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--Manuscript Draft—

Addressing the risk of disproportionate maternal mortality among black and brown women

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Abstract:	A plethora of research and inquiry have considered why women are dying in pregnancy, labour and during the postpartum period. Some of the studies have focused on seeking answers for why Black and Brown women are three times more likely to die in childbirth or up to six weeks after childbirth compared to their White counterparts. The rationale behind the significant death of Black and Brown women from some studies has been attributed to factors such as pre-existing medical conditions and low socio-economic backgrounds. Pre-existing medical conditions and low socio-economic backgrounds are however factors that are within our society and could affect any women regardless of their race and is therefore a weak explanation for the high mortality rate for Black and Brown women during pregnancy, childbirth and the postpartum period. Several critical factors including racism and a predominantly White midwifery educators and profession are contributory factors to the high mortality rates of Black and Brown women during pregnancy, childbirth and the postpartum period. The significant lack of diversity in midwifery education, educators and profession is a catalyst for a lack of culturally focused care. A lack of culturally responsive care negatively impacts on the care given to Black and Brown women with consequential suboptimal experiences and outcomes. Black and Brown women, midwives, the Nursing and Midwifery Council, Health Education England, Higher Education institutions which deliver midwifery education, the government, NHS Trusts and key stakeholders must work collaboratively. The tailored collaborations must focus on concrete actions and impact measuring approaches that will reduce the high mortality rate of Black and Brown women and improve their outcomes to make maternity safe for all women. The author declares no conflict of interest for the paper submitted.

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Addressing the risk of disproportionate maternal mortality among black and brown women

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Black and brown women are three times more likely to die in childbirth or up to 6 weeks postpartum compared to their white counterparts. Several critical factors contribute to this inequality, including racism and a predominantly white population in midwifery and education. The significant lack of diversity in midwifery education, among educators and in the profession as a whole is a catalyst for a lack of culturally focused care. Collaborative work is needed between black and brown women, midwives, the Nursing and Midwifery Council, Health Education England, higher education institutions that deliver midwifery education, the government, NHS trusts and key stakeholders. Tailored collaborations must focus on concrete actions and impact-measuring approaches that will reduce the high mortality rate among black and brown women and improve outcomes to make maternity care safe for all women. Maternity care in the UK has been under significant scrutiny in the past decade. High-profile reports of neonatal and maternal deaths in several hospitals, such as the Ockenden (2022; 2026) inquiries, have reported how families affected by poor maternity care are consistently seeking answers for the trauma they have experienced and the deaths of women and babies. The number of women dying in UK during or soon after pregnancy has increased to levels that have not been seen for over two decades (Rimmer, 2024). In 2017–19, MBRRACE-UK (2021) reported that there were 8.79 deaths per 100 000 maternities. This increased to 13.41 deaths per 100 000 maternities in 2020–22 (MBRRACE-UK, 2024). Women from black, Asian and minority ethnic groups are significantly more likely to die in childbirth in the western world compared to their white counterparts (Serbin and Donnelly, 2016; Knight et al, 2020). The MBRRACE-UK (2024) report highlighted that black women in the UK were approximately 3.7 times more likely to die during pregnancy or within the first year of postpartum compared to white women, and Asian women were 1.8 times more likely to die than white women. The report suggested that black women have consistently remained at the highest risk of death in childbirth and highlighted the ongoing issue of siloed working across health and social care agencies, which contributes to the high mortality rate in childbirth (MBRRACE-UK, 2024). Brader (2023) similarly reported that rates of maternal deaths for black women remain consistently high, with several studies having reported that they are approximately three times higher than rates for white women.

The higher maternal mortality rate in black and Asian women in childbirth is mirrored in the US, where Hoyert (2024) documented that maternal mortality for black women was 50.3 deaths per 100 000 live births, compared to 14.5 for Caucasian women, 12.4 for Hispanic women and 10.7 for Asian women. Reasons cited for this disparity include lower socioeconomic status and pre-existing medical conditions, such as hypertension and diabetes (Creanga et al, 2017; Howell, 2018; Hoyert, 2024). In the UK, the Women and Equalities Committee (2023) explored data from 2015–2018 in England, Scotland and Wales, and noted higher rates of pre-existing conditions, such as hypertension and diabetes, among black and Asian women compared to white women. The committee emphasised that the high maternal mortality and neonatal death rates among black women and babies is not driven by a single factor, but is the result of the interplay between various compounding factors, such as socioeconomic inequities and access barriers (Women and Equalities Committee, 2023). Caution is needed when attributing higher maternal deaths in black and brown women to pre-existing medical conditions. The Marmot (2010) report extensively documented how low socioeconomic status impacted health outcomes for all populations, regardless of race or ethnicity. It can be argued that the population of black and brown women in the UK is significantly smaller than the population of white women, and therefore that the higher deaths rate in maternity care may not be solely attributed to pre-existing conditions and lower socioeconomic status.

Farrant et al (2022) explored the role of ethnicity in high-level obstetric clinical incidents through a review of cases from a large UK NHS maternity unit. They reported that pre-existing risk factors were more common among white women than women from ethnic minorities; 68% of white women had these conditions compared to 50% of women from ethnic minorities. The study further highlighted that there was no statistically significant difference in the severity of pre-existing medical conditions between white women and women from ethnic minority backgrounds, although it did not distinguish between ethnicities within the ethnic minority groups explored (Farrant et al, 2022). A letter to the Women and Equalities Select Committee from the NHS Confederation (2022) warned that while pre-existing conditions are relevant to maternal disparities, they cannot be viewed as a single genetic cause. The suggestion that higher maternal mortality among black and brown women is the result of pre-existing health conditions and low socioeconomic status risks implying that white women, despite more commonly having pre-existing medical conditions, have better bodies and health than black or brown women. Such an assertion supports the racial theory from historic legacies that white bodies are genetically better than black bodies. Historical perpetuation of racism in obstetrics and gynaecology has included exploitation, experimentation and the abuse of black women who were then slaves. James Marion Sims, named as the ‘father of modern gynaecology’ pioneered a surgical technique that repaired vesicovaginal fistula (Wall, 2006). Sims is widely known to have performed crude experiments on black slave women without anaesthesia, as he believed that black people did not feel pain (Wall, 2006). Owens (2018) purported that the roots of caesarean section stem from a procedure perfected on black female slaves by Francois Marie Prevost, known as the ‘father of caesarean section’. It is paramount and highly critical for maternal healthcare professionals to understand the link between this history and some present day ideologies, in order to challenge and dispel them. Such notions include the myth that black women do not feel pain or have a higher threshold for pain. These historical legacies have the propensity to shape our thinking, actions and the manner in which we deliver care, perpetuating racism in healthcare delivery.

Professor Marian Knight, who leads MBRRACE-UK investigations into the deaths of babies and women during pregnancy and childbirth, informed the British Medical Journal that 'women from different ethnic groups are dying from the same causes but at disproportionately greater numbers … we actually need to be looking at morbidity to see progress and see how changes in services or different interventions can actually make a difference' (Linton, 2025). Reviews of maternity services have indicated that women are often ignored or dismissed when receiving maternity care (Ockenden, 2022; 2026). Suboptimal care puts all women at risk, particularly those who are already vulnerable, including a proportion of women who receive care driven by microaggressions and racism. Systemic failures in maternity care sandwiched in racism and microaggressions is a triple risk that inadvertently disadvantages all women and contributes to poor outcomes (Knight et al, 2022). An inquiry into racial injustice in maternity care attributed high rates of maternal death among black women to the experiences of care received during childbirth (Birthrights, 2022). The inquiry revealed that these women experienced racism, neglect, microaggressions and stereotyping, as well as failures to identify or diagnose life-threatening medical conditions because of the colour of their skin. The report highlighted a blatant lack of respect for religion, culture and trauma, including experiences of breaches of consent for black and brown women. Religion has also been reported to relate to these issues; an inquiry by Gohir (2022) into the maternity experiences of Muslim women from racialised minority communities noted that implicit and explicit racism was a cause for poor maternal outcomes and a higher mortality rate for women who were not white. The experiences of black and brown women in labour reported by the Birthrights (2022) inquiry included dismissal and denial of pain relief and minimisation and dismissal of pain and life-threatening symptoms. Responses to the inquiry from the trusts who delivered care highlighted a blame and fear culture in the NHS, as well as a lack of black representation in senior roles and lack of a safe or clear route of escalation for reporting racism (Birthrights, 2022).

A diverse and valued workforce has a direct correlation to improved staff wellbeing and the care that patients receive (Quirk et al, 2018). It is becoming internationally recognised that a lack of cultural and ethnic representation in the midwifery workforce is likely to be a hindrance to providing safe and culturally competent care (Serbin and Donnelly, 2016; Birthrights, 2022). However, white people govern and occupy most decision-making roles in nurse education (Ramamurthy et al, 2023) and dominate the more stable and valued clinical and leadership positions in healthcare settings (NHS England, 2025). This has contributed to the normalisation of racial hierarchy and further deepened ignorance (Bell, 2021). In an interview with The Guardian, Professor Donna Kinnair, the then Chief Executive of the Royal College of Nursing, stated that 'the leadership of the NHS is not reflective of the workforce, or the communities we serve' (Kale, 2020). A lack of diversity in midwifery is detrimental to fostering culturally sensitive care. An ideology of 'whiteness' exists when white history, culture, beliefs and identities dominate as the accepted norm. This bestows relevance to a white identity that was formed from colonial social relations, protected by law with possession established on exclusion and exploitation (Harris, 1993; Gillborn, 2005). The notable and known consequences of a whiteness ideology encompass unreported and widespread racism and racial harassment not being appropriately addressed (Ash et al 2020; Universities UK, 2024). The Birthrights (2022) inquiry concluded that the perception of white bodies as the norm led to a failure to recognise conditions such as jaundice or sepsis in black and brown women or babies. Greenwood et al's (2020) study reported that black newborn

babies who were cared for by black doctors were more likely to survive than those cared for by white doctors. The Office for Equality and Opportunity (2025) analysis highlighted how women from ethnic minorities felt that midwives who came from the same ethnic backgrounds were more empathetic and compassionate to concerns that they raised, and had a greater ability to understand and address concerns raised. Examples cited included their ability to better recognise how medical conditions manifested in different ethnic groups and skin tones. A lack of cultural understanding and a failure to recognise that black and brown women know and understand their own bodies leads to epistemic injustice and epistemic racism and deaths.

Fricker (2007) described the ideology of epistemic injustice as forms of injustice that are 'a wrong done to someone specifically in their capacity as a knower'. Social and epistemic practices of giving information and interpretation of our experiences is pivotal to our being, how we think and rationalise, and our identity, agency and dignity. Injustice that harms our testimonies and hermeneutical capabilities can be perceived as a source of deep harm (Kidd and Carel, 2017). Fricker's (2007) work postulated that a person or group whose accounts or testimonies are not believed will gradually lose their epistemic confidence as a result of enduring the constant erosion of their credibility; time and repetition will cause them to expect and experience not being heard. Listening and representation matters for all women in the delivery of safe and compassionate care. Representation is key in fostering care that is tailored, culturally astute, embraces diversity and supports the reduction of racism in maternity care. Racism is a 'system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race") that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources' (Jones et al, 2008). Persistent racism in the UK's health sector and higher education system exists in the form of interpersonal, institutional and structural racism (British Medical Association, 2022). Bailey et al (2017) explored structural racism in the form of historical, institutional and cultural practices that reinforce racial inequalities, such as through conscious exclusions of minority populations in health data. Racism can be intersectional, such as gender hierarchies that imply that women experience racism differently (Collins, 2000; Bailey, 2021). Bailey's work suggested a distinct intersection of gender and race, highlighting misogynistic stereotypes that portray black women as emotional, angry, strong, pain tolerant, sexualised and domineering matriarchs. Collins (2000) and Etowa et al (2017) suggested that such stereotypes occur in healthcare discourses that establish and endorse white knowledge and emotions as the norm. Such notions and ideologies perpetuate racism by assuming black women as the contrary (Bailey, 2016).

Racism must be recognised and acknowledged, including the role it plays in NHS organisational culture and in maternity care. This will enable the review of and changes to cultures and practices in maternity provision, including the decolonisation of midwifery curricula, to ensure safety for all recipients of maternity care, including black women. An analysis by the Office for Equality and Opportunity (2025) found that ethnic minority women lacked trust in the maternity care that they received and felt unsafe giving birth in hospitals in England. A report by NHS Digital (2023) reported that black women are afraid of giving birth in the UK, as they have more stressful birth experiences compared to women of other ethnicities. The voices of black and brown women need to be leveraged by policymakers to

dismantle the institutional and structural racism and barriers that inhibit racial justice and equity in maternity care. Birthrights (2022) and other key inquiries (Ockenden, 2022; 2026) have not seen any measurable change in how the government, NHS trusts and key stakeholders ensure equity in maternity care for all women. The government, trusts and higher education institutions need to address inequalities in maternity care, as these are causing significant emotional and physical harm and trauma for black and brown women. These women have reported a callous indifference to their needs, making them feel dehumanised (Birthrights, 2022). The Birthrights (2022) inquiry reported that black and brown women experienced epistemic racism, injustice and a lack of choice or informed consent in labour. In addition to the higher maternal mortality rate for black and brown women, these reports highlight the urgent need for systemic reforms in healthcare and community settings, with an overhaul of impact evaluated well-tailored policies. All NHS trusts should have a clear route and processes for reporting racism, including mandatory annual cultural competence training for all midwives, as recommended by the Health and Social Care Committee (2025).

Campinha-Bacote's (2002) model described the process of cultural competence in the delivery of healthcare services. The model emphasises that cultural competence is an ongoing process built on cultural awareness, knowledge, skill, encounters and desire. The use of this model in the provision of maternity care, from taking a booking history to discharge, will ensure better and more culturally sensitive care for all women. Antenatal appointments could be enhanced through greater continuity of care and ensuring adequate time is spent with women, in order to undertake holistic assessments in a realistic timeframe. This will enable delivery of respectful and compassionate safe and effective care for all women. This is particularly poignant when English is spoken as an additional language or when interpreter input is needed. A deeper understanding of cultural competence, including a skilled and thorough holistic and culturally appropriate risk assessment, will enhance excellent communication skills and build mutual trust between midwives and the women they care for. Midwives need to actively listen with respect, without dismissing a woman's concerns, including being mindful of any unconscious biases that may hamper the safe and compassionate care needed by all women. Midwives also need to avoid microaggressions and demeaning behaviours, such as undermining the views of the woman through patronising and judgemental attitudes and comments. Cultural astuteness can be maintained by engaging with Campinha-Bacote's (2002) model to support building a therapeutic relationship, rapport and trust needed between the midwife and the woman. Cultural competency training for midwives and maternity support workers will ensure greater awareness and the delivery of compassionate culturally sensitive care. Annual cultural competency training for student midwives would enable cultural astuteness and ensure sound midwifery practice on qualification.

Pain is a complex phenomenon and manifests differently in different women. Timely pain relief should be offered to all women during all stages of labour, with informed consent. The impact of mental health on pregnancy, labour and the postpartum period needs recognition and a timely interprofessional and collaborative approach. The background of all women needs to be respected and thoroughly reflected on throughout care delivery to ensure compassionate, culturally focused and equitable care. Midwives should be able to recognise how issues such as infection, sepsis and anaemia manifest in different skin colours. They should also be able to recognise and appropriately address pre-existing conditions, such as

type 1 and type 2 diabetes, hypertension, sickle cell disease, thalassemia and low vitamin D. Existing curricula in all healthcare professions require scrutiny to ensure that all ethnicities are represented. All knowledge formed should be legitimate, valid and representative of all populations. There is a need to identify and contextualise the interconnectedness between a lack of culturally responsive care, midwifery education and predominantly white leadership. All women should receive culturally competent and responsive care from a diverse pool of midwives. A diverse midwifery workforce that represents the population is better able to understand and acknowledge the cultural and ethnic aspects of care. A clear co-created strategy needs women as key stakeholders in developing evidence-based, measurable approaches that challenge and address racism and disparities in care among women of different ethnic backgrounds. No woman should feel unsafe or die in childbirth, regardless of her race, colour, creed, socioeconomic background or pre-existing medical condition.

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Key points

Racism and microaggressions in maternity care contribute to poor care for black and brown women.

Addressing high mortality rates among black and brown women in childbirth needs co-creation and a collaborative approach.

Making cultural competence training mandatory for midwives will support the provision of holistic care, which will contribute to safe and effective care for all women regardless of their ethnic background.

Encouraging diversity in midwifery education and the profession as a whole will enrich the midwifery profession.

CPD reflective questions

How do pre-existing medical conditions and lower socioeconomic status impact maternal outcomes?

Are these factors alone enough to explain the disproportionately higher mortality rates among black and brown women?

How might racism in midwifery practice contribute to poorer outcomes for black and brown women?

Is midwifery education and the profession dominated by white colleagues and how could we move towards fair representation for all women?

Will a diverse midwifery education and workforce support culturally sensitive care and improve trust between midwives and women?