Parent's experiences of the impact of ethnicity and skin pigmentation on perinatal care.

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Abstract

Objectives

This study aimed to explore the perceived impact of ethnicity and race on perinatal care among parents from diverse ethnic minority backgrounds or who had a Black, Asian, or ethnic minority child born in the UK within the last five years to better understand areas of ethnic inequality within perinatal care.

Design

This study employed a focused ethnography, recruiting a purposive sample through posters, professional organisations, and social media platforms. Efforts to ensure maximum phenomenon variation included diverse ethnic and geographical representation. Semi-structured interviews using the digital platform, Zoom, explored experiences of accessing and receiving care, with a focus on challenges and perceptions related to ethnicity, race or skin pigmentation. Interview schedules underwent stakeholder validation and pilot testing. NVivo software facilitated qualitative analysis, employing an inductive approach with rigorous coding and thematic analysis.

Results

Ethnic minority parental experiences (n=24) revealed significant systemic challenges within the healthcare system. Three major themes were observed: Parent's voices not being heard, Systemic factors and Discrimination. Participants expressed feelings of marginalisation and inadequate communication with healthcare providers. Instances where concerns were dismissed or belittled, coupled with issues related to consent, highlighted pervasive systemic shortcomings. Structural barriers such as difficulties in scheduling appointments and perceived organisational neglect further compounded these challenges. Discriminatory attitudes and racial stereotypes also influenced the quality of care received, contributing to disparities in health outcomes and maternal wellbeing. Participants noted feelings of social isolation, exacerbated by pandemic-related restrictions and a lack of tailored support networks.

Conclusion

These findings underscore the urgent need for systemic reforms aimed at ensuring culturally safe and anti-racist practice, addressing communication barriers, and reducing discriminatory practices to enhance healthcare experiences and outcomes for ethnic minority parents. This includes training all healthcare staff around cultural safety.

Key words:

Ethnic minority; Women's health; Maternity care; Maternal experiences; Healthcare disparities; Migrant health; Neonatal health; Racism; Discrimination

Introduction

Sustainable Development Goal (SDG) 3, to ensure healthy lives and promote wellbeing, specifically targets reducing global maternal mortality and neonatal deaths by 2030 (United Nations, 2015). Additionally, within the UK national guidance published by the Department of Health (2016) around Safer Maternity Care called for a focus on safe maternity care, as well as increased choice and personalisation within maternity care. Despite this, routine examination of each maternal mortality within the UK through the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) process has consistently shown higher maternal mortality rates for Black, Asian and other ethnic minority women since 2015 (Knight et al., 2022). Additionally, higher rates of stillbirth and neonatal mortality are seen in Asian and Black women (Webster & NMPA Project Team, 2021; Draper et al., 2022). Inequalities according to ethnicity have also been shown around many other maternal and neonatal outcomes including Caesarean birth, low birth weight, and admission to a neonatal unit (Webster & NMPA Project Team, 2021). These outcome inequalities have led to a growing recognition of significant differences in the provision and experience of maternity care within ethnic minority groups, with differences noted in quality, accessibility,

and care outcomes according to race, and ethnicity and their intersectionality with other health determinants such as socio-economic status, location, gender and disability (Webster & NMPA Project Team, 2021). Inequity in healthcare within the UK has further been highlighted by the COVID-19 pandemic with higher rates of infection and mortality among those from ethnic minority groups (NHS Race and Health Observatory, 2022; Aldridge et al., 2020).

Much of the research around racism in healthcare has been based in the United States of America (Hamed et al., 2022). However, a systematic review of migrant women's experiences in Europe found 47 studies of which 17 were undertake in the UK, although only 3 were published after 2015 (Fair et al., 2020). Two further reviews, one of UK migrant or ethnic minority women's experiences (Obionu et al., 2023) and the other of Black, Asian and minority ethnic women's experiences of maternity care (MacLellan et al., 2022) included a further 13 UK based studies published from 2015. However, of the 16 studies within these reviews that had been published since 2015 the majority included small sample sizes, with eight having a sample size of twelve or less (Fair et al., 2020; MacLellan et al., 2022; Obionu et al., 2023). Since commencing this study, three additional UK based reports have been published on ethnic minority women's experiences of maternity care (Birthrights, 2022; Gohir, 2022; Peter & Wheeler, 2022), all with survey sample sizes of over 1000 women, as well as one further qualitative study of Black women (n=13) (Williams et al., 2023). However, experiences of migrant fathers in the UK remains an underexplored area with a recent review of migrant father's experiences of perinatal care not finding any UK based studies (Vo et al., 2024).

Within the previous research of ethnic minority women's maternity experiences, recurrent themes include communication issues with both language difficulties (Fair et al., 2020; Birthrights 2022; Gohir, 2022; MacLellan et al., 2022; Obionu et al., 2023) and cultural misunderstanding (Fair et al., 2020; Birthrights 2022; Gohir, 2022; MacLellan et al., 2022; Peter & Wheeler 2022; Obionu et al., 2023), disrespectful care including being ignored,

dismissed or not listened to (Fair et al., 2020; Birthrights 2022, Gohir, 2022; MacLellan et al., 2022; Peter & Wheeler, 2022; Obionu et al., 2023; Williams et al., 2023) and feeling discriminated against or negatively stereotyped (Fair et al., 2020; Birthrights, 2022; Gohir, 2022; MacLellan et al., 2022; Peter & Wheeler 2022; Obionu et al., 2023; Williams et al., 2023). Poor communication was noted to lead to lack of informed consent (Fair et al., 2020; Birthrights 2022; MacLellan et al., 2022). Additionally, women not being listened to evoked feelings of fear and was believed to contribute to emergency situations (Peter & Wheeler, 2022), with a lack of trust in healthcare services also seen to influence women's choice to access maternity care services (Fair et al., 2020).

It has been suggested that one of the most significant factors contributing to inequality in maternity care is systemic racism and bias (Fair et al., 2023; Hamed et al., 2022, Kapadia et al., 2022). Research suggests that clinicians' implicit bias and unconscious beliefs may influence their care of ethnic minority patients (Vela et al., 2022; Watson et al., 2019) and reports from racially minoritised women suggest racism as the root cause of less respectful treatment (Fernandez Turienzo et al., 2021). Racial and ethnic discrimination has been reported to take multiple forms such as microaggressions by healthcare providers, dehumanisation of ethnic minorities and the delivery of inadequate care (Fair et al., 2023; Peter & Wheeler, 2022; Straus, McEwen, & Hussein, 2009).

Systemic barriers are also known to exist within healthcare. For example, the accuracy of some medical equipment in ethnic minority groups has been questioned, with pulse oximetry shown to differ in those with darker skin pigmentation, meaning hypoxaemia may remain undetected in those with darker skin pigmentation (Shi et al., 2022). National policies in the UK for neonatal conditions such as hypoxia and jaundice have also previously been identified as failing to account for differences according to skin pigmentation (Furness et al, 2024). Additionally, it is recognised that the National Health Service (NHS) within England is under increased pressure after the COVID-19 pandemic, with waiting times to see a consultant, as well as emergency care waiting times markedly higher than pre-pandemic

(BMA, 2025). These systemic factors, coupled with high staff vacancy rates (BMA 2025) has led to concerns that inequalities and the experience of maternity care across different populations will most likely have widened (Birthrights, 2022; NHS Race and Health Observatory, 2022).

While some UK research around experiences of inequalities in maternity care has been undertaken, none to date has considered the experiences of ethnic minority fathers, as well mothers. Additionally, research in the post COVID-19 era is essential to further understand the impact of stretched healthcare services on quality of care for those from ethnic minority backgrounds. This is particularly pertinent given the NHS Race and Health Observatory (RHO) have identified maternity and neonatal care as key areas needing urgent attention (NHS RHO, 2022). Therefore, identifying what women need in these settings will provide healthcare providers and organisations with the tools to facilitate change and develop initiatives that can reduce perinatal inequalities within the UK.

Aim

This research therefore sought to explore the experiences of parents of ethnic minority neonates, including fathers, of the perceived impact of ethnicity and skin pigmentation on perinatal care, including both maternity and neonatal care.

Methods

Study design

This study was part of a larger project reviewing neonatal assessments and practice in Black, Asian and ethnic minority babies. Within the larger project parents or carers of a Black, Asian or ethnic minority child born in the UK in the last five years were interviewed specifically around their experiences of neonatal assessments that assess skin colour, namely the Apgar score, jaundice and cyanosis. Parents were also asked more widely about

the perceived impact of ethnicity or skin pigmentation on perinatal care, with the results of this wider aim written up within this manuscript.

This research took an anti-racist stance, acknowledging that ethnic inequalities that exist within the UK are evidence of systemic racism. By taking an anti-racist stance, it placed ethnic minority voices at the centre of the research to better understand the barriers and oppressions that they face (Dei, 2005). Within this, a focused ethnography was employed to deeply understand the experiences of maternal and neonatal care among ethnic minorities (Cruz & Higginbottom, 2013; Higginbottom, Boadu, & Pillay, 2013; Trundle & Phillips, 2023). Focused ethnography is of value to explore the complexities around an issue (Cruz & Higginbottom, 2013). It is recognised as a pragmatic way to gather data on a topic of importance and to determine ways of improving care or care processes (Higginbottom Boadu, & Pillay, 2013). It has an edge over traditional methods by delving into specific community aspects, facilitating deeper analysis within targeted areas of interest (Cruz & Higginbottom, 2013).

Participants

Eligibility

Parents who were themselves from an ethnic minority or who had a Black, Asian or ethnic minority child born within the UK in the last five years were considered eligible for inclusion within the study.

Recruitment

A purposive sampling strategy was used. The study was advertised via poster and shared within professional organisations, local networks and via LinkedIn, Facebook and Twitter. Interested participants contacted the research team to register their interest in being interviewed. Every effort was made to ensure maximum phenomenon variation by recruiting

participants from different ethnicities and from different geographical areas. Participants were screened before arranging an interview to ensure demographic diversity within the group. Recruitment was undertaken between August 2022 and January 2023. Recruitment continued until data saturation was achieved as no new topics were emerging from the data.

Data collection

Semi-structured interviews were undertaken with 24 participants. The interview schedule contained basic demographic questions followed by primarily open-ended questions to elicit in-depth responses from participants. Parents were asked about their experiences of accessing care in the UK during pregnancy, intrapartum and for their ethnic minority neonate. Interviewees views were elicited around any challenges faced when seeking or accessing care for themselves or their infants, any inappropriate or discriminatory treatment they or their baby received and the role that they believed that ethnicity or skin pigmentation played in their care.

The interview schedule was developed in collaboration with a range of stakeholders to confirm the comprehensiveness, acceptability and clarity of the schedule. Following this the interview schedule was piloted by two parents, with minor amendments made before finalising the interview schedule.

Given the wide acceptance of digital technology post-pandemic, interviews were undertaken via Zoom and audio recorded, then transcribed verbatim.

Data analysis

Qualitative data analysis was conducted utilising NVivo software. The analysis followed an inductive approach outlined by Roper and Shapira (2000). The process involved several steps, including coding of transcripts line by line, with descriptive labels closely tied to the text, sorting initial codes based on emerging patterns, identifying outliers or disparate cases,

generalising to identify constructs and theories and memoing to include reflective remarks (Roper & Shapira, 2000).

To ensure coding credibility and transferability, one transcription was independently coded by two researchers and then compared. Subsequently, two researchers independently coded all transcripts, with a subset shared with other team members. The entire team then discussed emerging patterns, constructs, and theories. The team's ethnic diversity and inclusion of maternity user group representatives were viewed as strengths during this process.

The researchers needed to minimise personal biases and preconceptions during analysis. The inherent social construction and interpretation of all research raises questions about the complete elimination of biases (Cruz & Higginbottom, 2013). To address this, researchers practised reflexivity through memoing at all stages of data interpretation to acknowledge potential influences on their interpretations.

Member checking and participant validation were employed to enhance the trustworthiness of the findings. Additionally, two stakeholder workshops were conducted to discuss interim study results. The analysis is presented narratively, with extensive direct quotations provided to support and verify the researchers' interpretations.

Results

Parents' demographics

A total of 24 parents participated in interviews, with each interview lasting around 30 minutes [range 16 to 55 minutes]. Basic demographic details are outlined in Table 1. The interviewees comprised 20 mothers and 4 fathers, with one of the mothers interviewed as the carer of a relative's child who was under 5. Parents' ages ranged from 25 to 41 years, and the age of their youngest children ranged from 8 weeks to 5 years. Participants were recruited from across the United Kingdom. In terms of racial background, 15 participants

identified as Black (Black African, Black Caribbean, and other Black backgrounds), three participants as Asian (including Indian background and other Asian background). Three participants identified as mixed race, with two of these participants identifying as Black Caribbean and White British, and one participant identifying as African-Asian. Two participants belonged to other ethnic groups, both of middle Eastern descent. One mother identified as White but had a child of mixed race.

Characteristics	**N (%)**
Parity	
1	12 (50.0%)
2	9 (37.5%)
3	3 (12.5%)
Race	
Black	15 (62.5%)
Asian	3 (12.5%)
Mixed	3 (12.5%)
White	1 (4.2%)
Other	2 (8.3%)
Age (in years)	
25-29	7 (29.2%)
30-34	11 (45.8%)
≥ 35	6 (25.0%)
Country of birth	
UK	11 (45.8%)
Non-UK	13 (54.2%)
Sex	
Female	20 (83.3%)
Male	4 (16.7%)
Occupation	
Routine / manual occupation	4 (16.7%)
Intermediate occupation	6 (25.0%)
Managerial / professional occupation	14 (58.3%)
Education level	
GCSE or equivalent	2 (8.3%)
A level or equivalent	3 (12.5%)
Undergraduate degree	12 (50.0%)
Postgraduate degree	7 (29.2%)

Table 1. Study participant characteristics.

Interview themes

The interview data revealed five interconnected themes (see Figure 1). How parents were treated within the healthcare system (parent's voice not being heard, systemic factors and discrimination) as well as more widely in society (contextual issues) were all viewed as contributing to the health inequalities seen within maternal care. Each theme is presented below alongside illustrative quotations, with additional quotations provided in Supplemental Material Table S1.

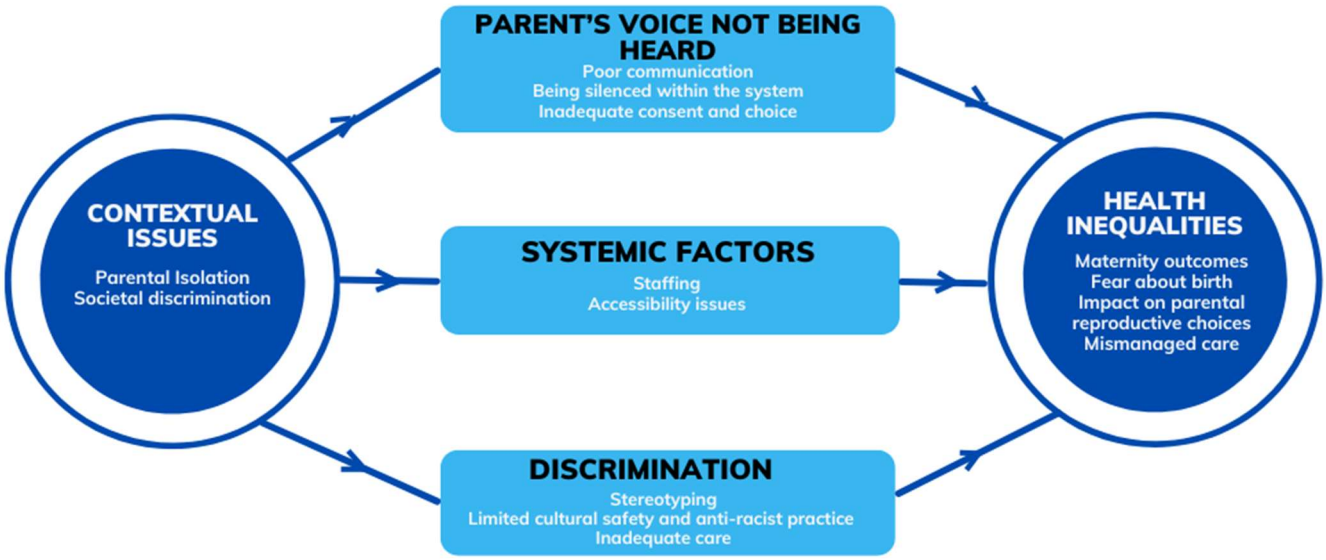

Figure 1. Themes identified within the interviews

Parent's voice not being heard

The first theme was around parents not being given a voice. This was due to communication issues, being deliberately silenced and inadequate consent and choice.

Poor communication

Parents felt poorly communicated with and unsupported by Healthcare Professionals (HCPs). Procedures and processes were often not adequately explained to families, with some parents relying upon over-hearing conversations between HCPs to keep themselves

informed. Concerns were expressed that those with a poor understanding of the English language or who had limited medical knowledge may not have the ability to "*fight"* to be heard.

> *"They took my daughter away, in the same room still, but they were I guess I don't know administering some sort of care to her. I say that because I don't know, they never kept me informed … Both in that moment and in the aftermath, no one ever told me what was happening."* **PA20 Black mother**

> *"The labour period was where I felt that I wasn't being given enough information. I didn't feel like, like they, it was as if I was too thick to be told anything ... that's how I felt like it was."* **PA13 Asian mother**

Being silenced within the system

Many parents reported not feeling listened to. Parents voiced being dismissed and belittled by staff about their labour progression, pain and their or their infant's health. Ethnic minority families felt the HCP's dismissal led to adverse clinical situations arising and unnecessary pain for mothers.

> *"I was dismissed in the sense that and they didn't really believe that I was in active labour … I kept asking for gas and air and they kept saying things like you're early, you're in early labour, so, you know, we'll try and get you the gas and air, but something along the lines of you just have to wait and be patient."* **PA07 Black mother**

> *"I'm not really listened to until there's a human head."* **PA04 Black mother**

One parent recounted a particularly traumatic experience where her husband was not let into the room whilst she was in labour, which he suggested was because the HCPs did not want him to *"advocate"* for her. For this parent undertaking the interview was a way for her to feel that her voice was heard.

> *""It was interesting talking to my husband about it afterwards, 'cause he's of course very loyal to the NHS [as an employee] and he said something quite offhand, which I thought was really profound, disturbing. I was saying, I don't understand why they didn't call him … 'cause he would have been able to support me. … He said, 'Oh, they probably didn't want me there because I would then advocate for you.' And I thought my God, that's horrendous because you know, it felt like they actively didn't want me to have a voice! … It's good to have it [the interview] and it's I feel also that this is me being heard."* **PA22 Mixed ethnicity mother**

To feel heard and get the correct care parents suggested they had to "*cause a scene*" and be *"assertive"*.

> *"He [her child] was admitted to hospital and I felt like they were happy to just like, you know, like just brush us off. But it wasn't until I actually, like, made a scene and you know, said like "He's not well, he's really not well, like someone needs to see him", that they actually tested him. … and then in the end it did show that he had a high infection rate."* **PA01 Other ethnicity mother**

When concerns were voiced through formal complaints, all participants who submitted complaints had no resolution.

> *"I've laid a complaint about her [a doctor], but over a year later, I still haven't heard back from the hospital. They keep sending me updates to say or they're still investigating or because of lack of resources, blah di blah blah blah. Yeah, so they still haven't given me an outcome of the complaint process."* **PA20 Black mother**

Inadequate consent and choice

Parents felt their consent was not adequately requested for procedures such as giving medications, injections or before operations. Parents suggested feeling coerced into consenting, or not being given enough information to make informed decisions.

“I didn't feel like I was given any information or enough information to make any decisions, decisions or choices or whatever.” **PA13 Asian mother**

“How can you ever possibly illicit informed consent for me… because I know that to get us onto labour ward that I have to allow you to do this [vaginal examination] so it’s not proper consent then is it.” **PA23 Black mother**

Systemic factors

The second theme identified was around structural and organisational barriers including accessibility and staffing issues.

Accessibility issues

Parents recounted instances of appointment mix-ups, last-minute appointment notifications and cancellations. The lack of access to community care was raised, which was felt particularly strongly by first-time mothers and in the postnatal period. Mothers wanted someone to ask *“little queries*” and specific cultural questions too. One mother hypothesised the lack of care she received was due to the midwife identifying her large support network, others suggested it was because of National Health Service (NHS) backlogs and *“service wide issues”* causing delayed appointments.

“The second health visitor appointment, they called last week I think Tuesday and said they're coming this Thursday and I said that doesn’t really work for me 'cause I have another appointment and then they were like well that's when we're coming. We're very busy. We're backlogged. I know you've called on Tuesday and say you're coming on Thursday, I've already got an appointment and that's super short notice!” **PA04 Black mother**

“*I don't know if it's because my midwife so like saw I had quite a good support system or whatever, but I don't feel like there was much aftercare … I would have expected a bit more care, as in once you give birth. And checking on the baby a lot more, because*

I am a first time mom, I seriously don't know what I'm doing." **PA01 Other ethnicity mother**

The system was viewed by one parent to "*be a system that is not supportive or promotes individual rights*" **(PA23 Black mother).** Because of a lack of appointments parents recognised they had to be "*proactive"* or "*fight"* for appointments.

"Our health visitor, she's very good, very friendly. But I have to be proactive with her in terms of getting appointment." **PA02 Asian mother**

While difficulties with accessing midwife, health visitor and general practitioner (GP) appointments was voiced by most, one mother did feel that they were more likely to get a GP appointment for their baby than for themselves.

"I feel like the GP probably does take you a little bit more seriously if it's a baby. Like if you need an appointment, then they're not going to give you one. If your baby needs an appointment they'll probably give you one." **PA01 Other ethnicity Mother**

The NHS charging immigrants to access care impacted not only those who were charged but anyone without British citizenship. One woman recounted a shocking instance of having to prove their right to access NHS services when arriving at the hospital having a miscarriage.

"The kind of administrator wanted me to fill out the form to prove that I had access, I had the right to use the NHS … like seeing your passport number and of course in the moment of going to the hospital that wasn't my priority … [There's] this sense that you are not, you're not welcome, you don't belong, even in this moment of incredible vulnerability and pain, it's still more important for us to figure out whether you have a legal entitlement" **PA20 Black mother**

Staffing

Staffing ratios were described as inadequate by many parents and a further cause of inadequate care.

> *"I definitely don't think I should have been left alone for that for periods of time, especially during like the end of labour, where I'm about to actually push the baby out."* **PA07 Black mother**

Two parents suggested having a Black, Asian or minority ethnic HCP positively impacted the care they or their baby received. However, two others reported that their care was negatively affected when cared for by HCPs from similar backgrounds.

> *"Something had changed … like my first pregnancy to my second pregnancy. I was being told, you know you, You have rights you have right to not be examined … First one they were all English, White and with the second … there was one that I did see a little bit more regular and she was Asian."* **PA13 Asian mother**

> *"I feel like he was expecting me to just take his word for it because obviously we're like, you know, similar backgrounds."* **PA01 Other ethnicity mother**

While many of the systemic factors that the parents described were generic to all who access perinatal care regardless of ethnicity, for example difficulty obtaining appointments, being discharged quickly after delivery due to bed shortages and staffing issues; ethnic minority parents identified that these NHS struggles when also mixed with discrimination made in riskier for Black, Asian and minority ethnic families in particular.

> *"I think the NHS is just purely in firefighting mode and they're waiting for things to get really bad before they intervene rather than doing preventive stuff, which is where it gets more expensive and more difficult and more risky and dangerous for people. And then potentially more risky, dangerous for not White people, if there are prejudices in there as well."* **PA22 Mixed ethnicity mother**

Discrimination

The theme of discrimination recurred throughout the dataset. Many parents reported discrimination within their perinatal care, with some parents also reporting instances of discrimination from other patients. A few parents however did not feel that their care differed due to their ethnicity or skin pigmentation, although for some of these parents it was due to them making mitigations to ensure their care was not impacted. The treatment of ethnic minorities was suggested to vary between institutions, with some parents undertaking background research of their local hospitals to ensure their level of care was good. Another interviewee felt they did not experience any differences in care due to their ethnicity because they lived in a location with *"a diverse ethnic community"* **PA21 Other ethnicity mother**

> *"I think generally there's a lot of racism. And people tend to treat people that seem different from them, differently … I think it was just a normal challenge, I take it everywhere … I just felt that they weren't being nice, was like they were nicer to White people."* **PA18 Black mother**

Three specific areas of discrimination were identified including 'stereotypes', 'limited cultural safety and anti-racist practice' and 'inadequate care'.

Stereotyping

It was assumed that ethnic minority parents were uneducated and that they didn't speak English. Several parents talked about making sure HCPs knew their profession, with some parents reporting HCPs attitudes changing after they learned of their profession, or the parent demonstrated a good understanding of perinatal care. Parents also felt that they benefited from sounding 'British', with one woman also having an English-sounding name which meant in a *"telephone conversation with someone, you probably wouldn't be able to identify my ethnicity based on how I sound."* **PA23 Black mother**

"My first maternity care I did feel like people almost didn't take what I was saying seriously, but once they could tell that I wasn't stupid and had kind of read up about it and that I knew what I was talking about when I was saying things that they would take me more seriously because of that." **PA16 Asian mother**

Assumptions were also made about the mother's lifestyle. If she attended appointments alone it was presumed the pregnancy was unplanned or the paternity of her child was questioned.

"There were questions about the paternity of my child. They wanted to know … if the dad was an African man like me, or you know if the dad was White." **PA06 Black mother**

Concerns were expressed about assumptions made by HCPs that women of Black and minority ethnic descent were "*high-risk bodies"*, which led to their childbirth being "*over-medicalised"* due to their skin pigmentation rather than individually ascertained risk. However, an invisibility/hypervisibility paradox was also noted for people from ethnic minorities where they were presumed to be high risk but were still not listened to. Additionally, pain thresholds were assumed to differ between women of different ethnicities with women's pain therefore not taken seriously and HCPs making assumptions about the level of pain women were experiencing and how they should be managing it.

"I was in a lot of pain so I was denied any pain relief, uh, well they offered me paracetamol, but that was it and said that's all I could have." **PA22 Mixed ethnicity mother**

"This belief a Black woman can handle more pain, It starts first when it comes to child birth, but they there is no pain that surpass gender, woman being White or being Black, do feel the same pain." **PA19 Black mother**

Limited cultural safety and anti-racist practice

Interestingly, few parents within the interviews felt their culture was not understood. Those who did voiced issues around co-sleeping and presumptions around religion. Other assumptions were made about assuming they were in a coercive relationship or about cultural practices such as female genital mutilation FGM) because of ethnicity.

> *"You can't do it, and you shouldn't be doing it [talking about co-sleeping], rather than if you choose to do it, please make sure you do it safely. Here are some resources so that you can go and do it safely…"* **PA23 Black mother**

However, for one father the lack of impact of his culture upon care was due to him no longer practicing his culture within the UK. When asked if they were treated differently due to their culture he responded:

> *"No … I don't really practice my culture over here."* **PA03 Mixed ethnicity father**

Inadequate care

Instances of inadequate care or negative healthcare provider attitudes were reported by 21 of the parents. One concern expressed was the use of racial microaggressions by caregivers. Some felt they had been treated differently or not as '*nicely*' as their White counterparts, with seven parents also reporting that they felt they were not seen as quickly as their White counterparts. One woman also noted that HCPs spoke differently to her White partner than to her. Others felt they were being treated differently because of their ethnicity or skin pigmentation but were not entirely sure. Parents described their care as *'shonky'* and *'not the best experience*'; when asked what could have been done better in the hospital one mother replied *'everything'.*

> *"You know we Blacks, we tend not to be attended to quite fast and other than the White folks."* **PA03 Mixed ethnicity father**

"It's hard, I think when you are of colour. You sometimes don't know you, kind of you don't know if you are being treated different." **PA13 Asian mother**

One mother felt the repercussions of her poor care impacted her *'golden hour'* and was an *'upsetting start to my relationship'* with her baby **PA20 Black mother**

Some described inappropriate comments from HCPs, including remarks regarding the skin, hair, or eye colour of their neonates. Parents described receiving poor care from their HCPs, believing it was due to their ethnicity. The poor care described included instances of being made to feel like an inconvenience when requesting more support, being left unattended, incorrect medication prescribed, mistaking patients' identity, not allowing a partner onto labour ward for support, not being respected by their HCPs and being left in vulnerable states and conditions. Negative HCP attitudes described by parents included staff being dismissive, not welcoming, patronising, making the woman feel like a burden or lacking respect.

"I had obviously had a C-section. I was in hospital for a couple of days. So when I needed help with breastfeeding, uhm, there were times when it felt like an inconvenience when I'm calling them 'cause I don't, I didn't know how to hold the baby, I just didn't know." **PA13 Asian mother**

One mother described feeling like *"a problem that they needed to deal with as quickly as possible*" and to not feel *'like a human being'* due to the way she was cared for describing *"lying there with my legs in stirrups with my vagina uncovered and I wasn't able to hold my baby breastfeed etc while I was waiting."* **PA20 Black mother**

Several parents were also concerned that the care they or their infant received was inadequate simply because staff were not trained to recognise conditions in ethnic minorities for example what anaemia, jaundice or infection may look like.

"[We weren't treated] inappropriately, but differently, just purely on the basis that they're trained as a textbook 'White child'." **PA14 White mother**

Mother's poor experiences with staff were noted to subsequently result in concerns about whether their child would receive adequate care.

> *"I remember being really worried 'cause I thought if they A) aren't listening to me and B) don't know where I'm at in part 'cause [they're] not listening to me. I don't think they're monitoring my baby, and I don't think they'll know if there's something wrong with him, it's going to be a real problem because they don't know what's going on."* **PA22 Mixed ethnicity mother**

While many negative care experiences were reported by parents, all parents also reported instances of good care, although for some this was limited to a specific location such as at the GP or to an individual care provider. The attributes of individual HCPs that parents highlighted as positive included being attentive, comforting, friendly, helpful, kind, listening, patient, responsive, supportive and their willingness to answer questions.

> *"The way that the nurses and doctors treated my wife they took care of her as if she was hers, and they give her whole professional needs and care that they could and everything was just perfect. My wife never had to complain about anything."* **PA05 Black father**

> One mother reported that staff: "C*ouldn't do enough to help"* Her health visitor had *"just said, oh just let me know how often you want me to come and I'll come as often as you want."* **PA16 Asian mother**

Contextual issues

Parents of newborns suggested they felt isolated and in need of a support network due to living far away from their families or friends but reported being largely unaware of social resources and support groups. Parents described COVID-19 restrictions increasing their feelings of isolation and others felt that HCPs relied upon them having a good support

network, which may be difficult for those who don't have family around. When they did have such a support network it was really appreciated by parents.

> *"I got quite a lot of kids and my neighbours come around, check out the wellbeing of my child and my wife and probably when I wasn't quite there around because of my busy schedule at work I had helping hands from the community. And these are truly being very, very helpful, especially during the first one months of after delivery."*
> **PA05 Black father**

The care parents received was frequently interpreted through the lens of the discrimination they faced in society in general. Parents talked about being treated differently in society, including being called names and being dismissed.

> *"In terms of community and neighbourhood, I would say that we're still getting discriminated, yeah. So that's not like a new thing to me."* **PA11 Black father**

> *"I think it [discrimination] was just a normal challenge, I take it everywhere.*" **PA18 Black mother**

Health Inequalities

Parents acknowledged the prevalence of ethnic inequalities regarding healthcare outcomes, particularly around maternal and infant mortality and stillbirths, but also wider inequalities highlighted by the COVID-19 pandemic. One parent was also aware that her ethnicity was linked to a higher risk of gestational diabetes. Additionally, parents who had had an infant admitted to the NICU noted that there were more ethnic minorities admitted than White infants. One mother directly attributed poorer maternity outcomes to inadequate care during pregnancy or labour. These known health inequities made parents fearful about their safety during the perinatal period, to have low expectations about their care and to be relieved when things went well.

> *"You know generally Black women are more likely to die during pregnancy after birth … I think it's basically pregnancy after birth kind of thing I felt like the Black women are not given the kind of attention they need … I think there are more health complications and inadequate care, especially during the antenatal care ... For the Black babies there is increase risk of stillbirth. This is one of the things that do happen quite a lot … There should be a way where Black women can be safe during childbirth"* **PA19 Black mother**

> *"I actually think I got away with it quite lightly, in the sense that I know others have had you know more complications."* **PA21 Other ethnicity mother**

> When one participant was asked what was good with her care she replied *"What was good. What was good. The fact that me and the baby are both alive?"* **PA04 Black mother**

The concern over health inequalities and racist behaviour within healthcare impacted parents' choice, behaviour and feelings during their maternity care. Parent's experiences of racism and discrimination during birth negatively impacted their desire to have more children and led to a distrust of NHS services. One father was very aware that, *"we live in a society where most minority people tend to get low-quality care"* **PA11 Black father.** This had led him, as well as other parents to view and study the ratings of multiple hospitals before deciding which institution to receive their care from.

> *"My advice to people of ethnic minorities is that they should try as much as possible to know the type of hospital that their people are administered with here."* **PA11 Black father**

> *"I obviously have a lot less trust in doctors [after her birth experience]."* **PA22 Mixed ethnicity mother**

Parents also described changing their birth preferences due to concerns over hospital, staffing and racism. Examples included changing to home birth to mitigate concerns over discrimination or due to previous negative birth experiences and feeling the need to employ a doula.

> *"By the time I was having my third I was like I don't really wanna step foot in hospital."* **PA23 Black mother**
>
> *"I knew that there are you know higher rates of maternal and infant morbidity and mortality and so my whole intention of choosing homebirth was trying to avoid that."* **PA20 Black mother**

However despite wishing for a homebirth, one mother had struggled in reality to achieve this, stating *"There was only one outcome and I was going to give birth in the hospital and it felt like no one was interested in…"How can we get you to the birth that you want"."* **PA20 Black mother**

The fear around childbirth experienced by Black mothers led to more stressful birth experiences with some preferring as a result to return to their home country to give birth.

> *"The Black mothers are really scared of giving birth to be honest … Black woman wish to go back to their homeland for the birth because they felt they are more understand, that they're more understood there."* **PA19 Black mother**

There was a sense among parents that their care had been mismanaged. Concerns were expressed that the mothers' medical notes or care plans were not read, mental health was not taken into consideration, antibiotics were not given when required, breast pumps were not provided, and medical conditions such as tongue tie were not picked up by professionals. Parents talked about being threatened with or fearing a social care referral because of their parenting choices, for example if they did not give birth on the labour ward which added *"an extra layer of fear"* to their childbirth experiences. Parents also worried that their child's slate grey nevi birthmarks may be highlighted as a potential safeguarding

concern due to their similarity in appearance to bruising. They therefore insisted every HCP recorded the birthmarks at each visit. The perceived potential for being reported to social care, alongside the power imbalance, meant parents feared raising concerns to HCPs.

Discussion

As part of a larger project, this study aimed to explore the experiences of perinatal care among ethnic minority parents. While some parents initially reported no perceived differences in their care based on ethnicity or skin pigmentation, they subsequently described numerous instances of discrimination within the interview. The findings reveal significant challenges within the healthcare system including lacking having a voice within their care due to poor communication and lack of consent, as well as experiencing discrimination and structural barriers. These healthcare system issues were set within the wider context of societal discrimination and health inequalities seen within maternal care. This study included the voice of fathers, which has largely been ignored previously, especially within UK-based research. Prior studies have documented inequalities in maternity healthcare provision (Gohir, 2022; Peter & Wheeler, 2022; Swords & Sheni, 2022). This study confirms the pervasive impact of systemic racism on maternal and infant care, highlighting how discrimination adversely affects women's choices, rights, and safety.

The feeling of being dismissed and not listened to is not new to this research. The Black Equity Organisation report highlighted that being listened to by HCPs is often a privilege for ethnic minority women and therefore emphasised the necessity of patient advocates due to the ineffectiveness of HCPs in listening to patient voices (Swords & Sheni, 2022). In light of not being heard, women too have reported feeling the need for someone to advocate on their behalf, such as a male partner or someone of White ethnicity (Gohir, 2022).

An imbalance of power between healthcare providers and service users can leave parents feeling belittled and coerced into making decisions. Addressing these power differentials and

empowering service users is crucial for promoting cultural safety and anti-racist practice (Lokugamage et al., 2023). The power imbalance has been criticised for its negative impact on clinical effectiveness (Laverty, McDermott, & Calma, 2017). For example, within these interviews and previous literature, ethnic minority women have reported feeling coerced into vaginal examinations (Peter & Wheeler, 2022). Additionally, the COVID-19 pandemic has further compromised women's rights and bodily autonomy, leaving many uncertain about their rights (Fair et al., 2023; Hill, 2020).

NHS chronic understaffing is widely reported in the media due to difficulties in retaining and recruiting staff (Tonkin, 2024; Yang, 2024). Due to this understaffing NHS employees feel they cannot do their job effectively (Yang, 2024), which therefore impacts the quality and safety of maternity care (Beesley, 2022; Wise, 2022). Interview participants reflected on the state of maternity care within the NHS as a potential reason for poor treatment, with many ethnic minority parents believing that systemic issues within the healthcare service negatively affected their experience (Gohir, 2022). While systemic issues such as understaffing and lack of NHS resources would not exclusively impact ethnic minority families, the significant disparities in maternal outcomes between White women and those of other ethnicities (Peter & Wheeler, 2022; Knight et al., 2022), serves to highlight the potential additional impact such systemic issues may have on those from ethnic minorities through poor care or negligence. However, further research should be done to evaluate the impact of understaffing on discrimination in healthcare.

Stereotyping takes many forms. Women from ethnic minorities are often overmedicalised yet invisible and poor awareness of Black women’s physiology has been widely reported (Gohir, 2022; Hoffman et al., 2016; The All-Party Parliamentary Group [APPG], 2024). Being more likely to be viewed as abnormal and so require intervention is in direct juxtaposition to also being assumed to have a higher pain threshold and therefore requiring less support (Birthrights 2022, Peter & Wheeler, 2022). Within this study assumptions made by HCPs went beyond biological, with parents reporting their children’s paternity being questioned, as

well as assumptions made about the woman's occupation. Assumptions made by HCPs means women are less likely to ask for help (Gohir, 2022), therefore perpetuating further disparities.

HCP responses to cultural practices arose within interviews. Systemic racism and bias in healthcare significantly contribute to disparities, impacting the disrespectful treatment and poorer health outcomes of ethnic minority communities. The need to provide culturally safe and anti-racist care has recently been identified as crucial to mitigating racial and ethnic disparities (Gopal et al., 2022). Cultural safety aims to remove barriers faced by minorities in mainstream healthcare by addressing systemic racism (Lokugamage et al., 2023). Encompassed in this, cultural safety and anti-racist practice necessitate healthcare providers to remain mindful of cross-cultural elements that could influence clinical interaction (Betancourt, 2006). The NHS auditing body, the Care Quality Commission (CQC) stated ethnic minority women are not treated like individuals and the lack of culturally safe and anti-racist practice shown by HCPs is a key barrier to care (CQC, 2023), with culturally safe services for women and neonates criticised for being a 'postcode lottery' depending on place of care (Fernandez Turienzo et al., 2021). Previous studies connote women are berated for co sleeping (Peter & Wheeler, 2022), with the NHS only just releasing safe co-sleeping practices (NHS, 2024). Other assumptions such as FGM are frequent and often incorrect, leading to embarrassment and women feeling attacked by HCPs (Karlsen, Carver, Mogilnicka, & Pantazis, 2020). Acknowledging such systemic racism and its impact on health is one of the seven Anti-Racism principles outlined by the NHS Race and Health Observatory to guide healthcare organisations towards an equitable healthcare landscape (NHS RHO, 2024).

Maternity service users consistently describe their care as inadequate, highlighting systemic issues within healthcare provision. Instances of racist microaggressions from authoritative figures are extensively documented in the literature (Peter & Wheeler, 2022; CQC, 2023; Swords & Sheni, 2022), often resulting in feelings of dehumanisation and disrespect (Peter

and Wheeler, 2022). These microaggressions, perceived as subtle and not always recognised as racism, are frequently minimised by bystanders (Cruz, Rodriguez, & Mastropaolo, 2019; Swords & Sheni, 2022). For example, incidents of mistaken identity are a reoccurring theme, which is concerning as illustrated by participant experiences (APPG, 2024; Cruz et al., 2019). Moreover, racism in this study was suggested by some participants as an expected aspect of their experiences. Healthcare encounters were often viewed through the lens of broader societal racism, indicating that these issues are not isolated to maternity care experiences.

Study strengths and limitations

This study possesses several strengths. It specifically targeted parents of Black, Asian, or ethnic minority children born within the last five years, ensuring relevance and capturing recent experiences. Participants included fathers as well as mothers, with ethnic minority fathers rarely if ever given a voice within maternity care research within the UK previously. Participants were recruited using a purposive sampling strategy, which involved targeted advertising across diverse platforms and networks. This approach ensured a broad spectrum of perspectives from various ethnicities and geographical locations ensuring a comprehensive exploration of diverse experiences within the UK. The study also brought in wider societal issues that could influence maternity experiences, such as the impact of racism within society which are recognised to influence parent's expectations of care interactions.

We must acknowledge several limitations in this study. All interviewed participants were fluent in English and did not need an interpreter, potentially excluding high-risk groups. However, efforts were made to engage these groups, including offering interpreter services within project advertisements. Additionally, using a purposive sampling strategy where

participants self-selected to participate means that the sample may not be representative of the whole population and therefore the findings may not be generalisable.

Conclusion

Addressing maternity care inequality is vital for improving health outcomes and equity. This requires systemic changes to address racism, improve access to quality care, and personalise services to meet diverse needs. These findings emphasise the need for healthcare reforms to enhance communication, ensure informed consent, provide culturally safe care, and eliminate discrimination, particularly for ethnic minority mothers.

Implications for practice and policy

All healthcare staff who care for parents during the childbearing period should receive training on anti-racist practice, alongside culturally safe, compassionate care, with good listening skills to meet the needs of a diverse, multi-ethnic society and to reduce current health inequalities.

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Declarations

Ethics approval

This study received ethics approval from Sheffield Hallam University, [ER44006021]].

Before the interview participants were emailed a participant information sheet and consent form. All participants provided voluntary informed consent to participate in the study by signing the consent form and returning it electronically to the research team. Consent was also confirmed verbally at the start of the interview. Before participation, participants were informed of the voluntary nature of their involvement, and their right to withdraw at any time. Parents were given a £20 gift voucher to compensate them for the time they had given to participate in the interview. They were assured of the confidentiality of their responses, data was stored securely and accessed only by authorised personnel. A code number was given to each participant within the transcripts and with the illustrative quotations provided.

By participating in the study, participants consented to the use of their anonymised data for research purposes and publication.

Consent for publication

Not applicable

Availability of data and materials

All data generated or analysed during this study are included in this published article [and its supplementary information files].

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Author contributions

Frankie Fair- Contributed to the conceptualization and design of the study. Assisted in developing interview protocols. Participant recruitment, Conducted interviews with participants. Transcribed and organized interview data. Analysed interview transcripts for thematic patterns. Assisted in data interpretation and synthesis. Drafted the manuscript. Reviewed and revised the manuscript for intellectual content, style, and formatting. Approved the final version of the manuscript for submission.

Amy Furness- Contributed to the conceptualization and design of the study. Participant recruitment, Conducted interviews with participants. Transcribed and organized interview data. Analysed interview transcripts for thematic patterns and assisted in data interpretation and synthesis. Drafted the manuscript. Approved the final version of the manuscript for submission.

Hora Soltani- Supervised the overall research project. Contributed to the conceptualization and design of the study. Assisted in developing interview protocols. Guided study design and methodology. Participant recruitment. Assisted in data interpretation and synthesis. Coordinated collaboration among co-authors. Drafted the manuscript. Reviewed and revised the manuscript for intellectual content, style, and formatting. Approved the final version of the manuscript for submission.

Sam Oddie- Assisted in developing interview protocols. Participant recruitment. Reviewed and revised the manuscript for intellectual content, style, and formatting. Approved the final version of the manuscript for submission.

Gina Higginbottom- Provided expertise in qualitative research methods. Participant recruitment. Assisted in developing interview protocols. Reviewed and revised the manuscript for intellectual content, style, and formatting. Assisted in data interpretation and synthesis. Approved the final version of the manuscript for submission.

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