Facilitators and barriers to access to midwife-led birth settings for racialised women in the UK: A scoping review.

Abstract

Background: In UK maternity care, racialised women have worse experiences and clinical outcomes than White women. Midwife-led birth settings (MLBS); home births and midwife-led units, both free-standing and alongside hospitals, are available as a choice for low-risk women in the UK. MLBS deliver optimal outcomes for low-risk women with uncomplicated pregnancies, including for racialised women, and can offer culturally specific care, possibly mitigating existing social inequalities. Evidence suggests that racialised women access MLBS less than White women.

Aim: Map existing literature on facilitators and barriers to access to MLBS for racialised women and identify emerging themes.

Method: A scoping review of UK literature over the last 10 years using OVID, Ebsco Host and grey literature. Search, selection, and data extraction were performed using PRISMA and JBI guidelines. Data were analysed using inductive thematic analysis.

Results: Fourteen articles met the inclusion criteria, only one addressing the research question directly and others containing some relevant material. Six themes were identified: admission criteria, information giving, the role of antenatal groups, bias and assumptions, beliefs about birth, and MLBS as empowering.

Conclusion: There is a lack of research on racialised women's access to MLBS. Community outreach, midwifery services embedded in the community, defaulting to MLBS for women categorised as low risk, continuity of carer and interventions achieving a reduction in care-giver bias may improve access and outcomes.

Keywords: Midwifery-unit, birth centre, home birth, racism, Black women, BAME, Ethnic minority

Definitions

We use the term 'racialised women' to encompass maternity service users who are not White and are racialised by UK society. Where relevant or for the veracity of reporting, we use the study authors' terms such as Black, Asian and minority ethnic (BAME). We acknowledge that not all those who get pregnant identify as women. In our review we use the word woman throughout as this is

the term used in all the studies. In the discussion this should be taken to include people who do not identify as women but who are pregnant or giving birth.
Midwife-led birth settings (MLBS) refer to the home and midwifery units or birth centres, both alongside hospitals' obstetric units and freestanding. In these settings midwives take primary professional responsibility and practice a midwifery model of care. [1,2] Access means not just the supply of services, but the extent to which women can utilise them and how acceptable they are, and may depend on organisational, social or cultural factors. [3]

As authors we identify as two White British, one White Irish, one Black American and two White Italian. Four of us are midwives all of whom have all worked with racialised women accessing midwife led birth settings. All of us currently live in the UK and variously have Jewish and Irish heritage, are migrants, or live in mixed race families. We have all brought our own perspectives, both insider and outsider, of different facets of this issue.

Background

Maternity outcomes and ethnicity

Racialised women in the UK have a higher likelihood of suffering inequality, including lower economic status, [4] practical and psychological stress due to racist migration laws[5] social and cultural inequalities, [6] including health inequality and institutional racism. [7–10] Over time the persistent, repeated, unceasing nature of these onslaughts can accumulate and become a cause of poor health in a process described as 'weathering'. [11] The UK has a well-established midwifery service and access to obstetric care, free at the point of use. Despite this, Black women in the UK are still four times more likely to die in the perinatal period[12], and babies born to Black women are up to twice as likely to die. The 2021 UK Maternity Audit reported an overall caesarean rate of 33% for Black women and 25% for White women,.[13] However, the data does not show us if this is due to a difference in morbidities or a difference in care. Research on racialised women using UK maternity services consistently cites direct and indirect racism, such as not being listened to or respected, hearing racially discriminatory language, and assumptions being made about education level or background, pain tolerance and behaviour in labour. [14–16] There is a reported lack of midwives' knowledge about culture and about physiology (such as presentation of clinical conditions on darker skin) [16,17]. This can have an impact on access as a mistrust of services can lead to some women withdrawing from care. [18]

Research into migrant women in the UK and pregnant women seeking asylum in comparable high-income countries has an overlap with our population of interest as a significant proportion of migrant women are racialised.[17,19] Research revealed them feeling isolated, ignored and alone. Other

reported barriers to access for migrants include not being aware of the specificities of the NHS maternity system, insufficient translation or interpreting services for those with limited English, and lack of money for travel to appointments. [17,20]

Benefits of midwife led birth settings for racialised women

- For healthy women with uncomplicated pregnancies MLBS compared to obstetric units have lower rates of caesarean or instrumental birth and post-partum haemorrhage, better breastfeeding rates, reduced medium- and long-term maternal morbidities, no difference in neonatal outcomes [21–25] and higher levels of maternal satisfaction. [26–28] Secondary data from the Birthplace Study showed both racialised women and White women had an equally reduced chance of intervention such as instrumental deliveries in MLBS compared to obstetric units. [29] The community-based Albany Midwifery Practice had high rates of MLBS (34% home birth rate) for racialised women for racialised women) and notably better maternal and neonatal outcomes for racialised women and their babies than contemporary national averages.[30]

The midwifery model of care can offer highly personalised, woman-centred relational care and the possibility of continuity of carer.[6,30–32] MLBS are better placed than obstetric-led settings to offer culturally safe care embedded in the communities of women they serve. There are reports of the beneficial effect of midwife care for racialised women specifically, such as *'knowing there is someone who cares for you*', [19(p531)] and woman-centred continuity of care models resulting in positive experiences. [33–35].[36]

UK research into midwives' views showed a will to mitigate systemic inequality and gain cultural competencies needed to care adequately for a diverse population. [20] Midwives' autonomy and the centrality of the midwife-mother relationship increases the chance of women being listened to and respected, at best acting as a restorative force against the backdrop of racism and weathering. [37,38]

Midwife led birth settings and access

Only 15% of women in the general population in England access MLBS [39,40] despite an estimated 45% being eligible for MLBS at the start of labour. [41,42] Research into access and utilisation of MLBS falls into themes of organisational factors, midwives' influence, and women's culture and beliefs. Organisational barriers include a lack of service provision, [43,44] inconsistent service provision caused by short staffing, [45] lack of commitment by providers to regard MLBS as a core part of the service perceiving it instead as an optional add-on, [42] the depth of the culture of medicalisation, the construction of birth as inherently risky, [46,47] fears of litigation (realistic or otherwise),[42] and an 'us and them' attitude between obstetric unit staff and MLBS midwives.[42] Women may face challenges

with admission in early labour [45] and find it logistically easier to opt for birth in an obstetric unit rather than MLBS. [46]Midwives' own preferences, biases and attitudes to risk show some seeing freestanding midwifery-led units as being less safe and less popular with women.[42] This affects the information they give, and thus women's decision making. [42–44,46]

Racialised women's access to midwife led birth settings

There is evidence that rates of MLBS use are even lower for racialised women. The Birthplace study revealed a higher proportion of affluent White women accessing freestanding midwifery units and home births, and shows that of women starting labour in MLBS, 89% were White and 11% racialised women, compared to women biomedically classified as low-risk starting labour in the obstetric units at 82% White and 18% racialised women. [21] A study on women biomedically classified as low-risk who had waterbirths, which are vastly more common in MLBS, showed Black and Asian women were less likely to have a waterbirth at 6% and 4%, respectively, compared to 15% of White women. [48] Henderson et al[49] analysed data from a survey of over 24 thousand women in England collected in 2010. They report that 6.7% of White women respondents accessed MLBS, but there were significantly fewer Pakistani (4.2%) and Black African women (2.7%) using them. Waterbirth rates for Pakistani (0.2%), Indian (1.9%), Bangladeshi (1.6%) and Black African (2.2%) women were significantly lower than White women (5.2%). In Tower Hamlets, London, the home birth team showed 29% of its small caseload of 59 women in 2018 to be from 'BAME' backgrounds compared to 55% of the local population. However, a well-established MLU in the same borough achieved a higher proportion of women from Black and South Asian backgrounds, arguably as a result of extensive community outreach and a continuity of care model. [36,50] Research in the US showed race being the single most important factor for the rate of transfer from midwife-led to obstetric care even when adjusted for other variables, possibly due to provider bias (being quicker to refer) or poor provider-patient communication.[51]

Objective

This scoping review will investigate what literature exists on facilitators and barriers to access to MLBS for racialised women in the UK and what the literature shows.

Methods

We followed JBI scoping review guidelines[52,53] and registered a protocol developed with the team researching "Accessibility of midwife-led birth settings in the UK to racialised people". [54,55]A scoping review was chosen as the most appropriate method for the identification, mapping and summary of

the existing literature, allowing for inclusion of articles with other main focuses, differing methodologies and grey literature .[56]

The Inclusion criteria were: UK-only research due to the unique racial history and specific context of NHS midwife-led services; the last ten years to reflect the contemporary situation; and academic and grey literature to decrease any systemic (racial) bias in academic publishing and increase the possibility of including grassroots-produced material, although in fact none were identified. Due to the paucity of data on the subject, we included texts with only brief reference to our topic.

Databases CINAHL and Medline Complete were searched using the EBSCO Host platform, and EMB Reviews, Embase, Global health, MIDIRS and Social Policy and Practice via the OVID platform. Searches were performed in January, March and April 2023 (see Fig 1). Further literature was identified using back-chaining, grey literature searches (City University of London Library, Grey Matters, NHS England and Gov.uk), and professional networks.

OR	AND	OR	AND	OR
Black		Midwi* led		Access to care
Brown		Midwi*		Facilitat*
BAME		Birth* centre		Enable
Ethnic minority		Midwi* unit		Barrier*
*Caribbean		Home*birth		Respond* to needs
Migrant				Access
Refugee				
Asylum seeker				
Racialised				
African				
Asian				
Muslim				

Fig 1. Search terms

After duplicate removal and application of inclusion and exclusion criteria, 336 articles were selected for screening. Two researchers screened independently by title and abstract. Discrepancies were resolved through discussion resulting in 96 articles for full-text screening. A total of 14 articles containing relevant material were selected for inclusion in the review (see Fig 2). Data were extracted using a bespoke data-extraction form primarily by one researcher, with oversight by a second. We applied the method-appropriate CASP critical appraisal checklist. This aided rigorous analysis and ensured the methodology and quality of each study was fully considered.[52,53]. All fourteen articles demonstrated sound methodological quality, lending trustworthiness to our review.[57] We performed inductive thematic analysis adapted from the method described by Thomas and Harden with the aim of thematic summary and analysis, but not thematic synthesis, as this is beyond the remit of a scoping review [52,58]

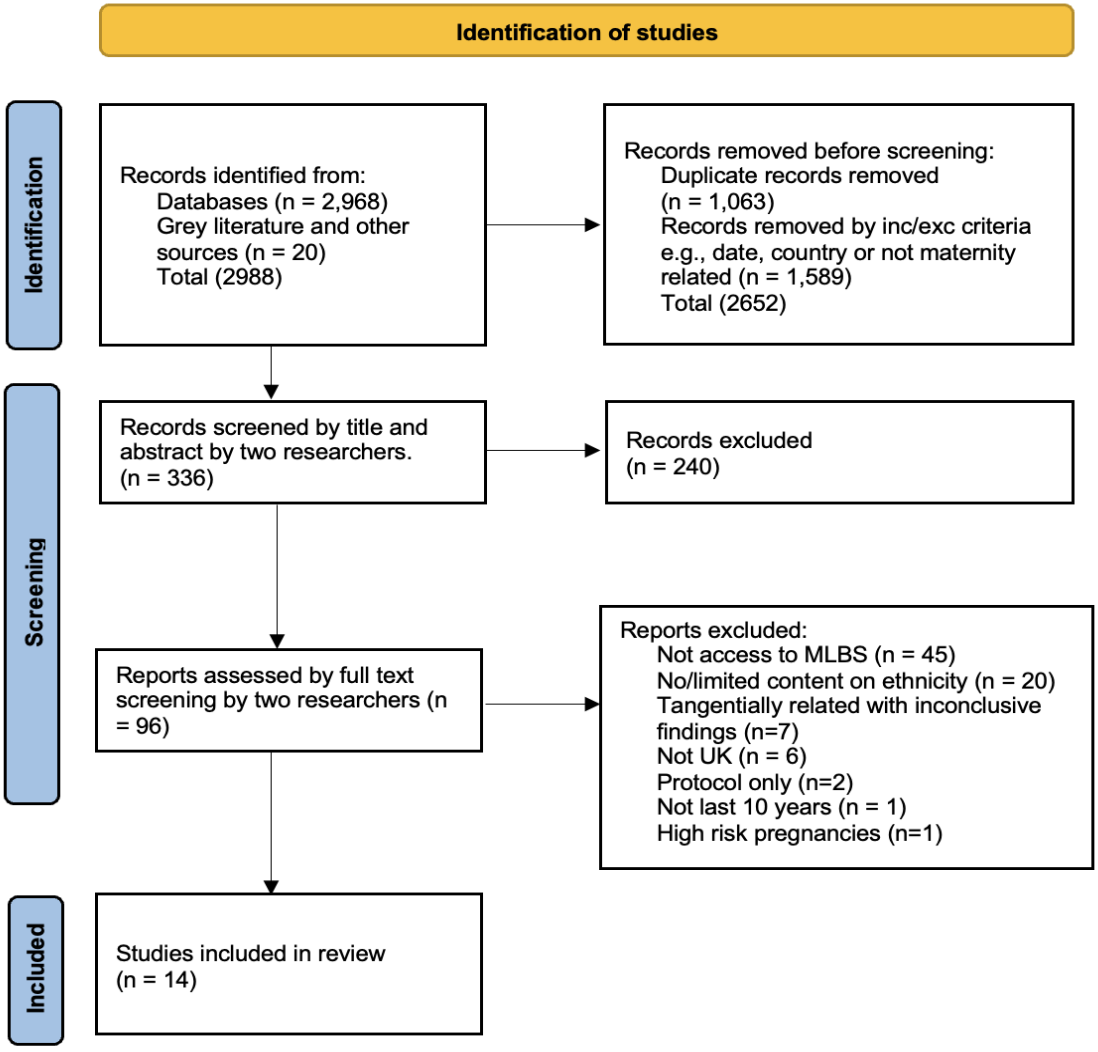

Fig 2. Prisma diagram.

Summary of results

Fourteen texts had content addressing our question; two systematic reviews (treated as texts in their own right), eight qualitative studies, one mixed-methods study, two audits and one quantitative study (see table 1a and 1b). A significant finding was the lack of literature addressing the question of access and utilisation of MLBS by racialised women (fig 4). Only one article, Reeve Jones[59], addressed the research question directly. Of the other thirteen studies, most addressed our question as a minor point in the context of studies on place of birth that did not focus specifically on racialised women [30,45,46,50,60–62] or studies on racialised women regarding outcomes or experience that do not focus specifically on MLBS or place of birth. [33,49,63–65] In the thematic summary below, only the small amount of text directly relating to the review topic is referred to.

Authors, (date) [reference number]	Title	Research design	Sample and question	Data from	Key findings	CASP score /10	Proportion of text directly relevant to our question (%)
Coxon, Sandall and Fulop (2014) [70]	To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions.	Qualitative, longitudinal narrative study from 3 maternity units.	Women of diverse, class, race, urban/rural. Views on birth place choice.	2009-2010	Many African background woman see hospital as safer than home birth. Obstetric unit as default.	9	4.4
Foley, Callaghan and Olusile (2019) [51]	Creating a dedicated home birth team in Tower Hamlets: a review of outcomes from the first year.	Audit and evaluation of data from homebirth team.	Data on 90 women re referral, birth place, transfer and outcomes.	2018	Proportionally fewer Bengali women referred or accepted to homebirth team. Reasons: housing, midwife bias, lack of time at antenatal appointments. Need for community outreach.	9	6.9
Goodwin, Hunter and Jones (2018) [67]	The midwife–woman relationship in a South Wales community: Experiences of midwives and migrant Pakistani women in early pregnancy.	Ethnographic qualitative Semi structured interviews and observation.	9 Pakistani women, 11 Midwives on relation and antenatal care.	2015	Influence of Pakistani culture. Some lack of confidence in midwives. Women and midwives have different expectation of maternity care.	10	17.3
Henderson, Gao and Redshaw (2013) [50]	Experiencing maternity care: the care received and perception of women from different ethnic groups.	Quantitative. Statistical secondary analysis.	>24300 women (15% not white) on experience of maternity care.	2010	Women in all minority ethnic groups had a poorer experience of maternity services than White women including lack of choice.	9	2.8
Henshall,Taylor, Goodwin, Farre, Jones and Kenyon (2018) [64]	Improving the quality and content of midwives' discussions with low-risk women about their options for place of birth: Co-production and evaluation of an intervention package.	Mixed method study on service improvement. Qualitative, focus groups.	10 focus groups of 38 midwives about service improvement impact.	2015 - 2016	Midwife bias apparent in information on options and depth of conversation re MLBS according to cultural assumptions.	10	5.2
Homer, Leap, Edwards and Sandall (2017) [30]	Midwifery continuity of carer in an area of high socio-economic disadvantage in London: A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009).	Retrospective analysis of existing data set. Audit of data collected by homebirth team. Service evaluation.	2568 women booked with Albany community midwifery caseload service (total cohort).	1997 - 2009	Importance of case-loading community based midwifery. High homebrith rate. Homebirth seen as positive and normal within the community. Birth place option left open.	10	2.9
Hunter, Da Motta, McCourt, Wiseman, Rayment, Haora, Wigginsa and Harden (2019) [69]	Better together: A qualitative exploration of women's perceptions and experiences of group antenatal care.	Qualitative. Focus groups and semi-structured interviews.	26 women before and after group antenatal care.	2014, 2015 and 2017.	Group antenatal care as empowering. Better relations with midwives. Expanded horizons. Place of birth decision after full discussion. MLBS as option.	10	11.2

Table 1a

Authors, (date) [reference number]	Title	Research design	Sample and question	Data from	Key findings	CASP score /10	Proportion of text directly relevant to our question (%)
Jomeen and Redshaw (2013) [66]	Ethnic minority women's experience of maternity services in England	Qualitative. Post questionnaire.	219 Black and minority ethnic women.	2012	Hospital perceived as safe place. Bias and racism of midwives. Lack of care overall.	9	1.9
Khan (2021) [68]	Ethnic health inequalities in the UK's maternity services	Systematic review of UK studies.	Eight papers (3 same as this study).	Pub: 2013 to 2018.	Maternity services and systems. Communication and midwife-woman relationship sometimes poor.	9	5.7
MacLellan, Collins, Myatt, Pope, Knighton and Rai (2022) [33]	Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis	Systematic review with qualitative evidence synthesis	24 papers (2 same as this study).	Pub: 2000 - 2021	Lack of flexibly. Rushed, one size fits all, antenatal care and place of birth discussion. Lack of continuity of carer and trust. Lack of control in decision making.	9	13.4
McCourt; Rayment; Rance and Snadall (2014) [63]	An ethnographic organisational study of alongside midwifery units: a follow-on study from the Birthplace in England programme. Chapter 5. Women and partners' experiences and perspectives.	Qualitative, observation and interviews.	35 women. 12 Birth partners. (12 BAME) about access to MLU.	2011 - 2012	Information on place of birth from friends, unit tours, antenatal classes. Etc (not midwife). Cultural assumptions by community midwife. Perceived as a luxury.	10	6.9
Naylor-Smith, Taylor, Shaw, Hewison and Kenyon (2018) [65]	'I didn't think you were allowed that, they didn't mention that.' A qualitative study exploring women's perceptions of home birth.	Qualitative. Focus groups.	28 women in 5 focus groups. Many ethnic minority gorups. On NHS homebirth service.	2014	Assumption of obstetric unit by women. Lack of information on home birth. When option is made clear many Black women choose homebirth.	9	11.2
Rayment, Rance, McCourt and Sandall (2019) [45]	Barriers to women's access to alongside midwifery units in England.	Qualitative. Observation and interviews.	Observations (>100). staff interviews (n=89). Women and partners interviews (n=47)	2011 - 2012	Barriers: 1. when choosing MLBS. 2. Early labour. Advantage of opt-in vs opt-out. Cultural assumptions by community midwife.	10	9.1
Reeve Jones (2022) [62]	An ethnographic study of an urban free-standing birth centre with focus on the increase of Bengali women choosing the Birth Centre as place of birth.	Ethnographic. Qualitative. Service audit and semi structured interviews.	Audit: All women birthing at MLU. Interviews: Bengali women who had birthed at MLU.	2021	Generational change - UK born women choosing the MLU. Sisterhood and kinship - the imporantance of knowing others who had used MLU. Reproductive agency and choice. Birth stories and representation.	10	100.0

Table 1b

Thematic summary

We developed six inter-related themes from the limited material related to racialised women's access to MLBS (fig 3). None of the papers emphasised practical barriers such as transport or (lack of) access to free NHS care.

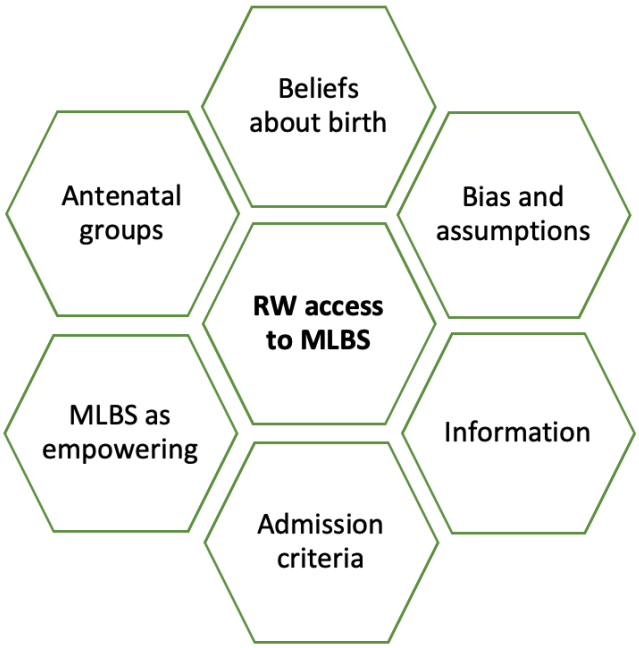

Fig 3. Thematic diagram.

Admission criteria and guidelines

The initial barrier to MLBS is categorising women as 'high-risk', occurring at any time in the pregnancy, labour and birth journey. [60] This may disproportionately disadvantage racialised women as a higher proportion of racialised women may fall outside of the biomedical low-risk category, for example a higher rate of pre-existing comorbidities of diabetes and hypertension found in Black and South Asian women in Great Britain.[13] More research needs to be done on this subject to interrogate the reasons for this. [51] Jomeen and Redshaw[63] interviewed a UK-born Black Caribbean woman who was encouraged to choose the obstetric unit over home birth due to being a grand-multiparous woman, which she felt to be discriminatory. Women interviewed by Reeve Jones[59] attempted to stay 'low risk' by managing their BMI or diabetes, for example. Naylor Smith et al. [62] revealed some

White study participants, but no racialised participants, exercised agency by changing their place of birth to access care outside their trust guidelines. However, after attending group antenatal care, some racialised women made active decisions to stay in midwife-led care, including those with intermediate risk factors where obstetric care was offered. [66]

Information

The assumption that women would be using the obstetric unit, an automatic referral to an obstetric unit, and lack of information about place of birth options, was reported in most studies. [45,49,60,62,67] Women who sought information from informal networks, work colleagues, internet research, social media or private antenatal classes were more likely to see MLBS as a viable option [45,59,60] MacLellan[33] reported that some women were unaware of place of birth choice such as home birth, and a large 2014 survey showed a third of the women were only aware of the obstetric unit. [61] Naylor Smith et al. quote: *'I think I was aware of home birth as an option, but certainly not from a health care professional'.* [62(p7)]

Rayment et al. [45] explain that only after women had opted-in to the MLU did they receive full antenatal information regarding the MLU. Racialised women in Naylor Smith et al.'s [62] focus groups were initially less aware of the range of choices and less likely to make active place of birth choices than White women, however, once made aware, there was an interest in MLBS. Rayment et al. quote, "*I didn't know [AMU] was there. I just thought I would go the Labour Ward bit. But when I found out I could go to [AMU] I was like, oh great [laughter], that's much better."* [45 (p82)] Homer et al.[30] and Foley et al.[50] expressed the importance of outreach and visibility of MLBS. McCourt et al.[60] concluded that an 'opt-out' system for MLUs might reduce disparity of access by establishing it as the normal pathway for all 'low-risk' women. Women with the Albany Midwifery Practice did not make a fixed place of birth choice in pregnancy, rather kept the final decision about place of birth an open question until labour onset.[30]

Antenatal classes and groups

Reeve Jones[59] noted the importance of antenatal classes for information and confidence building. "*Active birth classes were fundamental to most of my respondents in terms of decision making and getting their husbands or birth companions on board".*[59(p23)]. However, Henderson et al.[49] and MacLellan et al.[33] revealed that racialised women were significantly less likely to attend antenatal classes or be directed to them, in line with earlier studies. [68]

Group antenatal care can redress imbalances by relocating knowledge of pregnancy and birth back to the women through self-checks and discussions. Hunter et al[69] found it shifted the dynamic away

from the passive patient role that abdicates decisions to medical authority (potentially leading to obstetric unit birth), and pregnancy and birth from a medical to a social occurrence (potentially leading to MLBS as an option). It also helped those with limited English as women helped each other express their questions or comments. The discussions helped women challenge accepted norms by talking with those outside their immediate communities (rare for some of them), normalising the choice of MLBS. [66]

Bias and assumptions

Lack of control, feeling like a task to be rushed, and overly standardised care, was highlighted in almost all the papers. Racialised women particularly are left uninformed with little time to discuss place of birth. [33,50] Issues such as language barriers, cultural differences or social complexities cannot be resolved in a rushed, overstretched service, leading to direct and indirect discrimination. [33,65] Henderson et al. found that racialised women were significantly less likely to report being given understandable information, involved in decision making, or given a choice regarding place of birth.[49]

Both midwives and women had assumptions about ethnicity and place of birth. MLBS and water births were referred to as 'hippy' or 'for White women' by those interviewed by Reeve Jones, Hunter et al. and Naylor Smith et al. [59,62,66] Foley et al.[50] cite the proportionally low rate of midwife referrals for homebirth for Bengali women. Many midwives shaped their discussion about place of birth based on cultural assumptions, restricting genuine choice. [45,50,60–62] These assumptions include that a 'type' of woman chooses home birth, that birth environment is only important to 'White middle-class women', or that women's social relationships, home environments and socio-demographic variation would make them more or less likely to choose a MLBS.[45]

Reeve Jones[59] and Naylor Smith et al.[62] found that discussing place of birth at each opportunity aided informed decision-making and choice for MLBS, implying lack of discussion may mean women are missing out. White women however, did not shift their opinion during focus group discussions led by Naylor Smith et al. [62] indicating that more discussion might be particularly important for racialised women's access to MLBS. Racialised women accessing antenatal care later in pregnancy and engaging less may decrease the opportunities to discuss place of birth. [49] However, this pattern may result from experiencing racism in healthcare settings or lack of understanding of the NHS maternity care system.[64] The Albany Practice normalised home birth within the community, and it became a popular option across the class and race spectrum. [30] Continuity of carer fosters a genuine woman-midwife relationship that can engender a sense of control for the woman, making it more likely she will access MLBS. [33]

Influence and beliefs about birth

A significant factor in the choice of place of birth is the woman's cultural norms, in some cases influenced by older women in the community [60,66.] Some first-generation migrant women, including of Pakistani or Bengali origin, placed a particular value on hospital-based, doctor-led, obstetric care as safe and modern. These migrant women then perceive UK based MLBS as less advanced, less safe, carrying a stigma or associated with higher mortality rates in 'the village' in the origin country.[59,60,64] Even after one or two generations, this influence was significant, particularly so in studies related to women from Pakistani and Bengal backgrounds.[59,60,64] For some women from Bengali communities it created a 'burden of choice' about possible blame if anything did go wrong, leading them to keeping their choice for a MLBS from their families.[59] One emerging point was the female-only nature of MLBS, which echoed the positive aspects of their foremothers' births in Bangladesh as safe from undesirable attendance by male healthcare professionals. [59 64]
When making choices that diverged from family expectations, membership of antenatal groups and knowing someone in the community who had given birth there were significant factors in choosing a MLBS, especially if the woman heard their birth story. [30,59,62] Some women found that~~e~~ wider social media gave them access to networks around physiological birth, water birth and MLBS. Tours of the MLU helped reassure and enabled some women to be the first in their community to choose an MLBS. Representation in the form of photos and birth stories of women of the same ethnicity displayed in the MLU building and posted on social media pages was a positive factor in normalising the choice.[59,60]

As a result of a risk-averse medical culture and media influences, both midwives and women can have a perception of MLBS as 'risky' despite strong evidence to the contrary, [21,24] deterring midwives from offering it as a genuine choice. [45,60,61,64,67] Midwives can feel caught between woman-centred choice and the tension of professional accountability, exacerbated when negotiating unfamiliar cultural practices.[45,61,64] Goodwin et al. [64] interviewed midwives who believed Pakistani women would be less likely to seek medical help due to religious beliefs, although they noted good relationships with women reduced prejudice. Foley et al.[50] and Naylor Smith et al.[62] discuss the issue of living in large extended families as a barrier to choosing homebirth, although both note this was not the case for everyone.

Midwife led birth settings as empowering

Racialised women being pleasantly surprised by the MLU environment was reported by McCourt et al.[60], Reeve Jones[59], [63] and Rayment et al.[45]. Racialised women felt treated in a way that they did not normally experience; as special, accessing a luxury akin to a spa or like royalty.[45,60] *"I felt like a*

princess. Maybe that's how Kate Middleton and them lot get treated when they give birth in their private hospitals. But it wasn't private. I didn't pay anything for it, but the service was just first class honestly" [59(p25)]. Women found the MLU calm, clean and '*absolutely fantastic'* [63(p290)] and choose it as a place they received respect and kindness.[59]

Women who have a first birth at a MLU tend to have subsequent births there and to influence other women in their communities, viewing it as safe and straddling both physiological birth and access to obstetric care if needed. [59,62,63] The sense of pride in forging a new path and choosing a MLBS became a significant part of some women's identities, different from their mothers and grandmothers, including questioning the medical professionals and making empowered decisions.[59]

Discussion

Statement of principal findings

There is a sparsity of existing literature on the factors affecting access to MLBS for racialised women. Of the 14 articles we found with any reference to the theme, only one specifically addressed the question. Nevertheless, we developed some clear themes. There is reported bias in information given by midwives regarding place of birth choices and evidence of gaps in professional provision of accurate evidence-based information. There are some systems-level barriers such as admission criteria. For some in the studies, community beliefs about birth and cultural norms played a part; at times conflicting with recent evidence-based information showing MLBS as able to provide safe women-centred care.

Strengths and weaknesses of this review

The strength of this scoping review is taking a specifically midwifery lens to the problem of racial inequality in birth and place of birth. The main limitation was the lack of material directly related to our question, with most of the research used containing minimal reference to our central question. As it was not the focus of the selected research, it makes the conclusions somewhat rhizomatic. A second limitation was most of the research focusing on women already classified as 'low-risk' as we discuss further below. Thirdly is the issue of using the broad category of 'racialised women'. Whilst it is useful to identify common structural issues, there is a risk of implying homogeneity and taking too broad a stroke. Finally, it could be that local or grassroots innovations are taking place that were not revealed in our searches due to the material being less widely publicised.

Review findings in the context of existing research and UK policy

Most research on MLBS, including the studies used in this scoping review, focuses on place of birth for 'low-risk' women only. This is despite that fact that the Birthplace Study showed that women with 'intermediate' risk factors who had home births showed comparative neonatal outcomes and better maternal outcomes, compared to women with the same intermediate risk factors birthing in an obstetric unit. [69,70] It is important to note that how women become classified as 'high-risk', is historically and geographically specific, and may have a racialised aspect. Most research on the higher proportion of racialised women classified as 'high-risk' focuses on the effect of allostatic load or 'weathering' and the correlation of race with lower socioeconomic status. [11,71,72] However, it is possible that racialised women may be more likely, compared to White women, to be treated as 'high-risk' when they have 'intermediate' factors that could have relatively good outcomes in MLBS. Additionally, seeing White women's and White babies' bodies being the 'norm' can risk pathologising what is normal, and conversely missing what is pathological for racialised women and their babies. For example, the problems of standard BMI parameters, or neonatal APGAR scores and jaundice recognition based on White populations.[73,74] These factors could contribute to explaining both a lower use of MLBS, and the (related) higher medical intervention rates among these women.

Our review echoes the NHS Race and Health Observatory's 2022 report[75] concluding with the role of local hubs, the need to focus on communities and institutions rather than individual solutions alone, and the need to involve women from ethnic minorities in the co-production of interventions and research. Unlike obstetric settings, midwifery services and MLBS *can* be geographically and culturally situated in the community. The House of Commons Women and Equalities Committee on Black maternal health[71] emphasise professional bias and racism, and promote staff training as a part of the solution. Similarly, the UK's Maternity transformation programme places emphasis on personalised care for all [76]. Our review shows the importance of both specific interventions embedded in communities of racialised women, and the unique role midwife led care and MLBS can play in redressing balance. The power relations and hierarchy inherent in the NHS organisation, the health issues, and medical model as outlined by Black British feminists, such as Bryan et al[77], come into sharp focus regarding racialised women's access to MLBS. What is unique about our report is the emphasis on engaging in women-centred biopsychosocial care, thus having a higher chance of offering care from a genuine 'midwifery standpoint'. [78] This relational care may lead to improved experiences, and possibly improved outcomes for racialised women. Group antenatal care, by relocating authoritative knowledge back to the women, with facilitative midwifery and peer support is particularly important for those who have been at the sharp end of dehumanising and disempowering medical practice as individuals and with a cultural legacy of systemic racism.[66]

Implications for policy

Making MLBS available for all women is the first step to making them available for racialised women. This could include increased provision and information, decision-making aids, staff training and institutional support for midwife led care.[13,42,71,79,80] An 'opt-out', or defaulting to a MLBS, for women without biomedical risk factors, with full discussion about options of obstetric-led care in the event of clinical need or maternal choice, could remove the barriers of biased information giving.[60] Home assessments in early labour with the place of birth not fixed prior to that point could also remove the barrier of defaulting to the obstetric unit.[30]

To overcome bias and structural inequality, equal access for racialised women requires additional measures. Community outreach, including to older generation women, could help shift the dominant discourse within communities to reflect the safety and comfort of MLBS. [64] An increase in MLBS use and the sharing of stories normalises MLBS and increases the community's knowledge and confidence in MLBS and in women's physiology and capabilities.[67] Representation in the form of pictures and accessible information about MLBS may help with women's and midwives' assumptions about who such services are for. [30,59,81]

Our review showed that better midwife-women relations in the antenatal period may lead to increased access for racialised women to MLBS. Therefore services with time and flexibility may have a positive impact, as might Public Health England's aim to improve outcomes for racialised women through midwifery-led continuity of carer.[82]

Situating MLBS within settings used by racialised communities may increase access by providing visibility and a sense of familiarity. Long term integrated community outreach, along with opt-out models and education for midwives may go some way to addressing the problem.

Need for future research

The paucity of data we found indicates the need for robust research focusing specifically on the question of racialised women's access to MLBS, both in terms of the barriers and the possible solutions. The results of this research could help increase access to MLBS, thus engender a shift from hierarchical to relational care, and hopefully improve outcomes and experience for racialised women. Risk classifications and MLBS criteria is an area that also merits future research. A review of risk classifications and MLBS admission criteria, and a move away from a 'high-risk' / 'low-risk' binary may be of benefit.

Words: 4654

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