The Women's Health and Maternal Well-being Initiative responds to NICE Induction of Labour recommendations

The Women's Health and Maternal Well-being Initiative has constructed comments and responses to the NICE recommendations on IOL. We were concerned that the recommendation instead of being underpinned by robust research was informed by experience and knowledge of the committee. Your signatures are being collected in relation to our General statement but please be aware that we have submitted additional comments to the proposed guidelines. Your name will appear on a document that includes both sections. Your name will be published so please feel free to use an alias if you wish to protect your identity. *UPDATE: We will be keeping this open until the end of the week after which we will publish the signatories along with the full response on our website.

GENERAL

The Women's Health and Maternal Well-being Initiative C.I.C. deem the recommendations included in this draft concerning Black, Asian and minority women to be unsupported and dangerous, as opposed to them being supported by a wide scope of strong evidence and research literature. Despite a general lack of research concerning the health narratives and experiences of Black women, much of the research that has been collected criticises race-based interventions and policies for perpetuating harmful untruths and stereotypes about the primary risk factors that put Black women at higher risk of complications. The proposed recommendations specific to Black, Asian and ethnically diverse people in the updated NICE 'Inducing labour' clinical guideline reinforce the erroneous presumption that non-white women do not possess the ability to safely birth their babies without medical intervention. Offering induction of labour for uncomplicated pregnancies belies a systemic distrust in non-white birthing bodies, while failing to acknowledge how systemic racism within maternity systems contributes to poor pregnancy outcomes for Black, Asian and marginalised ethnic groups. The role, context, and risk factors of structural violence and institutionalised racism must be emphasised and not completely ignored. Moreover, this position has been shared by both lay and academic/professional Black women; who have been raising concerns long before the wider critical reflections on race, power, institutional racism, and health risks brought about by the resurgence of racial justice ethics.

Regardless, the Committee has made the recommendation to offer induction of labour at 39+0 weeks in an effort to reduce poor maternal outcomes in uncomplicated pregnancies despite stating that there is no research evidence to support this recommendation (beyond their personal experiences and opinions). The overall recommendation of early induction of labour for Black women is, therefore, unfounded, irresponsible, insensitive, and will most likely directly contribute to greater racial disparities in maternal health including reduced satisfaction with intrapartum experience, increased rates of assisted birth and operative birth, more birth injuries and a contested reduction in stillbirth. There is certainly a place (and need) for medical policies and practices which are tailored to ethnic minorities, with the aim of providing them with specialist, personalised care and support, and the long-term vision of reducing the health inequalities and disparities they face. However, these must be informed by:

1) Coproduction: hard data collected and narratives shared by Black women (including those from smaller, grassroots organisations)

2) Interdisciplinarity: research from outside of the medical sciences, like that from the social sciences (e.g. medical anthropology and sociology, etc)

3) Black professionals: the centring of research conducted by Black women for (primarily) Black women and their health disparities.

When tailored practices and policies do not follow these doctrines, they run the risk of (re)producing the power disparities that lead to Black women not only being failed by service providers/the wider healthcare system, but the very actions and mentalities that physically harm them and their babies.

As the Committee will most likely know, Black women have been five times more likely to die in pregnancy, during childbirth, or six months postpartum than their white counterparts, according to the MBRRACE Report (Knight et al., 2018). This is despite England's overall decrease in maternal morbidity and mortality rates. The latest MBRRACE Report, however, shows that their risk is now four times more likely (Knight et al., 2020). This reduction has been acknowledged by many, but so has the fact that the decrease was not significant and Black women remain at the highest risk.

Research conducted by Black academics, Black health professionals, and Black lay women alike have outlined the same probable reasons; major ones being (historical) institutionalised anti-Black racism in medical theory and policy and implicit racial bias in practice. In addition to that toxic working culture exacerbate the poor outcomes experienced by vulnerable groups. In sum, racism, misogynoir (sexist racism), and toxic-culture result in poorer maternal experiences and increased maternal morbidity and mortality risks, with Black women across the country and across generations consistently reporting discrimination and a lack of informed decision making. Service-users also report that they are less likely to receive pain relief- because staff assume they are "stronger", and/ or are lying about their pain levels, and/ or are simply being hysterical. Knowing this, a recommendation which increases Black women's likelihood of being offered early induced labour - which the Committee have noted is generally more painful than physiological birth - puts them in a very vulnerable position, where their lives are at even greater risk. This is in addition to the increased risk of maternal morbidity and adverse outcomes including severe perineal trauma, haemorrhage, birth trauma and uterine rupture. Black women's "near misses" have recently also been emphasised in discussions about how dire the Black maternal health crisis is, and the role of misguided, uninformed practices – thus, unless NICE recognises the deeply racial systemic issues in maternity care, these recommendations will only exacerbate the aforementioned.

Furthermore, we do not believe that the committee have adequately made plain the interlinked relationship between infant health and wellbeing and maternal health and wellbeing. Black babies are already at increased risk of being stillborn, premature, and at a lower birth weight; institutional racism makes them equally as vulnerable to greater morbidity and mortality and maladaptive medical practices as their mothers are. There is also a lack of consideration given to the fact that induced births require more care of the mother and infant and, within the context of an NHS which is already over-stretched, under-staffed, and suffering from deeply-entrenched racism which affects both ethnic minority staff and patients. Public hospitals are simply not equipped to meet the increased demands of care precipitated by mass labour induction. We make this assertion based upon feedback from midwives and clinicians currently working in maternity services, despite the Committee stating that offering inductions to more women will not overburden the already beleaguered NHS. Therefore, we believe such a recommendation is irresponsible and dangerous, especially if it is not accompanied by a standard of excellence and kindness for Black women and their babies.

The Women's Health and Maternal Well-being Initiative urges that the Committee consults with us, and similar organisations, for a deep examination of the socio-medical, qualitative research that speaks to the issues raised.

It is our informed opinion that it would be unsafe and unethical for a midwife (or any qualified medical professional/student) to adopt these suggested guidelines, as they contradict their professional obligation to provide person-centred, culturally safe and evidence-based care. Nor do we believe that by masquerading as what racially-sensitive, tailored care looks like, these recommendations promote an understanding of the institutionalised role and responsibility of racism/misogynoir. There is strong evidence that asserts midwifery-led care and care in midwifery-led units have better outcomes than in other settings, we welcome an emphasis on increasing access to midwifery-led care and increased choice in place of birth. Consequently, we recommend that more emphasis should be placed on high quality training that is underpinned by cultural safety, human rights in childbirth and increasing choice and personalisation through informed decision-making.