

Debate Pack

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Black Maternal Health Week

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1

Background

Black maternal health awareness week runs from 13-18th September 2021 and is dedicated to raising awareness about the disparities in maternal outcomes for Black women. It was founded in 2020 by Five X More, “a grassroots organisation committed to changing Black women's maternal health outcomes in the UK”.¹ Its [website](#) explains that the organisation:

... was initiated in 2019 when two Black mothers came together with the dream of improving maternal mortality rates and health care outcomes for Black women.

Five X More is dedicated to supporting mothers with its campaigning work and recommendations. It focuses on empowering Black women to make informed choices and advocate for themselves throughout their pregnancies and after childbirth.

BLACK WOMEN IN THE UK ARE FOUR TIMES MORE LIKELY TO DIE IN PREGNANCY & CHILDBIRTH (MBRRACE, 2020)

Analysis of maternal deaths, stillbirths and neonatal deaths shows mothers and babies from Black/Black British and Asian/Asian British ethnic groups and women living in the most deprived areas of the country have poorer outcomes.²

The table below shows data from the latest 2020 MBRRACE-UK report on the [Confidential Enquiry into Maternal Deaths 2016-18](#) highlighting the number of maternities and associated deaths by ethnicity. The data is pooled over a three-year period because the small number of cases means that the estimated rates can be associated with a large degree of uncertainty. The associated relative risk of death for women from ethnic groups compared with white women is also provided, along with the confidence intervals associated with these ratios.³

The confidence intervals shown below suggest that women from Asian, Black or mixed race backgrounds have an elevated risk of maternal death compared to women from White backgrounds. Among Black women, the

¹ [Fivexmore website](#)

² MBRRACE-UK, [Saving Lives, Improving Mothers' Care](#), December 2020

³ The uncertainty of a ratio can be estimated by calculating a confidence interval (CI) around the estimate to give an indication of the range within which the “true” ratio is likely to arise. The confidence intervals are important in interpreting differences. A confidence interval expresses the degree of uncertainty associated with a statistic and gives an indication that that actual “true” value may lie somewhere between the lower and upper confidence interval. You can use the overlap in confidence intervals as a quick way to check for statistical significance. In general, if the intervals do not overlap there is a statistically significant difference (at a certain level of confidence – usually 95%) whereas if there is an overlap, then the difference is not significant.

central estimate of the risk of maternal death is more than four times higher than for white women.

Maternal deaths by ethnicity England 2016-2018						
Ethnic group	Total maternities	Deaths	Death rate per 100,000 maternities	Relative Risk: BAME compared with white		
				Relative Risk ratio	Lower CI	Upper CI
White	1,486,428	117	7.9	1.0		
Asian	191,145	28	14.7	1.9	1.2	2.8
Black	81,704	28	34.3	4.4	2.8	6.6
Chinese/other	75,270	6	8.0	1.0	0.4	2.3
Mixed race	31,823	8	25.1	3.2	1.4	6.5

Source: [Confidential Enquiry into Maternal Deaths 2016-18, Table 2.10](#)

Further details of MBBACE-UK's work is available on its [website](#).

1.1

Maternity Review and the Better Births Plan

In March 2015, Sir Simon Stevens, Chief Executive of NHS England [announced a major review of maternity services](#) as part of the [NHS Five Year Forward View](#). Drawing on wide-ranging evidence, and in consultation with women and their families and stakeholders, the [review published its findings in February 2016](#). The [Better Births: Improving outcomes of maternity services in England](#) report⁴ is a five year forward view for maternity care.

The review did not include any specific findings in relation to maternal mortality rates by ethnicity but did find that Black or Black British Asian or Asian British babies had a more than 50% higher risk of perinatal mortality.⁵ The review report did not include specific recommendations or commitments for mothers from different ethnic groups. It set out how services might need to tailor their approach for mothers from different ethnic groups:

- a. For families from black and minority ethnic (BME) backgrounds, this might mean greater engagement between service providers and their communities. On an individual level, it might mean taking the extra time to gauge understanding of the language being used at an appointment or to understand cultural differences and the additional support that

⁴ NHS England, [Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care](#), February 2017

⁵ *Ibid*, para 4.38

might be needed for fathers to play a supportive role in the birth process, particularly during the antenatal stage.

b. For those who have difficulty communicating, it might mean providing information in a format which is easy to read and understand, free from complex concepts or medical terminology. Alternatively, it might mean providing an interpreter or translating the key points into their native language.

c. For women in the Gypsy and Traveller communities this might mean professionals taking extra time to discuss and understand their lifestyle choices and not make assumptions about their feeding preferences or about the safety of their home environment.⁶

In response to Better Births and as part of a wider [Maternity Transformation Programme](#) the Government launched its [Safer Maternity Care action plan](#) in October 2016 as “part of the national ambition to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth, by 2030.”⁷ The Plan states that in relation to maternal deaths:

Public Health England (PHE) is leading the ‘improving prevention’ workstream of the Maternity Transformation Programme. This involves a range of work to prevent poor outcomes through action to improve women’s underlying health, both in the preconception period and during and after pregnancy, since pregnancy is a window of opportunity to encourage women to live healthier lifestyles. The work focuses on reducing levels of the risk factors known to influence poor outcomes, including rates of stillbirths, neonatal deaths and maternal deaths. These include smoking during pregnancy, obesity and substance misuse.⁸

1.2

The NHS Long Term Plan

NHS England’s [NHS Long Term Plan](#), published in January 2019, set out a number of proposals to “achieve a 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025”.⁹

Targeted support for BAME groups and vulnerable mothers included (emphasis added):

Developing continuity of carer teams across the country – with the aim that in 2019, 20% of pregnant women will be offered the opportunity to

⁶ Ibid, p36

⁷ Department of Health, [Safer Maternity Care action plan](#), October 2016, Executive summary

⁸ Ibid, p16

⁹ NHS England, [The NHS Long Term Plan](#), January 2019; para 3.9

have the same midwife caring for them throughout their pregnancy, during birth and postnatally. **By March 2021 the aim is that most women will receive continuity of the person caring for them during pregnancy, during birth and postnatally.**¹⁰

The plan stated that women who receive continuity of care were:

16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth. This will be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.¹¹

The Plan also stated that recommendations from the ‘National Maternity Review: Better Births’ were being implemented through Local Maternity Systems:

These systems bring together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting. **By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative.** Every national, regional and local NHS organisation involved in providing safe maternity and neonatal care has a named Maternity Safety Champion. Through the Collaborative and Maternity Safety Champions, the NHS is supporting a culture of multidisciplinary team working and learning, vital for safe, high-quality maternity care. Twenty Community Hubs have been established, focusing on areas with greatest need, and acting as ‘one stop shops’ for women and their families. These hubs work closely with local authorities, bringing together antenatal care, birth facilities, postnatal care, mental health services, specialist services and health visiting services.¹²

1.3

Better Births Four Years On: A review of progress

A [review of progress report on Better Births](#) was published in March 2020. The review found that mortality rates remain higher for Black or Black British and Asian or Asian British babies. Whilst stillbirth rates for these groups had reduced over the period 2015 to 2017 from 8.17 to 7.46 and from 5.88 to 5.70 per 1,000 total births respectively, neonatal mortality rates increased over the same period from 2.45 to 2.77 and from 2.50 to 2.86 per 1,000 live births

¹⁰ Ibid, para 3.13

¹¹ Ibid

¹² Ibid, para 3.12

respectively. The neonatal mortality rate for England and Wales for all groups was 1.6 per 1,000 live births between 2014 and 2017.

In relation to the care of Black, Asian and minority ethnic mothers, the review repeated the commitment made in the January 2019 NHS Long-term plan to improve maternity services by developing continuity of care services for all pregnant women, targeting vulnerable groups including women from BAME groups. The 2020 review stated (emphasis added):

Inequalities in outcomes from maternity services for women and babies must be tackled if we are to offer families the best start in life. The NHS Long Term Plan set out in January 2019 clear and costed plans to prioritise improvements in maternity services for the most vulnerable groups – **Black, Asian and ethnic minority families, and those from the most deprived areas – particularly rolling out the continuity of carer service model to 75% of this group by March 2024.** These improvements, and identifying how transformation can reduce health inequalities across all fronts, are key priorities for the Maternity Transformation Programme as it enters its next phase.¹³

1.4

Support for pregnant Black, Asian and Ethnic Minority (BAME) women during the pandemic

In June 2020 the Government announced additional support for pregnant Black, Asian and Ethnic Minority (BAME) women following research showing that they were at a heightened risk of hospitalisation with Covid-19. The [announcement](#) stated that NHS England's Chief Midwifery Officer, Jacqueline Dunkley-Bent, had written to all maternity units in the country calling on them to take four 'common sense steps' to minimise the additional risk of Covid-19 for Black, Asian and minority ethnic women and their babies. The steps are:

- Increasing support of at-risk pregnant women – e.g. making sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women from a BAME background.
- Reaching out and reassuring pregnant BAME women with tailored communications.
- Ensuring hospitals discuss vitamins, supplements and nutrition in pregnancy with all women. Women low in vitamin D may be more vulnerable to coronavirus so women with darker skin or those who always cover their skin when outside may be at particular risk of

¹³ NHS, [Better Births Four Years On: A review of progress](#), March 2020; p5

vitamin D insufficiency and should consider taking a daily supplement of vitamin D all year.

- Ensuring all providers record on maternity information systems the ethnicity of every woman, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes.¹⁴

1.5

Parliamentary reports

Joint Committee on Human Rights Inquiry

The Joint Committee on Human Rights, in its wider inquiry on [Human Rights, Black people, racism and human rights](#) in 2020-21 examined the issue of higher rates of death among Black pregnant women. During an evidence session with Jacqueline Dunkley-Bent, the Chief Midwifery Officer at NHS England and NHS Improvement (NHEI) told the Committee that the Government did not have a target to reduce the racial disparity in death rates of pregnant women¹⁵.

In its report on the inquiry, the JCHR said of the Government's approach to improving the care of Black, Asian and ethnic minority mothers:

The NHS's Maternity Transformation Programme, "Better Births" which began in 2016 made no specific commitments in relation to women from Black, Asian and ethnic minority backgrounds. Not until the NHS Long Term plan was published in January 2019, was a commitment made to ensuring that by 2024, three-quarters of pregnant women from Black, Asian and minority ethnic minorities will receive care from the same midwife before, during and after they give birth. This pledge was repeated in the review of the Better Births programme, published in March 2020. It was the only specific recommendation relating to Black, Asian and minority ethnic women. When we questioned Professor Jacqueline Dunkley-Bent about this, she stressed that the NHS Long Term plan works on "the principle of proportionate universalism, providing care at a level of scale and intensity that is equal to the level of disadvantage." So, while elements such as "continuity of care" are a universal offer, "black, Asian and minority ethnic women will benefit where they are considered to be more likely at risk."

The report included specific recommendations that the Government: introduce a target to end the disparity in maternal mortality between Black

¹⁴ NHS England, [NHS boosts support for pregnant black and ethnic minority women](#), 27 June 2020

¹⁵ Oral evidence: [Black people, racism and human rights](#), HC 559; Q17

women and White women;¹⁶ and implement the Chief Midwifery Officer's four-point action plan to better support ethnic minority women during the Covid-19 pandemic as a matter of urgency.¹⁷

The full report and the Government's response to the inquiry are available on the [Committee website](#).

Health and Social Care Committee Inquiry

In July 2020, the House of Commons Health and Social Care Select Committee launched an inquiry into [The Safety of Maternity Services in England](#). The Committee's call for evidence announced that the focus of the inquiry was to examine "recurrent failings in maternity services" and the action needed to improve safety for mothers and babies.

Although the remit of the inquiry was to examine the provision of NHS maternity services for all women, evidence of the inequalities faced by Black and ethnic minority mothers emerged as a recurring issue in the evidence presented to the Committee during the inquiry. During an evidence session with Professor Ted Baker, the Chief Inspector of Hospitals at the Care Quality Commission (CQC), the Committee asked what steps CQC was taking to understand and address the racial disparities in maternal and neonatal deaths.¹⁸

Professor Baker's view was that the statistics were a measure of the lack of understanding of the issues of safety in some health services. He told the Committee that CQC were examining building "ethnic differences in outcomes into our inspections because we recognise that is an important aspect of safety."¹⁹ He added:

Not only is it about the safety of individual women; it is also about the safety culture of the organisation that it does not allow such disparities to occur. We think it is very important to focus on that going forward, and to see it as an important measure of the overall safety of the unit and the leadership culture of the unit. We will be focused on that going forward. For too long, we have seen major disparities, particularly in maternal mortality for black and minority ethnic women, but also, as you say, neonatal mortality.²⁰

The [Committee's inquiry report](#), published on 26 July 2021, was critical of the lack of action taken by the Government to address health inequalities for women from minority ethnic and socio-economically disadvantaged

¹⁶ Joint Committee on Human Rights, [Black people, racism and human rights](#), 11th report of 2019-21; HC 559/HL paper 165, November 2020; para 45

¹⁷ Ibid, para 48

¹⁸ Health and Social Care Committee [Oral evidence: Safety of maternity services in England](#), HC 677, 29 September 2020

¹⁹ Ibid Q36

²⁰ Ibid

backgrounds.²¹ It found that despite those “disparities being well documented for many years there has been little progress in closing the gap.”²² The Committee agreed with the earlier recommendation of the JCHR that a target be introduced to end maternal health inequalities. It said:

Given the underlying causes of these outcomes for women from Black, Asian and minority ethnic groups relate to a range of issues beyond the remit of the Department, we recommend that the Government as a whole introduce a target to end the disparity in maternal and neonatal outcomes with a clear timeframe for achieving that target. The Department must lead the development of a strategy to achieve this target and should include consultation with mothers from a variety of different backgrounds.²³

An [evaluation report](#) of the Government’s commitments for maternity services by the Health and Social Care Committee’s Expert Panel was published on the same day as the Committee’s inquiry report. The Panel awarded ‘CQC-style’ ratings to Government commitments on maternity safety. The commitments were on: maternity safety; continuity of carer; personalised care and support plans; and safe staffing. The Panel’s overall ratings for each commitment were either ‘inadequate’ or ‘requires improvement’.²⁴

The Expert Panel also examined ‘equality of maternity outcomes’ and found that:

- Data provided by the Department demonstrate an increased risk of neonatal death, stillbirth and maternal death for women and babies from some minority ethnic and socio-economically deprived backgrounds.
- The disparity in safety outcomes for disadvantaged women and babies has persisted since 2010.
- Written submissions and testimonies from our focus group illustrate that women from disadvantaged backgrounds are more likely to have disproportionately negative birthing experiences.
- Evidence from our roundtable events demonstrates a lack of centralised resourcing and support for targeted initiatives to reduce inequalities in maternity experiences and outcomes.²⁵

²¹ Health and Social Care Committee, [The safety of maternity services in England](#), HC 19, 6 July 2021

²² Ibid p4

²³ Ibid para 138

²⁴ The Health and Social Care Committee’s Expert Panel: [Evaluation of the Government’s progress against its policy commitments in the area of maternity services in England](#), HC 18, 6 July 2021

²⁵ Ibid, p9

2 Parliamentary Material

2.1 Committee Material

[The safety of maternity services in England](#)

Fourth Report of Session 2021–22

House of Commons Health and Social Care Committee

HC 19

6 July 2021

[The Health and Social Care Committee’s Expert Panel: Evaluation of the Government’s progress against its policy commitments in the area of maternity services in England](#)

First Special Report of Session 2021–22

House of Commons Health and Social Care Committee

HC 18

30 June 2021

[Black people, racism and human rights: Government Response to the Committee’s Eleventh Report of Session 2019–21](#)

Fourth Special Report of Session 2019–21

House of Commons & House of Lords Joint Committee on Human Rights

HC 1210

11 February 2021

[Black people, racism and human rights](#)

11th Report of Session 2019–21

House of Commons & House of Lords Joint Committee on Human Rights

HC 559 HL Paper 165

11 November 2020

2.2 Early Day Motions

[Black maternal health](#)

EDM 1709 (session 2019-21)

12 Apr 2021

Bell Ribeiro-Addy

That this House recognises the existing racial inequalities in maternal health; notes with great sadness that Black women in the UK are four times more likely to die in pregnancy and childbirth, that women of mixed heritage are three times more, and Asian women are two times more likely to die in pregnancy and childbirth; further notes that women of Black African heritage are 83 per cent more likely to suffer a near miss in childbirth, and women of Black Caribbean heritage are 80 per cent more likely; acknowledges the MBBRACE analysis which has found that black babies have a 121 per cent increased risk for stillbirth and a 50 per cent increased risk of neonatal death; supports the work of Five X More and their efforts to raise awareness of Black maternal health inequalities; is shocked by the 2020 Black people, racism and human rights report which confirms statistics but reveals that there is no target to end it; and urgently calls on this Government to fully acknowledge these disparities and commit to working with the NHS to improve Black maternal health outcomes.

2.3

Debates

[Black Maternal Healthcare and Mortality](#)

Motion, That this House has considered e-petition 301079, relating to Black maternal healthcare and mortality.

19 Apr 2021 | House of Commons | Westminster Hall | 692 cc148-174WH

2.4

Parliamentary Questions

[Maternal Mortality: Ethnic Groups](#)

16 Jul 2021 | 29891

Asked by: **Marsha De Cordova**

To ask the Secretary of State for Health and Social Care, what assessment he has made of proposals to set a target to reduce the maternity mortality gaps experienced by Black and Asian women.

Answering member: Ms Nadine Dorries | Department: Department of Health and Social Care (DHSC)

The Health and Social Care Committee published its report on 6 July following its inquiry into the Safety of Maternity Services in England. The report recommended that the Government introduce a target to end the disparity between black, Asian and minority ethnic groups and white women in maternal and neonatal outcomes with a clear timeframe for achieving that target. The Department is assessing the proposals and recommendations

made by the Health and Social Care Committee and will publish its response in due course.

Maternal Mortality: Ethnic Groups

06 Jul 2021 | 24176

Asked by: Catherine McKinnell

To ask the Minister for Women and Equalities, what steps the Race Disparity Unit has taken to support the Department of Health and Social Care in reducing maternal mortality rates among black women.

Answering member: Kemi Badenoch | Department: Women and Equalities

The government is committed to understanding and addressing the ethnic disparities in maternal mortality rates. Maternal deaths are fortunately rare and overall women's experiences of maternity care are positive, but it remains important we encourage every expectant mother to engage with NHS maternity services so they get the support they are entitled to.

I have been supporting the Department of Health and Social Care (DHSC) in this area since last summer. This includes co-hosting a roundtable discussion on maternal mortality rates for ethnic minority women in September 2020, which identified the need for more intelligent use of data to target action.

Following this, officials in the Race Disparity Unit have been working with DHSC colleagues to understand how data can be disaggregated and flow more easily among NHS agencies, and research bodies. They have also been supporting DHSC officials on initiatives such as the new £7.6m Health and Wellbeing Fund that will support 19 projects to reduce health inequalities among new mothers and babies.

Maternity Services: Ethnic Groups

30 Jun 2021 | 22067

Asked by: Rachel Hopkins

To ask the Secretary of State for Health and Social Care, whether he is going to implement the recommendations of the Joint Committee on Human Rights Eleventh Report of Session 2019–21, Black people, racism and human rights, relating to Black Maternal Health.

Answering member: Ms Nadine Dorries | Department: DHSC

The Joint Committee on Human Rights report recommends that the Government introduces a target to end the disparity in maternal mortality between black and white women.

Work is being undertaken by the Chief Midwifery Officer for England to understand why mortality rates are higher, consider evidence about what will reduce mortality rates and take action to improve equity in outcomes and experience of care for mothers and their babies. Research is also being

carried by the Policy Research Unit in Maternal and Neonatal Health and Care at the University of Oxford to better understand the reasons for any disparity, assess local variation and also identify areas with less disparity and hence best practice. The Department does not plan to introduce a target to reduce inequalities in maternity outcomes in England whilst this work takes place.

Maternity Services: Ethnic Groups

30 Jun 2021 | 22066

Asked by: Rachel Hopkins

To ask the Secretary of State for Health and Social Care, if he will implement a plan to improve maternal outcomes for Black women.

Answering member: Ms Nadine Dorries | Department: DHSC

The Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent, is leading work to understand why mortality rates are higher, consider evidence about what will reduce mortality rates and take action to improve equity in outcomes for mothers and their babies. NHS England and NHS Improvement are also working to develop an equity strategy that will focus on reducing disparities for women and their babies from black, Asian and minority ethnic (BAME) groups and those living in the most deprived areas.

The NHS Long Term Plan commits to ensuring that by 2024, 75% of BAME groups and a similar proportion of women who live in the most deprived areas, will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.

Maternity Services

28 Apr 2021 | 179522

Asked by: Marsha De Cordova

To ask the Secretary of State for Health and Social Care, what proportion of new mothers from Black, Asian and ethnic minority backgrounds was offered the continuity of care midwifery model in (a) 2019-20 and (b) 2020-21.

Answering member: Ms Nadine Dorries | Department: DHSC

NHS England and NHS Improvement's latest survey of 108 trusts indicated that in October 2020, services had continuity of carer teams in place to offer continuity to 15.9% of women. That represents 2,322 midwives offering continuity of care to an estimated 94,000 women. Of these teams, over 60% or 214 were reported as being placed in areas of deprivation and approximately half or 165 in areas with high proportions of black, Asian and mixed ethnic groups.

Information on the proportion of new mothers from black, Asian and ethnic minority backgrounds offered continuity of carer in 2019-20 and 2020-21 is not available. NHS England and NHS Improvement are working with trusts to improve the quality of data recorded in maternity information systems, so

provision of continuity of carer can be evidenced nationally from routine care records of all women, including those that are of black, Asian and mixed ethnic groups, or living in deprived areas.

Maternal Mortality

27 Apr 2021 | HL14779

Asked by: The Lord Bishop of London

To ask Her Majesty's Government when they expect to publish a report on the work to reduce health inequalities around maternal mortality rates, in particular the higher rate of death in childbirth for Black women, led by Professor Jacqueline Dunkley-Bent OBE; and what action will be taken as a result of this report.

Answering member: Lord Bethell | Department: DHSC

NHS England and NHS Improvement are working with a range of national partners, led by the Chief Midwifery Officer for England and the National Specialty Advisor for Obstetrics, to develop an equity strategy which will focus on women and their babies from black, Asian and mixed ethnic groups and those living in the most deprived areas.

The National Perinatal Equity Strategy is in its final stages of development and will be published in the coming months. Following the publication, the Local Maternity Systems will be asked to submit an equity analysis covering health outcomes, community assets and staff experience and a co-production plan by 30 September 2021. Local Maternity Systems will then co-produce equity action plans by 31 December 2021.

Mental Health: Ethnic Groups

21 Apr 2021 | 181325

Asked by: Thangam Debbonaire

To ask the Secretary of State for Health and Social Care, what steps his Department is taking to end the disparity in maternal health outcomes between white women and black, asian and minority ethnic women.

Answering member: Ms Nadine Dorries | Department: DHSC

We have established the Maternity Inequalities Oversight Forum to bring together experts to address the inequalities for women and babies from different ethnic backgrounds and socio-economic groups. Additionally, the Chief Midwifery Officer for England is leading work to understand why mortality rates are higher, consider evidence about what will reduce mortality rates and take action to improve equity in outcomes and experience of care for mothers and their babies.

Under measures set out in the 2021/22 Planning Guidance, most women from black, Asian and mixed ethnicity backgrounds will be placed on a continuity of carer pathway by March 2022. This will ensure that thousands of women

receive safe and personal maternity care, improving outcomes for both mother and baby and reducing health inequalities.

Maternal Mortality: Ethnic Groups

11 Jan 2021 | 133765

Asked by: Ms Lyn Brown

To ask the Minister for Women and Equalities, what conclusions were reached on further actions that can be taken to tackle ethnic disparities in maternal mortality, following the roundtable of 2 September 2020.

Answering member: Kemi Badenoch | Department: Women and Equalities

Following the roundtable on 2 September, officials in the Cabinet Office Race Disparity Unit are supporting the Department of Health and Social Care in driving positive actions through a number of interventions on maternal mortality from an equalities perspective.

For example, NHS England and Improvement are introducing a funded and comprehensive national support offer which will be mobilised later this year. This will require Local Maternity Services to work towards achieving the ambition that 75% of Black and Asian women receive continuity of care by 2024.

Maternal Mortality: Ethnic Groups

11 Jan 2021 | 133764

Asked by: Ms Lyn Brown

To ask the Minister for Women and Equalities, what conclusions were reached on the causes of ethnic disparities in maternal mortality, following the roundtable of 2 September 2020.

Answering member: Kemi Badenoch | Department: Women and Equalities

At the roundtable on 2 September, leading experts in the field clarified that underlying health conditions and comorbidities largely explain ethnic disparities in maternal mortality rates.

Maternity experts also linked this to a reluctance by some women from minority backgrounds to attend routine appointments and check-ups where many of these conditions are typically identified.

The government continues to work with maternal health practitioners and ethnic minority women to drive positive actions and interventions in this area so that our actions can benefit more women. This includes the recently launched NHS campaign 'Help us Help You', informing pregnant women about the importance of attending check-ups, and providing reassurance that the NHS is there to see them safely.

Maternal Mortality: Ethnic Groups

06 Jan 2021 | 120861

Asked by: Jackie Doyle-Price

To ask the Secretary of State for Health and Social Care, what steps he is taking to reduce the rate of maternity deaths among Black, Asian and minority ethnic women.

Answering member: Ms Nadine Dorries | Department: (DHSC)

The NHS Long Term Plan outlines plans to reduce health inequalities and address unwarranted variation in maternity care. This work is led by NHS England through the Maternity Transformation Programme. Targeted and enhanced continuity of care from the same midwife, or group of midwives can significantly improve outcomes for women. The NHS Long-Term plan sets out that 75% of black women will receive continuity of carer from midwives by 2024.

Work to reduce health inequalities around maternal mortality rates is being led by Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer. This includes understanding why mortality rates are higher, considering evidence about what will reduce mortality rates and taking action.

Maternal Mortality: Ethnic Groups

07 Dec 2020 | 122820

Asked by: Kate Osamor

To ask the Secretary of State for Health and Social Care, if he will make it his policy to introduce a target for the NHS to end the disparity in maternal mortality between Black women and white women.

Answering member: Ms Nadine Dorries | Department: DHSC

Work to reduce health inequalities around maternal mortality rates is being led by Professor Jacqueline Dunkley-Bent OBE, the Chief Midwifery Officer. This includes understanding why mortality rates are higher, considering evidence about what will reduce mortality rates and taking action.

We have established the inequalities oversight forum, with a group of clinical experts, to understand the reasons why the death rate for black women in childbirth is five times higher than for white women and to find out what we can put in place to ensure that, by addressing those issues, we reduce the number of deaths.

3 Press and journal articles

The following is a selection of news and media articles relevant to this debate.

Please note: The Library is not responsible for either the views or the accuracy of external content.

3.1 Press articles

[Is childbirth more dangerous for Black women in the UK?](#)

Open Access Government

23 August 2021

[Higher ethnic minority maternity risk examined](#)

BBC

22 June 2021

[‘I felt humiliated’: parents respond to NHS maternity care racial bias inquiry](#)

Hannah Summers, The Guardian

13 April 2021

[New dedicated mental health services for new expectant and bereaved mums](#)

NHS England

6 April 2021

[NHS commits £95m to maternity safety after Shrewsbury scandal](#)

Mimi Launder, Nursing in Practice

1 April 2021

[The Black Maternity Scandal: Women react to the Dispatches documentary on black mothers' mortality rates](#)

Ellie Abraham and Nadine White, The Independent

30 March 2021

[The Black Maternity Scandal: Dispatches](#)

Channel 4 Dispatches

26 March 2021

[My pregnancy nearly killed me and my daughter did not survive, says MP](#)

Lewis McKenzie, Press Association via Nexis News [may require subscription]

11 March 2021

[Black women in the UK four times more likely to die in pregnancy or childbirth](#)

Hannah Summers, The Guardian

15 January 2021

[Black mothers in the UK are four times more likely to die in childbirth than their White counterparts. Little is being done to find out why](#)

Tara John, CNN

14 January 2021

[Human rights of Black people not equally protected, say Committee](#)

Human Rights (Joint Committee), UK Parliament

11 November 2020

['Something has to be done': tackling the UK's Black maternal health problem](#)

Alexandra Topping, The Guardian

2 October 2020

[NHS boosts support for pregnant black and ethnic minority women](#)

NHS England

27 June 2020

[Five X More: First UK Black women's maternal health awareness week](#)

Melan

15 September 2020

3.2 Journal articles

[Structural racism is a fundamental cause and driver of ethnic disparities in health \[requires subscription\]](#)

Mohammad S Razai, Azeem Majeed and Aneez Esmail, BMJ

12 April 2021

[What did the Commission on Race and Ethnic Disparities say on health?](#)

Gareth Iacobucci, BMJ

9 April 2021

[Disparity in maternal deaths because of ethnicity is "unacceptable"](#)

Matthew Limb, BMJ

18 January 2021

3.3 Press releases

[Government working with midwives, medical experts, and academics to investigate BAME maternal mortality](#)

Government Equalities Office, Race Disparity Unit and Kemi Badenoch MP
2 September 2020

- Maternal mortality now occurs in fewer than 1 in 10,000 pregnancies, but the disparity between Black women and White women has widened
- Government brings together frontline midwives, medical experts, and health academics to ensure every mother has access to a safe, special birth
- Minister for Equalities, Kemi Badenoch, says: “Whoever you are and wherever you live, the birth of a child should be a wonderful, momentous time”

[RCOG Position Statement: Racial disparities in women’s healthcare](#)

Royal College of Obstetricians & Gynaecologists

6 March 2020

4 Further Reading

4.1 Reports

[Saving Lives, Improving Mothers' - Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18](#)

MBRRACE-UK
December 2020

[Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust](#)

Donna Ockenden
11 December 2020

[Ockenden review of maternity services](#) (Letters)

NHS England
11 January 2021

[Better Births Four Years On: A review of progress](#)

NHS England and NHS Improvement
4 March 2020

[Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care](#)

NHS England
February 2017

4.2 Websites

[Five X More](#)

A grassroots organisation committed to changing Black women's maternal health outcomes in the UK

[MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK](#)

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