Royal College of Obstetricians & Gynaecologists

Policy position: Racial and ethnic equality in women's health

Introduction

This statement sets out the RCOG's position and recommendations on the key areas for change across NHS England and UK Government policy to address inequalities in Black, Asian and minority ethnic women's health and care.

Ending racial and ethnic health inequalities and improving outcomes for all women and people who use obstetrics and gynaecology (O&G) services is possible. However, this requires co-ordinated action from the government and NHS, support for health services and the women's health workforce, and collaboration across government departments to address the root causes of health inequalities.

Recommendations in brief

1. **The UK Government must urgently develop strong, cross-government targets to end inequalities in maternity outcomes.** Targets to end inequalities in maternity outcomes should be supported by ring-fenced funding and wider investment in public health and NHS services, co-produced with ethnic minority women, backed by evidence on expected impact, and linked with a cross-government focus on health inequalities.

2. **The UK Government must take a cross-departmental, life course approach to improving women's health, developed in close collaboration with women**. This includes maintaining a focus on implementing the Women's Health Strategy, supported by long-term funding and a commitment to ensure that it retains tackling health inequalities as a core ambition.

3. **Equity and accountability must be embedded throughout the health service to support the women's health workforce and good health outcomes across women's life course.** Equity must be a standing concern of decision-making structures at every level of the NHS, supported by ongoing efforts to develop leaders who are able to drive cultural change and support the O&G workforce.

4. **Support equitable access to NHS and sexual and reproductive health services through co-production and effective commissioning.** Listening to women and their families is fundamental to providing person-centred care, and so co-production of services with women must be implemented wherever possible. Commissioning of women's health services must improve access and respond to the needs of women from all ethnic groups.

5. **Improve data collection to support the design of women's health services and research.** All services should make sure that women's self-reported ethnicity is asked and accurately recorded, using agreed ethnic group coding systems which are updated regularly in accordance with the most current census groups.

6. **Support personalised care and informed decision making, and ensure all women who need it have access to a high quality interpreting service.** NHS England must ensure that interpreters supporting maternity care are trained to provide high quality services in this specific context, and

consider ways to improve the availability and usage of appropriate interpreters. Services should be supported by additional funding to deliver this where needed.

7. **Ensure all women can easily access high quality maternity care which meets their needs.** This includes services providing access to pre-pregnancy and post-pregnancy counselling for women at greater risk of medical problems during pregnancy. This also includes services taking all possible steps to support women who can experience additional barriers to care, for example, implementing RCOG, RCM and Maternity Action guidance on improving access to maternity care for women affected by overseas charging regulations.

8. **Continue developing the evidence base to deliver effective interventions across women's life course,** by developing and evaluating interventions, funding research into underexplored conditions, ensuring research is inclusive of gender and ethnicity, and supporting research careers in women's health.

A note on intersectionality and language

Political and cultural factors, including the social categories someone is or is perceived as being a part of, can all shape the factors that influence our health.[1] People are members of multiple social categories, and disadvantages and discrimination can intersect and compound throughout their lives. This document focuses on racial and ethnic health inequalities, but it is important to recognise that inequalities relating to other aspects of someone's identity, beyond the scope of this document, can also shape their health.

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

Racial and ethnic inequality across women's life course

Examples of racial and ethnic inequality in women's health

Across many aspects of women's health in the UK, Black, Asian and minority ethnic women are found to have worse outcomes and experiences than white women. These health inequalities – avoidable and unfair differences in health across the population, and between different groups[2] – can have significant repercussions for women's lives, influence health across the life course, and shape future interactions with health services.

Examples of racial and ethnic inequalities in women's health outcomes in the UK today include:

- **Gynaecology** – ethnicity is often not reported in studies on many gynaecological conditions, so there are gaps in our understanding of differences in experiences and prevalence of gynaecological conditions based on ethnicity in the UK. Some conditions, such as uterine fibroids, have a higher incidence in Black and Asian women compared to white women.[3] Cultural barriers may also prevent some ethnic minority women talking about gynaecological problems or accessing services.[4]

- **Sexual and reproductive healthcare** – fragmented commissioning between the NHS and local authorities, and real-terms cuts to sexual and reproductive healthcare (SRH) services, are likely to disproportionately impact women from some ethnic minority backgrounds.[5]
- **Pregnancy** – continuing a decades-long disparity, compared to white women, women from Black ethnic backgrounds are three times more likely to die during pregnancy or shortly afterwards, and women from Asian ethnic backgrounds twice as likely.[6] Racial and ethnic inequalities have been evidenced in rates of miscarriage, emergency caesarean birth, pregnancy-related complications such as hypertension in pregnancy and gestational diabetes, and pre-existing conditions associated with adverse pregnancy outcomes.[7] Significant variation by ethnicity has been found in access to perinatal mental health services in England.[8]
- **Neonatal outcomes** – babies from Black and Asian ethnic groups are more likely to be born prematurely,[9] and stillbirths among babies from Black and Asian ethnic groups are consistently higher than their white counterparts.[10]
- **Fertility treatment** – IVF birth rates are consistently lower for ethnic minority women at all ages compared to white women, and lowest for women from Black ethnic groups.[11] Black women are typically older when starting fertility treatment than other ethnic groups, are least likely to access NHS funded IVF cycles, and are most likely to experience multiple birth, which comes with increased risks of health problems.[12]
- **Gynaecological cancers** – South Asian women and women from Caribbean and African backgrounds have been found to be more likely to be diagnosed with breast or ovarian cancer at a later stage, when treatment is less likely to be effective.[13] Black women are more likely to be diagnosed with uterine cancer at a later stage, and have higher mortality rates than other ethnic groups.[14] Black and Asian women have been found to wait on average five to six days longer from referral to treatment for ovarian cancer than white women.[15] Women from some ethnic minority backgrounds are less likely to attend cervical screening appointments.[16]

Understanding and addressing the causes

The causes of racial and ethnic inequalities across women's life course are multifactorial and complex. Taking an intersectional, life course approach is essential to understanding and addressing specific health outcomes, as outcomes are shaped by health and wellbeing throughout our lives, as well as the wider determinants of health.[17]

Recognising and naming racism

It is important to recognise and name racism as a factor that can influence women's health services and health outcomes, and an explicitly anti-racist approach should be taken in all efforts to improve outcomes.

Racism, whether structural, institutional or interpersonal,[18] can be identified in many of the factors that shape women's health outcomes, including those set out below. Experiencing racism and discrimination over the life course can also directly contribute to chronic stress and the development of metabolic disease.[19] Governments and health services must be confident in recognising and addressing this. You can read more about the RCOG's work to confront racism and cultural bias in O&G here.

The impact of wider inequalities in society

The wider contexts of women's lives, such as access to good quality housing, healthy, affordable food, good quality work and a robust social security system, significantly influence health outcomes.[20]

Racial discrimination can play a role in shaping people's living and working conditions, and can also intersect with and compound gender inequalities.[21] Poverty, which can have a significant health impact across women's lives and creates barriers to accessing healthcare, is much more likely to affect women from some ethnic minority groups compared to white women.[22]

The impact of poverty and deprivation is just one potential factor of many in shaping health outcomes, and inequalities can persist across all deprivation levels.[23] Nonetheless, sustainable progress towards equality in women's health has to be supported by changes to every part of society which shape our health outcomes. You can read more about this in the RCOG's position on poverty, deprivation and women's health.

Access to and experiences of healthcare services

Many recent reports have illustrated poor care experienced by ethnic minority women, particularly in maternity settings. This includes care which is influenced by racial stereotypes held by healthcare professionals, women not being listened to when they present with pain or concerns about their health, and staff being less confident recognising symptoms on darker skin tones.[24] This reflects an unmet need for better training of healthcare professionals in cultural awareness, identifying and counteracting bias in their practice, and clinical skills suitable for service users of all ethnicities.

Poor past experiences can contribute to distrust and avoidance of health services,[25] as can historical discriminatory practices in medical research or within the O&G specialty in the UK or elsewhere, such as forced sterilisation, eugenics or the involvement of ethnic minority groups in research without informed consent.[26]

Problems with interpreting services and translated materials can impact the care and experiences of women from ethnic minority backgrounds with limited English proficiency.[27] National policies and laws can also lead to barriers which disproportionately affect ethnic minority women. For example, NHS overseas charging regulations, particularly in England, can deter women from accessing maternity care.[28] You can read more about this in our position on migrant women's access to maternity care.

Research, guidelines and healthcare technology designed for the whole population

The evidence base underpinning medical research, guidelines and technology is not yet equitable. This can ultimately influence care and outcomes and contribute to health inequalities, for example through treatments that are less effective or not appropriate for some populations or contributing to distrust of services and treatments.[29]

People who are female, from ethnic minority backgrounds, older or pregnant are often still under-represented in clinical studies, including in major disease areas like cancer and cardiovascular disease.[30] In addition, some women's health conditions, and effective interventions to address inequalities, are under-researched, as are the barriers to participation in research.[31] UK guidelines for neonatal assessment have been found to be less relevant to babies with darker skin tones,[32] and a recent independent review of equity in medical devices noted that trials of new devices often do not include representative proportions of women or ethnic minorities.[33]

Supporting the women's health workforce

An inclusive, well-supported and anti-racist O&G workforce is crucial to delivering equitable health outcomes and ensuring the women and people they care for feel safe and listened to.[34] However, the NHS Workforce Race Equality Standard has highlighted that more must be done to address existing discrimination. For example, white applicants are still more likely to be appointed from shortlisting across all roles, with staff from ethnic minorities less likely to feel that their trust provides equal opportunities for career progression or promotion.[35]

Addressing the significant pressures on the O&G workforce is also fundamental, through tackling high levels of burnout, retaining existing staff, and boosting workforce numbers. You can read more about our work towards racial equality in the speciality here.

Recommendations

1. The UK Government must urgently develop strong, cross-government targets to end inequalities in maternity outcomes, supported by ring-fenced funding and wider investment in public health and NHS services

We welcome the UK Government's manifesto commitment to set an explicit target to close the Black and Asian maternal mortality gap, which the RCOG has recommended for several years. Ambitious targets must be developed without delay. To support this ambition, we urge the UK Government to consider also setting a target to end the higher risk of maternal mortality for women living in more deprived areas.

Suitable targets must be:

- **Supported by substantial ring-fenced funding** to support urgent investment, meaningful co-production, and cross-departmental innovation.
- **Co-produced** with ethnic minority women and communities.
- **Supported by evidence on expected impact,** a plan for evaluation and reporting to ensure transparency and trust.
- **Linked with a cross-government focus on health inequalities,** including an ongoing focus on tackling health inequalities as part of the Women's Health Strategy.
- **Backed by clear lines of accountability for delivery** within the DHSC.

Targets must be reinforced by wider investment in the NHS and public health services, both of which play a crucial role in ensuring women can maintain good health throughout their lives and make decisions about their reproductive, preconception and pregnancy health. Long-term funding commitments are needed to promote lasting change in services given the entrenched nature of ethnic inequalities, alongside investment in NHS digital infrastructure to improve the flow of information between services and support data collection.

Investment in the maternity workforce is fundamental to achieving these targets. It is vital that services are safely staffed to levels which are reflective of their local populations and that healthcare professionals have the time to provide personalised care, undertake training, and implement quality improvement programmes designed to reduce health inequalities. You can read more about our recommendations on investing in maternity services here and gynaecology services here. You can read more about our recommendation on increasing the public health grant here.

2. The UK Government must take a cross-departmental, life course approach to improving women's health, developed in close collaboration with women

A whole-Government strategic approach is required across women's life course to sustainably prevent health inequalities and to address the wider determinants of their health. It is also central to any policies seeking to achieve racial and ethnic equality in women's health outcomes. **The UK Government must therefore:**

- **Maintain a focus on implementing the Women's Health Strategy,** supported by long-term funding and a commitment to retaining tackling health inequalities as a core ambition.
- **Ensure all government initiatives to improve women's health or end inequalities in maternity outcomes make explicit connections across all relevant departments** to achieve long-term improvements.
- **Focus on specific interventions for groups of women at greatest risk of poorer outcomes or who face more significant barriers to care within and beyond the health system.** For example, this may include tackling racism and discrimination in the workplace, the causes of poverty and deprivation, or the disproportionate impact of air pollution on ethnic minority communities. You can read more about our recommendations for tackling women's health inequalities driven by poverty and deprivation here.

3. Equity and accountability must be embedded throughout the health service to support the women's health workforce and good health outcomes across women's life course

The Government must ensure equity is a standing concern of decision-making structures at every level of the health service, from the NHS England Board and Integrated Care Boards to the boards of all NHS providers. **This must be supported by ongoing efforts to develop leaders at all levels** who are able to drive cultural change and support the workforce to end racism in the workplace.

Within the O&G workforce, **it is vital that doctors are supported with their wellbeing and ability to escalate concerns, and that there are mechanisms in place to ensure fairness in opportunities and career progression.** Psychological safety must be championed, and an environment where people are accepted and respected and feel to challenge when they have concerns or questions must be built.[36] **Where the MWRES and WRES identify racial inequalities in workforce experiences or progression within NHS organisations, there must be accountability for change,** with targets and timelines set out to deliver equitable outcomes for doctors from all ethnic backgrounds.

At the local level, Local Maternity and Neonatal Systems (LMNS) be supported by their ICB, with a clear framework on roles and responsibilities between the two structures. There must also be opportunities for LMNS staff to share best practices and take up leadership roles within ICBs. LMNSs also need to be supported with the tools to robustly track and evaluate maternal and neonatal outcomes to ensure comprehensive oversight.

4. Support equitable access to NHS and sexual and reproductive healthcare (SRH) services through co-production and effective commissioning

The NHS has committed to providing convenient, easy access services that meet the needs of communities, in a way that does not discriminate.[37] Health services must, therefore, have the structures in place to strive towards equity in outcomes and overcome the barriers that prevent women from accessing care.

Listening to women and their families is fundamental to providing person-centred care, and so co-production of services with women must be implemented wherever possible.[38] This includes involving service users from all backgrounds in all aspects of care, including co-production of services, training of the multi-professional team and investigations following adverse events. Innovation and outreach should be used to engage with women who are underrepresented, and services need to be financially supported to deliver this.

NHS commissioners must consider how local funding or eligibility criteria may have unequal impacts on women from ethnic minority backgrounds, and where services need to respond to the needs of particular groups. For example, making sure the cervical screening programme responds to lower attendance by women and people from some groups,[39] or giving regard to how eligibility criteria for NHS fertility services can have unequal impacts on women from some ethnic groups.[40] You can read more about these recommendations, in our joint position statement on gynaecological cancers with the British Gynaecological Cancer Society and our call to action on ethnic disparities in fertility treatment with the Human Fertilisation and Embryology Authority, British Fertility Society and Fertility Network UK.

Current NHS England equity programmes and initiatives relevant to reducing women's healthcare inequalities, such as the Equity and Equality guidance for local maternity systems and the Core20PLUS5 approach,[41] should be co-ordinated and aligned to reflect the life course approach and to support ICBs to collaborate on budgets. Equity initiatives should also be regularly evaluated and adapted to ensure they are suitable tools for improvement.

The UK Government can also support women's access to services and pre-conception health through facilitating better integration of women's SRH services and implementing the women's health hub model. You can read more about our recommendations for commissioning women's health services here.

5. Improve data collection to support the design of women's health services and research

Services need an accurate understanding of the ethnicities of those they serve to best identify inequalities, design appropriate services, and support research on effective interventions. However, better data collection on ethnicity and healthcare outcomes, particularly in gynaecology, is currently needed.[42]

All services should make sure that women's self-reported ethnicity is asked and accurately recorded, using agreed ethnic group coding systems that should be updated regularly in accordance with the most current census groups.[43] Healthcare staff should be aware of and able to explain to service users the reasons for ethnicity data collection, how it can be used, and why it is so important for health, as recommended by the Race Equality Foundation.[44]

Ethnicity data should also be incorporated into safety and quality metrics, with regular reporting required to monitor progress and identify areas needing improvement. This requires data and research support, and training to support staff to collect data appropriately.

6. Support personalised care and informed decision making and ensure all women who need it have access to a high quality interpreting service

Governments and health services should consider how to improve the availability and quality of information about choices during pregnancy and labour, with particular attention to the

development of evidence based shared decision making tools for place, mode and timing of birth and pain relief options.[45]

Provision and use of good interpreting services and translated materials are crucial to support women and people using O&G services in making informed decisions about their care. However, RCOG members have reported variation in provision between and within healthcare providers, unreliable, slow interpreting services that take up valuable clinical time, and a lack of funding allocated to protect this essential service. Deficiencies with interpretation or translation provision have also been raised in MBRRACE-UK confidential enquiries into maternal deaths and by a BBC investigation.[46]

Every maternity service must provide access to a high quality interpreting service, and consider ways to improve the availability and usage of appropriate interpreters. Services should be supported by additional funding to deliver this where needed. Commissioners of maternity services must take into account the cost of interpreting requirements, including NICE recommendations for professional interpreters and the need for longer appointments, when commissioning and funding services.

NHS England should ensure that interpreters supporting maternity care are trained to provide high quality services in this specific context, setting out minimum competencies in a nationally agreed standard. You can read more about our recommendations on improving access to interpreters in maternity care here.

7. Ensure all women can easily access high quality maternity care which meets their needs

Services must ensure equitable access to pre-pregnancy and post-pregnancy counselling for women and people planning a pregnancy who have medical conditions or a previous complicated pregnancy. There should also be continuous and protected support for NHS Maternal Medicine Networks, which have an important role in reducing maternal mortality and morbidity from medical problems in pregnancy. We also support developing and implementing tools that can help assess and identify risk early.

The RCOG has made specific recommendations for improving access for women seeking asylum or with insecure migration status, who are often at higher risk of poor outcomes.[47] **NHS Trusts have an important role in minimising the impact of NHS overseas visitors charging regulations on maternity outcomes, and should implement the RCOG, RCM and Maternity Action Guidance on improving access to maternity care for women affected by charging.** You can read all of our recommendations for supporting access to maternity care for migrant women here.

It is vital that services are set up to learn when things go wrong, and that the potential relevance of race and ethnicity as contributing factors are fully and confidently explored. This includes ensuring complaints processes are accessible for all service users, working with those with lived experience. Maternity care providers should ensure oversight and monitoring of complaints to identify patterns and learning. Ethnicity should be a mandatory field on local incident reviews and tools, supported by adequate time for staff to create a psychologically safe space to encourage dialogue and confidently identify where racism, stereotypes or bias may have affected a woman's care.

A continued focus on addressing bias and knowledge gaps in care is important to ensuring women feel comfortable accessing care. **We welcome dedicated investment across the health system in anti-racist and culturally safe education, training and practice, backed by regular evaluation.**

8. Continue supporting women's health research, developing the evidence base to deliver effective interventions across women's life course

A robust evidence base is fundamental to healthcare interventions and policies which are equitable and effective across diverse populations. When looking to address maternity inequalities, building the evidence base for effective interventions and delivering an anti-racist service must be the focus. **A substantial piece of research is needed to understand and develop practical solutions to the mechanisms behind poorer care and outcomes in maternity services, and to evaluate existing interventions.** Mechanisms should be in place to rapidly escalate learning across the system to shape service delivery and clinical recommendations where required.

We also urge the UK Government to deliver a review of equity in the medical devices encountered during pregnancy and the neonatal period, as recommended by the recent independent review into equity in medical devices.[48]

In order to reverse historical underinvestment in women's health research, particularly for gynaecological health, **we urge the UK Government to commit to long-term investment in women's health research, and additional funding to tackle inequalities in women's gynaecological health across their life course,** supporting the welcome National Institute for Health and Care Research (NIHR) Challenge on tackling inequalities in maternity care and NIHR Policy Research Unit on Reproductive Health. This could support much-needed research into conditions that disproportionately affect some ethnic minority women, access to pain relief across women's health, and the relationship between gynaecological and other health conditions that can contribute to inequalities in fertility treatment outcomes.[49]

It is vital that research funders and journals support proportionate representation of ethnicities in clinical studies, such as by specifying the use of the NIHR-INCLUDE frameworks and requiring studies to be co-designed with representative groups of women. Further research into understanding and addressing the factors that lead to less diverse recruitment to clinical studies should also be considered.

Finally, we need to invest in the next generation of women's health researchers, ensuring people from all ethnic backgrounds are able to participate. This includes supporting the women's health workforce and ensuring that clinicians receive the time and flexibility to undertake research alongside their clinical work.

Further reading

- Read more about the College's ambition for race equality
- Policy position: Poverty, deprivation and women's health
- Policy position: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women
- Maternity safety resource hub
- Tackling racism eLearning
- Workforce Behaviour Toolkit
- Blog: Understanding and addressing the influence of colonialism on Obstetrics and Gynaecology specialty training in the UK

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