Portfolio Volume 1: Major Research Project

Black Maternal Experiences of Birthing and Postnatal Care During the COVID-19 Pandemic

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Abstract

Background

With a longstanding backdrop of maternal health inequalities, literature exploring the experiences of Black mothers in maternity services in the UK is sparse. The Covid-19 pandemic has presented challenge, trauma and complexity across societies. With a disproportionate impact on women from Black and Ethnically Minoritised backgrounds within the perinatal period, their voices and lived experiences urgently need honouring and reflecting in research.

Method

This study used a qualitative approach and through purposive and snowballing sampling, recruited 13 self-identifying Black women who gave birth in the context of the pandemic. Semi-structured interviews were completed to explore experiences of care during birth and postnatally from maternity services and perinatal mental health services. The study aimed to explore recommendations and ideas for service improvement and policy change.

Findings

Reflexive Thematic Analysis (RTA) was used from a critical realist stance to interpret data and generate three themes: *'The Ripples of Covid'*, *'Inequality within Inequality'* and *'Conscientious Change for Maternity Systems'* with subsequent sub-themes. The context of the pandemic revealed multiple layers of experience with participants sharing what facilitated and hindered their experiences of the care they received. Highlighted were existing inequalities and significant intersections of identity woven into the experiences of birthing and navigating the postnatal transition. Findings were further conceptualised using relevant maternal health literature and psychological theory.

Conclusions & Implications

The strengths and limitations of the study are outlined including scope for further research such as, experiences and journeys of birthing partners, professionals and the voice of the infant during the pandemic. The implications of the study are explored relevant to communities, maternity services, perinatal mental health services, commissioners, and policymakers to truly tackle Black maternal health inequalities with commitment and sincerity.

Chapter 1: Introduction

Overview

This qualitative research study seeks to explore the experiences of women who identify as Black and have given birth during the coronavirus pandemic in the United Kingdom (UK). This research explores participants experiences of care from maternity settings and perinatal mental health services, during labour and postnatally. With intention to seek views around how services can improve care within the context of long-standing inequalities. This introductory chapter will set the context and initially describe relational aspects between myself as researcher and the topic under investigation, whilst defining key concepts and exploring the epistemological position threaded throughout. Next, a summary of the existing relevant research in maternal health and perinatal mental health including policy documents and contextual information will be presented. This will be followed by the systematic literature review of existing research, offering a synthesis of the literature and research areas for development. Finally, the chapter will end with a presentation of the rationale and aims of the empirical study.

Relationship with the Research Project

Qualitative research and the ways in which knowledge is generated can be considered contextual across a broad range of intersections including culture, age, ethnicity and socioeconomic status (Dodgson, 2019). The influence of these factors is important to recognise within the relationship between researcher and participant, and can be achieved through self-reflexivity. This process entails a researcher applying self-monitoring and awareness of what they are bringing to the interpretation and associated outcomes of research

including lived experience, beliefs, and assumptions (Berger, 2015). Therefore, the subsequent section will offer an insight into personal connections to the research and intentions for reflexivity.

This study is being approach from an 'insider researcher' position whereby there is connection to and familiarity with the community in which the research is being carried out (Aiello & Nero, 2019). The lens I bring to this study is informed by my position as a Jamaican, Italian and Ukrainian mixed heritage heterosexual woman and mother of two children. My relationship to this research topic is deep-rooted, not only connected to my own transitions into parenthood but is located within my family's history and experiences of migration and refuge to the UK. This rich cultural rooting offers a unique perspective as an insider researcher, the implications of this positioning will be discussed in greater detail in a latter section of this chapter. My interest in perinatal research is inspired by personal experiences of birth trauma, postnatal distress, pregnancy loss and anxiety. Within the context of my family and cultural communities, similar experiences are not uncommon. I slowly learned of the stark inequalities that exist within maternal health based on factors including a person's ethnicity, age and socioeconomic status, this generated feelings of anger and sadness. Despite this bleak picture, there remains little insight into or acknowledgement of lived experience and meaning making for women holding their stories untold. My emotional responses and lived experience fuel and ignite my passion to research this topic and contribute towards better outcomes for future generations. I embarked on this journey knowing that it would require emotional investment and vulnerability. I used this to energise intentions to dispel the myths that position Black women as 'hard to reach' and hope that together as a community, voices can be raised.

Epistemological position

Epistemology derives from philosophical enquiry into the theory of knowledge. Whilst questioning claims made, epistemology seeks to understand how inferences are made and what knowledge claims are privileged over others (Siegel, 2014). This is closely linked yet different to ontology which refers to the assumptions made about realities (Scheurich and Young, 1997). When applied within the context of research, it is of significance to understand a researcher's epistemological position because research is the very process in which data is interpreted and informs the creation of knowledge through research outcomes rooted within social history (Scheurich and Young, 1997). This is of particular importance within qualitative research because the process of interpretation of words involves creating meaning and identifying patterns (Hook, 2015). These are methodological processes which cannot be separated from context and are an integral part of how data analysis is approached. Therefore, researchers must ask themselves reflexive questions to understand how and what is being attended to and considered relevant to the research (Hook, 2015).

The epistemological stance for this research is rooted within critical realism due to the invitation for the researcher to go beyond the story shared. Critical realism encourages an expansion and deepening of knowledge through attending to what is observed within accounts of lived experience, alongside the inherent structural processes that remain unobserved yet equally influential to the phenomena (Willig, 2019). Critical realism also acknowledges that a phenomenon can exist independently, without direct observation, but witnessing can add weighting and validation of the reality (Speed, 1991).

Critical realism is a suitable fit for the current study because it provides a rich framework for knowledge construction by considering the multifaceted connections between the social context surrounding an individual alongside the subjectivity and meaning of a person's experience (Braun & Clarke, 2022). Therefore, as applied to the current study, a

critical realist approach seeks to understand the underlying processes that influence the care Black women receive, whilst attending to the perceptions and meaning made of those experiences, which together represent reality. The rationality critical realism brings to the current study is the validation and acknowledgment of the social context of the pandemic, alongside the backdrop of inequality within maternity outcomes and maternal mental health, which may help to explain and critique what is happening.

Self-reflexivity.

Self-reflexivity within the arena of qualitative research refers to the ability to be transparent and genuine with the self, the research project and people who engage with the research (Tracy, 2010). The aim is to demonstrate self-awareness and acknowledge how the research has been approached, why conclusions have been drawn and to evaluate how the reflexive journey both enriched and limited the research (Tracy, 2010). Therefore, within the context of the current research study, self-reflexivity can help researchers consider personal intersectional identities, experiences, culture, and heritage.

In my case being of Black mixed heritage and having had children, this perspective can bring advantages with regards to connections with people taking part, shared understanding, and attention to meaning (Dwyer & Buckle, 2009). A disadvantage of this position is the potential for biases and assumptions which may influence the interpretation of findings (Dwyer & Buckle, 2009). However, the context of birthing during the pandemic is one I am unable to connect with, therefore I am open to occupying a 'space between' whereby as an insider researcher I acknowledge this complexity and lean into positions of vulnerability and learning (Dwyer & Buckle, 2009).

Additional factors I have considered relevant to the research and my relationship with participants, are the influence of colourism and assumptions around my positionality. As someone of mixed cultural heritage I have experienced horizontal hostility within the

communities to which I belong, entrenched within colonial histories and narratives (Campion, 2019). However, for me, the strong connection I have had growing up with predominantly Jamaican and Italian cultural influences, I feel rooted within my rich cultural identity and less impacted by assumptions. Nevertheless, as Fisher (2015) writes, I have considered the ways in which I might be subject to the racialised gaze of others and thus enter a process of renegotiating my positionality. Therefore, holding openness and curiosity within self-reflexive practices are crucial to my ongoing journey of learning and personal development.

The ways in which I have applied self-reflexive tasks include journaling, embracing musical musings, connecting with online communities, and having in-depth supervisory discussions. It has been imperative to continuously engage in these activities throughout the study to unpick what aspects and how research processes are influenced by my positions and the personal connections I have with the topic. Hook (2015) speaks of such tasks as deeply connected with epistemological positioning and believes that engaging in self-reflexivity can open space for new meanings within research. At early stages of study development, I engaged in a bracketing interview and discussed my assumptions and what the research might bring up for me. I extended these discussions within the supervisory space, and as a team there was an exploration of positionings which facilitated ongoing dialogue. I will give insight into the personal journey I have taken and meanings I have created by sharing extracts of my reflective journal (appendix A).

Context and language

This next section of the chapter will warm the context further by outlining intentions around language used within the research. Gergen (1985) speaks of the importance and function of language to negotiate assumptions, express emotions, and motives, engage and share within communities including the power it has to shift societal structures. Language is a

tool often used to dismiss and minimise discourses around inequalities and maintain structures of power, giving justification to oppressive practices (Orelus, 2012). Therefore, given the context of the pandemic and aim of the empirical study to address experiences linked to inequalities, attention to language is crucial.

Ethnicity and Culture

Nagel (1994) describes ethnicity as a negotiation of characteristics such as, language, appearance, religion, and ancestry, ascribed by self and others. Culture is closely linked to ethnicity and can be considered pivotal to the construction and meaning unique to individual ethnic categories, including shared beliefs, traditions, art, music, language and religion (Nagel, 1994). The ethnic term 'Black' derived from early conceptualisations of racialised difference, separating White people from others based on observed skin-colour, throughout history this served as a socio-political weapon for racism and oppression of blackness being associated with inhumanity and inferiority (Fernando, 2017). In defiance Narayan (2019) speaks of the initiation of Black power and political blackness woven throughout British history rooted within activist and community-based acts of resistance to address racial inequalities heightened between the 1960s and 1970s. Narayan (2019) reminds readers of the importance of reconnecting with oppressive realities of the past, recognising the continued ripples present within current society and seek to dismantle oppressive systems that maintain ethnic inequality. Therefore, to honour the socio-political history of Black activism, this term will be used throughout this thesis, except for contrasting terminology used by authors whose work will be cited. For the purposes of the empirical study, the term Black will be used as an indicator of how people taking part are self-identifying ethnically as linked to their family ancestry and cultural heritage. The term 'race' will not be used, due to its social and colonial conceptual roots which categorised and created a racialised social hierarchy to justify acts of

violence and racial discrimination. Yet, to not use this term is not to deny the impact and reality of racism Kinouani (2020).

Gender

The title of the study developed from expert by experience consultation focuses on Black ‘mothers’ and ‘women’s’ experiences, this also aligns with the language used in the vast majority of perinatal literature.

Maternity and maternal health

Maternity services according to the National institute for Health and Care Excellence (NICE) encompass intrapartum care and postnatal care including maternity settings, midwifery and obstetrics and mental health, this will be the focus of the current research study.

Background Literature

This section offers an initial insight into constructions of motherhood, followed by a focus on the social context and societal representations of Black women. There will then be consideration of maternity and perinatal mental health services with key reports and relevant literature discussed, mapping a history and current inequalities facing Black women during the perinatal period. This section will conclude with a focus on the context of the pandemic and the indicated ramifications for Black mothers.

Motherhood

The journey into motherhood is a unique experience. Expectations are often shaped by societal discourses promoting positivity, scattered with idealised notions of commitment

and perfectionism, absent are the fraught realities of negotiating a transition of loss from individual to mother (Shelton & Johnson, 2006). However, this process of shaping and moulding expectations of motherhood are dominated by cultural norms and values characterised through a White, middle-class and heteronormative gaze and experience (Prikhidko & Swank, 2018).

Motherhood from the Black woman's standpoint is tainted with societal representations of Black female bodies including associations with narratives of strength and harnesses of anger (Afuape, 2011). Within the context of families, Black females can be regarded as leaders and hold key roles in perpetuating acts of misbehaviour and crime in their offspring (Afuape, 2011). This to a degree contrasts with the way in which Black motherhood is celebrated within the originating principles of attachment parenting that promote mother-infant bonding through responsivity and physical contact such as, the use of baby slings. Despite this, the promotional face of attachment parenting is laden with Whiteness, highlighting the need to re-claim and transform the image of the Black mother through the Westernized gaze from inferiority to reaffirming parenting values derivative of African origins (Hamilton, 2021). Overall, this depiction provides an important passage in the transition to understanding encounters faced by Black women in maternity settings.

Maternal health inequalities

Maternity settings are fraught with gross inequality of maternal mortality between ethnic groups, this can be dated back as far as 1970. A study analysing data between 1970 and 1985 found elevated levels of risk of maternal death for women who were identified as Black African and Black Caribbean and born outside of the UK, with moderate risks identified for women born in Asia and Russia (Ibison et al, 1996).

UK-based cohort study from the Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries (MBRRACE) across the UK found that higher rates of severe maternal morbidity often linked to maternal deaths also known as ‘near-miss’ events, were of higher prevalence in non-white women and twice more likely in Black African or Black Caribbean women (Knight et al, 2009). Another MBRRACE report (Knight et al, 2018) found that the maternal mortality rate of Black mothers was nearly five times that of White women in the UK, calling for urgency amongst maternity professionals to address underlying causes of the growing disparity.

The literature indicates that culture and ethnicity can impact a woman’s experience of safety, negatively influence communication, increase a sense of loneliness and mistrust at childbirth and when receiving postnatal care (Magee & Askham, 2008, Henderson, Gao and Redshaw, 2013, McLeish et al, 2020). Puthessary et al (2010) found that although UK-born minority ethnic mothers connected to a sense of more equitable care overall, an important finding was that the most significant accounts about negative experiences were from Black Caribbean and Black African participants.

Similarly, across perinatal mental health community team (PMHCT) services the representation of Black and ethnically minoritised women is low compared to White women (Jankovic et al, 2020). Suggested barriers to access have been located at multiple levels including individual factors, sociocultural influences, systemic and structural levels. Jankovic et al (2020) also noted that once Black and ethnically minoritised women had gained access to a PMHCT, the rate of appointment cancellations and non-attendance was lower than White women, indicating that barriers to support remain located within accessibility of services. Challenges in access may reside in the conceptualisation of perinatal mental health symptomology and distress for Black mothers. Edge & Rogers (2005) found that emotional distress can be linked to personal identity and narratives of strength, resilience and attributed

to physical health concerns, meaning that there is a decreased likelihood that support would be actively sought. Therefore, professionals may not consider the alternative ways in which Black women experience and communicate distress, failing to conceptualise low mood beyond 'normative' expectation located within Western culture, indicative of racialised stereotypes (Edge & Rodgers, 2005).

Some attribute low access to perinatal mental health services for Black and ethnically minoritised women to a lack of awareness, cultural expectations, stigma, and culturally insensitive services (Watson & Soltani, 2019). Women identified ethnically as White, are more likely to be offered mental health support than those who identified as Black or Asian during the perinatal period (Redshaw & Henderson, 2016). Thus, indicating a potential unmet mental health need and opportunity for services to support the psychological wellbeing for women. This has implications for negative impacts on systemic long-term mental health need, including that of their children and families (Redshaw & Henderson, 2016).

The 2019-2021 context: key reports and publications

The years 2019 to 2021 held significance amongst Black communities globally, catapulted by the accessibility of social media, the world witnessed the murders of Black people including Breona Taylor and George Floyd in the United States of America. This sparked global demonstrations and movements to stand up to racial violence and oppression.

Within the UK, the years 2019 onwards also marked the publication of significant reports and documents relevant to Black communities and maternity outcomes. For example, Knight et al (2019) focused on learning from confidential enquiries into maternal death and morbidity between 2015 and 2017 and indicated a widening gap of five times greater difference in maternal mortality between Black and White women. A subsequent report found then shifted from five to fourfold difference in mortality rates (Knight et al, 2020d).

The large-scale discussions and media coverage around the reports published encouraged activism within Black communities. An example was a UK campaign Fivexmore, a grassroots organisation founded by two mothers who initiated an online petition in June 2020 to improve Black maternal outcomes, this generated mass support and was subsequently debated in Parliament in 2021 (Fivexmore, 2020). Through the launch of the UK's first Black maternal health week, they developed key recommendations for professionals and expectant parents in support of addressing systemic racism in maternity care. This included encouragement for advocacy, for people to seek clarity and information independently, whilst highlighting the importance of documentation (Fivexmore, 2020).

A recent MBBRACE report (Knight et al, 2021) shows that Black women remain at four times more likely to die during childbirth than White women. Key recommendations emphasise that at a community, health and social level, promoting that 'we are all part of the solution'. The statistical disparities between ethnic groups and mortality indicate an array of potential contributors including physical health conditions and mental health difficulties (Knight el al, 2020c).

The succession and timeline of the summarised key reports, provide an insight into the types of narratives surrounding Black mothers including that of vulnerability, risk and mistreatment. This also emphasises the wider discussions had at a societal level stressing the importance and need for change.

The Coronavirus pandemic

The start of 2020 saw the rise of the coronavirus (Covid-19) pandemic, it marked a global health emergency. The pandemic has had a disproportionate impact on ethnically minoritised communities with significantly higher death rates, linked to longstanding

inequities and discrimination across a multitude of sectors including health, education, employment, and criminal justice (Farquharson & Thornton, 2020).

The pandemic changed how maternity services operated to decrease the spread of the virus, including limiting who could accompany mothers at antenatal scans, birth partner arrangements and decreased postnatal visits (Esegbona-Adeigebe, 2020). Routine checks were changed to virtual clinics and options around birthing restricted, with some NHS trusts suspending home birthing services (Karavadra et al, 2020). The communication around these changes relied on websites being up to date with restrictions in place varying across regions in the UK. A countrywide survey outlined a plethora of barriers facing maternal care including, a lack of support and accessibility of healthcare professionals, a resistance to inconvenience the immensely strained NHS, limited communication, and information sharing (Karavadra et al, 2020).

Exacerbated inequalities

The pandemic appears to have highlighted the existing maternal health inequalities, this was demonstrated through the stark 88% of women who died from covid-19 infection were categorised within the Black, Asian and minority ethnic background groups (Knight et al, 2020b). Karavadra et al (2020) highlighted that the 6% of total respondents who identified as coming from Black and Minority Ethnic backgrounds, shared experiences of greater challenge in seeking maternity support during the pandemic. Maternity surveillance reports and guidance (Knight et al, 2020a) suggested that services should lower admission threshold for people from ethnic groups minoritised by society, with clinicians encouraged to consider increased risk levels and adapt careful screening. The pandemic has added a layer to the experiences of minoritised communities and particularly for people during the perinatal period, including balancing knowledge around increased risk, financial implications

regarding risk and employment contexts. Thus, making it crucial to understand how people who have birthed during the pandemic have navigated support during this changing and uncertain time (Esegbona-Adeigebe, 2020).

Conclusion

The literature and relevant context discussed shares data which indicates inequity in maternal health access, heightened risk of co-morbidity and mortality. Despite this, the focus on the experiences of Black women on their maternity journey remains neglected and largely invisible within the literature relevant to the UK healthcare context. The publication of covid-19 data urgently calls for change to address the disproportionate impact on Black women within maternity services. The next section will present a mixed methods systematic literature review which examines inequalities within maternity service provision for Black women to understand what is known to date, identify gaps within the literature and consider scope for future research development.

Systematic Literature Review

A systematic literature review tries to capture the complexity and evolving nature of research, where studies may pose complimentary or conflicting conclusions which inform the generation of new knowledge and insight (Siddaway et al, 2019). The review process seeks to analyse and critique the literature whilst considering the quality of research, highlighting areas where knowledge may be lacking and there remains scope for development of the evidence-base (Siddaway et al, 2019).

An initial scoping search about Black maternal health was conducted via relevant database searches such as the Cochrane Library, indicated that research within the UK context offered a relevant but limited picture in comparison to the United States (US) for example. Literature highlighted exploration into issues including Black mothers and birth trauma and maternal mortality. Following the scoping task, the decision was made to initially focus the intention of the systematic review of literature on the health inequalities that exist for Black women in maternity services in the UK. This decision was due to a what appeared to be several relevant studies alluding to various poor outcomes for Black women during the perinatal period, with no succinct summary. However, at the earlier stages of the systematic review process this returned a very large and unmanageable number of papers for the project timeline, with many papers of which combined findings for Black women under the umbrella of 'BAME'. Therefore, a decision was made to refine the question and focus literature searches on maternity inequalities reflected in direct experiences of Black women.

The systematic literature review research question was: 'What are the health inequalities that exist in maternity services in the UK as experienced by Black women?'. The question posed aims to summarise, synthesise and critique the current literature specific to Black women's maternity journey and draw attention to gaps in the knowledge base. It is believed that this review was original as checked and the protocol registered on the

International Prospective Register of Systematic Reviews (PROSPERO), registration number CRD42022300744 (please see appendix B). This review is of relevance within the context of perinatal health in the UK linked to ambitions of the NHS Long Term Plan (2019). The plans aim to reduce maternal and neonatal mortality, serious brain injury and stillbirth, particularly for Black, Asian and Minority Ethnic people who have the poorest outcomes (NHS Long Term Plan, 2019).

Method

The systematic literature review used a narrative synthesis (Popay et al, 2006), this refers to data extracted from the literature as presented in tabular form whilst predominantly using narrative interpretations (Boland et al, 2017). This approach was considered a suitable way to address the research question through explanatory and interpretative mechanisms seeking to integrate quantitative and qualitative data. This contrasts to a meta-summary approach which seeks to address an intervention-specific question (Noyes et al, 2011), and subsequently was deemed incongruent to the aim of the review. The literature review included studies using quantitative and qualitative data, this gave breadth and range in the dataset including variation in design, analyses and perspectives, which was highly relevant to the context of the research question and narrative synthesis.

Literature from 1981 was included because the year 1980 was a socio-political point of reference in the UK and saw the publication of The Black Report. This report was taken out of circulation, however, was the first report of its kind to address and bring to the fore, health inequalities growing within the UK since the formation of the National Health Service in 1948, a transformation which sought to eradicate inequality and offer equitable healthcare for all (Gray, 1982). Therefore, it was decided that literature and studies published over the last 40 years (1981-present) in the wake of this report were fitting to the research question

and context. The inclusion and exclusion criteria for the literature review is presented in Table 1.

Table 1

Systematic Literature Review Inclusion and Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**
The study must include women who identify as Black with a sole or primary focus in study findings (either the main participant group or as a focused comparator population alongside one other ethnic group)	The study includes data from a Black participant group but analyses and discusses under the umbrella term 'BAME'
The study must focus on participants over the age of 18	The study includes data from participants both over and under the age of 18 where results are not analysed separately
The study must be conducted in the United Kingdom	The study is published in another language than English and has been conducted outside of the UK
The study must be focused within the following settings: maternity and perinatal care as delivered by midwives, obstetricians, general medical practitioners and mental health professionals. Inclusive of physical health settings such as,	The study is focused on mothers and is not specific to maternity and perinatal care settings

hospitals, in the community, community mental health settings and at home	
The study must address experiences, physical and/or mental wellbeing of mothers in the perinatal period. 'Perinatal' as defined from pregnancy up to 12 months postpartum	The study is focused on the wellbeing or experiences of associated populations including, infants, partners, and health professionals
The study must include data collected between the years of 1981 and (February) 2022	
The study must be qualitative, mixed methods or quantitative including peer reviewed journals, articles, book chapters, journal summaries of published theses, and randomised control trials, all of which must have a data analysis/research component	Systematic or literature reviews due to not using primary data Studies ongoing

Search strategy

Five bibliographic databases were accessed between January and February 2022, they were chosen due to their relevance and reputable publication of health and social science related publications, these were Scopus, PubMed, Cinhal Plus, Medline and PsycArticles. The search strategy was developed initially using the thesaurus functioning in a database and through running several pilot searches to capture the most used terms in relevant literature. This process was further enhanced by following the population, intervention, comparison-outcome (PICO) framework which has epidemiology roots and is often used to support the development of a literature review research question (Booth, 2016). This trial-and-error

process refined and supported the generation of four main search concepts. Entering all search terms did not provide a sufficient number of papers and when narrowed down to three concepts the results were too vast and identified papers which were irrelevant including studies related to areas such as, women's health, infant and partner outcomes and experiences. Therefore, the decision was made to narrow down the search strategy to two main concepts (please see table 2), ethnicity and maternity which focused the types of relevant studies identified through search engines.

Table 2

PICO Search Strategy

Concept 1	**Concept 2**
Postnatal AND	Black AND
Labour OR	African OR
Obstetric OR	Caribbean OR
Maternity OR	African Caribbean OR
Pregnancy OR	Black and Minority Ethnic OR
Birth OR	BAME OR
Labour care OR	Racial
Breastfeeding OR	
Antenatal	

The process followed for the systematic review is outlined below, please see figure 1 for a visual representation of the literature review procedure using a preferred reporting items for systematic reviews and meta-analyses (PRISMA) diagram. The PRISMA was developed via

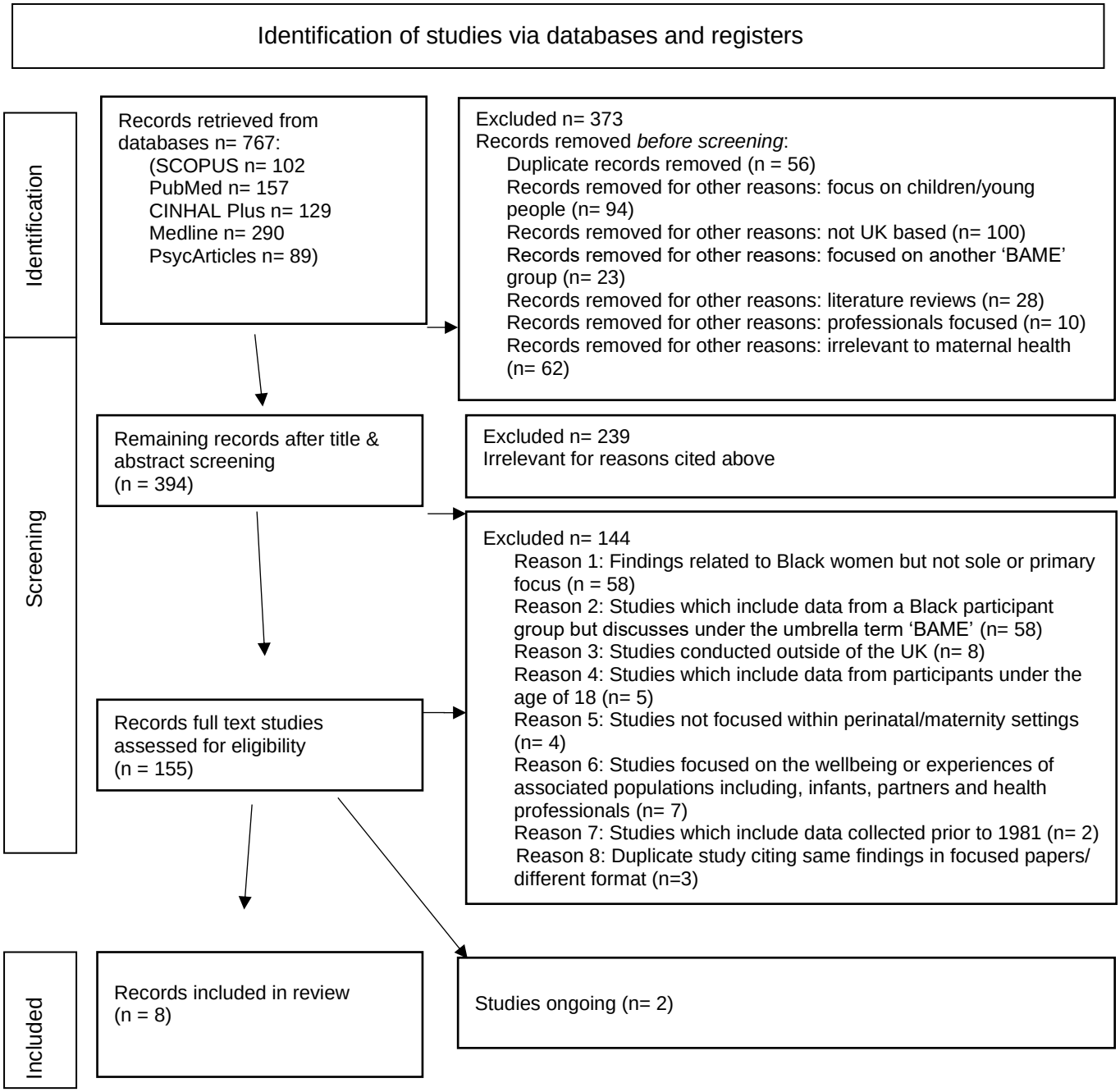
a checklist and phased flow diagram to support consistency and transparency in the reporting of systematic reviews (Liberati et al, 2009). The reason this was used is because it is considered an essential and clear approach for researchers to utilise and guide their work (Liberati et al, 2009).

1. Search results were exported from databases to reference management software
2. Duplicates removed
3. Titles only screened
4. Abstracts screened with inclusion and exclusion criteria applied
5. Full-text articles assessed with inclusion and exclusion criteria applied

The search identified an initial 767 papers which were then narrowed down following a title screen, papers were excluded at this point for reasons including duplications and clear non-UK based studies. Where it was unclear from the title only that the inclusion criteria could be applied, these papers were taken forward for abstract screen, leaving a total of 394. To support a transparent systematic process of reviewing the literature, the Covidence online review management system was used to track all 394 articles and the decision-making process in line with the review protocol. The research question and subsequent exclusion criteria were refined to enrichen and thicken the data, guided by the PICO framework (Booth, 2016) please see figure 1 below to further illustrate this process.

Figure 1

PRISMA diagram



Following this, the reference lists of the selected articles were manually searched to check for any additional relevant literature that met the inclusion criteria. The three studies associated with reason eight within the above PRISMA diagram were all linked to one dataset

with multiple publications (Edge et al, 2004, Edge 2005 & Edge & MacKain, 2010) and included within the review were two associated papers (Edge, 2007 and Edge, 2011) because the papers used two different analyses providing different results. Following this, a final number of eight papers were included in the current review (please see summary in table 3).

Table 3 *Summary of Studies*

Title and Location	Participants and Aims	Research Methodology	Key Findings and Implications	Strengths and Limitations
Chaudhry et al 2004 Title A comparison of foetal and labour outcomes in Caucasian and Afro-Caribbean women with diabetes in pregnancy Location UK	Participants Information available for pregnancies from 766 Caucasian women and 90 Afro-Caribbean women Aims To compare the prevalence of adverse foetal (early foetal loss classed as below 24 weeks, neonatal and perinatal mortality and infant size at delivery) and labour outcomes (mode and time of delivery) between women	Data collection Quantitative Retrospective analysis from 1990 to 2002 of labour and foetal outcomes from diabetes in pregnancy database Data analysis Regression analysis- logistical and least square. Ordinal outcomes- Mann–Whitney test	Key Findings Groups show similar outcomes Greater proportion of Caucasian women with type 1 diabetes and Afro-Caribbean women with type 2 diabetes with significantly later attendance at first antenatal clinic, potentially linked to decreased awareness in implications of late attendance/service availability and cultural differences Lower rates of caesarean section for Afro-Caribbean women despite equal rates of large weight newborn babies which can be a rationale for caesarean delivery, potentially linked to higher decision-making threshold of clinicians for Afro-Caribbean women who needed c-sections and a lack of awareness of women about elective caesarean/ birth trauma risk Significantly higher BMI in Afro-Caribbean women, more likely to have gestational diabetes and impaired glucose tolerance Implications There have been some improvements in antenatal care, maternal and foetal outcomes for women with diabetes due to comparable outcomes Black and minority ethnic groups needs require further study	Strengths Study drew attention to Afro-Caribbean group in an ethnically diverse area of the UK compared with one other ethnic group Information recorded from six obstetric units with consistency across diabetes-antenatal clinic and recording of outcomes Limitations Difference in measure of glycated-haemoglobin values meaning this data was omitted, therefore unable to compare glycaemic control between diabetes subtypes and ethnic groups The sample size of Afro-Caribbean women was small, and therefore, the study may be under-powered to detect small differences

Chinouya & Madziva 2019 Title Late booking amongst African Women in a London Borough, England: implications for health promotion Location UK	Participants 23 Black African women They were all first-generation migrants born in Ghana (N= 6), Kenya (N= 5), Uganda (N= 4), Nigeria (N= 3), Somali (N= 4) and Zimbabwe (N= 1) Aims To gain a deeper exploration of insights, experiences and cultural factors to understand reasons for later antenatal booking clinic appointments for Black African women	Data collection Qualitative semi-structured interviews Data analysis Framework method for thematic analysis	Key Findings Four themes identified; 'unresolved immigration status' 'the importance of culture', 'lack of awareness' and 'cultural expressions of pregnancy' Shared values of non-disclosure of pregnancy within the first 3 months due to the discourse of 'risk' and cultural norms/beliefs Narratives around immigration services and deportation push women away from services Implications Ongoing understanding is needed to explore ethnic and migration differences in relationships to health and services including political and economic factors influencing early booking Encouraged thinking about how the term 'Black African' masks nuances and difference of people who identify with this ethnic label The medical model central to early booking appointments does not account for social factors which influence health seeking behaviours, recommended a collaborative community approach Cultural sensitivity and awareness are needed in practitioners Need to address policies/guidance around health service entitlements for people who have migrated	Strengths Study explored the experiences of migrant African women using culture as analytical tool for understanding timing of the booking appointment Researchers' ownership of similarities and differences to participant group and use of reflection to understand personal approaches to recruitment, interviewing and data analysis Limitations Limited to one London Borough Snowballing sampling strategy used an established contact with a person who recommended other people in their network therefore likely selection bias

Davies & Bath 2001 Title The maternity information concerns of Somali women in the United Kingdom Location UK	Participants 13 women, age range 21 to 40 years, all living in the UK with the majority have resided in the UK for less than 10 years. The median number of pregnancies in participants was three, 85% were married and two women had experienced miscarriages Aims To explore maternity information concerns of a group of Somali women in a Northern English city. To investigate relationships with maternity health professionals	Data collection Qualitative semi-structured interviews Focus group Data analysis Theme analysis	Key Findings Themes identified; 'contact with health professionals' which highlighted difficulties obtaining and understanding information, understanding service provision and communication 'language support and information' which included use of family as interpreters, issues around confidentiality which limited ability to disclose, independent interpreters can delay access/support, individual differences in translation not accounted for Implications Highlighted the need for education for midwives and nurses to address racial stereotyping and provide information on needs/experiences of ethnically minoritised women The need to improve communication and information sources The need to challenge poor standards of care professional to professional Further research to explore level of unmet need, generalisability of findings through a quantitative study and the role of language in racial stereotyping	Strengths Study explored and focused on the needs of a group whose pregnancy outcomes are poorly understood, it highlighted experiences of discrimination, language barriers and structural issues in maternity Use of two qualitative methods of data collection, semi-structured interviews allowed for in-depth individual exploration and focus group supported peer-led, lived experience generated discussion that may have been missed in an interview alone Limitations Purposive and convenience sampling used for recruitment with likely selection bias, sample may not be representative of Somali women in the UK Researchers' ethnicity, position and ability for participants to fully disclose experiences/views Length of time participants spent in the UK was not considered when selecting for the focus group and may influence community belonging and how information provision may have changed over the years

Edge, 2007 Title Ethnicity, psychosocial risk and perinatal depression- a comparative study among inner-city women in the United Kingdom Location UK	Participants 101 women of Black Caribbean ethnicity and 200 women of White British ethnicity, recruited at antenatal and postnatal stages. Additional demographics collected included age, partner support/presence, deprivation and mental health history Aims To examine the relationships between ethnicity, psychosocial factors including socio-economic status, social support, education and mental health history and prevalence of perinatal depressive symptoms	Data collection Quantitative using The Edinburgh Postnatal Depression Scale. Follow-up questionnaire to gather demographics and psychosocial risk, deprivation calculated on wards of residence Data analysis Fishers exact test and Mann Whitney, mean scores compared via independent sample t-tests and paired samples t-tests within groups	Key findings A quarter of Black women and a third of white women scored above the clinical threshold for depressive symptoms at some point in the perinatal period, the mean score was significantly lower for Black women placing scores below clinical threshold Small numbers but concluded that access to community-based mental health intervention offer was lower for Black women Psychosocial risk factors for Black women in the perinatal period included higher likelihood to live in deprived areas, feel socially isolated, live on benefits, be lone parents and less likely to receive spousal support Mean depression scores declined between antenatal and postnatal phases for both groups Implications Nuances/ethnic differences in the meaning/impact of psychosocial risk and mental health Further study needed into prolonged, cumulative adversity and coping, role of ethnicity and culture in psychological measures/symptom presentation, invisibility in services and unmet need Need to support primary mental health in a multicultural context	Strengths Addressed under-representation of Black Caribbean women in diagnosis of perinatal depression Highlighted outcomes alongside a 'majority' ethnic group to consider similarities and differences Large sample Limitations Cultural sensitivity of the measure used for depressive symptoms; psychologic morbidity not detected by EDPS in Black Caribbean women The nature of using self-report measure often gives higher prevalence of symptoms than clinician-rated measures Levels of depressive symptoms among White British women might have been artificially inflated by the inclusion of a high percentage of women who reported having a history of depression/postnatal depression Location of study and mainly inner-city sample means findings cannot be generalised to women from more affluent backgrounds or those with serious psychiatric illnesses

Edge, 2008 Title 'We don't see Black women here': an exploration of the absence of Black Caribbean women from clinical and epidemiological data on perinatal depression in the UK Location UK	Participants 12 women of Black Caribbean ethnicity recruited via purposive sampling from a large teaching hospital antenatal clinic (Part of a larger mixed methods comparative study, Edge 2007) Aims To explore factors which may account for low levels of consultation for perinatal depression and the absence of inclusion in perinatal research	Data collection Qualitative in-depth interviews Data analysis Analysed thematically using Glaser's constant comparative approach	Key findings Themes identified; 'social and structural barriers to help-seeking', including how depression is understood at a systemic level, the normalisation and minimisation of distress, positioning, interactions and differences with professionals. The other theme was 'personal barriers to help-seeking', including personal agency, cultural narratives and beliefs Some unfamiliarity noted in the concept of depression Implications Highlights the need for the inclusion of women from a range of backgrounds to be included in research and develop a better understanding to support culturally appropriate interventions Professionals to support with antenatal education and work to understand personal and structural barriers Black Caribbean women face Demonstrates the need for professionals to develop knowledge in the concept of depression so it is approached and supported in a culturally informed manner and validation given accounting for difference in presentation and treatment on offer	Strengths The study enables Black Caribbean women's experiences to contribute to the body of evidence on perinatal depression for the first time Gives Black Caribbean women the opportunity to share their views and inform an understanding of culturally appropriate interventions Limitations Findings have limited generalisability Small sample size Study period was 12 months and linked to a wider quantitative study therefore self-selected sample were motivated to engage therefore limiting generalisability

Edge, 2011 Title 'It's leaflet, leaflet, leaflet, then see you later' Black women's perceptions of perinatal mental health care Location UK	Participants 42 women, settled migrants, the majority of women were born in the UK & self-labelled as being 'of black Caribbean origin', age range 18 to 43 years. Included women who lived in urban and rural areas, women who were single, married and co-habiting. Aims To explore Black Caribbean women's reasons for presenting at lower rates for perinatal depression diagnosis and treatment and what might be done to improve consultation, influence policy and practice in mental health	Data collection Qualitative focus group- five groups in total between 6 and 10 women per group Data analysis Framework analysis	Key Findings Themes identified; 'Experiences of current services and barriers to care', including mental health and physical health care received during and after pregnancy, such as positive and negative experiences and interactions with professionals. Another theme: 'alternative models of care', which explored views around an ideal service and models/ways of working. Agreement in support needed for BME groups opposed to mono-ethnic groups and advocacy to ask women what they want Implications Highlights the importance of interactions and building trust with professionals, reflections on wider systemic issues including resource and practice and how these might influence Black women's ability to access services and share mental health struggles Support for community-based and socially focused interventions which are collaboratively designed, opposed to medication and use of a stepped care approach to support	Strengths Addressed under-representation of Black Caribbean women in receiving perinatal mental health support Qualitative focused allowed for an exploration of reasons why and thinking about future areas of study detection and treatment via antidepressants Interview schedule based on existing literature for robustness Limitations Focus on views of relatively homogenous group of Black British women of Caribbean origin in one region of the UK which limits generalisability

Gardner et al, 2014 Title The experience of postnatal depression in West African mothers living in the United Kingdom: A Qualitative Study Location UK	Participants 6 west African mothers (Nigerian n=3, Ghanaian n=3) age range 22 to 36 years. Recruited via purposive sampling recruited through the NHS in the Manchester area in a service for under-five year olds Aims To explore the lived experience of postnatal depression in West African mothers living in the UK	Data collection Qualitative semi-structured interviews based on the depression module of the non-patient version of the structural clinical interview for DSM-IV 10 item self-rated questionnaire used for the identification and screening of PND Data analysis Interpretative Phenomenological Analysis	Key findings Themes identified; 'conceptualising PND', 'isolation', 'loss of identity', 'issues of trust', 'relationships as a protective factor'. Themes were linked and connected under the concepts of distress and understanding including themes of meanings, language, cultural conceptualisation, identity, distrust of self, others and services Implications Highlights cultural lens of PND not seen as an illness and importance of psychosocial strategies for coping and opportunities for collaborative community psychology approaches Highlighted specific contexts for ethnically minoritised women in the UK where there may be a lack of extended family networks Influence of African culture on help-seeking behaviour Shows need for professional awareness of PND disclosure/differences in presentation Demonstrates the need for further research on expectations and understanding of professional roles	Strengths The study is the first of its kind and insights essential for delivery of effective, culturally sensitive care Qualitative method allowed for a rich understanding and lived experience focus Limitations Findings have limited generalisability Small sample size Participants had accessed NHS services and this support would've influenced their experiences Only interviewed women who could speak English Measure used although validated in African populations it does not reflect the sensitivity of needs, understanding and perceptions of women from this group

Treisman et al, 2014 Title The experiences and coping strategies of United Kingdom-based African women following an HIV diagnosis during pregnancy Location UK	Participants 12 women of Black African ethnicity recruited via purposive sampling from the geographical of London, age ranges between 23 and 41 years, length of time living in the UK ranged between 2 and 19 years, time since diagnosis ranged between 10 months to 7 years. Range of employment, marital status, education, tribal, cultural backgrounds and religion, varied immigration status. Aims To understand experiences and coping strategies of United Kingdom-based African women following a HIV diagnosis during pregnancy	Data collection Qualitative semi-structured interviews Data analysis Interpretative Phenomenological Analysis	Key findings Master theme 1: HIV as part of a wider tapestry included emotions and experiences of diagnosis, education Master theme 2: Community and systemic influences and responses to HIV included discrimination, responses of others, health professionals, media influence, social support Master theme 3: Experiencing a different story of HIV included being accepted and embraced, healthy lifestyle and expert with experience Master theme 4: Mother-child relationship included protective factor, fear for child's health and future and complexity of not breastfeeding Implications Highlighted experiencing HIV in a different light in a way that challenged beliefs such as, new meanings, identities and the relational context through the lens of coping and resilience Identified the complexities of HIV diagnosis during a time of identity transition in pregnancy Advocates for formulating and working in a different way considering systemic factors Implications for HIV antidiscrimination training for professionals, media awareness and education to address misconceptions Future research focusing on partners and healthcare providers	Strengths Qualitative method allowed participants to explore issues important to them and have their experiences reflected in the evidence base, enabled a rich understanding Offers themes not prominent in existing literature for future research and to generate new knowledge/ways of understanding Focuses on mothers' experiences supportive of enhancing maternal wellbeing and child outcomes/early intervention, few studies have focused on this Researchers' reflexive process Limitations Only interviewed women who could speak English Findings have limited generalisability, small sample size IPA focuses on the phenomenon of the study and does not seek more definitive answers and is linked to the researcher's interpretation Selection bias participants were accessing specialist services and engaged in support groups, limiting the experiences beings shared which may be different to those who have not engaged with services or support

Quality Appraisal of the Literature

Within systematic literature reviews it is essential to follow steps to critically appraise research and consider whether the studies included within a review are reliable, relevant and aim to address the research question (Boland et al, 2017). The studies included in the review were evaluated using the critical appraisal skills programme (CASP, 2018) quality appraisal tools. These tools include checklists for qualitative and cohort study for quantitative research and use a number of questions with most answered using 'yes, no or can't tell' with prompting sub-questions in support of elaboration and critical thinking. The checklist covers ten items for qualitative and twelve for quantitative, offering an assessment of broad categories including rigor, relevance and validity. These appraisal tools were chosen because they provided consistency, ease of use and were recently published. Moreover, another similarly focused systematic literature review considering ethnicity-based maternity inequalities from a 'BAME' perspective also used CASP as one of the appraisal tools for qualitative research (Khan, 2021), showing relevance of this tool to the current review.

Checklist approaches to quality assessment within literature reviews has a longstanding history, however it has been noted that for qualitative research the process of appraisal may require thought around purpose and interpretation (Dixon-Woods et al, 2007). Therefore, throughout the review process I utilised supervision to reflect on my position, cultural heritage and lived experience which influenced my approach to the evaluative process. It was useful and important to protect space to make reflective notes in addition to supervisory discussions, in turn enhancing review credibility. Credibility within research refers to whether findings and conclusions generated from research can be trusted (Tong et al, 2012). The review of papers was checked by the supervisory team and discussed in supervision to enhance credibility and reduce the likelihood of bias. In addition, two doctoral student colleagues reviewed 25% of the final papers which supported agreement in ratings

and improved transparency of the process for future review development. The critical appraisal summaries of the final eight papers were tabulated and demonstrated a high quality of research literature each with empirical components from peer-reviewed sources.

Overall, the quality of the research papers were sufficient, with good methodological strategies and recruitment considerations which matched the suitability of the research aims and intentions with some focus on maternity and a larger proportion of studies focusing on perinatal mental health. The majority of studies included participants who had self-identified as Black women and recruited predominantly from communities through social media, community workers, places of worship and posters disseminated in community settings with some acknowledgement of the potential for selection bias. Some of the studies were also specific to geographical areas. One of the studies used an NHS database in support of determining ethnicity and inclusion in the study. Of additional studies where recruitment took place in the NHS, this targeted existing groups for Black women and a hospital setting with high local populations of Black women. Thus, highlighting how different recruitment strategies have the potential to either group Black women heterogeneously through systems where ethnicity has already been accounted for or reliance on self-identification. Recruitment settings also demonstrate the importance of considering the transferability of findings across geographical context and between clinical and non-clinical groups. There is scope for future research to consider gaps in the evidence base where recruitment focus could shape the rationale and the focus of the research.

Table 4 *Critical Appraisal Qualitative Checklist Summaries*

CASP criteria for qualitative research	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Chinouya & Madziva, 2017	Yes	Yes	Yes, however no justification for design choice	Yes, clearly described	Yes	Yes, clearly described	Yes, but no mention of ethics committee	Yes	Yes	Yes, limited research from an African perspective of antenatal booking
Treisman et al, 2014	Yes	Yes	Yes	Yes, and discussed influence of recruitment strategy	Yes	Can't tell, mentioned in the context of interpretation but no evidence of research relationship	Yes, clearly described	Yes, but reflexivity referred to in process but not detailed in paper to explore own role/biases	Yes	Yes, limited literature reflecting experiences of African mothers living with HIV in the UK
Edge, 2008	Yes	Yes	Yes, clearly states the link to a wider mixed methods study, reporting qualitative results	Yes, clearly described including link to wider study	Yes	Can't tell, author mentioned in analysis but no evidence of research relationship	Yes, clearly described	Yes, but no evidence of reflexivity in own role/biases	Yes	Yes, new area of research and explicit note of findings being interpreted with caution

										due to link to wider study
Davies & Bath, 2001	Yes	Yes	Yes, clear rationale described including advantages and disadvantages of approaches	Yes, clearly statement of how participants were recruited including exceptions to the criterion, no explanation around why	Yes, clearly described procedures	No, no evidence of research relationship or response to events during the study	Can't tell, consent and anonymity explicitly described but no mention of ethics committee	Yes, but no evidence of reflexivity in own role/biases	Yes, clear statement around validity	Yes, clearly described implications for midwifery and nursing and limitations in finding generalisability
Edge, 2011	Yes, clearly described	Yes	Yes, clearly linked to previous research and context of services	Yes, clearly described	Yes, clearly described	Can't tell, no evidence of research relationship or response to events during the study	Yes, clearly described	Yes, but no evidence of own role/biases	Yes, clearly described	Yes, clearly described value for policy makers and practitioners
Gardner et al, 2014	Yes	Yes	Yes, clearly described	Yes, clearly described and linked to NHS service, no reason as to why this decision was made	Yes, clearly described, noted the use of measures with no explanation as to why these measures were chosen to verify PND	No, no evidence of research relationship or response to events during the study	Yes, clearly described	Yes, but no evidence of own role/biases or any contradictory data	Yes, clearly described	Yes, noted implications for service development and clinical intervention, however no further detail given about how this is linked in practice

Table 5 *Critical Appraisal Quantitative Checklist Summaries*

CASP criteria for a cohort study	Did the study address a clearly focused issue?	Was the cohort recruited in an acceptable way?	Was the exposure accurately measured to minimise bias?	Was the outcome accurately measured to minimise bias?	Have the authors taken into account of the important confounding factors including in design and/or analysis?	Was the follow up of subjects complete enough?	What are the results of this study?	How precise are the results?	Do you believe the results?	Can the results be applied to the local population?	What are the implications of this study for practice?
Edge, 2007	Yes	Yes	Yes (both groups were administered the same measures)	Yes	Yes	Yes, survey administered 6 weeks after delivery, nonresponse differences reported	Clearly described & highlighting differences between cohorts	Yes, P values reported	Partially, inclusion of participants with history of depression may have influenced self-report outcomes	No, results specific to inner-city and area specific population where the study was located	Yes, clearly described
Chaudhry et al, 2004	Yes	Yes	Yes (analysis of outcomes measured consistently across settings)	Yes	Yes	Can't tell, no mention of a follow up due to retrospective analysis	Clearly described	Yes, P values and confidence intervals reported	Yes	No, small sample size of Afro-Caribbean women compared to another cohort	Yes, clearly described

Synthesis

The systematic review synthesised findings from the final eight papers using a narrative synthesis approach with guidance outlined by Popay et al, (2006). Narrative synthesis addresses four main components within literature reviews, the development of a theory, a preliminary synthesis of findings, exploring data connected relationships and demonstrating robustness (Popay et al, 2006). Initial familiarisation and extraction of key elements of the data allowed for the identification and generation of links across papers and the process was supported by review guidance. Data was collated and organised by the researcher in a tabular form presented in table 3 and for synthesis a tabulation technique was used to collate and compare data across all studies which then informed the development of themes (Popay et al, 2006).

Review Findings

The systematic literature review addressed the research question: *'What are the health inequalities that exist in maternity services in the UK as experienced by Black women?'*. The studies explored experiences and outcomes for women who identify as Black, with four studies of which had recruited women born outside of the UK, and four studies recruited from specific geographical localities, these details were considered when interpreting findings. The studies captured various points in the perinatal journey with four studies mental health focused and four studies relevant to maternity care and physical health. The studies are described below through themes with the aim to highlight similarities, differences and interpret findings through a descriptive process whilst considering the data as a collective narrative (Boland et al, 2017).

Theme 1: Unequal access to care.

Access to maternity care and support is deemed as a way of addressing health inequalities, this is due to the promotion of early detection of problems, risks or needs which if intervention is offered earlier can support better health outcomes (Chinouya & Madziva, 2019). Five studies referenced access to care for Black women during the perinatal period (Edge, 2007, Chaudhry et al 2004, Chinouya & Madziva 2019, Davies & Bath, 2001 and Edge 2011) with varied sample sizes from 13, 23 and 42 within qualitative studies (Davies & Bath, 2001, Chinouya & Madziva, 2019 and Edge, 2011) and larger samples of 90 and 101 in quantitative comparator studies (Chaudhry et al, 2004 and Edge, 2007). Access to care within these studies reported inequalities in the form of having less information about physical and mental health services and knowledge of maternity options and being less likely to receive appropriate diagnoses.

Linked to depressive symptomology Edge (2007) reported within the frame of psychosocial risk factors, and the increased likelihood for Black mothers to live in geographical areas with higher deprivation, to be in receipt of government-based income support and to live in single parent households with decreased spousal support. However, despite these factors Black mothers had reported lower levels of depressive symptoms and for the minority of women who had received mental health

intervention, they were less likely to have received community-based support than their White counterparts. This finding was reported by Edge (2011), who described experiences of care, perceptions of services as mistrusting and negative interactions with professionals, which in turn influenced a lower likelihood of disclosing emotional distress and poorer access rate to mental health services. Similarly, within the context of antenatal appointments, Chinouya & Madviza, (2019) reported that Black women accessed care later which was a result of a mistrust around making pregnancies known if there was unsettled migration status. Overall, indicating that for various reasons Black mothers experience inequalities within service access due to being less likely to receive support and a mistrust in services, resulting in no or little access to support.

Contrastingly, when access to care is described in studies based in antenatal maternity settings, it was described by linking themes around access to information which may be preventative of complications or supportive of knowledge for mothers. Davies & Bath (2001), when interviewing 13 women of Somalian descent, inequity in access to care was understood within a relational context between patient and healthcare professional. It was suggested that as the general practitioner was the sole utilised point of contact and source of information around maternal health, this therefore limited other avenues or services available on the maternity journey due to a lack of awareness. Chaudhry et al, (2004) found significantly later antenatal clinic attendance for diabetes care amongst Afro-Caribbean women with potential reasons given linked to decreased awareness of the importance and implications of antenatal clinic attendance and a lack of access to information. Chinouya and Madziva (2019) interviewed 23 Black women and found that a lack of information and understanding around the implications of accessing antenatal care earlier in the pregnancy journey was also cited as an important aspect of the maternal experience. Delays in accessing antenatal care was described as a contributing factor towards maternity inequalities such as, adverse pregnancy and birth outcomes and maternal mortality (Chinouya & Madziva, 2019). Two of the five summarised studies (Davies & Bath, 2001, Chinouya & Madziva, 2019) recruited women who had migrated to the UK, and so access to care, knowledge, and information around NHS systems, may have heavily influenced the presence and

impact of what it means to access care. Therefore, conceptualisations around access to care should be interpreted with this in mind, had the sample sizes been similar across all studies and participant recruitment been similarly focused, perhaps different or richer conclusions may have been drawn. Overall, access and care antenatally, although measured by each study differently, appeared to place Black women in vulnerable positions with less knowledge, access to information and subject to inequitable outcomes. Implications of delayed access to care can impact birthing options and outcomes, for example for African-Caribbean women with diabetes, the data showed that was lower prevalence of delivery by caesarean section which therefore may have increased the likelihood of vaginal delivery associated birth trauma. These differences were explained by potential cultural factors, clinical bias and a lack of knowledge about services, birthing options and relevant healthcare information (Chaudhry et al, 2004).

Theme 2: Systemic racism and barriers.

A total of five studies featured reports of discrimination, ethnicity-based bias and professional responses which have been summarised under the theme of systemic racism and barriers. These experiences varied across context and were significant within interactions and communication with others. Treisman et al (2014) highlighted stigma and discrimination as integral to experiences of HIV diagnosis during pregnancy, whilst Davies & Bath (2001) described racial bias and prejudices as influencers in care and information-giving and gave voice to challenges including, obtaining information, understanding service provision and difficult interactions. Similarly, participants in Chinouya & Madziva's (2019) study described cultural and religious differences between themselves and healthcare workers adding to experienced stigma at antenatal appointments. Moreover, framed as a barrier, Edge (2011) reported experiences where participants summarised interactions with professionals including a lack of care, trust, compassion and anticipation of being let down. Finally, Chaudhry et al (2004) suggested that regarding the likelihood of assisted childbirth by caesarean section, physicians may have a higher threshold for African-Caribbean women for vaginal delivery linked to potential unconscious bias influencing clinical decisions. Specific detail about the

underpinnings of this bias were not explained, however the difference between the two comparator groups was ethnicity. Consequently, inequalities faced by Black mothers as indicated across the five studies were directly linked to systemic experiences of ethnic difference, prejudice and interactions with professionals which in turn may act as a barrier and impact relationships with maternity focused physical and mental health services.

Theme 3: Cultural disrespect and inconsideration.

Whilst centering the voices and experiences of women self-identifying as Black, authors across six studies attended to the importance of understanding culture and respecting difference. Linking a lack of understanding and respect as a contributing factor to inequalities (Edge, 2008, Edge 2011, Gardner et al, 2014, Chaudhry et al, 2004, Treisman et al, 2014 & Chinouya & Madviza, 2019). Cultural knowledge however, should be held with humility and an openness to learn, given the nuance, richness and diversity of cultures encompassed by the ethnic category 'Black' (Chinouya & Madziva 2019).

Inequalities explained in antenatal booking clinics were found to be linked to varied views and behaviours around pregnancy disclosure due to faith, African cultural beliefs and norms (Chinouya & Madziva 2019). Edge (2007) suggested that the impact of social and material risk is experienced differently due to culture with narratives linked to overcoming adversity and strength, this acts as a protective factor against perinatal mental health distress. Similar conclusions were echoed within Treisman et al's (2014) study, who also demonstrated the importance of cultural consideration and they suggested that a diagnosis of HIV during pregnancy when considered through a cultural lens could be experienced in a different light not considered within a Westernised model. Although experiencing a diagnosis of HIV can be accompanied by difficult emotions and a journey of acceptance, looking through a cultural lens could also yield the creation of new meanings, identities and the relational context promoting narratives of coping and resilience.

Edge (2008) considered epidemiology and perinatal depression with key findings indicating that social and structural barriers to help-seeking may be influenced by the way depression is understood at

a systemic level, within services and culturally, the normalisation and minimisation of distress by professionals. Participants spoke about their positioning and interactions with professionals which were governed by norms wider than the individual. Then when considering conceptualisation at an individual level, through the lens of Black culture there are beliefs around overcoming adversity, independence and showing strength as a 'strong Black woman' which may be reinforced by narratives constructed socially and through religious beliefs (Edge, 2008). Interestingly, across three of the studies which were mental health focused there was defined in-culture and community-based stigma adding to a reluctance to discuss emotional distress (Edge, 2008, Edge 2011, Gardner 2014).

It seems that conceptualisation of distress linked to individual meaning, the use of language and culture are all influencing factors for women of West African heritage experiencing perinatal depression (Gardner et al, 2014). When combined with personal identity, mistrust in self, influences of community and faith and a distrust in mental health services, it was indicated that African culture may influence interactions with professionals and reduce help-seeking. This was of particular significance for women who have migrated to the UK and there may be a lack of extended family or a supportive network. It was suggested that because postnatal depression is not understood as an illness in West African culture (Gardner et al, 2014). Therefore, whether the context is antenatal maternity care or perinatal mental health, inequality can be understood as perpetuated by a Eurocentric system which does not respect nor consider cultural difference such as, variation in conceptualisation, language and the role of stigma.

Theme 4: Under-Representation and a Lack of Collaboration

Under-representation within the literature was cited as study rationale across seven studies, therefore locating inequality within exclusion in research. Of the seven, three were maternity context based and four were mental health focused, showing similarities in meanings relevant to inequalities across settings. Six of these studies acknowledged a poor amount of research focusing on Black women (Chinouya & Madziva 2019, Davies & Bath 2001, Treisman et al, 2014, Edge 2008, Edge 2007, Edge, 2011). Emphasising this research terrain also supported the authors campaign to raise awareness about

the necessity for further exploration of the needs of women from ethnically minoritised backgrounds to develop person-centered and culturally sensitive approaches (Chinouya & Madziva 2019, Davies & Bath 2001, Edge 2011, Edge 2008, Gardner et al 2014 and Edge 2007). Edge (2007) described the implications of exclusion from research as a mirror of clinical services and low representation of Black women, potentially indicating a level of unmet need. Of these studies, four researched the needs of Black women who had migrated to the UK, where nuances dependent on migration status may further influence representation in the literature and services, including entitlement to care and knowledge of healthcare systems.

Thus, with exclusion across both research and clinical services, under-representation also demonstrates a lack of collaborative working and service engagement with local communities. This was reported by Treisman et al, (2014) who promoted a holistic understanding of HIV and working in collaborative ways which shift away from the Westernised medical model. Similarly, more culturally appropriate and efficient services with a focus on mental health education during the antenatal phase would support Black Caribbean women (Edge, 2008). Furthermore, when asked about an ideal mental health service, Black Caribbean women described an alternative therapies offer, aimed at women with mild mental health needs whilst centering the wishes of women around how groups are run (Edge, 2011). A community informed approach to psychological support was also advocated by Gardner et al (2014) who described the need for empowerment within communities, development of psychosocial strategies for coping, recognition of collective needs and collaborative community psychology approaches within mental health support infrastructure. Davies & Bath (2001) spoke about the importance of communication and the need to encourage women to get maternity-related information. Collectively, through the proposition of ideas to improve service representation, this demonstrates a lack of collaboration with Black women to ensure maternity and perinatal mental health services are tailored and supportive of needs for all.

Evaluation

The number of studies included within the review were sufficient to answer the review question and offer an understanding of health inequalities from the perspective of Black women in maternity services. The themes identified linked significance in meaning across studies from Black women's experiences and outcomes, emphasising inequalities as poor access to care, systemic racism, and barriers, overlooked aspects of cultural, under-representation and a lack of collaborative working. However, one could propose that as demonstrated in figure 1, there were a high number (n=155) of studies eligible for full text review, indicating that had the research question remained as broad as it initially was intended then this could have offered scope for wider perspectives to answer the question including that of professionals and societal viewpoints about inequalities. Through trialling the search strategy and application of concepts, the decision was made to limit the concepts used and focus the research question. The implications of this could have produced too narrow of a focus, however the steps prior to the decisions to develop the review decreased the likelihood of important studies being missed including, manually checking reference lists included in studies.

The current review is uniquely positioned and one of the very few that seek to collate existing literature relevant to Black women and maternity services which is a strength. It should be noted that had the review focused on studies where study recruitment was aimed at Black women only, then the number of studies would have decreased to six. Therefore, indicating a lack of attention to nuance and commitment to equality within the evidence base. The findings may be generalised to perinatal settings, however, should be interpreted with caution due the modest number of studies, small sample sizes and for five of the studies they highlighted locality specific findings which may not be applicable across other regions. Three of the studies also reported limitations with regards to recruitment and the impact of participants having accessed a clinical service and participants being selected from a larger 12-month study which may have influenced narratives. This means that for the purposes of the current review, the narratives and outcomes synthesised may be under-representative and not holistic reflections of inequalities. For future literature reviews, seeking to explore experiences of clinical populations may improve applicability and generalisability in clinical settings. Burchett et al, (2020) links

generalisability of research findings to understanding how and why interventions are valuable through the mechanism of action. They suggested that it may be too simplistic to consider differences across study populations as central to generalisability and considering what underlies findings may offer a richer insight. However, the current lack of research in the area presents challenge and perhaps future literature reviews can attend to these mechanisms and processes as the evidence base grows.

The current systematic literature review achieved its aim and addressed the research question which considered UK health inequalities in maternity services as experienced by Black women. A strength of the review process was the inclusivity of the chosen synthesis, the approach supported the process of drawing together information from a variety of sources and offering an insight into connecting themes. A total of 58 studies looked at experiences of ethnically minoritised mothers but used 'BAME' as an umbrella term so Black mothers' specific experiences could not be identified, and were therefore not included in the current review. However, the findings despite these limitations appear to hold some consistency in insight, such as conclusions around poorer outcomes and experiences for women of ethnically minoritised backgrounds (Rayleigh, 2010) and systemic failures within the care received and perceptions of feeling care for (Jomeen & Redshaw, 2013).

Furthermore, where studies (n=70) did specifically discuss findings related to Black women, but they were not a primary focus as determined by the sample population, of those studies 49 (84.5%) were quantitative. This demonstrated that although many of the studies included in the current review were qualitative, when considered within the wider context of the relevant literature, the number of studies focusing on the voice and experience of Black women is very limited.

Given that the review focused on the literature spanned a 40-year time frame and found only eight papers relevant to the inclusion criteria demonstrates that inequalities have been maintained through the sparsity of literature available. Moreover, the studies included did not explicitly focus on inequalities and considered specific experiences and/or outcomes, demonstrating that inequalities were highlighted through the synthesis process itself. A lack of direct questioning around perinatal inequalities could be considered another maintenance factor of the inequalities themselves. The expansion of the evidence-base to understand perinatal experiences readily grouped ethnicities under

the umbrella term ‘BAME’ or recruited small numbers of Black women within their studies, in turn narrowly focused the frame and dismissed differences within perinatal communities. This also highlights a lack of progress over the years for inclusive and representative research. Thus, failing the human rights, needs and the context of the Black body, culture and ethnicity.

Implications

The current systematic review highlighted some important recommendations for systems and professionals working with Black women within the context of maternity and perinatal mental health. For example, Chinouya & Madviza (2019) spoke about ongoing understanding needed to explore ethnic and migration differences in relationships with health services which expand further than professional relationships, and consider the impact of the political and economic context. They also called for urgency around the review of policies and procedures for women who have migrated to the UK and require access to healthcare. Treisman et al, (2014) recommended anti-discrimination training for professionals and education to address misconceptions. Similarly, Davies & Bath (2001) reported the need for training with an emphasis on language to tackle racial stereotyping alongside systemic change in support of professionals challenging one another on observations of poor care standards. Chinouya & Madziva (2019) further recommended collaborative community approaches, cultural sensitivity and awareness are core ways of working for healthcare practitioners.

When linked to the current UK landscape including the ongoing impact of austerity, Brexit, the terrain of migration and the Windrush scandal, to name but a few of the legislative and political changes of the past few years. A further recommendation can be made around the current contextual urgency to address and consider the vitality of trust between Black communities and public services. The importance of building trust was discussed by Edge (2011) and Gardner et al (2014) with recommendations to work alongside communities, listen to concerns, have flexibility and a person-centered ethos within clinical approaches to support outreach and improve access for all. Therefore, clinical services could benefit from taking steps relevant to locality-based communities and resist implementing generic ideas to promote equality and diversity. Consequently, the less is known and

understood about Black women's needs within the perinatal period, the intersecting inequalities such as poor access, systemic racism and a lack of cultural understanding from professionals, are maintained.

Conclusions

In summary, the current systematic literature review offered a broad overview and appraisal of the most relevant literature exploring maternity inequalities as experienced by Black women. The review demonstrated the lack of inclusion of Black women within research, similar to that of the under-representation observed in clinical services. Across the qualitative studies, conclusions highlighted experiences of Black women in maternity and perinatal mental health, with attention given to culture, community, relationships with distress and contact with professionals and/or services whether support had been accessed or considered inaccessible. The quantitative studies similarly demonstrated the importance of access to care for Black women and both compared outcomes of women of Black and White ethnicities, showing some similarities and differences, whilst advocating the need to further delve into the contributing factors such as the impact of morbidities and socio-economic status. All studies encouraged further research to develop the evidence base and improve Black women's experiences, clinical setting service delivery and policies. Across several studies there was a recognition of the importance for people working in healthcare to better understand the needs of Black women and ensure there is an offering of equitable care.

Six studies were published in relevant journals across general and clinical practice, midwifery and nursing with two studies published in a psychosomatic research journal and another in health promotion international. All of these contexts and journals are of upmost relevance to maternity, however highlighted a need for more research to contribute to multi-disciplinary practice and service development. Potential implications for clinical practice were discussed and recommendations made to consider the current socio-economic landscape.

Aims & Rationale for the Current Empirical Research Study

When the broader context of research is considered, there must be a focus on how the knowledge base has been socially and politically constructed. Powell et al (2022) acknowledges the layers of systemic racism embedded within health research has resulted in stark inequalities. Maintained by injustice, racism influences the funding of research including study rationales, diversity within participant recruitment, exclusion of ethnically minoritised academics within institutional spaces and editorial boards, which in turn impacts future generations of academics and research publication (Powell et al, 2022). With this context in mind, it is not surprising that there remain few UK-based studies focusing on inequalities for Black women within maternity services, from my perspective this indicates that racism within research and academic institutions is surviving and thriving.

The broad aims of the current empirical study are to explore Black mothers' experiences of birthing and postnatal care during the covid-19 pandemic. As demonstrated by the systematic literature review, there remains little evidence that exclusively and primarily focuses on Black women during the perinatal period and no studies to date which are located within the context of covid-19. Therefore, it is pertinent to fill this gap within the literature alongside a consideration of contextual reasoning and the potential significance of the research.

Predominantly, the coronavirus pandemic has sharpened existing inequalities. For instance, John et al's, (2021) study found that from interviews with 16 women from ethnically minoritised backgrounds at antenatal and postnatal stages during the pandemic, there was a collective sense of challenges. This included the effect of the pandemic, communication and interactions with healthcare professionals. These experiences within the context of coronavirus exacerbated and intersected with existing ethnicity-based disparities within maternal health and maternity care, and it was suggested that if left unattended, this could widen inequalities further. John et al's (2021) study was noted to be the first of its kind to explore experiences within the pandemic context, however, was limited to one Scottish health board and recruited 16 women of ethnically minoritised backgrounds with half of the participants self-identifying as Black. Although this enabled important conclusions to be drawn, there remains a lack of understanding and reflection of the Black experience. Therefore, it is essential to

explore the experiences of care received by Black mothers, including elements of best practice and areas of learning, alongside a consideration of views around longstanding inequalities. A unique feature of this study is a focus on and opportunity for Black mothers to be co-constructors in what recommendations can be made to address inequalities and improve services. This develops John et al's (2021) study which did not invite service improvement discussions with participants.

This piece of exploratory research is less concerned with what the inequalities are and is focused on a specific period where heightened inequalities reside. Within a pandemic context fraught with anxiety, pain and suffering, it is imperative that this study seeks to explore maternity experiences located within the social, cultural and political sphere. Making such links is important to support the understanding of a cumulation of multiple traumas (Afuape, 2011). The current study proposes to offer a meaningful platform for Black mothers to have their recommendations heard without diluting views under the umbrella of 'BAME' as used by authors in the field. Another aim is to extend the knowledge base by building on and addressing the gaps evident across the six existing qualitative studies focusing on Black women's experiences in the UK. It is of importance that policy and systemic change is generated and influenced by lived experience. The exploratory research questions outlined below were generated from an appraisal of the gaps in the current evidence base alongside consultation with an expert by experience, of which their involvement will be detailed in a later chapter.

1. How have Black women experienced birthing and postnatal care in the covid-19 context? What has been helpful or unhelpful?
2. What recommendations/suggestions do Black women have for services to improve and address inequalities?

Chapter 2: Methodology

Overview

This chapter will outline the methodology, comprising of research design rationale and epistemological positioning of reflexive thematic analysis. The development of the study will be described including expert by experience involvement, study recruitment, participant characteristics, ethical considerations and quality appraisal of the study.

Qualitative Research Methodology

Qualitative research design uses linguistic and visual material to gain an understanding around content, intention and communication of emotion, thoughts and experiences, the focus of which may vary dependent on the epistemological lens and qualitative methodology being used to approach the data (Barker et al, 2016). Qualitative research can work in tandem and as complimentary to quantitative research by uncovering and validating social processes underlying the occurrence of phenomena. It may also seek to understand and observe human behaviour or viewpoints which cannot be captured quantitatively (Pope & Mays, 2020). There is a consensus that the data gathered for example, during conversational interviews are influenced and constructed by both the interviewer and interviewee. This interaction cannot naturally occur and is pertinent to the meaning-making process and subsequent production of knowledge through a qualitative lens (Pope & Mays, 2020).

Qualitative Design Rationale.

As demonstrated in chapter one, a comprehensive review of the research evidence-base indicated that there is limited literature which addresses inequalities within UK maternity settings from the perspectives of Black women. The systematic literature review highlighted that 84.5% of studies screened for eligibility included findings relevant to perinatal health inequalities, through a predominantly quantitative lens with fewer qualitative insights. Then of this literature eight papers included in the final review primarily focused on Black women's needs and outcomes, only six of which were qualitative studies indicating a gap within the literature. Thus, posing an important opportunity to develop the qualitative evidence-base centering the under-represented experiences of

Black women within the context of maternity services. Through motivations aligned with injustice there is an urgency and importance of meeting needs and validating experiences of Black mothers, which can be achieved through the development of a meaningful platform of research to honour lived experiences (Scholars, 2020). Cypress (2015) discussed the aims of social justice applied to qualitative research within healthcare, as an intention to humanise and understand the influence of behaviours, beliefs and expectations within clinical practice, the delivery of care and health outcomes. Therefore, a qualitative research study design was selected in support of enriching a contextual understanding of the perspectives of Black women navigating the perinatal journey whilst upholding social justice calls to honour experiences and humanise care.

Strengths of qualitative methodology include the holistic nature of making sense of lived experiences through attending to meanings and interpreting the stories shared by people who participate as located within context (Tracy, 2019). Critiques of qualitative approaches tend to concern validity such as, whether the research question measures what it intends to, and the interpretation of data being limited through the lens of the research team (Willig, 2008). However, there are processes in place to account for this, such as data collection methods which allow for participants to share contrasting meanings or views to the researcher, researcher reflexivity as an integral part of the process to continuously review and question assumptions brought to the data (Willig, 2008). Furthermore, rigour can be demonstrated through principles of trustworthiness which include the researcher's immersion with the data, member checking and the presence of thick description for readers to decide whether findings can be transferred across setting and context (Maher et al, 2018).

Introducing Reflexive Thematic Analysis.

Reflexive Thematic Analysis (RTA) uses a six-stage process which sits under the umbrella of thematic analysis methodology, interpreting patterns through the development of codes and themes across qualitative datasets (Braun & Clarke, 2020). These stages are as follows; data familiarisation, coding, creating initial themes, theme development, refining and defining themes and finally, report write up (Braun & Clarke, 2006).

The RTA method encompasses values, assumptions and practices which offer process guidelines for researchers to actively engage with their data (Braun & Clarke, 2021). Assumptions made by RTA include positioning researcher subjectivity as a resource for data analysis, an appreciation of data analysis and interpretation through gauging levels of insight and complexity. In addition, the theoretical assumptions underlying the analysis process require attention and reflection. Within RTA there is also an emphasis on how themes are developed through immersion and active construction, whilst giving the researcher permission to take thinking space away from the data and engage in creative ways to map data (Braun & Clarke, 2022). There are four types of approaches to analysis which support code formation including inductive and deductive, where the driver of the codes are the researcher or participants, and concrete and conceptual codes which consider whether constructs are named explicitly or are abstract. This approach was considered suitable to answer the research question due to there being no theoretical or epistemological alignment and the approach allowed participants realities to be explored and underlying phenomena understood directly from lived experience (Braun & Clarke, 2021). Furthermore, the research questions asked participants more than about their experiences but sought views on what had helped and hindered their care including recommendations for service change. Therefore, the breadth of RTA and offering of practical outcomes within a context specific to the pandemic rendered RTA more suitable.

Another determining factor in selecting RTA was the emotional proximity I hold to the research topic and the openness, flexibility, and subjectivity the approach invited which could compliment my position as an insider-researcher. Reflexivity is a crucial part of the research process and RTA acknowledges the fluidity and evolutionary nature of the perspective's researchers bring to the topic and analysis. This approach offers a continuous learning journey about personal positioning which can never be fully checked or complete (Braun & Clarke, 2021). Given the context of personal experiences within my perinatal journeys, alongside the socio-political urgency to address injustice and inequality, the invitation of ongoing reflection was an important priority to understand how my positioning influenced and shaped the research.

As discussed in chapter one, epistemology forms the lens by which we view the world, how we learn and produce knowledge including what gives knowledge credibility (Pope & Mays, 2020). The epistemological stance for this research is rooted within critical realism this framework allows for insight into how Black mothers have interpreted their experiences of receiving care. The context of these realities entrenched within culture and language, through a critical realist frame offers the opportunity for reflexive thematic analysis to provide a clear interpretation of the data anchored by lived experience, whilst considering how the context of the pandemic has shaped the navigation of the social world as participants experienced birthing and postnatal care.

Strengths and Limitations.

RTA is a method and way of approaching thematic analysis its design offers flexibility in terms of the theoretical and philosophical positions it can lend itself to, it can analyse a variety of qualitative datasets simultaneously including interview transcripts, online content and visual imagery (Braun & Clarke, 2022). The openness and interactive nature of RTA means that it can be used to explore an array of research questions (Braun & Clarke, 2021). Thematic analysis allows for similarities and differences to be understood from different perspectives alongside unexpected insights (Nowell et al, 2017). This aligns with using RTA with a critical realist lens and working from the stance that there are factual aspects of reality to be revealed subject to individual perception, therefore emphasising participants experiences alongside understanding the social and cultural foundations that influence this (Braun & Clarke, 2022).

Although there is this strength of flexibility of the approach, it has also been commonly misapplied with publications claiming to have used the methodology with little transparency and problems can arise when analysis is not conducted properly (Braun & Clarke, 2021, Braun & Clarke, 2006). Misconceptions around flexibility have resulted in publications where the reported content from the interview guide has been used to inform theme development and themes have overlapped which has weakened data analysis, meaning researchers have worked from an assumptive stance (Javadi & Zarea, 2016). The methodology is unable to support researchers' ability to assert views about language and its

functioning which may offer further insight into lived experiences by making sense of contrasts and similarities within individual narratives (Braun & Clarke, 2006).

Alternative Methodologies.

Thought and consideration was given to what could be enhanced methodologically by using a different approach to address the research question. I contemplated using Interpretative Phenomenological Analysis (IPA) which involves an in-depth analysis of accounts of lived experience and is concerned with how an individual talks about, makes sense of and emotionally responds to an experience (Smith, 2011). This approach uses small sample sizes and focuses on the meanings and sense made of that experience. A critical aspect of IPA focuses on how the researcher makes sense of the participants experience alongside this (Smith, 2011). From an epistemological stance IPA does not seek a 'truth' and holds the individual subjective experience at the heart of understanding phenomena. The double hermeneutic process of sense-making means that a core component is the researchers own interpretation of the participants sense-making process (Emery & Anderman, 2020). I decided this was not the most suitable way to address my research question because I intended to validate participants realities and honour lived experiences by positioning participants as experts. This was opposed to engaging in a process which considers how I make sense of participants trying to make sense of their experiences. IPA centres the exploration of subjective meaning whilst attending to the unique experiences of individuals and meanings across all participants. My intention however was to gather a broader picture with a larger sample size and gain insight into how the pandemic may have influenced experiences of care, including geographical variation and difference in maternity setting guidance over the course of the pandemic.

Contrastingly, Narrative Analysis (NA) was another methodology considered, this approach is concerned with experiences conveyed through people's stories. Researchers seek to analyse the way people experience the social world and navigate complex life events as represented, constructed and reconstructed through the stories shared (Webster & Mertova, 2007). I was drawn to this approach, however considered the emphasis of language and epistemological stance of social constructionism

which puts forward that language generates realities (Braun & Clarke, 2022). I bought it back to my research question and intentions to understand and reveal the participants worlds from their perspectives rather than have their experiences appraised as reflections of realities.

Study Development

Expert by Experience Involvement.

Videmšek (2017) discussed the history of involvement of people with personal experience of adversity or services, also known as experts by experience, in research teams, including, collaboration and consultation. They also speak about the value experts by experience bring to research whilst emphasising the need for ethical consideration and authenticity from researchers in support of the co-creation of work.

For this study expert by experience involvement was sought through one of my colleague's personal connections. They identified as a Black mother and welcomed a baby during the pandemic, they were passionate about changing longstanding inequalities across maternity and mental health services. This was of mutual benefit because the study supported a shared desire for change and to make a difference within the communities of which we belong. From the outset I was mindful of ethical considerations informed by the wider socio-political context and had explicit discussions around the research not being intended to add emotional labour and burden following what had been a difficult year for Black communities. I positioned expert by experience involvement as negotiated by individual capacity with no expectation for ongoing connection. Personal circumstances meant that early project involvement was most suited to the expert by experience, and a shopping voucher at a relevant retailer of choice was offered as an acknowledgement of their time. I utilised Centre for Research in Public Health and Community Care (2018) guidance for researchers to anchor and support ongoing reflection on my practice to uphold values of reciprocity, respect and relationships, throughout the study.

Meaningful and collaborative involvement was gained at the early developments of the study including meetings to discuss the development of the research question, intentions and wording used in the interview schedule. Discussions with expert by experience and grassroot organisations took place

through messaging, emails and meetings, generated reflections around what I will bring by virtue of my positioning as a person and researcher, including the acknowledgement of Black history and current context (please see appendix C). I also took part in a podcast recording to discuss maternal health inequalities and the study, this opportunity, alongside connection with online communities generated thoughts around recruitment opportunities and barriers.

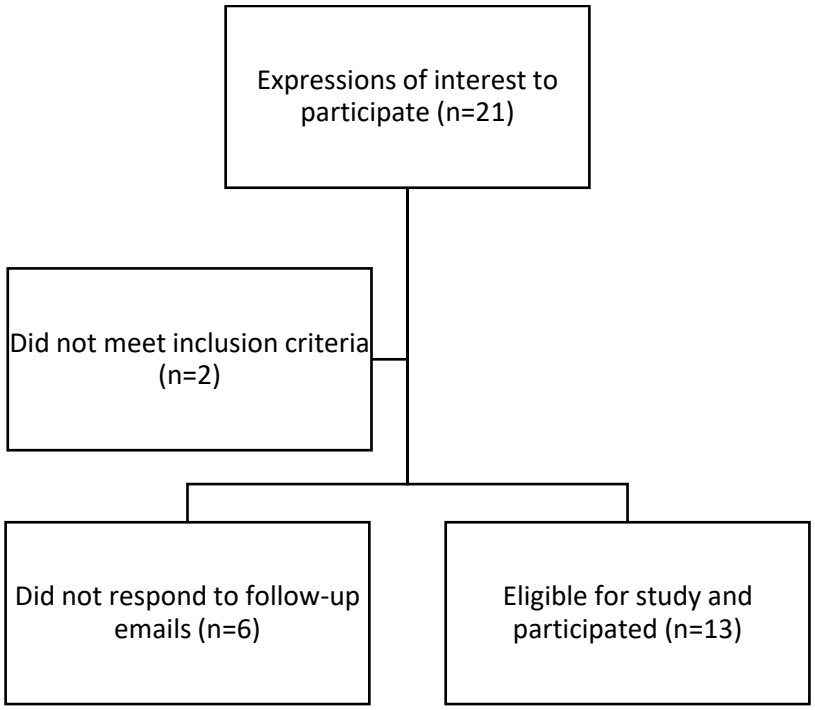
Recruitment

Participant recruitment took place between July 2021 and February 2022 and encompassed a combination of purposive and snowballing sampling in support of reaching a diverse sample of Black women. Organisations working within the field were contacted and invited to share the recruitment poster (see appendix D) and information sheet (see appendix E) citing the inclusion and exclusion criteria which I circulated via email and promoted on social media platforms using the study social media account. These are strategies commonly used in qualitative research (Robinson, 2014) and the use of social media can lend itself to ease and accessibility of linking in with professional groups or community organisations closely aligned to the intended participant group, this was pertinent within the context of the pandemic (Leighton et al, 2021). An advantage of this strategy was the ability to connect with people who may not ordinarily be approached to participate in research (Leighton et al, 2021). Recruitment also involved online community outreach with attendance at webinars and online community meetings to discuss maternal health inequalities. The study participant information sheet summarised the study and provided information about how to participate including the link to a recruitment video (see appendix E). The video aimed to support with personalisation and building rapport. Video clips have been found to improve and support accessibility within the recruitment process (Mattock et al, 2020). A social media account was developed for Twitter and Instagram for the sole purpose of the study, this was to ensure boundaries were maintained between personal and research related social media accounts due to the nature of openness and dialogue permitted by social media (Bender et al, 2017). Social media presence allowed for connections to be made with grassroot community groups and organisations who were involved in supporting perinatal mental health and

maternity inequalities. In respect of choice and informed consent once an interested person contacted requesting more information, I sent across the consent form (please see appendix F) and participant demographic information sheet (please see appendix G). I then followed up interested individuals with one email sent 2-3 weeks after initial contact allowing for questions, contemplation and informed decision making. Please see figure 2 below outlining recruitment processes, interviews took place between August 2021 and February 2022.

Figure 2

Recruitment Flowchart



Study Criteria.

Participants able to take part in the study included women who self-identified their ethnic heritage as Black. This was considered a way to ensure accessibility of the research and to acknowledge the complex history and social context of racialisation including, but not limited to the different relationships people may have with Blackness in terms of identity and societal imposition of

this identity (Kinouani, 2021). This study asked for participants to have given birth post-February 2020 as this marked the beginning of the covid-19 pandemic outbreak in the UK (please see inclusion and exclusion criteria in table 6 below).

Table 6

Inclusion and Exclusion Criteria

Inclusion Criteria	**Exclusion criteria**
Women who self-identify as Black (this will include women who are of Black mixed heritage) and are over the age of 18	Women who have given birth less than 6 weeks prior to the interview due to the potential impact on the early parenting experience and insufficient time to process the childbirth experience (Dunning, 2016)
Women who have given birth to a baby post-February 2020 (including first-time and mothers with multiple children)	Women who have experienced pregnancy or baby loss [1]
The study is open to a small number of mothers whose first language is not English [2]	Women who are unable to give informed consent, for example if an individual lacks the mental capacity to make an informed decision about their participation in the study

[1] Women who have experienced pregnancy or baby loss because the support from subsequent services require a specialist pathway

[2] The study was open to a small number of mother's whose first language is not English to ensure accessibility and appropriate interpretative support. Access to interpretative services is limited to 3 participants due to the cost implications and limited research budget

Participants

I contacted participants to seek their perspectives around pseudonyms. Allen & Wiles (2015) attended to issues around ethics, epistemology and power when researchers choose pseudonyms for participants, noting that selecting names is not a neutral act and they recommended that researchers have explicit discussions about this with participants. Therefore, I offered the opportunity for participants to choose their own pseudonyms, for me to choose as researcher or to express no preference. Seven out of thirteen participants responded and unanimously expressed a preference for me to choose on their behalf, therefore I held in mind individual contexts for participants and selected pseudonyms accordingly.

Table 7

Participant Information

Pseudonym	Age	Self-defined ethnicity	Month and Year of birth reflected on	Number of children	Area of the UK care was received
Dominique	33	Black British	October 2020	2	London
Sade	30	Mixed White & Black African Caribbean	March 2021	2	London
Grace	27	Black British	September 2020	1	East Midlands
Natasha	33	White & Black Caribbean	August 2021	1	East of England

Farah	32	Black African	June 2021	1	London
Vea	36	Black British Caribbean	June 2020	1	East of England
Leah	23	Black British	October 2021	1	East of England
Jade	28	Black British Caribbean	November 2020	2	West Midlands
Asma	25	Black African	April 2020	2	South East England
Tendai	27	Black British	January 2021	3	London
Keisha	31	Black African	November 2020	1	East of England
Aaliyah	30	White and Black African	January 2021	1	West Midlands & London
Eshe	41	Black British African	May 2020	1	East Midlands

Ethical Considerations.

Full ethical approval was granted by The University of Hertfordshire ethics committee with two amendments made over the duration of the study and ethics was exited upon completion of the study (see appendix H).

The British Psychological Society (BPS, 2021) outlines ethical considerations for carrying out psychological research, these were guidelines which were adhered to throughout the study. One key

consideration was confidentiality and anonymity to ensure information obtained about a participant is held in line with the Data Protection Act (2018). Consent forms containing identifying information were stored on an encrypted storage device with files password encrypted and uploaded onto the secure one drive server hosted by the University of Hertfordshire. Recordings were saved using individual identification numbers and accessed only by the research team. Electronic records were password protected and stored separately from interview data. Files were password protected and given a non-identifiable file names. Encrypted storage devices were stored in a locked cupboard in the researcher's home. All documents with personal information on such as, consent forms, demographic data and audio recordings will be deleted on completion of the study.

Another consideration was informed consent and making sure that participants took part voluntarily with full knowledge of the study, participants were provided with an electronic copy of the participant information sheet. This outlined study expectations around the research, rationale, and options they had regarding how the interview was conducted including an invitation to ask questions or express queries should they arise. All participants provided written and verbal consent prior to participation. To uphold rights to redact data, participants were given the opportunity to withdraw data prior to data analysis as communicated on the consent form and following the interview process. Ethics around risk were also considered given the sensitivity of the research topic and the ongoing Covid-19 pandemic, distress as a result of participation was a possibility. Therefore, a distress protocol (see appendix I) was developed using a framework developed for addressing sensitive research areas in qualitative research (Dempsey et al, 2016). This supported the process of ensuring that participants were treated with respect and courtesy throughout. Furthermore, a participant debrief sheet was shared after interviews which included national and local avenues of emotional wellbeing and peer support available across the UK (please see appendix J).

Data collection

Through collaboration with an expert by experience, the interview guide was developed (please see appendix K). Within thematic analysis it is of vital to attend to the structure and order of questions

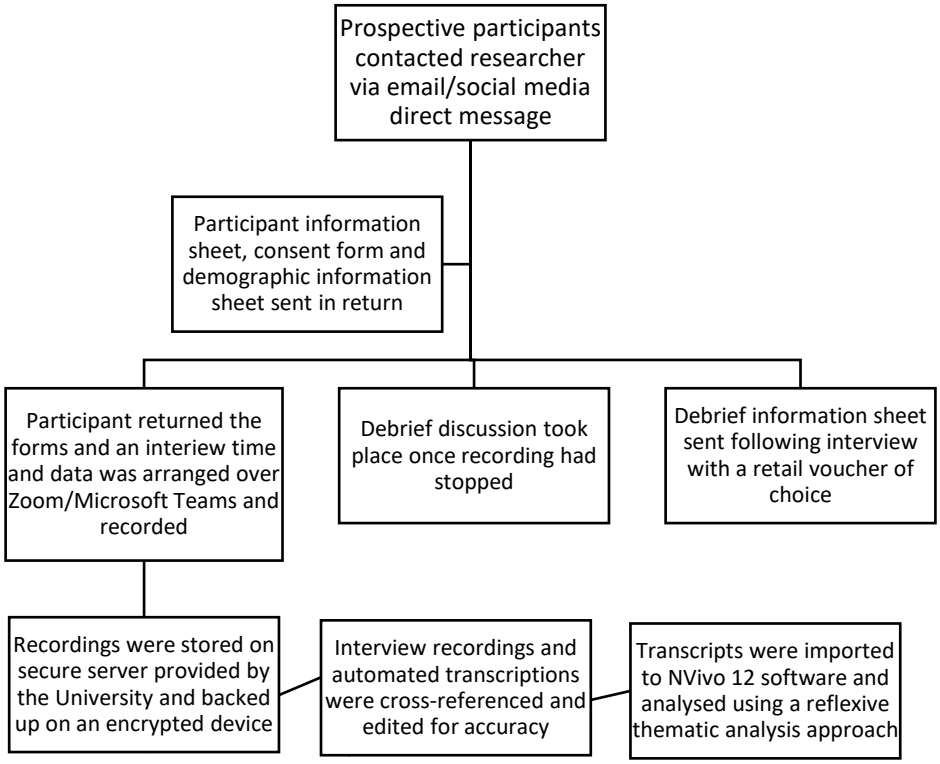
being asked, be open to questions being re-worded as poorly constructed questions may negatively influence interactions, with a need to be open and concrete (Braun & Clarke, 2013).

Within qualitative research semi-structured interviews are not piloted formally as the intention is not to generate a rigid approach to data collection, but early interviews are encouraged to generate reflection and development of questions (Braun & Clarke, 2013). The order and exact wording are also influenced and dictated by the relational space, including the style of the interviewer and responses of the interviewee (Braun & Clarke, 2013). Therefore, at the end of the first interview I asked the participant for their feedback on the interview and reflected on comments in supervision. Furthermore, supervisors went through the first interview transcript and feedback was provided around the narrative shared, my interview style and approach. This process supported the subsequent development of an additional question about the influence of the pandemic and supported tailoring prompting questions.

Over the course of data collection, I used my reflexive diary alongside leaving myself voice notes following each interview for immediate reflections and to debrief myself. This supported a chronological tracking of interview interactions and the research process, particularly helpful for understanding what I was bringing to the research. Journaling is a vital part of reflexive thematic analysis and helps to deepen the process by addressing potential reasons for researcher response to the data, including how and why this is significant for the study at hand (Braun & Clarke, 2022). In support of understanding these reflections and how these had informed my approach to coding and thematising data, I created a timeline pertaining significant reflections over the course of the research (see appendix L).

Figure 3

Recruitment and Interview Process



The Interview Process

Interviews took place with participants being given the choice of telephone or video call platforms, all participants chose to conduct their interviews over video call. The length of interview time ranged between 60 and 120 minutes, and at the start of each interview consent and an opportunity to discuss questions. Alongside this a brief summary of key points about the interview process were discussed with participants including distress protocols. Each interview was audio and video recorded, and an automatic transcription function was used during recording. There were some instances where discussion and recalling personal experiences generated understandable emotional responses such as tearfulness from participants, this was sensitively discussed and attended to in line with the study distress protocol. Where there were significant emotional impacts from a researcher perspective, alongside my reflexive diary, discussions were had within research supervision.

Data Analysis

The data analysis strategy used reflexive thematic analysis (Braun & Clarke, 2022) to guide methodology for the active identification, analysis and description of themes across participants accounts. These stages offer a guidance process which enables fluidity and invites reflexive interpretation, please see table 8 below summarising my movement through these steps. Prior to starting the analysis process, I familiarised myself with the most recent reflexive thematic analysis literature and made notes in support of consolidation and learning.

Table 8

Data Analysis Phase Processes

Phase	My Process
Familiarising yourself with the dataset	Video calling platforms included an auto-transcription function and I used this alongside the NVivo 12 transcription service. To familiarise myself with the data, I then went through the downloaded transcripts reading each line whilst listening to the recordings and corrected inaccuracies such as, words which were transcribed incorrectly or moments where the video/audio recording included glitches. Throughout this process I used my reflexive diary to note moments helpful for my learning and approach to interviewing whilst attending to non-verbal communication. I also made note of what

	content I was noticing when revisiting interviews and potential reasons why I was viewing the data in the way I was and considering different ways I could understand the data. Alongside this I made notes in support of processing my emotional responses from a lived experience positioning.
Coding	I then went through the data and coded line-by-line using a combination of NVivo software and pen and paper. I removed my questions when going through the data to allow me to really connect with what people had said. I found that being able to sit with the data and utilise the floor space to map out the dataset offered new reflections and sense-making. Also bringing a sense of my personal learning style to this helped to ground me within the data, I played music in the background on occasions and also sat with the data in outdoor spaces, with and without children around which again rooted me within participant context. My supervising team independently went through a transcript, and we used a supervision session to present the codes I

	had generated and this encouraged reflective conversations around similarities and differences in what was being seen within the data. It is good practice in reflexive thematic guidelines to have a single coder, because multiple coding is not to reach agreement but to develop richness (Braun & Clarke, 2022). I therefore utilised reflective spaces to reflect on and deepen my understanding of the data.
Generating initial themes	I started to look for wider patterns of meaning across the dataset whilst identifying commonalities in experience within the study sample. To do this I used paper based and NVivo software to begin to thematise the codes using maps (please see appendix M). I found it useful to have the research question noted on a piece of paper in view. I also linked the notes I made in my reflexive diary to connect with meaning conveyed by participants during their interviews, which enabled more of an inductive approach. Please see an example of coding processes in appendix N. I then reviewed an initial 62 codes and through the process of thematic maps I generated 27

	thematic maps. This process allowed for difference across accounts of experience, including the varied impact of the pandemic across different parts of the UK and meaning making.
Developing and reviewing themes	Themes were developed from the data with patterned meanings identified across accounts. I used NVivo to organise an initial list of themes and from further in-depth immersion with the data, I started to collapse themes yet when renamed I incorporated the names together so not to lose a sense of development. Reflexive conversations within supervision supported an ongoing relational dynamic whereby ideas were noted, questioned and reflected on.
Refining, defining and naming themes	There was ever-evolving dialogue between reflections around my lived experiences, the interview process and attention to participant meaning were influencing how I was thematising the data. I mapped my thoughts out by hand as themes developed (please see appendix O) this helped me keep rooted the assumptions and personal values I brought to the research. Using my

	reflective diary to capture helped me to understand how my experiences interacted with the analysis process and subsequent production of knowledge, I attended to both latent and semantic meaning. At times I felt all consumed by the analysis process. The framing described by Braun & Clarke (2022) as a recipe and an adventure helped keep me grounded. I created 27 paper and electronic based thematic maps of codes then grouped together using concept maps to create five themes (please see appendix P).
Writing up	Please see chapter four self-reflexivity section

Quality Appraisal

Quality appraisal is commonly used to support best practice in research to evaluate methodological rigour and critically consider the findings of a study, research processes and study implications (Majid & Vanstone, 2018). The eight big tent criteria (Tracy, 2010) were used to consider quality, table 9 below outlines how this framework was utilised. I chose this framework because it offered a comprehensive and in-depth approach to appraising quality research, in comparison to alternative qualitative appraisal tools such as CASP (2018) used in the systematic literature review. Checklists have been considered not as well suited to qualitative research due to the depth required in thought and interpretation involved in the appraisal of qualitative research (Dixon-Woods et al, 2007).

Table 9

The Eight Big Tent Criteria Quality Appraisal

Quality Criteria	**Study Application**
Worthy Topic	The topic of the research study meets the criteria of being worthy because it is of relevance and a significant area of development within the evidence-base. This is due to the limited research in the area which prioritises the experiences of women who identify as Black. Addressing this research gap adds worthiness and interest for informing service development and policy changes to understand and address maternal health inequalities.
Rich Rigour	This research meets the criteria of rich rigour through its appropriateness of researching a population currently under-represented in the literature. The co-construction of the interview schedule with an expert by experience and use of sampling which included 13 participants. The interview data and analysis process offer a richness in rigour. The research team held collective skills to identify distinct detail and understand intricacies presented by the data specific to the study intention. The coding processes were reviewed by the research team alongside reflexive discussions which took place in supervision and focused on processes of coding. The use of a reflective journal enabled a deeper reflexive process and these practices collectively added rigour and supported the development of themes across the dataset.
Sincerity	The criteria of sincerity were met through self-reflexivity which was positioned and transparent from the outset of the study. The lens of insider researcher has been a central part of study development in terms

	of shared motivation and hopes with an expert by experience. The self-reflexive elicited a sense of vulnerability and honesty which was needed throughout the study to understand potential biases and consider the influence on the research process. Having open conversations with the research team in supervision and utilising reflexive activities supported clarity around the assumptions bought to the process, including opportunities for learning and challenges. Self-reflexivity was encouraged by questioning positioning, the influence of lived experience and personal values. Using a reflective diary supported an in-depth transparency.
Credibility	Credibility was demonstrated through thick description and illustration of cultural meaning including exploring beneath surface meaning and experiences across multiple participants with shared realities as Black women. Trustworthiness was achieved through triangulation and positioning from the epistemological lens that accepts that all realities are shaped by their context and do not seek to validate a single reality. The use of research supervision was imperative to this and allowed the contextual interactions of the data to be explored through multiple lenses within the research team which in turned deepened understanding.
Resonance	The criteria of resonance was demonstrated by the accounts shared by Black women who participated in the study, they shared experiences of connectedness, validation and gratitude around ethnic and cultural visibility within research (please see appendix Q for further detail). Resonance was further achieved by the wider impact within professional groups, organisations and at a community level shared in accessibly using forms of multimedia. This process generated new connections and

	highlighted narratives in a meaningful and sensitive way, alongside actioning social justice and sharing recommendations with people in positions of policy-changing power. Furthermore, with the pandemic ongoing having impacted society in various way and the ripples still being navigated, the study findings have offered transferability and opportunities for learning across a unique global context.
Significant Contribution	This research topic offered a significant contribution and extended knowledge within the area of maternal health by platforming voices and experiences of mothers neglected by the current evidence-base. The practicality and implementation of recommendations has supported the shaping and improvement of maternity and mental health services through recommendations rooted within lived experience as directly addressed by participants in interviews. The research also holds significance for future research with invitations for methodological developments.
Ethical	Ethical considerations have been centered throughout this study, particularly around emotional and psychological distress. This was relevant to the ongoing navigation of the pandemic and acknowledgement of the wider socio-political context and experiences of Black communities at the time the interviews were conducted. Ethics were upheld throughout including confidentiality, informed consent and the right to withdraw. Finally, exiting ethics were held central from the start of the study and beyond, with connections made within online communities honoured through sharing relevant content.

Meaningful Coherence	The criteria of meaningful coherence is evidenced by the achievement of aims, utility of methods to meet study purpose alongside interconnectedness with the evidence-base. This was demonstrated as the study fulfilled its aims and explored experiences of participants to answer the research question. Coherence by intentions and plans to meaningfully share study findings upon dissemination to ensure accessibility and community orientation. The coherence was strengthened by the study alignment with the epistemological position of the research which was threaded throughout the research process.

Self-Reflexivity

Self-reflexivity is a crucial part of the researcher-participant relationship supportive of understanding power dynamics, positionality, personal context influences and to enhance research validity (Tarleton & Heslop, 2020). As a Black mixed heritage mother of two with experience of perinatal emotional distress, I pondered over my insider-researcher positioning (Dwyer & Buckle, 2019). I also considered how the role I was placed in as researcher, not as a peer placed me in an 'outsider' position and influenced relational power (Dwyer & Buckle, 2019, Tarleton & Heslop, 2020). To help me disentangle and comprehend what this meant for me and the study, I worked through aspects of a social identities map (Jacobson & Mustafa, 2019), please see appendix R. This visual mapping offered scope for self-reflexive growth which complimented the reflective journal I kept alongside learning and reflection following supervisory discussions.

Chapter 3: Findings

Overview

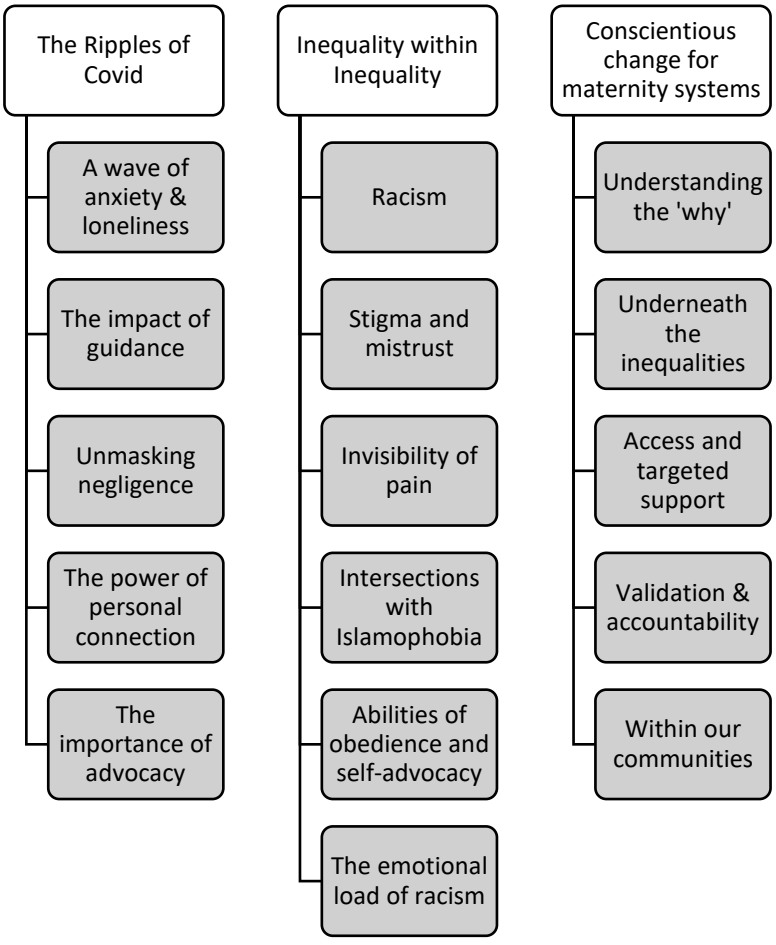
Through a reflexive thematic analysis interpretation of the data, themes and sub-themes were generated, these will be presented illustratively with example extracts to support analytical conclusions.

Findings

The analysis process generated three main themes outlined in figure 4 below.

Figure 4

Mapping of Themes



Theme 1: The Ripples of Covid.

The first theme captures the ways in which participants described the pandemic alongside experiences of care received and the rippling influence it had whilst birthing and recovering postnatally. The data outlined the presence of anxiety and loneliness as a constant and core part of

experienced care and featured throughout all stages of the maternity journey. These notions were either generated directly by experiences of care or were already present and compounded by the pandemic. Participants accounts also highlighted the varied impact infection control guidance had on experiences of care in maternity settings. The final sub-themes illustrate participants experiences of person-centered care and ways this was facilitated. Overall, participants' maternity journeys illustrated the ways in which the pandemic had influenced their care at various junctures.

Sub-theme 1: A wave of anxiety & loneliness.

The resounding feeling and realities of loneliness reverberated throughout participants accounts. They spoke about how loneliness had featured in key decisions including where to birth, who to have support them as influenced by government restrictions for birthing partners attendance in maternity settings. Birthing during the pandemic was consumed by processes where choices were compromised, and loneliness was both experienced in absence of care and a felt repercussion of the pandemic.

For some participants, the very thought of being alone brought up fear and was a situation that where possible needed to be resisted. For instance, Aaliyah recognised a sense of vulnerability with the prospect of being alone, and chose to take control in an unpredictable context and made the decision to have a home-birth.

> *'So again, during covid, my choices are being a hospital by myself, […] or be in my own home with my own food, in my own bed where I can control everything, with my own family'*
>
> *(Aaliyah)*

With reports of having concerns dismissed and antenatal clinics shut down, there was a sense of wariness for participants who described the impact of having essential checks missed.

'I missed my gestational diabetes […] I had about two or three months late too late and then they found out that I had it […] those kind of things can mean the difference between a woman's life or health' (Sade)

Meaning that antenatal experiences of care brought a sense of apprehension to the next stage of birthing and postnatal care. A few participants talked about the pressures of attending antenatal appointments without a birthing partner such as, the mental load required to relay important information about the progress of pregnancy. There was particular attention drawn to how experiences had impacted fathers' suggesting a culminated sense of loss in expected experiences.

'… I think it's so unfair […] to miss out on appointments, seeing a baby at a scan, you know hearing a heartbeat. You can't really replicate that, it doesn't like videos and stuff doesn't do it […] it was horrible, really hard' (Dominique)

Several participants shared how aspects of feeling alone during their antenatal journey influenced their birthing and postnatal experiences. Having had antenatal clinics and groups stopped, participants leaned on online resources and social media for information, which for first-time mothers impacted levels of confidence and connected to a loss of expected experiences.

'I think covid in the community setting just meant that I ended up […] we didn't have the those antenatal clinics so there were things I was looking forward to doing there and asking. So my resource was YouTube and YouTube had more Americans videos on antenatal clinics so I had to just read up on that and listen to that because that's the only resource that I had' (Eshe)

The pandemic context added anxiety, reluctance and pressure to seek support from professionals. In some cases, there was denial of early birthing stages because maternity settings symbolised an unknown and fearful territory, signifying the gravity of what it was like to feel lonely.

[…] From the get go from being pregnant, especially during the whole pandemic […] I had anxiety, a lot of anxiety about going to hospital to be honest with you […] it's supposed to be the most special time of my life and there's all these stories about women giving birth on their own […] even thinking about it makes me cry' (Keisha)

Whereas for other participants, the presence of anxiety and loneliness was more than a fear, it was a lived reality of their experiences. Being left alone in the absence of care and support from professionals, where without the context of the pandemic, it can be presumed that this would not have happened. Several participants described the intense emotional and physical implications of experiencing significant delays in expected and crucial processes whilst birthing and postnatally.

'[…] I was quite upset […] I had given birth they couldn't find me a bed so here I am on the table I was on the table for about an hour and a half […] with the pandemic […] not enough beds, not enough staff' (Farah)

The sense of loneliness exacerbated by national lockdowns and stepping into transitions of motherhood in a world with little to no social support and interaction were expressed by a few participants.

'[…] my husband was not there, we were in lockdown, he couldn't come and also dealing with the baby, I was feeling very very isolated and not really feeling like I had support' (Eshe)

Despite the different experiences across accounts, all instances signified and acknowledged the gravity of loneliness as a feeling, reality and consequence of maternity journeys and care experienced during the pandemic.

The imposition of birthing partner restrictions due to covid, resulted in a number of participants having to choose one birthing partner and entering triage assessment units during early stages of labour alone, in turn creating anxiety and a sense of loss.

[…] I don't know when my waters gonna break and we don't know how long it's going to be, quickly is not a tangible amount of time […] there was nowhere to park and it took him a bit longer than we hoped, and he missed the birth, he missed it (Dominique)

'Disheartened and you feel I felt really alone because I couldn't have my partner' (Grace)

Several participants spoke about how covid left them feeling anxious and alone due to the lack of breastfeeding support. Being left to work things out and suffer in pain, hence accepting that there was no support available and being self-sufficient and navigating breastfeeding journeys in isolation.

'I struggled with was breastfeeding. I didn't really get much help with the things like colostrum and things like that, all those things I couldn't get because of Covid' (Eshe)

This sub-theme highlighted how the pandemic resulted in mothers feeling or being left anxious, alone and with no choice but to work out their maternity journeys with limited and compromised professional support.

Sub-theme 2: The impact of guidance.

The impact of guidance sub-theme illustrates the different ways guidance effected experiences of care. Most participants acknowledged the need for infection control guidance, specific to the time they gave birth including during lockdowns or at points restrictions had changed. Within a global

context never before experienced, the guidance itself was imposed with urgency and intensity. It was evident that at times the guidance was prioritised over observed distress.

> *'I'm in labour, and with the hormonal drip, it's getting tense is getting more tense every so often so she wanted me to keep my face mask on and I was like I can't do that 'cause you're restricting my breathing […] I was getting stressed um which made the baby get even more distressed […] it was just constant, like with my with my birthing partner it was can you move your chair just a little bit back […] She was constant, repetitive, very repetitive with the can you keep your face mask on and just little things like that' (Jade)*

> *'I don't see why I had to take a bloody covid test when I was seven centimeters dilated, like why would you get me to stick something up my nose when I'm screaming my arse off […] it was very rushed […] they didn't even have time to even give me the results so it was actually pointless' (Keisha)*

At particular moments where family support was needed, participants perceived the guidance as punitive, weaponised and insensitive to individual contexts.

> *'[…] It wasn't covid at all, it was covid was the excuse for them to say no you're not going in to see your daughter' (Natasha)*

> *' I just thought you know I'm on a recovery ward just had major surgery, my child has been taken to the NICU* […] *I can get procedures and protocols because of covid but, you know, in some instances, they should just let some things slide' (Leah)*

This sub-theme captures how the pandemic guidance impacted maternity professionals who needed to attend to the transition and upheaval the pandemic caused. Participants accounts described

how the guidance itself was overwhelming in nature and there was a pressure for NHS staff to know and implement the latest procedures. This leads to the next theme where the impact of guidance was felt with such intensity that it started to unmask negligence and poor care.

Sub-theme 3: Unmasking negligence.

This sub-theme illustrates shared experiences of participants whose care was received in birthing centre and ward environments, describing poor levels of care linked to reduced staffing.

'They [midwives] said that staff were quitting […] a lot of staff weren't even coming in and whatnot, so all the wards were kind of rushed off their feet with each other' (Leah)

'You'd ring the buzzer, nobody's responding for feeding, nappy changes, anything like that […] I just struggled, […] I had to ask for my catheter to be removed because my bag was so full' (Grace)

The ramification of reduced staffing meant that care was negligent, and mothers were spoken to with disrespect and needs ignored or minimised.

'I got shouted once saying there's plenty of other women on here that need us more than you do' (Sade)

'And it wasn't I could overhear other people getting ignored as well, so it wasn't just me but it would be like, I would ask, and that was the annoying thing they'd they would listen to you, they'd shut your buzzer off, go away and forget about you' (Grace)

Consequently, understaffing combined with visiting restrictions in place due to the pandemic led to an increased reliance on professionals. However, professionals' inability to meet needs left mothers in challenging and undignified positions as illustrated below. This added a layer of emotional exhaustion for mothers to advocate for themselves and request support, this was voiced strongly by a few participants who had assisted births by caesarean section.

> *'But I was like having a C-section, I'm so more reliant on you guys to help me and assist me […] if my husband was here he could have done all of this […] but because of Covid he wasn't allowed to be there […] Having to constantly ask for help and constantly be like, please, can you help me like one time […] you can see I'm in my own vomit' (Farah)*

Manifestations of negligence for a few participants appeared to create issues with medical notes and poor communication, leaving mothers feeling frustrated and disappointed.

> *'I mean when it comes to reading her [baby] notes I found out things that they thought she had sepsis, they thought she had a heart murmur just a lot of little things that I wasn't made aware of' (Leah)*

> *'They couldn't find my daughter on the system at all, they had me on there but no baby attached to me' (Sade)*

Negligence also manifested under the umbrella of the pandemic and impinged on the basic human rights of a few participants whose care was dictated by risk management practices and basic needs such as food were dismissed, in turn producing exhaustion and frustration as conveyed by phrases such as *'stressful'* (Sade), *'tired'* (Jade) and *'vulnerable'* (Dominique).

'We had to stay the postnatal room for like we was in there for me and my sister was in there 36 hours just because the number of staff there was hardly anybody there […] My sister was like, my sister hasn't eaten anything and because there was so much going on, the lady was like, oh, well, you missed the food times, so you can't have anything' (Sade)

'I asked her [midwife] what there is to eat […] I've got allergies […] I waited about half an hour, she didn't come back, when she did come back she was like I'm sorry […] so there's nothing, I've not had food now […] I ate all the snacks that I bought. But that's all I had […] basically I'm starving' (Jade)

There was an awareness of the strain and pressure the Covid-19 context had brought to the NHS and participants' accounts identified stresses being held by staff in maternity settings, being taken out on them, at the detriment of mothers and babies health and wellbeing.

'It's your job, it's what you're trained to do and if you're that miserable or if you're that annoyed at your job, then you shouldn't take it out on the patient 'cause it's the patient who does get the raft of you not passing on the information, so ideally the communication could have been a lot better'(Jade)

'It was horrible […] like covered in my vomit asking for help and feeling like I'm bothering them and I'm just like you chose to do this profession […], you chose to work in this job to help women like me' (Farah)

Alongside this there were a few participants who described and reflected on the uniqueness the pandemic presented and held onto compassion despite experiences of poor care.

'It was bad, […] And this is how drained they're going to be forever and they have to work so hard and then to be put under that pressure. It does make me feel sorry for them that that that's it could potentially be the way that they have to work for the foreseeable' (Grace)

The manifestations of negligence and poor care resulted in a number of participants self-discharging, believing *"I might as well go home"* (Eshe) or *"I refuse to do this another night…I refused to be on my own"* (Farah) because the ward environment was not supportive: *"there's not much help for me here"* (Grace);*"they're not doing much for me"* (Eshe). Thus, emphasising sentiments of self-sufficiency through need, with no choice but for Black mothers to adapt and prioritise wellbeing.

Sub-Theme 5: The power of personal connection.

Despite the reports about how maternity settings changed as a result of the pandemic and the processes surrounding the implementation of guidance led to experiences of poor care, participants expressed gratitude where this challenging context was navigated together. Person-centered experiences of care were supported by professionals who connected with participants on a personal level, thus, symbolising collective coping.

For instance, a number of participants spoke about the significance of connecting through shared ethnicity and having Black healthcare professionals involved in their care which offered feelings of reassurance and support.

'I had the consultant come in, which was so refreshing that she was a Black woman, about the same age as me. I was like, this is cool, my midwife was also a Black woman so that was really awesome' (Dominique)

'[…] Three or four black nurses, so I felt a lot more comfortable […] because I just resonated with them a lot more' (Leah)

Participants spoke about how personal connection supported flexibility with visitor restriction guidance which was met with gratitude. This illustrates a process of sharing power where the pandemic generated conflict for professionals placed in moral dilemmas where there was a need to follow rules, yet rules could be shifted where the situation warranted it.

> *So, the three black nurses was like, look, I'm not gonna say nothing and they were like if she [sister] comes in here, we won't say nothing but you just have to. If you get caught, you get caught [breaking visiting restrictions] […] the three nurses they didn't say a word didn't mention anything (Leah)*

> *'You can't have two people, but I know how hard that is so I'm going to I'm going to see this and not see this' (Vea)*

Personal connection with healthcare professionals allowed for reassurance, meaningful conversations and *'banter'* (Jade) which within the context of birthing in the pandemic fraught with uncertainty and disconnection, was of significance for participants.

> *'I had a really nice, the midwife I did have she was really really relatable, I think because we're both young, we were just talking, just it was nice so was really reassured me that she was trying to support me as best as she could' (Asma)*

> *'It was almost like like building a friendship […] having that social interaction that you need knowing that you can't have your birthing partner with me' (Jade)*

Contrastingly, a few participants had existing personal connections with the maternity settings themselves, which enabled an appreciation of better care and support.

'[…] obviously my mum [additional birthing partner] wasn't meant to be in there because of the whole covid thing so the fact that um, she was allowed in and OK, that was the main part I guess that was the highlight. And because they were just very like, just calm and relaxed' (Natasha)

'[…] They also worked with my mum so I think they treated me a lot better than maybe they would have anybody else' (Leah)

This sub-theme emphasises the privileges afforded by personal connection to people and settings in contexts where strict guidance and change was imposed. Where, as a Black mother, if this connection is not there or felt it can prevent receipt of good care deserved by all.

Sub-theme 6: The importance of advocacy.

Alongside personal connections, a few participants spoke of their gratitude for their birthing partners and wider families who offered strength and help during birth and postnatally, for instance:

'To be honest with you my partner was the most helpful person, my partner was really helpful and I say that because he he was actually assisting the midwives' (Keisha)

'My husband he was and then also our parents, the grandparents were really really helpful' (Tendai)

The power of peer support appeared to prevail as identified across several accounts, where connections made either in the hospital setting or existing friendships offered a safe space to name struggles, support and encourage one another.

'We [other patients] supported each other because that's all we had, you know' (Dominique)

'And one of the parents came over and was like oh my god what is wrong, all the parents in the room were lovely that all of us got along, I still got all the numbers and whatnot' (Leah)

This sub-theme illustrated how advocacy for and by Black mothers was meaningful and of great magnitude during the pandemic where experiences of care were connected by anxiety, loneliness and vast changes to the delivery of maternity services.

Theme 2: Inequality within Inequality.

This theme related to how participants accounts demonstrated how the pandemic exacerbated existing inequalities. Participants experiences of care through multiple layers of identity, highlighted existing inequalities pertinent to birthing and transitioning postnatally as a Black mother. This includes experiences of pain, intersections with Islamophobia, stigma and mistrust, racism, power and the load of emotional processing.

Sub-theme 1: Racism.

Racism manifested in various ways across participants' accounts from covert to overt comments from professionals seemingly unaware of racial stereotypes and the impact it can have on an individual. Participants experiences of care captured how different forms of racism including interpersonal, structural, internalised and racial trauma, were navigated.

The way experiences of care were discussed evoked the notion of professionals as largely unaware or in one instance as illustrated below, partially aware of racial stereotypes which intersected with and were underpinned by harmful narratives about gender. The data described the ways in which participants positioned themselves in response to racism, with some expressions of frustration and

anticipation of microaggressions. This demonstrated the lived reality of being a Black woman, accentuated within maternity care.

> *'When I went to have a midwife appointment […] she said to me at the end of the appointment. Wow, you speak really good English and I was like pardon, I was shocked and I was like, I was born here and she's like and she was shocked […] so just little microaggressions like that' (Asma)*

> *'I told her that he [father] was black and she […] something along the lines of black girls are beautiful, […] black boys are naughty […] she's not surprised that he didn't stick around and white boys are good and I should've gone for a white boy' (Leah)*

> *'They called another midwife to come, you know to come and try and help me calm down and they were like it's not about race, it's not about race […] of course it is because you think […] less of me ultimately and it's only when I went off with the other midwife that then there was a Black midwife in the room and she was like yeah it was about race' (Aaliyah)*

Structural racism manifested through intersecting aspects of Black mothers' identities including country of origin and human immunodeficiency virus (HIV) and female genital mutilation (FGM), as illustrated in extracts below. This demonstrated how structural racism facilitated assumptions to be made and acted upon when intersecting aspects of identity are attended to within the maternity context.

> *'And then 'cause they identify where your partners from that gives you a risk factor for my partner he's not from [country] but anyway if he was it would have put me in a high factor of HIV positive or something and then when my blood tests came back she went oh it's HIV negative, oh that's brilliant. Well done [name] in my mind, I kind of went what was she*

expecting, what was she expecting […] I just thought it's not good, to always good to make these assumptions' (Eshe)

'They put on my forms that I was a risk for FGM. And when I asked them why they started saying something about oh in Somalia, the risk of FGM is higher. And I'm like I'm not Somalian' (Aaliyah)

Participants spoke about their awareness of how racism manifests in the form of preconceptions and therefore modified their behaviour to receive the right care and resist being labelled an 'angry Black woman'. This adds an emotional layer to the birthing experience where is energy depleted and concern given to the views of others during highly vulnerable situations.

' […] they [professionals] would always you know she gets angry and all she gets this and that but I wouldn't even raise my voice at them, but I would just be saying what I want, how I felt. So she would constantly call me sassy and she did make a comment which I just let slide because I couldn't be bothered with the aggro' (Leah)

'And there is a racial element that comes into my head and it comes into my head for a reason because I don't want to get portrayed as a an angry black woman in the hospital' (Keisha)

A final way in which structural racism as an existing inequality was highlighted, was the lack of representation and ethnic diversity in breastfeeding resources discussed by a few participants. The pandemic illustrated reduced breastfeeding support where mothers struggled alone. The impact this had on Black mothers specifically linked to barriers in identifying need and seeking medical assistance for commonly experienced difficulties such as, mastitis.

'All the magazines around your nipples and kind of how baby latches didn't have any Black people. It was just White people […] I don't connect with that so much [..] that soreness and […] having darker nipples […] I was like, okay, if someone had told me that in itself would have been really useful to know, but I had to learn that' (Vea)

Sub-theme 2: Stigma and mistrust.

Participants' accounts demonstrated meaning and presence of stigma alongside mistrust, particularly where professionals were stigmatising which generated mistrust and inability to disclose struggles.

'[…] you can't disclose all this information out to to the services because you never know how it's going to be misinterpreted […] worried about potentially falling into that category of being an unfit mum or leading to be supervised extra because they have mental health' (Jade)

'From personal experience as well, I feel like when the question is asked to me [about mental health support], I feel more inclined to say that I'm okay or no, I'm fine. Because, again, is it actually going to help me or am I going to be judged for it?' (Sade)

Some participants expressed views around the way mental health is perceived for Black mothers and the presence of stigma within communities, making it difficult to talk to family members and access support from professionals.

'[…] When a mum is struggling to them [others] it can be just normal but emotionally it can be really difficult. […] *But also the perception of things like depression in my culture[…] it's quite taboo as a topic, so people don't discuss it' (Eshe)*

'I think there's a stigma around, in the Black community anyway, if you're struggling with postnatal depression, you're probably not able to look after your child as well' (Tendai)

Alongside a sense of judgement regarding mental health, participants spoke of mistrust and fear of social services: *'I kind of gave in because I think I've always in the back of my mind got this thing about social services […] social services gets used as a threat' (Aaliyah)*

The threat of social services turned into a reality for two participants who expressed a lack of transparency following the involvement of social services and how it left them feeling despondent and compounded mistrust.

'The guy [social worker] said to me […] I would just be careful because next time we won't take it so lightly […] I was just like wow like it's is that even allowed? […] that was really actually really really painful especially knowing what I'm going through, I'm already feeling enough like a failure […] I didn't know that social workers would be involved and so I think the way they did it was quite secretive as well' (Tendai)

'I don't understand why I'm on safeguarding, why haven't I been told that I'm on safeguarding […] I don't want them [professionals] to, to hear what I'm saying with my friends or family, to judge, […] I just felt like it was, it was embarrassing to have that on me […] and I felt like a shame that oh my god I've done something wrong' (Leah)

Overall, this sub-theme emphasises how experiences of care for Black mothers were influenced by and situated within a multi-levelled cycle of stigma and mistrust, in relation to mental health and social services.

Sub-theme 3: Invisibility of pain.

This sub-theme portrays experiences of care in relation to pain and pain management. Across accounts, participants highlighted how pain was navigated and experienced by Black mothers, underpinned by professionals' misconceptions of pain which was associated with stereotypes about how pain is experienced and presented. For instance, Vea described how presenting in pain was considered unusual with expectations of being in so much pain and unable to walk when in active labour.

> *'[…] they were like, Oh my gosh, you're five centimetres [dilated] and then you're walking in. Most people come in and they're less than that' (Vea)*

Perceptions as illustrated above, resulted in participants being ignored '*I was in invisible pain like so, it's just the way it was' (Asma)* and needing to continuously ask for support, *'I just need pain relief. That was all I was asking […] I'm in pain and no one's really taking my pain seriously' (Grace)*. Thus, describing alongside physical pain, the emotional distress caused by professional misconceptions.

The data drew attention to the ways in which the pandemic concealed and dismissed Black mothers' pain under a weighted blanket of ignorance and carelessness.

> *'[…] And I kept on crying out for more pain relief […] I felt like I didn't feel listened to when I was saying, I need a pain relief […]. There was no urgency and in my mind, I was like, I'm in pain here, and there was definitely no urgency' (Vea)*

> *'I felt like I needed my pain relief. Nobody checked what my pain threshold was like or if I was comfortable. […] I remember looking at her [midwife], finally opening my eyes and saying, please, can you examine me again?' (Grace)*

Some participants spoke about postnatal recovery and how a lack of support from professionals led to women questioning their own expressions of pain and internalizing reasons for not being supported: *'Nobody, nobody is understanding me so, it must be me. If I'm asking so many times. And I'm not being understood. There has to be miscommunication here, so they must be coming for me' (Grace)*

Another participant described the need to go into survival mode and cope alone following the process of ongoing subjugation, whereby over time there is compelled feeling to not ask for help because experience has proven that the maternity system will not support Black mothers.

> *'You need to be in front of somebody's face in pain for somebody to bother like there's no follow up. […] Let me just get on with it and that's how I felt like, what's the point? I want to just get on as best I can, and if I am not like collapsing on the floor, then should I even calling anybody up?' (Sade)*

A few participants made comparisons to the Westernised norm around birthing and pain management which formed their reasons for not wishing to have pain relief.

> *'It was very important to me to have a drug free birth although I still didn't have a drug free birth […] I think maybe there was an element of culture because back home I'm of African origin and we they barely do drugs' (Keisha)*

There were reflections around similar values of birthing, with norms reinforced by Westernised beliefs and the loss of birthing knowledge through colonialisation.

> *'You end up with a medicated birth because you from the very beginning you've been told you won't be able to cope with the pain' (Aaliyah)*

'I think losing that knowledge because even historically and are in our history and our culture is there's such a rich culture of uhm, birth knowledge and the postpartum knowledge that we've lost' (Asma)

The above quotes collectively illustrate how colonial views which shape midwifery education influence experiences of care, with participants describing the how experiences through a Western medicalised model can be incongruent with cultural beliefs and preferences.

Sub-theme 4: Intersections with Islamophobia.

This sub-theme describes the extent to which and how Black mothers of Islamic faith experienced double discrimination within the care they received. Three participants described how their identity as Muslims interacted with stereotypes made about them adding another layer of emotional processing to the birthing experience.

"*They [professionals] would have just basically just thought here I was another black Muslim woman who's going to go off and circumcise her daughter herself, uneducated, unaware' (Farah)*

'I mean, I think from the beginning I could tell that I was coloured not only by my skin colour, but also by my religion' (Aaliyah)

Participants who experienced Islamophobia emphasised the emotional labour of being judged on their religion, which required constant self-advocacy and resistance to harmful stereotypes.

'I think it's a very layered thing [...] I think as someone who covers in that way so often you're ignored so so often you're like sidelined, so often you feel like you have to really advocate for yourself and show people look, I'm not here to play games' (Asma)

The notion of double discrimination demonstrated above, stresses the subtle ways religious and ethnic biases were activated and influenced harmful interactions and professional judgements.

Sub-theme 5: Abilities of obedience and self-advocacy.

This sub-theme demonstrates the ways in which participants managed the presence of structural racism and the inherent links it had to power, described within experiences of care. Narratives emphasised the gravity of what it meant to be a Black mother negotiating birth and postnatal care largely intensified by an association with life and death.

Some participants felt a need to conform for survival and accept poor care whilst at the mercy of professionals who held positions of power, highlighting how during the pandemic there were moments where professional duty of care and responsibility to do no harm was disregarded. These instances suggested a difference in tone to challenging racism as discussed earlier, because there was a communicated urgency and consequential awareness of what it would mean to not conform when lives are in the balance.

'I think is an ethnic thing […] this idea of just accepting what's given to you and not questioning back and I see a lot with my mum […] when she talks to white professionals, she kind of like she never questions them, she kind of just accepts all they say and I think […] what I saw in her, I kind of just mimicked, just accepting whatever they said, being apologetic, trying to not like not trying to upset them basically 'cause in my head I was like, oh, if you upset them they will just treat you worse' (Farah)

‘ […] I had been there for so long I didn't know how much longer I was going to be there. I just felt like I couldn’t say nothing because my whole life and my child's life is in their hands’ (Leah)

The imbalances of power in maternity settings between healthcare professionals and patients resulted in an increased vigilance in mothers and birthing partners, with participants speaking of time spent observing and attending to the behaviours of others to ensure they could advocate as much as possible and receive the level of care they are entitled to.

‘I think my husband was really conscious of that [Black maternal health inequalities] and he did lots of reading […] he was obsessed with like you know what the stats shows that you know Black and women from BAME communities tend to have worse experience’ (Farah)

‘I was just making sure that [by self-advocating] everybody was doing the right thing like nobody was cutting corners. Everybody was like really listening to what I had to say’ (Asma)

This sub-theme emphasises Black mothers’ need to self-advocate and be obedient during the moments of increased vulnerability during the pandemic, an ability of which should not be expected by anyone within maternity care settings.

Sub-theme 6: The emotional load of racism.

The emotional load of racism sub-theme refers to the ways in which participants experienced their care as activating heightened emotions and how the wider context of maternal inequalities required another psychological load to be responded to and processed. Participants described a need to make-sense of their experiences of care in maternity settings and the relationship this may or may not have had with racism.

The hesitance to 'bring race' into how participants experienced care resonated similarly across a distinct number of accounts. Suggesting that naming this may compound emotional distress and generate potential conflict with professionals.

'I mean, you could bring the race thing into it, but at the same time, it could just be because she was, she thought she was more important than she was' (Natasha)

'I don't want to bring race into it at all really but I just think to myself if I was a White woman, would I have been treated any differently? […] these were all the things I was thinking in my head and this is not what I should be thinking when I'm giving birth' (Keisha)

'[…] even if I said […] "I think you think I've got a higher threshold like" […] I don't think it would have gone down well' (Vea)

A further example of bearing the emotional load of racism was how participants talked about the media coverage around ethnic disparities in maternal mortality including the publication of reports around the time of birthing and whilst pregnant. This weighed on a number of participants minds emphasising fear and trauma.

'[…] even like the statistics about you know there's statistics about Black women are four times more likely to die during pregnancy. I mean, I know that that was a big thing, but hearing that as a pregnant woman is very traumatizing as well' (Tendai)

Where concerns about Black maternal health were voiced and featured across a large proportion of participants' accounts, the responses from professionals were experienced as invalidating and gaslighting in nature. There was a lack of proactive approaches and discussions from professionals in individual appointments about the highly publicised maternity reports.

'I did express to her that I do have a lot of concerns about giving birth right now, because this feeling in the back of my mind, especially from the facts, and that care is not provided by Black maternal health and the fact that black women are five times more to die in delivery, I expressed this and do you know what I didn't think it was taken seriously' (Keisha)

Being taken seriously was understood between participants as the need for professionals to name the inequalities without waiting for mothers to raise this themselves, and then importantly from this offer reassurance and have open discussions about ways to cultivate safety.

'I was like what are you gonna do to make me trust you, because it's not my job to make you trust me, it's your job. You are the untrustworthy one. It is your trust that has allowed Black women to die in labour. It's your responsibility when you continue to work for an NHS Trust that allows Black women to die you are also responsible, so you should be the one who's in charge of making sure, that Black women in your care feel safe' (Aaliyah)

Two participants spoke about the hesitancy to engage in reading and a need to minimise exposure to maternal health reports and a high-profile documentary about maternity inequalities for Black women which aired in March 2021, due to anxiety and the desire to preserve joy in the maternity journey. Again, demonstrating the additional layers of coping and emotional processing needed whilst birthing as a Black mother. Where the ability to be grounded in the moment, were compromised by the wider context specific to the time of birthing during the pandemic.

'So I kind of I remember doing a bit of reading and then going actually that's too, I don't want to delve into that and I could've delved into it, looked into it a little bit more and I just thought, No, I I want to try and enjoy my experience and hope that it doesn't go badly because, you know, you could read, you have the extremes' (Vea)

'I didn't watch it, he [husband] watched it because for me I didn't want to watch it because it was just too close to home. I was like I'll watch it once I've given birth because I just didn't want all of that in my head to build my anxiety already like I was already anxious about giving birth' (Farah)

The way participants spoke about their experiences of care indicated experiences of birth trauma, further evidenced by observations of participants tearfulness during conversations and the description of their experiences which indicated unresolved feelings and ongoing processing of childbirth.

'[…] To have such a bad experience […] it's gonna bring back memories, not good ones'. (Natasha)

'[…] The experience was I think a little bit traumatic, I've forgotten bits and pieces'. (Asma)

In conclusion, the specific combination of the pandemic and maternal health inequalities coverage alongside how participants appraised their experiences of care, indicated a heightened and exceptional emotional load being carried and navigated.

Overall, the theme inequality within inequality demonstrates how existing lived experiences, inequalities and intersections of identity specific to women birthing while Black, have been highlighted and exacerbated by experiences of maternity care during the pandemic.

Theme 3: Conscientious change for maternity systems.

This theme related to how participants experiences viewed the wider maternity system. Reflections were shared around why as participants, they received the care they did. Contributing

factors and thoughts about what underlies Black maternal health inequalities were also discussed. Participants accounts demonstrated that there was a need to consciously process experiences of the maternity system retrospectively. Finally, latter sub-themes addressed the second research question and summarises participants' views to improve service provision and change policies located across services, policy structures and within communities.

Sub-theme 1: Understanding the 'why'.

This subtheme illustrates the role of intersectionality and reasons for experiences of care, participants talked about the interactions of age and ethnicity.

Views were shared aligned with classist undertones of racial stereotypes within service provision, with noted changes in treatment and interpersonal style when these aspects of their identities were revealed.

> *'I didn't get a sense that they were kind of seeing things differently, but I don't, I don't know if people can do that in a conscious way I think that maybe, I don't know unconsciously. I think people respond to me differently when they know about my education' (Dominique)*

> *'I don't even think it's race anymore, I think it's class […] like your level of education […] if you are a professional I think you get respected more than if you were not a professional […] even though me and my husband are both Black and we identify as Black Africans. We're just not in that stage where we would accept race to be a reason why you treat us differently' (Farah)*

There were also a couple of sentiments shared about the influence of age and ethnicity, demonstrating another power differential and how intersections of identity shape experiences of care.

'I felt like it was because I was Black in [location] on the ward I was on, I saw one other black woman […] but I kinda just felt like it was probably, I think I was the youngest on the ward and, and I probably spoke up a lot more than other patients did' (Leah)

This sub-theme illustrated how participants experiences required reflection and curiosity about intersecting aspects of self both visible and invisible, to negotiate and make sense of care received postnatally.

Sub-theme 2: Underneath the inequalities.

Participants meaning making of their experiences alongside the backdrop of maternal health inequalities was linked to colonial history and roots of racism. Their accounts evoked ideas of professionals' beliefs and preconceptions of Black mothers as inherently located across time, in turn positioning interactions and care provided.

'These [biases] are historical aren't they, you know, anybody that knows the history of black women and how they play their part in, you know, slavery in history. You know they were the main childbearing, people, they they breast fed a lot in terms of, you know their children and their slave owners children. They were seen at the bottom of the pile […] there's a big historical element (Keisha)

'Black women, Black people have just well, for years now just seem less important then White people […] White people seem to get the help first […] Black people come last, I mean like how it's been for bloody centuries' (Natasha)

There were views shared around intersectionality and how points of difference often underlie maternal health inequality including *'institutional racism'*, *'Islamophobia'*, Black bodies as *'fetishised'* and Black Muslim women as *'oppressed' (Aaliyah).*

> *'[…] it's just instilled in the system as well […] this is a strong black woman, she's not in as much pain as she said she is […] I guess it's been installed in them just to think it Black women can just handle anything, handle any pain, handle any mental illness' (Tendai)*

Narratives such as these, appeared to leave participants needing to position themselves as activists with energy to challenge Western ideology and resist harmful stereotypes.

> *'We need to cuss to their [professionals] face […] when it's only a few of us who are cussing to their faces, they label us as angry Black women' (Aaliyah)*

Participants also shared views that underlying inequalities was the adopted notion of the 'strong Black woman' a survival mechanism linked to colonialist times. This idea was of significance because it demonstrated ways in which structures of racism have been internalised, an identity socialised and co-opted. Which in turn influence experiences of maternity care in duality including Black mothers' emotional expressions and professionals' responses and interactions.

> *'And sometimes, particularly for Black Caribbean women, the way that we cope with feeling vulnerable is to bolster ourselves and feel and come across as more empowered than we actually feel. […] There's this misconception about strength and Black women and I think we also have that we, we have internalized that as well, (Dominique)*

'[…] kind of not letting your pain be so visible, verbalizing it so much is that the idea that being a strong black woman. […] Female dominated on my mum's side so it's like we all just go crack and get on with things. You're strong' (Vea)

When inequalities and experiences of care during the pandemic are understood and connected to parts of Black history. The data brings to light the ways in which Black mothers have needed to engage themselves in active resistance but also acknowledge the legacy of the 'strong black woman'.

Natasha was the only participant to speak to a sense of hopelessness around tackling structural racism and power imbalance in maternity, suggesting that disillusionment may be a consequence of feeling unable to shift the colonial foundations of the maternity systems.

'So I don't know I don't think that's gonna change much to be honest. Yeah, 'cause it if if a person thinks that way and they treat someone like that because of race, it's hard to change that person just from a course on equality, you know? So I don't think that's that's really gonna change to be fair' (Natasha)

Sub-theme 3: Access and targeted support.

The vast majority of participants shared sentiments of hope and passion when asked about maternity service improvement, *'We need to be heard. We need to be seen' (Grace)*. Responses were united by the need for conscientiousness within services and communities with ideas around education, peer spaces, trust building and accountability.

Several suggestions were focused on giving information, accessibility and need to actively address inequalities specifically for Black women. Suggesting that there is a pressing need for Black women to feel cared for and needs prioritised given the longstanding history of inequalities.

'Look into the reasons why women are, Black women are having such traumatic births or why they are losing their lives, from what causes and how that can be prevented. Can it be prevented by specialist care, more appointments, more routine appointments, more follow up' (Sade)

'I think if you know that as a as an ethnic minority that we're at higher risk of complications during childbirth, more should be done […] supervision for Black women needs to be a lot higher' (Jade)

Alongside the need for follow-up and specialised support, participants also spoke about basic aspects of care including respect, choice, information and being treated equally, all of which every birthing person has the right to.

'I guess just to say treat them with respect, that's it and treated like you deserves to be treated' (Natasha)

'[…] These are the varying choices that you can make. We [professionals] recommend these things this is why we recommend these things, but actually you don't have to have them and these are the repercussions if you don't' (Aaliyah)

'I always feel like they should be a leaflet of giving people information of things that are common that basically are ignored […] just having something, produce something that goes on a phone that's in their language that we just read' (Eshe)

These actions are of importance particularly given accounts where participants spoke about and embraced cultural birthing practices such as, drug-free births and the need to have wishes respected.

Sub-theme 4: Validation and accountability.

This subtheme illustrates the ways participants emphasised the importance of having maternal health inequalities which specifically effect Black women, being openly named and discussed. Thus, outlining the importance of Black mothers seeing services show commitment to change and do not lean back on tried and tested methods to address inequalities, *'Training is just not good enough' (Farah)*. Suggesting that services have demonstrated initiatives to raise awareness about disparities through training and can no longer hold this position. Participants ideas stressed the need for action and engagement in a lifelong journey of learning to inform clinical practice and actively build trust with Black mothers given the multitude of barriers and structural discrimination faced.

'Yeah, just that reassurance that they care […] information leaflet or anything, this is what we're doing to show that we care […] that they want to improve the statistics […]' (Tendai)

'I think we need to we need to be valued a lot more, we need to be seen as individuals […] our opinions do matter, how we feel do matter and how we're feeling proves it's not a lie, you know, we feel what we feel when it should be followed up on, it shouldn't be disregarded' (Keisha)

'Treating us fairly […] just making sure we're OK […], not making us feel any different any less cared for' (Natasha)

A few participants spoke about the need for services to be accountable and the need to encourage Black mothers to complain about their experiences of care to effectively generate change. This outlines the importance of dual processes of validation and accountability between communities and services.

'Like if you don't, if you see any of this or if any of these policies are violated like report to this like just so there's some sort of accountability' (Tendai)

'And ultimately those people will realize we can't keep doing things […] we are fortunate in this country that civil servants are held to a certain level of account […] so if all of us were doing those things [complaints] and it starts affecting their outcomes, their complaints, then they have to make a change' (Aaliyah)

' [feedback] needs to be at a higher level […] I think it could easily get lost about what is needed […] I think Trusts need to take stock of kind of how many people like who's coming through, what are the experiences and stuff and do something different' (Vea)

These recommendations position communities and services in dynamic roles, removing potential for passivity and creating a feedback loop for accountability. Participants described this process as allowing space for healing and creating trust with maternity services. This shows that alongside hope for an accessible complaints system, it is of equal importance to create safety for Black mothers to complain.

Sub-theme 5: Within our communities.

This sub-theme describes the importance of change within and between communities to truly address disparities. A number of participants spoke about change located within communities in support of coming together to break stigma, uncover experiences, and strengthen community. This illustrated a resistance to universal approaches and the active agency required for a whole systems approach to ensure support is tailored and specific to local need.

'So it's supporting organisations that are in the community doing the work because it's very clear […] they want to have a band aid over things without actually sitting down and doing the

work that is needed to uproot the problems. […] So, and that's another issue, work with our communities to uproot these stories' (Asma)

'I think it's so important for us as Black women to get each other, be a community within ourselves' (Aaliyah)

'So I think having the education in our communities is very important. Educate mums to know the signs because they'll mask it with religion. They'll mask it with culture' (Eshe)

These extracts when considered collectively describe the need to bring a conscientious process whether at a professional, service or community level, that promotes visibility and actions towards building trust. There was a particular emphasis around relationships for and with Black mothers which could serve to heal, empower and break cycles of harm.

Finally, participants also spoke about the value of taking part in the study and having their voices heard, the interview process cultivated safety in speaking with a researcher with an insider perspective, enabling space for unfiltered conversation. This highlighted another important issue of research inclusivity and underrepresentation, for further detail of participants interview experiences please see appendix Q.

Self-Reflexivity

The process of creating themes and sub-themes reminded me that the analysis and reflexive process is never truly complete. I initially attempted to select data extracts first and construct the narrative using these, but this process proved difficult to maintain direction. I then read through the entire dataset and used my reflections to narrate the storytelling process, I also found it useful to revisit my reflexive diary and discuss theme development in research supervision. I wrote the research question, 'so what' and 'what are the wider patterns and why' and had this in view whilst I drafted the

findings. I made a table where I was able to link participants, themes and quotes, this structure also helped me to consider the narrative I was telling and why the meanings were linking. I worried about not honouring participants stories therefore, I stepped away from digital maps and used pen and paper to map out participants, their experiences and I listened to key aspects of interviews. This reconnected me to the journey I had taken rather than feeling overwhelmed by the task at hand. I was thoughtfully encouraged by one of my supervisors to imagine I had 15 minutes to summarise my findings and consider what the salient points were to communicate. They also inspired me to take a more experiential approach and close my eyes, trust in the knowledge and journey I had been on with the research to connect with feelings of anger, sadness and joy, this advice was invaluable. The resounding message from my supervisory team was to believe in myself, carry the confidence and trust my participants had placed in me to tell their story. It was truly moving to have embodied data analysis in such a way that I felt the presence of my participants as they walked alongside me every step of the way.

Chapter 4: Discussion

Overview

This next chapter offers an overview of the essential findings of the study connected to the research questions and aims. The findings will be summarised and conceptualised alongside relevant theory and current literature, and further contextualised by attending to the strengths and limitations of the study. Finally, the implications and recommendations for the development of future work will be discussed alongside closing conclusions and reflections.

Summary of Findings

The research question asked the following:

1. How have Black women experienced birthing and postnatal care in the covid-19 context? What has been helpful or unhelpful?
2. What recommendations/suggestions do Black women have for services to improve and address inequalities?

Participants shared varying experiences of care during the covid-19 pandemic context, from the swell of changes including service structure and delivery of care, to implications for Black mothers' physical health and mental health. Experiences of care were compounded by the imposition of government restrictions on maternity settings and infection control guidelines, demonstrating some punitive approaches and some flexibility. The context appeared to exacerbate existing inequalities present within maternity services.

Participants spoke of instances where professionals and significant others navigated care together on a journey fraught with uncertainty, needs were cared for, and a person-focused authenticity shone through. This was helped by aspects of shared identity, personal connection, and advocacy. Highlighting that amidst a global crisis, prevailed moments of reciprocal compassion and understanding, where appropriate levels of care were delivered, and support was given to all. This contrasted with participants experiences of poor care, feelings of anxiety and loneliness where human

rights were compromised, and physical pain dismissed. The meaning across experiences intersected with participants layered identities such as, ethnicity, age, faith and class, which influenced situational appraisal and coping.

The pandemic demonstrated the different ways racism can manifest within the maternal health journey and the ways in which mothers' survived and managed structures of power. Acts of microaggression and stereotypes appeared to go unnoticed by professionals, in turn dehumanising and making invisible the needs of Black mothers. Participants made sense of their experiences of care alongside the longstanding history of maternity inequalities and considered reasons why care was delivered and received in the manner it was, locating origins across time, generation and culture. Finally, participants shared their recommendations and generated ways forward encompassing intentionality and conscientiousness within professional approaches, the focus of services and community working. To contextualise and discuss findings further, themes will be discussed in conjunction with relevant theoretical perspectives and existing literature.

Theme 1: The Ripples of Covid.

Sub-themes: A wave of anxiety & loneliness, the impact of guidance, unmasking negligence, the power of personal connection and the importance of advocacy.

The findings of the current study emphasising care received and changes to maternity provision due to the pandemic, resemble findings echoed by van den Berg et al (2022). They highlighted staffing challenges including burnout, organisational pressure and changes to clinical practice. It can be understood that the context of the covid-19 pandemic worsened pre-existing strains and stresses within maternity services in the NHS. This included staff shortages and the deficit of midwives who trained elsewhere in Europe and following the 2016 Brexit referendum have left the NHS alongside fewer joining the UK midwifery register (Royal College of Midwives, 2018). This is of relevance to

participants accounts of noticing the unprecedented pressures and constraints of the ward environment, a lack of bed availability and low levels of staffing.

With the literature surrounding the psychological impact of the pandemic on antenatal and postnatal mothers still emerging, what is understood is that the changes within maternity care have left scars of emotional trauma, distress and consequences of reduced essential appointments (Sanders & Blaylock, 2021). This links to the findings of the current study indicating heightened anxiety and loneliness. Similarly, Dib et al (2020) conducted an online survey for new mothers in May 2020 within the context of the first UK national lockdown and found that respondents showed signs of depression, anxiety and loneliness. Highlighting links to the current study which mapped experiences for mothers between May 2020 and October 2021, following three national lockdowns and varied changes to maternity settings, where loneliness was a core feature across accounts, alongside some sharing of mental health distress within the perinatal period. The current study described the choices mothers faced with birthing options due to the pandemic and the resounding accounts around the lack of support available across various departments within maternity settings and services. These findings corroborate with a recent survey of professionals which revealed large reductions in antenatal and postnatal appointments, alongside reports of the temporary removal of the choice of home births (Jardine et al, 2020).

The current study highlighted the impact of restrictions around birthing partner support during early stages of labour and postnatally, leaving an overarching sense of loneliness and anxiety. These sentiments are supported by the findings of Stacey et al, (2021) who found that maternity experiences of women and their birthing partners linked to visiting restrictions generated sentiments of feeling lost and let down by the system, highlighting the need for support for wellbeing. The lack of breastfeeding support alongside sentiments of anxiety and loss of expected postnatal experiences for participants, highlighted that during the pandemic the NICE guidelines for postnatal care (2021) were not upheld. Recommendations include breastfeeding programmes, discussions and emotional wellbeing assessment which are crucial to attachment and bonding with infants. Where breastfeeding difficulties persist, research predicts an impact on mother-baby bonding and the likelihood of developing postnatal

depression (Roth et al, 2021). Moreover, the literature advocates for evidence-based approaches with personalisation and sensitivity from professionals providing breastfeeding support (Blixt et al, 2019). Therefore, the experiences where participants talked about the pandemic context restricting the ability of professionals and access to clinics to provide appropriate support when needed, may have far reaching consequences for all who birthed during this time.

The connections of the current study to recent and developing literature demonstrates that there has been a significant impact on maternity experiences of care during the pandemic. The existing literature focuses on maternal health across a variety of ethnicities, whereas the current study focuses on Black mothers' experiences of care. This was of great importance and value, given the need to address the disproportionate impact the pandemic has had on Black and Ethnically Minoritised mothers and birthing people, this research offers insight and understanding at a time of urgency and public health priority. The current study captured experiences where care was received over a 17-month period spanning the pandemic context, therefore the long-term impact on Black mothers physical, mental health and wellbeing remains unknown. Future research would benefit from gaining further understanding of lasting effects and seek to generate new ways to reduce maternal health inequalities whereby the pandemic context may have contributed uniquely to and shifted existing inequalities.

Captured across a global context, Semaan et al, (2020) found from a survey of maternity professionals, reported high levels of knowledge and skills needed to tailor maternity care within the pandemic context, however experiences were accompanied by extensively higher stress levels. Similarly, strained interactions with staff, notions of loss, peer support and the impact of covid-19 restrictions resonated across the current study in that of McKinlay et al (2022). Through qualitative interviews, they generated themes around the impact of social distancing, the significance of supportive relationships, loss around perinatal experiences, mental health impact and stressors placed on staff and maternity settings. Findings from the current study show the impact of negative interactions with professionals and reduced levels of compassionate and person-focused care. This mirrored feelings and discussions within society which highlighted frustration with performative gratitude and the realities of risk and death (McKay et al 2021).

Findings of the current study also captured participants expressions of gratitude and empathy for professionals, and this aligned with the wider societal context of positioning the NHS during the pandemic, including that of community spirit and public solidarity for healthcare workers who were hailed as heroes (McKay et al 2021). Thus, highlighting how participants accounts connected with these contrasting discourses which in turn may indicate the ways in which societal representations of the NHS and healthcare workers influenced participants experiences of care.

Theme 2: Inequality within Inequality.

Sub-themes: Racism, stigma and mistrust, invisibility of pain, intersections with Islamophobia, abilities of obedience and self-advocacy and the emotional load of racism.

The current study found that during the pandemic there have been instances where Black mothers have had their needs around pain dismissed or ignored. Despite racism manifesting in different ways there was a need to trust, conform and continue to request support for basic needs. This supports the findings of a recent study into maternal mortality which found evidence of structural bias and microaggressions within experiences of care specifically for Black, Asian and Ethnically Minoritised women between 2009 and 2018 in the UK (Knight et al, 2022). The recent Birthrights inquiry (2022) represented the voices of 300 people including professionals, women and birthing people from various ethnically minoritised backgrounds. The inquiry focus groups identified the following experiences which correspond with the current study including poor pain management, racism, neglectful care through individual disregard and dehumanisation. There were also experiences of positive care shared with features of effective communication and cultural sensitivity that hold similar conclusions to the current study.

The subtheme of the current study illustrating the role of racism, went beyond John, Curry & Cunningham-Burley's (2021) insights, which discussed examples of indirect racism through family and friends, and the current study located the various ways racism revealed itself and directly impacted experiences of care. This can be understood through the lens of 'covid-racism' which encompasses the

revival of racist and xenophobic rhetoric that plagued society, narratives of which have been cultivated through systemic and socioeconomic factors which were subsequently emphasised in the wake of the covid-19 pandemic (Elias et al, 2021). The findings illustrated the role of intersectionality including faith, age and class, then when combined with ethnicity can have a significant impact on experiences of care and can be linked to the overall maintenance of inequalities. This is supported by Jardine et al's (2021) who found associations between ethnicity and socioeconomic status to avoidable devastating outcomes including stillbirth, preterm birth and fetal growth restriction specifically for Black and South Asian women.

The findings of the current study drew attention to perceptions and experiences of pain, including dismissal and not having needs recognised, reflect those of Henderson et al (2013) who found that Black and Minority Ethnic women had poorer experiences of care and of that sample, Black African women were less likely to receive the appropriate pain relief. This can be conceptualised as linked to the historical view of Black women as slaves and the inhumane treatment endured to generate submissive behaviour (Bryan, Dadzie & Scafe, 2018). The notion of invisibility can be further explained by Neel & Lassetter (2019) who discuss situational appraisals of goals and threats. They conclude that Black women through processes of stigmatization can be rendered more likely to be subject to interpersonal invisibility with some instances of higher visibility dependent on the context. This explanation encompasses the influence of stereotypes, including Black women as irrelevant, based on physical characteristics and symbols of strength and independence. Applied to the current study, there appeared a dynamic and fluid process of interpersonal invisibility and visibility, which informed how professionals responded to participants. Although the current context and time are vastly removed from the violence of the Trans-Atlantic Slave Trade, the invisibility of pain and dismissal of needs, appear linked to the undercurrents and reverberations of slavery. Owens and Fett (2019) centre Black maternal health inequalities within structural racism born out of the gynaecological experimentation and childbearing bounds of Black women. They concluded that modern day professionals act on unconsciously held beliefs rooted within the oppressive beginnings of Western medicine. The findings of the current study illustrate that such beliefs are subtle, yet salient within interactions, and although

not the only cited contributing factor, professional stereotypes and biases can play a part in ethnicity-based health inequalities (Nelson, 2002).

Finally, the participants who spoke about birthing values and beliefs around unmedicated births were linked back to African culture and norms. This is of great importance to acknowledge and validate. This is supported by the work of Romanzi (2014) who reflects on hearing accounts of African women who strive to step away from medical systems when birthing both to honour tradition and due to a lack of trust in Western medicine. This perspective compliments current study findings and suggests that alongside the strength in cultural value and respect for tradition, not being consumed by the medicalisation of childbirth could be interpretated as an act of resistance against structurally racist medical care and oppressive healthcare systems in the Western world. This idea of medical resistance was highlighted in experiences of adolescent pregnancy amongst African females by Brubaker (2007). Resistance was understood as a way to maintain agency and autonomy in systems which are restricted by cultural influences and wider structures that deny choice around antenatal care.

Another significant outcome from the current study highlighted through the emotional load of racism theme. The impact of the knowledge of Black maternal health inequalities and how this featured within participants experiences of care, either generating avoidance, anxiety and vigilance from either participants or their birthing partners. This is supported by the work of Geronimus et al (2006) who described the cumulative physical impact of coping and navigating systemic discrimination as the weathering hypothesis, which positions that the prolonged exposure to racism, disadvantage, and heightened physiological stress responses, result in poor health and higher morbidity, particularly for Black women. Therefore, within the frame of this hypothesis, participants experiences of care and reactions to the maternal health inequality literature and knowledge, indicate that there was a stress response which over time combined with other experiences could contribute to weathering. The increased hypervigilance and anxiety reported by participants cannot alone be linked to maternal health inequalities knowledge, and should consider wider societal and global events in tandem. The weight of high covid-19 mortality rates which coincided with the highly publicised murders of Black people in the United States at the hands of authority figures, which have been termed the ‘viral Black death’.

These atrocities have acted as a catalyst for increased rates of reported psychological distress known as ethno-racial trauma amongst Black individuals and communities (Akerele et al 2021). Therefore, participants experiences and psychological wellbeing may have also been shaped by individual distress and collective traumas pertinent to the space and time in which they embarked on their maternity journey.

The presence of birth trauma within current study findings are supported by conclusions of a study based in the United States, indicating higher rates of trauma symptoms following childbirth during the pandemic (Diamond & Colaianni, 2021). Their findings also demonstrated a negative psychological impact because of visitor restrictions, reduced support from significant people and unintended birthing plans. This is a finding of which is corroborated outside of the pandemic context where the absence of a caring environment and positive relationships with professionals, yields a greater impact of postnatal trauma symptoms (Baptie et al, 2020). When conclusions from both of these studies are applied to the current study, there is a resounding illustration of the importance to understand future needs of parents and infants who experienced higher levels of trauma during the pandemic. Collective racial trauma which coincided with the pandemic, trauma and loss as a result of the pandemic. When this is held alongside the presence of intergenerational patterns needed to survive maternity systems, all of which culminated at a time where professional and birthing partner support was severely compromised due to visiting restrictions. This complex wider context when applied to the current study, supports the presence of the emotional load being held and experiences indicative of birth trauma. Beck (2004) invites maternity professionals to consider birth traumas as residing within the ‘eye of the beholder’ with a requirement to position every birthing person in this way, have discussions and observe with compassion. Ayers (2017) emphasises the importance of recognising both risk and resilience within the context of birth trauma and seeking opportunities to reinforce growth and strength in adaptation and overcoming through the encouragement of positive emotions. This stance aligns well with participants views in the current study who advocated for validation of experiences and did not agree with Westernised norms of childbirth. These responses and social processes could be

understood as a way of distancing from the 'strong Black woman' and 'angry Black woman' stereotypes to positions of prosperity and empowerment.

Finally, the findings captured by the inequality within inequality theme illustrate the multifaceted ways in which poor experiences of care can be influenced by racist foundations. Of which can manifest across time and context, with a detrimental impact on individuals experiences and wellbeing. This was of significance given the pandemic combined with the 'viral Black death' context of which saw the resurrection of societally fuelled racial discrimination and violence.

Theme 3: Conscientious Change for Maternity Systems.

Sub-themes: Understanding the 'why', underneath the inequalities, access and targeted support, validation and accountability, within our communities.

A key finding across this theme, was participants views around why they received the care they did linked to intersectionality and reasons underlying maternal health inequalities. This included the role of history and narratives around strength and anger, all of which combined engulf structural barriers of the maternity system. Graham & Clarke (2021) explain the 'strong Black woman' (SBW) stereotype as linked to principles of Black women overcoming adversity within the context of and with this providing leadership and care as the matriarch of their families. It was identified through focus group discussions that the SBW motivated the concealment and diminishment of distress, alongside cultural narratives of hesitancy to speak of problems outside of the family unit. Linked to current findings, the social challenges of the pandemic coupled with the ideals of the SBW, saw participants potentially minimise distress which both embodied and absorbed the SBW stereotype as placed on them by the gaze of others and, yet needed to be leaned upon on order to survive. The SBW notion may also have been viewed by professionals and when combined with misconceptions around pain, allowed for needs to be dismissed and ignored.

Within the sub-theme of stigmatised connections to mistrust, a few participants spoke of how mindful they were of the way they would be positioned and judged by professionals particularly within

the realms of social care and mental health. A way to understand stigma and mistrust is through the writings of Keating (2002) who depict the circles of fear. This refers to the relational dynamics between Black communities and statutory mental health services, situated within fear, mistrust and a reluctance to seek support pertaining to a legacy of racism and located within structural, material, educational and psychological barriers to change (Keating, 2002).

Participants of the current study shared insight into their educational background and shared thoughts that class and access to power inherently linked to professionalism may have impacted the interactions they had with professionals. This corresponds with a recent systematic literature review which concluded that lower socioeconomic status was associated with higher adversity and increased risk of multiple poor antenatal outcomes (Thomson et al, 2021).

The findings across a number of themes which feature the importance of the relational dynamics with professionals as key to experiences of care. The role of personal connection and good experiences of care, perceptions of pain, mistrust and racism with classist stereotypes are mirrored in a recently published report by Fivexmore (2022). The survey looked at attitudes towards and experiences of maternity services for Black women in the UK over the past five years and found that attitudes, knowledge, and assumptions linked to professionals were critical to experiences. This included ignoring individual concerns and ethnicity-based stereotypes with bearings on pain management and the leverage education and class can have when accessing appropriate support. It is important that the current study has developed these findings specific to the pandemic, because it offers insight into a longitudinal journey of Black mothers in maternity services.

Implications and Recommendations

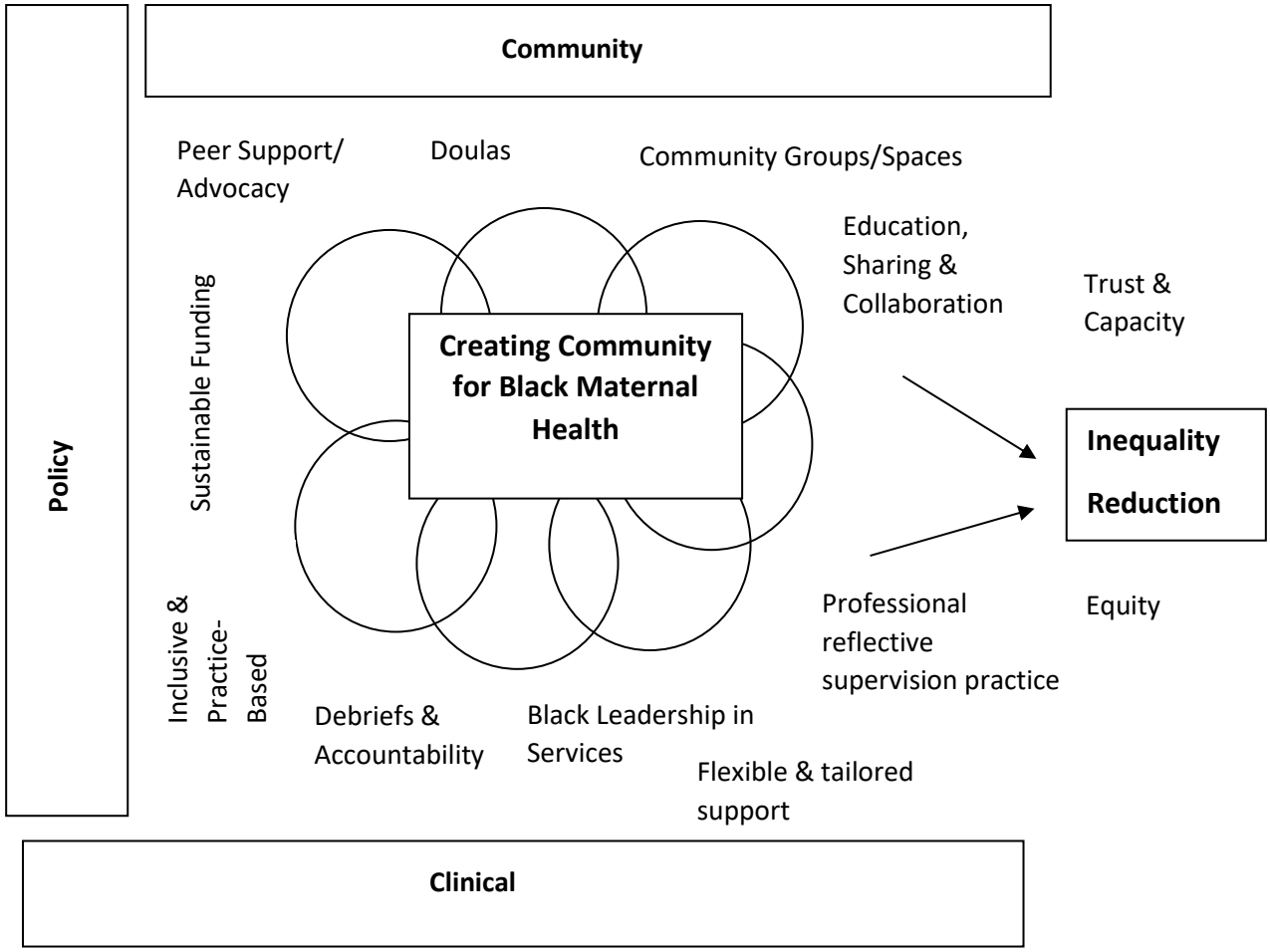
The current study focused on Black mothers' experiences of care across maternity service provision within a unique societal point in space and time with the global pandemic. This coincided with a time of unrest for Black communities with triggering of racial trauma and publications demonstrating the plight of maternal health inequalities. All of which called for a whole systems

approach to reducing inequalities and placed responsibility with all professionals (Knight et al, 2020a, Knight et al, 2020b, Knight et al, 2020c & Knight et al, 2021). The Birthrights inquiry (2022) called for five main actions at service and policy levels, three of which focused on systemic anti-racism, decolonisation in education and diversity in organisational leadership and therefore, map directly onto the participant generated recommendations of the current study.

Participants of the current study shared their recommendations and ideas for change to reduce maternal health inequalities (please see thematic map in appendix S). Key points are presented in the below figure 5 and form the basis of the implications and recommendations of the current study alongside considerations for future research. Dissemination plans of the current study include multimedia methods for sharing findings, participation in a follow-up podcast recording and potential presentation at relevant conferences and an online community space with a community interest company.

Figure 5

Black Maternal Health Community Framework



Note. This figure is adapted from the Community Resilience Framework (Cafer et al, 2019)

Figure 5 was generated using the shared views of participants and adapted the community resilience framework, which was produced in support of developing community resilience (by Cafer, Green & Goreham, 2019). This model applied to maternity offers a holistic representation of key stakeholders and approaches to support ongoing assessment, monitoring and strengthening of systems around Black maternal health. I will now go through each subheading of the model to outline key recommendations of the current study. The implications described could provide a basis for processes to enable change across policy, clinical settings and within communities.

Policy.

From a political stance Kyriakides (2008) speaks of the need for racism and unconsciously fuelled emotion to be re-defined within law to weave a conscientiousness and consequential approach to policy. Therefore, by locating recommendations of the current study within policy is to seek social justice and invite consideration across multiple levels of the system to guide change. Clinical Psychologists possess skills which can expand individualistic, and team orientated working, to macrolevel working required for policy (Browne, et al, 2020). Skills, including the application of psychological formulations for organisations and structures, working alongside professionals from other disciplines, such as public health to address inequalities and embed community psychology principles, position Clinical Psychologists well to do this work.

Participants spoke about the need to ensure that services are funded appropriately to address the specific needs of Black mothers and birthing people, they spoke of the need to commit to understanding contributing factors of Black maternal health inequalities. This is of importance because failures in government priorities and funding have created within communities, rifts in the fight for addressing ethnicity-based inequalities (Harries et al, 2019). Therefore, a crucial recommendation of this research is for policy makers to embed co-production and collaboration within funding bids for community organisations to create sustainability and inclusivity.

Moreover, participants talked about the importance of ensuring Black mothers and birthing people are included in research and service evaluations, with changes needed to ensure feedback is provided to professionals in powerful positions and acted upon. This can be defined as the appraisal of practice in clinical settings which is used to create the evidence-base, adding relevance and moving away from studies focused of effectivity (Honeycutt et al, 2017). Clinical Psychologists are able to use participatory research and work collaboratively with the communities served, this is considered a suitable way to develop practice-based evidence as it is situated in lived experience and applicable settings (Green, 2008). Recommendations of this study encourage the creation of community-based

Black and ethnically minoritised policy consultation groups alongside healthcare commissioners, local authorities and NHS trust leads. The aim of these groups provide scope to meet the needs of local communities via participatory research projects which inform the development of local policy.

Recommendations from participants also described the importance of representation and diversity amongst people in leadership roles to support key policy decision-making processes. This is relevant to a wider issue across the NHS where it has been found that the highest leadership positions are dominated by people who identify ethnically as White. Without representation mirroring that of local communities and diversity in thinking, health inequalities will remain (Kar, 2021). Supported as a recommendation of this study are the proposals of Kar (2021) to implement mandatory evidencing of diversity in leadership roles, with personal accountability and financial consequences for NHS Trusts and commissioning boards, to generate meaningful change.

Clinical.

Participants emphasised the necessity for improvements within education and the midwifery curriculum to better support the needs of Black mothers whilst understanding differences within culture and applying cultural sensitivity. Hall and Way (2018) highlight the need for midwifery education and the curriculum to align in tandem with innovation in clinical standards of practice, therefore strengthening theory-practice links. Moreover, within higher education and anti-racist offerings, Cole (2022), highlighted the utility of adopting a Critical Whiteness Studies (CWS) position in attempts to apply anti-racist practice. The CWS position seeks to understand colonialism whilst inviting educators to work with internalised and subtle manifestations of oppression. They argue that for this approach to be most useful it must be applied in solidarity with grassroots activism and Black scholarship through synchronised action. Its necessity to support changing practices in higher education through decolonising movements and anti-racist praxis, can only be done when postcolonialism is foregrounded with black feminism and racial capitalism. Therefore, a recommendation of the current study is to

decolonise practice across both education and clinical practice alongside Black scholars and community activists.

Participant generated recommendations stressed the need to humanise and validate experiences and concerns around Black maternal health inequalities. An established part of Clinical Psychologists role within perinatal and maternity services is to provide psychologically informed environments and training to staff teams (BPS, 2016). A recommendation of this research is for professional bodies within Clinical Psychology to work alongside Black and ethnically minoritised women and birthing people, to develop a culturally trauma-informed approach which embeds racial trauma. This is to enhance training and strengthen inclusivity with the intention to foster psychologically informed environments.

Trauma-informed care is important to hold alongside study findings describing the impact of racial and birth trauma. It may be that needs specific to Black women and birthing people who received maternity care during the pandemic, require a more nuanced approach. It cannot be assumed that existing standardised trauma symptom measures will capture this. For example, NHS perinatal mental health services have the option to utilise the City Birth Trauma Scale (Ayers, Wright & Thornton, 2018) which was developed and normed against a 93.3% White ethnicity sample, and at the time of its development authors called for further research for ethnically minoritised groups. Therefore, it is recommended that Clinical Psychologists, research academics and Black peer researchers invest in practice-based research to develop a measure which assesses trauma through a racialised lens and evaluates intervention specifically for Black women and birthing people.

Participants expressed hope for change as located within professionals, including calls for commitment to address biases, discrimination and generate learning. There was a resounding sense that overdue change to professional practice to address inequalities cannot be tackled through training alone. Clinical leadership forms an integral part of Clinical Psychology training and the trajectory of the career path with emphasis placed on service development, supervision and team management (Mason et al, 2016). It has been found that within psychology, having peer supervision which centre multicultural issues of clinical cases are invaluable (Somerville et al, 2019). Although requiring further

research, Scott, O'Curry & Mastrovannopoulou, (2021) found that group debriefs following stressful can be supportive of reducing distress and supporting learning in clinical settings. In turn, another recommendation of this study positions the responsibility for all professionals working within maternity contexts to engage in supervision, reflective practice spaces and clinical debriefs with a focus on anti-racism.

Recommendations from participants also described the importance of accessible, flexible and tailored support across maternity and perinatal mental health, indicating the need to consider wellbeing holistically. In line with the NHS Long Term Plan (2019) Clinical Psychologists are established within perinatal mental health teams and form part of the essential multi-disciplinary approach, often using a bio-psycho-social model in support of individual therapeutic formulations (BPS, 2019). Perinatal service provision guidelines for Clinical Psychologists (BPS, 2016) encourage the use of trauma-focused interventions including cognitive behavioural therapy (CBT), eye movement desensitisation, compassionate mind therapy, cognitive and narrative therapy in perinatal services in support of birth trauma pathways and within Improving Access to Psychological Therapies (IAPT) services, CBT is the only approach offered. In support of attachment and bonding there is a promotion of the use of CBT based approaches, parenting support, video feedback and mentalisation (BPS, 2016). These psychological interventions are in line with the perinatal mental health NICE guidelines (2020) which encourage the use of CBT-based treatments. Although this is the therapeutic landscape, there is scope for further development, Akinyela (2014) proposes that through decolonizing and cultural democracy principles, therapies can push against the euro-centric position of evidence-based therapies. In turn, better meeting the needs of marginalised ethnic groups where using narrative concepts can through creativity, encourage healing (Akinyela, 2014). Recommendations of the current study call for perinatal services form an organised approach for the delivery of therapies such as, the Tree of Life narrative methodology. Systems should seek to support the appropriate use of data collection, for a broader view of practice-based evidence can evolve. There is a key role for Clinical Psychologists to mobilise and show how the approach is more culturally sensitive and honouring of understanding intersectional identities. NICE guidance currently recommends therapies which are not normed on an ethnically

diverse population, and therefore are not responsive to the needs of Black and Brown women and birthing people. Clinical Psychologists hold key roles in consultation, the development and evidencing of therapeutic approaches. Alongside this, commitment is needed within the Clinical Psychology curriculum to ensure teaching specifically reflects racial and birth trauma through a decolonised approach. Finally, the BPS guidance (2016) should strengthen and weave the importance of equality and diversity throughout best practice guidelines to ensure that Psychologists commit to a lifelong journey around unconsciously held biases and engage in anti-racist practice.

Finally, conclusions draw attention to indirect impact of perinatal struggles within the context of the pandemic on infants and birthing partners, indicating potential areas of future unmet need. The discussed role of trauma highlights it's potential for transferability and the collective impact struggles with breastfeeding, bonding and mental health can have on a family unit, particularly within the context of existing and exacerbated inequalities. It is with urgency that service providers and commissioners consider needs of family units to heal and strengthen resilience following the traumatic destruction left in the wake of the pandemic.

Community.

Ideas for change produced by participants requested that professionals explicitly name inequalities in consultations and state intentions to ensure safety. Emphasised was the importance of validation, ethnic representation across the workforce and the need for professionals to prioritise individualised and dignified care. This supports the community values and ethos of a Black-led birthing centre in America who contest that to be most effective in addressing maternal health inequalities is to centre the power and operationalise from a community-informed position (Welch et al, 2022). Recommendations of this research invite maternity services to consider the development of Black led antenatal and postnatal spaces. This could include Black mothers and birthing people as collaborators, alongside empowered Black professionals to curate psychological safety, trauma-informed principles and alleviate fear. Intentions may validate cultural knowledge of birthing lost through coloniality and

reflect within maternity services as a way to address inequalities. Furthermore, another recommendation is the threading of Black women and birthing people's expertise within the development of birth reflections clinics. This could serve as way to respond to participants calls for professionals to highlight in the inequalities rather than increasing the emotional burden of women and birthing people to do this. Finally, culturally informed birth reflection spaces could enable relational safety and physical maternity safety for Black women and birthing people. This could generate healing and improve outcomes for Black infants whilst supporting professionals to develop a deeper understanding of biases in a more organised way. Recommendations such as these could support the validation of antenatal care concerns, offer continuity in care and break cycles of harm by building trust within and between community and services.

Participants highlighted the need for an accessible complaints system which adds weighting and evidence as means to accountability holding. Providers of perinatal mental health and maternity services could address this by developing co-produced leaflets with Black mothers and birthing people. The leaflet could emphasise qualitative facts and outline commitments to improve outcomes, information, areas of resource and signposting. This leaflet could be made accessible and be introduced early in the maternity journey such as, at the antenatal booking clinic.

Jason et al, (2016) outlines some of the gifts from community psychology and from a systems standpoint advocate for research to honour the social support and wellbeing enhancing practices observed within communities. By doing so research findings can be set within frameworks, guidance and models opposed to using theory to offer explanation through a theoretical frame only. Lightbody (2017) outlines the importance of collaboration and community inclusion within the practices of community working, including finding ways to share power, build trust and work together tackle inequalities. Lived experience should be held central and inform a key part of policy changes and work with local commissioners, reflecting individuality and not seeking to reduce inequalities through generic approaches, there will be community specific needs and considerations to be made. For all working within maternity settings, policy makers and commissioners, it is essential that actions and steps taken to address inequalities are done with communities, and not for communities.

Strengths & Limitations

A strength of the current study is that of its unique position, it is the first qualitative research study to explore and primarily centre Black mother's experiences of birthing and postnatal care during the coronavirus pandemic in the UK. This study builds on the existing literature emphasising the importance of gaining insight into Black mothers' experiences during the pandemic particularly given the disproportionate impact on ill-health and mortality (Stacey et al, 2021, John, Curry & Cunningham-Burley's, 2021 & McKinlay et al, 2022). However, the growing evidence pertinent to covid-19 is yet to focus on the nuances of the Black experience. Thus, the current study adds utility through the findings which offer insight at a unique time and link to longstanding maternal health inequalities, and enhances value to the evidence-base in view of the sparse literature. Study completion in turn demonstrates the possibilities and opportunities available when research is inclusive from expert by experience involvement during project development to meaningful engagement with participants and wider online communities. The current study captured experiences of care over a 17-month period, across a number of geographical locations and found shared meanings unique to Black mothers. The findings of the study offer an insight into how Black mothers have experienced care and navigated maternity services within an unpredictable and challenging context, and with the pandemic ongoing, building on this knowledge is crucial. I will now present a critical evaluation of the study focusing on fundamental aspects of the research process including methodology, study sample and recruitment.

Methodology.

Within qualitative research there are different categories of generalisability applicable to RTA (Braun & Clarke, 2022), a strength of the current study is its contextualisation through detailed description of participants and situation which offers the reader the opportunity to assess whether conclusions can be transferred across context and setting. The current study offered a clear rationale for the use of RTA given the aim to capture a diverse sample to gain insight into the variation in impact of

the pandemic across the UK and capture patterned meaning across the data with breadth. Therefore, to capture further depth within a smaller sample and develop findings of the current study, future research could utilise thematic analysis with a phenomenological frame (Braun and Clarke, 2021) or could consider the use of IPA (Smith, 2011) to build and understand subjective meaning-making processes for Black mothers.

Study Sample.

The study sample included thirteen women who self-identified as having Black heritage, recruitment was not focused on one Black sub-group, therefore shifting transferability across all Black subgroups. The use of Black as an identity and inclusion on a self-identified basis did not acknowledge the potentially oppressive and homogenising connotations of using this overarching category as some may consider its roots in racism and elimination of the cultural richness across Black communities and cultures (Kinouani, 2021). Future research may benefit from further understanding nuance and intersectionality further such as, within sub-group ethnicities such as, the Black mixed group, Black African and Black Caribbean, social class and education and how they interact with experiences of care. The current study focused on the experiences of people who identified as Black mothers/women, as discussed in an earlier chapter, the decision around this was influenced by both discussions with experts by experience and also aligned to the language used in vast majority of reports and literature in the topic area. Upon reflection, it is crucial to ensure self-identified birthing people are made to feel visible and needs recognised in healthcare (Kerrpola et al, 2018), therefore a development of this study for future research should focus on the importance of gender-neutral language and support inclusivity of the entire birthing community.

Recruitment.

A strength of the study was the focus on relational ethics throughout the recruitment process including the use of a recruitment video which was positively received. Following interviews, the

feedback from participants about the study spoke of the importance of research to address inequalities and connection between themselves and researcher.

The primary recruitment strategy focused on online opportunities such as email and social media, the advantages of which include accessibility, increasing breadth in reach, cost-effectiveness and efficiency particularly within research where information is commonly sourced online (O'Connor et al, 2013). The use of online platforms was also the most suitable approach given the pandemic context in which the study was conducted with varying guidance and infection control considerations had to be made. However, limitations of online snowballing recruitment include the challenges online recruitment can present for people who do not have readily available Internet access (Bragard, Fisher & Curtis, 2019), meaning that people with lower economic status or contextual factors which limit electronic or telephone device use were unable to access the study.

Future Research

The current study platforms the voices of Black mothers, whose experiences of maternity care and recommendations for service improvement and policy change. As demonstrated in the systematic literature review, this perspective and lived experience has not been represented enough, particularly given the breadth of literature indicating that Black women have the poorest perinatal outcomes. Therefore, future research would value from focusing and strengthening the literature base of the Black experience. This would help relevant services better understand experiences and ways of adapting practice as one way of addressing maternal health inequalities. This aligns with the NHS Long Term Plan (2019) intentions and commitment to learning from near miss and serious incidents to ensure improvements are made. Future research could also benefit from understanding the perspectives and experiences of birthing partners to gain insight into how they feel able to fulfil supportive roles and the potential barriers. These research areas could be enhanced by a participatory action research (PAR) approach which shares power within the process of research, honouring the value of lived experience

via co-researching with experts by experience. This in turn raises voices of marginalised communities supports activism (Doucet et al, 2021).

Additionally, future areas of focus could consider experiences of maternity care specific to national lockdowns during the pandemic and develop knowledge around heightened stressors, coping and perceptions linked to the Black experience. Research could also seek to explore shared identities between Black mothers and Black maternity staff to strengthen understanding around person-focused care and the experiences of delivering care within the wider context of professional, societal and global trauma. Linked to the discussions about study relevance to infant bonding and attachment, future research questions could seek to focus on the perspective of the baby including reflections from birthing mothers about experiences in utero, early weeks of life and developmental milestones to consider the needs of future generations of children and young people.

At the time of writing this report, the government infection control guidance have shifted with less restriction placed on maternity settings. This offers the opportunity for alternative methods of data collection including in-person focus groups which could enable and create a focus of research on the community recommendations of the current study by asking groups about ways to develop communities and peer support specifically for and with Black mothers. The pandemic changes could offer scope for recruitment and data collection in people's homes and community hubs such as Children's centres in support of flexibility and access to participation. Finally, to widen the evidence-base further, the viewpoint of maternity professionals and perinatal community mental health teams could offer an understanding into their experiences, roles and perceptions whilst caring for Black women during the pandemic.

Conclusion

Despite the maternal health inequalities Black women have endured over the years, as illustrated in the systematic literature review. The evidence and research capturing Black mothers experiences and views of maternity services and care is minimal. The current study therefore, aimed to

understand how Black mothers experienced birthing and postnatal care during the covid-19 pandemic. A reflexive thematic analysis uncovered varying experiences of care within the pandemic context laden with uncertainty and change, participants shared the importance of connection and advocacy which facilitated person-focused support. There were expressed challenges whilst birthing and recovering postnatally in maternity settings including that of negligence and the impact of infection control guidance on experiences of care. The pandemic context disproportionately affected Black and Ethnically Minoritised communities presented a wider inequality. Therefore, participants poor experiences of maternity care and service provision were further conceptualised within existing and broader inequalities highlighted within the pandemic, including ethnicity-based stereotypes, intersectional assumptions, racism and the psychological impact this can have. Participants expressed their views of why they experienced the care they did and what may underlie the history of Black maternal health inequalities, perspectives of which located professional and systemic perceptions as entrenched within colonial narratives. Finally, the current study centered participant generated recommendations for service and policy change, with themes identified across accessibility and tailored support, validation and accountability and the importance of working with and strengthening community. These recommendations are for the attention of communities, grassroot organisations, professionals working across maternity and perinatal mental health services, commissioners and policymakers. Societies have changed as a result of the pandemic; therefore, it is important to acknowledge the long-term ripples yet to be seen, the lasting impact and needs specific to this cohort of parents and their families.

Closing Self-Reflexivity

I embarked on this research project knowing that it would require a lot of energy, to have reached the point of submission I am left feeling torn between contrasting emotions. I am excited and honoured to have the opportunity to share participants stories, yet I am frustrated and saddened. This stems from the particularly challenging two years faced by Black communities globally, it’s infuriating

to acknowledge the experiences of Black mothers and indirect impact on their newborns at the hands of structural discrimination. These are sadly not new experiences but reside within a catalogue of evidence and literature that have pointed to inequalities, mistreatment and poor outcomes for Black mothers, for far too long. Yet our voices have been silenced and lived experience ignored. I have moved between feeling hopeless and disillusioned to enthused and connected by people who share the same passion to generate change. Throughout this journey I have noticed myself feeling conflicted by my positioning, I longed to be seen and navigate this journey primarily as mother. However, I acknowledge the responsibility I hold as a researcher alongside this, combined with my lived experiences, has felt a particularly hard balance at times. Yet the connections made, and experiences shared have restored faith not only for change but for the necessity for lived experiences to actively shape and strengthen our communities in the fight for equity in care. I focus on the next steps of sharing this research with intention and renewed hope, that the power of the collective with unrelenting energy can and will fracture the structures that maintain oppression.

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Appendices

Appendix A: Reflective Journal Excerpts

Reflections following interviews:

Hearing, seeing, 'getting it' echoed

Feeling, knowing and understanding struck

I can feel my intergenerational heart ache

The pain is not invisible

You are not invisible

We are not invisible

The disappointment and sadness rippled

Anger turned into intention

Intentions met with support and connection were visceral

Words cannot do justice to the power of community

Community is power

We are power

We walk together to fight this injustice

We will not be silenced

Podcast reflections: It felt so important, connecting and nourishing to be part of the podcast, this research is bigger than me and institutions, its about community and it felt so important to pause and reflect on that today. It felt somewhat cathartic, its very easy to get sucked into the practicalities of research and deadlines that this felt a lovely way to deepen that connection with my personal values and reasons for doing this research. Even if people are unable to take part I hope that listening into the conversation gives people an understanding of what it means to participate in research and build connections and collaboration that we try to hold as a key part of projects but can sometimes feel tokenistic. We touched on this in research supervision and thought about what does it truly mean to have expert by experience involvement, how can we ensure there is a network and not just falling on one person who is impacted by their own context, how can we make the relationship mutual and reciprocal not just for benefit purposes but to work together? Who decides what is adequate EbE input and shouldn't this be defined by people and communities themselves? This will be so individual for each topic that its important to centre this and contextualise it, what is needed and helpful right now.

Analysis, anxiety and me:

Member-checking: why did I not consider this when seeking consent? Feels like a learning point for me, I spent too long questioning whether it fit in with RTA. Myself and my supervisors named the anxiety and lack of confidence surrounding my process of analysis, I was so cautious not to dishonour my participants words or to taint the connections I made. It was feedback that I had been thoughtful and caring but why was I resisting this? A cord struck when I was asked whether it was my lived experience, I noticed from the start that I was resistant to 'research' to my affiliation with an institution and to a profession. There were also observations from supervisors about a potential parallel process unfolding as I questioned myself during the naming of sub-themes. I realised I wanted to talk mother to mother but instead found myself conflicted. I spent time thinking about why this was important and reviewing some of my participants words who spoke of the importance of evidence, the importance of sharing and the need to record things otherwise they did not happen, that shifted me from a place of discomfort to a place of pride and knowing that I needed to embrace this position to utilise my research hat for the better. I realised it was okay because my participants were alongside me, not for one moment did I not hear someone's voice in my mind, as I was writing, as I was reading, that's how close I was to this research and that's how important it is to me. I am a mother with personal experiences and I am also a researcher, they are my gifts.

Appendix B: Prospero Protocol

UNIVERSITY of York
Centre for Reviews and Dissemination

Systematic review

This record cannot be edited because it has been marked as out of scope

1. * Review title.

Give the title of the review in English

A systematic review of Black maternal health inequalities in the UK since 1981

2. Original language title.

For reviews in languages other than English, give the title in the original language. This will be displayed with the English language title.

3. * Anticipated or actual start date.

Give the date the systematic review started or is expected to start.

27/01/2022

4. * Anticipated completion date.

Give the date by which the review is expected to be completed.

28/02/2022

5 [1*change] Stage of review at time of this submission.

This field uses answers to initial screening questions. It cannot be edited until after registration.

Tick the boxes to show which review tasks have been started and which have been completed.

Update this field each time any amendments are made to a published record.

The review has not yet started: No

Review stage	Started	Completed
Preliminary searches	Yes	Yes
Piloting of the study selection process	Yes	Yes
Formal screening of search results against eligibility criteria	Yes	Yes
Data extraction	Yes	Yes
Risk of bias (quality) assessment	Yes	Yes

Data analysis	Yes	Yes

Provide any other relevant information about the stage of the review here.

6. * Named contact.

The named contact is the guarantor for the accuracy of the information in the register record. This may be any member of the review team.

Candice Williams

Email salutation (e.g. "Dr Smith" or "Joanne") for correspondence:

Mrs Williams

7. * Named contact email.

Give the electronic email address of the named contact.

cw19ace@herts.ac.uk

8. Named contact address

Give the full institutional/organisational postal address for the named contact.

University of Hertfordshire

Hatfield

Hertfordshire

AL10 9AB

9. Named contact phone number.

Give the telephone number for the named contact, including international dialling code.

10. * Organisational affiliation of the review.

Full title of the organisational affiliations for this review and website address if available. This field may be completed as 'None' if the review is not affiliated to any organisation.

University of Hertfordshire

11. * Funding sources/sponsors.

Details of the individuals, organizations, groups, companies or other legal entities who have funded or sponsored the review.

Not applicable

Grant number(s)

State the funder, grant or award number and the date of award

12. * Conflicts of interest.

List actual or perceived conflicts of interest (financial or academic).

None

13. Collaborators.

Give the name and affiliation of any individuals or organisations who are working on the review but who arenot listed as review team members. **NOTE: email and country must be completed for each person, unless you are amending a published record.**

Question.

State the review question(s) clearly and precisely. It may be appropriate to break very broad questions down into a series of related more specific questions. Questions may be framed or refined using PI(E)COS or similar where relevant.

Background: Within the context of maternity, it can be hypothesised that ethnicity dictates the risk of complications and probability of dying dating back as early as the 1970s (Ibison et al, 1996). Recent reports indicate that Black women are four to five times more likely to die during childbirth when compared to women who identify as White (Joint Committee on Human Rights, 2020, Knight et al, 2020c). The reasons between ethnic groups and statistical disparities remain unclear with some research indicating contributory factors including physical health conditions and mental health difficulties (Knight el al, 2020c). This urgently calls for justice and change. Therefore, a summary and examination of the evidence base to understand the breadth of health inequalities specifically for Black women/mothers may highlight the gaps in the literature and inform steps to reduce long-standing inequalities.

Review Question: What are the health inequalities that exist in maternity services in the UK as experienced by Black women?

State the sources that will be searched (e.g. Medline). Give the search dates, and any restrictions (e.g. language or publication date). Do NOT enter the full search strategy (it may be provided as a link or attachment below.)

Search strategy: Searches will be conducted on electronic databases including Scopus, MEDLINE, CINAHL Plus, PubMed and PsycArticles

The searches will be carried out between January and February 2022. This search will be run again prior to

publication to consider any further study inclusions.

Restrictions: English and literature published between 1981 and 2022.

17. URL to search strategy.

Upload a file with your search strategy, or an example of a search strategy for a specific database, (including the keywords) in pdf or word format. In doing so you are consenting to the file being made publicly accessible. Or provide a URL or link to the strategy. Do NOT provide links to your search **results**.

Alternatively, upload your search strategy to CRD in pdf format. Please note that by doing so you are consenting to the file being made publicly accessible.

Do not make this file publicly available until the review is complete

18. * Condition or domain being studied.

Give a short description of the disease, condition or healthcare domain being studied in your systematic review.

Maternal health inequalities.

Specify the participants or populations being studied in the review. The preferred format includes details ofboth inclusion and exclusion criteria.

Inclusion criteria:

Population: Women/Mothers who identify as Black.

The study must include women who identify as Black with a sole or primary focus in study findings (either the main participant group or as a focused comparator population alongside one other ethnic group)

Rationale: ethnic category ‘Black’ chosen as used widely in collection of UK demographics for ethnicity. People in this category have the poorest maternal health outcomes.

The terms ‘women/mothers’ chosen as reflective of terminology commonly used in the literature, however will include birthing people assigned female gender at birth who no longer identify in those categories.

Age: Adult (18+). Rationale: To link directly to the context of the empirical study and the ethical considerations for adolescents requiring a specific focus.

Language: English. Rationale: Limitations of research budget and timeline

Dates: 1981-2022. To consider UK health inequalities following the publication of the Black report in 1980 (landmark in social history).

Exclusion criteria:

Studies conducted outside of the UK. Rationale: To focus on the context of the empirical study

The study includes data from a Black participant group but analyses and discusses under the umbrella term 'BAME'

Studies not focused on women's the woman/mothers health (such as, infant health, partners' views and professionals' experiences)

Rationale: To gather literature on the specific population

20. * Intervention(s), exposure(s).

Give full and clear descriptions or definitions of the interventions or the exposures to be reviewed. The preferred format includes details of both inclusion and exclusion criteria.

Interventions: Maternity and perinatal care as delivered by midwives, obstetricians, general medical practitioners and mental health professionals. Inclusive of physical health settings such as, hospitals, in the community, community mental health settings and at home. 'Perinatal' as defined in services delivering care as from pregnancy up to 12 months postpartum.

21. * Comparator(s)/control.

Where relevant, give details of the alternatives against which the intervention/exposure will be compared (e.g. another intervention or a non-exposed control group). The preferred format includes details of both inclusion and exclusion criteria.

Not applicable.

22. * Types of study to be included.

Give details of the study designs (e.g. RCT) that are eligible for inclusion in the review. The preferred format includes both inclusion and exclusion criteria. If there are no restrictions on the types of study, this should be stated.

Types of study: Peer-reviewed journals, articles, books and book chapters, journal summaries of published theses, and randomised controlled trials. Qualitative, mixed methods, and quantitative studies. Rationale: To gather a broad scope of the literature/evidence base and these types of studies support understanding of health outcomes.

23. Context.

Give summary details of the setting or other relevant characteristics, which help define the inclusion or exclusion criteria.

Context: Studies conducted in the United Kingdom. Studies in physical and mental health care of women during pregnancy and in the perinatal period in hospital and community settings and at home addressing physical and mental wellbeing of mothers. Rationale: contextual to the empirical study.

24. * Main outcome(s).

Give the pre-specified main (most important) outcomes of the review, including details of how the outcome is defined and measured and when these measurement are made, if these are part of the review inclusion criteria.

Aim:

To systematically identify research evidence relating to maternal health inequalities for Black women

To review the quality of the existing evidence base.

The review of existing evidence may inform service improvement and policy changes to reduce health inequalities.

Measures of effect

Please specify the effect measure(s) for you main outcome(s) e.g. relative risks, odds ratios, risk difference, and/or 'number needed to treat.

Not applicable.

25. * Additional outcome(s).

List the pre-specified additional outcomes of the review, with a similar level of detail to that required for main outcomes. Where there are no additional outcomes please state ‘None’ or ‘Not applicable’ as appropriate to the review

None.

Measures of effect

Please specify the effect measure(s) for you additional outcome(s) e.g. relative risks, odds ratios, risk difference, and/or 'number needed to treat.

Not applicable.

26. * Data extraction (selection and coding).

Describe how studies will be selected for inclusion. State what data will be extracted or obtained. State how this will be done and recorded.

The studies identified from databases and manual searching will be assessed for inclusion based on title and abstract with relevant records assessed on full text eligibility. Study characteristics recorded will include study title, year, population ethnicity, country and data collection technique. All findings from the eligible studies will be screened reading through the full text to support the selection of final studies which match the inclusion criteria.The final study papers/texts will be downloaded and imported into qualitative analysis software programme NVivo to support the process of coding themes and presentation of data within the review. Where the study is mixed-methods the Bayesian approach (Crandell et al, 2011) will be applied to attribute findings into themes. The final list of studies will also be independently checked="checked" value="1" by a member of the study supervisory team.

27. * Risk of bias (quality) assessment.

State which characteristics of the studies will be assessed and/or any formal risk of bias/quality assessment tools that will be used.

The CASP Quality Appraisal Tool for systematic reviews (2019) and additional checklists which are study type specific including qualitative and case control checklists will be used to assess record quality, bias,

validity and reliability. Alternatively the mixed method appraisal tool (MMAT, 2018) can be used to appraise the quality of five study types; quantitative, qualitative, RCTs, non-randomized studies and mixed methods studies. Half of the sample of the final studies will be checked="checked" value="1" by the supervisory team and referenced alongside completed checklists. Any discrepancy in the review process will be discussed andquality agreed. The quality of the papers will be taken into consideration throughout the review process and summarised in the review report.

Strategy for data synthesis.

Describe the methods you plan to use to synthesise data. This **must not be generic text** but should be**specific to your review** and describe how the proposed approach will be applied to your data. If meta-analysis is planned, describe the models to be used, methods to explore statistical heterogeneity, and software package to be used.

Popay et al's (2006) narrative synthesis approach will be used to summarise and describe the evidence basecomprised of a variety of research which focuses on maternal health inequalities for Black women in the UK. This has been chosen as a suitable approach due to the scoping review informing of a long-standing history of maternal inequalities. The aim of adding a narrative synthesis to this is to support the research to tell a story. This approach can collate the existing research to demonstrate what has been learned over time, look across the evidence base and consider themes or trends for what systemic differences could be made to bring about change to practice and policy to reduce maternal inequality.

29. * Analysis of subgroups or subsets.

State any planned investigation of ‘subgroups’. Be clear and specific about which type of study or participant will be included in each group or covariate investigated. State the planned analytic approach.

None planned.

30. * Type and method of review.

Select the type of review, review method and health area from the lists below.

Type of review

Cost effectiveness

No

Epidemiologic

Yes

Narrative synthesis
Yes

Systematic review
Yes

Health area of the review

Alcohol/substance misuse/abuseNo

Health inequalities/health equityYes

Mental health and behavioural conditionsYes

Pregnancy and childbirth

Yes

31. Language.

Select each language individually to add it to the list below, use the bin icon to remove any added in error.English

There is not an English language summary

32. * Country.

Select the country in which the review is being carried out. For multi-national collaborations select all thecountries involved.

England

33. Other registration details.

Name any other organisation where the systematic review title or protocol is registered (e.g. Campbell, or The Joanna Briggs Institute) together with any unique identification number assigned by them. If extracted data will be stored and made available through a repository such as the Systematic Review Data Repository(SRDR), details and a link should be included here. If none, leave blank.

34. Reference and/or URL for published protocol.

If the protocol for this review is published provide details (authors, title and journal details, preferably inVancouver format)

Add web link to the published protocol.

Or, upload your published protocol here in pdf format. Note that the upload will be publicly accessible.No I do not make this file publicly available until the review is complete

Please note that the information required in the PROSPERO registration form must be completed in full evenif access to a protocol is given.

35. Dissemination plans.

Do you intend to publish the review on completion?

Yes

Give brief details of plans for communicating review findings.?Plan to approach relevant journal for publication.

36. Keywords.

Give words or phrases that best describe the review. Separate keywords with a semicolon or new line. Keywords help PROSPERO users find your review (keywords do not appear in the public record but areincluded in searches). Be as specific and precise as possible. Avoid acronyms and abbreviations unlessthese are in wide use.

Maternal; Inequalities; Black; Women

37. Details of any existing review of the same topic by the same authors.

If you are registering an update of an existing review give details of the earlier versions and include a fullbibliographic reference, if available.

38. * Current review status.

Update review status when the review is completed and when it is published.New registrations must beongoing so this field is not editable for initial submission.
Please provide anticipated publication dateReview_Ongoing

39. Any additional information.

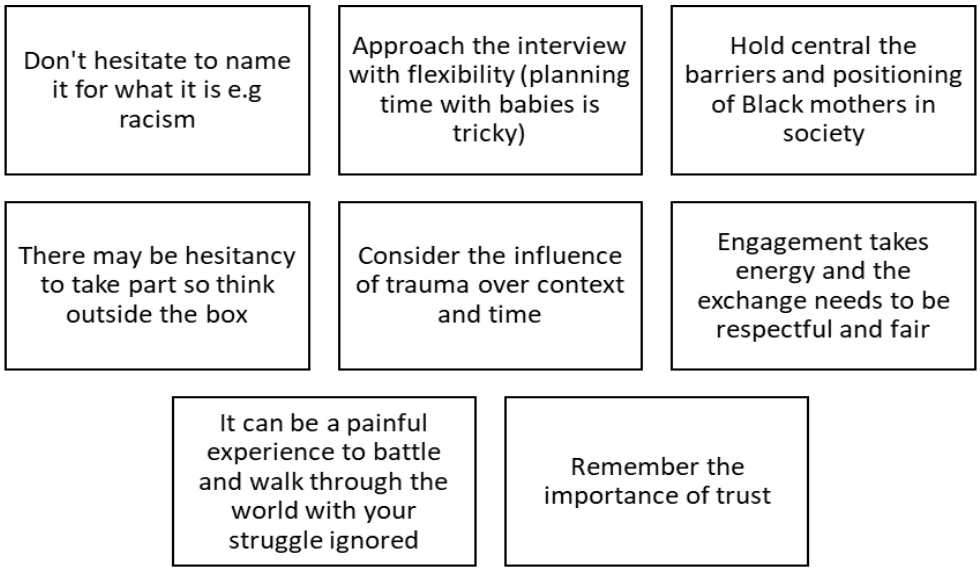
Provide any other information relevant to the registration of this review.

40. Details of final report/publication(s) or preprints if available.

Leave empty until publication details are available OR you have a link to a preprint (NOTE: this field is noteditable for initial submission). List authors, title and journal details preferably in Vancouver format.

Give the link to the published review or preprint.

Appendix C: Key reflections from Expert by Experience and Grassroot Organisation Discussions



Appendix D: Study Recruitment Poster

Appendix E: Participant Information Sheet

UNIVERSITY OF HERTFORDSHIRE

University of Hertfordshire UH Ethics Committee

Participant Information Sheet

Title of study

Black mother's experiences of care received from services during labour and postnatally within the covid-19 context

Introduction

You are being invited to take part in a study conducted by Candice Williams, a Trainee Clinical Psychologist at the University of Hertfordshire. The research is part of my Doctorate in Clinical Psychology. This thesis is supervised by Dr Rachel McKail, who is a Clinical Tutor on the Doctorate in Clinical Psychology.

What is the aim of the study?

The research aims to find out about the experiences of Black mothers who have given birth during covid-19

Why am I interested in this research?

***Trigger warning** (some information outlined below may cause distress)

Longstanding statistics have indicated health inequality and poor outcomes for Black women during the perinatal period. Societal and structural inequity has been highlighted during the pandemic and the context has changed how services have been running and supporting mothers. Little is known about Black mothers' experiences of healthcare in the UK and the pandemic presents another urgent call to address this.

This study seeks to bring together a collective representation of Black mothers' voices to share experiences of labour and postnatal care linking maternity and mental health care service provision. This study is aiming to honour, and platform lived experiences, supporting your ideas to shape and inform changes to policy and service design. I am passionate about reducing these inequalities and raising our voices as mother's.

As a Black mixed mother of two, my personal experiences of distress in childbirth and postnatal recovery are what motivate me to use my position as a Trainee Clinical Psychologist to support the wellbeing of my communities.

I hope to engage in levels of action within my profession, alongside other professionals, policy makers, service providers and the public, to support meaningful change.

Please see video clip link to hear me speak about the research aims and interests
https://vimeo.com/555365353/f9ed8d7f7f

Can I take part in this study?

To take part:

- You need to be a mother who identifies as Black and you have given birth during the coronavirus pandemic (baby was born post-February 2020) and your baby is at least 6 weeks old at the time of interview.
- You will need to be over the age of 18.
- Your participation in this study is entirely voluntary.
- You are free to withdraw your data up to two weeks after your interview but before the data is analysed, without giving a reason.

What does taking part involve?

If you do agree to take part, you will be asked to give your consent to complete an interview as well as some information about yourself (e.g. ethnicity, age and whether the child is their first-born or if you have other children). There will be a short 10-15 minute phone call to discuss your eligibility for the research. If you are eligible and still interested, we will agree to a time and place for an interview. This interview will be no longer than 90 minutes. The interview may be a telephone interview, or a remote interview using video software (e.g. Zoom or other video call software). There will be flexibility to support you to choose a date, time and preferred interview option that best suits you.

What are the advantages of taking part?

As a mother, this is your chance to stand up and be heard, sharing in your words what is important to you. Taking part in this study will offer a chance to contribute to a collective platform of Black mothers' voices and share your ideas and recommendations to support change. If you take part you will receive a voucher of your choice as recognition for the time involved in taking part in the interview.

What are the possible disadvantages of taking part?

During the interview sensitive and/or distressing topics may come up when discussing your experiences, please be assured that the interview can be stopped at any time and we will discuss what the most helpful next step is for you.

Will I be identified if I take part?

All information you provide in this study will be kept anonymous and confidential and will be used only for research purposes. This includes the secure recording and storage of

interviews with demographic information collected being coded against individual participant codes. Your data will be stored in accordance with the Data Protection Act 2018, and only research team will have access to the data. The data will be stored on a password protected computer. An approved transcription service may be used to transcribe your interview. The service will sign a non-disclosure, confidentiality agreement, and recordings will be anonymously labelled. Within the final write-up there may be some short, anonymised quotes which are used to honour your lived experiences, any information which may identify you as an individual will be withheld and/or modified accordingly.

The only limit to confidentiality would be if you share that yourself or someone else is at risk of harm, I have a professional responsibility to help keep you safe. Therefore, we would discuss reasons and intentions to share information and work together to inform the most appropriate agency to best support you.

What will happen to the results of this study?

Research findings will be submitted as part of my doctoral thesis. In addition, I will write up an article for publication in a journal. The research may be presented at conferences and written up for mainstream media, this can also include key people involved in policy making and service development such as local authorities and providers of maternity and mental health services.

Who has reviewed this study?

This study has been reviewed by:

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. Ethical approval for this study has been obtained from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

The UH protocol number is LMS/PGT/UH/04621

Taking part in this study

If you would like to know more and/or you are interested in taking part in this study, please contact me by email (cw19ace@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please contact my supervisor (Dr Rachel McKail at r.mckail@herts.ac.uk) and/or write to the University's Secretary and Registrar at the following address:

Secretary and Registrar University of Hertfordshire College Lane, Hatfield. Herts AL10 9AB

Thank you very much for reading this information and giving consideration to take part in this study.

Appendix F: Consent Form

Consent Form

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE') FORM EC3 CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here*, *in BLOCK CAPITALS]*

……..…

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..……

hereby freely agree to take part in the study entitled *[Black mother's experiences of care received from services during labour and postnatally within the covid-19 context]*

……..

Please read the following statements before you agree to take part in this study.

1) I confirm that I have read and understood the participant information sheet and I understand what my participation in this study involves.

Yes No

2) I understand that my participation is voluntary and that I am free to withdraw up to two weeks after interview but before data analysis (anticipated to be January-March 2022), without giving any reason. If I withdraw from the study, the data that I have submitted will also be withdrawn at my request.

Yes No

3) I understand that the information that I will submit will be confidential and anonymous, used only for the purpose of this study in line with data protection guidance.

Yes No

4) I agree that research data gathered for the study may be published and if this occurs precautions will be taken to protect my anonymity.

Yes No

5) Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.

Yes No

6) I would like to know the outcome of the study and have the opportunity to access a summary of the project.

Yes No

7) I agree to take part in the above study

Yes No

Signature of participant……..…Date……

Signature of (principal) investigator……Date……

Name of (principal) investigator *[CANDICE WILLIAMS]*

……

Appendix G: Demographic Information Sheet

Demographic Information Sheet

Age …….. / prefer not to say

Ethnicity …….

Number of children……../prefer not to say

What month and year you gave birth……..

Region of accessed maternity care in 2020/2021 (tick appropriate)

London		West Midlands	
North East England		South East England	
Yorkshire & the Humber		South West England	
North West England		Scotland	
East of England		Northern Ireland	
East Midlands		Wales	

Appendix H: Ethical Approval & Exit

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Candice Williams
CC	Dr Rachel McKail
FROM	Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chair
DATE	18/06/2021

Protocol number: **LMS/PGT/UH/04621**

Title of study: Black mother's experiences of care received from services during labour and postnatally within the covid-19 context.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Rukhsana Arshad (External/Secondary Supervisor)
[redacted] (Project consultant/expert by experience)

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is

valid: From:

18/06/2021

To:03/06/2022

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Candice Williams
CC	Dr Rachel McKail
FROM	Dr Simon Trainis, Health, Science, Engineering and Technology ECDA Chair
DATE	05/04/2022

Protocol number: **aLMS/PGT/UH/04621(2)**

Title of study: Black mother's experiences of care received from services during labour and postnatally within the covid-19 context

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Rukhsana Arshad (External/Secondary Supervisor)
[redacted] (Project consultant/expert by experience)
Dr Deborah Chinn (Project Mentor)

Modification: Detailed in the approved EC2 application

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and mustbe complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of thisprotocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests,for this study.

Invasive procedures: If your research involves invasive procedures you are required tocomplete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 05/04/2022To:

03/06/2022

Ethics exit Email:

From: Candice Williams [Student-LMS]
Sent: 06 June 2022 15:41
To: hsetecda, UH
Cc: Rachel McKail
Subject: Notification End of Study

Dear UH Ethics Committee colleagues

This is a courtesy email to inform you that the study titled: Black mother's experiences of care received from services during labour and postnatally within the covid-19 context, has now come to an end. Protocol number: aLMS/PGT/UH/04621(2)

Thank you for your support, for reference please find attached a draft abstract of the study, many thanks.

Kind Regards
Candice
Candice Williams

Appendix I: Distress Protocol

The researcher will intervene if the participant is:

- Experiencing anxiety or distress during the interview. The participant will be asked if they would like to take a break and if they wish for the audio-recorder to be switched off.
- Continuing to show signs of upset. The participant will be asked if they would like the interview to end and if they would like the researcher to support them to call someone to spend time with them, such as a family member or friend.
- Unduly distressed. The researcher will remain with the participant until they are calm and composed. The participant may then decide to continue with the interview or not.

The interview will be terminated if:

- The participant decides to terminate the interview.
- The participant decides to participate in the interview at another time or place.
- The researcher considers the levels of distress too high and the interview process as not supportive.

The researcher will, with the participant's consent:

- Discuss the potential support services available for them to access.
- Seek permission and ask if they would like a family member, friend or someone from the local community to call them to offer support.
- Relevant contact details and places of emotional support will be provided to all participants.

The researcher will:

- Use their professional duty of care and code of conduct accordingly, if there is high risk of serious harm, the researcher will contact services such as, emergency services, to support and keep the participant safe.

Appendix J: Participant Debrief

Participant Debrief

Debrief Sheet

Your interview is now complete.

Thank you for giving your time to take part in this research project. I hope this research will help improve understanding of the experiences of Black mothers' during labour and postnatal care and service provision during the pandemic with relevance now and in future.

The information that you have provided will be kept confidential. All data will be safely destroyed after the completion of the research. You are free to withdraw up to two weeks after your interview but before the data is analysed, without giving a reason. Any data provided will not be used in the results if you do withdraw before the analysis takes place.

If participation in this research has caused you any distress, discomfort or feelings that feel difficult to process, you may wish to contact immediate sources of support such as your family, friends, GP or a mental health professional.

If you would like further support, please find below the details of some organisations that may be useful. These sources of support will be able to help you regarding any concerns or worries you have regarding your emotional and psychological wellbeing.

Your GP

Please consider contacting your GP if you are feeling distressed.

Psychological therapies

If you think that you may benefit from engaging in a talking therapy then you may wish to consider self-referring to your local psychological therapies service or asking your GP to refer you.

To find your nearest service, you can search on the NHS choices webpage:

https://www.nhs.uk/Service-Search/Psychological-therapies-(IAPT)/LocationSearch/10008

NHS Choices
If you're worried about an urgent medical concern, call 111 and speak to a fully trained adviser.
Website: https://www.nhs.uk/pages/home.aspx Helpline: 0113 825 0000

Samaritans

This is a 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress. Freephone: 08457 90 90 90 Website: www.samaritans.org

Lifeline (Northern Ireland)

This is a 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress in Northern Ireland. Freephone: 0808 808 8000 Website: https://www.lifelinehelpline.info

National Perinatal Support

The Motherhood Group (Black maternal peer support and advocacy) website: https://www.themotherhoodgroup.com/

Fivexmore (Black Maternal health campaign) website: https://www.fivexmore.com/

PANDAS Foundation (PND Awareness and Support) phone 0808 1961776 (daily 11am to 10pm), website: www.pandasfoundation.org.uk

Action on Postpartum Psychosis (for anyone affected by postpartum psychosis) www.app-network.org

Perinatal Positivity (information and community signposting for people experiencing mental ill-health) http://perinatalpositivity.org/support/

The Association for Post Natal Illness (informal post-natal support) https://apni.org/

Birthrights (information and advice organisation for human rights in pregnancy and childbirth) https://www.birthrights.org.uk/about-us/

The Birth Trauma Association (information and advice for women who have experienced traumatic births) https://www.birthtraumaassociation.org.uk/for-parents/what-is-birth-trauma

Webinars

Perinatal mental health and covid-19

https://www.hampshirethamesvalleyclinicalnetworks.nhs.uk/perinatal-mental-health-covid19-webinars/

https://www.wellbeingofwomen.org.uk/news/webinar-looking-after-your-mental-health-before-and-after-pregnancy

https://www.lincslmc.co.uk/perinatalmentalhealthwebinar

https://www.hpft.nhs.uk/information-and-resources/coronavirus/advice-on-coping-with-coronavirus/

https://sandwellandwestbhamccg.nhs.uk/sustainability-and-transformation-partnership-stp/stp-news/2337-black-country-perinatal-community-mental-health-service

Resources

Mum’s Matter (Mind) website: https://www.mind.org.uk/information-support/mums-matter/

Postnatal Depression (Birmingham & Solihull NHS) website: http://www.selfhelpguides.ntw.nhs.uk/bsmhft/leaflets/selfhelp/Postnatal%20Depression.pdf

Self-help workbook (University of Exeter) website: http://psychology.exeter.ac.uk/pmh/

Please see overleaf a list of services divided by different areas of the UK, feel free to look into any organisations or areas of support relevant to you should you wish.

Once again thank you for your time, energy and effort.

Area specific services

Access to Perinatal NHS services is usually via your GP referral, some services accept self-referrals please check websites for further details

Scotland

Perinatal Mental Health Team (covering Greater Glasgow & Clyde) website: https://www.nhsggc.org.uk/your-health/health-services/mental-health-services/other-services/west-of-scotland-mother-and-baby-unit/community-perinatal-mental-health-team/

Perinatal Community Mental Health Team (covering Lothian) website: https://services.nhslothian.scot/Maternity/PregnantWhatNext/Pages/Mental-Health.aspx

Perinatal Mental Health Service (covering Lanarkshire) website: http://www.elament.org.uk/perinatal/

Maternal Mental Health Scotland (peer support, information and resources) website: https://maternalmentalhealthscotland.org.uk/

Perinatal and Infant Mental Health fund (information and directory of services) website: https://www.inspiringscotland.org.uk/perinatal-mental-health-services/

Northern Ireland

Community Mental Health Perinatal Team (covering Belfast) website: https://belfasttrust.hscni.net/service/community-mental-health-perinatal-service/

CAUSE (peer-led support service for families experiencing mental health distress) website: https://www.cause.org.uk/

Wales

North Wales Perinatal Mental Health Service (covering North Wales) website: https://bcuhb.nhs.wales/health-services/health-services1/services1/services/mental-health/perinatal-mental-health/

Perinatal Mental Health Services (covering South Wales) website: https://cwmtafmorgannwg.wales/services/adult-mental-health-test/inpatient-2/prams/

PRAMS (peer support for parents based in Wrexham) website: https://en.infoengine.cymru/services/prams-parental-resilience-and-mutual-support?utm_source=infoengine_widget&utm_medium=embe

North East

The Perinatal Community Mental Health Team (covering Newcastle, Gateshead, North Tyneside, Northumberland, Sunderland and South Tyneside) website: https://www.cntw.nhs.uk/services/perinatal-community-mental-health-service-community-ashgrove/

Tees, Esk and Wear Valleys NHS Perinatal Community Mental Health Team (covering Teeside) website: https://www.tewv.nhs.uk/services/perinatal-community-mental-health-team-teesside/

Tees, Esk and Wear Valleys NHS Perinatal Community Mental Health Team (covering County Durham and Darlington) website: https://www.tewv.nhs.uk/services/perinatal-community-mental-health-team-county-durham-and-darlington/

North East Counselling Service (private counselling service with services for parents) website: https://necounselling.org.uk/privatecounselling/

Raindrops to rainbows (perinatal peer support for mothers and fathers) website: https://raindropstorainbows.co.uk/about/

North West

Cheshire and Mersey Specialist Perinatal Service (covering Halton, Knowsley, St Helens and Warrington) website: https://www.nwbh.nhs.uk/specialist-perinatals

Specialist Perinatal Community Mental Health Team (covering Lancashire & South Cumbria) website: https://www.lscft.nhs.uk/perinatal-accessing-our-service

Perinatal Community Mental Health Team (covering Greater Manchester) website: https://www.gmmh.nhs.uk/perinatal-community/

Perinatal Community Mental Health Team (covering North Cumbria) website: https://www.cntw.nhs.uk/services/perinatal-community-mental-health-team-north-cumbria/

Perinatal Community Mental Health Team (covering Newcastle, Gateshead, North Tyneside, Northumberland, Sunderland and South Tyneside) website: https://www.cntw.nhs.uk/resource-library/perinatal-community-mental-health-team/#:~:text=The%20Perinatal%20Team%20provides%20a,history%20of%20severe%20mental%20illness.

Parents in Mind St Helens (peer support for women at pre and postnatal stages) website: https://www.nct.org.uk/about-us/commissioned-services/parents-mind-perinatal-mental-health-peer-support/parents-mind-halton-and-st-helens

Black Mum Magic Project (based in Merseyside and Cheshire) website: https://www.improvingme.org.uk/community/black-mum-magic-project/

Yorkshire and the Humber

Humber Teaching NHS Foundation Trust (covering Hull, East Riding, North Lincolnshire and North East Lincolnshire) website: https://www.humber.nhs.uk/services/perinatal-mental-health.htm

Light Peer Support (peer support for parents at pre and postnatal stages) based in Sheffield, website: https://lightpeersupport.org.uk/

Specialist Mother and Baby Mental Health Service (covering Bradford, Airedale, Wharfedale & Craven) website: https://www.bdct.nhs.uk/services/specialist-mother-baby-mental-health-service/

Sheffield, Rotherham and Doncaster Perinatal Mental Health Service (covering Sheffield,

Rotherham & Doncaster) website: https://www.rdash.nhs.uk/services/our-services/adult-mental-health-services/sheffield-rotherham-and-doncaster-perinatal-mental-health-service/

Perinatal Mental Health Team (covering North Yorkshire & York) website: https://www.tewv.nhs.uk/services/north-yorkshire-and-york-perinatal-mental-health-service/

South West Yorkshire Perinatal Mental Health Team (covering Barnsley, Calderdale, Kirklees & Wakefield) website: https://www.southwestyorkshire.nhs.uk/services/perinatal-mental-health-team/

Perinatal Mental Health Team (covering Leeds) website: https://www.leedsandyorkpft.nhs.uk/our-services/perinatal-service/

Mummy Buddy (peer support groups and classes for mothers in Leeds) website: https://www.mummybuddy.org.uk/

Women's Counselling and Therapy Service (offering free and low cost therapy for mothers from disadvantaged backgrounds) based in Leeds, website: https://www.womenstherapyleeds.org.uk/

West Midlands

Perinatal Mental Health Service (covering Coventry & Warwickshire) website: https://www.covwarkpt.nhs.uk/perinatal-mental-health/

Herefordshire Perinatal Mental Health Team (covering Herefordshire) website: https://www.hacw.nhs.uk/services/service/perinatal-mental-health-team-herefordshire-137/

Perinatal Mental Health Service (covering Birmingham & Solihull) website: https://www.bsmhft.nhs.uk/our-services/specialist-services/perinatal-mental-health-service/

Perinatal Community Mental Health Team (covering South Staffordshire) website: https://www.staffordshireconnects.info/kb5/staffordshire/directory/service.page?id=Ki9QU6X8w04&localofferchannel=0

Perinatal Community Mental Health Team (covering Staffordshire) website: https://www.mpft.nhs.uk/services/mental-health-perinatal-community

Birmingham Acacia Family Support (pre and postnatal depression support service) website: https://www.acacia.org.uk/

Parents in Mind peer support for pre and postnatal women covering Coventry, Leamington, Stratford, Nuneaton & Rugby, website: https://www.nct.org.uk/about-us/commissioned-services/parents-mind-perinatal-mental-health-peer-support/parents-mind-coventry-warwickshire

Sunflower Family Support Group (peer support postnatal group based in Staffordshire) website: https://www.facebook.com/sunflowerfamilysupport/

East Midlands

Lincolnshire Perinatal Team (covering Lincolnshire) website: https://www.lpft.nhs.uk/

The Northamptonshire Specialist Perinatal Mental Health Service (covering Northamptonshire) website: https://www.nhft.nhs.uk/perinatal

Derbyshire Healthcare Perinatal Mental Health Team (covering North and South Derbyshire) website: https://www.derbyshirehealthcareft.nhs.uk/services/mental-health-and-emotional-wellbeing/perinatal-mother-and-baby-services

Nottinghamshire Perinatal Services (covering Nottingham, Worksop, Newark on Trent and Sutton in Ashfield) website: https://www.nottinghamshirehealthcare.nhs.uk/perinatal-services

Open House Nottingham (peer support group for mothers living with postnatal depression) website: http://openhouse-notts.org/

Leicestershire and Rutland Perinatal Community Mental Health Team (covering Leicester City, Leicestershire and Rutland) website: https://healthforunder5s.co.uk/leicestershire/services/specialist-support/the-perinatal-mental-health-service/

Mum's Mind (Leicestershire Mum's text chat service) **07507 330 026** https://healthforunder5s.co.uk/leicestershire/services/specialist-support/mums-mind-perinatal-mental-health-support-service/

Birth and Beyond Community Support (voluntary peer support service for women who are pregnant and have children under the age of two) covering South Lincolnshire, Peterborough and Wisbech

FWT Perinatal Mental Health BME Peer Support (based in Coventry) website: http://www.fwt.org.uk/health/perinatal-mental-health-project/

South East

The Buckinghamshire Perinatal Team (covering Aylesbury, Amersham and Chesham, Wycombe,

Woburn Green and Southern Buckinghamshire) website: https://www.oxfordhealth.nhs.uk/buckinghamshire-perinatal-mental-health-service/

Oxford Perinatal Mental Health Team (covering Oxfordshire, Buckinghamshire, Wiltshire and Bath & North East Somerset) website: https://www.oxfordhealth.nhs.uk/oxfordshire-perinatal-service/

Southern Health Perinatal Mental Health Team (covering Portsmouth, Hampshire, Isle of Wight and Farnham) website: https://www.southernhealth.nhs.uk/services/mental-health/specialist-mental-health-services/perinatal-mental-health-services/

Mother and Infant Mental Health Service (covering East Kent) website: https://www.kmpt.nhs.uk/our-services/mother-and-infant-mental-health-service-mimhs-east-kent/

Maidstone and Tunbridge Wells NHS Trust Perinatal Mental Health Service, website:

https://www.mtw.nhs.uk/service/maternity-old/your-pregnancy/perinatal-mental-health/

East Sussex Perinatal Mental Health Service (covering East Sussex, West Sussex, East Surrey, Brighton & Hove) website: https://www.sussexpartnership.nhs.uk/perinatal

Berkshire Perinatal Mental Health Service (covering Bracknell, Windsor ascot, Maidenhead, Slough, Reading, Wokingham & Newbury/West Berkshire) https://www.berkshirehealthcare.nhs.uk/our-services/mental-health-and-wellbeing/perinatal-mental-health/

SHaRON (online parenting support network) accessed via professional referral email: gateway@berkshire.nhs.ukEast of England

Surrey and Borders NHS Partnership NHS Foundation Trust (covering East Surrey and North East Hampshire) website: https://www.sabp.nhs.uk/our-services/mental-health/perinatal/contact/perinatal-north-west

Parent-Infant Mental Health Service (covering Surrey) website: https://childrenshealthsurrey.nhs.uk/services/parent-infant-mental-health-service

South West

Perinatal Mental Health Team (covering Bristol, South Gloucestershire and North Somerset) website: http://www.awp.nhs.uk/services/specialist/perinatal-units/

Perinatal Mental Health Team (covering Dorset) website: https://www.dorsethealthcare.nhs.uk/patients-and-visitors/our-services-hospitals/mental-health/perinatal-mental-health

Specialist Perinatal Mental Health Service (covering Cornwall) website: https://www.cornwallft.nhs.uk/perinatal-mental-health-team/

Devon Perinatal Mental Health Service (covering Devon, Exeter, Torbay and South Hams)

website: https://www.dpt.nhs.uk/our-services/pregnant-women-and-new-mothers/accessing-the-service

Perinatal Mental Health Service (covering Gloucestershire) website: https://www.ghc.nhs.uk/our-teams-and-services/perinatal-glos/

Perinatal Mental Health Service (covering Somerset) website: https://www.somersetft.nhs.uk/perinatal-mental-health/

Perinatal Mental Health Service (covering Plymouth) website: https://www.livewellsouthwest.co.uk/project/perinatal-mental-health-team

Make a move (community group sessions to support emotional wellbeing for mothers experiencing low mood and perinatal depression) covering Bath and North East Somerset, website: www.makeamove.org.uk

My time, my space (creative sessions offering emotional support through art for women with postnatal depression), based in Somerset, website: https://www.creativityworks.org.uk/what-we-do/for-mental-health/my-time-my-space/

Open space (psychotherapy postnatal support group) website: http://www.dominibarry.com/postnatal-support-groups

Appendix K: Interview Guide

Interview Guide

Introduction

As we discussed this interview forms part of my data collection for my thesis which is focusing on experiences of labour and postnatal care during the pandemic.

Just to remind you that we can take a break at any time during the interview if you need to. I will offer you a break during the interview, but please ask if you would like us to pause. We can break the interview into smaller parts and finish it on another day if you need to.

Sometimes talking about personal experiences can bring up difficult emotions so please let me know if the interview is feeling too overwhelming and you would like to stop for a while, or you do not want to answer a specific question/topic. If you wish to stop the interview completely, that's okay. I will offer you a break if I think that it is becoming upsetting.

With regards to the interview questions themselves, I will be asking about the care you received and service provision during labour and postnatally, the wider context of 2020 and the recommendations or ideas you have for service improvement. Just a gentle reminder I am not asking about details of childbirth but focusing on experiences of care.

It may feel unusual in that some of my questions may appear very obvious or explicit in wording, this is because I can't make assumptions about what you mean and I want to capture your story, in your words as much as possible.

Before we get going I also want to check-in about use of [platform], I know we discussed this briefly on the phone but just a reminder that should we get into any technical difficulties or there are moments we can't hear each other please use the chat function and if our call ends suddenly can I just check it's okay to call you on the same number as before to see where we go from there? Do you have any questions before we start? When you are ready I will start recording. Just to let you know I will keep recording until the very end of the call.

Questions around the context and care received during labour

I will firstly be asking about your experiences of care received during labour

1. Can you tell me about your experiences of the care you received during labour? What was it like for you?
2. What, if anything was a helpful aspect of the care you received during labour? Can you tell me more about these experiences?
3. What if anything, hindered or were unhelpful aspects of the care you received during labour? Can you tell me more about these experiences?

Prompts:

- You said…what was it about covid that influenced this experience for you?
- Why do you think that was your experience of care?
- Can you tell me about anything else that influenced your experience during this time, any changes physically and/or emotionally that contributed to this?

- What was it about being a Black woman that may have influenced your experience or expectations of labour care?
- Clarify around meaning- why that was- what makes you say that? What made you think? What about the situation influenced your experience?

The context and postnatal care

1. Can you tell me about your experiences of the care you received after you had given birth and during postnatal recovery?
2. What, if anything was a helpful aspect of the care you received postnatally? Can you tell me more about these experiences?
3. What if anything, hindered or were unhelpful aspects of the care you received postnatally? Can you tell me more about these experiences?

Recommendations and suggestions for policy and service change

This section of the interview is focused on how the experiences you have shared can influence policy and service change. During our interview, you mentioned receiving care from [summarise services/care received] Did you received any other labour or postnatal care?

1. How do you hope that professionals support Black women during labour and postnatally?
2. What ideas do you have to improve labour and postnatal service provision including physical health and mental health support, for Black women?
3. Research has shown that there is inequality for Black women in the care received during labour and postnatally. Do you have any views about why these inequalities exist? Can you tell me your suggestions for what can be done to reduce these inequalities?

Prompts

- How do you hope services respond to the needs of Black mothers?
- How do you hope services support equity of care and access to support for Black mothers?
- What can services do differently?
- What do you think the inequalities are?

<u>Ending</u>

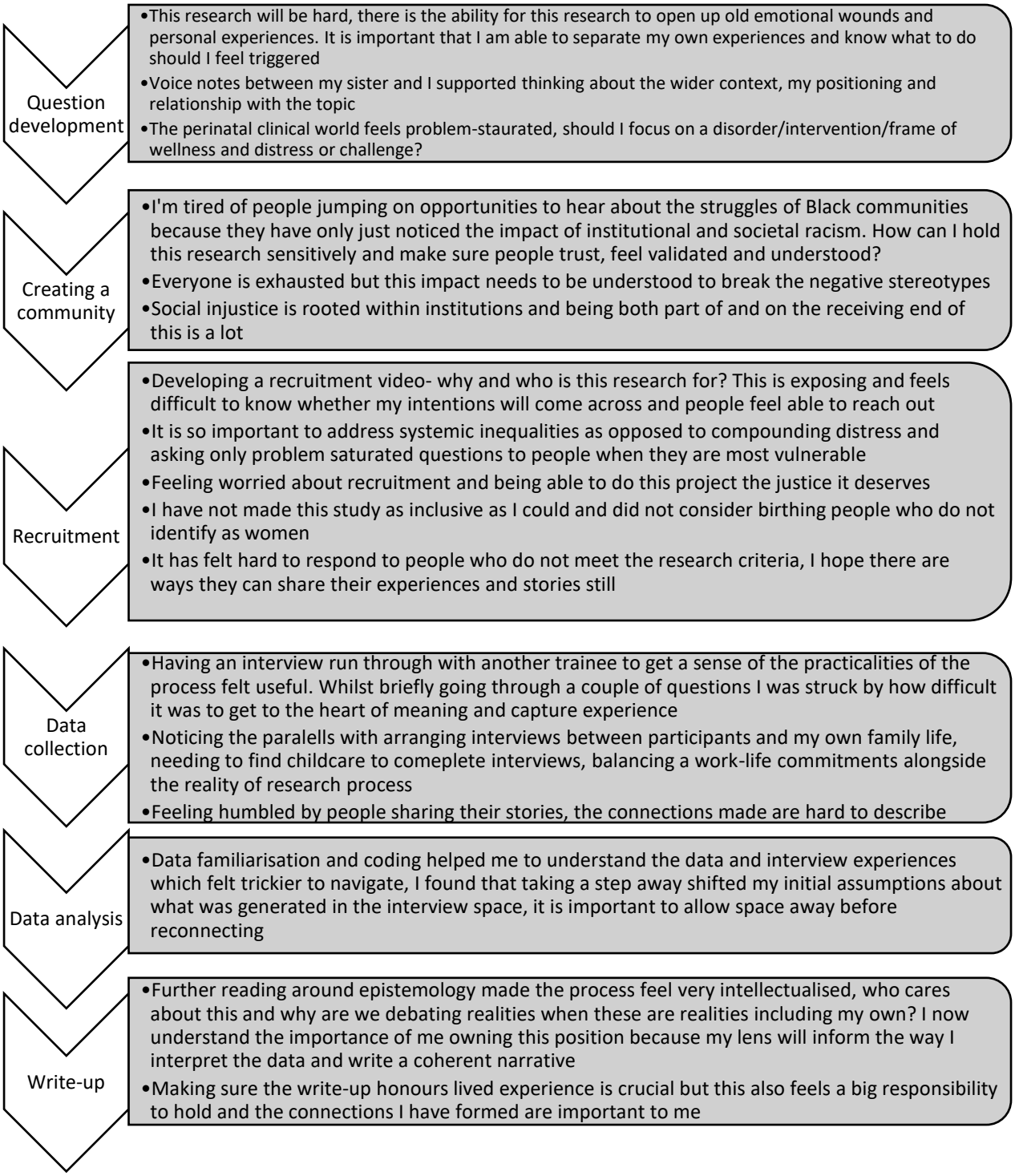
We have now come to the end of the interview and are in the debrief section, thank you for sharing your experiences with me today it has been a real privilege to hear your personal story.

How has it been for you talking with me and being part of this research today?

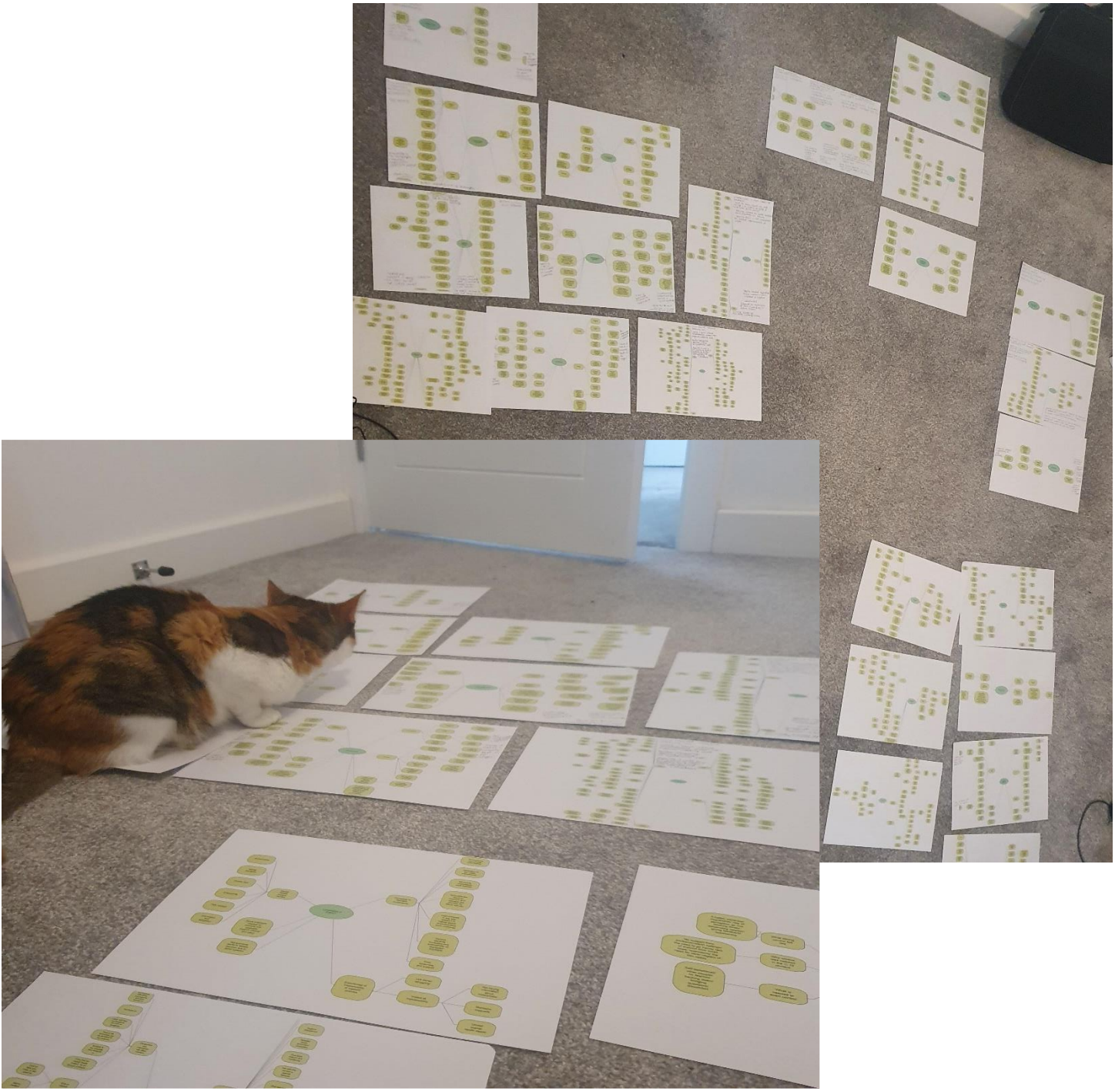
Before I stop recording is there anything else you wish to share?

Appendix L: Reflective Diary Timeline

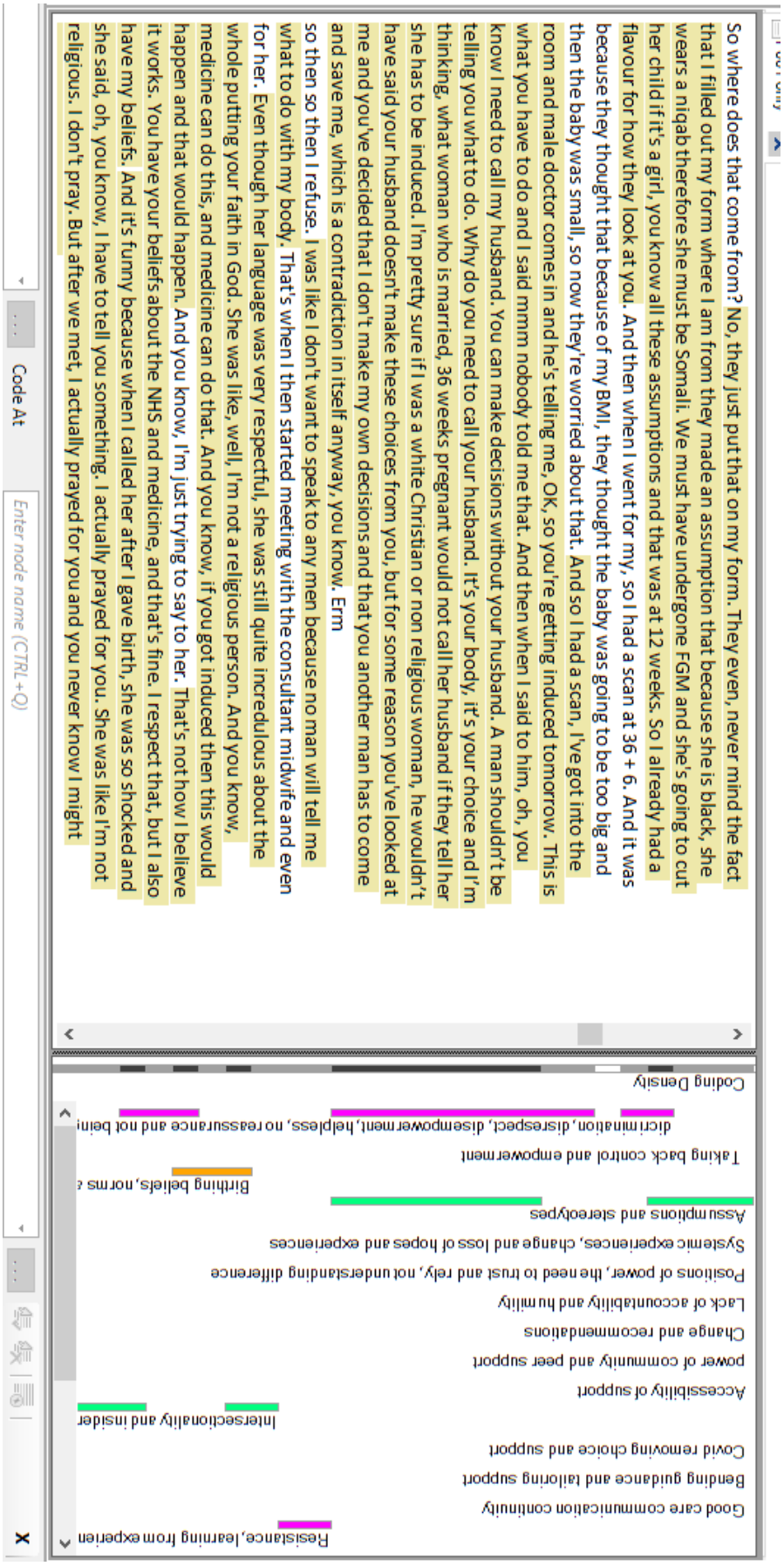
Reflective Diary Timeline



Appendix M: Reviewing Codes and Maps



Appendix N: Transcript Extracts and Nvivo Coding



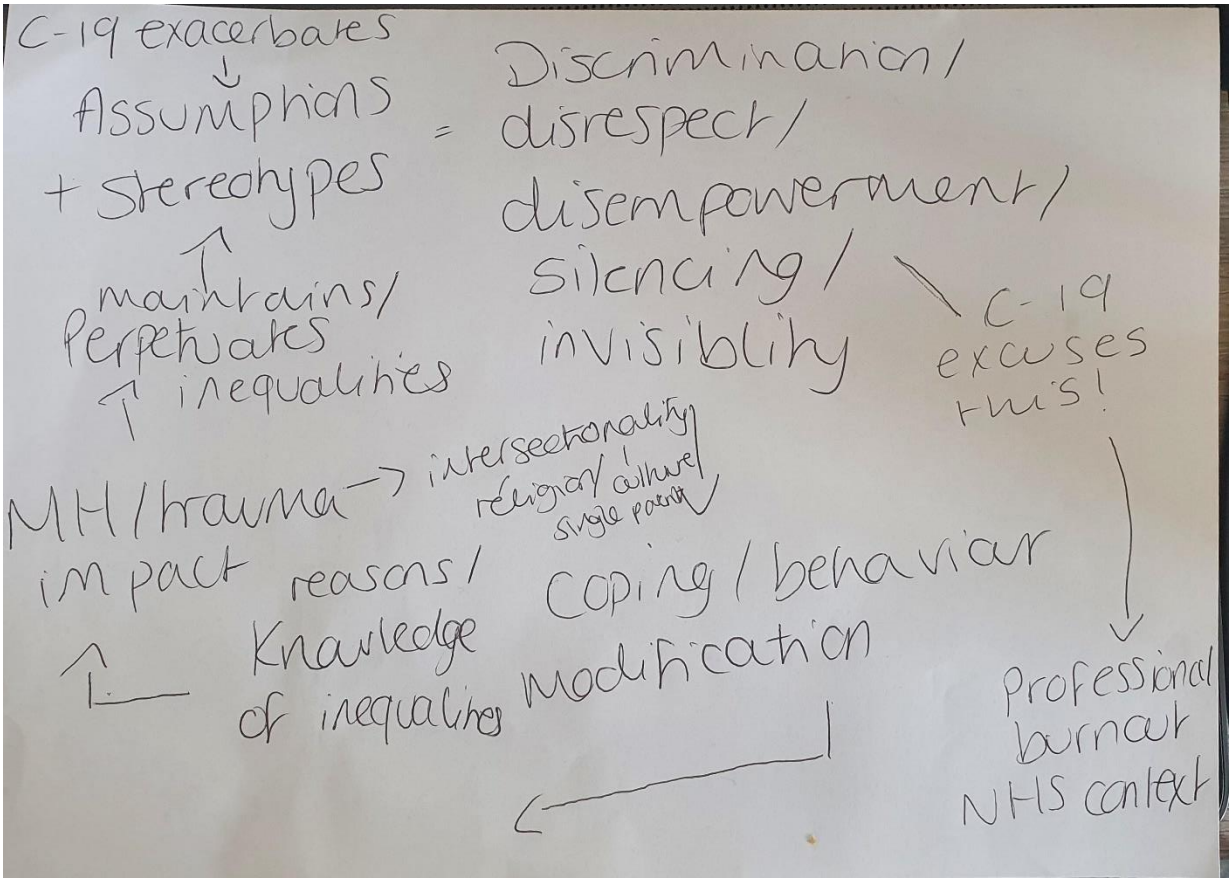
Number one because they're racist, number 2 because their Islamophobic and number 3 because they don't know what normal birth looks like. Erm in terms of racism, we all know about institutional racism. They don't believe that we were in pain when we say we are. They don't believe that we look after our children or our bodies like they do. They don't understand that our bodies might look and work differently than theirs do. They almost. What's the word? Fetishise us at times. In terms of the Islamaphobia they see it as a Muslim woman, I am oppressed. They think that a man is controlling me and their remedy to that is to tell me what to do and to get a man to tell me. And then when it comes to birth. Ultimately, you know I always say to people, why do you go to hospital? You go to hospital because there's something wrong with you and you need to be fixed. Giving birth is one of the most natural things you do. Giving birth has happened for as long as time has existed. There was nothing wrong with me and I don't need to be fixed. Therefore I don't need to be in hospital. But I think when you put you know, I mean when you take one of those things you have a problem, but when you put all three of those things together. They have no box to put you in because I think also there's a stereotype that only white middle class women have home births. So when. So if you're a white middle-class woman, they might kind of understand why you want to have a homebirth, but when you don't fit into that group they were like hhmm OK. Well, this is a little bit of that, and she's a little bit of that. But she doesn't do that thing that I think that those people are supposed to do so. I don't know what to do with her. I don't know how to treat her, you know, and I think one thing is, most women in my experience are uneducated about birth, so it's very easy for them to tell you do this. Do that. Take this, eat that. Come here, go there, because most women just say yes, Sir, no Sir. 3 bags, full Sir, they're just so grateful that somebody's gonna come along and, you know, take away all this pain and anguish for them, whereas for people like me who are educated on birth where like no, I don't want that. No I'm not gonna eat that. No thank you. I don't want those medicine and they're like, oh, you know, even like I remember being berated by a midwife. She was she was doing like that checklist. Have you done this, are you
Coding Density
Resistance, learning from experience and self trust
Good care communication continuity
Bending guidance and tailoring support
Covid removing choice and support
Intersectionality and insider knowledge
Accessibility of support
power of community and peer support
Change and recommendations
Lack of accountability and humility
Positions of power, the n
Systemic experiences, change and loss of hopes and experiences
Assumptions and stereotypes
Birthing beliefs, norms and expectations
Taking back
dicrimination, disrespect, disempowerment, helpless, no reassurance and not being heard,

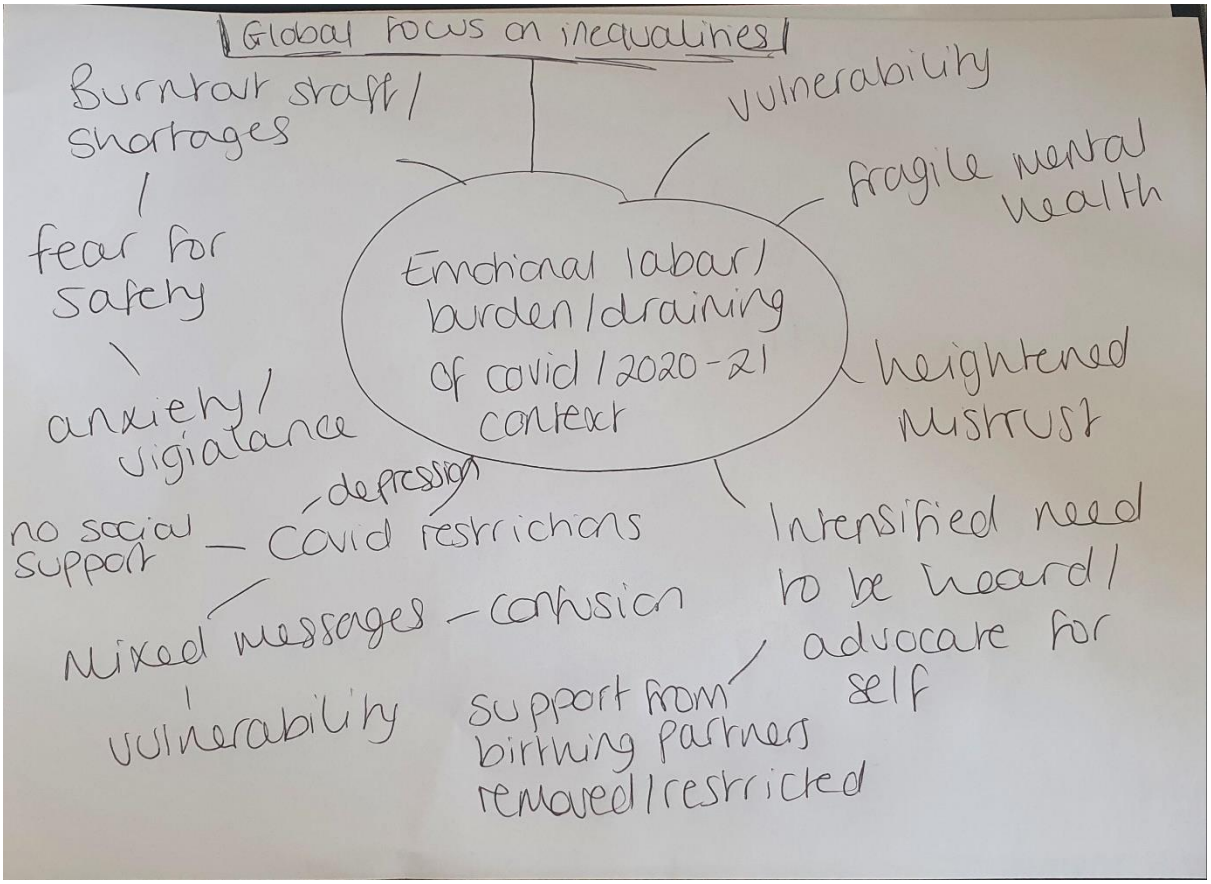
Sharing stories and interview experience
Positions of power, the need to trust and rely, not understanding difference
Taking back control and empowerment
Perceptions of pain
Antenatal journey
Birthing beliefs, norms and expectations
Good care communication continuity
Vulnerability, loneliness and
impact of trauma
Covid removing choice and support
Covid impact on setting and staff
Systemic experiences, change and loss of hopes and experiences
Cultural narratives, stigma and family supportsocial services
Assumptions and stereotypes
discrimination, disrespect, disempowerment, helpless, no reassurance and not being heard, i
Change and recommendations
power of community and peer support
Bending guidance and tailoring support
Accessibility of support
Representation matters, shared identity and understanding
Mental Health and emotions
Intersectionality and insider knowledge
Covid impact on postnatal care
Coding Density
hospital for the induction because I didn't want to go, my appointment was spli
and I was just taking my sweet time. Because I was just like do I have to. I don't
really want this, it just felt like something I didn't want. I didn't feel like my baby
was ready to come out. And I asked the consultant I said if you're so worried
about me, she is at the right percentile and I'm not big. Can't you scan me one last
time? If you're concerned I can come for another scan this week, you're saying to
me that oh at 39 weeks you are at risk of still birth but you've just scanned me
right now and everything is fine. I can have one more scan and just come in.
But she said, oh because of covid we might not have the staff. And secondly, what
if you got covid then it's gonna be really bad. So I I I need to do benefit outweighs
the risk. You need to have your child when you are well, and when we've got staff
so I can't report OK, fair enough. So it's a clinical decision. So I arrived late and
when I arrived late I settled into. I actually cried when my family left me at the
door. They didn't see me, but I started crying because I felt all alone because
there was no visitors.
And I'm thinking I'm not even allowed to necessarily see the wards because of
covid it's closed. So when I went in, the interesting thing is that they knew I was
coming at 4 but I was on my own for a long time.
Uh, so I was on my own until I think they only started to properly admit me into
and do my paperwork in the evening I think when the night staff came on so the, I
arrived at 4pm and was shown my bed, welcome welcome I just see myself in,
dinner came I had dinner and the midwife, I'd seen I didn't see again. Because they
were attending to the other women who had been induced and it's only the night
Code At
Enter node name (CTRL+Q)

Yeah, I do think that did play a lot I think, as they say Black women are stronger and they kind of have this notion with it. And, I mean, even down to I had pre-eclampsia and an infection after I gave birth so I was nil by mouth for 24 hours and my painkillers after having major surgery was, I was only given paracetamol and I think like ibuprofen which for the first 24 hours I didn't feel anything anyway because I still, the aesthetic was still there. But because I couldn't drink anything I was only allowed two dribbles of water to take the medication and then they gave me, ice, which they did top up quite regularly. But they told me to savour the ice because obviously if I take it too quick then I've taken in too much liquid. The following day is when the pain started to kick in, I thought it was great I thought oh my gosh, is this what you feel like after major surgery I haven't got any pain, and then anaesthetic wore off and then I would literally be screaming in pain I would ask oh I need something stronger. And I think I think I got the liquid morphine probably about twice and I think I got codeine, a couple of times that was mainly from there was a nurse that looked after me who looked after me a few times on the prenatal ward, think she said, I think she was mixed race and we got along really really well, and recovery was her main ward she said so she was there for, I think I was there for maybe two nights and she was just amazing. Anything I needed when I was in pain she gave to me, even down to, I didn't see my daughter for the first 24 hours, because they couldn't wheel me down and they have like a video call thing that you can do to NICU and she set it up up for me, she made sure that I got to see her which was nice because everyone else kept saying, we'll wheel you down, we'll wheel you down, we'll do this, we'll do that and then didn't actually end up coming back. Whereas was she was really busy, truly busy but she kept coming back saying don't worry, I'm coming back, I will set it up for you. I just need to sort XYZ out, which was nice to actually was remembering and paying attention to the fact that I've just given birth, I haven't actually seen my child for longer than two minutes, and obviously I didn't expect to see what I saw on the screen with the c-pack mask, all these wires and stuff. So I think I was only on it for about five minutes and I was
Coding Density
impact of trau
Antenatal journey
Coping, mistrust and behaviour modification
discrimination, disrespect, disempowerment, helpless, no reassurance and not being heard, ig
Intersectionality and insider knowledge
Mental Health and emotions
A battle and a fight
Assumptions and stereotypes
Good care communication continuity
Vulnerability, loneliness and reliance on professionals
Accessibility of support
Representation matters, shared identity and
Cultural narratives, stigma and family supportsocial services
Change and recommendations
Perceptions of pain
Covid removing choice and support
Covid impact on setting and staff
Bending guidance and tailoring support

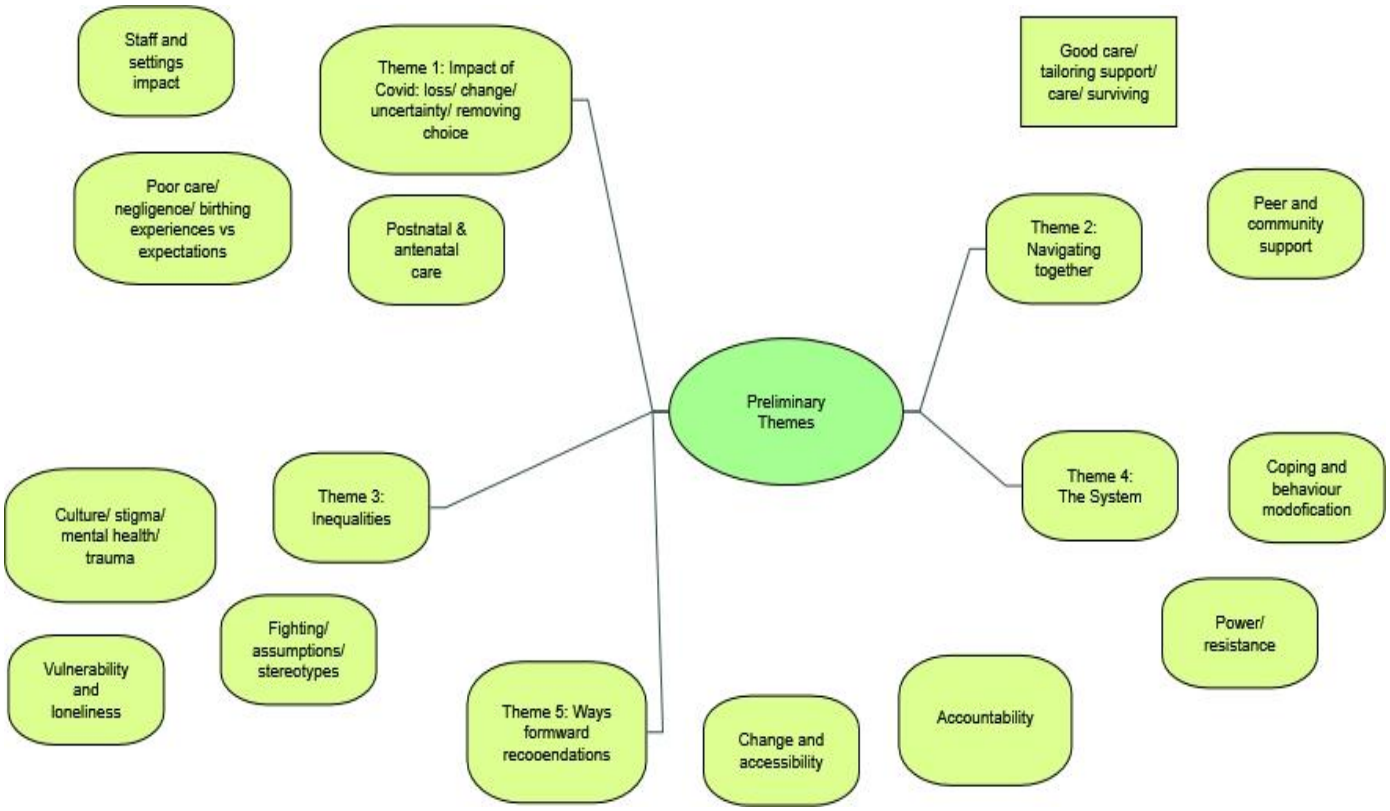
night time um I got to the hospital, they did their checks. They come, they checked my temperature, all that stuff, my mum was able to be with me at that time but it was. It did feel quite like, I felt sorry for them in a way because like procedures, like regulations were always changing, so one minute my mum was allowed to be there another minute my mum wasn't allowed to be there and then there was confusion. One midwife is like oh no she could come, she can't come so that was, it was interesting to see [laughs] so.
Yes, yeah so that I think because I went after I had my checks and they checked okay yeah like yeah you're in labour. Uhm, you haven't you're one centimeter before you were you were completely closed at 1 centimeter and your contracts. You are having contractions um okay we're going to monitor you to see, like, okay if the baby is OK, like. Just you know, they just wanted the extra monitoring just because I wanted to go for a VBAC and um they just wanted to know precaution just precautionary to make sure that I didn't rupture or anything like that so I stayed in the hospital for some time I think [laughs] this is where it gets a bit hazy, I was in the hospital for some time my contractions were coming and going, Um I didn't even like, my mum wasn't actually able to be in the in the room, I remember, but I know I was there for some time then they moved me to um what's it called? They moved me to not the triage, but they move me to another bit of the hospital before I go onto the labour ward and I was there and I was having contractions. They were coming and going, but I was trying to walk and keep active and do all those type of things and um I didn't to be honest, I did feel quite alone, even though my mum was there, she was there ut it wasn't like I had someone to like, oh OK you know support me that way in terms of like, OK, you're doing good da da da, the midwife will come in and check on me and stuff like that, they weren't really too um I feel like it was their normal 'cause there wasn't many midwives on the ward. I think
Covid removing choice and support
Covid impact on setting and staff
Fear of covid and unknown
Sharing stories and interview experience
Representation matters, shared identity and understanding
Taking back control and empowerment
A battle and a fight
power of community and peer support
Coping, mistrust and behaviour modification
discrimination, disrespect,
Systemic experiences, change and loss of hopes and experiences
Birthing beliefs, norms and expectations
Intersectionality and insider knowledge
Lack of accountability and humility
Impact of trauma
Mental Health and emotions
Perceptions of pain
Good care communication continuity
Cultural narratives, stigma and family support social services
Covid impact on postnatal care
Change and recommendations
Coding Density

Appendix O: Developing themes





Appendix P: Initial Themes

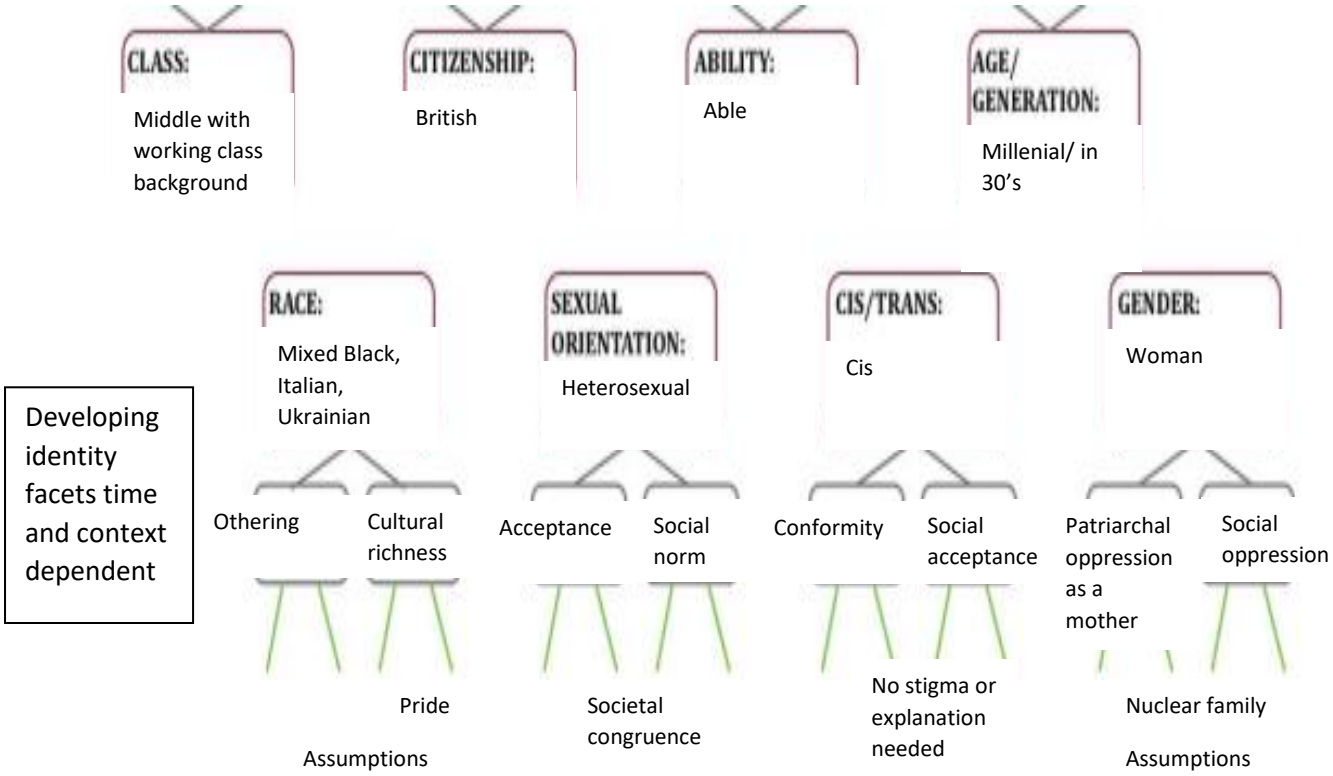
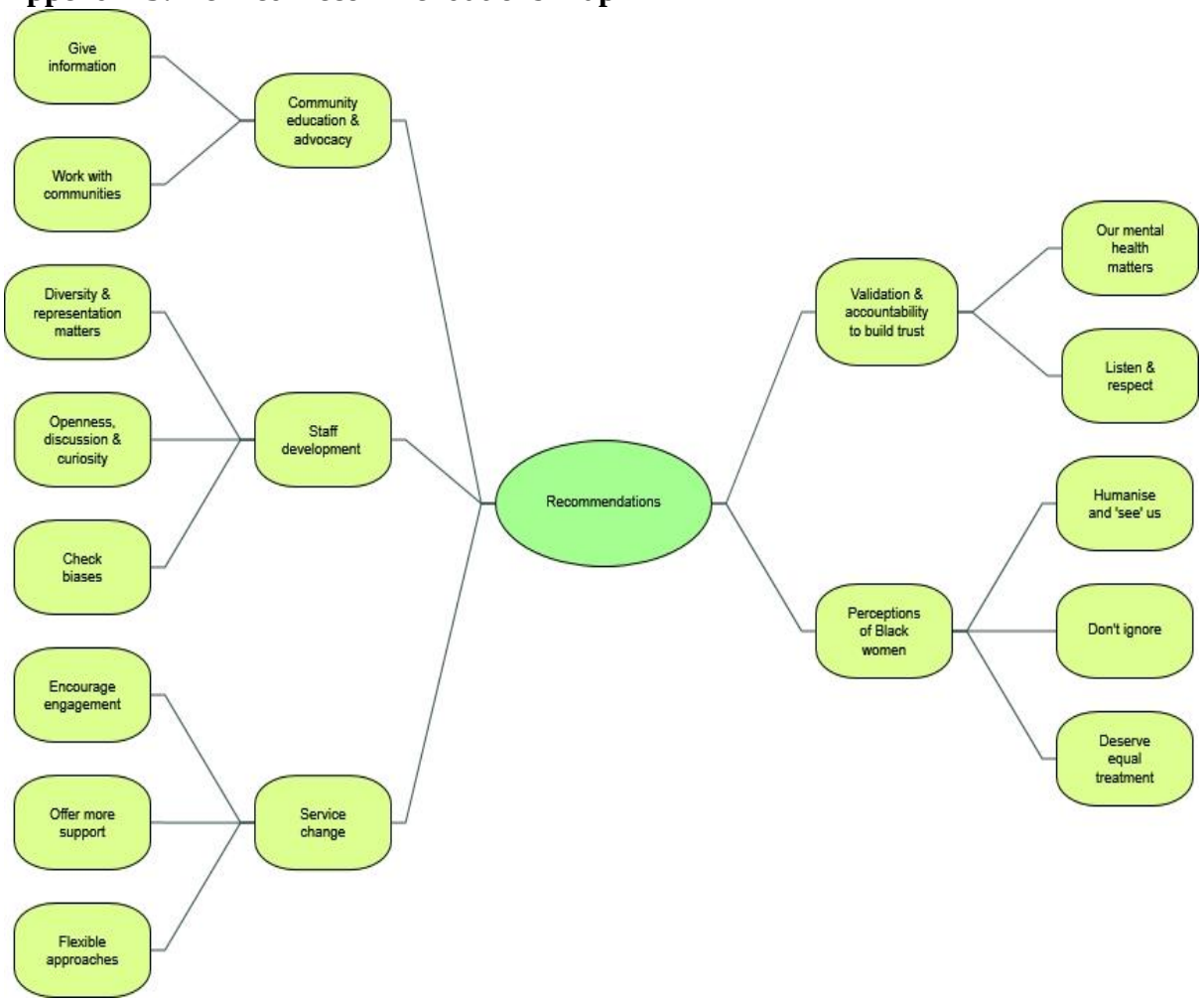


Appendix Q: Participants Experiences of Interviews

Experiences of Sharing Stories

- Evidence is needed
- Space to talk is good
- Feeling listened to & heard
- Sharing as a healig process
- Reassuring knowing someone 'get's it'
- Reflection is useful and sharing is liberating
- Talking helps with thinking & processing of trauma
- Research is key to change
- Sharing is comforting
- Stories need to be shared to make a difference
- Expressing ideas about service improvements is meaningful
- Having stories heard can help others
- The pandemic has left little room to reflect so sharing is good
- It is important to recognise and process trauma
- Appreciative of opportunity
- Talking is cleansing
- Helped for thinking about future intentions & experiences
- Connection feels good

Appendix R: Social Identity Map



Appendix S: Refined Recommendations Map