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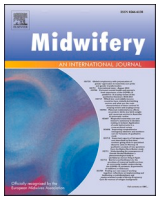

"We need to be heard. We need to be seen": A thematic analysis of black maternal experiences of birthing and postnatal care in England within the context of Covid-19

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ABSTRACT

Objective: Inequalities for Black women within maternity settings are longstanding, with evidence showing higher mortality, complications and distress compared to White women. The Covid-19 pandemic saw unprecedented changes to maternity services, with emerging evidence highlighting a disproportionate impact on mothers from ethnically minoritized backgrounds. This uniquely positioned study explores Black women's experiences of services during Covid-19.

Design: The study used a qualitative design with semi-structured interviews, data were analysed using reflexive thematic analysis.

Setting: The study took was open to all in the UK, participants who took part were from England and were recruited via social media and community led organisations.

Participants: The study recruited 13 self-identifying Black women, aged between 23 and 41 who received maternity care across settings (NHS wards, home birth and birthing centre) across England.

Measurement and findings: Three themes were generated from the study: *'The Ripples of Covid'*, *'Inequality within Inequality'* and *'Conscientious Change for Maternity Systems'*, with sub-themes including the impact of regulations, the invisibility of pain and the importance of accountability. Alongside multiple layers of inequality and emotional labour for Black women, the study found connection and advocacy as facilitators of good care.

Key conclusions: Supporting existing research, Black women's experiences of maternity services during Covid-19evidence ongoing of structural racism within maternity provision, founded on stereotypes of strength and pain. Though moments of advocacy and connection, however, Covid-19 appeared exacerbated ongoing existing inequalities for Black women. Changes to service provision contributed to isolation, distress, and consequential inadequate care.

Implications for practice: The findings, generated by Black women, established important implications for practice and policy, including an emphasis on creating conscientious change of systems through a racialised lens, the importance of meaningful equity, representation, and the need for co-production alongside Black communities.

Gross inequality across multiple areas of maternity service provision for Black women has been documented for decades, with the earliest reports dating back to the 1970's (Ibison et al., 1996). Most significantly, research has found increased risk and four-fold likelihood of mortality compared to White women (Knight et al., 2020d). Evidence also indicates that ethnicity impacts on women's experience of safety within maternity services and negatively influences communication and leads to an increased sense of loneliness and mistrust (Henderson et al., 2013; Magee and Askham, 2008; McLeish et al., 2020).

Inequality is also evident in access to maternal mental health support, for example within perinatal mental health community teams (PMHCT) the representation of Black women is low compared to White women. However, once there is engagement, the rate of appointment cancellations and non-attendance was lower than White women, indicating that inequality remains located within structures and service accessibility (Jankovic et al., 2020).

Covid-19 changed how maternity services operated to decrease the spread of the virus, including restrictions within antenatal clinics,

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virtual appointments, and reduced birthing options (Esegbona-Adeigebe, 2020; Karavadra et al., 2020). Maternity surveillance reports recommended optional adaptations for maternity settings, such as a lower admission threshold for people from ethnically minoritised groups (Knight et al., 2020a). Alarmingly, a stark 88 % of women who died from Covid-19 infection were categorised as being from Black, Asian, and Minority Ethnic (BAME) backgrounds (Knight et al., 2020b). One of the first studies focusing on perinatal experiences of ethnically minoritised women during Covid-19 evidenced racism, and challenges with communication and interactions with professionals (John et al., 2021). Publications such as these urgently called for mobilisation to influence change, address the disproportionate impact of Covid-19 within maternity settings and to focus on Black perinatal experiences which remain severely neglected within the UK evidence-base.

Despite the longstanding and growing quantitative evidence of inequality for Black women in maternity services (Ibison et al., 1996; Knight et al., 2009, 2018), an understanding of Black women's experiences is sparse. A systematic literature review conducted as part of this research (Williams, 2023), indicated existing qualitative research has combined findings for Black women under the umbrella of 'BAME', leaving the specific experiences of Black women unknown. Moreover, though Covid-19 has reportedly had a disproportionate impact on ethnically minoritised women, Black women's experiences of maternity settings during Covid-19 also remains unknown, providing the rationale for this study.

The aims of this study were to specifically focus on the Black maternal experience and understand: 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?

Method

Design

A qualitative design was used to answer the research questions, to provide a rich, contextual understanding of maternity services for Black women during Covid-19. The epistemological stance was rooted within critical realism which allowed for insight into how Black mothers have interpreted their experiences of receiving care. The study drew on Expert by Experience consultation (Videmšek, 2017) in its design and the primary researcher worked alongside a Black woman with personal experience of birthing during Covid-19 and engaged in consultation within a wider network of grassroots organisations led by Black women, the consultation process focused on the research question, interview guide and recruitment, with ethics of its use considered through supervision and aligned with the Centre for Research in Public Health and Community Care (2018) guidance.

Recruitment

Recruitment used a combination of purposive and snowballing sampling in support of reaching a diverse sample of women who birthed during Covid-19 and met the inclusion criteria (Table 1). Recruitment was supported by grassroot organisations and multi-media creators (e.g., SpeakOn, Dope Black and The Motherhood Group) and a podcast focusing on Black Maternal inequalities and aims of the study hosted by SpeakOn. Recruitment included the use of a poster, a participant information sheet and recruitment video shared via email to community organisations and relevant social media platforms Twitter and Instagram.

In total there were 21 expressions of interest, two prospective participants did not meet the study criteria and six did not respond following the sharing of the participant information sheet.

Table 1
Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion criteria
Women who self-identify as Black (including 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 et al., 2016)
Women who have given birth to a baby post-February 2020 (including first-time and mothers with multiple children)	Women who for the pregnancy relevant to the current study had experienced pregnancy or baby loss
	Women who are unable to give informed consent (e.g., lacks capacity)

Participants

Thirteen women took part in the study. Participants were aged between 23 and 41 years old and included first-time mothers and mothers of multiple children. Participants accessed maternity and/or perinatal mental health services including NHS wards ($n = 11$), home birth ($n = 1$) and a birthing centre ($n = 1$). Participants accessed care across various parts of England including London ($n = 4$), South-East ($n = 1$), East of England ($n = 4$) and the Midlands ($n = 4$).

Data collection

Semi-structured interviews took place over video call, lasting between 60 and 120 min. The interview guide questions focused broadly on helpful and unhelpful experiences of care received, with prompts around meaning making and the impact of the societal context (Williams, 2023). Each interview was audio and video recorded and used the automatic transcription software. These were downloaded, and video data deleted following the checking process of the automated transcription to attend to potential audio glitches.

Data analysis

Reflexive Thematic Analysis (RTA) was used through a six-stage process and interpreted patterns through the development of codes and themes (Braun and Clarke, 2022b). The video data was not used as part of the analysis process and served to support accuracies of audio transcript, facilitate researcher learning and reflection of the interview process only, please see a summary table of the data analysis process below in Table 2.

A reflexive diary was used throughout the research process, to support discussion around potential bias and draw upon resources of shared aspects of identity of the primary researcher as a Black mixed heritage woman, a mother and representative of a helping profession within the NHS with lived experience of birth trauma. Throughout the data analysis process, research supervision offered support to consider positionality and the potential influences on the research. Collectively, the research team held different intersectional identities and personal contexts to one another, meaning that conversations were supportive of attending to different lenses and understanding of the data, reducing bias of holding an insider researcher position.

Ethics

Full ethical approval was granted by the Health, Science, Engineering & Technology ethics committee at the University of X. All participants provided written and verbal consent prior to participation and were given the opportunity to withdraw their anonymised 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 ongoing Covid-19 context.

Table 2
Data analysis phase processes.

Phase	Research Process
Familiarising yourself with the dataset	Video calling platforms included an auto-transcription function, this was used alongside the NVivo 12 transcription service. For familiarisation transcripts were read whilst listening to the recordings and inaccuracies corrected. A reflexive diary was used throughout and supported learning for interview approach and when revisiting interviews how data was viewed/understood.
Coding	Data was coded line-by-line using a combination of NVivo software and pen and paper. Questions were removed from transcripts to focus on participants' words. 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). However, to support validity the research team independently reviewed a coded transcript, and supervision was used to reflect and deepen understanding of the data.
Generating initial themes	Wider patterns of meaning were generated through paper-based processes and NVivo software to begin to thematise the codes using maps. This was also reflected on alongside reflexive diary entries immediately after interviews, which enabled more of an inductive approach. There were an initial 62 codes and 27 thematic maps generated. This process allowed for difference across accounts of experience, including the varied impact of Covid-19 across different parts of England.
Developing and reviewing themes	Themes were developed from the data with patterned meanings identified across accounts. NVivo was used to organise an initial list of themes and then collapsed whilst incorporating names together so not to lose a sense of development. Research supervision and continued use of the reflexive diary supported the development of ideas and themes.
Refining, defining, and naming themes	The 27 paper and electronic based thematic maps of codes were grouped together using concept maps to create three themes, as outlined in Fig. 1. This was supported by a process of examining the researcher's own interpretations and the reflexive journal was utilised to support the separation of the shared experiences of the researcher with the participants.
Writing up	The research findings were written up and are presented below. During the write-up process a range of reflexive activities were used including a diary, voice notes and research supervision, these spaces supported meaning-making and shaped the narrative of the data.

Therefore, a distress protocol was developed using a framework established for addressing sensitive research areas in qualitative research (Dempsey et al., 2016; Williams, 2023). For example, participants were offered breaks, and where any moments of distress were noted, the researcher responded. There were some instances where recalling personal experiences generated emotional responses from participants, such as tearfulness, this was sensitively discussed, wellbeing prioritised and in line with the distress protocol and ethical procedures, offered the opportunity to cease the interview if they wished. Furthermore, a participant debrief sheet was shared after interviews which included national and local (bespoke to where participants lived) wellbeing and peer support available across England.

Consent forms containing identifying information were stored and managed in line with the Data Protection Act (2018). Data were saved on an encrypted storage device with files password encrypted and uploaded onto a secure server. Audio 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. All documents with personal information were deleted on completion of the study.

Results

For the purposes of this paper, the findings will be focused on salient themes for Black women and are presented with participant quotations to support analytical conclusions (see table 3 and 4 for further quotations). Participant pseudonyms were used with consideration around ethics, epistemology, and power within research (Allen and Wiles, 2015), participants were contacted and those who responded requested pseudonyms were chosen on their behalf.

Theme 1: The Ripples of Covid

The first theme captures the ways in which participants described Covid-19 alongside experiences of care received and the rippling influence it had whilst birthing and recovering postnatally. This was a key theme as it described how the everchanging guidance and changes to the delivery of care, brought about a sense of wariness, fear and loss. Key milestones and moments expected on the maternity journey were missed or delivered with varied experience and/or expectation, this was crucial given the broad impact of Covid-19.

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 Covid-

Table 3
Theme 1: Further supporting quotations.

Theme 1: The Ripples of Covid	Participant Quotes
Sub-theme 1: A wave of anxiety and loneliness	*'… 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)* *[…] 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)* *'Disheartened and you feel I felt really alone because I couldn't have my partner' (Grace)*
Sub-theme 2: The impact of Covid-19 regulations	*'[…] Having a C-section, I'm so more reliant on you guys [staff] to help me and assist me […] Having to constantly ask for help and constantly be like, please, can you help me […] you can see I'm in my own vomit' (Farah)* *'I'm in labour, it's getting tense is getting more tense […] she wanted me to keep my face mask on and I was like I can't do that 'cause you're restricting my breathing' (Jade)* *'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)* *'[…] 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)*
Sub-theme 3: The power of connections	*'It was almost like building a friendship […] having that social interaction that you need knowing that you can't have your birthing partner' (Jade)* *'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)* *'We [other patients] supported each other because that's all we had, you know' (Dominique)* *'To be honest with you my partner was the most helpful person, my partner was really helpful, and I say that because he was actually assisting the midwives' (Keisha)*

Table 4
Theme 3: Further supportive quotations.

Theme 3: Conscientious Change for Maternity Systems	Participant Quotes
Sub-theme 1: Undercurrents and why inequalities exist.	*'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)* *'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 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)*
Sub-theme 2: Access and targeted support	*'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)* *'[…] 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)*
Sub-theme 3: Validation and accountability	*'Look into the reasons why Black women are having such traumatic births or why they are losing their lives, from what causes and how that can be prevented' (Sade)* *'Training is just not good enough' (Farah)* *'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)* *'Treating us fairly […] just making sure we're OK […], not making us feel any different any less cared for' (Natasha)*
Sub-theme 4: Within our communities	*'I think it's so important for us as Black women to get each other, be a community within ourselves' (Aaliyah)* *'So, it's supporting organisations that are in the community doing the work […] they [services] want to have a band aid over things without actually sitting down and doing the work […] work with our communities to uproot these stories' (Asma)* *'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)*

19. 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-centred care and ways this was facilitated. Overall, participants' maternity journeys illustrated the ways in which Covid-19 had influenced their care at various junctures, and acknowledges the impact experienced globally.

Sub-theme 1: A wave of anxiety & loneliness

The resounding sense of loneliness reverberated throughout participants' accounts. This highlighted how Covid-19 resulted in intense emotional responses, including anxiety or being alone and with no choice but to navigate their maternity journeys with limited and compromised professional support, for example experiencing significant delays or absences of care at crucial postnatal stages left mothers in challenging and undignified positions: *'[…] I was on the table for about an hour and a half […] with the pandemic […] not enough beds, not enough staff' (Farah)*

Sub-theme 2: The impact of Covid-19 regulations

This sub-theme illustrates the different ways regulations effected experiences of care. Within an unprecedented global context, regulations were imposed with urgency and intensity. Participants described poor levels of care linked to reduced staffing, the ramification of which meant that care at times was negligent, disrespectful and needs ignored or minimised which left people in challenging and undignified positions and impinged on basic human rights:

> *'We had to stay in the postnatal room for […] 36 h just because the number of staff there was hardly anybody there […] the lady [staff] was like, oh, well, you missed the food times, so you can't have anything' (Sade)*

Some participants described staff within context and held onto compassion towards them despite experiences of poor care: […] *they [staff] have to work so hard and then to be put under that pressure (Grace)*. However, the conditions of birthing settings resulted in several 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). Thus, emphasising sentiments of self-sufficiency through need, with no choice but to adapt and prioritise wellbeing.

Sub-theme 3: The power of connections

This sub-theme encapsulated gratitude for significant others at the time whose presence offered strength. Participants expressed gratitude where there were experiences of person-centred care and shared identities with professionals; *'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)*.

Additionally, support from women who also birthed during this time and birthing partners allowed for reassurance and a felt sense of trust, having connection was meaningful and crucial during this time. Thus, symbolising the value of collectivism and relational coping at times of heightened uncertainty.

Theme 2: Inequality within Inequality

The theme inequality within inequality emphasised how Covid-19 exacerbated existing inequalities that Black women faced when receiving care in maternity settings, whilst birthing and postnatally. Overall, racism was a pertinent theme throughout participants' accounts, experienced across settings which had real implications for the care that participants received, their birthing and postnatal experiences, and added a layer of emotional processing of racism on top of existing emotional impact that childbirth can have on women. Further inequality within inequality was evident for Black women occupying multiple marginalised identities, who experienced discrimination not only on grounds of ethnicity and gender, but also based on religion.

Sub-theme 1: Racism

Racism manifested in various ways from covert to overt comments from professionals seemingly unaware of racial stereotypes and their impact. The data described the ways in which participants positioned themselves in response to racism, with some expressions of frustration and anticipation of microaggressions. The way findings indicated that

professionals were largely unaware of their racism:

'I told her that he [father] was black and she [midwife] […] [said] 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)

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 stereotyped.

'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)

Sub-theme 2: 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 during the birthing experience, underpinned by professionals' misconceptions, stereotypes and beliefs about how pain is experienced and presented. Assumptions resulted in participants being ignored and needing to continuously ask for support, *'I was in invisible pain, it's just the way it was' (Asma)*.

Thus, alongside physical pain, there was additional emotional distress caused by professional negligence and beliefs about pain expression. Participants drew attention to how depleted staffing and changes to the operational management of maternity settings potentially contributed to existing misconceptions and dismissal of pain.

'[…] 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)

This led to some to question and internalise reasons for not being provided with pain relief: 'Nobody, nobody is understanding me so, it must be me. If I'm asking so many times. And I'm not being understood' (Grace)

Sub-theme 3: Intersections with Islamophobia

This sub-theme describes how participants of Muslim faith experienced triple discrimination within the care they received '*…from the beginning I could tell that I was coloured not only by my skin colour, but also by my religion' (Aaliyah)*. Three participants described how their intersecting Black, female and Muslim identities interacted with stereotypes made about them: '*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 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)

This additional layer of discrimination added to emotional distress and need for women to psychologically process their experience of racism and islamophobia whilst trying to navigate giving birth.

Sub-theme 4: Stigma and mistrust

Participants' accounts demonstrated the implications of stigma and mistrust within and towards services, across family and community contexts. The fear associated with social services in particular influenced decisions made during the birthing journey: *'… I've always in the back of my mind got this thing about social services […] social services gets used as a threat' (Aaliyah)*. The contact with social services for two participants emphasised stigmatised layers, psychological harm, and a lack of transparency.

'The [social worker] said to me […] I would just be careful because next time we won't take it so lightly […] that was really actually really really painful especially knowing what I'm going through […] 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)

Sub-theme 5: Navigating structural racism and positions of power through obedience and self-advocacy

This sub-theme attended to the various ways in which participants managed the presence of structural racism and the imbalances of power in maternity settings between themselves and healthcare professionals. This resulted in an increased energy and vigilance required of themselves and/or birthing partners to ensure they received the level of care entitled to; *'I was just making sure that […] nobody was cutting corners' (Asma)*. Some participants communicated long-standing narratives and consequential awareness around conformity for survival for Black women and an acceptance of care whilst at the mercy of professionals who held positions of power: *'I think is an ethnic thing […] this idea of just accepting what's given to you and not questioning back […] being apologetic, trying to not like not trying to upset them [professionals] […] if you upset them they will just treat you worse' (Farah)*

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. The resonance across accounts which link to how race may have played a role in experiences of care, suggested that naming this may compound emotional distress and generate potential conflict with professionals.

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

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.

'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)

In addition, participants were aware of wider media coverage and publications focused on ethnic disparities in maternal mortality, contributing to fear and trauma: *'[…] there's statistics about Black women are four times more likely to die during pregnancy […] hearing that as a pregnant woman is very traumatizing' (Tendai)*. However, there was an absence of proactive discussion about inequalities at appointments which resulted in participants raising concerns and being met with invalidation, dismissal, or silence.

'[…] 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)

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

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 Covid-19.

Theme 3: Conscientious Change for Maternity Systems

This theme was key as it addressed the second research question

which asked for participant-led ideas and views about services, and the change desperately needed to eliminate longstanding maternal health inequalities. The data described the wider maternity systems and how participants made sense of the inequalities they experienced along with several recommendations to improve standards of care within maternity settings for Black women.

Sub-theme 1: Undercurrents and why inequalities exist

This theme illustrates the role of intersectionality, how participants' experiences of interactions and care were influenced by professionals' preconceptions of Black people, underpinned by colonially racist roots that continue to exist across time such as the internalisation of the 'Strong Black Woman' stereotype:

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

Sub-theme 2: Access and targeted support

This theme highlighted how participants positioned maternity services as crucial for meaningfully providing validation of lived experience as integral drivers for change. Many participants shared sentiments of hope and passion when asked about maternity service improvement, *'We need to be heard. We need to be seen' (Grace)*. Several participants spoke about basic aspects of care including respect, choice, information and being treated equally, all of which everyone has the right to. Responses were united by the need for conscientiousness within services and communities, needing to actively address inequalities by providing accessible education and information:

'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)

Sub-theme 3: Validation and accountability

This illustrated the importance of having maternal health inequalities openly named and discussed in NHS consultation spaces, showing services take responsibility and recognise inequalities with commitment to change. 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.

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

Participants shared how maternity services could improve, highlighting the importance of validation of lived experience with voices of Black women being a central and integral driver for change:

> *'… 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)*

Sub-theme 4: Within our communities

This emphasised the importance of community. Participants described the need for change within and between communities to truly address disparities, including building a collective voice, breaking stigma, sharing experiences, and strengthening community. This illustrated a resistance to universal approaches, active agency needed for a whole systems approach for tailored support which aligns with local need.

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

Discussion

The study found varying experiences of maternity care during Covid-19, from the changes in service structure and delivery of care, to implications for Black mothers' physical and mental health. With literature focusing on experiences and psychological impact of Covid-19 still emerging, there is evidence of emotional trauma, distress, and consequences of reduced essential maternity care (Sanders and Blaylock, 2021). The findings raise the importance of relational dynamics as key to experiences of care, and the role of anxiety and loneliness recognised at a global scale. For some, there were instances where professionals, birthing partners and fellow patients 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 which prevailed moments of reciprocal compassion and understanding to positively support experiences of care. Similar themes of connection and good experiences, perceptions of pain, mistrust and racism with classist stereotypes are mirrored in a recently published report (Peter and Wheeler, 2022). The current study has contributed to the literature by centring and primarily focusing on the experiences of Black women, thus offering a pertinent insight.

Overall, existing inequalities specific to Black women navigating maternity services have been highlighted and exacerbated by Covid-19. 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 and safe spaces for and within communities which could serve to heal, empower, and break cycles of harm.

The study demonstrated the different ways racism manifests within the maternal health services and the ways in which mothers survived and managed structures of power, including a dismissal of pain based on pervasive colonial ideas of Black identities. Acts of microaggressions and stereotypes appeared to go unnoticed by professionals, in turn dehumanising and masking crucial needs. This study supports, and provide nuance for Black women's experiences, of existing inquiries into maternal mortality which found evidence of structural bias and microaggressions within experiences of care specifically for 'BAME' women between 2009 and 2018 in the UK. Furthermore, the underlying inequalities in care were located across time, generation, and culture, revealing the longstanding influence of racism (Knight et al., 2022). The Birthrights inquiry (2022) similarly identified experiences of poor pain management, discrimination, and neglectful care through the disregard of needs for ethnically minoritised women.

The current study highlights how direct and indirect influences of discrimination were exacerbated for those who occupied other marginalised identities including Muslim faith and being working class. Findings support literature that highlights discriminatory and bias beliefs of professionals are subtle, yet salient within interactions, and professional stereotypes and biases play a part in ethnicity-based health inequalities (Nelson, 2002). These experiences were not new or unique to context, and the contribution of the current study provides a nuanced insight and understanding focused on Black women.

Another important outcome from the current study was the emotional load of knowledge Black women held of maternal health inequalities and recognising how this featured within participants' own experiences of care. When experiences are acknowledged within the context of wider global events in tandem, there are indicators of the mass emotional load being held and the potential for individual and collective ethno-racial trauma (Akerele et al., 2021). A re-frame of this considers the development of resilience, and the impact of post-traumatic growth and strength through adaptation (Ayers, 2017).

A key finding was participants' views around undercurrents and reasons for the maintenance and existence of inequalities, engulfing structural barriers within maternity systems. Graham & Clarke (2021)

explain the 'strong Black woman' (SBW) stereotype as linked to principles of Black women overcoming adversity and with this providing leadership and care as the matriarch of their families. The social challenges of Covid-19 coupled with the ideals of the SBW, saw a potential minimisation, embodiment, and absorption of a stereotypical gaze of others. The SBW proved essential and needed to be leaned upon to survive and contributed to professionals' misconceptions of pain, allowing needs to be dismissed and ignored.

Strengths, limitations and future research

This study is one of the earliest qualitative examinations that centres Black mother's experiences of care during Covid-19 in England. The qualitative design of the study was a strength that addressed previous limitations of research that has failed to platform Black women's experiences, providing a nuanced understanding during covid 19 which is imperative given both the inequalities in mortality for Black women in maternity services and the disproportionate impact of Covid-19 on ill-health and mortality rates (John et al., 2021; Stacey et al., 2021).

The recruitment strategy was a strength of the study, working alongside trusted grassroot organisations and creating a video supported a range of participants access to and interest in the study, and it represented experiences of care across England. However, wider experiences across the UK were not captured and the study did not focus on analysing differences between participants in different locations. Given that the resource and systems across NHS Trusts and birthing facilities varies widely, this limits localised recommendations. Therefore, future research may benefit from a geographical focus on experiences of care to inform tailored service development.

Though the recruitment strategy was successful in recruiting a range of participants, the use of online recruitment may have led to digital exclusion for those unable to access the internet. Moreover, though rich data was captured for this study, interviews were restricted to online only due to Covid-19, offering participants limited choice in how they would prefer to participate. There may have been hesitation to engage in an emotive topic online, and most likely within people's own homes, without a chance to meet the researcher in person and build a relationship that might have influenced the findings of the study.

The position of the primary researcher as an 'insider researcher' offered strength to the study by offering a nuanced and deeper understanding of the research topic, commitment to conduct meaningful research that generates change at multiple levels, whilst maintaining trust with participants and grassroot organisations. This position could also have limited the study for example, participants may have perceived shared knowledge during the interviews, rather than elaborating on their own descriptions. Whilst steps were taken to reduce the influence of the researcher's own experience (research supervision/ research team holding different identities, reflexive diary), this inevitably will have influenced the process of the research.

As highlighted by study findings, women with further marginalised identities experienced additional layers of discrimination, therefore future research may benefit from a richer understanding of nuance and intersectionality. For example, consideration of the ways in which the Black identity, faith, gender, sexuality, and social class are attended to within maternity settings. Furthermore, the study grouped participants all as Black and did not explore any differences for example, for Black mixed heritage, Black African or Black Caribbean women, offering a potential avenue for future research to explore.

Future research could 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. 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. Finally, 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 Covid-19

Implications

The recommendations from the current study are driven by participants' accounts, (theme 3) and wider evidence and are intended for use at multiple levels.

Fig. 2 outlines recommendations and supporting questions services can use when seeking to implement change to address inequalities in service provision for Black women.

Through a racialised lens

Currently, perinatal mental health services may utilise standardised trauma symptom measures such as the City Birth Trauma Scale (Ayers et al., 2018) which was normed against a 93.3 % White sample, with authors calling for further research for ethnically minoritised groups. Beck (2004) invites maternity professionals to consider birth traumas as residing within the 'eye of the beholder' to allow space for open discussion and compassionate observation. As the study has highlighted, the triggering of birth-trauma and misconceptions around pain indicate crucial preventative opportunities to improve birthing experiences. There is a key role for researchers and clinicians to form an organised approach for data collection, to develop and evaluate a bespoke clinical tool which assesses pain and measures birth-trauma through a racialised lens. Moreover, services need to show a commitment to address biases further than training and develop supervision, reflective practice spaces and clinical debriefs with a focus on anti-racism. It is the responsibility of all professionals to develop a culturally and racially trauma-informed approach to foster psychologically informed environments through non-Westernised approaches that encourage healing (Akinyela, 2014).

Equity & representation

Recommendations from participants emphasised the importance of representation and diversity in NHS leadership which remains largely epitomised by White professionals. The cycles of decision-making processes and approaches to health inequalities require a representative workforce that mirrors local communities' services are working with (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 accountability and financial consequences residing with Trusts and commissioning boards.

Participants suggested the need to ensure that services are funded appropriately to address the specific needs of Black mothers and birthing people, and 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 rifts within communities, in the fight for addressing ethnicity-based inequalities (Harries et al., 2020). Therefore, a crucial recommendation of this research is for policy makers to embed collaboration within funding bids for community organisations to create sustainability and inclusivity.

Co-Production & Black communities

This research has highlighted the necessity for improvements within education and research to inform clinical practice. The adoption of Critical Whiteness Studies (CWS) seeks to decolonise within an educational context using an anti-racist praxis, and invites educators to reflect and work with manifestations of oppression. This is most effective when implemented in collaboration with Black community activism and academic expertise (Cole et al., 2021). Therefore, a recommendation of the current study is for maternity services to align and meaningfully connect with Black grassroot organisations, activists, and academic professionals to generate an inter-agency whole systems approach to change. Recommendations of this research invite commissioners and maternity

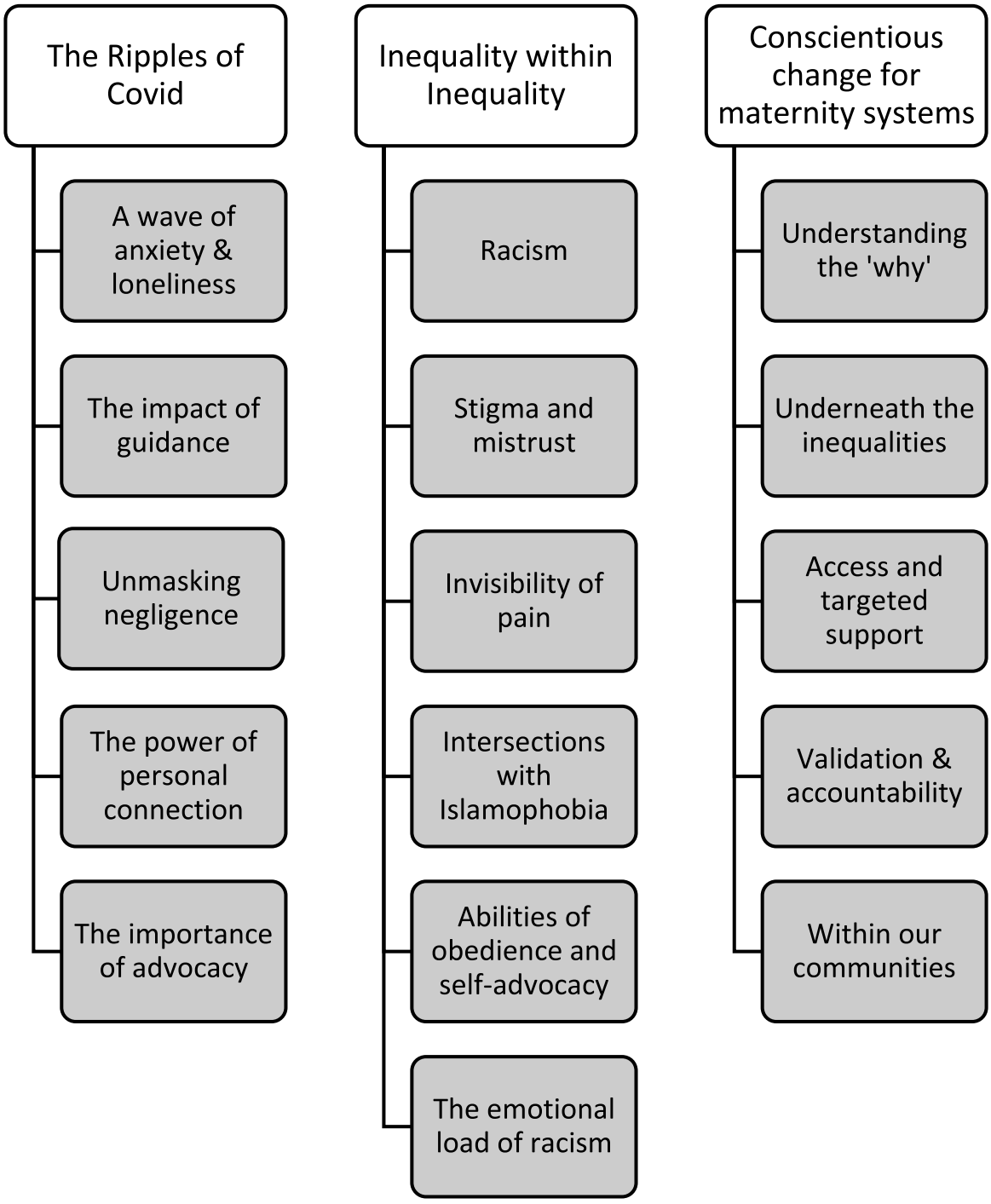

Fig. 1. Themes.

service managers to sustain and develop Black led antenatal and postnatal spaces, co-produced between Black communities and professionals to curate psychological safety and validate cultural knowledge of birthing lost through coloniality. The threading of lived experience within these spaces may enable relational and physical maternity safety, allow scope to unpack the layers of intersectional assumptions which uphold stereotypes around the Black birthing experience. This supports the community values and ethos of a Black-led birthing centre in America who argue 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).

Furthermore, the threading of Black women's expertise within the development of culturally informed birth reflections clinics, could serve to respond to participants calls for professionals to highlight in the inequalities rather than increasing the emotional burden of women to do this. This could enable relational safety and physical maternity safety, improve outcomes, and 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.

There is a need for accessible information sharing and complaints system in support of accountability. Providers of services could address this by developing co-produced leaflets which focus on key information about the maternity journey, including the patient advice and liaison service, areas of resource and signposting such as peer community

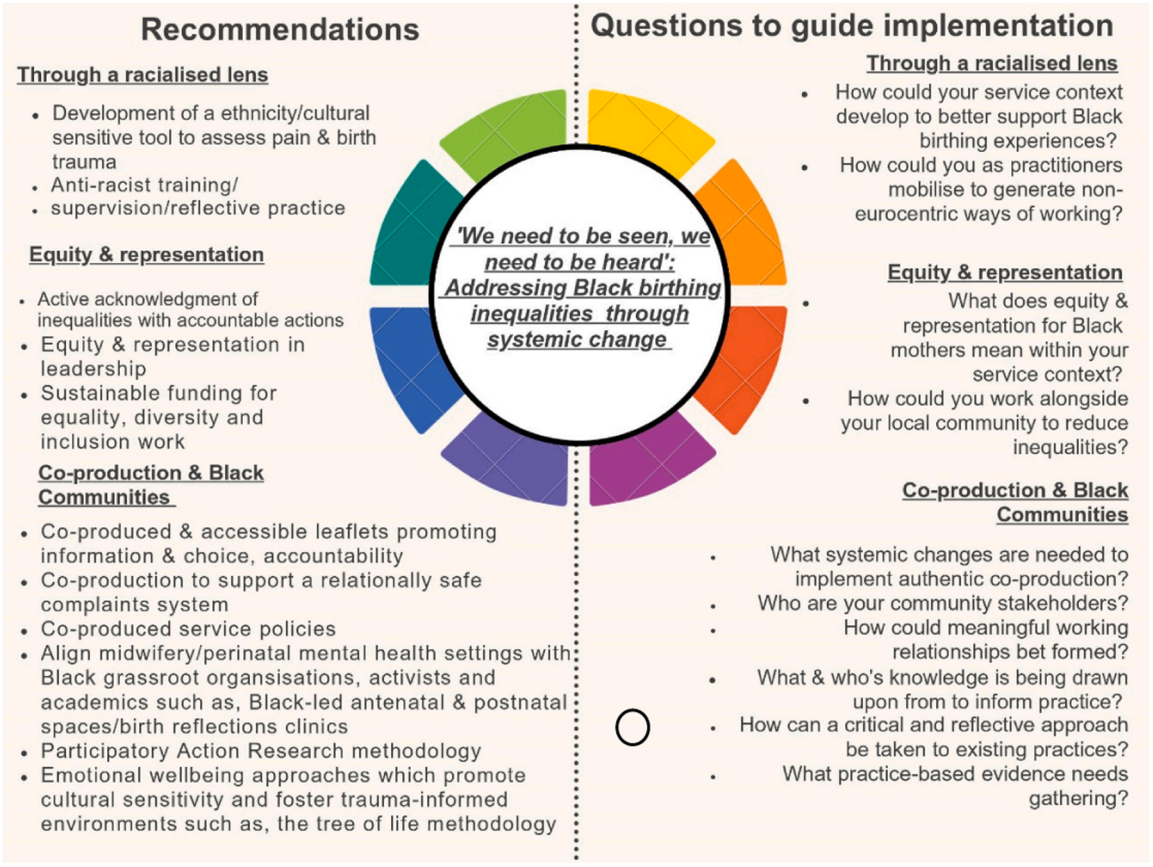

Fig. 2. Recommendations.

spaces which could allow for advocacy support. This leaflet could be made accessible and be introduced early such as, at the antenatal booking clinic. Meaningful implementation of this could be supported by maternity settings funding and appointing cultural ambassadors who hold positions of lived experience and can offer peer support.

For all working within and responsible for maternity services, it is essential that actions taken to address inequalities are done with communities, and not for communities. Participatory action research (PAR) approaches inform co-produced practice and policy development. This study highlighted the importance of humanisation, validation, and active response to feedback, this has important implications for clinical practice, and recommendations of this research which champions co-production. These recommendations are for the attention of communities, grassroot organisations, professionals working across maternity and perinatal mental health services, commissioners, and policymakers. Thus, sharing the responsibility for change and ensuring the process is multi-faceted.

Conclusion

A reflexive thematic analysis uncovered experiences of maternity care within the Covid-19 context laden with uncertainty and change, emphasising the importance of connection and advocacy which facilitated person-focused support. Black women experienced racism, negligence, resulting from colonial ideas about pain and adapted service provision during Covid-19. This study emphasises that the responsibility for change and reduction of maternal health inequalities resides with service providers, in collaboration with Black women and community organisations. Participants highlighted strength in discussions around community resilience and resistance, however this comes with a price where unpaid labour and tokenistic gestures have the potential to fall under the guise of co-production and community partnership working. Health provider responsibility and accountability must remain central.

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Ethical approval

Ethical approval for this study was obtained from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. Protocol number: LMS/PGT/UH/04621

CRediT authorship contribution statement

Candice Williams: Conceptualization, Methodology, Software, Formal analysis, Investigation, Data curation, Writing – original draft, Writing – review & editing, Visualization, Project administration. **Rachel McKail:** Methodology, Validation, Writing – original draft, Writing – review & editing, Visualization, Supervision. **Rukhsana Arshad:** Conceptualization, Validation, Writing – original draft, Visualization, Supervision.

Declaration of Competing Interest

None Declared.

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