Perinatal Mental Health Network
Community of Practice Cultural Awareness Event

What does the MBRRACE report tell us?

Key findings and recommendations from the report

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MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

- Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK
- Two annual reports:

1. MBRRACE-UK Maternal Mortality Surveillance and Confidential Enquiry Report
2. MBRRACE-UK- Perinatal Mortality Surveillance Report for Births

National audit to examine information on all late fetal losses, stillbirths, neonatal deaths and maternal deaths.

What do the figures tell us?

- The MBRRACE report has continued to show a disparity in maternal mortality rates between women from Black and Asian aggregated ethnic minority groups and white women
- Whilst the 2022 report showed a slight decrease in this disparity, it has not shown a significant reduction.
- According to MBRRACE 2022, Black women were 3.7x more likely to die than white women and Asian women were 1.8 x more likely to die than white women.
- The 2019 report figures showed black women was 5x more likely to die, women of mixed ethnicity were 3 x more likely and Asian women were 2x more likely to die.
- Following the 2019 report and the key message around “The Gap”, it was felt that there had been a positive response in tackling the unequal outcomes.

Effect of ethnicity and deprivation on perinatal mortality

1. Stillbirth and neonatal mortality rates increased with deprivation across all ethnic groups.

2. Stillbirth and neonatal mortality rates were lowest for babies of White ethnicity from the least deprived areas (2.78 stillbirths per 1,000 total births and 1.26 neonatal deaths per 1,000 live births).

3. The multiple impact of ethnicity and deprivation is highlighted by a stillbirth rate of 8.10 and 7.96 per 1,000 total births for babies of Black African and Black Caribbean ethnicity respectively from the most deprived areas.

4. Neonatal mortality rates were over 3 per 1,000 live births for babies of Pakistani and Black African ethnicity from the most deprived areas.

5. Due to considerably higher proportions of babies of Black African, Black Caribbean, Pakistani and Bangladeshi ethnicity being from more deprived areas, they are disproportionately affected by the higher rates of stillbirth and neonatal death associated with deprivation

- MBRRACE acknowledges that focusing on ethnicity does not tell the whole story.
- Women who die are more likely to face multiple adversity including mental and physical health and complex social factors.
- The 2022 report shows that more women from deprived areas are dying and this continues to increase
- It is important that addressing these disparities remains a focus.

Access to Care

- Case Study –

A Black African woman had much of her antenatal care overseas. On return to the UK in the third trimester she was seen by her GP who recommended immediate review in the hospital because of her raised blood pressure. She declined an ambulance and said she would make her own way to the hospital. She was found later that day, unresponsive. She died from an intracranial haemorrhage.

- For the triennium reviewed, half of the women who died from an antihypertensive disorder were from black or Asian backgrounds, 2 of which were born outside of the UK.
- Health professionals must be aware that some women will not be aware of the importance and benefit of good antenatal/postnatal care.
- Some women may have anxieties around attending a clinic which may lead to some women, particularly vulnerable women or migrant women not accessing care or following advice.
- Healthcare providers and the ‘system’ should engage with the complexities of their lives i.e ability to access childcare or transport

- MBRRACE reported in 2022 that deaths from psychiatric causes as a whole account for nearly 40% of deaths occurring within a year after the end of pregnancy with maternal suicide remaining the leading cause of direct deaths in this period.
- At least half of the women who died by suicide and the majority of women who died from substance misuse had multiple adversity
- A history of childhood and/or adult trauma were very frequent.
- Recommendation - **Recognise the importance of a trauma history in the assessment of risk.**

- Case study 2 - A non-English speaking woman contacted her health visitor at three months postpartum concerned about her baby. She herself had not slept for over a week. She was directed to the Emergency Department where the psychiatric liaison team did not identify any low mood using a telephone interpreter. She was not referred to a specialist Perinatal Mental Health Team. She was commenced on an antidepressant but did not continue it as she was breastfeeding. A week later her health visitor referred her to the Perinatal Mental Health Team. She was called by a member of the specialist team within the week after referral, who offered a talking therapy which she declined. She was also referred again to the specialist team who suggested she should be advised to attend the emergency department but did not attempt to coordinate an urgent assessment. She died by jumping from a height three days later.

- Stigma around mental health may be more prevalent in some cultures compared to others
- This can influence the willingness of women to be open about mental health concerns.
- Concerns around involvement of social services and subsequent removal of a child could also influence openness about mental health illness.

- Recommendation - **Be alert to factors, such as cultural stigma or fear of child removal, which may influence the willingness of a woman or her family to disclose symptoms of mental illness, thoughts of self-harm or substance misuse.**

What is being done to address inequalities?

"Ethnic disparities in health outcomes have been shown to clearly exist despite socioeconomic factors and other demographic variables"

Racial Disparities in women's healthcare. RCOG,2020

“The Bias Trap”

- Racial biases
- Covert racism/ unconscious bias – the impact on decision making
- Negative stereotyping and lack of ‘cultural competence’ among maternity staff reveal elements of poor care experiences unique to women from ethnic minorities (Jomeen & Redshaw, 2013).

- The Bias Trap - A Way Forward - Welcome (southeastclinicalnetworks.nhs.uk)

What is being done?

- Five X More https://www.fivexmore.com/about
- RCOG Race Equality Taskforce
- Welsh Government Race Equality Action Plan – An Anti-racist Wales - https://www.gov.wales/introduction-anti-racist-wales-html
- MatNeo Safety Support Programme co-designed and developed with ethnic minority communities and stakeholders
- Education –BirthRights Systemic Racism, Not Broken Bodies
- MVP's and PAGs – lived experience.

Thank you for listening.

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Rhwydwaith Mamolaeth a Newyddenedigol Cymr

Wales Maternity and Neonatal Network