Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk' pregnancies: A qualitative study

Abstract

Problem

Childbearing women from ethnic minority groups in the United Kingdom (UK) have significantly poorer perinatal outcomes overall.

Background

Childbearing women from ethnic minority groups report having poorer experiences and outcomes in perinatal care, and health professionals report having difficulty in providing effective care to them. Yet barriers in relation to providing such care remain underreported.

Aim

The aim of this study was to elicit midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk' pregnancies and how to overcome these barriers.

Methods

A qualitative study was undertaken in a single obstetric led unit based in London, UK. A thematic analysis was undertaken to identify themes from the data.

Findings

A total of 20 midwives participated. They self-identified as White British (n=7), Black African (n=7), Black Caribbean (n=3) and Asian (n=3). Most (n=12) had more than 10 years' experience practising as a registered midwife (range 2 – 35 years). Four themes were identified: 1) Communication, 2) Continuity of carer, 3) Policy and 4) Social determinants. Racism and unconscious bias underpin many of the findings presented.

Discussion

Co-created community hubs may improve access to more effective care for childbearing women from ethnic minority groups. A focus on robust anti-racism interventions, continuity of carer, staff wellbeing and education along with the provision of orientation and bespoke translation services are also suggested for the reduction of poorer outcomes and experiences.

Conclusion

Along with policies designed to promote equality and irradicate racism, there is a need for co-created community hubs and continuity of carer in perinatal services. Further research is also required to develop and evaluate culturally safe, and evidence-based interventions designed to address the current disparities apparent.

Keywords

Pregnancy; Midwifery care; qualitative research; cultural safety, community hubs

Statement of Significance

• Problem or Issue

Perinatal outcomes and experiences are significantly poorer for women from ethnic minority groups

• What is Already Known

Midwives report challenges in providing effective perinatal care to women in this context. Yet their perspectives on the barriers to and provision of effective care for childbearing women from ethnic minority groups with 'high risk' pregnancies in ethnically diverse areas remain underreported.

• What this Paper Adds

This paper offers new insights in relation to the perceptions of midwives on the barriers in providing effective perinatal care for women from ethnic minority groups and how to overcome them. In answer, suggested interventions are proposed for future development.

Introduction

A recent national population-based cohort study conducted in the United Kingdom (UK) has reported disparities, with black women experiencing a fivefold higher maternal mortality rate (1). There is also repeated evidence of an association between stillbirth risk and ethnicity (2). Moreover, childbearing women from ethnic minority groups who migrate are at greater risk of adverse perinatal outcomes in comparison to women born in their host country (3)(4). Such pregnancies complicated by any factors (e.g., pre-eclampsia), which threaten the well-being of the mother and/or fetus have been defined as being 'high risk' (5), and thus will frequently involve specialist perinatal care.

Whilst not all women who migrate will be part of an ethnic minority group, the direction of travel to a more ethnically diverse future in the UK through migration is certain (6). Undocumented migrant women including those refused asylum can experience complex barriers to perinatal services and have poorer obstetric outcomes in England, where they are not entitled to free access to perinatal services (7). Such restrictive governmental policies for undocumented migrants have been criticised for neglecting the right to health or universal healthcare coverage (8), and thus may further impact upon the delivery of care in this context.

Although other UK policies explicitly promote 'woman-centred' approaches, there has been a paucity of evidence in relation to how these may impact upon the current inequities apparent for ethnic minorities in healthcare services. In 2007, researchers argued that this was predominantly due to a lack of awareness of ethnic minority groups and their needs (9). Historically, women from ethnic minority groups have experienced a multitude of barriers in relation to their childbearing journey's, including a lack of interpreter services and unequal access to services, along with language stereotyping, racism, and a lack of cultural understanding from health professionals (10) (11). More recent research gathering the views of women from ethnic minority groups, including those who migrate, has unearthed similar themes (12) (13). However, the perspectives of midwives in relation

to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk' pregnancies in ethnically diverse areas of the UK are seemingly underreported. The aim of this study was therefore to elicit midwives' insights in an ethnically diverse area of the UK in relation to common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk' pregnancies and how to overcome these barriers. Whilst here the words 'women' and 'woman' are used, it is important to remain mindful of the fact that there are some birthing people who identify with different genders or no gender at all.

Methods

The underlying epistemology for this research is based on the theory of social constructivism, which assumes that individuals create meaning through interacting with others and their environment (14). A qualitative design was chosen as insight, experience, meaning, and context were considered essential in meeting the aim of this research. This study used a semi-structured interview design. The research setting was a single obstetric led unit in an ethnically diverse area of London, where any woman with a pregnancy associated complication living within the catchment area may attend to receive antenatal, intrapartum, and postnatal care. This research setting was deemed appropriate as it gave access to a sample of midwives with contemporary experience of delivering care to women from ethnic minority groups deemed to have 'high risk' pregnancies.

Sample and recruitment

The sampling strategy was purposive. All midwives working in the obstetric led unit were invited to participate via a total of 6 emails including a participant information sheet outlining the details of the study.

Participants were included if they were registered as midwives with the Nursing and Midwifery Council (NMC) and had experience of providing midwifery care to women from ethnic minority groups considered to have 'high risk' pregnancies as defined by Lee et al., (2014). Midwives in preceptorship programmes or returning to practice were excluded due to their relative and/or

recent inexperience. Midwives in management roles were also excluded so as to capture a 'grass roots' perspective on current clinical practice. As we were interested in the insights of those midwives with recent experience of caring for women from ethnic minority groups with 'high risk' pregnancies, we did not seek to recruit midwives working in community settings or birth centres. A total of 20 midwives were recruited to participate.

Data Collection

Data collection occurred in 2019. Semi-structured interviews were used to generate data using an interview guide (see Table 1). Such tools can usefully guide the narrative string developed by the interviewee (15). This interview guide was developed, and peer reviewed by both the research team and internal academic peer groups following a brief scoping review of the literature on this topic. The interview guide started with practice related questions, inquiring about midwives' experience, situations and working practices in relation to providing care to woman from ethnic minority groups they considered to have 'high risk' pregnancies. The flow of the interview was set by participants' responses along with the interviewer's use of probes and follow up questioning. To capture participant characteristics, brief demographic information was collected in relation to participants' ethnic background and number of years' experience as a registered midwife.

At the start of the interview the aim of the research was reiterated to participants, enabling them to voice any queries or concerns before giving consent to having their interview audio recorded. Subsequently, the 7 questions from the interview guide were asked in numerical order. Interviews lasted between 45 and 75 minutes in total. All interviews were conducted by the lead author, who was previously unknown to participants. Anecdotal reports suggest that the study setting was unusually quiet on the days when interviews were conducted. No interviews took place whilst midwife participants were simultaneously assigned clinical duties. Interviews took place in a single, vacant, and secluded clinical consultation room within the study setting at a time convenient to each participant.

Table 1: Interview guide

	Question prompts
1	Can you tell me about any experiences you have had with caring for a woman from an ethnic minority group whom you believe was considered to have a high-risk pregnancy?
2	Can you tell me about a situation where things went well or when things did not go as well as you would have liked?
3	Do you observe any barriers or challenges to providing effective care to these women within the unit? If so, what are they?
4	Do you find you have to adopt different ways of working with this client group? If yes, can you expand on this?
5	What is your understanding of cultural competency?
6	Can you tell me about the support and education you have received for caring for this particular group of women?
7	How do you think services could better support you to care for this particular group of women?

Data analysis

Audio recordings of the interviews were transcribed verbatim by an independent transcriber. Braun and Clarke's (16) method for thematic analysis was then used to analyse, generate, and report patterns (themes) from the data set. Primarily, the lead researcher (SC) independently examined each interview transcript to become familiar with the data and identify insights and understandings about barriers pertinent to the aim of the study. This analytic process involved paying close attention to the data, listening to the audio files, and re-reading transcripts throughout. Codes were then assigned to statements and developed into the themes identified via a succession of refinements. The second author (SP) also analysed the data separately and joined the lead researcher in further iterative analyses whereby the researchers moved back and forth to ascertain final codes and themes via a series of academic discussions, some of which included the entire

research team. Such researcher triangulation can compensate for single researcher bias (17) and contribute toward the trustworthiness of findings (15). NVivo software (version 12) (18) was used to assist in this process.

Ethical considerations

Middlesex University and NHS ethics committees approved the study protocol (Project No. 6110). All midwives were assured that their responses would be kept anonymous and confidential, that their participation was entirely voluntary, and that they could withdraw at any time. None chose to do so. Participants were invited to read through a consent form and to sign this as confirmation of understanding the projects aim and agreeing to take part. Data collection only commenced once consent was obtained.

Findings

Overall, 20 midwives participated in a total of 20 interviews. At the time of interview these midwives were predominantly working with women during their labour and birth. Between them, participants had a considerable number of years of experience, with 12 having more than 10 years experience (range 2 - 35 years). The participants were therefore also able to proffer insights based on prior experience of caring for women from ethnic minority groups in other services, including the antenatal period in particular. Participants self-identified as being White British (n=7), Black African (n=7), Black Caribbean (n=3) and Asian (n=3).

Four themes, encompassing both barriers and how these might be overcome, were identified from the data: 1) Communication, 2) Continuity of carer, 3) Policy and 4) Social determinants.

Theme One: Communication

Here, participants reflected on the failure of some other staff members to listen to childbearing women from ethnic minority groups. They related how some women often appeared disempowered and as a consequence, were often not taken seriously. Racism and unconscious biases in relation to communication were thus often referred to as barriers to effective perinatal care.

"…… ***I looked after a black woman. When I took over the shift the woman said that she had been telling staff she was not feeling well, and she felt they didn't believe her. The lady ended up with an eclamptic seizure. Thankfully, she was fine in the end but if she would have been listened to earlier things could have been different***" **(P 13)**

Some midwives also described how women from ethnic minority groups with high-risk pregnancies can implore staff to **"believe them." (P17)**

"……***there is a lot of stereotyping that black women do not want to take their health seriously, but we are not looking beyond that, why is it that they are not actually coming for the appointments, and what more should we be doing for them***" **(P2)**

There was emphasis placed upon the importance of staying open to a childbearing woman's point of view in order to promote cultural safety. Participants also stated the need and importance of "***listening… to understand, rather than listening to answer"*** **(P 4)**

A common barrier participants expressed was in accessing robust interpreter services. They largely reported on how a lack of a process during emergency treatment meant they were challenged to fully explain procedures.

"…. where it is difficult to obtain, like a proper history from the patient [sic]***, even though, you***

know, we do use the interpreters, but it's a phone call, isn't it, so I don't know whether it is ideal, because you don't know what the other person is saying to the woman and with limited time the call is very rushed especially when it's an emergency;…. it's difficult to ascertain if its full consent you just don't know" **(P 1)**

Some midwives also described the challenge of not knowing whether information had been communicated effectively.

"We did have the Language Line, but you never know how this information that we were transferring to the women, how it was communicated, because when you speak to the person on the Language Line, then they translate in their language, of which you wouldn't be knowing whether, what they're now speaking is actually what you've actually conveyed for them to explain to the women" **(P 6)**

Some participants acknowledged the usefulness of interpretation services in dealing with language barriers and contribution to the provision of safe care to women. Yet participants also reported that they sometimes rely heavily on colleagues to help with interpreting and in directly translating if they speak the same language as the woman, though this is not recommended.

"*……sometimes their English is very limited, so I have been lucky to care for people from my own country, so when the doctors talk, I translate it to their language. I realise that if they understand what you are telling them, they cooperate with you, but if they don't, they don't really, and they will complain*" (P 4)

Another participant stated that ***"When I speak to my patients*** [sic] ***in their own language, they feel more comfortable, secure and confident"*** **(P 19)**

Some participants who spoke the same language as some of the women receiving care in the unit reported that provision of language concordant care improves women's experience, increases their comfort, enables them to feel listened to and enhances their satisfaction with the health care service they receive.

"*it is such an added benefit when I care for women that speak the same language as myself. I have full confidence that they there is full informed consent and that they are in control of their labour*" (P 17)

In order to overcome communication barriers, participants also described other approaches used in practice, including friendly body language, adjusted speaking styles, innovating creative picture cards, and using language apps on digital devices. Some even took time to learn other languages.

Participants also considered that interpreters and apps do not always understand midwifery and obstetric medical terminology, resulting in misinterpretation and miscommunication of the information, which is neither cost effective nor efficient. Participants also considered that, due to an absence of clear and supportive policies, their ability to speak multiple languages often resulted in extra pressure on them. This was especially the case when they were needed to interpret for other childbearing women in addition to their existing midwifery caseload.

"Sometimes it is hard to finish other jobs if you are going to interpret for another colleague. If you have a woman in active labour, then it is not possible" **(P 13)**

Some participants considered that their ability to speak multiple languages added to their workload and made them accountable for things not clearly articulated in their job description or caseload.

Seemingly, having additional language capabilities can also result in a source of extra work not necessarily recognised or valued by a midwife's organisation.

"I speak 4 languages, and this sometimes is such a disadvantage to me as it puts such extra added workload and responsibility. It is also frustrating as it is not officially recognised, and I do not know if it adds anything to when I apply for promotions" **(P 15)**

Theme two: Continuity of carer

When offering their insights in relation to working models and patterns, participants reflected that some women's experiences had been negative, yet may have been improved by midwives forming better relationships with women within a continuity of carer model. Nevertheless, whilst midwife participants spoke positively on the implementation of continuity of carer models, most did not have direct experience of working in this way.

"I think the biggest barrier is the fact that you can't have – I suppose you could do, depending on what you're looking at – but not having a continuity of care is a big barrier, because you don't form that relationship with the women…." **(P 5)**

"Continuity of carer improves outcomes and policies identifying that all pregnant women should receive midwifery continuity of carer throughout the continuum of pregnancy, birth and new motherhood." **(P 17)**

Yet some participants also reflected that despite their willingness to work within the continuity of carer model, they had apprehensions about how it would affect their working patterns. There was also some concern expressed that working within the continuity of carer model would not be sustainable.

***"The continuity of care model is very expensive and it's probably not one that's sustainable in the long term but it's very important to try for women especially the disadvantaged and BAME (Black, Asian, and Minority Ethnic) women*" (P 16)**

Thus, whilst midwives held doubts about continuity of carer throughout the antenatal, intrapartum, and postnatal periods, they recognised that such care provision would form better relationships and benefit those disadvantaged and/or from ethnic minority groups.

Theme three: Policy

Whilst this theme relates to policy, it also aligns to an underlying theme of racism in that government policy is seen here to contribute to the development of negative attitudes in midwives and negatively impact upon those accessing care. Various midwife participants expressed their concern about how some women, particularly women who seek asylum or migrate appeared to be too scared to seek care from the National Health Service. This was because some may be directed by policy to move home or to pay for their care if they had no immigration status. Some midwives also expressed discomfort in being responsible for enforcing policies which reduced access to care, the quality of care, and a sense of safety for such women.

"we have a high proportion of women here who are charged for their care and I do think that impacts women's engagement, especially with ante-natal care, because they get frightened, they get bills, ... which can affect their immigration status. So, I think that is one area in amongst a big issue that I think we need to seriously work towards" (P 19)

Paying for healthcare seemingly changes the attitudes of some midwives, as one participant reported that they had ***"seen some of the negative attitudes midwives have towards women who are not eligible to free care…." (P 18)***

Participants also stated how at times they feel obliged to undertake tasks they feel are beyond their remit of practice and care as registered midwives, such as referring women to healthcare payments teams.

"…the system should not make us feel like cops but give all women good care regardless of where they come from. As midwives there is too much pressure in assessing and referring women to payments teams and takes me away from looking after the mother and baby…. It makes me feel physically sick doing it."
(P 10)

Although participants did not talk in detail about the impact these experiences have on the way in which they practise, the added emotion for midwives working with and caring for these vulnerable women because of the UK policy context was visible. Some participants demonstrated empathy in cases where pregnant women had been moved to a different geographical area close to the birth of their babies.

"……it makes it so difficult for the women…. a new home, new surroundings…it is pretty overwhelming for these women and isn't right" **(P 13)**

Many participants stated that fear is quite apparent in asylum seeking women, who are often through policy, housed in temporary accommodation. Midwives reported how they were not always informed when service users had been moved, and therefore had to spend time trying to locate them. This reportedly resulted in preventable gaps in care.

*"**the Government could please, irrespective of what status, they should make it open, because these women are afraid, that is the bottom line; they think once they are caught, they will be***

***repatriated back to wherever they come from, so if the Government could make it clear to them that, irrespective of whatever status, if they are pregnant, they should please attend their ante-natal clinic*" (P 20)**

Theme four: Social determinants

Many participants reported how some women from ethnic minority groups experienced difficulties in accessing care due to social determinants of health, poor health literacy and/or competing social demands. Women were also considered to face challenges when tasked with attending numerous appointments. This in turn impacted on their engagement and ability to manage their medical conditions effectively. Such barriers were largely related to the social determinants identified and reported within this theme.

***"the woman is in hospital; she is admitted to bed rest because of her blood pressure; the man has got to go to work – again, you can see where he is coming from - if he doesn't work, he doesn't get paid; most of them are on zero contract hours; so, they bring the toddlers to come and stay with the mother in hospital. How is she going to get any rest if she is looking after the toddler, because he has got to go to work. They struggle with childcare and this affects the number of times they come into the hospital"* (P 5)**

Some participants expressed that for several women, strength and support came from their faith communities. These midwife participants also reportedly recognised the potential for problems to arise should women rely solely on prayer as opposed to receiving antenatal care. In such cases, participants reflected the need for education.

"Some women believe what is happening to them is spiritual and say – I am going to pray, – my pastor is praying for me; this will help me. The women need education from the antenatal period

to help them understand and educate them on the pregnancy complications which can be normally treated." **(P4)**

Several participants reported their frustration as some women from ethnic minority groups are seemingly unable to engage safely with services as they have a minimal local family support base.

"the lack of support, especially with their other children, they tend not to comply. They will be in a rush to go home, because there is nobody that will look after the other kids and, as a mother, they get caught in between, you understand – 'which, is what I do if I were in her situation as well?" **(P 15)**

In particular, white British participants reflected how they rely on their colleagues from ethnic minority groups to help them understand such challenges, both culturally and contextually. In some cases, such increased understandings boosted feelings of empathy.

"…….my colleagues from the Nigerian community have helped me understand how some women have very little support with family and childcare…….it has immensely made me feel more empathetic to these women and we as maternity services need to do more for them." (P 20)

Discussion

In this qualitative study, we elicited interview responses from 20 London based midwives in relation to the common barriers in providing care to women from ethnic minority groups with 'high risk' pregnancies and how to overcome these barriers. Findings suggest that barriers to effective perinatal care for women from ethnic minority groups persist throughout the perinatal period. Such barriers broadly relate to communication, continuity of carer, policy, and social determinants.

Whilst we have presented our findings under four overarching themes, many of them are underpinned by racism and unconscious bias. This is concerning as lack of diversity, awareness and racism in perinatal services have profound and negative effects upon both the midwifery profession and childbearing women from ethnic minority groups (19). Alternate research pursuing the perspectives of women from ethnic minority groups has also highlighted a lack of cultural sensitivity and valuing of sociocultural norms in perinatal services as having a negative impact upon the quality and safety of perinatal care delivered (20)(21). Similarly, the findings presented here from the perspective of midwives suggest that unconscious biases, where the midwife's background and personal experiences along with societal stereotypes and cultural context can also have a negative impact upon their midwifery practice, and thus any care delivered (22). Drawing from a scoping review of the literature on implementing anti-racism interventions in healthcare settings, it is suggested that healthcare institutions need to incorporate an explicit, shared language of anti-racism; leadership buy-in; dedicated resources, support and funding; a multi-level approach beginning with policy and organisational interventions; transparent accountability mechanisms for sustainable change; long-term meaningful partnerships with people of colour; and ongoing, mandatory, tailored staff education and training (23). Additionally, as government policies impact upon organisational policies which can in turn have an impact on care, future policies could usefully consider how such impacts may be mitigated in favour of promoting equality and irradicating racism in perinatal services. Continuity of carer models may also aid midwives to develop greater

understanding of the many barriers women from ethnic minority groups face and thus also potentially reduce such racism and discrimination apparent in perinatal care.

Many of the participants within the current study advocated for the use of the continuity of carer model. The NHS's Long-Term Plan (24), informed by a study of outcomes for 2568 women in London, 57% of whom were in ethnic minority groups, including women with risk factors (25) has set out detailed plans in this regard. Specifically, a target of 75% of women from ethnic minority groups are to receive continuity of care in perinatal services by 2024 has been set. This is significant, as midwifery-led continuity of carer is linked to significant improvements in clinical outcomes for childbearing women from ethnic minority groups (25), and childbearing women who seek asylum (26). The argument for relational continuity is also prominent in the recent National Perinatal Review (27), and can enable culturally responsive, trusting relationships, including effective collaboration when those with high-risk pregnancies require the services of an interdisciplinary team (28) (29) (30). However, our findings demonstrate apprehensions in relation to how this service provision would be coordinated and made sustainable. On the contrary, evidence has refuted the idea that midwifery continuity of care is not sustainable or cost effective (31). Moreover, the provision of continuity of midwifery care has been evidenced as being beneficial for midwives in contrast to working in shift-based models, which can result in the provision of fragmented care and thus enhance the risk of developing work-related psychological distress (32). Hence, it will be important to communicate that it is often not until midwives work within midwifery continuity of care models that they may fully appreciate the benefits of working in such ways (33).

In relation to communication barriers, the finding of inadequate and/or unavailable translation services replicates those reported in previous studies (34)(35). Yet it is highly concerning that participants here report that midwives who speak the same language as some women from ethnic minorities are at times being asked to act as interpreters, a practice against recommendations (36). Our findings also highlight that in some cases, this practice has resulted in midwives feeling

pressured to represent and interpret the experiences of women without acknowledgment and be solely responsible for their advocacy at times. This may in turn contribute to the work-related psychological distress which midwives experience, thus adding further to the negative impact upon the safety and quality of perinatal care delivered (37). Such division of a bilingual midwife's focus in clinical practice may also compromise the quality and safety of care given. Consequently, attention and value must be placed upon staff wellbeing, along with robust and effective translation services which relieve bilingual midwives from such additional pressures and allow them to focus solely on their own work allocation. Such services may also usefully be tailored for perinatal services, where context specific terms and practices may be better understood and communicated within dedicated teams.

Policy in this context presents barriers in providing effective perinatal care where systems, services and procedures can be overwhelming and complex to navigate. Midwife participants in this study reportedly observed asylum-seeking women and women who have migrated to the UK in particular to be vulnerable, overwhelmed by services and thus dissuaded from seeking perinatal care. Whilst not all women who migrate or seek refuge may be Black, Asian, or part of any ethnic minority group, these findings are also reflected in other research, where a woman's immigration status has similarly acted as a barrier to accessing and navigating effective perinatal care via complex systems (38)(38). The liminality of living between two cultures is also a ubiquitous experience for women seeking perinatal care in high income countries and may further complicate and exacerbate disparities in this regard (39). Furthermore, the findings presented here demonstrate that participants viewed political systems as the basis of some asylum-seeking women's fears and difficulties in accessing services: namely having to pay for healthcare provision. This finding has also been captured elsewhere (38). As such, the use of structural competency as an educational approach to catalysing change in relation to such inequalities may be useful in this context. This is because limiting one's focus to culture alone may not enable professionals to fully recognise the influence of deeper structural forces that may confine a person's agency and thus contribute to further health disparities (40).

Bespoke orientations to services facilitated by service navigators may also further reduce feelings of being fearful and overwhelmed in this context.

Within this study, social determinants reportedly posed barriers to effective perinatal care, particularly in relation to accessing services. These findings echo those published elsewhere in relation to women born outside of the UK, many of whom may be from an ethnic minority group (38)(41). Yet despite this, there remains a paucity of specific antenatal interventions for pregnant women from ethnic minority groups at high risk of poorer perinatal outcomes in the UK (42). As in similar contexts (43), educational interventions and accessible perinatal services co-created in partnership with faith leaders may be useful for those women who depend on the faith and prayer specifically referred to by participants here.

Whilst our findings have been reported in four overarching themes, many of the barriers reported are complex and thus intersect. For example, policies around interpreter use affect barriers in communication, policies relating to healthcare costs and the social determinants of health impact upon access to services and midwives' need for ongoing education around cultural safety. Yet the reality is that racism still underpins many of these health inequalities and poorer clinical outcomes and can therefore be categorised as a public health issue. Thus, we align with the calls of others for the dismantling of both organisational and structural racism (44). Drawing from our findings, we also propose that the development of community hubs may usefully facilitate attentive listening, along with person centred care and practice as part of a participatory learning process. Such developments may also be useful for the promotion of both cultural safety and knowledge exchange, which may in turn empower both women and midwives in this context. Moreover, the promotion of social support, bespoke orientations to services and increased access to more robust interpreter processes may be better facilitated in such hubs. To enable childbearing women from ethnic minorities to feel confident in accessing them, these hubs could also usefully consider the employment of bicultural workers.

In the current context, women from ethnic minority groups have been found to be more likely to die from COVID-19 and be at higher risk of developing complications from COVID-19 (45). Moreover, of the 10 COVID-19 related maternal deaths reported, seven (88%) were from Black and ethnically diverse groups (46). Thus, community hubs as a model of care in partnership with a continuity of carer model might further offer women from ethnic minority groups and staff access to knowledge exchange and participatory learning in response to COVID-19 and be facilitated online as required.

The present study has focussed on barriers in relation to providing care to women with 'high risk' pregnancies as opposed to all women and/or women with 'low risk' pregnancies, and only included midwife participants working within an obstetric unit. A comparable study including midwife participants working in a variety of settings (e.g., community settings and other hospital wards) reported a similar theme in relation to language barriers and communication (47). Comparable barriers were also presented in relation to midwives' often addressing the needs of women beyond the scope of their own practice, access to care, cultural and/or religious practices and the need for further education (47). This may suggest that there is little difference in the barriers to providing effective perinatal care to women from ethnic minority groups experiencing a variety of pregnancies in UK settings. Nevertheless, further research in this area is required.

The strength of this study is its focus on practising midwives' insights in relation to their experiences of common barriers in providing care for women with 'high risk' pregnancies from ethnic minority groups in London, and how to overcome them. The trustworthiness of the findings are supported by using a purposive sample to generate data grounded in midwives' practice experience giving a 'grass roots' perspective. The midwives recruited and interviewed worked within an obstetric led unit and were restricted to one geographical area of the UK. Therefore, the findings are limited in their transferability. Also, as participation was voluntary, some selection bias may be apparent.

Conclusion

This study has uniquely reported the perspectives of midwives on the barriers to caring effectively for women from ethnic minority groups with 'high risk' pregnancies in an ethnically diverse area of London and how to overcome them. Further research is needed to develop and evaluate culturally safe, and evidence-based interventions designed to address the current disparities apparent in perinatal services. Future ethnographic studies will also be required to explore and illuminate any future challenges that midwives and women from ethnic minority groups may face in perinatal services as part of an ongoing and urgent call to action.

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