

Induction of Labour Rapid Report 2021

A surveyed investigation into Black British women's experiences of, and attitudes towards, induction of labour

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The Women's Health & Maternal Well-being Initiative C.I.C.

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Foreword

This report was written in response to the proposed revised guidelines to offer induction of labour at 39+0 weeks for women with otherwise uncomplicated, singleton pregnancies who are at increased risk because of age, BMI, race, or assisted conception. The proposed guidelines by NICE (the National Institute for Health and Care Excellence) sparked nationwide concern, and in some cases anger, due to the categorising of ‘race’ as an essentialising biological risk factor. It also did so without supporting evidence. The WHMWI were concerned that the recommendation was informed by individual experiences, inadequate racial knowledge, and biases of the NICE proposal committee instead of being underpinned by robust critical research and thorough evidence. Acting on our concerns, we were propelled to construct an open letter which took the public response to the NICE recommendation into account; this letter received 630 co-signatories from a range of backgrounds and disciplines (see [here](#)). In short, our argument can be summarised in this short excerpt:

“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”.

Following the open letter, we wanted to better understand Black women’s views on, and experiences of induction of labour, and so we created a short survey. This report is a result of the findings. Written by Princess Banda, a medical anthropologist who is now a PhD researcher at the University of Oxford, our report provides insight around Black women’s recent experiences of induction of labour as well as the complexities, risks, and nuances around induction being used as a method to reduce racial maternal-infant health disparities.

Princess has demonstrated excellent scholarship exploring the developing biopolitics of gendered-racial maternal health crisis in the UK. Bringing a critical lens to the conversation, Princess applies a qualitative approach underpinned by anthropological, socio-medical, and narrative-based perspectives to the discussion around Black women’s health and, in particular, Black maternal health. In short, her work examines the how and why of the issue, and we welcome this refreshing outlook.

Natasha Smith, Founder and Managing Director

Executive Summary

Introduction. Black women in the UK are in a maternal health crisis, and have been for a very long time. A few attempts to address this have been put forward, such as NICE's updated suggestions to their induction of labour (IoL) guidelines. They suggested that clinicians should offer IoL at 39+0 weeks for women with otherwise uncomplicated, singleton pregnancies who are at increased risk because of age, BMI, race, or assisted conception. The risk factors of age, BMI, and assisted conception have been well documented and evidenced. The usefulness and truthfulness of 'race' as a biological risk factor, however, have **not** been well-evidenced in medical research or practice (as admitted by the guideline's committee themselves (p.24)), nor have the social constructions and consequences of *racialisation* been identified as contributing risk factors for Black women in the update. Unsurprisingly, many Black women have felt objectified and dehumanised by the suggestion that their 'race' inherently makes them more vulnerable to maternal mortality and morbidities, and believe that this recommendation will be used against them to reduce their agency and autonomy in their labour and birthing processes. Many have cited existing (and evidenced) *institutional racism, implicit racial bias, and medical misogyny* as reasons for this belief. It is within this context that we have conducted the Induction of Labour Survey.

Methods & Ethics. The survey created was a part of a qualitative study which aimed to have 2 parts: an online survey and follow up focus groups. However, due to limitations in both time and funding, only data from the survey was collected. The target participants were monoracial and mixed heritage Black women- 18 years and older- who live in Britain and have been offered IoL in at least one pregnancy in the last 8 years. The survey, itself, was composed of 3 sections which encompassed a mixture of closed and open-ended questions. The survey was disseminated via social media for further reach. In total, the questionnaire obtained 18 *complete* responses.

Data. Ethnicity: 44% of participants were Black Africans, with 28% being Black Caribbean and the other 28% being Black mixed. Place of birth: 89% were born in the UK and 11% were born elsewhere. Age: 39% were between the ages of 25-34 and 61% were between the ages of 35-44. Highest education qualification: 6% had an NVQ, 44% had a bachelor's degree, another 44% had a master's degree, and 6% had a doctorate. Disability and chronic conditions: 94% did not have a disability, 6% did. The percentages, respectively, remained the same for having a chronic condition and not having a chronic condition. Pregnancy status: 100% of participants were surveying for a previous pregnancy. High risk pregnancy: 39% did not have a high-risk pregnancy, 50% did, and 11% were unsure. Survey question and answer themes: experience(s) of induction, methods of induction, experience(s) of labour, pain relief, and cultural sensitivity and good, respectful care during pregnancy, birth, or the postnatal period.

Key messages. 1) Black women with a higher level of education are not at lower risk of intervention, as is often assumed. 2) Maternal morbidity remains the highest reason for IoL. 3) Women are not being given sufficient information to make an informed decision (e.g. about the risks of IoL). 4) Women need more knowledge on their options of IoL methods. 5) Women are dissatisfied with their experiences of IoL. 6) The administration of pain relief still requires improvement despite satisfaction in the type of relief offered. 7) More racially conscious and culturally-sensitive care is needed.

Conclusion. It is clear that Black women, overall, have complicated experiences of IoL, with many enduring significant negative acts of practice, care, and medical theory. Therefore, they not only

need a general improvement in the way IoL is carried out, but require racially conscious, culturally-sensitive personalised care. A policy of pre-emptive IoL (based on their biological racialisation) is not the way forward; particularly when practices and theories of induction, generally speaking, still need much improvement, as does the public health system's economy of care.

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Introduction

Black women in the UK are in a maternal health crisis, and have been for a very long time. However, it was not until the 2018 publication of the MBRRACE report- from the University of Oxford's National and Perinatal Epidemiology Unit (Knight et al., 2018)- that Black women's disproportionate mortality and morbidity risks were taken seriously both in, and out of, the healthcare system. The MBRRACE report found that Black women in Britain were 5x more likely to die of childbirth complications than their white counterparts, ensuing collective shock, outrage, and calls for change, including through socio-cultural/ popular culture projects. Fast forward to the latest MBRRACE report, published in early 2020, which has found that Black women's maternal mortality risk during pregnancy and up to 6 weeks post-birth has reduced to 4x more; however, this is not a cause for celebration because the reduction bares little statistical significance, and because Black women still have the highest risk out of the ethnicities studied (Knight et al., 2020). Equally as important, Black babies' mortality rates remain the highest, with the most recent findings showing that their stillbirth rates are more than twice as high as those of white babies (ibid).

Historically, there has been a belief that population-level disparities and crises in Black women's maternal and reproductive health are due to genetic predispositions and/ or degenerative cultures and behaviours (see Butchart, 1998; Meisenhelder, 2003; Keller, 2006; Yancy, 2008; Prather et al. 2018). Whilst such rhetoric still lingers, there has been a strong rejection of these ideas within fields which utilise and explore critical analysis, such as subfields within the social sciences, and the fields of critical gender and race studies. Unfortunately, this rejection and critical analyses of the ideas behind biological race and social racialisation are yet to be formally taken up at the highest levels of the public health system and within medical education (although there has been a clear and evident move to include them by Black and non-Black medical staff, experts, and teachers, in particular, in small pockets).

Recently, a show of this rejection against racial biological essentialism and its intersection with the Black maternal health crisis has come through the #NotSoNICE campaign; a grassroots 'movement' created to protest against the National Institute for Health and Care Excellence's proposed updates to their IoL guidelines. They have suggested that women with uncomplicated pregnancies should be offered IoL at 41+0 weeks to avoid the risks of prolonged labour, instead of between 41+0 - 42+0 weeks as has been the recommendation. However, what is of particular great contention is the suggestion that clinicians should offer IoL at 39+0 weeks for women with otherwise uncomplicated, singleton pregnancies who are at increased risk because of age, BMI, race, or assisted conception. The risk factors of age, BMI, and assisted conception have been well documented and evidenced. The labelling of 'race' as a biological risk factor, however, has not been well-evidenced nor is it well-founded (as admitted by the guideline's committee themselves (p.24)). Additionally, the social constructions and consequences of racialisation have not been identified as contributing risk factors for Black women by the NICE committee either. Unsurprisingly, many Black women have felt objectified and dehumanised by the suggestion that their 'race' inherently makes them more vulnerable to maternal mortality and morbidity, and believe that this recommendation will be used against them to reduce their agency and autonomy in their labour and birthing processes. Many have cited existing (and evidenced) institutional racism, implicit racial bias, and medical misogynoir as reasons for this belief.

Whilst NICE- with additional pressure from the Royal College of Gynaecologists (RCOG, 2021)- have stated that they will reassess their proposed inclusion of healthy Black women in their preventative guideline, Black women still have much fear and anxiety towards IoL, as well as the wider racism within maternal health services. It is within this context that we have conducted the Induction of Labour Survey. As a Black women-centred health initiative, the WHMWI wanted to keep

the conversations regarding Black women's experiences of IoL going past the initial outrage. Thus, we conducted the survey as a means of collecting qualitative, narrative-based primary data which can not only add to the lack of such data, but that provides Black women with the formal opportunity to record their past and present experiences with IoL (and the Black maternal health crisis, more widely).

Background & Context

Medical Context

Induction of labour is the process and practice of artificial induction by either mechanical or pharmacological tools.

1 in 5 labours in the UK are induced (NHS, 2020), so IoL is a normal and, relatively, safe intervention. Typically, it is offered when a vaginal delivery is not possible due to the baby being ‘overdue’¹ and/ or because of medical reasons that put the mother or baby at increased risk of death or disease (such as pre-eclampsia and prelabour rupture of membranes, or stagnated growth or prematurity²). In cases of the former, IoL has only been considered if the woman has had a “straightforward pregnancy”, so is otherwise low risk, because the risks of stillbirth or neonatal death have been found to increase when gestation goes beyond 40 weeks (Middleton et al., 2020). However, it remains unclear whether a policy of IoL can reduce these risks. For women who want to continue pregnancy after 40/ 41/ 42 weeks, the option is still there; they are simply monitored very closely until natural labour or they choose IoL. This is known as ‘expectant management’³.

It is also important to remember that due dates are only a *guide*. Most babies are not born on their due date (only 1 in 20 are), and there is no way to tell whether they will arrive on time (NHS Inform, 2021). Therefore, most babies are born either “early” or “late”, depending on the definitions and cultural understandings of due dates of those involved. It is also worth noting that many non-Western cultures and non-biomedical models of health have very different (i.e., less rigid) comprehensions of the gestational period and due dates, as has been evidenced by both patient narratives and in many anthropological ethnographies. These are often rooted in their indigenous ontological philosophies⁴, and are likely to be perceived as being in opposition to Western medical advice by clinicians, who tend to undermine and ignore women who maintain their cultural models of maternal health in addition to the biomedical model. In cases of the latter, IoL is planned in advance.

Although labour may not start immediately after artificial induction, and is likely to be more painful than natural induction, IoL is a very useful aid which can be necessary in some cases. Methods of induction vary and can be chosen based on the woman’s preference(s), as well as the readiness of her cervix⁵. Mechanical methods have, traditionally, been used as the primary methods to ripen the cervix and induce labour; they have been suggested to be advantageous above their pharmacological counterparts. This is because they are widely available, low in cost, and reduce the potentially fatal/ harmful side-effects and risks of IoL (such as uterine hyperstimulation), which improve neonatal outcomes because, if contractions are too long or very close together, the baby may not receive sufficient oxygen (de Vaan et al., 2019). Mechanical methods include:

- Membrane sweeps
- Balloon catheters
- Breaking waters artificially

¹ Overdue is described as “not go[ing] into labour naturally by 42 weeks” (NHS, 2020)

² <37 weeks

³ Expectant management is when a pregnant person and their baby are monitored when the estimated due date has passed, so that the pregnancy can progress naturally but safely.

⁴ Indigenous/ cultural understandings of maternal and neonatal health are not necessarily always dichotomous to those of biomedicine. In fact, they are often complimentary but require biomedicine to become less rigid and to value the legitimacy of their stipulations.

⁵ The cervix is assessed using a vaginal examination and is categorised by the Bishop score (NICE, 2021a)

However, mechanical methods have been substituted by pharmacological methods in recent decades. These include, but are not limited to,:

- Prostaglandins
- Hormone drips (e.g. Oxytocin via drip in arm)
- Pessaries
- Gels

The limitations (and cons) of IoL are that it increases the likelihood of assisted delivery⁶ and that, if unsuccessful, a second induction or C-section is offered and this increases the number of the interventions the woman goes through (as well as the severity). Moreover, IoL limits the choice of place of birth because of the need for additional equipment and procedures; aids such as oxytocin infusion and continuous foetal heart rate monitoring are not typically available at home births or in midwife-led birth units. In addition, IoL (NICE, 2020a):

- Increases the need for an assisted vaginal birth and this, subsequently, increases the risk of obstetric anal sphincter injury (e.g. third- or fourth-degree perineal tears);
- Increases the frequency of uterus contractions (called hyperstimulation), and these too-frequent contractions can lead to changes in foetal heart rate and result in concerns about foetal wellbeing;
- Increases risk of emergency c-sections;
- Increases risk of uterine rupture, cord prolapse, and antepartum haemorrhage.

Risk Factors for Delayed Labour and Artificial Induction

Prolonged labour- formally known as dystocia- is a common birth complication and usually results in instrumental deliveries and/ or delivery by emergency c-section. Prolonged labour has also been on the rise in affluent countries, especially amongst nulliparous women, for the last 10 years (Kjærgaard et al., 2010). However, despite its commonality, diagnosing it is a very difficult (and controversial) task; its most common definition/ criteria is either a protraction disorder (slow progress) or an arrest disorder (total cessation of progress), but there are concerns regarding the usefulness of this criteria because it is based on historical evidence that may no longer be clinically valuable or relevant (Nystedt & Hildingsson, 2014).

Nevertheless, prolonged labour is a legitimate reality for many women and often results in morbidities and suffering that may have lifelong implications. Foetal biomedical risk factors include a heavy birth weight, large head circumference, and occiput posterior⁷ presentation (Nystedt & Hildingsson, 2014). Maternal biomedical risk factors include pre-pregnancy overweight/ obesity, primiparity (first baby), being above 30 years of age, having a small stature, and caffeine intake of 200–299 mg/day (Kjærgaard et al., 2010; Nystedt & Hildingsson, 2014; Middleton et al., 2020), as well as (pregnancy-related) diabetes, high blood pressure, and intrahepatic cholestasis of pregnancy (alternatively known as obstetric cholestasis) (NHS, 2020). The biomedical factors believed to be the most prevalent in, and relevant for, Black women's risk are:

⁶ forceps or ventouse suction are used

⁷ In occiput posterior presentation (also called sunny-side up), the foetus is headfirst but is facing up (toward the mother's abdomen). It is the most common abnormal position or presentation. When a foetus faces up, the neck is often straightened rather than bent, and the head requires more space to pass through the birth canal

- 1) Kidney disease (for more information on risk, impact, and management, please refer to NICE, 2019a);
- 2) Obesity (for more information on risk, impact, and management, read NICE, 2019a);
- 3) Hypertension & pre-eclampsia (for more information on risk, impact, and management, please refer to NICE, 2019b);
- 4) Diabetes (for more information on risk, impact, and management, please refer to NICE, 2020).

Moreover, prolonged labour has been found to be associated with greater pain than is usually expected, leading to greater use of artificial induction methods (i.e. oxytocin augmentation and early amniotomy) and epidurals, and increased risk of operative interventions such as emergency c-sections (Nystedt & Hildingsson, 2014). Interestingly, however, research has found that although the use of oxytocin is likely to reduce the length of labour, its use does not increase the rate of ‘normal’ (non-caesarean) births among women with slow progress (see Bugg et al., 2013). This critical finding can be understood to agree with- and support- Nystedt & Hildingsson’s study conclusion that there is a dire need for increased clinical skill in the identification and classification of prolonged labour, in addition to a more thorough comprehension of the limitations of biomedical knowledge and interventions in the reduction of dystocia rates.

Biopsychosocial Factors, Race, & Racism

As is often the case, Black women have been identified as being at increased risk of IoL in addition to increased susceptibility to the range of risk factors that contribute to its utilisation. Within the context of deep racial health disparities and dire racial socio-structural inequities, Black women’s risk of IoL is unsurprising, especially because (seemingly unrelated) racial health or social disparities are often a gateway into bodily states of immediate emergency or slow crises that build over time. Although little- if not zero- research has been conducted on the relationship between socio-structural and medical racism and risk of IoL in Black women living in the UK, work has been done on how racism and biological/ cultural notions of race (in this case ‘Blackness’) affect Black women physiologically. Theoretically, this is often framed within the concept of ‘biopsychosociality’ (see James, 1994; Levenstein et al., 2001; Brondolo et al., 2003; Dressler et al., 2005; Hamilton, 2017) and ‘reproductive justice theory’⁸. It is also adjacent to the concepts of ‘syndemics’ (Singer et al., 2017; Willen et al., 2017; Mendenhall, 2019), ‘embodiment’ (Nichter, 2008), ‘structural violence’ (Gultung’s, 1969; Karlamangla et al., 2005; Cuschieri et al., 2017; Angier et al., 2019; Higi, 2019; Kolak et al., 2019), and ‘misogynoir’⁹. Specifically, biopsychosocial research has investigated how racism-related physiological changes not only influence Black maternal health disparities, but how they are legitimate risk factors that play a significant role in racial health disparities more generally. Admittedly, this research has largely been conducted on, by, and for African American women. However, given that the past and contemporary histories of anti-Black racism and medical misogynoir are very similar between the UK and the USA, the findings of this research can be confidently- albeit cautiously- applied to Black women living in the UK to better (i.e. holistically) understand, analyse, and articulate the health disparities and inequities they face.

The compounded nature of this report limits the depth that this critical socio-medical research can be explained and analysed in depth, so readers are encouraged to read original research papers and

⁸ Coined in 1994 by the Women of African Descent for Reproductive Justice group, reproductive justice theory highlights the politics behind Black women’s collective experience of poor reproductive health (Ross, 2017). However, reproductive justice is not solely a theory; it is a principle for activism.

⁹ Misogynoir was coined in 2008 by African American, queer feminist Moya Bailey whose aim was to define the “historical anti-Black misogyny and [the] problematic intraracial gender dynamic” that affects Black women in not only their health, but in popular and political culture (Bailey & Trudy, 2018: p.762).

ethnographies, as well as related work which has further explored the theories and findings (see Hamilton, 2017; Banda, 2020a & 2020b for example). Nevertheless, the critical research that has been conducted over the past few decades can be partially summarised in two points:

- 1) It largely draws from the Black feminist concepts of *reproductive justice* and *misogynoir*, and it bridges science with critical social and political thought within the wider paradigm of critical gender/ race/ post-colonial theory. However, this does not mean that the research is less credible medically.
- 2) Together, the theories, arguments, and concepts have resulted in a growing epistemological paradigm whose founding belief is that Black women's (reproductive) health crises are *intersectional*; they are the legacy of the gendered-racial oppression of slavery and colonialism (Meisenhelder, 2003; Yancy, 2008; Prather et al., 2018), and are the product of contemporary, deeply biased, hyper-racialised (medical) systems which devalue Black bodies and Black personhood (Fanon, 1963; Kings Fund, 2015; Kmietowicz et al., 2018).

Moreover, there are three medical theories that hold particular significance for, and relevance to, the Black maternal health crisis and IoL experiences:

- 1) **Sojourner Syndrome.** Penned by late African American anthropologist Leith Mullings, Sojourner Syndrome provides a more advanced framework for Black womanhood, as symbolised through the life of Sojourner Truth. It supplements the theories of reproductive justice and misogynoir by incorporating theories of embodiment, stress, psychology, and biology. It argues that socio-structural, medical, and intraracial misogynoir are significant factors in Black women's (reproductive) health disparities because they result in the build-up and prolongation of acute stress (Mullings & Wali, 2001; Mullings, 2002). More specifically, it suggests that the physiological consequences of stress during pregnancy (i.e. the releasing of certain hormones, spikes in cardiovascular reactivity, decreased immune resistance, etc) increases Black women's susceptibility to maternal medical complications (such as spontaneous labour, preterm delivery, pre-eclampsia, etc) and death (Mullings & Wali, 2001; Wadhwa, et al. 2001).¹⁰
- 2) **The Weathering Hypothesis.** Pioneered by public health expert Arline Geronimus, weathering is another, original analytic framework which posits that the *early health deterioration* (and subsequent health disparities) Black women face are the result of the life-long, cumulative social exclusion and political marginalisation that comes from living in a racist society (Geronimus 1992; Geronimus et al., 2006). It argues that the racial differences in risk and prevalence cannot be reduced to mere socio-economic inequality (and the poor health behaviours that are a consequence) because there is evidence of early health deterioration in Black people across all socioeconomic levels; this critical reassessment of the significance of socioeconomic status has also been supported by several other pieces of research (see Levenstein et al., 2001; Dressler et al., 2005; Karlamangla et al., 2005; Okereke & Manson, 2017; Mendenhall, 2019 for example). Like Sojourner Syndrome, it also draws on a biopsychosocial understanding of the high-effort coping and chronic stress that are a part of Black womanhoods.
- 3) **Culture Talk (*cultura obscura*).** Conceptualised in a ground-breaking paper by sociologist Ruha Benjamin (2017), the theory of culture talk addresses realities of race and power in

¹⁰ Additionally, it must be noted that even though the relationship between stress and morbidity/ mortality has a strong theoretical foundation (see Hans Selye's pioneering stress model of health, (1956)), the relationship between stress, racism, gender, and maternal health has a weaker socio-medical theoretical foundation than other iterations of stress theory (e.g. 'John Henryism' (James, 1994)). However, this is not reflective of its statistical significance, but of the epistemological gap that has resulted from the lack of support given to qualitative, socio-medical research on Black women (Douglas, 1992).

racial discourse in the health sciences. Culture talk is a "discursive repertoire that attributes distinct beliefs, behaviours, and dispositions to ethno-racialised groups" (ibid: p.225); it creates a smokescreen of equality through the dual processes of obfuscating the social reality of its subjects, and the true positions of those creating the narratives. In this sense, culture talk results in 'cultura obscura'. Understanding racial stereotypes and cultura obscura within the contexts of each other is particularly important in perceiving, therefore unpacking, Black women's maternal health experiences and outcomes (as well as the outrage from Black women regarding their inclusion in NICE's IoL guidelines). This is because they unveil a stressor which is often alluded to in Black women's health narratives, both past and present: implicit racial bias¹¹ (Chapman et al., 2013; Hall et al., 2015; Fitzgerald & Hurst, 2017; Guardian, 2019). Loosely defined as unconscious prejudice based on racial/ ethnic stereotypes, implicit racial bias has historically aided Black women's harm particularly because clinicians do not believe them about their pain, symptoms, or discomforts, or even their good health, resulting in racial disparities/ inequities in the prescription of medication and the cascade of interventions¹² (Chapman et al., 2013; Benjamin, 2017; Fitzgerald & Hurst, 2017).

¹¹ Implicit racial bias can be situated within the 'European imagination' (Meisenhelder, 2003: p.100), as has been done by many historians, anthropologists, and other kinds of critical scholars. The European imagination is a construction of white supremacy where the white imagination projects its own fears and misunderstandings onto the Black body through mythopoeia- the creation of myths (Yancy, 2008). Consequently, the Black woman's body is othered and coded as inherently pathogenic- a site of reduced value (Fanon, 1963; Butchart, 1998; Meisenhelder, 2003; Yancy, 2008), and one that is in pre-emptive need of (biomedical) intervention based on biological and essentialising notions of race.

¹² In America, this was recently evidenced in an evaluation of an algorithm used to predict the healthcare needs of patients; it was found that Black patients' care needs are under-estimated by 50% (Telegraph, 2019). This shocking statistic, whilst not formally recorded in the UK, is most likely to be found here due to the countries' similar racial history. Whilst bold, such a prediction of racial bias in treatment and care is supported by a survey finding that societal racial bias is present (Guardian, 2019) and that, despite our poor-quality data on racial health inequalities (Nazroo et al., 2009), there is still clear evidence of prejudice against BAME patients (Kmietowicz et al., 2019).

Reflections

If understood within the contexts of each other, the above can begin to paint a fuller picture of why Black women are- and have been- experiencing a highly racialised maternal health crisis. This is in addition to why medical perceptions, practices, and policies of IoL run the risk of becoming systemic forms of medical misogyny, especially when explicit or implicit constructions of biological race (e.g. Black babies' younger gestational ages) inform ideas of Black women's risk, and are included in the reasoning for pre-emptive intervention without sufficient, peer-reviewed, socially informed, multidisciplinary evidence.

Furthermore, although the focus of this report is on Black women, we recognise that there is a desperate need for greater *critical* study on the biopsychosocial factors that influence Black infants' health risks here in the UK, as well as how racialisation and notions of genetic race impact the care they receive, especially in-utero. Recently, as a result of the backlash against NICE's proposed IoL guidelines, a few doctors and healthcare professionals have come forward in defence of otherwise healthy Black women being pre-emptively induced at 39 weeks, using the argument that Black babies have younger gestational ages so are at high risk of death or disease if left past 39 weeks. Through discussions and posts on mostly social media, they have cited findings which argue that the presence of meconium¹³ in amniotic fluid is evidence for 'natural' (i.e. biological) earlier maturity in Black foetuses because meconium is associated with foetal maturity. This was the conclusion in Patel et al.'s 2004 UK-based study on 122,415 nulliparous women with single pregnancies; they found that the median gestational age at delivery was 39 weeks in Black and Asian women, and 40 weeks in white Europeans, concluding that the 'normal' gestational length is shorter in Black and Asian women compared with white European women, and that foetal maturation occurs earlier. Nevertheless, what Patel et al. and others who promote this heavily racialised, genetic race-affirming argument neglect to consider- albeit unconsciously- is the equally valid fact that meconium is also a sign of foetal (di)stress, and its pre-birth passage can be independent of foetal maturation (Lakshmanan & Ross, 2008). In fact, meconium-stained amniotic fluid is thought to be a direct sign of maternal stress which, according to critical perspectives of Black women's maternal health (such as Sojourner Syndrome and the weathering hypothesis), is very plausible and is more likely to be the reason. Additionally, if Black women biologically mature at younger ages as a physiological result of a stressful, racist environment- as per the weathering hypothesis- then, theoretically, the same can be true for Black foetuses who are in their mothers wombs and are embodying the same stressors their mothers are embodying. Moreover, the occurrence of meconium-stained amniotic fluid has long been considered the predictor of adverse foetal outcomes, such as meconium aspiration syndrome and perinatal asphyxia; both lead to perinatal and neonatal morbidity and mortality (Addisu et al., 2018). Therefore, the argument and defence that the pre-birth meconium passage that is often found in Black foetuses is a sign of a biological race-based, earlier gestational age norm- and not maternal (di)stress- is incredibly misguided and dangerous in IoL policy, practice, and medical education .

All in all, the 'best' timing for IoL in all women is still unknown, and further exploration of risk profiles, values, and preferences is still needed (Middleton et al., 2020). Black women are, of course, should be included in this further research, and the WHMWI's IoL survey is a contributing resource.

¹³ Meconium is a germ-free, thick, black-green, odourless material which is usually recognised in the foetal intestine at approximately 12 weeks of gestation, and is stored in the foetal colon throughout gestation (Addisu et al., 2018). It is normally passed 24-48 hours after birth but can pass in-utero; in the latter case, it is believed that this is a sign of a problem (although the exact aetiology of meconium-stained amniotic fluid remains unclear).

Methods & Ethics

Methods

The survey created was a part of a qualitative study which aimed to have 2 parts: an online survey and follow up focus groups. However, due to limitations in both time and funding, only data from the survey was collected.

The target participants were monoracial and mixed heritage Black women, 18 years and older, who live in Britain, and have been offered IoL in at least one pregnancy in the last 8 years.

The survey, itself, was comprised of 3 sections which encompassed a mixture of closed and open-ended questions:

- ‘About you’; a section obtaining socio-demographic and health background information on participants;
- ‘About induction of labour’; a section regarding the informed consent aspect of IoL;
- ‘Your experience of induction of labour’; a section exploring the physiological and technical aspects of IoL, in addition to participants’ opinions of their lived experience of IoL and pain relief.

Participants also had the option to leave further comments if they wished to expand on their answer.

The survey was disseminated via social media for further reach; the WHMWI shared it across our formal Facebook, Instagram, and Twitter pages, as well as the independent pages of some of the grassroots organisations in our network. In total, the questionnaire obtained **18 complete** responses.

Ethics

As an independent organisation, the WHMWI are not a part of a registered health or social authority with its own ethics board. Because of this, conducting this study according to a high ethical standards and practice was of utmost importance, and we acknowledge the debate surrounding the dilemma of how ethical a study can truly be without the approval of an independent ethics committee. Nevertheless, the WHMWI (like many other Black-led, grassroots organisations) are in a precarious ethical position in regard to this dilemma due to the question of: is it less ethical to ignore a wide-scale problem because one does not have authoritative support in the collection of useful and needed data, or is it less ethical to collect data under the (loose) assumption and untested application of ethical considerations? This dilemma is one the WHMWI have tried to navigate and will continue to explore as we become further established.

For now, the ethical considerations made followed the ‘Ethical Guidelines for Good Research Practice’ of the Association of Social Anthropologists of the UK and the Commonwealth (ASA, 2020); this is because the primary project research lead is an anthropologist by training, so has experience collecting data using these guidelines. In addition, the survey’s introductory page included information on privacy protection (e.g. anonymity and privacy in data storage), participants’ rights, risks and discomforts, how the data would be used, and who to go to with questions- all of this information was condensed from the WHMWI’s privacy notice.

Data

Participant Profiles

Table 1.0- Participant characteristics

Characteristics	No. of Participants
Ethnicity	
Black African	8
Black Caribbean	5
Black Mixed	5
Black Other	0
Born in UK	
Yes	16
No	2
Age	
18-24	0
25-34	7
35-44	11
45-54	0
Highest educational qualification	
None	0
Primary school	0
GCSE	0
BTEC	0
NVQ	1
A-levels (or equivalent)	0
Bachelor's degree	8
Masters	8
Doctorate	1
Disability	
Yes	1
No	17
Unsure	0
Chronic illness	
Yes	1
No	17
Pregnancy status	
Current	0
Past	18
High risk pregnancy	
Yes	7
No	9
Unsure	2

Experience(s) of Induction

Table 2.0- About Induction of Labour

IoL	No. of Participants
Week(s) at which IoL was offered	
<37 (premature baby)	4 (20 wks, 28 wks, 34 wks, 36 wks)
37	2
38	3
39	3
40	5
41	1
≥ 42	0
Reason(s) for IoL	
Unclear (from survey response)	2
Maternal morbidity	7
Maternal other	1 (age)
Foetal morbidity	0
Baby overdue	3
Baby other	2 (slow labour; small foetus size)
Both maternal and foetal	3
Belief that sufficient information was given to make an informed decision	
Yes	8
No	7
Unsure	3

Table 2.1. Direct Quotes for Reasons for IoL

“Diabetes, brain tumour”	“My son was measuring up as small on his scans, so I was on a growth pathway”	“Hyperemesis gravidarum, gestational diabetes, obstetric cholestasis”
“Shortness of breath but I believe I should not have been induced”	“I had high blood pressure and they said they worried I would get Pre-eclampsia”	“Yes. Yes, baby was no longer growing and issues with kidneys”
“Postdate (i.e went over 40 weeks)”	“Past due date”	“Waters broken over 24 hours and labour not progressing”
“I was not clearly informed of the reason but I have one average size fibroid and the baby was measuring on the large size and my sugars were reading high but not classified as diabetic”	“With my first, I had OC and with second my blood pressure was high and had difficulty breathing throughout pregnancy”	“Due to prelabour rapture of membranes in my first pregnancy, and due to reduced baby movements in my second pregnancy”
“Because my baby was 15 days overdue”	“Severe pre-eclampsia”	“My age as I was 40 on my due date”

Table 2.2- Beliefs regarding experience of IoL

Statements	No. of Participants
I understood exactly what induction of labour involved	
Strongly agree	3
Agree	8
Neither agree or disagree	3
Disagree	4
Strongly disagree	0
The benefits of induction of labour were explained to me in a way I could understand	
Strongly agree	2
Agree	9
Neither agree or disagree	4
Disagree	2
Strongly disagree	1
The risks of induction of labour were explained to me in a way I could understand	
Strongly agree	3
Agree	2
Neither agree or disagree	5
Disagree	5
Strongly disagree	3
I understood why induction of labour was appropriate to my personal circumstances	
Strongly agree	3
Agree	11
Neither agree or disagree	1
Disagree	2
Strongly disagree	1
I felt that I was given enough time to make a decision about accepting induction of labour	
Strongly agree	3
Agree	3
Neither agree or disagree	5
Disagree	5
Strongly disagree	2
I was given the option of going home after my induction began	
Strongly agree	1
Agree	1
Neither agree or disagree	4
Disagree	1
Strongly disagree	11

Methods of Induction

Table 3.0- Methods of Induction

Methods	No. of Participants
Methods of induction	
Stretch & sweep	7
Balloon	1
Pessary	11
Gel	6
Hormone drip	1
Other	1 (AROM)
Number of methods used	
1	11
≥2	7
I was given a choice in method of induction of labour	
Strongly agree	3
Agree	2
Neither agree or disagree	3
Disagree	4
Strongly disagree	6
I have/ had preferred for method of induction of labour	
Strongly agree	3
Agree	3
Neither agree or disagree	9
Disagree	2
Strongly disagree	1

Experience(s) of Labour*Table 4.0- Experience(s) of Labour*

Labour Practices	No. of Participants
Assisted birth	
Yes	4
No	13
Unsure	0
Types of instruments used in assisted birth	
Kiwi suction cup	1
Ventouse	2
Forceps	0
Other	0
Unknown	1
Episiotomy	
Yes	1
No	16
Unsure	1
Emergency c-section after induction	
Yes	8
No	10

Table 4.1- Overall Experience of IoL

Experience of IoL	No. of Participants
Rating	
Very good	2
Good	4
Neither good nor poor	3
Poor	4
Very poor	5
Belief that experience could be/ could have been improved	
Yes	14
No	3
Undecided	0
Not answered	1

Table 4.2- Direct quotes on how experiences of induction could have been/ can be improved

<p>“Yes, I would have been grateful to have been given time rather than to have been coerced. I would have loved to have been told that I can birth naturally without any induction. Being strapped up and immobile was a very, very distressing factor; I would have loved to have been encouraged to move or stand upright”.</p>	<p>“Continuous communication and explanation instead of me using google to answer my concerns”.</p>	<p>“Being listened to, especially about my pain I was brushed off”.</p>	<p>“I wish I knew more and [that] it didn’t [have to] lead to an emergency c-section”.</p>
<p>“The male doctor sat on my bed. He presented all the worst-case scenarios [which could happen] if I was not induced/ had a homebirth. It was coercive and not balanced. When I was sharing my choices and that I was making an informed choice, he looked at my husband as if to say ‘talk to your woman, I am a white male doctor and know what’s best.’ My husband remained silent for the whole appointment and supported my choices. A membrane sweep was agreed upon and administered by female midwife. It was painful, invasive and unwanted. It was a compromise to [the] consultant’s insistence. I had discomfort and cramping for three days after [but] before going into labour. The</p>	<p>“I wish I was given a bit more time to not have oxytocin to see if my cervix would dilate by itself. Also, I don't think my waters should have been broken so soon, although [they were] broken 48hrs after the balloon was put in, it was very painful. But I was forced for it to happen. But before they broke my waters, they told me of the risk the umbilical cord could come down and then I would have to have a c-section. However, I do feel it was the right decision for me to be induced because baby was small and, in the end, my son's heart could not cope with the contractions so I had to have an emergency c-section. My other two children were also small but I didn’t know until I gave</p>	<p>“Decisions were made without really consulting me, and certain outcomes weren’t made clear. For example, that I would have to have continuous monitoring (which resulted in my daughter having a bruise on her head), or that I would only be allowed to push for an hour”.</p>	<p>“Proper explanation of risks and midwives listening to me when on the hormone drip”.</p>

<p>risks of the intervention were not explained at all. Had I known of the continued pain and risks, I would have declined. I then went in for monitoring once and declined any other form of induction”.</p>	<p>birth. This was in 2014 and 2016, which I kept on mentioning to the consultants but, as my uterine artery doppler at 20 weeks was 0.2 too fast, they didn't want to risk that happening again”.</p>		
<p>“More choice or say in the process, my partner being present for the whole thing, [and] having the same staff”.</p>	<p>“Being induced during COVID was stressful; it would have been ideal to have my partner with me and also a clearer idea of why [I was] being induced”.</p>	<p>“Not for me as I was contracting for 36 hours prior without much progress”.</p>	<p>“Not really. It was quite straight forward, fast, and successful”.</p>
<p>“Just continuing the process instead of stop[ping] because of [lack of?] bed space”.</p>	<p>“Although I feel I had adequate care up until my induction when the midwives changed over, the new midwife had not taken time to listen to my concerns. I was offered paracetamol and codeine although I was convinced I was in active labour. It wasn't until I asked her to check my cervix rather than rely on the monitor that she realised I was 5 cm dilated and had to move me to the delivery suite quickly”.</p>	<p>“My partner wasn't allowed in at the start due to COVID. I had a midwife who seemed disinterested in me. I wish I'd been offered a c-section as an alternative to an induction, now knowing that most end in some kind of intervention”.</p>	<p>“I felt disempowered as I knew I was ill, but the doctors were inconsistent in the plan. And, I would have liked to be induced with my labour progressing quicker. I was induced and nothing happened, so I was left to wait until my blood pressure got dangerously high and they were concerned about me fitting”.</p>

Pain Relief

Table 5.0- Experience of pain relief

Statement	No. of Participants
Belief that pain relief received was timely	
Yes	11
No	7
Undecided	0
Satisfied with pain relief choice	
Yes	14
No	4
Undecided	0

Table 5.1- Direct quotes on pain relief

<p>“I chose the air and gas. I requested an epidural but was denied thankfully”</p>	<p>“I was only given gas & air until my c section and wasn’t told how to use that properly until another midwife came to cover mine”</p>	<p>“I was on gas and air post-AROM, then an epidural was administered to get ready for syntocinon. However, this was bypassed for theatre”</p>	<p>“Just gas and air”</p>	<p>“I had an epidural”</p>	<p>“I only needed the epidural because of hormone drip induction”.</p>
<p>“I only needed the epidural because of hormone drip induction”.</p>	<p>“I was told I was only 2cm dilated so had a second sweep which made my waters break and put baby in distress as there was mycomen in my waters. By the time I got to the labour ward and re-examined, I was 6cm and [the] only pain relief options were gas and air or epidural. I also caught an infection due to the mycomen and so felt forced to have an epidural as I was physically shaking with a fever so my body could not relax at all”</p>	<p>“I was offered gas and air as by the time they checked, I was already in active labour so [there was] no time for [the] pain injection to work”</p>	<p>“[I] was not offered the pain relief gradually; the midwife said I could cope as a first time mum and was forcing [the] epidural I rejected and went for pethidine (baby came out very soon after)</p>	<p>“Was offered gas and air, did not use it”</p>	

Cultural Sensitivity and Good, Respectful Care During Pregnancy, Birth, or the Postnatal Period

Table 6.0.- Direct quotes on culturally sensitive and good, respectful care during pregnancy, birth, and/or postnatal care

<p>“My midwife- who was white- wasn’t fantastic during the golden hour. Whilst I was at the ward, I was alone and lacked support. There was a point that I did not receive any food on the 2nd night. The 2nd night was difficult as breastfeeding was my choice of feeding, I called midwives for help but at no avail. Thankfully my sister friend (Yemeni) was a student midwife that night and, as she was doing her rounds, she came to my cubicle and sat with me and helped me with breastfeeding. I felt accomplished by that time. From then all was well. The midwives/ health visitors I had seen during 6-8 weeks were all Black and have been in the whitewashed system for so long that they don't even know themselves anymore. I took it upon myself to care for myself better than what they had required”.</p>	<p>“Yes, my wishes were always taken into consideration”.</p>	<p>“No, I feel I was treated as any other mother. However, the consultants and sonographers did acknowledge that their systems need to change, to take into account my size, birth weight of my other children, and my ethnicity to determine whether I just grow small babies”.</p>	<p>“Yes, my whole pregnancy the care was great from my midwifery team at [redacted]. Maybe because most of them were Black I felt more comfortable at appointments. They were relatable, like talking to my Aunties. Although the midwife that delivered me was a young white girl, she was also great, caring, considerate, and took the time to read my birth plan. Overall, I was happy and this is my second birth at [] but first induction”.</p>
<p>“Yes, I thought the aftercare was good but I’ve never had a baby</p>	<p>“Yes, all was given as all midwives and nurses were brilliant”.</p>	<p>“When deemed low risk, [my] midwife was friendly and</p>	<p>“My consultant (a POC) was conscious of my cultural</p>

<p>before so I can't really compare it".</p>		<p>personable and answered all questions and provided me with additional reassurance when expressed concerns. This was based in the birthing centre".</p>	<p>background when asking about my diet in regard to managing my low iron; one of the midwives at my birthing clinic gave me pointers on how to advocate for myself as a Black woman due to the statistics".</p>
<p>"On postnatal ward - day 5 weight drop & bf issues - the hospital facilitated side room so husband could stay and supported presence of 6 visitors to have naming ceremony on day 7 with Imam and family members".</p>	<p>"Generally, my care was good – [but] I cannot say or pinpoint any specific examples that were culturally sensitive".</p>	<p>"I believe I was treated like any other pregnant woman"</p>	

Analysis: Key Messages

1) Black women with a higher level of education are not at lower risk of intervention, as is often assumed.

Although a direct question on class/ level of household income was not included, all but one of the women had a bachelor's degree as their educational minimum, with 9 out of the 17 of them holding postgraduate degrees. Research, generally speaking, has often found that those with a low level of education (i.e. without a bachelor's degree or an equivalent) are more susceptible to illness and have higher levels of risks. The finding that the majority of the women (95%) had a higher level of education- which *can* signify having a higher socioeconomic status (SES)- is important because it challenges the often-made assumption that low SES factors are the primary reason for Black women's risk. Without the complete backgrounds of the women's socio-economic statuses, it is unwise to assume that they were definitely of a higher SES (especially due to the complexity of the class system and the increasingly precarious relationship between education level and employability/ income). Nevertheless, the finding that the participants were mostly educated to a higher level has important implications for the assumptions of unintelligence, naivety, apathy, poverty related 'bad health behaviours', and other implicitly racial prejudices that are commonly held by medical staff, and affect how Black pregnant women are treated and cared for during their pregnancies and labours.

Moreover, 9/ 18 (50%) of the women did not identify as having had high risk pregnancies. This brings into question the medical narrative that the majority of Black women are inherently at risk, thus need to be offered interventions pre-emptively, based on their race. Research has acknowledged that more investigations are needed before more advanced, socially-informed risk profiles for IoL are confirmed (Middleton et al., 2020; NICE, 2021b; RCOG, 2020); within this, there must be an acknowledgement of how race has been incorrectly cited in the past (biologically and not socially), and how race as a category must be replaced with a more nuanced, intelligent understanding of how Black women can be predicted to have low risk pregnancies yet end up requiring induction due to *racism* and *misogynoir* (i.e. the social constructions and consequences of racialisation), as well as the limitations of biomedicine itself. For example, IoL can result from a passive development, such as a slow labour or the baby passing its due date. In many low-risk cases (and Black cultures), the mother may not see or physically feel that the 'slowness' of labour progression is a delay or a sign that something is awry. Yet, they may be met with much anxiety and fear mongering from medical staff who believe otherwise (as has been documented in several ethnographies and narrative-based studies, e.g. Mullings & Wali, 2001; Brathwaite, 2020). On the other hand, low-risk women can be offered IoL as the consequence of discrimination and other forms of (implicitly) racialised differences in treatment during their labour (as is exemplified in *Table 4.2*).

2) Maternal morbidity remains the highest reason for IoL.

Maternal morbidity was the most cited reason for IoL (7), closely followed by simultaneous maternal and foetal issues (3). This means that, in total, 10 women (56%) were offered inductions because of their own poor health. This finding further challenges the belief that high levels of education (and its assumed relation to a higher SES) acts as a protective measure against poor health, and supports the increasingly understood reality that- when it comes to Black women (and the intersection of the factors of race, gender, and class)- relationships between risk factors which are assumed to be linear are seldom so. As per critical iterations of Black women's increased biomedical risk, such as the weathering hypothesis and Sojourner syndrome, the finding that maternal morbidity is the most

significant reason for IoL is unsurprising. However, what these critical concepts can offer both lay Black women and medical professionals are nuanced frameworks and the accurate language to describe *why* their health remains at risk and increases their need for IoL to such a great extent. Oftentimes, and as has been the case historically, language which seeks to explain Black women's poor health is rooted in biomedical reductionism and reflects the legacy of colonial medicine (Meisenhelder, 2003; Benjamin, 2017); it invokes imagery of a Black body diseased from the genetic level up so is inherently- almost cursefully- diseased on the basis of its biological race. This kind of essentialist discourse has acted as a small plaster over the very deep, gaping wound of Black women's health risks, and has meant that medical staff have not been adequately equipped to understand (i.e. heal and manage) the development of ailments in Black women in, or out of, pregnancy because racism/ environmental factors often play a significant role but are overlooked (Mulling & Wali, 2001; Singer & Clair, 2003; Singer et al., 2017; Willen et al., 2017; Marmot et al., 2020). This is especially the case for many of the conditions mentioned by participants (refer to *Table 2.1*, for example): diabetes (Mendenhall, 2019), high blood pressure (James, 1994), and breathing difficulties (which can relate to undiagnosed respiratory issues that arise from environmental racism via housing and pollution (Diez-Roux, 2003)).

Therefore, in order for Black women's maternal morbidities to be better, holistically, and truthfully understood, more research is required. This research **must** be framed by critical knowledge of the intersections between gender, race, and health if Black women's maternal morbidities are to reduce on a population level. Additionally, it is crucial to remember that understanding the biopsychosocial nature of Black women's high morbidity risks does not ignore their autonomy and responsibility in participating in health promoting behaviours- rather, understanding it helps medical professionals to better appreciate the nuances of their autonomy, including its limitations. The biopsychosocial model of health does not work against the biomedical model of health in the analysis of racial health disparities and risk, but with it.

Moreover, the finding that only 3/ 18 women (17%) were induced because their baby was overdue challenges the idea that being overdue is a significant factor in reasons for IoL and justification for pre-emptive IoL. The epistemology of 'overdue' is a contentious one because there is no one, single epistemology; there are *epistemologies* because the biomedical model of health is not the only legitimate one. For women of Black heritages especially, 'overdue' also has varying measurements depending on which medical model(s) the woman is familiar with, so medical staff need this cultural awareness. Furthermore, there is much racial trauma attached to ideas and measurements of 'overdue' Black babies. The biological argument about their reduced length of gestation, for example, is just one factor that has resulted in the fearmongering and coercion of many Black women who have been forced to undergo IoL and give birth before their bodies are naturally ready. It is important to remember that what science/ medicine/ the biomedical model of health have considered 'normal' and 'abnormal' have been questionable for decades (Cahill & Tuuli, 2013); this is evidenced by research in evolutionary medicine (particularly the anthropological branch), which has investigated infant caregiving strategies and maternal health from the earliest humans and how practices have evolved (Lozoff & Brittenham, 1979; McKenna et al., 2007; Elton & O'Higgins, 2008; Gettler & McKenna, 2011; Haig, 2014; Ball, 2017). Therefore, it is very possible that the maternal risk frameworks that have been pushed for Black women are not fully correct.

Whilst this survey's participant sample was small, the findings still hold meaning and can be used as lessons if situated within a wider context of critical, qualitative research. With this being said, maternal morbidity has been found to be the most significant factor for IoL, suggesting that research and practice efforts should focus on delving into their 'why' and 'how' instead of relying on the scientifically disproven notion of biological race and objectifying factors which are largely subjective.

3) Women are not being given sufficient information to make an informed decision.

The data on the participants' beliefs regarding their experience of IoL is concerning (as seen in *Table 2.2*). In sum, most of the women stated that they understood what IoL was, its benefits, and why it was appropriate for their personal circumstances; 61%, 61%, and 78% respectively said that they either agreed or strongly agreed with the statements given. However, what is concerning is that the majority did not explicitly agree with the statements "the risks of induction of labour were explained to me in a way I could understand" and "I felt that I was given enough time to make a decision about accepting induction of labour". There was either mostly neutrality or a type of disagreement; for the former statement, 28% were responded with neutrality (i.e. "neither agree or disagree") and a sum of 44% chose a disagree option, whereas 28% also responded with neutrality for the latter statement and a sum of 39% chose a disagree option. Whilst, individually, these percentages may not signify a problem, if looked at as a whole, it should be worrying that the majority of women did not express confidence and clarity in two factors which are imperative in informed decision making; only 26% chose an agree option for the statement pertaining to the explanation of risks, and only 33% did the same for the statement regarding being given enough time to make a choice. Looking at the data from this perspective, it is clear that, overall, there is a lack of consistency in the belief that Black women are being given sufficient information to make an informed decision.

For truly informed decisions to be made, medical staff should not be satisfied with their Black patients having *mostly* either neutral or negative beliefs regarding a sufficient explanation of risks and being given enough time to make their decision. Whilst IoL is a safe and common practice, so women (in theory) have little to be worried about, the reality is that there is much racial trauma attached to regular procedures in healthcare, especially those related to maternal health. This is largely because of the very real and very pervasive issues of culture talk, implicit racial bias, and the legacies of colonial medicine- as has been explained in previous chapters- in addition to the general systemic racism in the UK's healthcare system, as is also experienced by Black and ethnic minority medical staff (Nagpaul, 2018). With these issues as context, the findings of mostly neutrality and disagreement for such key factors are- and should be- of great concern and should be interpreted as significant. The act of informed decision making is a great one and is not always easy for patients who are often victims of systemic violence. With this being said, it is also not always easy for medical staff to cultivate an environment which aids thoughtful informed decision making in times of emergency, especially for women with low-risk pregnancies who have not planned an IoL. Nevertheless, staff should always endeavour to provide accurate and sufficient knowledge on everything involved in induction- especially risks- and balance the time women need to make a decision with the lack of time that is at hand.

4) Women need more knowledge on their options of IoL methods.

As can be interpreted from *Table 3.0*, a sum of 56% of women disagreed that they were given a choice in the method of their induction, and a sum of only 33% agreed that they had a preferred method. Overall, pessaries were the most used method (61%) with the majority of women only needing one method (61%). In resources about IoL, choice of method is often stated as a given and a right unless there is an emergency. Therefore, choice of method is an important part of informed decision making, as well as a crucial element of expecting women's ability to exercise agency and autonomy during their labour process. Its knowledge is something all expecting mothers should be armed with, so the finding that the Black mothers in this survey mostly did not have a preferred choice (67% in sum) can be interpreted to signify a lack of knowledge. This is an additional cause for concern because the

majority of participants had low-risk pregnancies, as is the current trend, so should have been equipped with the same level of knowledge regarding methods as women with high-risk pregnancies. A recent Cochrane review on methods of IoL (de Vaan et al., 2019) has found that, globally, an increasing number of women are undergoing non-urgent IoL; this means that the safety of methods are becoming more important and should come under greater scrutiny. Whilst IoL methods are largely safe, the normalisation of non-urgent IoL procedures amongst low-risk women should result in an increased medical effort of women receiving as much information as they can on the range of methods so that they are in the best position to make a well thought out, informed decision. Women, of course, have a responsibility to self-educate but the onus of the education is on the medical staff who care for them throughout their journeys. Moreover, whilst it is possible that most of the women did not have method preferences because of a nonchalance that can come from confidence in the ability of the staff, as opposed to lack of knowledge, it is strange that they would not have a preferred method because labour is a very precarious process where many things can go wrong very quickly. Most women have a detailed birth plan which they aim to stick to as much as possible so, even in the cases of unplanned yet non-urgent inductions, they most likely want to have choices and a preference depending on what they are most comfortable with. However, most people (generally speaking) have preferences only when they are confident that they understand the choices before them well enough to have a preference. Therefore, it is unusual that the majority of the women- who mentioned birth plans and regrets about their inductions (*Table 4.2*) would not have a preferred method of induction. The most logical (and culturally/ historically-aware) interpretation of this finding is that it is due to a lack of knowledge.

“[I would have liked to have had] Continuous communication and explanation instead of me using Google to answer my concerns”.

“I wish I knew more and [that] it didn’t [have to] lead to an emergency c-section”.

“Yes, I would have been grateful to have been given time rather than to have been coerced. I would have loved to have been told that I can birth naturally without any induction”.

“The risks of the intervention were not explained at all. Had I known of the continued pain and risks, I would have declined. I then went in for monitoring once and declined any other form [i.e. method] of induction”.

There is a deeply misogynoirist stereotype that Black women are wilfully ignorant and uneducated, especially when it comes to their health journeys. Reading, and listening to, their health narratives on social media and in interpersonal interactions teaches us a lot about their everyday experiences in the healthcare system, and how pervasive sexist and racist biases about their willingness to learn and take their conditions seriously are. Candice Brathwaite’s book ‘I Am Not Your Baby Mother’ (2020) is a must-read. Research-wise, they have also been extensively evidenced in socio-medical qualitative studies, such as in Black woman anthropologist Leith Mullings’ ethnography on African American women’s social context of reproduction (Mullings & Wali, 2001). In Mullings’ ethnography, many women shared their first-hand experiences of being spoken down to by medical staff, as well as assumptions of ignorance and low levels of education, a lack of care for their (unborn) children, and a

reluctance to participate in relevant classes because of laziness. What the ethnography also exposed was how these experiences are not only common for Black women, but how they are symptoms of systemic misogyny. Moreover, the study evidenced how these assumptions made by staff were categorically untrue, exposing how what comes across as an unwillingness to engage in medical education and listen to medical knowledge is, in reality, a nuanced, complex defence mechanism against systemic misogyny and interpersonal microaggressions. The ethnography, and many more narrative-based studies, show that Black women are very active mothers and want to be proactive in their health journeys, maternal or not. What inhibits them are forms of structural violence (such as social and economic issues in their private lives, which medical staff seldom take account of), as well as major feelings of disrespect, discomfort, and coercion in health practices themselves. Said feelings were touched upon in women's survey responses (seen in *Tables 4.1 and 4.2*), but further research is needed for expansion.

All in all, knowledge is power and Black women need more knowledge to be kindly and wisely shared with them in order to be further empowered on their maternal journeys, and enact agency in all of their decisions (especially methods of IoL). They also need the decisions to be respected.

5) Women are dissatisfied with their experiences of IoL.

In the contexts of the information relayed in key messages 3 and 4, it is unsurprising that a sum of only 33% of the women rated their experience of IoL within the 'good' range, and 78% stated their experience could have been improved (*Table 4.1*). Analysis of the further comments written (as seen in *Table 4.2*), shows the themes and experiences of:

- Coercion
- Withholding of knowledge
- Emotional distress
- Poor communication
- Lack of listening
- Disbelief about pain
- Sexism
- Physical discomfort and pain
- Decisions made without consultation
- Lack of choice
- Lack of care and compassion
- Disempowerment
- Medical mistreatment

Unfortunately, these themes are common in women's labour journeys, pregnancy journeys, and general health journeys, as has been widely shared by themselves (Brathwaite, 2020; Maternity Engagement, 2020; FIVEXMORE, 2021), evidenced in research, and theorised in the theories of culture talk, implicit racial bias, and (medical) misogyny. Moreover, generally speaking, it has been well documented that medical professionals- such as midwives and obstetricians- can often gatekeep women's general choices in their maternity journeys by limiting their available choices, resulting in the diminishing of women's feelings of agency, respect, and independence/ strength (Jomeen & Redshaw, 2013), and that their individual needs have not been met (McCourt and Pearce, 2000). Inevitably, women are left with dissatisfaction and negative (sometimes legitimately traumatic) experiences. As always, there is an *additional* racial element to this medical gatekeeping and dissatisfaction, where Black (and ethnic minority) women have been evidenced to be given even fewer choices and receive even less knowledge even after adjustment for other demographic factors; for example, being unaware of a home-birth option (or being stigmatised out of choosing it, like was shared by a participant in *Table 4.2*), and being offered only one hospital option for care (Redshaw and Heikkila, 2011). Furthermore, whilst language barriers were not communicated in the women's responses, it should be remembered that they do exist for many (im)migrant Black women as has been investigated in qualitative- but mostly small scale- studies (Singh & Newburn, 2000; Edwards, 2004, Ockleford et al., 2004). Altogether, these factors work in tandem to increase Black women's chances of being vulnerable to negligent care.

The findings of *why* the women were so dissatisfied should still remain of concern and should inform careful consideration of IoL practices and policies (such as the recommended updated guidelines by NICE (2021c)). The experiences recalled in the women's responses are shocking and unacceptable; no patient should have to endure such treatment but the fact that Black women collectively do so, and have been doing so for centuries, has become so normalised that there is little sincere effort to improve their experiences, eradicate gendered-racial discrimination, and increase their satisfaction with long term, systemic changes. With this being said, these experiences (which, we must emphasise, are a few of tens of thousands shared online and in private community spaces), further challenge the idea that a policy of IoL is the "best" or "healthiest" action for Black women. Therefore, until a larger proportion of Black women are recorded to be satisfied with their IoL experiences- in addition to experiencing the aforementioned (often traumatic) themes statistically significantly less- then IoL should not be recommended to those who have low risk pregnancies and are otherwise healthy.

6) The administration of pain relief still requires improvement despite satisfaction in the type of relief offered.

A positive and encouraging finding was that 14/ 18 women (78%) revealed that they were satisfied with the pain relief given, with 11/ 18 (64%) stating that their pain relief was timely (as seen in *Table 5.0*). This finding is surprising given the evidence- and historical precedent- that medical staff do not tend to believe Black women about their pain, symptoms, or discomforts; this results in racial disparities in the prescription of medication and procedures both in, and out of, maternal care (Chapman et al., 2013; Benjamin, 2017; Fitzgerald & Hurst, 2017). In America, this was recently evidenced in an evaluation of an algorithm used to predict the healthcare needs of patients; it was found that Black patients' care needs are under-estimated by 50% (Telegraph, 2019). This shocking statistic, whilst not formally recorded in the UK, is most likely to be found here due to the countries' similar racial history and systemic racism in their medical systems. Whilst bold, such a claim of racial bias in treatment and care is supported by many (informal) health narratives shared by Black and ethnic minority citizens, as well as multiple reports on the existence of racial bias is on a societal level (Joint Committee on Human Rights, 2020; Runnymede, 2020) and that, despite the UK's low-quality data on racial health inequalities (Nazroo et al., 2009), there is still clear and strong evidence of prejudice against Black and ethnic minority patients (Kings Fund, 2015; Fitzgerald & Hurst, 2017; Kmietowicz et al., 2019). Additionally, there is a particularly deadly stereotype that Black people are more likely to exaggerate their pain, meaning that they are often not believed because they are assumed to be lying (Mullings & Wali, 2001; Brathwaite, 2020; Ramsay, 2021). There is a long and complex history on the belief that Black women- and Black people, more broadly- cannot be trusted to be truthful, as well as an intersecting history of the physical, mental, and intergenerational trauma that has come from the pain Black women have been forced to endure in the medical field, particularly that of gynaecology and obstetrics. Both go beyond the scope of this report but what is important to remember is that the aforementioned information on the concepts of mythopoeetry and biopsychosociality especially are pertinent and relevant for comprehension.

With all of this being said, it is therefore crucial to not misinterpret the survey's findings by looking at them outside of context and theory. This finding should *not* be taken as evidence that 'everything is fine' or that Black women's historic relationship with pain in maternal care has been (over)exaggerated; there was still room for improvement for some of the women surveyed, and there is dire need for structural change in both medical practice and education regarding the way Black pain is theorised and perceived, as seen in *Table 5.1*:

“I was only given gas and air until my c-section, and wasn’t told how to use that properly until another midwife came to cover mine”.

“I was told I was only 2cm dilated so had a second sweep which made my waters break and put baby in distress as there was mycomen in my waters. By the time I got to the labour ward and [was] re-examined, I was 6cm and [the] only pain relief options were gas and air or [an] epidural. I also caught an infection due to the mycomen and so felt forced to have an epidural as I was physically shaking with a fever so my body could not relax at all”.

“[I] was not offered the pain relief gradually; the midwife said I could cope as a first-time mum and was forcing [the] epidural I rejected and went for pethidine (baby came out very soon after)”.

7) More racially conscious and culturally-sensitive care is needed.

Although there were some positive experiences of good, racially and culturally-sensitive care (*Table 6.0*):

“When deemed low risk, [my] midwife was friendly and personable and answered all questions and provided me with additional reassurance when expressed concerns. This was based in the birthing centre”.

“On [the] postnatal ward - day 5 weight drop & bf issues - the hospital facilitated [a] side room so [my] husband could stay, and supported [the] presence of 6 visitors to have [a] naming ceremony on day 7 with Imam and family members”.

The responses show that there is still a need for patient-centred, racially-conscious, culturally-sensitive care:

“Generally, my care was good – [but] I cannot say or pinpoint any specific examples that were culturally sensitive”.

In the context of the Black maternal health and wider systemic racism in both society and the medical system, ‘colour-blind’ care is not the most effective method of helping Black women or improving their experiences (Mullings & Wali, 2001; Brathwaite, 2020). Appropriate and tailored provision for ethnic minority women has been acknowledged as integral to good maternity care since the 1992 Select Committee on Health and the recommendations of *Changing Childbirth* (Jomeen & Redshaw, 2013). However, little has been done to transform this acknowledgement into real policy and practice, as evidenced through the very existence of racial health disparities in maternal health, as well as their enduring persistence. Although it is not extensively reflected in the survey responses, Black women have repeatedly made calls for maternal care which recognises the positions and risks they are vulnerable to because of power inequities (not genetics), particularly in the last few years since the publication of the 5x more statistic from MBRACE (although calls have been made for decades at local, grassroots levels outside of formal studies). Such calls, unfortunately, have been met with much scepticism from medical professionals, but should be welcomed as they are most certainly in line with the concepts of ‘patient-centred care’ and ‘personalised medicine’- concepts which are slowly being integrated into practice. Care which is cognisant of medical misogyny, societal racism, and the

biopsychosocial nature of the morbidity (and mortality) risks Black women face would be incredibly helpful as has been consistently repeated by Black women in their personal/ private health narratives, research, and even in some of the survey responses:

“Yes, my whole pregnancy the care was great from my midwifery team at [redacted]. Maybe because most of them were Black, I felt more comfortable at appointments. They were relatable, like talking to my Aunties...”.

“My consultant (a POC) was conscious of my cultural background when asking about my diet in regard to managing my low iron; one of the midwives at my birthing clinic gave me pointers on how to advocate for myself as a Black woman due to the statistics”.

What is apparent from these particular responses is that the personalised, racially conscious, culturally-sensitive care the women received came from staff who were either fellow Black people or were non-Black people of colour (NBPOC). What has been continuously stated in Black women’s health narratives- as well as the experiences of Black and NBPOC medical professionals and students alike- is that sharing the same racial or cultural background is very helpful in reducing communication barriers, makes creating an environment of empathy and compassion easier, and simply helps patients to be better seen and understood because they are being cared for by someone who most likely has a personal understanding of the struggles and limitations they face, whatever they may be. The contexts Black women are in are particularly significant when we consider the environments of pregnancy and birth as socially and culturally constructed, and influenced by the values of the societies from which women come and in which care is delivered (Mullings & Wali, 2001; Jomeen & Redshaw, 2013; Banda, 2020x; Brathwaite, 2020). This is not to say that white staff cannot provide the personalised care and emotional support Black women need, but is to reiterate the reality that conversations about the lack of ethnic minority staff (and healthcare students) are not divorced from conversations about racial health disparities and the systemic racism, implicit racial biases, and racialised negligence that put ethnic minority patients at further risk.

“My midwife- who was white- wasn’t fantastic during the golden hour. Whilst I was at the ward, I was alone and lacked support. There was a point that I did not receive any food on the 2nd night. The 2nd night was difficult as breastfeeding was my choice of feeding, I called midwives for help but at no avail. Thankfully my sister friend (Yemeni) was a student midwife that night and, as she was doing her rounds, she came to my cubicle and sat with me and helped me with breastfeeding. I felt accomplished by that time. From then all was well...”

There remains a great invisibility of Black women’s experiences in maternal health with a chasm between what (mostly white) medical professionals seem to witness and what Black women are experiencing (and recording). What is needed now is not simply greater awareness, but the *application* of what is being learned into medical practice, policy, and education. Nevertheless, the solution to more racially and culturally-sensitive care cannot merely be the employment and retention of ethnic minority staff alone (although this is a non-negotiable factor); it is possible for ethnic minority staff and students to internalise the racism of the medical system and biomedical education, and unknowingly perpetuate violence and harm against Black women in the same manner as some of their white counterparts:

“...The midwives/ health visitors I had seen during 6-8 weeks were all Black and have been in the whitewashed system for so long that they don't even know themselves anymore. I took it upon myself to care for myself better than what they had required”.

The internalisation of racist systems in Black people has been extensively theorised in critical, intersectional theories of gender and race, and are situated in broader critical theories of power (e.g. those pertaining to ‘subjects’, ‘objects’, ‘the State’, ‘hegemony’, etc.). Therefore, in order for Black, NBPOC, and white medical staff to holistically understand how to best turn the ideal of racially and culturally-sensitive care into a reality, it must be understood that doing so is an *interdisciplinary* task that goes beyond the boundaries and assumptions of (bio)medicine, and requires real learning (even for Black and NBPOC staff and students).

Conclusion

The world of maternal health has had many new discoveries in the past few decades, with IoL being an area of much curiosity. Whilst this survey's participant sample was small, the findings still hold meaning, and can be used as lessons, if situated within a wider context of critical, qualitative research, *as well as* the lay maternal health narratives shared by Black women via social media and popular culture (e.g., the recent documentary aired by Channel 4: 'The Black Maternity Scandal' (2021)), community spaces, and in non-academic books.

Black women are at the mercy of the maternal health system, with a staggering 80%-83% (Caribbean and African, respectively) likely to experience a 'near miss' during pregnancy or childbirth (UK Parliament, 2021). Equally as important is the fact that their babies are at a 121% risk of stillbirth (ibid). They are facing a state of crisis which has been borne out of centuries of societal racism and medical misogynoir alike. From the experiences and reflections shared in our survey, Black women have a complicated relationship with maternal health that cannot- and should not- be reduced to genetic race/ biological essentialist arguments. The context of this rapid report (specifically NICE's updated IoL guidelines) only show that we continue to be faced with the difficult reality that there is much work that is left to be done regarding risk profiles for induction and management of labour, but also systemic medical misogynoir, the limitations of biomedicine, the role of biopsychosociality in racial health disparities, and Black women's intergenerational maternal care trauma.

It is clear that Black women, overall, have complicated experiences of IoL, with many enduring significant negative acts of practice, care, and medical theory. Therefore, they not only need a general improvement in the way IoL is carried out, but require racially conscious, culturally-sensitive personalised care. A policy of pre-emptive IoL (based on their biological racialisation) is not the way forward; particularly when practices and theories of induction, generally speaking, still need much improvement, as does the public health system's economy of care. Additionally, there is little mention of Black women requiring IoL for safety reasons in recent relevant research (e.g. Middleton et al.'s paper on methods in the Cochrane Database of Systemic Reviews (2020)). If anything, an increased number of interventions can affect labour progress negatively, so puts forward for the need for newer, more critical standards and epistemologies which include recognition of the 'soft variables' which impact women's experiences of the length labour, the risk of emergency c-sections, and their view towards future reproduction (Cahill & Tuuli, 2013; Nystedt & Hildingsson, 2014). For Black women, in particular, it seems that the significance of 'soft' variables- usually measured and investigated in qualitative studies like this survey- is not lower than the significance of 'hard' variables, and future (biomedical) research must recognise this if Black women are to have better, safer experiences of IoL and if the Black maternal health crisis is to be solved long-term.

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