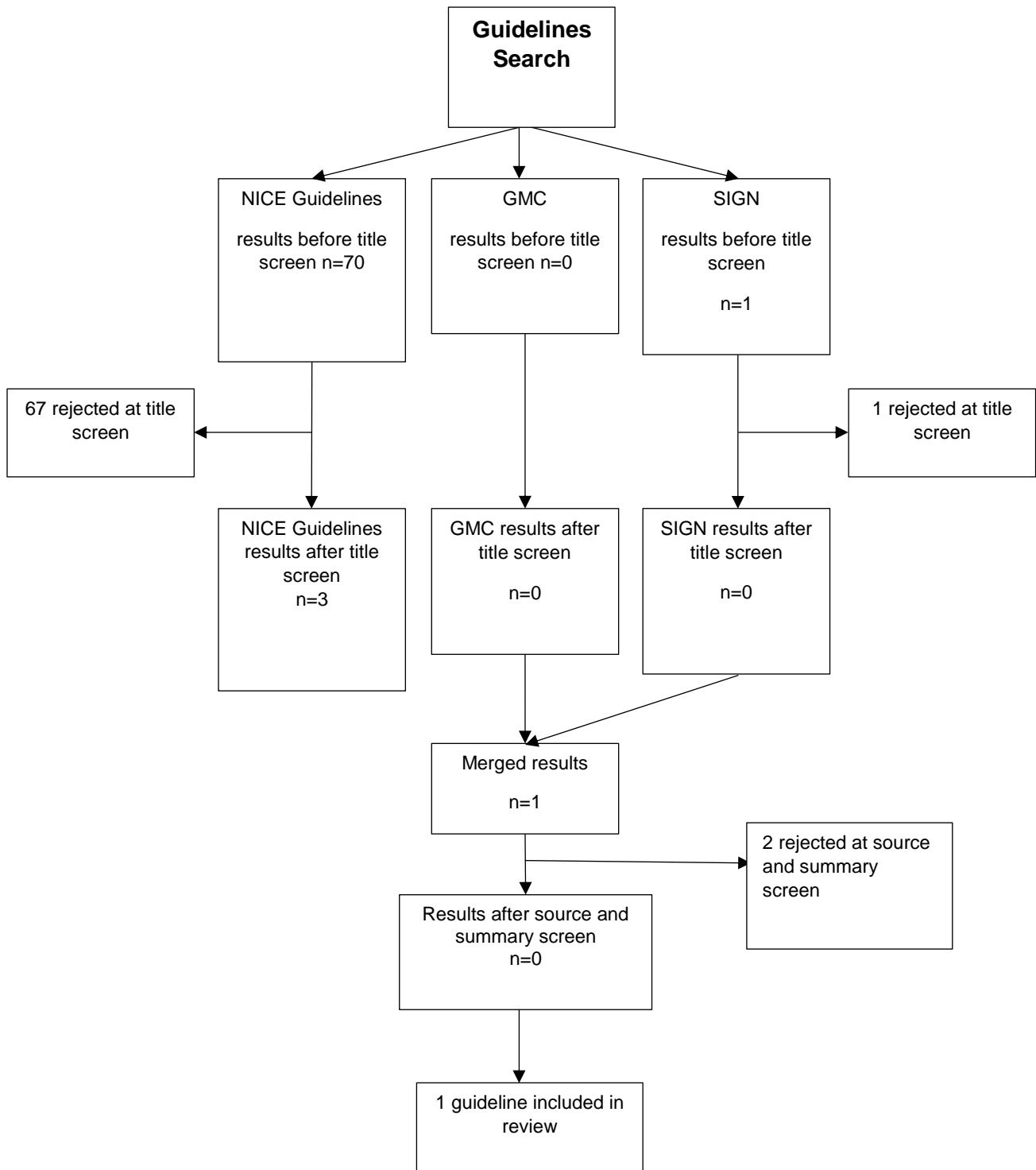


Figure 1: Flowchart showing inclusion and rejection of guidelines

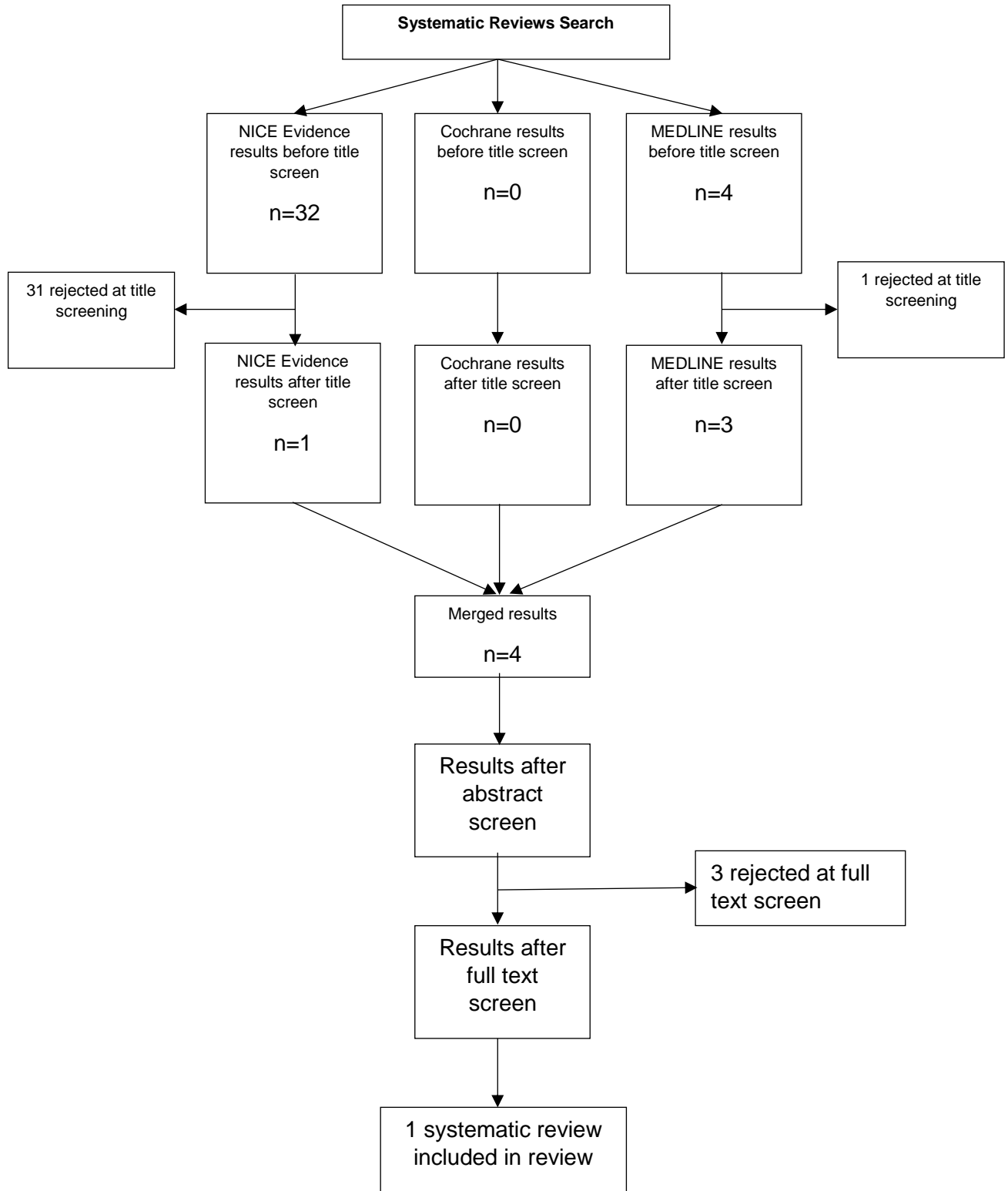


Figure 2: Flowchart showing inclusion and rejection of Systematic Reviews

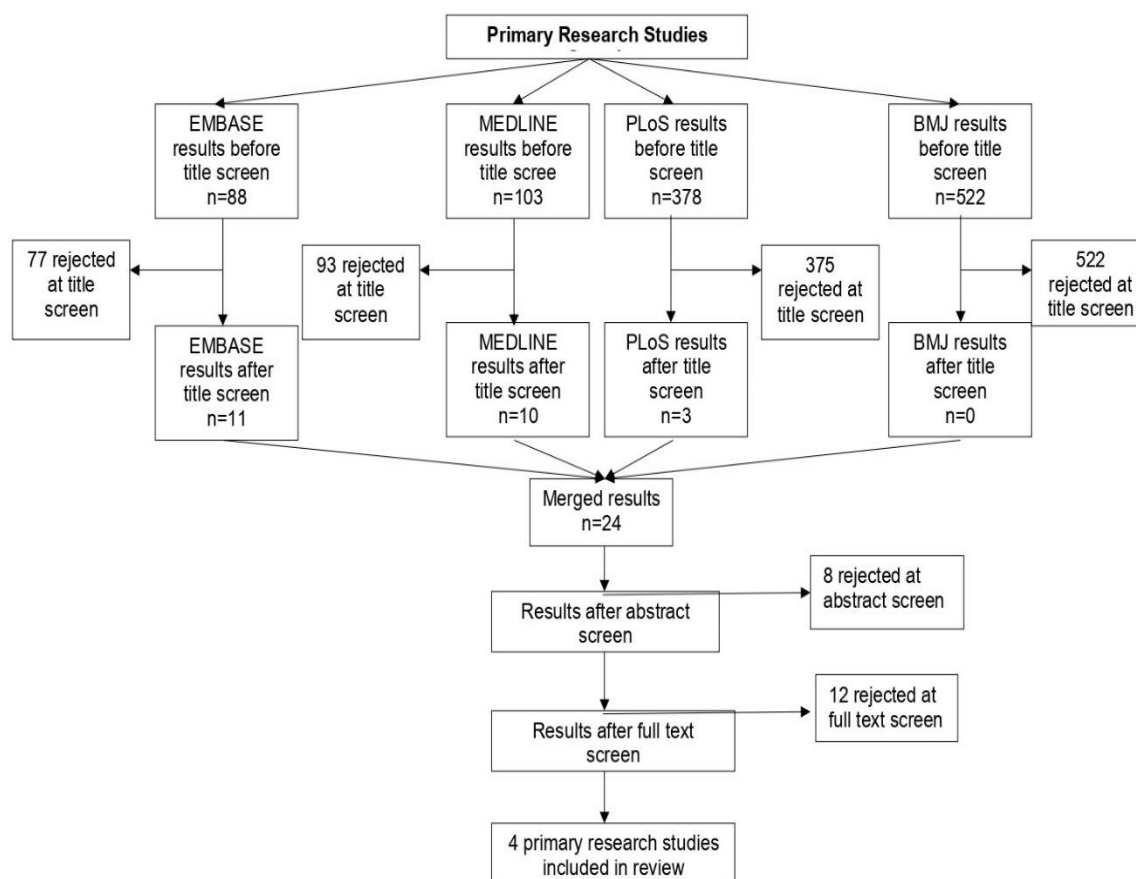


Figure 1: Flowchart showing inclusion and rejection of Primary Research Studies

3. Literature review

The independent literature search captured one guideline, one SR, and four primary evidence studies (Henderson, Carson, Jayaweera, Alderdice, & Redshaw, 2018; Henderson, Gao, & Redshaw, 2013; Jomeen & Redshaw, 2013; National Institute for Health and Care Excellence, 2010; Watson, Harrop, Walton, Young, & Soltani, 2019).

3.1 Guidelines (National Institute for Health and Care Excellence, 2010)

This guideline draws attention to the increased need for support for four groups of pregnant women. The group applicable to this review is 'recent migrants, asylum seekers or refugees, and women who have difficulty reading or speaking English'. The Guideline Development Group (GDG) outlines 5 barriers BAME women experience: 'language, lack of available interpreters, discrimination from HCPs, not understanding how to access the healthcare system, and the HCPs' lack of knowledge of cultural and religious differences.

Furthermore, the guidance suggests that HCPs require training in specific health, social, religious, and psychological needs of BAME women, with examples such as social inclusion midwives.

The search strategies for finding the evidence supporting these guidelines are outlined in the appendices with references to PICOs and inclusion and exclusion criteria. However, it must be noted that studies conducted outside the UK were not excluded. Therefore, the variation in healthcare systems may decrease the applicability of these guidelines to our target population.

The evidence was found from a literature search conducted through eight appropriate databases identifying randomised controlled trials, observational and qualitative studies, and SRs. The search terms have been outlined in a table alongside explanations of why studies were excluded. Whilst this methodology has been clearly described, there is no explanation of the number or role of researchers; therefore, it cannot be determined if the search was done independently. This makes the findings less reliable as if the search was conducted by one researcher; biases may have been introduced.

With regards to the development of the guidelines, the Guideline Development Group (GDG) included various personnel such as obstetricians, social workers, perinatal mental health staff, midwives, and practice development managers. This increases the trustworthiness of the guideline as it reduces the possibility of bias in interpreting the evidence.

In addition, it mentions that two members of the GDG have declared non-pecuniary conflicts of interest. However, how these were addressed was not declared, so it is hard to tell what effect this could have had on producing the guidelines.

3.2 Systematic Review

(Watson et al., 2019)

This SR found that BAME women lack awareness of perinatal mental health problems and that culture impacts their experience of mental health. The results were aggregated into themes such as 'Awareness and beliefs about mental ill health', 'Influence of culture', and 'Isolation and seeking support'. These showed that BAME women experiencing perinatal mental ill-health feel isolated, and some avoid services. When they do try and access them, they must overcome practical and cultural barriers as well as HCPs attitudes.

The title of this SR shows they are looking for papers within Europe. However, the fifteen included studies took place in the UK. Whilst the fact that papers from no other countries were included means this review did not appropriately address its question, it makes this SR more appropriate for our review. Furthermore, all but one study has been published since 2016, so they are up to date with societal views, which is key with regard to mental health. However, there was no mention of healthcare provision being provided by NHS or privately, so the results must be applied to with care.

The types of studies included in the SR were qualitative, quantitative, and mixed-method, yet for a question addressing experiences, which are subjective events, qualitative designs alone would be more appropriate. On the other hand, this is justified by transforming quantitative into qualitative findings (thematic synthesis approach). The paper states that both qualitative and quantitative methods produce data that "can be readily transformed into each other". Whilst this makes the use of quantitative and mixed-method studies more appropriate, qualitative and quantitative are two separate types of data that are difficult to compare.

The quality of papers included was assessed using the qualitative NICE appraisal tool and the CASP for questionnaire-based surveys. As a result, each article was given a quality score of high, acceptable, and low (of those included two, nine, and four, respectively).

Furthermore, only 10% of the articles were appraised by a second reviewer, with a referral to a third if disagreements could not be resolved. All included articles should have been independently assessed by two researchers to maintain the rigor of quality assessment.

Finally, the results of the studies are displayed in the discussion as quotes with a breakdown of twelve specific findings within the seven themes which emerged. Results appear similar from study to study, with some quotes supporting others. However, it should be noted that this could be due to selective inclusion and exclusion of supporting and contrasting data showing a lack of reflexivity from the researchers.

3.3 Primary Evidence Studies

Condon et al. (2014)

This qualitative study explores the views on infant feeding and HCP support within the Gypsy and Traveller community. Themes having an influence on feeding behaviour included 'Centrality of family', 'Beliefs and traditions', 'Travelling lifestyle', and 'Interaction with HCPs'. Overall, women felt they did not require professional help as they had support within their own communities. However, where English and Irish Travellers wished to attempt breast-feeding, HCPs failed to realise the taboo within the community regarding this issue.

In this study, semi-structured interviews were an appropriate method of qualitative data collection. Interviews allow participants to freely express views which may result in more reliable and representative data. Furthermore, pre-determined questions enable the interviewer to be somewhat objective.

Additionally, there is no mention of modifications to the methodology, for example, rewording of questions or additional points of conversation, which could reduce the reliability of data.

Furthermore, some interviews were audiotaped and transcribed, whilst others were documented by hand. It is plausible that information may have been missed without audiotaping, creating a discrepancy between participants and thus skewing results.

It is explicitly stated in the study that a sample of audiotaped interviews was checked for the validity of translation by independent Romanian interpreters, increasing reliability. However, the use of Romanian rather than Romani interpreters could cause inaccuracies (Migreat Blog, 2015).

Finally, it is mentioned that the small sample size was chosen in order to consider differences between the ethnic groups. Considering that similar studies often consider the minority a homogenous group, failing to recognise key distinctions so creating a less representative sample is hugely positive. However, a larger group could offer a more varied and representative data set.

Jomeen et al. (2013)

This qualitative study exploring BAME women's experiences of maternity care summarises the views of 368 respondents under the following themes: 'feeling cared for', 'expectations of care', 'policies, rules and organisational pressures', and 'staff attitudes and communication'. Key issues identified centre around insensitive care and feeling unheard. Cultural insensitivity was apparent in cases where a female doctor was requested, and patients were met with hostility, whilst those struggling with English felt that information was not appropriately explained. It is argued within the study that although these problems are not specific to BAME women, their care is neglected to a greater extent.

In this study, data was collected by mailing a questionnaire consisting of three open-ended questions addressing elements of maternity care. It was sent to a randomly selected sample of 4,800 women who had given birth three months previously. A telephone interview was available to women who wished to participate, and an interpreter was offered.

Whilst this research design has not been justified; a questionnaire is an appropriate method to procure opinions. However, they can hinder participant's abilities to express themselves, potentially leading to less representative results. Conversely, the study suggests that anonymised communication via a questionnaire may allow participants to express themselves without fear of judgement. This is supported by (Katbamna, 2000), who identified that Bangladeshi and Gujarati women struggled to complain of mistreatment for fear of appearing ungrateful (Katbamna, 2000).

Furthermore, a set questionnaire prevents alteration of questions ensuring no participant is treated differently. In interviews, this can vary, leading to unreliable results. On the other hand, not interacting with participants may result in misinterpretation of the questions or answers. Also, the nature of the first two questions is more negative, meaning that those with complaints are more likely to respond, generating bias and contributing to less reliable results.

The study fails to provide justification for the method of recruitment. However, randomisation eliminates selection bias by generating a representative sample of women from many backgrounds. Conversely, it must be acknowledged that this has several limitations. Despite the benefits of random sampling, the results are subject to attrition bias as those who respond are often categorically different from those who do not. The study confirms this by stating that non-respondents were younger, less educated, and more likely to be born outside of the UK.

(Henderson et al., 2013)

This cross-sectional study is a secondary analysis of a maternity care survey (2010) (NHS Patient Surveys, 2010). Results showed significant differences in the use of services and the perceptions of maternity care between BAME and White women. Key findings include that BAME women were less likely to rate maternity care as good. There was also less engagement with services by ethnic minority women during antenatal care, especially the Black Caribbean, Pakistani, and Black African women.

The cross-sectional design of this study is appropriate for investigating the use of services as it is objective. However, for more subjective measures such as experiences, using a close-questioned survey is not sufficient to truly gain an understanding. Purely qualitative methods, such as interviews, should have been used to allow for more in-depth analysis.

The population in this study was well-defined, with a large sample of 24,319. However, considering there were only 163 Bangladeshi and 162 Black Caribbean women compared to 20,633 White women, the sample size of these populations could be too small to be considered valid, as important differences may have been missed leading to a risk of type 2 error.

Furthermore, the sizes of groups were considered appropriate; however, there were 142 Chinese women that were aggregated with 'any other ethnic group'. Therefore, the cut-off point for how many participants make up a valid population is subjective, which potentially reduces internal validity.

In addition, the 52% response rate for this study is poor. However, as there are similar proportions of each ethnic minority compared with the national census, non-response appears consistent between groups (Office for National Statistics, 2013). Non-responses have also been corrected for analysis via propensity modelling; however, no information about non-responders was collected, and there was no comparison of non-responders to responders. Therefore, responder bias has not been investigated adequately.

Moreover, it seems baseline characteristics were sufficiently investigated, and most found to be statistically different between groups were adjusted for analysis (e.g., age and parity). However, the factors 'language spoken at home' and 'living with family members other than partner' were not adjusted for even though both were stated as significantly different, and both could affect the experience of maternity care.

Finally, the way the researchers interpreted the original survey data appears to be oversimplified through analysis by turning questions with four or more answers into simple yes/no categories. For some questions, this is appropriate; however, in others, it reduces the response possibilities.

(Henderson et al., 2018)

Much like Henderson et al. (2013), this study was a secondary analysis of a cross-sectional maternity survey (National Perinatal Epidemiology Unit, 2012). It found significant differences in the perceptions of maternity care between immigrant and UK born women. All migrants were more likely to rate their experiences throughout maternity care as poorer than UK born women. Migrants, particularly from Accession countries, were less likely to feel that they were treated with kindness and spoken to in a way they could understand. Recent migrants (three years or fewer) were less likely to report that staff had been kind and respectful than older migrants (four years or more). However, they were more likely to rate their care as good.

This study has a clear aim to examine how the experience of maternity care may vary between women based on both recency of migration and region of origin. As with Henderson et al. (2013), the problem of perceptions being subjective and difficult to measure in a close-questioned questionnaire persists (Henderson et al., 2013)

Recruitment strategies of the original survey have been outlined in this study; a letter, information leaflet, and questionnaire were sent out to 10,000 randomly selected women, as well as a sentence in 18 languages that proposed completing the questionnaire via an interview or interpreter. Perhaps the questionnaire itself should have been in multiple different languages, as participants whose English was poorer may have been less likely to respond via the questionnaire.

In addition, the selection process was described as random; however, there is no further detail provided. Random selection is important to reduce bias, but without specifics, one cannot say whether the method of randomisation was appropriate.

The study population is well defined and appears to be of adequate size, with 5,332 participants. However, the recent migration group size is concerning; 166 compared to 4,108 UK born women. This group is then subdivided into those from accession countries (36) and 'rest of world' (130). 36 participants are very small and reduce the statistical power of this study. Additionally, the 'rest of world' group is too heterogenous and should have been subdivided further, although this would have led to extremely limited sample sizes.

Furthermore, between the groups, baseline characteristics have been investigated and adjusted for analysis, reducing the number of potential confounders.

Finally, the response rate (54%) for this study is concerning as a non-response error may have been introduced. However, differences between responders and non-responders have been investigated adequately by using information about the whole sample provided by the office of national statistics.

Themes	Qualitative Papers (<i>Condon et al. and Jomeen et al.</i>)	Systematic Review (<i>Watson et al. 2019</i>)	Quantitative (<i>Henderson et al. 2013 and Henderson et al. 2018</i>)
Attitudes and communication	<i>Jomeen et al.</i> Women experienced issues of communication, respect, and sensitivity, as well as not being included in decision-making. However, some experienced respect, kindness, and understanding making the womens' experiences positive.	Language problems negatively impacted some BAME women's experiences.	<i>Henderson et al. (2013)</i> Women from minority ethnic groups said that staff didn't speak to them in a way they could understand, and they didn't feel involved in making decisions. They also felt they weren't treated with kindness. <i>Henderson et al. (2018)</i> Over 80% of migrant women thought they were spoken to in a way they could understand as well as over 70% feeling respected and treated with kindness. However, compared to UK-born women, they were more critical and satisfaction lower.
Stereotyping	<i>Jomeen et al.</i> Women felt when being offered certain vaccines that they were targeted due to their ethnicity.		

Table 4: Combined results of studies into common themes.

As previously stated, the evidence in this review consists of one SR, two qualitative papers, and two quantitative papers. We have summarised the results by grouping them into themes, as this is how the results of the SR and the two qualitative papers were presented. Whilst this is not how the results of the cross-sectional papers were presented, the data seen can be interpreted into themes as it is still describing the experiences of BAME women.

4. Findings

One of the main points from this review is that information is not delivered adequately, and BAME women do not feel involved in the decision-making process. HCPs fail to keep women informed, often leaving them frustrated and confused, as shown by Henderson et al., where migrants were spoken to in a way they could not understand (Henderson et al., 2018). Involving patients with their own care and empowering them to make informed decisions leads to improved outcomes and experiences, but it seems many BAME women are not being afforded this (National Health Service).

This negative view of communication is exacerbated through cultural insensitivity. Jomeen and Redshaw quote a Muslim woman requesting a female doctor, only to be chastised (Jomeen & Redshaw, 2013). At a time of vulnerability, it is understandable that such mistreatment can impact one's experience of maternity care. Although it is impossible to cater to every patient's wishes, greater care should be taken to understand patient perspectives to allow more open communication between HCPs and BAME women.

Watson et al. provide further evidence of cultural insensitivity with regards to failing to empathise with cultural taboos, often resulting in women shying away from mental health support (Watson et al., 2019). This is acknowledged by Condon et al., where professionals failed to recognise the stigma attached to breast feeding within the English and Irish traveller community, thus resulting in inadequate support (Condon & Salmon, 2015).

This misunderstanding of cultural needs may be due to ignorance and a lack of education; Jomeen et al. highlight that BAME women often feel HCPs carry preconceived ideas, likely based on stereotypes (Jomeen & Redshaw, 2013). This negatively impacts the patient-doctor relationship and causes ineffective communication. NICE guidelines state that HCPs should 'avoid making assumptions based on a woman's culture, ethnic origin or religious beliefs'. However, the evidence (published after the guidelines) suggests that guidance alone is not sufficient to remove these prejudices.

Additionally, although patients understand the pressures of medicine, this does not take away from feeling neglected by HCPs. Jomeen et al. reported that staff is unable to provide attentive care leaving mothers feeling isolated (Jomeen & Redshaw, 2013). Further evidence from Henderson et al. details that BAME women are more likely to feel 'left alone at a time when it worried

them' (Henderson et al., 2013). However, these differences may be explained through cultural variation. For example, many BAME women grow up in a collectivist culture, particularly throughout much of Asia and Africa, which involves a strong sense of community and interdependence. (Hui & Triandis, 1986) Therefore, participants of this culture are more likely to report feeling isolated (Lykes & Kemmelmeier, 2013). The dichotomy between the expectations generated by growing up in collectivist cultures and the individualistic culture of the UK may therefore explain differences in feelings of isolation.

Furthermore, as reported by Jomeen et al., language barriers lead to a worse experience (Jomeen & Redshaw, 2013). NICE guidelines state that when communicating with women who have difficulty reading or speaking English, one must 'provide the woman with an interpreter'; however, the study describes a 'lack of interpreting support' (National Institute for Health and Care Excellence, 2010). Furthermore, Condon et al. acknowledge that providing English leaflets to Romani-speaking women is an inappropriate form of communication. Therefore, it is clear guidelines are not being followed and further research is needed to investigate why to ensure this is avoided in future (Condon & Salmon, 2015).

Henderson et al. provide evidence of the impact of this communication barrier (Henderson et al. 2013). For instance, BAME women access antenatal care later and are less likely to attend post-natal checks. This may be due to feeling belittled and ignored by HCPs. Therefore, reduced access to maternity services is present despite the guidelines advice to improve engagement of BAME women, so either the NICE guidelines are not being followed, or they are not sufficient.

The overall results illustrate that HCPs require education to combat stereotypes and rectify ignorant behaviour. Recognition of varying cultural will allow professionals to empathise with patients and meet their needs. Furthermore, these results should fuel the research and development of policies to ensure that women from all backgrounds feel supported during pregnancy.

One limitation in this area of research is the aggregation of distinct ethnic minority groups into the BAME umbrella. As reported by Henderson et al., not all ethnic minority groups' experiences are the same. Each group had a different engagement with services, health outcomes, and perceptions of care. Therefore, combining the heterogeneous groups and assuming they are all treated the same diminishes their individual experiences.

Furthermore, with reference to the guidelines, it is important to note that many BAME women are not migrants, refugees, or asylum seekers, and many do not have difficulty reading or speaking English. In the future, research should be done into other ethnic minorities so more specific guidelines can be generated.

5. Conclusion

This systemic review aimed to assess the experiences of BAME women's experiences of maternity care in the United Kingdom, as there is a paucity of evidence regarding this important topic. BAME women receiving maternity care in the UK have poorer perceptions of care than White women. They feel less supported and more isolated and experience communication issues. Additionally, there are problems with accessing maternity services.

This systemic review is the first known of its type regarding this important subject matter. It illustrates that fundamentally, HCPs require further education to rectify ignorant behaviours, empathise further with BAME women.

Despite guidelines being present, evidence suggests that either these are not being followed or they are not adequate in addressing the issue. Further research is required to produce more specific guidelines to firstly ensure that BAME women have the same satisfaction with maternity care as White women, and secondly to explore why these guidelines are not being followed.

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