Health Inequalities – People's experiences of services before, during and after pregnancy.

March 2025 Briefing Paper

Table of Contents

This briefing paper is provided by Healthwatch across West Yorkshire and pulls together extensive engagement from Healthwatch, NHS partners and other research and third sector sources. It is a summary of the key messages relating to people's experiences of maternity and before pregnancy (preconception) that we have heard, with a specific focus on health inequalities in the following areas:

- Inequalities in mental health support before, during and after pregnancy (perinatal)
- Smoking cessation services in maternity
- Support before pregnancy (preconception)
- Inequalities in access to maternity pathways including time of booking.

The key themes and messages have come from reviewing collated insight from the following sources:

- Insight and reports from our local Healthwatch organisations and Integrated Care Board engagement colleagues.
- Conversations during January to February 2025 with the five Maternity and Neonatal Voices Partnership Leads that cover the West Yorkshire and Craven area and the Maternity and Neonatal Independent Senior Advocate. You can find out more about the role of the Maternity and Neonatal Voices Partnership on the maternity voices website: www.maternityvoices.co.uk . And more information about the role of the Maternity and Neonatal Independent Senior Advocate can be found on the West Yorkshire Partnership website in the Our Priorities: Maternity section.
- Conversations with West Yorkshire Voice members: Leeds Gate; the Yorkshire and Humber Perinatal Mental Health Coproduction group.

- Other relevant reports and insight relating to maternity and preconception.

For more details about the sources we collated, please see the references section at the end of this report. This briefing brings together the key themes relating to people's views and experiences of maternity and preconception services in West Yorkshire and identifies some key recommendations (see section 7).

It is important to note that because of the focus in this paper on aspects of people's experiences that relate to inequalities in access, outcomes and experience, there will undoubtedly be more feedback about the barriers people have experienced and when things haven't worked well. We want to acknowledge alongside this that many people have shared very positive experiences of their maternity and postnatal journeys giving examples of good person-centred and compassionate care. We also need to recognise that often people do not just identify with one characteristic associated with greater risk of health inequalities and we should always consider how 'layers of inequality' can often multiply the impacts on people's health, experience and access to services.

Finally, we would like to thank everyone who has contributed to or shared their experiences that has resulted in us being able to pull together this report.

1. Support before pregnancy (preconception)

From the sources available, there was limited insights on people's views and experiences of the support they received before pregnancy. The feedback that does exist [1] highlights the following themes:

- Lack of awareness about services available (See section 2.4).

- Lack of information on lifestyle factors potentially affecting someone's ability to get pregnant such as smoking and drinking alcohol.
- Absence of information about miscarriage and where people can go to access support.
- Varied awareness and understanding of contraception to help people make informed decisions.
- Knowing where to go for mental health and wellbeing support.
- Lack of information around getting pregnant (pre-conception) and support for people assigned male at birth to make proactive steps in increasing the chance of pregnancy.

We heard positive feedback about the Bradford maternity circles (support groups for pregnant or new parents)You can find out more about the maternity circles and Abbie's story on the Bradford and Craven Health and Care Partnership website. One of the positive outcomes has been upskilling and building confidence in the community organisations where the circles are hosted. This has supported these organisations to have better and ongoing conversations with people accessing their services around things like contraception, effects of smoking and drinking on conception and pregnancy and support available.

2. Access to maternity services

2.1 Early access to Antenatal care (care while pregnant)

In 2023, some workshops were run with 26 people (South-East Asian, Sudanese and White British) in Bradford, Leeds and Kirklees about their understanding of antenatal care and experiences of booking appointments[2].

Overall, there was some basic understanding of what antenatal care involved and how to book, however, this was less likely to be the case for first time mothers and people who had recently arrived in the UK. There were gaps in knowledge of the 'book by 10 weeks' message with people thinking they should book anywhere between 6 and 12 weeks. People also lacked detailed knowledge of the benefits to the pregnant person and baby of early booking.

There was a preference for booking the first antenatal care appointment via the GP which most people reported finding straightforward. However, we did also hear via the Leeds Maternity and Neonatal Voices Partnership about people being turned away by GP receptionists if they were less than 10 weeks pregnant, which was confusing for them as it contradicts the current messaging.

People from two of the four focus groups (Bradford and Kirklees), reported experiencing difficulties with the online booking system. This was echoed by mixed experiences in a very recent piece of work in HX1 and the surrounding areas of Calderdale[3] where some people found the process easy, straightforward and helpful whilst others found it difficult, especially if they needed language support.

“Really difficult, I needed my husband to do it. He had to ring the midwife three times to get the link sorted to get online… I couldn’t have done it without my husband.”

“Really struggling with my pregnancy notes. Staff at family hub are helping me to know where to go. Find my pregnancy notes very difficult to navigate and have missed appointments because of it.”

We also heard via the Calderdale Maternity and Neonatal Voices Partnership that people are having varying experiences when they turn up at their GP surgery to register with a midwife. Some are being directed to the online form and to the Family Hubs if they need support with registering, but not everyone is told about this support being available. In Wakefield district, people reported that it was not clear what happened next after they’d completed the online registration and there was some feedback that people had come close to 12 weeks pregnant before they had been seen by a midwife.

From all our collated insight, the following have been identified as possible barriers to early booking:

- Fear of judgement or social service involvement, e.g., because of young age, personal circumstances or because already ‘late’ booking.
- Cultural differences, such as the family being the primary support in pregnancy, or superstition about loss before three months. Some pregnant African-Caribbean people in Bradford said that early booking sometimes did not happen due to fear and suspicion around baby mortality[4].
- Perceptions that appointments will be difficult to access, or uncertainty about what is involved, especially for first time parents or people who are newly arrivals to this country.

- Lack of knowledge about what to do, or how to book an appointment, especially for those without prior experience.
- Lack of confidence in speaking to health professionals.
- Difficulty in physically attending appointments (e.g. transport barriers or costs, lack of parking or having childcare responsibilities). Lack of childcare provision at appointments could also make attendance difficult for some people.
- Language barriers and low health literacy (see sections 2.3 and 2.4).
- Online booking processes where non-digital options are not offered.
- A lack of available, accessible appointments.
- Lifestyle factors such as being homeless, addictions, experiencing domestic abuse etc
- Refugees and asylum seekers may assume that they need to pay for maternity services, so delay seeking care[5].
- We heard that for some people from the Gypsy and Traveller community, tradition is very important with people relying on their extended family for advice. The suggestion of external help can sometimes be viewed as insulting – ‘we know how to look after our own’ - and fear of discrimination is also an underlying issue. This was also expressed by Romanian women in a focus group.[25]

  “We (Romanians) are prepared for everything in life. We’re a big community who share information and prepare each other for life, so we don’t need to ask midwives or doctors everything.”

- People from the Gypsy and Traveller community also told us that modesty can be important, and this coupled with high rates of children not attending school, result in conversations around puberty, sex etc often not happening. This means a lot of people have no idea what to expect when pregnant but won’t seek professional help.

People shared the following about what may help with early booking:

- Accessible, community-based, child friendly locations for antenatal appointments that have a less formal feel and are integrated with other services, e.g. health visiting, welfare advice.
- Non-digital options for booking appointments that are accessible for all.
- Making it easy for women to understand the process including how to book, where they will go, what will happen, and where antenatal care fits into the pregnancy pathway.
- Simple straightforward English language was preferred by some. Use of visuals to explain.
- Inclusive, non-judgemental approaches and personalised care.
- Raising awareness of the importance of early antenatal care and the benefits this can bring, including what parents are eligible to receive (e.g. folic acid, benefits, wellbeing support).
- A more diverse and representative workforce.
  "If the midwifery team could reflect the community in which the team support… It helps to have someone who looks familiar and gives a real sense of trust and confidence especially when you can't speak English well."

2.2 Receiving care across geographical boundaries

This was raised as an issue by some people in Wakefield, Kirklees and Calderdale where their GP and community midwives were in a different area to where they chose to give birth. The main issues reported were systems not talking to each, the onus on the birthing person to supply information, and differences in care in different areas.

2.3 Language barriers/access to interpreters

The following themes were identified from some work done in Leeds with refugee and asylum seekers[6] alongside wider feedback from across West Yorkshire.

- There was a mixed experience of access to interpreters. Some people reported a good experience, whilst others reported interpreters not being available for appointments, scans and during labour, despite them being requested.
- People with Haamla midwives in Leeds said that they always used telephone interpreters whilst others with non-specialist midwives said interpreters weren't always used.
- Sometimes interpreters who spoke a specific dialect weren't available, resulting in people having to communicate in their second language. Recording people's country of origin and any dialect spoken is just as important as the language spoken.
- Sometimes people prefer their family members or friends to interpret for them but other times they are relied on in the absence of an interpreter which means people having to share sensitive information with people that they may not have otherwise chosen to.
- Some people said they felt they were not offered interpreters because of their reasonably good level of conversational English. Sometimes the assumption was also made that if a person speaks English (even if it is their first language) that they can also read written English which is not always the case. This can be a common issue for Gypsy, Traveller and Roma communities.
- People may miss their appointments or other important information because they can't read English or are illiterate. The Maternity and Neonatal Independent Senior Advocate gave an example of the

candour letters, which are sent after the loss of a baby, only being written in English.

- There were varied reports of the quality of interpreting, with interpreters sometimes not interpreting information fully or using incorrect terminology. Interpreters may also not understand medical terms, so it is important that things are explained clearly by professionals in plain English.

2.4 Knowledge, information and education

Lack of awareness about the services and support available to people before, during and after birth was a recurring theme identified by groups most at risk of health inequalities and where there might be additional barriers around language and literacy.

People told us that information is not always written and in a format that is accessible to different communities, e.g. in different languages, formats. For example, Healthwatch Wakefield heard from an autistic expectant parent who was struggling to fit all her questions into her appointments and wanted clearer directions as to what information and support she could access and when.

Pregnant people who are new to the UK shared how confusing it can be to understand how maternity and post-natal services are structured as they are often very different to in their home countries[5]. Some people shared difficulties understanding the different terminology used, even if they spoke good English. They may not have encountered terms such as “birth plan” or understand the roles of different professionals they may encounter. Some people who weren’t giving birth for the first time shared that they felt staff assumed they didn’t need much support and that there was a lack of recognition that having a baby in a new country can be scary.

One Arabic woman explained on a visit to Calderdale Royal Infirmary how nervous she felt at 30 weeks pregnant, not understanding English, and the lack of signage in her language to tell her where to go in an emergency, or at onset of labour. She suggested how helpful it would be to have universal visual signage directing people to the maternity area of the hospital or having in person tours for pregnant women. Although there are website virtual tours of all the maternity sites in West Yorkshire, only one of these is in different languages (Leeds). Bradford is the only place that has in person tours (Stork Walks) of the labour ward and birth centre which are really welcomed by people.

People find the information they need during pregnancy in different ways. For example, family and friends and particularly mothers and mother-in laws are relied on in some communities. In recent conversations in HX1 and surrounding areas with predominantly Black and Asian people, many of whom were born overseas, attending a group or getting information from a health professional was the most preferred method[3].

"Too many leaflets and information at the start of pregnancy – I do not always understand it all, nothing feels personal. Be good to be able to drop in somewhere… and ask for support."

For some people, Google searches, online groups or video / pictorial format was generally preferred to leaflets[5]. Others said they relied on community organisations to support them, particularly those who were seeking asylum[2].

Information also extends to making sure people receive the information they need to improve their awareness of maternal health. People want information to be culturally appropriate, acknowledging differences in culture and values. This includes recognition that for people that are new to the UK, support may look different to their previous experiences in other countries. For example, Afghani women in Leeds raised with the Maternity and Neonatal Voices Partnership lead that conversations around caesarean sections and the risks that come with birth are not usual in their culture and felt frightening.

There are some excellent examples of where initiatives are helping with health education such as the parent education classes run by the Parenting Team at Bradford Royal Infirmary and the ante-natal group for Black African women in Harehills run by the Health Equity Midwifery Team in Leeds. There are also many community-based initiatives such as Bradford Doulas, maternity circles in Bradford, maternal journal in Leeds and Wakefield (see section 3 for more info) and specialist maternity services such as Haamla in Leeds.

"After the class I get more knowledge. Before I feel scared, but now happy to meet my baby soon." (Leeds maternal journal participant)

This work has been successful in taking a holistic approach to working with communities in supporting, educating, as well as improving confidence and wellbeing.

In a national survey of Muslim women, people shared that they were often not given specific information relating to increased risk of certain pregnancy complications for people from certain minority ethnic groups[7].

Members of the Sikh community in Leeds identified the importance of raising awareness of perinatal mental health to overcome barriers to access in their community[8].

"Language resources in Punjabi, including information in maternity packs to improve mum's awareness. Leaflets for mums in hospital, which will help

reduce guilt if people know about symptoms [of poor perinatal mental health].”

We also heard about the importance of addressing any fears that arise in communities because of investigations or media reports. For example, we heard that the 2021 investigation into neonatal deaths at Bradford Teaching Hospitals Trust led to fear amongst some South-East Asian communities in Bradford about accessing services and that there is ongoing work being done to rebuild trust with communities.

Specific issues identified by the Gypsy and Traveller community were:

- Support provided is different in every area which can be an additional challenge for travelling/roadside communities to keep having to understand new systems.
- It can feel like there is too much information about different services which can be difficult for people with low literacy levels to comprehend and navigate. This can also be an issue for people who are new to a country.

People highlighted that it was important that information is routinely and proactively offered as people may not feel confident or feel too embarrassed to ask. This is particularly relevant for information that may be sensitive, such as support with travel costs[5].

3. Access to mental health support before, during and after pregnancy (perinatal)

Feedback highlighted that once in the system for perinatal mental health support, the care was generally very good but that improvements are needed to better identify and provide referrals to people based on their individual support needs.

“My experience with the South West Yorkshire Perinatal Mental Health team was outstanding looking back… It could be to do with my home visiting mental health nurse as she was INCREDIBLE but also the consistency provided, as excluding holidays and illnesses, I saw the same person for almost 18 months, she knew me back to front and that was invaluable.”

The following barriers to accessing perinatal mental health support were identified from insight shared by Healthwatch, Maternity and Neonatal Voices Partnership leads and the Yorkshire and Humber Perinatal Coproduction Group.

- Lack of awareness of perinatal mental health support and delayed referrals from some GPs, health visitors, midwives and maternity professionals in hospital. It was felt that there needs to be more understanding of the high levels of risk (e.g. suicide, poor health, relationships, bonding with baby etc) and how quickly things can change dramatically for people. Professionals can play a crucial role in picking up signs that may lead to poor perinatal mental health, especially as some people can be very good at masking symptoms and appearing to be functioning in daily life. This can be due to fear of admitting that they are not coping and it’s important that professionals are aware of this.

  “I think my health visitor probably saved my life when she heard my cheery ‘everything’s fine’ after a very traumatic birth and sent someone to check on me a few weeks later ‘in case it hits you.’”

- Recent engagements (2023/2024) in Calderdale and Kirklees[9], Wakefield[10], Leeds[11], and North Yorkshire[12] around the 6 to 8 week GP postnatal checks, identified missed opportunities to pick up on people’s mental health concerns. Although experiences were mixed, many people reported that the check was heavily focused on the baby's health and that questions regarding their mental health, if mentioned at all, felt superficial.

"When asked about my mood and anxiety I expressed I had actually been experiencing heightened anxiety since the birth, but she [GP] simply said, 'But you have good support at home yes?' And then moved on. I am now undergoing CBT counselling for my anxiety months later with the help and advice of my health visitor."

In the Healthwatch North Yorkshire report, 72% of survey respondents said community midwives and health visitors discussed mental health whilst only 60% said that mental health was discussed at their 6 to 8 week GP check.

"Sometimes it just takes an extra five minutes of saying, 'Are you really OK?'"

- Peer support workers told us about inappropriate referrals to their services when people's needs are too high and require clinical input. They stressed that the support they can offer is useful to complement clinical support but not as a replacement.
- People falling between the gaps where need is too high for peer support, but not high enough for referral to specialist perinatal mental health support.
- Lack of understanding around what perinatal mental health is, recognising the symptoms and knowing what support is available. This is higher in some communities due to cultural factors and language barriers (see below).
- Practical factors such as the timing of appointments and not being able to take children to group sessions. Talking therapies for parents in

Wakefield was given as an example of good practice where people can bring babies under the age of one to appointments.

In addition to the above, the following factors have also been identified as leading to inequalities in perinatal mental health:

- Inconsistent provision of interpreters and difficulties establishing relationships through an interpreter (see section 2.3).
- Stigma around mental health in some South Asian communities resulting in lack of disclosure to professionals for fear of exposure, judgement shame and rejection.

  "Mental health can often be seen as a curse."

  "Shushed by the cultural norms, society, family, upbringing."
- Lack of appropriate words in some South Asian languages to express or understand symptoms appropriately and without judgement.

  "I think [women from South Asian backgrounds] do suffer from it, but they don't know what it is either."

  "The word 'mental' means 'crazy' in Punjabi."
- Distrust of services. For example, migrants with unsettled status may have fears of being reported to the home office, and some people may fear external agencies will be informed or that their children will be taken away. Others may have developed mistrust in health care professionals from negative past experiences.

  "I'm a young mum, converted Muslim, had troubles during my teens. If I spoke up about how I felt social services would be involved. I know how the system works and it's wrong to be judged like that."
- Disempowerment – people feeling they have limited control over the decisions made about them.

> **“It may be that women in certain communities, that therapy isn’t the right intervention for them… it may be that they need more community groups… peer support… or crisis lines… it may be that those people need something different... to feel more empowered in their care and treatment.”**

- Digital and financial exclusion – not having the means to access appointments digitally or funds to get to an appointment.
- Lack of cultural humility amongst professionals. Respecting traditions, cultural norms and expectations of women, and family support networks as well as sensitivity to what might be considered taboo or inappropriate for different communities is vital to building trust.
- There also needs to be cultural humility in relation to varied presentation and experiences of maternal health.
- Lack of diverse representation in the workforce.

> **“Representation of different cultures and people who look like us and can speak the language will make a difference to feeling safe enough to access support.” (Sikh person)**

- Racist and discriminatory attitudes can lead to people not feeling comfortable to disclose their worries. (see section 5.5)

Many of the above factors were identified as reducing the likelihood of people feeling safe or confident enough to access services.

There have been some excellent initiatives run across West Yorkshire aimed at providing a safe space and holistic support for people during and after pregnancy. One of these is maternal journal that have been successfully run in Wakefield (The Arthouse) and Leeds (Health Equity Team). Maternal Journal uses creative techniques with people to explore the huge changes, joys and challenges they go through in pregnancy, birth and parenthood. It also provides peer support, information and education about pregnancy, choice and services that are available. It has also been successfully used to help with cultural familiarisation and as a creative way of getting feedback from different communities about their pregnancy, maternity and birthing experiences.

"I definitely felt the benefit of having a creative outlet as another way to explore the different emotions that becoming a mother has brought. I found it really comforting and reassuring to know that other mothers were going through similar things. Coping with overwhelming feelings is an ongoing struggle I've had with my mental health, and I'm now really inspired to try using art journalling as a way to reflect on and process my emotions." (maternal journal participant, Leeds)

Other community-based initiatives providing holistic support include breastfeeding peer support groups and maternity circles. There has also been recognition nationally for the need for mental health support for partners, including same sex co-parents[13] and there is some good work being done with dads in West Yorkshire via Dad Matters, who you can find out more about at https://dadmattersyorkshire.uk/.

4. Smoking during pregnancy

From engagement carried out by Bradford and District Community Empowerment network[14], Leeds Teaching Hospitals Trust[15] and Healthwatch Kirklees[16], the factors given both by pregnant people and health professionals as most influencing why people smoked during pregnancy were:

- Helped people to cope with stress, anxiety and other life factors. (e.g. financial or housing worries, unplanned pregnancies, abusive relationships, having been brought up in care).

> **“I’m fully aware of all the support services out there. GPs and midwives are supportive, offered smoking cessation group to me, but it’s not the right time for me at the moment – cigarettes are my coping strategy.”**

- Other household members and friends also being smokers.
- Difficulty of stopping smoking – coping with addiction and cravings and loss of routine and habit.
- Lack of understanding of risk.
- Perception of Nicotine replacement aids not being as effective as vapes in helping to reduce smoking.
- Quitting not being a priority.
- Experience of previous children being fine, despite smoking during pregnancy.
- Not knowing about safe replacements for smoking during pregnancy.
- Difficulty of attending appointments with young children.
- Fear of being judged or looked down upon if attending a smoking cessation service.

People suggested the following ways of encouraging more people to stop or reduce smoking during pregnancy:

- Helping people to reduce their stress levels
- Educating about the health benefits for the baby and person giving birth as well as the financial savings.
- Involving family members in discussions to support person with stopping smoking and support wider family members to quit if they also smoke.
- Giving people more time at appointment to discuss issues in depth.

> **“If midwives…asked more detailed questions about smoking rather than, ‘Do you smoke?’ / ‘Do you want to stop?’”**

- Providing information on alternatives including vapes.

- Offering choices, to help people fit appointments around work and childcare commitments including evening and weekend, online and phone support options.
- Offering face to face appointments, either at home or in a local community setting appeared to be most effective for sustained engagement with the smoking cessation services.
- Providing more focused education around Carbon Monoxide and how it is linked to specific harms in pregnancy, nicotine addiction cycles, the safety of nicotine replacement therapy (NRT) and vapes. E.g. People felt the visual use of Carbon Monoxide monitoring at home was a motivator
- Making sure that people don't feel judged by staff.

Feedback from South Asian people who had smoked during pregnancy was that smoking was a covert habit for women in their community. They said that health professionals often assumed that they do not smoke and as a result they are not always offered cessation support. There was a strong fear of judgement, both from their communities and professionals, which also discouraged some people from accessing support services[14].

Eastern European people considered smoking as very much part of their daily routine and of those around them. They knew that services existed – and were positive about the offer in comparison to their countries of origin – but hadn't accessed them. Many did not express a desire to stop, or said they wouldn't know how to stop. More than the other groups, they stated they did not want to feel pressured by professionals to stop, preferring support to be more familiar and personal[14].

5. People's experience of care

Whether people have a good experience of care is important. It contributes to how people feel about accessing and engaging with services, and consequently the health outcomes for them and their baby. Below is a summary of the main themes we are hearing in relation to people's experiences of maternity services in West Yorkshire. Although most of these issues are raised by people from all parts of the population, the impact on people of not having a good experience can be greater for groups of people who may already face more barriers in accessing services, have faced discrimination or have less power in society.

5.1 Being listened to

Healthcare professionals listening to people who are pregnant or have given birth and their partners, is an essential part of delivering safe and compassionate care.

"My positivity comes from the amazing staff who have cared for me. They make me feel safe and secure, no question is a silly question, and I can ask them anything."

Although there were many examples of where this had happened well, there are also many examples where people haven't felt listened to and their concerns have not been addressed. Some people fed back that they felt staff didn't trust that they knew their own bodies and that they wanted to be taken more seriously when explaining how they felt.

Often, when things had gone wrong, people felt that situations could have been avoided if they'd been listened to and taken seriously. For example, they may have spoken up at the time about something not feeling right and been dismissed as it being 'normal' or nothing to worry about. Some people reported not being believed that they were in active labour, or that their waters had broken. Others reported that they were only believed when their health deteriorated, their baby became distressed or they were about to give birth, resulting in traumatic emergency situations. In addition to all the above, a common theme from Black and Asian birthing people[4,7,17] was not being believed about the severity of pain they were experiencing and being refused pain relief.

"Midwives could not read the women's pain and therefore usually underestimated the stage of labour. This appeared to be due to stereotypes of BAME women of perhaps exaggerating pain. Yet it was the opposite and in fact the women introverted the pain. Women would usually be then rushed in." (Former Doula)

Research has found that these disparities in pain management reflect deeply ingrained racial biases and false beliefs including the belief that Black people have higher pain thresholds or thicker skin, originally stemming from colonial ideologies that dehumanized Black bodies[18].

There is also the issue of wider proactive listening to feedback to improve and influence service change and a sense that patient voice is not always central or maintained throughout maternity services. Over the past few years, as seen from the sources cited in this report, there has been an increasing amount of listening work with underrepresented communities across West Yorkshire. However, it is clear that the Maternity and Neonatal Voices Partnerships have very limited resource and capacity to do everything needed in their areas to represent people's views on an ongoing basis at strategic level as well as the time needed for meaningful outreach to hear from people who are more at risk of experiencing health inequalities. As a result, people's voices are not always equally represented.

5.2 Informed choice and consent

Closely linked to whether or not people felt listened to and safe, was the theme of informed choice and consent. People need the right information to make informed decisions about their care and they need to be heard and taken seriously when they ask questions, raise concerns or express preferences.

The information parents are provided with during their journey is really important. Although we heard a lot of examples where people didn’t feel they had enough information to make good choices, there were positive examples where people described feeling valued, heard and involved in decision-making.

“Your opinion mattered, and it didn’t just get brushed off. And it did change you from being nervous at every appointment to understanding why they’re doing everything they’re doing to you.”

Some people told us they did not receive enough information to know what to expect or provide informed consent. A lot of feedback was given in hindsight in the form of, “If I’d known x, I wouldn’t have agreed to y.” People also talked about care as though they were not given choices, such as “I wasn’t *allowed* to give birth in a birthing centre.”, or being told, “We’ll have to wait to see what the consultant says.” People were more likely to feed back that they hadn’t felt informed when their care was consultant-led in hospital.

“My midwife was great. However, I was consultant-led, and they often spoke down to me, despite me being an intelligent person. Trying to pressure me into to certain procedures that I knew I didn't necessarily need. I had done my research and when this was flagged it was obvious they were annoyed.”

This was particularly the case around inductions. Feedback from Leeds[19], Bradford and Airedale, Calderdale and Kirklees Maternity and Neonatal Voices Partnerships indicated that some people didn’t feel they were given enough information about the increased risks or the length of time they may have to wait in hospital, and in hindsight said they wouldn't have opted to be induced. Some people expressed that they felt pressured into having an induction because of the way information made it sound vital to their baby's wellbeing (and even survival). People also said that once it was suggested, it was very difficult for women to turn it down, or that if they did, and something were to go wrong that it would be seen as 'their fault'.

We heard how healthcare staff sometimes failed to explain what they were doing and why, and that they did not always ask for their consent prior to procedures and examinations, which could be traumatising. The Wakefield Maternity and Neonatal Voices Partnership Lead heard from a group of Sudanese women from Kirklees/Calderdale, all of whom had had post-birth surgical procedures. They shared that before their procedures, they were just given some paperwork to sign and told that they were going to theatre but didn't know what for. They said that they weren't offered interpreting support and didn't want to challenge anything because culturally for them doctors are held in high esteem.

5.3 Choice of place of birth

There were varied experiences of having a choice of place of birth across West Yorkshire. Feedback from people in Wakefield, Kirklees and Calderdale indicated that sometimes people were told their choices weren't possible due to staffing issues in hospitals, birthing centres and home birth teams. In Bradford, the feedback was that people often didn't realise they had a choice, and just assumed they would just give birth at their nearest hospital. In Airedale and Leeds, people shared that home birth often wasn't being offered as an option, or people were actively dissuaded from it. White British people were more likely to be aware of their rights and proactively ask for the option of home birth whilst people from minority ethnic communities were less likely to be aware of this. There was positive feedback about the Leeds home birth support team and Bradford Doulas around how supportive they had been when talking through the choices and processes.

"She was very helpful. We walked through what was going to happen, my choices, made a birth plan and she gave me a birth ball to borrow. She was very reassuring and helped me stay positive" (Bradford Doulas)

5.4 Variability in staff attitude/compassionate care

Feedback about compassionate care was again very varied. Many people shared how they had felt well supported and treated with compassion and empathy, even when it was clear staff were busy.

"She [midwife]… was really like empathetic to my needs. There was no rushing, she was really, really good… She would just like listen, she would understand, she knew the area, she knew like families and things… But the fact that she just listened, and she didn't judge, that was really, really helpful."

However, we also heard many instances of women being spoken to disrespectfully, dismissively, insensitively, or feeling 'told off' by professionals. This can have a significant impact on people's wellbeing at a vulnerable time and can affects their willingness to raise concerns.

We heard that some teenage and care experienced birthing people said they had felt judged, patronised and that assumptions were made by professionals about them [5,20].

"I felt very judged all the time… This judgement added an extra level of stress and forced me to re-live traumatic childhood experiences." (care experienced young person)

We also heard about sex workers who had experienced judgement about their lifestyle and a lack of compassion when accessing maternity services, how distressing this was and how it directly affected their feelings about accessing services in the future[21].

"Yeah, it were just weird… when I was there with [baby daughter] and she come, and she said … have you had a baby recently? I said yeah last year. I said my son, I said but different… the difference is... I'm keeping this one. And I'm not – I'm not on drugs or anything and then she were just so, – she couldn't do anything, honestly she couldn't do enough for me kind of thing… 'If you need anything come to me and I'll get the – oh, how are you feeling are you alright sweetheart?' and it were a whole different … it was."

5.5 Racism and discrimination

A recent inquiry into racial injustice and human rights in UK maternity care,[22] found that Black, Asian and mixed ethnicity women feel unsafe, ignored and disbelieved, and experience a lack of choice about their maternity care. A recent Healthwatch England report[23] and local engagement with Black women in Bradford[4], Black African[24] and Gypsy and Traveller, and Roma communities in Leeds also provide some anecdotal evidence locally that there are racial disparities in people's experience of maternity care. This is a theme that would benefit from more in-depth local insight, and as such we have had to rely on national evidence for the purposes of this report.

In a 2022 national survey of 1340 Black and Black mixed heritage women and birthing people[17], 43% reported feeling discriminated against during their maternity care, with the most common reasons being race (51%), ethnicity (18%), age (17%) and class (7%). The report on this survey summarises that the factors contributing most to this were:

- People felt staff used offensive and racially discriminatory language and were dismissive of their concerns.

"I'd turn up in a tracksuit and be spoken to in a certain (dismissive) way until they learnt I was a lawyer…and they would be more respectful overall in my experience." (Black mixed woman)

- People felt there was poor knowledge about the anatomy and physiology of black women and a poor understanding of the of conditions in babies of black women.

"One midwife when doing the sweep said that the reason for dilation taking so long for me was "probably due to an African pelvis" – even though I was on pain relief I was mortified that she actually believed there was such a thing as an African pelvis." (Black woman).

- People felt there was racially biased assumptions about pain tolerance, education level and relationship status of black women.

"First visit a nurse said she was shocked I knew who the father was. As people like me usually don't know" (Black woman).

The report found that these interactions had a negative impact on people's mental and physical health and were pivotal in defining their feelings around their maternal care.

"Most worryingly, the research highlights that these interactions can be related to racial biases embedded in the health system and predicated on negative racial stereotypes held by healthcare professionals. The discriminatory behaviour and attitudes that follow have been shown to negatively impact women's clinical outcomes and experiences of care including influencing the type and amount of information that women receive (which has implications for informed decision-making); discouraging

women from raising concerns; and fostering a reticence to engage in maternity services in the future."[17]

Another national report published in 2022, based on the experiences of 1022 Muslim women and birthing,[7] found that approximately one third of the women surveyed (31%,) said they experienced microaggressions (i.e. indirect, subtle or unintentionally negative verbal / non-verbal interactions) during their maternity care. A further 11% were unsure whether what they had experienced were microaggressions because of their subtle nature. The most common microaggressions were negative tone of voice, patronising comments, judgemental comments and attitudes and physical actions (roughness of touch, dismissive gestures, avoidance of eye contact).

"The consultant was White female doctor… She was very condescending, belittling, and she said, 'I see five of you lot per day.' She tried to say we don't have slots to book you in, saying they were busy and booked up. I came out wanting to cry. I felt bullied, belittled and patronised." (Arab woman)

The Invisible report[7] asked people about different interventions they'd been given or whether they'd experienced particular outcomes, which is then compared with national data. The results show that Muslim survey respondents were less likely to receive pain relief or to be able to choose to have an elective caesarean. It also showed that Muslim people were more likely to have their labour induced, undergo an emergency caesarean, to have an instrumental birth, to have a prolonged labour, to have an episiotomy and to have excessive blood loss.

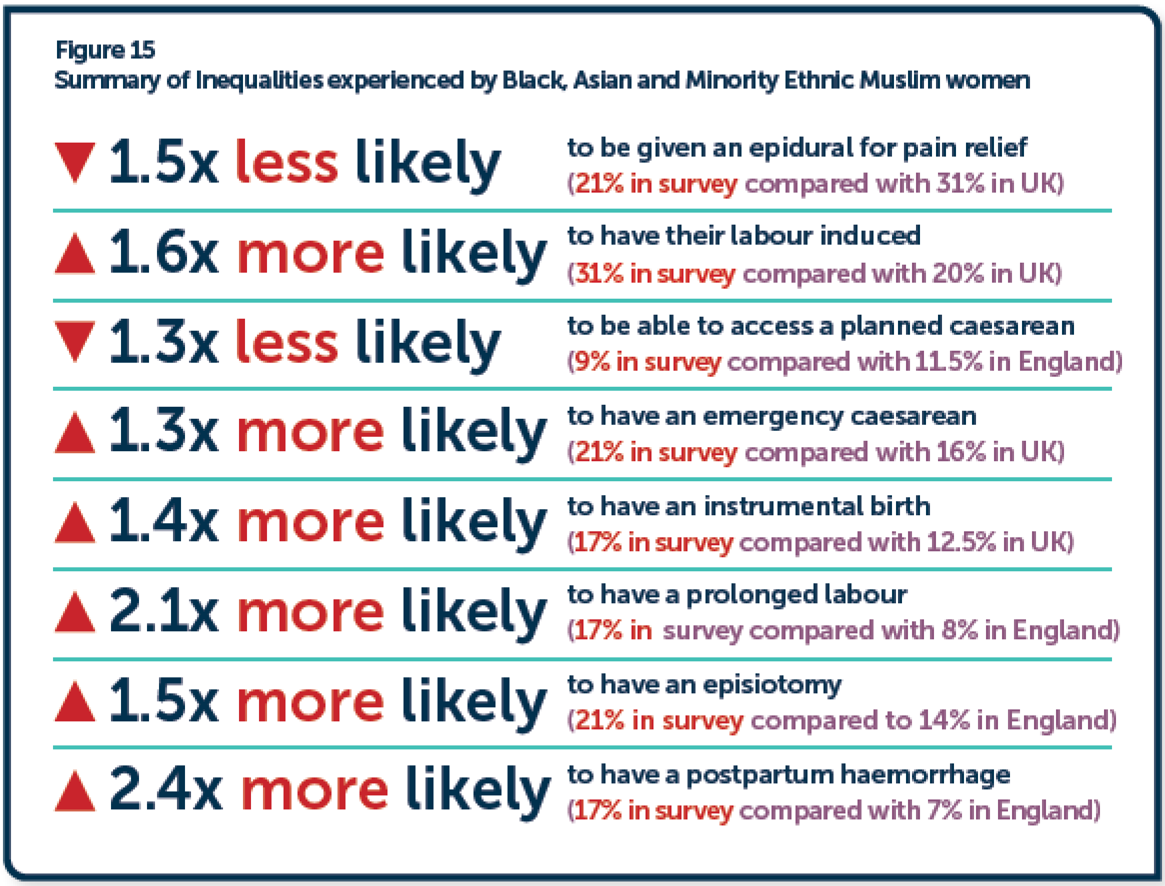

Figure 15
Summary of Inequalities experienced by Black, Asian and Minority Ethnic Muslim women

▼ 1.5x less likely	to be given an epidural for pain relief (21% in survey compared with 31% in UK)
▲ 1.6x more likely	to have their labour induced (31% in survey compared with 20% in UK)
▼ 1.3x less likely	to be able to access a planned caesarean (9% in survey compared with 11.5% in England)
▲ 1.3x more likely	to have an emergency caesarean (21% in survey compared with 16% in UK)
▲ 1.4x more likely	to have an instrumental birth (17% in survey compared with 12.5% in UK)
▲ 2.1x more likely	to have a prolonged labour (17% in survey compared with 8% in England)
▲ 1.5x more likely	to have an episiotomy (21% in survey compared to 14% in England)
▲ 2.4x more likely	to have a postpartum haemorrhage (17% in survey compared with 7% in England)

Table above taken from the Invisible – maternity experiences of Muslim women from racialised minority communities report. (Muslim Women's Network, 2022)

Both the above-mentioned reports provide detailed analysis of Muslim and Black people's experiences throughout their maternity journey and provide some very helpful recommendations.

5.6 Cultural humility and personalised care

"Getting to know your patients will naturally make them feel more safe."

People from different cultures and communities want staff to more aware of cultural differences and practices before, during and after giving birth and around the role of mothers and partners. They also want staff to understand different attitudes towards and perceptions of medical professionals, and the importance of face-to-face interactions or having a female health professional.[2]

“All the time there was only men doing the sonography, which I wanted a woman to do it because of my culture. On two occasions they had to send me home and reschedule my appointment as there were no female sonographers.”

However, they also don’t want to be stereotyped. For example, just because someone is from a particular ethnicity, they don’t want it to be assumed that there will be problems[5].

Some Romanian women have shared in a focus group how they have not felt safe in shared hospital bays due to cultural differences with other women and one person reported how having a doctor who spoke Romanian helped them feel more comfortable and well-informed about their care[25].

5.7 Continuity of care

Seeing the same midwife and health visitor was important to women in terms of building a trusted relationship, having continuity of care and making it easier to access services when needed.

“I had a good relationship with my midwife, I think she was friendly and listened if I needed her. I knew I could ring her or send her a text.”

In recent work in HX1, HX2 and HX3 areas[3], people born in another country were less likely to report seeing the same midwife throughout their pregnancy compared to women born in the UK. However, seeing the same midwife throughout pregnancy, labour and after the baby was born was more important to this group. Continuity of care was also more important for Black/Black African women and refugees or asylum seekers[2]

There was positive feedback about specialist midwifery services who provide excellent continuity of care and understanding of people’s whole situation, including social issues that may impact their journey through maternity services. Romanian people in Leeds who accessed a 'Continuity of carer' midwifery team, who were with them before, during and after their births shared how having a trusted midwife was "amazing" and gave them "confidence in labour"[25]. Similarly, people accessing the Haamla service in Leeds, reported feeling safe and held.

"[the midwife] explained it all to me – she was so gentle and treated me like a human being. It was the first time I felt really respected." (Haamla antenatal clinic for women who have undergone Female Genital Mutilation)

Across West Yorkshire, we have heard many reports of people seeing multiple different midwives who hadn't always read their notes meaning they had to repeat information and were concerned that issues would fall through the gaps. This can be retraumatising for some people.

"I think it is important to have the same team all the way through as it can be draining having to keep repeating information, they will also be able to understand your anxiety during pregnancy and how to support you best."

Some Black African women also reported experiences of not being able to contact a midwife when needed and how this would make it less likely they would call again in a time of need[24].

Having a 'support person' throughout pregnancy and birth (not just early booking), was identified as helpful by people who were new to the area, had mental health problems or language/communication barriers[2], or were sex workers[21]. People shared how a trusted support person had been invaluable in helping them navigate services, as well as acting as an advocate, particularly if there was no one else who could support them. People who had accessed services such as Bradford Doulas and Maternity Befrienders (Mid Yorkshire Teaching NHS Trust), reported feeling safer, more supported and having a more personalised experience than those who didn't.

"Having a doula made me feel like I had a mum/friend with me. This made me feel less scared… she came to the hospital and collected us to bring us home." (Bradford Doulas)

5.8 Postnatal care (care following birth)

Across West Yorkshire, people have raised concerns about the care they have received in hospital after giving birth, with people feeling that services were stretched, and their needs sometimes overlooked.

This has been a particular concern in Leeds, highlighted by the findings of a postnatal care focus group run by Leeds Maternity and Neonatal Voices Partnership in January 2025[26]. People raised issues around perceived short staffing, staff not responding to buzzers, people being left without pain relief, as well as general conditions on the ward and lack of support with feeding. Multiple women said that after one or two attempts at feeding, they had been advised to use formula and felt they had to agree rather as they felt there wasn't enough support for them to keep trying.

People also reported not being shown how to change their catheter and then feeling 'told off' by staff when it was full. Many of the women described their mental health plummeting during their time on the postnatal ward and being desperate to leave but being slowed down by delays to discharge.

On the whole, feedback we heard about postnatal care in the community was more positive. We heard about some good experiences of people using Family Hubs for things such as support with feeding, peer support groups and getting support from health visitors. People shared that the hubs provided a supportive, friendly, and convenient local environment which was easier than waiting to see a doctor. People also commented that it provided them with somewhere to 'get out of the house' and meet other new parents.

6. Voices missing from this report

We couldn't find much recent local insight about the experiences of the following groups who may be more at risk of experiencing health inequalities so there is a need for more work to understand their experiences.

- More widespread understanding of the experiences of Black and Asian women in West Yorkshire so we can be assured whether or not the experiences we have heard about nationally are reflective of people's experience in West Yorkshire.
- People with wider social factors affecting their lives such as substance dependency, domestic abuse, insecure housing or homelessness, being in contact with the criminal justice system and extreme poverty.
- Disabled people including people with learning disabilities, their carers and/or partners
- Fathers
- LGBTQ+, especially Trans and non-binary people
- People who are D/deaf or hard of hearing.

Although there is very little research about trans and non-binary people's experiences, we did find a small number of national research papers about LGBTQ+ people's experience more broadly. Themes from these were:

- LGBTQ+ partners voiced concerns that they were not recognised as 'partners' in the same way as heterosexual couples.[27]
- Concerns expressed by LGBTQ+ parent that the non-gestational parent (parent who did not physically give birth to the new child) might be

relegated to the status of birth partner only rather than being recognized as an expectant parent.[28]

- Currently, very few NHS Trusts collect data on the sexual orientation or gender of pregnant people or their partners; without this we cannot shape services to ensure that they are appropriate for LGBTQ+ new and expectant parents.[29] There is also the issue around people needing a 'gender recognition certificate' to have their gender recorded correctly in lots of settings and non-binary identities are not legally recognised.[30]
- Some LGBTQ+ people reported not feeling comfortable attending antenatal classes that were not openly inclusive, resulting in them missing out on important information and support[23].
- Inequalities relating to fertility treatment with LGBTQ+ individuals not having the same access to funding as their heterosexual counterparts[23]
- Lesbian parents want healthcare to be individualised with consideration of their unique needs[29] and further education for midwives regarding the politics of diversity for LGBTQ+ parent.[31]

7. Key Messages and recommendations

There are many recommendations that we could make from the broad themes covered by this report, but we have chosen to limit it to ten. These are based on the themes coming through most strongly from people's experiences, with a particular focus those more at risk of health inequalities.

1. Learn from and mainstream successful delivery models of holistic care such as doulas, maternity circles, maternal journal and targeted midwifery services that have had proven benefits for people at risk of health inequalities.

2. Recognise current cultural bias in systems and services and take steps to address this. One way this can be done is by making sure that we

keep listening to voices of individuals and communities that are identified as most at risk of experiencing health inequalities. Local Maternity Voices Partnerships need to be properly resourced to enable them to engage effectively and listen to these groups of people on an ongoing basis. We also recommend that more work is done specifically to understand the experiences of the groups of people identified in section 6 (Voices missing from this report).

3. All healthcare staff should be provided with training and reflective practice to improve their cultural humility of the different communities they work with, as well as understanding any biases or stereotypes that they may hold. This also needs to be built into education of health care professionals from the outset.

   > ***"Staff need to be aware of unconscious biases and stereotypes that can influence their behaviour. This is not about people being malicious or intentional, but rather about how societal norms about racism have shaped us."*** **(The Black Maternity Experiences Survey)**[17]

4. Work needs to continue to improve representation in the maternity workforce.

5. Work with communities to continue raising awareness of things such as perinatal mental health, maternal health and risks, and support that is available, in a culturally sensitive way.

6. There needs to be better training in primary care to raise awareness about perinatal mental health, including upskilling staff to have more in depth conversations about wellbeing and about the potential risks of missed opportunities. It would be helpful for training to include elements of lived experience.

7. Communication is important. Services and staff should proactively use inclusive language and listen to and take concerns seriously. Conversations need to be trauma informed, compassionate and sensitive to cultural issues and stigma.
8. Information needs to always be easy to understand and accessible and in different formats (pictorial, video, different languages etc). It also needs to be targeted in a way that is helpful and reassuring to people who may not be familiar the UK health system.
9. We need to get better at sensitive collection of demographic data in maternity services, complaints and Maternity and Neonatal Voices Partnerships, including about sexuality and gender identity.
10. People's experiences massively affect their trust and future engagement in the health system and consequently their health outcomes. The impact on people of not having a good experience can be greater for groups of people who may already face more barriers in accessing services, have faced discrimination or have less power in society.

Following discussion with West Yorkshire Integrated Care Board, we ask that this report and recommendations are considered at the West Yorkshire Integrated Care Board and local area Quality Committees.

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