University of Wales
Trinity Saint David
LONDON

The Impact of Ethnicity on Maternal Health Outcomes and Mental Well-being: A Focus on Ethnic Minorities in the UK

by

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Student Number:2415592

Word Count:14251

Submission Date:06/10/2025

A Dissertation submitted in partial fulfilment of the requirements for the degree of Masters of Science in Public Health and Social Care in Practice

The Institute of Inner-City Learning

University of Wales Trinity Saint David – London Campus

October 2025

DECLARATION

I, Farzana Akter Nipa declare that this dissertation has been composed by myself, that the work contained herein is entirely my own except where explicitly stated otherwise in the text, and that this work has not been submitted for any other degree or qualification, in whole or in part, except as specified.

Signed:…Farzana Akter Nipa…….....

Date:..…06/10/2025……

Acknowledgements

I would like to begin by thanking my supervisor, Dr. Odette Jack, for her patience, encouragement, and insightful guidance. Her support has been essential in shaping both my research and my confidence as a scholar.

I am also grateful to the lecturers and staff who provided advice and resources along the way. My heartfelt thanks go to my family, whose love, sacrifices, and unwavering belief in me have been the foundation of this journey.

Abstract

Background: Ethnic minority women experience significantly higher maternal health issues and mental well-being outcome in the UK. Studies indicates that women from Black, Asian, and others ethnic communities suffer from maternal mortality, severe morbidity, and mental health conditions. This systematic review aimed to examine the impact of ethnicity on maternal health outcomes and mental well-being, especially on Black and South Asian women in the UK.

Methods: A systematic literature search was conducted using PRISMA guidelines based on research objectives. A comprehensive database (PubMed, Scopus, Google Scholar, etc.) was searched for qualitative, quantitative, and mixed-methods studies. The studies used only those studies that were published within the last 10 years and conducted among UK people. Data were analyzed thematically.

Results: Ethnic minority women were found to face multiple, intersecting inequities affecting both maternal health outcomes and mental well-being Key issues identified included perceived discrimination, cultural insensitivity, and poor patient–provider communication in maternity care. A higher prevalence of perinatal depression and anxiety, coupled with significant underdiagnosis and delayed treatment due to stigma and cultural barriers. Moreover, Profound structural disparities, including socioeconomic deprivation, language barriers, and inadequate interpretation services, exist. Furthermore, the detrimental impact of social isolation and restrictive cultural norms, as well as healthcare system failures, such as inequitable access to services and a critical lack of continuity of care, erodes trust. The intersection of racism, discrimination, and poverty drives these challenges.

Conclusion: Women from ethnic minorities women found systemic discrimination and structural barriers which contribute to higher maternal health outcome and mental well-being in Uk. Structural racism, cultural insensitivity, and systemic barriers to access were the most significant factors identified. Achieving equitable maternal health outcomes requires transforming healthcare systems towards culturally inclusive and anti-racist practices, ensuring continuity of care, and providing practitioners with training that integrates equitable healthcare for all.

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List of abbreviations

The list of abbreviations is following:

UK	United Kingdom
PTSD	Post Traumatic Stress Disorder
BAME	Black, Asian and minority ethnic
IMD	Index of Multiple Deprivation
SES	Socioeconomic status
PMHS	Perinatal mental health services
SDH	Social Determinants of Health
WHO	World Health Organisation
SLR	Systematic Literature Review
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
U.S.	United States
CASP	Critical Appraisal Skills Program
NHS	National Health Service
SMM	Severe maternal morbidity
OCD	Obsessive-compulsive disorder
CMDs	Common mental disorders
SCID-I	Structured diagnostic interviews
OR	Odds Ratio
CMDs	Common mental disorders
CBT	Cognitive Behavioural Therapy
USA	United States of America

Chapter 1: Introduction

1.1 Background

Maternal health is a major component of public health which plays a essential role for health and well-being of mothers and infants. The physical, mental, and emotional health of women throughout pregnancy, delivery, and the postpartum phase are defined as maternal health and well-being (Ojong *et al.*, 2023). In developing countries like UK, significant advancements in maternal healthcare have led to overall improvements in maternal and perinatal outcomes. However, notable disparities still exist among different groups, particularly ethnic minorities (Ameh et al., 2008; Matthews, 2015).

Ethnicity is a complex and multidimensional concept that includes common cultural practices, languages, heritage, and identity (GOV.UK, 1994). It is widely recognized as a social determinant of health, often intersecting with socio-economic status, healthcare access, and exposure to systemic discrimination. A great amount of people in UK were from ethnic communities like the percentage of Asian, Black, mixed and others were around 9.3%, 4.0%, 2.9%, and 2.1%, respectively (GOV.UK, 2022). Although there has noticed a diversity of the overall UK's population, but the women from ethnic minority communities has been faced many of maternal health issues and mental condition compared to white people.

Previous research reported that Black, Asian, and others minority ethnic women significantly had the limitations to access maternity and mental health care, which impact on their maternal health condition and mental well-being. (Garcia *et al.*, 2015). They are faced numerous challenges like feels insecurity, being ignored by providers, treat inappropriately, lack of informed consent, and had limited access to culturally inclusive care (Geddes-Barton *et al.*, 2024). These conditions were influence by some other factors like racism, social inequalities, and language barrier etc., which lead to insufficient or delayed treatment (Geddes-Barton *et al.*, 2024). Because of this, ethnic women are often found suffer from several complications during pregnancy and childbirth. Reports showed that Black women found four times and Black women were two times higher mortality in the UK (MBRRACE, 2018). Furthermore, these women were had relatively poor quality of life and poor care that impact their Pré-existing health conditions (Pilav *et al.*, 2022).

Mental well-being during and after pregnancy is essential for both maternal and child outcomes. Around 10% of expecting women and 13% of recent mothers worldwide

experience a mental health problem, primarily depression (WHO, 2025). However, women from ethnic minority backgrounds frequently face barriers that impacts on their accessibility to mental health services and healthcare support (Edge, 2010). The period of pregnancy is vital for both the mother and the developing child. Several psychological conditions such as depression, anxiety, PTSD, were very common during pregnancy (Howard *et al.*, 2014; Jones *et al.*, 2014). An estimated 10–20% of women experience serious mental health challenges during this period (Ayers and Shakespeare, 2015; Howard and Khalifeh, 2020). A significant number of this women exhibiting symptoms remain unrecognized, especially those from minority ethnic groups (Prady *et al.*, 2013). Moreover, women from minority ethnic backgrounds who face racism on a daily basis are more likely to suffer from prenatal depression, negative obstetric complications such as premature birth, and overall perinatal death (Slaughter-Acey *et al.*, 2016; Knight *et al.*, 2021). This has raised a concern regarding the likelihood that women from Black, Asian, and minority ethnic backgrounds may be more susceptible to inadequacies within healthcare services (Edge, 2010).

Maternity care is an essential component of any healthcare system, providing support for women and birthing individuals, as well as their broader family units (Silverio *et al.*, 2024). A range of evidence indicates that access to and experiences of healthcare services, such as maternity and perinatal mental health services, are significantly inequitable (Rayment-Jones *et al.*, 2019). However, there remains a notable lack of study focus on how barriers to care affect women from diverse ethnic backgrounds within the broader context of their daily lives (Edge, 2008, 2011; Sambrook *et al.*, 2019). Several studies that have explored the obstacles to accessing services highlighted both systemic barriers within primary care, psychological therapy services, and maternity services, as well as psycho-social, cultural, and interpersonal impediments (Bayrampou *et al.*, 2018; Millett *et al.*, 2018; Viveiros and Darling, 2019; Watson *et al.*, 2019).

These barriers encompass a range of issues, including negative perceptions of mental illness, under-resourced services, language difficulties, variations in cultural norms, and the dispersion of services (Bayrampour *et al.*, 2018; Watson *et al.*, 2019a). Studies highlighted that migrant and ethnic minority women exhibit a heightened risk of anxiety symptoms and may encounter obstacles associated with social deprivation (Traviss *et al.*, 2012; Anderson *et al.*, 2019). However, many studies although find out some reasons but

still unclear whether these inequalities' were come from socioeconomic factors (Geddes-Barton *et al.*, 2024).

Ethnic women suffer from comparatively higher rates of maternal health and mental well-being outcomes in Uk. Although several studies have already tried to explore the influencing factors behind thus, but there has remained a gaps in critical analysis on the impact of ethnicity in maternal and mental health conditions. However, this systematic review aims to provide information about the current knowledge, identifying research gaps, and providing policy-based recommendations for equitable culturally inclusive policy for ethnic minority women.

1.2 Statement of Problem

Although there has been noticed remarkable improvement in the healthcare system in UK but there still remains a disparity of health access towards ethnic minority women. Studies already identified Black and other ethnic minority women suffer a lot in access to healthcare comparatively other group of people. As a result, they were found to have higher mortality and morbidity rates among these populations. Numerous factors like such as biological, racism, socioeconomic status, influence and impact receiving timely and appropriate care. Furthermore, ethnic minority women are found significantly more vulnerable in the time of their pregnancy and the postpartum period. However, there is still lack of evidence how ethnicity influence healthcare access as well as the maternal and mental outcomes among ethnic women in UK. This review will give a better understanding about access to healthcare, enhance service delivery, and ensure culturally inclusive healthcare.

1.3 Rationale for the Study

It is a fundamental right of everyone to have equal and better healthcare service in the time of pregnancy, which is essential for the health of both mothers and her child. A healthy mother carries a healthy child. In recent times, we have seen a great advancement in healthcare settings. But there has still remain inequalities in this healthcare. It has been found that ethnic minority women suffer from poor maternal health outcomes and mental problems. This disparity is not only because of biological things, which are considered

often deep rotted and complex problems. This study will evaluate the complex effects of ethnicity on maternal health and mental health outcome among ethnic minority women in the UK.

This study will help to develop policies for maternal healthcare that will be culturally sensitive, equitable, and tailored to the specific needs of diverse ethnic groups. The research is crucial because it identifies the disparities that still exist in the healthcare facilities in the UK and aids in the creation of solutions to minimize them. It will support lawmakers, government agencies, and non-governmental organizations in advancing policies guaranteeing culturally sensitive and easily accessible healthcare for pregnant women. It will also contribute to the conversation on equitable healthcare that reduces health disparities and promotes reproductive justice.

1.4 Research Question

This study will evaluate the following questions:

“How does ethnicity have impact on and maternal and the mental health outcomes of ethnic minorities in the UK?”

1.5 Aim

The purpose of this study is to investigate how ethnicity affects maternal health outcomes and mental health, specifically focusing on South Asian and Black individuals in the United Kingdom.

1.6 Research Objectives

I. To explore the impact of ethnicity on maternity experiences and mental health outcomes among ethnic minority women in the UK.

II. To critically discuss the structural, social, and healthcare-related disparities influencing maternal health outcomes among ethnic minority women in the UK.

III. To examine how intersecting factors such as ethnicity, socioeconomic status, gender, and migration background shape access to, and experiences of, maternal and mental health services among ethnic minority women in the UK.

IV. To critically evaluate the effectiveness of maternal and mental health services in improving outcomes for ethnic minority women in the UK.

Chapter 2: Literature Review

2.1 Cultural Perceptions and Expectations of Maternity and Mental Health

Pregnancy related issues were acknowledged differently in terms of cultural and religious practices, which often very one to another (Swihart *et al.*, 2018). Women have emphasized the importance of establishing a rapport with their healthcare providers. Many individuals report feeling a higher level of trust towards those who share a similar religion or race, as well as towards those from other minority ethnic backgrounds (Silverio *et al.*, 2023). However, women have also expressed dissatisfaction with the possibility of receiving genuine treatment from medical providers who may or may not belong to their ethnic minority (Silverio *et al.*, 2023), especially since many women from these communities face racism and discrimination.

In addition, these women experience challenges from poor communication, cultural misunderstanding, unfamiliar treatment. As a result, the mother and babies suffer from adverse health effects (Thomson *et al.*, 2022). In addition, cultural dissonance has also been identified as a factor contributing to institutional, interpersonal, and internalized racism experienced by Black, Asian, and Minority Ethnic women (John et al., 2021).

Studies have found that a significant number of women from ethnic groups report experiencing discrimination and unfair treatment within maternity services. They often have limited knowledge regarding the variety of treatments available and which may be best suited for them (MacLellan *et al.*, 2022a; Obionu *et al.*, 2023). Women from South Asia, Black Africa, and the Caribbean frequently encounter familial pressure to avoid discussing their distressing emotions. Research indicates that these women are less likely to seek maternal care from hospitals or other facilities due to fears of being judged or stigmatized (Watson *et al.*, 2019a).

2.2 Discrimination and Racial Bias in Healthcare Settings

Discrimination occurs when an individual is treated unequally based on a socially attributed characteristic(Alvarez-Galvez *et al.*, 2013). The group with the lowest mortality rate (white) and the group with the highest (black African) exhibit a disparity of more than fivefold (Schuitemaker *et al.*, 1998; Berg *et al.*, 2003). In other countries with advanced healthcare systems, similar disparities in maternal mortality rates among ethnic minorities have been documented, indicating that inadequate treatment contributes to these

differences (Van Roosmalen *et al.*, 2002). A study found that 90% of women who died during or within a year of childbirth had experienced several biases (Knight *et al.*, 2018). Some of these biases include health issues, language barriers, delayed prenatal care, and complex social circumstances such as domestic violence, smoking, and unemployment (Knight *et al.*, 2018). Nevertheless, the overall number of maternal deaths remains low in developed nations, even within the largest ethnic groups. It is important to recognize that minority ethnicity is not a homogenous category but includes distinct groups of people with varying degrees of exposure to these risks (Watson *et al.*, 2019a).

2.3 Mental Health Outcomes

Pregnant women are especially vulnerable to mental health conditions because of their biological conditions on this time (WHO, 2025). They have been severely affected from depression and other many others mental health problems, which causes severe outcomes such as suicide (WHO, 2025). This heightened emotional strain not only affects the mothers themselves but also has detrimental implications for the growth and development of their children (WHO, 2025). Among mental health challenges, postpartum depression is the most prevalent issue faced by mothers; however, other disorders such as anxiety, postpartum psychosis, PTSD, schizophrenia, and bipolar disorder also pose significant risks (eClinicalMedicine, 2024). Disturbingly, studies indicate that suicide accounts for approximately 20% of postpartum deaths, underscoring the severe impact of prenatal mental health challenges (eClinicalMedicine, 2024).

Several factors contribute to the increased likelihood of mental health issues during pregnancy. These include preexisting conditions, genetic predispositions, socioeconomic status, social isolation, experiences of racism and xenophobia, transgender identity, histories of trauma or mental illness, and varying traumatic experiences (eClinicalMedicine, 2024). Consequently, women from marginalized communities, including migrant and ethnic minority groups, face elevated risks of mental health complications during pregnancy (eClinicalMedicine, 2024). Research shows that migrant and ethnic minority women often experience higher levels of anxiety and frequently encounter obstacles related to social deprivation. This deprivation is assessed through the Index of Multiple Deprivation (IMD), which considers factors such as income, employment, education, health services, disability, crime rates, and housing conditions (Traviss, West and House, 2012; Anderson *et al.*, 2019). In particular, studies have found that Black Caribbean women are less likely to use perinatal mental health services when they receive

inadequate physical healthcare or perceive their treatment as lacking compassion (Edge, 2011). In the United States, barriers to accessing mental health care for minority ethnic women include a reluctance to use psychotropic medications (Nadeem et al., 2008).

2.4 Communication and Language Barriers

Communication and language barriers significantly impact the health and mental well-being of ethnic minority mothers in the UK. Issues such as the lack of available interpreters, insensitivity to diverse cultures, and insufficient culturally relevant information can exacerbate health problems, hinder access to treatment, and worsen mental health issues (Bansal *et al.*, 2022). Maternal mortality rates disproportionately affect women from ethnic minority groups (Louis *et al.*, 2015). These communication barriers can further exacerbate this disparity by making it more difficult for women to receive timely care and treatment (Cosstick *et al.*, 2022). A study found that 90% of women who died during or within a year of childbirth had experienced several biases (Knight *et al.*, 2018). Some of these biases include health issues, language barriers, delayed prenatal care, and complex social circumstances such as domestic violence, smoking, and unemployment (Knight *et al.*, 2018). These factors are directly related to, or may affect, how different ethnic groups access and utilize maternity care (Knight *et al.*, 2018). Another study revealed that women with limited English proficiency faced challenges in obtaining maternity care due to a shortage of interpreters, concerns about the privacy of interpreter services, and uncertainties regarding the accuracy of professional interpreters' translations during consultations (Rayment-Jones *et al.*, 2021).

2.5 Socioeconomic Inequality and Social Determinants of Health

The consistently high rates of maternal death among minority ethnic women are not only alarming but also represent a significant failure in maternity healthcare in the UK (Silverio *et al.*, 2023). Disparities in maternal services arise not only from the biological or social health factors that affect ethnic minority women but also from inadequate quality of care, unsafe practices, and instances of mismanagement (Knight *et al.*, 2022). It is important to recognize that minority ethnicity is not a homogenous category but includes distinct groups of people with varying degrees of exposure to these risks (Watson *et al.*, 2019a). The complex interplay between disease burden and socioeconomic status (SES) must be acknowledged, especially considering the substantial evidence of SES disparities among racial groups and the ongoing impacts of interpersonal and institutional discrimination

(Pickren, 2019). A previous study provided a more comprehensive understanding of the additional socio-demographic factors that minority ethnic communities face when seeking healthcare. Many conditions like sociodemographic conditions, economic and social status also influence it (Silverio *et al.*, 2023).

2.6 Healthcare Access and Quality of Care

Ethnic women found higher inequalities to healthcare access and limited care. Studies have already mentioned that Black, Asian, and others minority women feels barriers to access the maternity services in the UK (Knight *et al.*, 2018). According to a report, only 17% of the women who died received adequate treatment, and in 37% of those cases, improved care could have changed the outcome (Knight *et al.*, 2023). On the other hand, equivalent levels of mental distress, national cohort studies show that women from ethnic minority groups are less likely than White British mothers to obtain therapy for anxiety and depression during the postpartum period (Moore *et al.*, 2019). As part of a broader research project, a recent study found that women of other White ethnicities, Black women, and South Asian women were more likely to experience involuntary admission and used community perinatal mental health services (PMHS) less frequently than White British women (Jankovic *et al.*, 2020). Researchers have paid little attention to Black women's access to mental health care in the UK (Edge and Jackson-Best, 2017).

2.7 Service Accessibility and Inclusivity

A significant variation in maternal mortality rates exists among various ethnic minority groups (Bowyer, 2008). The group with the lowest mortality rate (white) and the group with the highest (black African) exhibit a disparity of more than fivefold (Schuitemaker *et al.*, 1998; Berg *et al.*, 2003). In other countries with advanced healthcare systems, similar disparities in maternal mortality rates among ethnic minorities have been documented, indicating that inadequate treatment contributes to these differences (Van Roosmalen *et al.*, 2002). Nevertheless, the overall number of maternal deaths remains low in developed nations, even within the largest ethnic groups.

Maternal mortality rates are notably higher among different ethnic groups (Van Roosmalen *et al.*, 2002; Waterstone *et al.*, 2002). Numerous studies suggest that access to care plays a crucial role in influencing ethnic disparities in health outcomes. A study on maternal fatalities revealed that many women from ethnic minority backgrounds who died either received prenatal care late (after 22 weeks' gestation) or did not receive it at all (Bowyer,

2008). Women from Black and minority ethnic groups were more likely than white women to delay acknowledging their pregnancy, seeking medical attention, and subsequently booking prenatal care (Maggie Redshaw, 2006). Furthermore, these women often felt that healthcare staff were less likely to treat them with respect or communicate in a language they could easily understand during pregnancy, delivery, and postnatal care (Knight *et al.*, 2009). They reported a perception of limited healthcare options, and an even smaller proportion had access to midwives' contact information for support throughout their pregnancy (Knight *et al.*, 2009).

2.8 Integration of Mental Health Support in Maternity Care

Mental health issues pose a significant public health and socioeconomic challenge in Europe (Watson et al., 2019). These issues are particularly prevalent during pregnancy, affecting approximately 10% of pregnant women and 13% of those in the postpartum period (WHO, 2018). Various mental health conditions, including depression, anxiety, PTSD, eating disorders, personality disorders, bipolar disorder, affective psychosis, and schizophrenia, may either predate or arise during pregnancy (Howard *et al.*, 2014; Jones *et al.*, 2014). Mental illness during pregnancy is a major contributor to maternal mortality, with suicide being the second leading cause of maternal deaths in the UK (Anderson *et al.*, 2019).

As part of a broader research project, a recent study found that women of other White ethnicities, Black women, and South Asian women were more likely to experience involuntary admission and used community perinatal mental health services (PMHS) less frequently than White British women (Jankovic *et al.*, 2020). The impact of maternal mental health disorders affects individual families, significant impact on the financial and resource burdens on healthcare systems (Kingston *et al*., 2012; Stein *et al.*, 2014; Prady *et al.*, 2016).

2.9 Theoretical Framework

This study is grounded by the intersectional theoretical framework, supported by the Social Determinants of Health (SDH) model and Ecological Systems Theory. The integration of these three frameworks provides a comprehensive lens to explore and analyze the multifaceted and interconnected factors influencing maternal health outcomes and mental well-being among ethnic minority women in the UK. The intersectional theoretical framework theory, which is considered the best fit for our studies. This framework is very

convenient to describe different social identity effects on their experience in terms of both privilege and oppression (Crenshaw, 2013; Collins, 2022). Since our study want to evaluate the system of oppression especially racism, cultural stigma, people perceptions, social determinates impact on maternal health outcomes and mental well beings of ethnic communities in UK. In addition, the Social Determinants of Health (SDH) models (WHO, 2008) and Ecological Systems Theory (Bronfenbrenner, 1979) for better understanding about the disparities.

Intersectional theoretical framework: An intersectional theoretical framework is one of the best models to describe how different social factors including race, gender, class, and sex, work together to create different experiences of privilege and oppression. Additionally, It depicts how various social positions influence on one another and help in shaping of individuals' lives (Crenshaw, 2013; Bauer *et al.*, 2021). This study used an intersectionality approach to analyze the compounding effects of racism, cultural stigma, institutional bias, and structural inequities faced by ethnic minority women (Bauer *et al.*, 2021; Collins *et al.*, 2021).

Social Determinants of Health (SDH) models: Social Determinants of Health (SDH) models are very important to describe how social and economic factors affect health outcomes. These models highlighted how many social structures and components are connected together and affect people's living conditions and health (WHO, 2008; Hosseini *et al.*, 2016).

Chapter 3: Methodology

3.1 Introduction

This chapter describes the methodology used in this study. This study focuses on ethnic minority women in the UK and examines the influence of ethnicity on maternal health outcomes and mental well-being. Studies identified numerous factors, such as social, economic, cultural, and institutional impact on maternal health (Pilav *et al.*, 2022). A rigorous and structured method was used to extract relevant literature. Through a comprehensive search strategy, concise inclusion and exclusion criteria, a methodical study selection process was followed. For validation and reliability, critical appraisal techniques, and the Systematic Literature Review (SLR) protocol, were used in the research (Bandara and Syed, 2024). Additionally, a PRISMA guideline were followed for study selection process.

3.2 Study Design

A systematic review is a comprehensive process which used for discovering, selecting, and assessing relevant literature on a certain study topic (Muka *et al.*, 2020). It help to collect all relevant papers and materials based on inclusion and exclusion criteria (Mengist, Soromessa and Legese, 2020). It used a fair, clear and methodical techniques to reduce bias and maximizes reliability (Mengist *et al.*, 2020). This study explores the literature to identify the research question like how ethnicity affects maternal health outcomes and mental health among ethnic minorities in the UK. It used mixed-methods research theory, extract both quantitative and qualitative and mixed-methods study (Sandelowski *et al*, 2007). Both type of studies increases the strength and validity of the findings, which reflets the comprehensive wide range of view of the problem.

3.3 Search Strategy

A comprehensive search strategy was followed to select the relevant studies. These strategies used five-stage process:

i) Database Selection
ii) Keyword Formulation
iii) Boolean Logic Application
iv) screening
v) selection.

3.3.1 Databases Searched

The systematic review used several rigorous and comprehensive academic databases to select peer-reviewed studies related to maternal health, mental well-being, and ethnicity. The databases included were following:

PubMed (MEDLINE): This database was selected for its extensive coverage of maternal health, ethnic disparities, and mental well-being, ensuring access to high-quality, evidence-based studies relevant to the UK context and global comparative insights. A leading biomedical database maintained by the U.S. National Library of Medicine,

Scopus: Scopus is a comprehensive abstract and citation database covering peer-reviewed literature across health, social sciences, and interdisciplinary research. It was included in this review to ensure broader coverage of relevant studies on ethnicity, maternal health outcomes, and mental well-being

Google Scholar: A freely accessible search engine that indexes scholarly literature from a wide variety of disciplines and sources, including grey literature, theses, and non-indexed journals. It was used to capture any relevant studies not covered by other databases.

ProQuest: A multidisciplinary database that includes access to dissertations, theses, reports, and peer-reviewed journal articles across health and social sciences, useful for capturing comprehensive and grey literature.

ScienceDirect: A scientific database hosting a large collection of full-text articles from Elsevier journals, especially in health sciences, clinical medicine, and psychology.

BMJ and BMJ Open: BMJ provides access to high-quality research and review articles across a broad range of medical disciplines, while BMJ Open offers open-access articles focusing on clinical medicine, public health, and health policy. These databases were included in the review due to their strong coverage of UK-based studies and health disparities research.

3.3.2 Keywords and Search Terms

In this systematic review, the search terms were derived from the main research question, aim and objectives, using synonyms. The search terms included: The Effect of Ethnicity

on Mental Health and Maternal Health Outcomes: An Examination of Ethnic Minorities in the United Kingdom.

Table 1: Search terms and synonyms

Search Terms	Synonyms
Ethnicity	Ethnicity, Ethnic Minorities, Ethnic minority, Minorities, Ethnic, Black, Asian, South Asian, Black Asian and Minority Ethnic, BAME
Maternal health	Maternal health, Pregnancy outcomes, pregnancy, perinatal, maternity, childbirth
Mental Wellbeing	Mental well-being, Mental Health, Psychological well-being, Emotional well-being, Well-being
Geographical	United Kingdom, UK, England, Scotland, Wales, Northern Ireland

Table 2: Mesh terms used for PubMed

Key terms	Subdivision	Mesh Terms
Ethnicity	Ethnicity	("Ethnicity"[Mesh] OR "Ethnic and Racial Minorities"[Mesh] OR "Minority Groups"[Mesh] OR "Black People"[Mesh] OR "Black or African American"[Mesh] OR "South Asian People"[Mesh] OR "Ethnic minority"[tw] OR "Ethnic minorities"[tw] OR "BAME"[tw] OR "Black Asian and Minority Ethnic"[tw] OR “Ethnic groups” [tw] OR "Racial Groups"[Mesh]

		OR “Racial disparity” [tw])
Maternal health & Mental Well-being	Maternal health & Mental Well-being	("Maternal Health"[Mesh] OR "Maternal Health Services"[Mesh] OR "Pregnancy Outcome"[Mesh] OR "Pregnancy"[Mesh] OR "Perinatal Care"[Mesh] OR "Maternity Care"[tw] OR "Parturition"[Mesh] OR "Childbirth"[tw] OR "Maternity"[tw] OR "Mental Health"[Mesh] OR "Mental Health Services"[Mesh] OR "Psychological Well-Being"[Mesh] OR "Emotional Well-Being"[tw] OR "Mental Well-Being"[tw] OR "Emotional Wellbeing"[tw] OR "Mental Wellbeing"[tw])
Geographical	UK	("United Kingdom"[Mesh] OR "England"[Mesh] OR "Scotland"[Mesh] OR "Wales"[Mesh] OR "Northern Ireland"[Mesh] OR "UK"[tw] OR "U.K."[tw] OR "Britain"[tw] OR "British"[tw])

3.3.3 Scopus Search Query

Ethnicity OR ethnic and racial minorities OR minority groups OR black people OR black or African American OR south Asian people OR ethnic minority OR ethnic minorities OR

BAME OR black Asian and minority ethnic OR ethnic groups OR racial groups OR racial disparity

AND

maternal health OR maternal health services OR pregnancy outcome OR pregnancy OR perinatal care OR maternity care OR parturition OR childbirth OR maternity OR mental health OR mental health services OR psychological well-being OR emotional well-being OR mental well-being OR emotional wellbeing OR mental wellbeing

AND

United Kingdom OR England OR Scotland OR Wales OR Northern Ireland OR UK OR U.K OR Britain OR British

For Google Scholar & ProQuest search:

("ethnicity" OR "ethnic minority" OR "ethnic minorities" OR "ethnic groups" OR "racial disparity" OR "racial groups" OR "minority groups" OR "BAME" OR "Black people" OR "Black or African American" OR "Black Asian and Minority Ethnic" OR "South Asian people")

AND

("maternal health" OR "maternal health services" OR "pregnancy" OR "pregnancy outcomes" OR "perinatal care" OR "maternity care" OR "parturition" OR "childbirth" OR "maternity" OR "mental health" OR "mental health services" OR "psychological well-being" OR "mental well-being" OR "emotional well-being" OR "mental wellbeing" OR "emotional wellbeing")

AND

("United Kingdom" OR "UK" OR "U.K." OR "England" OR "Scotland" OR "Wales" OR "Northern Ireland" OR "Britain" OR "British")

BMJ Search:

ethnicity OR minority OR BAME OR Black OR South Asian AND maternal health OR mental health AND United Kingdom OR UK OR Britain

ScienceDirect:

(ethnicity OR minority) AND (maternal health OR pregnancy OR mental health) AND (UK OR United Kingdom OR England)

All terms were examined within the title and abstract fields. Additionally, the fourth facet was investigated in the country of publication field or its closest equivalent. Controlled vocabulary terms were used where available.

3.3.4 Boolean Logic Application

The Boolean operators AND and OR were used, alongside truncation, were used to broaden or narrow the searches. The search keywords were following:

- **“**Ethnic minorities" OR "Black" OR "Asian" OR "ethnic groups", "BAME" OR "racial groups" OR "ethnicity" OR "racial disparity"
- "Maternal health" OR "perinatal outcomes" OR "pregnancy outcomes" OR "postpartum health" OR "birth outcomes"
- "Mental well-being" OR "postnatal depression" OR "anxiety" OR "psychological stress" OR "maternal mental health"
- "United Kingdom" OR "UK" OR "England"

Sample search string used:

("ethnic minorities" OR "Black" OR "Asian" OR "ethnic groups" OR "BAME" OR "racial groups" OR "ethnicity" OR "racial disparity") AND ("maternal health" OR "perinatal outcomes" OR "pregnancy outcomes" OR "postpartum health" OR "birth outcomes") AND ("mental well-being" OR "postnatal depression" OR "anxiety" OR "psychological stress" OR "maternal mental health") AND ("United Kingdom" OR "UK" OR "England")

Table 3: Search results

Search databases	Result
PubMed	456
Scopus	342
Google Scholar	15,700
BMJ Open	50
ScienceDirect	38,897
ProQuest	888

3.4 Screening

The screening process began with a thorough search using specific keywords across selected databases. To improve the relevance of the studies retrieved, specific filters were applied, including publication date range, study type, language, and geographical focus. Initially, the titles of the retrieved studies were reviewed to evaluate their relevance to the research topic.

3.5 Study Selection

The peer reviewed studies were selected based on inclusion and exclusion criteria. First, a comprehensive search approach was used in multiple databases, including PubMed, Scopus, Google Scholar, BMJ Open, ScienceDirect, and ProQuest. This initial search found around 56,333 documents.

After applying relevant filters, such as publication date range, language, and study type, and removing duplicates, there screened the results based on titles and abstracts in accordance with the research objectives. This process narrowed the pool to around 903 potentially relevant studies, which were imported into Microsoft Excel for further management and analysis. From this selection, there was downloaded and reviewed approximately 193 full-text articles in detail. Following a thorough assessment of the inclusion and exclusion criteria, ultimately included 15 studies in the final synthesis for the systematic review.

3.5.1 Inclusion Criteria

i. Research published between 2015-2025 on maternal health inequalities and mental well-being among ethnic minorities in the UK.

ii. Studies on ethnic minority communities in the UK, including Black, South Asian, and mixed ethnicities. However, research undertaken outside of the UK will be selected to fill any gaps in the UK literature.

iii. Focused on maternal health outcomes (e.g., mortality, morbidity, access to care, birth outcomes) and/or mental well-being (e.g., postnatal depression).

iv. Peer-reviewed journal articles published in English (quantitative, qualitative, or mixed methods).

v. Studies that are accessible for free and are full text

3.5.2 Exclusion Criteria

i. Studies published before 2015 were excluded from the study

ii. Research on women who are not pregnant or have not just given birth

iii. Articles not addressing ethnicity as a primary variable.

iv. Preprints that have not yet been published, conference abstracts that lack complete papers, and blogs, news items, reviews, opinion pieces, or editorial letters that have not

v. Non-English publications.

3.6 PRISMA Flow Diagram

A PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) diagram (Figure 1) was used to document the selection process, as follows:

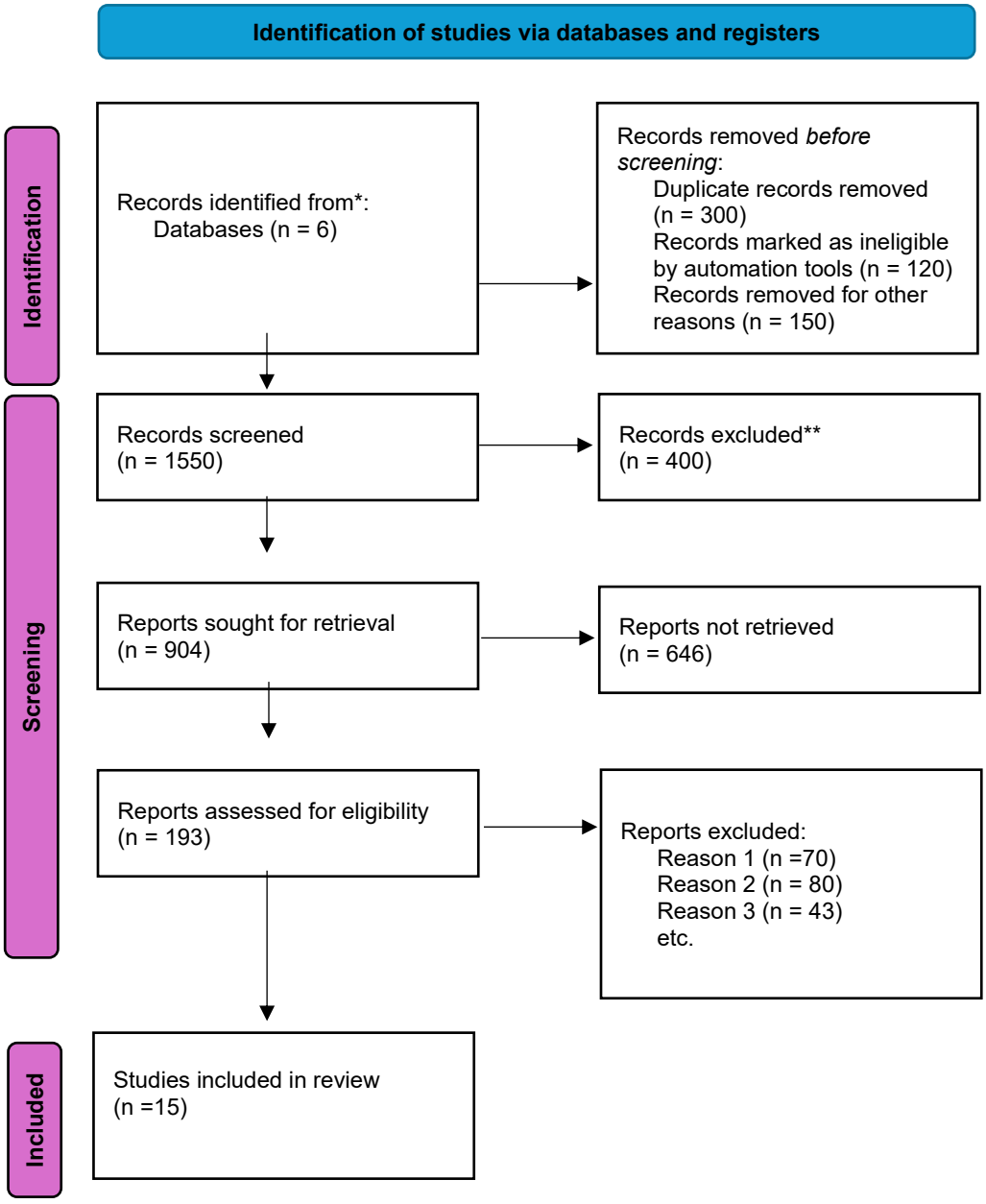

Figure 1: Study selection diagram

3.7 Critical Appraisal

The quality and reliability of the included studies were assessed for the systematic review using the Critical Appraisal Skills Program (CASP) criteria. Cohort studies, qualitative research, and systematic reviews are just a few of the study designs for which CASP offers well-structured resources. This guarantees a comprehensive and consistent evaluation of each study's methodological advantages and disadvantages (CASP, 2018).

Because CASP checklists are easily accessible, often used in health research, and consistent with evidence-based practice, they were selected. There was cross check different types of biases for integrity of this review including sampling biases, confounding factors, and statistical validity for both quantitative and quantitative studies based on the CASP Cohort Study Checklist. It were highly usable for assess ethical issues, data collection techniques, and theoretical frameworks (Long *et al.*, 2020). CASP improves openness, reduces subjective bias in the evaluation process (Al-Jundi and Sakka, 2017).

3.8 Data extraction

First, data was extracted based on exclusion and inclusion criteria. Then it is stored at Microsoft Excel in a predefined comprehensive way. Then relevant information was collected about a study included in authors, publication year, research objective, setting, sample size, participant demographics, data collecting methodology, analytic technique, and results. After justifying the study will go for full review, some are marked out and marked in. The elected paper then extracted the main key findings. See Appendix…….1

3.9 Data Analysis

An integrative approach to data analysis was employed in this study (Schaefer *et al.*, 2012). The systematic review and thematic analysis were conducted to synthesize qualitative and mixed-method findings from the selected literature that addressed comparable research questions. This strategy allowed the transformation and integration of data across different formats (Sandelowski *et al.*, 2006; Watson *et al.*, 2019b). As its methodical, adaptable, and well-known approach to finding, evaluating, and summarizing patterns (themes) in qualitative data, the Braun and Clarke framework was chosen (Braun and Clarke, 2006). Because it supports both inductive and deductive coding, this method

is especially well-suited for investigating the many sociocultural factors that contribute to maternal health inequalities (Zhou *et al.*, 2020).

3.10 Steps in Thematic Analysis

For thematic analysis, a structured, iterative approach was followed for analysis. The process first starts with familiarization, during which all included studies were read multiple times based on the title and abstract to identify initial patterns related to ethnic disparities in healthcare access, mental health challenges, and maternity care experiences. After familiarization, initial coding was systematically performed using Microsoft Excel. Relevant data extracts including participant quotes, author interpretations, and summaries were coded line-by-line to capture meaningful concepts and patterns. Frequently encountered codes reflected themes such as emotional distress, institutional barriers, perceived discrimination, stigma, and the dynamics of patient-provider interactions.

In the next phase, similar or related codes were grouped into preliminary themes based on conceptual connections and alignment with the research objectives. For instance, codes related to language difficulties, mistrust in the healthcare system, and culturally insensitive practices were categorized under the theme “Cultural Barriers to Healthcare Access.” Similarly, codes highlighting discrimination, social isolation, and the compounding effects of stigma were organized into themes such as “Intersectional Stigma and Mental Health” and “Racialized Maternity Care Experiences.” These themes were refined through repeated comparison to ensure clarity, internal consistency, and differentiation from one another. During the theme review phase, all emerging themes were re-examined concerning the full dataset to confirm their relevance and coherence. Themes that lacked sufficient supporting evidence or showed significant overlap were revised, merged, or discarded to enhance analytical rigor. Each finalized theme was then clearly defined and named to encapsulate its core meaning. These themes were supported by illustrative quotations and contextual examples drawn directly from the primary studies, ensuring that the findings remained closely grounded in the original data. Finally, the themes were synthesized into a coherent narrative that addressed the central research question.

3.11 Ethical statements

This systematic review cited all papers correctly. The review upholds high ethical standards while synthesizing the information on this significant public health concern by adhering to the PRISMA principles for transparent reporting and consulting pertinent ethical frameworks for health disparities research.

Chapter 4: Results

Table 4: Thematic Synthesis of Ethnicity-Related Disparities in Maternal and Mental Health among Ethnic Minority Women in the UK

Main themes	Sub themes	Corresponding Citation
Impact of ethnicity on maternity experiences among ethnic minority women in the UK.	Perceived discrimination and cultural insensitivity in maternity care	(Chitongo *et al.*, 2022; Pilav *et al.*, 2022; Thomson *et al.*, 2022; Bamber *et al.*, 2023; Conneely *et al.*, 2023; Silverio *et al.*, 2023; Geddes-Barton *et al.*, 2024)
	Limited availability of culturally appropriate information and support	(Chitongo *et al.*, 2022; Thomson *et al.*, 2022; Conneely *et al.*, 2023)
Impact of ethnicity on mental health outcomes among ethnic minority women in the UK during maternity period.	Higher prevalence of perinatal depression and anxiety among ethnic minority women	(Gibson-Smith *et al.*, 2015; Cook *et al.*, 2019; Mercer *et al.*, 2019; Saville, 2022; Solomon *et al.*, 2022; Thomson *et al.*, 2022)
	Underdiagnosis and delayed treatment of maternal mental health conditions	(De la Cruz *et al.*, 2015; Gibson-Smith *et al.*, 2015; Singh *et al.*, 2015; Cook *et al.*, 2019; Mercer *et al.*, 2019; Pilav *et al.*, 2022; Solomon *et al.*, 2022;

		Thomson *et al.*, 2022; Conneely *et al.*, 2023)
	Stigma and cultural barriers in acknowledging and seeking mental health support	(De la Cruz *et al.*, 2015; Gibson-Smith *et al.*, 2015; Singh *et al.*, 2015; Cook *et al.*, 2019; Pilav *et al.*, 2022; Solomon *et al.*, 2022; Thomson *et al.*, 2022; Conneely *et al.*, 2023; Wang *et al.*, 2024)
Structural disparities influencing maternal health outcomes among ethnic minority women in the UK	Socioeconomic disadvantages and employment insecurity affecting access to care	(Gibson-Smith *et al.*, 2015; Chitongo *et al.*, 2022; Saville, 2022; Bamber *et al.*, 2023; Geddes-Barton *et al.*, 2024; Wang *et al.*, 2024)
	Language barriers and lack of professional interpreters in health settings	(Gibson-Smith *et al.*, 2015; Singh *et al.*, 2015; Chitongo *et al.*, 2022; Saville, 2022; Thomson *et al.*, 2022; Bamber *et al.*, 2023; Conneely *et al.*, 2023; Silverio *et al.*, 2023; Geddes-Barton *et al.*, 2024)
	Disproportionate reliance on overstretched community health services	(Singh *et al.*, 2015; Solomon *et al.*, 2022; Conneely *et al.*, 2023; Silverio *et al.*, 2023)

Social disparities influencing maternal health outcomes among ethnic minority women in the UK	Social isolation and limited peer/family support during pregnancy and postpartum	(Gibson-Smith *et al.*, 2015; Chitongo *et al.*, 2022; Conneely *et al.*, 2023)
	Gender norms and cultural expectations shaping maternity experiences	(Chitongo *et al.*, 2022; Pilav *et al.*, 2022; Thomson *et al.*, 2022; Conneely *et al.*, 2023)
Healthcare-related disparities influencing maternal health outcomes among ethnic minority women in the UK.	Inequitable access to prenatal and postnatal services	(Gibson-Smith *et al.*, 2015; Pilav *et al.*, 2022; Saville, 2022; Thomson *et al.*, 2022; Bamber *et al.*, 2023; Conneely *et al.*, 2023; Silverio *et al.*, 2023; Geddes-Barton *et al.*, 2024)
	Lack of continuity of care and trust in healthcare providers	(Chitongo *et al.*, 2022; Pilav *et al.*, 2022; Bamber *et al.*, 2023; Conneely *et al.*, 2023; Silverio *et al.*, 2023; Geddes-Barton *et al.*, 2024)
Influencing intersecting factors on access and experience of maternal and mental health services	Intersections of ethnicity, migration status, and socioeconomic position	(Gibson-Smith *et al.*, 2015; Singh *et al.*, 2015; Cook *et al.*, 2019; Mercer *et al.*, 2019; Chitongo *et al.*, 2022; Saville, 2022; Solomon *et al.*, 2022; Geddes-Barton *et al.*, 2024)

	Effects of racism, discrimination, and poverty on maternal well-being	(De la Cruz *et al.*, 2015; Gibson-Smith *et al.*, 2015; Mercer *et al.*, 2019; Chitongo *et al.*, 2022; Saville, 2022; Solomon *et al.*, 2022; Bamber *et al.*, 2023; Conneely *et al.*, 2023; Silverio *et al.*, 2023; Geddes-Barton *et al.*, 2024)
Barriers and facilitators to effectiveness of maternal health services	Cultural misunderstandings, mistrust, logistical difficulties (transport, cost)	(Gibson-Smith *et al.*, 2015; Singh *et al.*, 2015; Chitongo *et al.*, 2022; Thomson *et al.*, 2022; Bamber *et al.*, 2023; Conneely *et al.*, 2023; Wang *et al.*, 2024)
	Use of community-based services and peer support groups	(Mercer *et al.*, 2019; Pilav *et al.*, 2022; Geddes-Barton *et al.*, 2024; Wang *et al.*, 2024)
	Importance of culturally competent midwives and bilingual healthcare staff	(Gibson-Smith *et al.*, 2015; Singh *et al.*, 2015; Pilav *et al.*, 2022; Bamber *et al.*, 2023; Conneely *et al.*, 2023)
Facilitators and barriers to improving mental health services for ethnic women during maternity	Stigma, lack of awareness, limited specialist perinatal	(De la Cruz *et al.*, 2015; Singh *et al.*, 2015; Cook *et al.*, 2019; Mercer *et al.*, 2019; Chitongo *et*

	mental health services	*al.*, 2022; Pilav *et al.*, 2022; Solomon *et al.*, 2022; Thomson *et al.*, 2022; Wang *et al.*, 2024)
	Integration of mental health support within maternity services	(Gibson-Smith *et al.*, 2015; Singh *et al.*, 2015; Cook *et al.*, 2019; Mercer *et al.*, 2019; Pilav *et al.*, 2022; Solomon *et al.*, 2022; Conneely *et al.*, 2023; Silverio *et al.*, 2023; Wang *et al.*, 2024)

Themes

After conducting a thorough familiarization and thematic analysis of the data, we identified seven core themes: conceptualizations of health, impact of ethnicity on maternity and mental health services, cultural norms and expectations, symptom navigation and coping strategies, isolation and support, barriers to access, experiences of care, and visions for improved services. Below, we provide a detailed description of these themes and their sub-themes.

4.1. Impact of ethnicity on maternity experiences among ethnic minority women in the UK.

The impact of ethnicity on maternity experiences among ethnic minority women in the UK is a well-documented and multifaceted issue. Across n=7 studies included in this review, three key subthemes emerged: perceived discrimination and cultural insensitivity, limited availability of culturally appropriate information and support, and variations in birth satisfaction and patient–provider communication.

4.1.1 Perceived discrimination and cultural insensitivity in maternity care

Across the studies (n=7), ethnic minority women consistently reported discriminatory treatment and cultural insensitivity that shaped their maternity experiences. Qualitative evidence revealed that women often felt disempowered, dismissed, and stereotyped by professionals. Silverio *et al.*, (2023) described how participants struggled to maintain agency during labour, with one woman stating, *"they started talking about induction and I said I don't want one… [they] booked it anyway" (pp:4).* Similarly, Pilav *et al.*, (2022) found that Black women's pain and concerns were frequently minimised, with some noting they were "seen as strong" and therefore ignored. Thomson *et al.*, (2022), showed that around 34% of women reported being treated differently due to ethnicity, and 31.9% said staff made incorrect behaviour with them. More than a quarter (25.3%) also reported that dietary needs were only partly met or unmet. These accounts were echoed in Conneely *et al.*, (2023), where women recounted how stigma, cultural misunderstanding, and a lack of empathy in perinatal mental health services created mistrust and reluctance to seek support.

Geddes-Barton *et al.*, (2024), showed that severe maternal morbidity (SMM) was significantly higher among minority ethnic women compared to White British women. For example, Black African women had 1.48 times higher likelihood (AOR: 1.84, 95% CI: 1.70–1.99) and Pakistani women had 1.36 times higher likelihood (AOR: 1.36, 95% CI: 1.28–1.44). Another study by Chitongo *et al.*, (2022) highlighted that racism and stereotyping were noticed in interactions with minority ethnic women. Midwives reported bad assumptions about women's needs and resilience that shaped both communication and care quality. De la Cruz *et al.*, (2015) showed that Black patients 57% less likely to access specialist OCD services than White British women.

4.1.2 Limited availability of culturally appropriate information and support

A consistent finding across the studies (n=5) is that ethnic minority women often lacked access to maternity and perinatal support that was culturally and linguistically appropriate. Thomson *et al.*, (2022) demonstrated that while translated materials were nominally available, in practice most women received only English-language information. This not only hindered comprehension but also led to reliance on relatives, often children, to interpret sensitive and complex health advice, raising concerns about accuracy and privacy. Echoing this, Conneely *et al.*, (2023), who conducted semi-structured interviews

with Black and South Asian women accessing perinatal mental health services, found that the support offered frequently felt disconnected from their cultural worldviews. One woman remarked, *"the advice they gave me just didn't fit with how my family or community see things, so I didn't feel like it was for me" (pp:10).* This mismatch fostered mistrust and disengagement, with some women reluctant to seek further help amid cultural stigma around mental illness being misunderstood or ignored.

Thomson *et al.*, (2022) found that Muslim participants expressed significant discomfort with male providers, highlighting a need for services to better accommodate modesty requirements. Furthermore, faith could influence engagement with medical services. According to Chitongo *et al.*, (2022), providers often felt unprepared to discuss culturally specific practices, such as traditional dietary customs, rest, or postpartum rituals, and admitted that, to avoid "getting it wrong," they sometimes avoided these conversations altogether. One midwife reportedly noted that she "felt uneasy raising cultural topics" because she lacked adequate training or knowledge to do so respectfully. Ethnic minority women were disproportionately concentrated in these areas; for example, more than half of Bangladeshi women (51.1%) lived in the most deprived quintile.

4.2 Impact of ethnicity on mental health outcomes among ethnic minority women in the UK during the maternity period

Ethnic minority women in the UK experience disproportionately higher rates of perinatal depression, anxiety, and psychological distress then White British women (n=10 studies). They are also less likely to receive timely diagnoses or appropriate treatment. These challenges contribute to underdiagnosis, delayed care, and poorer health outcomes, underscoring the urgent need for culturally responsive approaches to perinatal mental health.

4.2.1 Higher prevalence of perinatal depression and anxiety among ethnic minority women

Women from ethnic minority were face significantly risks of poor perinatal mental health compared to White British women. Gibson-Smith *et al.*, (2015) found that ethnic women reported nearly double the prevalence of common mental disorders (CMDs) (39.0%) compared with migrant women in Uk like 21.7%19.1%, respectively. Similarly, Solomon *et*

al., (2022) reported that ethnic women like Black African and Black Caribbean women had significantly higher rates of distress, with adjusted odds ratios of 3.34 ($p<0.05$) and 4.81 ($p<0.01$) respectively, compared with White British women.

Pilav *et al.*, (2022) highlighted how women struggled with the pressure to embody resilience, often feeling that admitting distress was at odds with cultural ideals of strength. In addition, Thomson *et al.*, (2022) reported that 40.5% of women who experienced postnatal mental health difficulties felt unable to disclose their feelings, pointing to the combined effects of internalized stigma and inadequate avenues for supportive communication. However, population-level analyses suggest that the area is complex. In Wales, Saville, (2022) found that "ethnically diverse" groups reported comparatively better mental health outcomes than Anglophone Welsh and English groups.

4.2.2 Underdiagnosis and delayed treatment of maternal mental health conditions

Around five studies (n=6) comprehensively describe the underdiagnosis and delayed treatment of maternal mental health conditions. Ethnic minority women often experience underdiagnosis and delays in accessing treatment for perinatal mental health problems. Gibson-Smith *et al.*, (2015) emphasized the value of structured diagnostic interviews (e.g., SCID-I) over screening tools, showing that conditions such as PTSD are frequently overlooked among migrant women. Notably, insecure immigration status was associated with an exceptionally high risk of PTSD (OR = 29.08), reflecting unmet needs in detection and care.

Women's accounts underscored these diagnostic gaps. Conneely *et al.*, (2023) described participants' surprise at learning about specialist services only after GP referral, with one mother stating, "I didn't know there was anything like this until my GP referred me. Before that, I thought I just had to cope on my own" (pp:8). Delays in referral pathways were also reported, with some women describing repeated visits to their GP before being taken seriously Pilav *et al.*, (2022). These accounts align with survey data from Thomson *et al.*, (2022), which revealed that more than one-quarter of women were never asked about their mental health postnatally, despite UK guidelines recommending routine inquiry. Singh *et al.*, (2015) showed systemic disparities at the point of crisis: although duration of untreated psychosis did not vary significantly by ethnicity, Black patients were over four times more likely to be detained compulsorily than White patients (OR = 4.56).

4.2.3 Stigma and cultural barriers in acknowledging and seeking mental health support

Stigma and cultural expectations emerged as powerful barriers to recognizing and addressing perinatal mental health difficulties among ethnic minority women. Gibson-Smith *et al.*, (2015) found that migrant women with insecure immigration status were less likely to report major depressive disorder but more likely to present with PTSD, suggesting that cultural differences in symptom expression and help-seeking may obscure true prevalence.

Qualitative studies vividly illustrate these dynamics. Women reported struggling to reconcile cultural ideals of resilience with personal experiences of distress. One participant in Conneely *et al.*, (2023) reflected, “They don’t expect you to be weak… I’m Black and I’m Caribbean” (pp:12), while another described being told to “just pray” when disclosing symptoms, which reinforced feelings of isolation and discouraged further help-seeking. Similarly, Conneely *et al.*, (2023) state that “In the culture they don’t really believe in mental health… I just feel I get worse when people don’t understand me” (pp:14). Fear of judgment, being labelled “crazy,” or losing custody of children Pilav *et al.*, (2022) further prevented disclosure to healthcare providers.

4.3. Structural disparities influencing maternal health outcomes among ethnic minority women in the UK

Structural disparities are critical determinants of inequitable maternal health outcomes among ethnic minority women in the UK. Evidence from n=8 studies in this review highlights three interconnected subthemes: the compounding effects of socioeconomic deprivation, persistent language barriers and inadequate interpretation services, and disproportionate reliance on overstretched community and healthcare systems.

4.3.1. Socioeconomic disadvantage and neighbourhood deprivation

Socioeconomic disadvantage was a significant structural barrier that systematically limited access to timely and effective maternity care for ethnic minority women. Quantitative evidence from Gibson-Smith *et al.*, (2015) demonstrated that migrant women were significantly more likely to be unemployed (34.3% vs. 16.5% among UK-born women) and to report lower household incomes (<£15,000: 19.8% vs. 8.0%). This economic precarity

was directly associated with delays in accessing care, with 25.1% of migrant women booking late for antenatal care compared to 9.2% of UK-born women.

This deprivation operated at both individual and neighborhood levels. Geddes-Barton *et al.*, (2024) identified a linear trend demonstrating increasing risk of severe maternal morbidity (SMM) with higher levels of deprivation (p = 0.001), with women in the most deprived quintile experiencing greater risk (aOR = 1.13). Ethnic minority women were disproportionately concentrated in these areas; for example, more than half of Bangladeshi women (51.1%) lived in the most deprived quintile. Financial insecurity also limited engagement with perinatal mental health support, with women from households earning below £25,000 being less open to remote therapies than higher-income groups (53.4% vs. 65.6%) (Wang *et al.*, 2024).

4.3.2. Language barriers and inadequate interpretation services

A consistent finding across the studies (n=5) is that systemic failures in providing professional language support severely hindered equitable access to care. Gibson-Smith *et al.*, (2015) established the scale of the need, finding that approximately 14.1% of migrant women required interpreters. However, the provision of these services was inconsistent. While professional interpreters were provided for some languages (e.g., Bengali, Urdu), women speaking other languages reported that support was not reliably available, limiting effective communication with providers (Conneely *et al.*, 2023).

Midwives themselves acknowledged the critical role of interpretation but highlighted severe operational challenges. Chitongo *et al.*, (2022) found that staff often relied on ad-hoc methods, such as using bilingual colleagues, a practice that is not recommended due to difficulties accessing professional services. One midwife noted, “I have been lucky to care for people from my own country... I realize that if they understand what you are telling them, they cooperate with you” (pp: 16), underscoring how language comprehension is foundational to consent and cooperation. Conversely, the reliance on rushed, phone-based interpreters in emergencies was described as unsafe, with one participant stating it was “difficult to ascertain if it’s full consent you just don’t know” (pp: 18) (Chitongo *et al.*, 2022).

4.3.3. Disproportionate reliance on overstretched community services

Ethnic minority women often found themselves reliant on a system of community and health services that were fragmented, under-resourced, and unable to meet their specific needs. Women frequently reported long waiting times, inconsistent follow-up, and a sense of being “abandoned” by formal perinatal mental health services (Conneely *et al.*, 2023). These gaps in statutory provision led many to seek essential support from peer-led community groups (Pilav *et al.*, 2022).

Service pressures were perceived to compromise care quality, fostering a “tick-box” approach where overworked staff defaulted to stereotypes to manage high workloads (Saville, 2022). Evidence indicates that these systemic failures extend beyond maternity care. (Singh *et al.*, 2015) showed that Black patients were more likely to enter the system through criminal justice rather than healthcare pathways (OR = 2.60), highlighting a broader institutional neglect. Midwives also noted how structural instability, particularly for asylum seekers, disrupted care continuity, as women were frequently moved into temporary housing without the service being notified (Chitongo *et al.*, 2022).

4.4. Social disparities influencing maternal health outcomes among ethnic minority women in the UK

Social determinants are critical in shaping the maternity experiences and outcomes of ethnic minority women in the UK. Two key social subthemes emerged across the n=5 studies included in this review: the profound impact of social isolation and limited support networks, and the powerful influence of gendered cultural expectations and norms.

4.4.1. Social isolation and limited peer and family support

Ethnic minority and migrant women consistently experienced significant social isolation and a lack of support during the perinatal period, which directly contributed to poorer mental health and reduced access to care. Gibson-Smith *et al.*, (2015) found that migrant women showed significantly lower social support then white women (mean = 79.03 vs. 85.18). Solomon *et al.*, (2022) identifies that social isolation were relatively more frequent among Black African (60.1%) and Black Caribbean (52.2%) women than White British women (25.4%, p = 0.03).

Qualitative findings provided in depth to these statistics, revealing the mechanisms through which isolation operate. Women often concealed mental health struggles due to intense fear of judgment and stigma within their communities, a strategy that ultimately reinforced their loneliness and prevented help-seeking (Conneely *et al.*, 2023). In severe cases, mental illness could lead to family rejection, with women describing being excluded by their in-laws and left without crucial informal support (Pilav *et al.*, 2022). The practical consequences of lacking local family networks were also stark. Chitongo *et al.*, (2022) documented midwives' accounts of women who struggled to attend appointments due to childcare responsibilities, sometimes even having to bring toddlers to hospital visits, which compromised both their rest and their engagement with services.

4.4.2. Gendered cultural norms and expectations

The maternity experiences of ethnic minority women were powerfully shaped by cultural and gendered norms that could conflict with healthcare advice and discourage open communication with providers.

Religious and modesty norms also created specific barriers to care. Thomson *et al.*, (2022) found that Muslim participants expressed significant discomfort with male providers, highlighting a need for services to better accommodate modesty requirements. Furthermore, faith could influence engagement with medical services. One midwife participant stated, "Some women believe what is happening to them is spiritual... The women need education from the antenatal period to help them understand... complications which can be normally treated" (pp:12) (Thomson *et al.*, (2022). Women often concealed mental health struggles due to intense fear of judgment and stigma within their communities, a strategy that ultimately reinforced their loneliness and prevented help-seeking (Conneely *et al.*, 2023).

4.5. Healthcare-related disparities influencing maternal health outcomes among ethnic minority women in the UK

Healthcare system failures are fundamental drivers of inequitable maternal health outcomes for ethnic minority women in the UK. Two key subthemes emerged across the n=8 studies included in this review: systemic barriers to accessing timely and appropriate

prenatal and postnatal services, and a critical lack of care continuity that erodes trust in healthcare providers.

4.5.1. Inequitable access to prenatal and postnatal services

Ethnic minority and migrant women face significant and systemic barriers to accessing timely and appropriate maternity care. Quantitative evidence highlights patterns of delayed engagement. Gibson-Smith *et al.*, (2015) found higher rates of unplanned pregnancy (41.7% vs. 27.1%) and late antenatal booking among migrant women, indicating gaps in preconception and early prenatal support. This was qualitatively echoed by Thomson *et al.*, (2022), who reported that more than a quarter of women in their study accessed care after 12 weeks, with multiparous women often feeling abandoned and "on their own."

Access to perinatal mental health support was particularly limited. A consistent finding across studies was a profound lack of awareness of available services. Conneely *et al.*, (2023) found that among 37 interviewed women, only 5 were aware of perinatal mental health support before seeking care. One Black American woman stated, “I didn’t actually know that the service existed,” while a Black Caribbean participant remarked, “I’ve never heard of a ‘Perinatal Team’ before... I asked her if she’s heard of it, and she said no” (pp: 13). This lack of awareness was the primary obstacle to seeking help. Structural barriers, such as reliance on self-referral systems, further restricted access, particularly for British Asian women (Pilav *et al.*, 2022). These access issues are reflected in national data, De la Cruz *et al.*, (2015) and Mercer *et al.*, (2019) showed an underrepresentation of Black/Black British women in both community and specialist mental health services, suggesting a systemic failure beyond maternity care.

4.5.2. Lack of continuity of care and erosion of trust

A critical barrier to equitable care was the widespread lack of continuity, which directly undermined trust and engagement between ethnic minority women and healthcare providers. Distrust was frequently reported and was often rooted in prior experiences with dismissive, disrespectful, or culturally insensitive staff (Pilav *et al.*, 2022). Women described feeling "abandoned" when referrals were not followed up or services were unresponsive, leading to disengagement. The challenges of accessing primary care further eroded confidence. One Asian Bangladeshi woman contrasted the difficulty of getting a GP appointment with the responsiveness of the perinatal mental health team, stating, “If I don’t get any help, I stop calling them but in perinatal... if I need any help, they

try to solve my problem. So, I feel safe" (pp:14) (Conneely *et al.*, 2023). This quote highlights how positive, reliable experiences are essential for building the trust necessary for ongoing engagement. Some women reported resorting to masking aspects of their cultural identity to avoid anticipated bias, a strategy that reflects a deep-seated lack of trust in the system's fairness (Silverio *et al.*, 2023).

4.6. The influence of intersecting factors on access and experience of maternal and mental health services

The access to and experience of maternity and mental health services for ethnic minority women in the UK are profoundly shaped by a complex interplay of social, economic, and structural factors. Across the n=7 studies included in this review, two key subthemes emerged: the compounding risks and protective effects created by the intersection of migration status and socioeconomic position, and the pervasive impact of racism, discrimination, and poverty on maternal wellbeing.

4.6.1. Intersecting vulnerabilities of migration status and socioeconomic position

The intersection of ethnicity with migration status and socioeconomic position creates complex and sometimes counterintuitive patterns of risk and protection for maternal mental health. Quantitative evidence reveals these nuances. Gibson-Smith *et al.*, (2015) identified a significant protective effect against common mental disorders (CMDs) for non-white migrant women (OR = 0.31) compared to their UK-born ethnic minority counterparts, suggesting the presence of a potential "healthy migrant effect."

Socio-cultural contexts further differentiate experiences. (Singh *et al.*, 2015) found significant differences in social and religious contexts, with Black and Asian patients reporting markedly higher rates of religious practice (54.3% and 74.4%, respectively) compared to White patients (15.6%), a factor that can influence coping mechanisms and help-seeking pathways. Conversely, social isolation emerged as a distinct concern, with Black patients being substantially more likely to live alone (48.6%) than Asian (9.3%) or White (17.8%) patients, potentially exacerbating isolation and creating practical barriers to accessing support.

4.6.2. The pervasive impact of racism, discrimination, and poverty

Racism, discrimination, and socioeconomic deprivation were identified across studies as fundamental drivers of disparities in maternal mental health experiences and outcomes. Although not always explicitly measured in every study, their impact was consistently inferred through disproportionate outcomes and women lived experiences. For instance, the highest prevalence of common mental disorders (CMDs) was found among UK-born non-white women (Gibson-Smith *et al.*, 2015), a finding suggestive of the deleterious effects of lifelong exposure to systemic inequities and cumulative discrimination, in contrast to the more recent exposure of migrant groups.

A pervasive and deeply rooted mistrust of health and social services was a significant barrier to care, particularly among Black women. This distrust was frequently rooted in the tangible fear of child removal and was explicitly linked by women to a legacy of historical and institutional racism (Conneely *et al.*, 2023). For example, some women brought advocates or doulas to appointments to mitigate anticipated bias and ensure their voices were heard (Silverio *et al.*, 2023). These strategies highlight the immense emotional labor required of women to navigate a system they perceive as hostile.

4.7. Barriers and facilitators to the effectiveness of maternal health services

The effectiveness of maternal health services for ethnic minority women in the UK is contingent upon their ability to overcome significant barriers and leverage key facilitators. Across the n=8 studies included in this review, three key subthemes emerged: systemic and cultural obstacles that hinder access and engagement, the critical role of community-based and peer support, and the importance of a culturally competent and representative workforce.

4.7.1. Systemic, cultural, and logistical barriers to access

Ethnic minority women face a complex array of systemic, cultural, and practical barriers that deter engagement with maternal health services. A consistent finding across studies was that cultural misunderstandings and a lack of cultural awareness among providers eroded trust. Women reported that clashes between biomedical explanations of distress and their own spiritual or faith-based beliefs created a fundamental disconnect, deterring them from seeking support (Singh *et al.*, 2015; Conneely *et al.*, 2023). This was

compounded by providers making incorrect assumptions; as one participant noted, statements like “nowadays women can go to university” created feelings of being stereotyped and mistrusted (Thomson *et al.*, 2022). These negative experiences were not isolated to maternity care. Mercer *et al.*, (2019) and Pilav *et al.*, (2022) found that poor communication and a lack of cultural sensitivity in primary care further undermined trust, creating a cycle of disengagement from services. Beyond interpersonal interactions, significant practical and systemic obstacles persisted. Quantitative data from Wang *et al.*, (2024) showed that attitudinal barriers, such as a dislike of discussing emotions (19.5%), intersected with instrumental barriers like financial costs (18.1%).

4.7.2. The facilitating role of community-based services and peer support

In contrast to formal health services, community-based support and peer networks were consistently identified as vital facilitators of engagement and wellbeing. Women frequently emphasized the value of support that was culturally sensitive and community embedded. The provision of trained interpreters and the use of translated diagnostic tools were recognized as essential, foundational efforts to make services more inclusive (Geddes-Barton *et al.*, 2024). However, when such adaptations were absent, language barriers remained a formidable obstacle.

Faced with these gaps in formal provision, women often turned to informal networks. Wang *et al.*, (2024) found that social networks, including family, friends, and workplace connections, were often preferred over formal health services. For some women, peer support groups provided a sense of shared experience, belonging, and cultural understanding that was perceived as lacking in professional care. This was particularly powerful when support was delivered by facilitators from similar cultural or religious backgrounds, making it feel more relevant and sensitive to their lived reality.

4.7.3. Culturally competent care and a representative workforce

The presence of culturally competent and empathetic staff was a cornerstone of effective care. For many women, having a clinician who shared their ethnic background was a significant factor in building trust and improving engagement, particularly among Black British and Arab participants (Pilav *et al.*, 2022). Silverio *et al.*, (2023) described how participants struggled to maintain agency during labour, with one woman stating, *“they started talking about induction and I said I don’t want one… [they] booked it anyway” (pp:4).* Similarly, Pilav *et al.*, (2022) found that Black women’s pain and concerns were

frequently minimised, with some noting they were “seen as strong” and therefore ignored. Thomson *et al.*, (2022), showed that around 34% of women reported being treated differently due to ethnicity, and 31.9% said staff made incorrect behaviour with them. More than a quarter (25.3%) also reported that dietary needs were only partly met or unmet.

4.8. Driving factors and barriers for mental health services for ethnic minority women

A comprehensive and well-functioning care is basic needs for a pregnant woman for the betterment of health conditions of the mothers. These themes were found across the n=8 studies included in this review, which is further classified into two subtheme: i) the pervasive impact of stigma, lack of awareness, and limited specialist services; ii) the importance of integrating mental health support within maternity care.

4.8.1. Stigma, lack of awareness, and systemic service limitations

Women often reported that there found the limited amount of culturally inclusive care (Pilav *et al.*, 2022). This lack of cultural safety was exacerbated by a shortage of diverse professionals. While many women expressed a strong desire for clinicians who shared their background, noting that it improved comfort and trust, as one Black Caribbean woman stated, “I would like to see more practitioners of color... it makes people feel more comfortable” (pp: 16) this was not a universal solution (Conneely *et al.*, 2023). For some, shared ethnicity could itself be a barrier due to fears of judgment and breached confidentiality within close-knit communities. One Asian Indian woman explained her distress at having a Punjabi therapist, fearing, “she might know my in laws... That was a nightmare for me” (pp: 15) (Conneely *et al.*, 2023).

This fear of judgment extended beyond clinicians to families and communities, where stigma often prevented open acknowledgement of distress and delayed help-seeking (Chitongo *et al.*, 2022; Pilav *et al.*, 2022). In some cases, cultural insensitivity from providers left women feeling isolated and misunderstood, with one Arab participant describing a lack of appropriate support as a single mother (Thomson *et al.*, 2022). The consequences of these barriers are systemic. Solomon *et al.*, (2022) found that for Black African and Caribbean women, stigma, poor cultural competency, and a sheer lack of specialist services all contributed to reduced access. Quantitative evidence from Wang *et*

al., (2024) confirmed that while knowledge was the strongest predictor of intention to seek care, stigma and negative attitudes remained significant deterrents.

4.8.2. Integration of mental health support within maternity services

A central facilitator for improving access and trust is the integration of mental health support within routine maternity care pathways. Women consistently reported that embedded support improved both accessibility and perceived safety. Quantitative evidence from Gibson-Smith *et al.*, (2015) demonstrated the utility of integrated screening, such as using the SCID-I in antenatal settings. Qualitatively, women praised small but significant accommodations that demonstrated cultural respect, such as clinicians adjusting medication schedules during Ramadan, which made care feel respectful and safe (Conneely *et al.*, 2023).

Proactive, integrated approaches were identified as key to overcoming barriers. Advocacy from midwives was reported as a critical protective factor, creating emotional safety and improving engagement (Silverio *et al.*, 2023). Similarly, integrated referrals for practical support with housing and finances, coupled with the availability of peer support, were highlighted as facilitators of positive experiences (Solomon *et al.*, 2022). Innovative service models showed particular promise. Wang *et al.*, (2024) found that more than half of women expressed willingness to use remote therapies, suggesting digital interventions could help overcome barriers related to stigma, transport, and childcare.

Chapter 5: Discussion

This systematic review demonstrated the impact of ethnicity on maternity and perinatal mental health outcomes faced by ethnic minority women in the UK. Our review study highlighted around eight concise themes that illustrate how disproportionately they suffer from perinatal mental health and adverse maternal outcomes. The analysis reveals that inequities are not only due to random factors but also to systematic ones, stemming from a complex interplay of interpersonal, systemic, and structural factors. The key findings indicate that ethnic minority women face a disproportionate burden of adverse outcomes, driven by experiences of discrimination, cultural insensitivity, systemic barriers to access, and the powerful influence of social determinants like isolation and gendered norms.

5.1 Relation to theoretical frameworks

The review highlights that discrimination, structural racism, cultural sensitivity, language barriers, and the role of social isolation have been described with our tripartite theoretical framework. First, the intersectional framework reflects the critical understanding that the experience of ethnic women cannot be defined solely by the ethnicity factor (Crenshaw, 2013; Bauer *et al.*, 2021). The interlinking of racism, discrimination, and social barriers caused their maternal and mental health outcome. For example, Pilav *et al.*, (2022) reported that Black women's pain and concerns are frequently dismissed or overlooked, which leads to poorer care experiences and lower levels of satisfaction. This factor is a clear demonstration of racism in healthcare access. Study also found that a wide range of women from ethnic communities report experiencing discrimination and unfair treatment in maternity services (MacLellan *et al.*, 2022a; Obionu *et al.*, 2023). Secondly, another model, the Social Determinants of Health (SDH) model, helps explain the intersectional experiences and wide range of structural inequities faced by ethnic minority women. The unequal health outcomes because of socioeconomic conditions, language inequalities, and culturally insensitive access to care can be explained by the SDH framework. For example, Women from ethnic minorities often face unequal access to healthcare because of racial discrimination and economic inequalities (Watson *et al.*, 2019a).

5.2 Summary of Findings

This systematic review highlights that ethnic women faced higher amount of perinatal mental health problems and mental health problems compared to white people. They have

been found to have higher rates of maternal and infant mortality compared to white people. Ethnic minority women disproportionately suffer from depression and anxiety. The findings reveal that maternity services were often disrupted by discrimination, cultural insensitivity, structural and social barriers, and systemic failures in healthcare access. Ethnic minorities have reported discrimination in access, stereotyping, and cultural insensitivity from healthcare staff in accessing proper health care. These factors diminished their trust and satisfaction with the healthcare system. Sometimes they did not find any culturally appropriate information about health conditions, which also limits their access to care. In addition, in some cultures, maternity and mental health issues were not given good attention, or there were cultural taboos, which may be other reasons for poor health outcomes in ethnic minority women.

Furthermore, Stigma and cultural norms exacerbate barriers to accessing healthcare and influence perceptions about health-seeking behavior. Importantly, Structural and social determinants significantly influence these outcomes. Various factors, including sociodemographic status, language barriers, inadequate language interpretation, and social isolation, exacerbate their limited access to timely and effective care. Furthermore, healthcare system failures, such as a lack of continuity of care and inequitable access, also impact it. The confluence of migration status, socioeconomic position, and experiences of racism creates complex vulnerabilities, which make women more vulnerable in society.

The study highlighted that the impact of ethnicity on maternity experiences among ethnic minority women in the UK is driven by multifaceted issues, such as perceived discrimination and cultural insensitivity, limited availability of culturally appropriate information and support, and variations in birth satisfaction and gaps in patient and provider communication. During pregnancy, labor and delivery, and postpartum care, they were less likely to have felt that staff members respected them and spoke to them in a way that they could understand (Redshaw *et al.*, 2007). Ethnic minority and immigrant service consumers do not have equitable access to sufficient information regarding maternity care (De Freitas *et al.*, 2020). Local healthcare systems may not be able to fulfill those wishes (De Freitas *et al.*, 2020). Some studies in other countries found that a significant number of women from ethnic groups report experiencing discrimination and unfair treatment within maternity services. They often have limited knowledge regarding the variety of treatments available and which may be best suited for them (MacLellan *et*

al., 2022a; Obionu *et al.*, 2023). A study carried out in the USA found that the likelihood of reporting significant shared decision-making was lower among Black women (Attanasio *et al.*, 2018). This is mainly due to several key factors. For ethnic minority women, woman-centered midwifery is frequently the exception due to overstretched "technocratic" systems, which diminish continuity and confidence (Henderson *et al.*, 2013). Gaps in cultural competency: Employees report receiving little instruction on religion and cultural customs, and they ask for programs that help them apply their knowledge in practice (Hassan *et al.*, 2019). Information and access infrastructure: limited targeted prenatal programs, uneven documentation of cultural needs, and inadequate interpretation services hinder individualized treatment (Garcia *et al.*, 2015). This emphasizes that the system's inability to deliver fair, person-cantered care is the issue, not the women. As a result, there is a need to strengthen community-based support systems, including partnerships with organizations representing minority groups, which can enhance trust and provide culturally tailored antenatal education, peer-led programs, and language support services (Dada *et al.*, 2021).

This review identified that woman faces significant systemic barriers in accessing timely and appropriate care. This finding is align with previous studies that showed the inequities in maternal mental healthcare among ethnic women (Edge, 2010; Knight *et al.*, 2023). A study on Netherlands reported that refugee women's experiences with reproductive care are impacted by both their gender and position (Ascoly *et al.*, 2001). Refugee women disclosed communication difficulties, informational demands, and significant financial and legal worries that influence their experiences during pregnancy and childbirth. Accessibility issues and a lack of consultation time are two of the health care system's weaknesses (Ascoly *et al.*, 2001). These factors limit access to timely and appropriate care, leading to persistent disparities. In addition, ethnic women face stigma and cultural expectations emerged as powerful barriers to recognizing and addressing perinatal mental health difficulties among ethnic minority women. Racial and ethnic discrimination is considered the most common in Europe. A study indicated that 64% perceived racial discrimination to be common (Eurobarometer, 2015). It is a significant obstacle to achieving equitable access to maternal healthcare services.

The review reported that ethnic women had disproportionately higher rates of perinatal depression, anxiety, and psychological distress compared with White British women. This result is consistent with a previous study carried out in USA found that ethnic women suffer

from more severely from physiological distress then other group of people (Breslau *et al.*, 2005). Another study found that ethnic minorities are less likely to obtain necessary mental health care than White Americans (Nadeem *et al.*, 2008). A meta-analysis revealed that BAME moms experienced significantly greater levels of depression (SMD = 1.5) and anxiety and stress (Delanerolle *et al.*, 2022). Another study carried out in California, USA reported that Black women had more depression symptoms during pregnancy but were less likely than White women to get counseling or medication after childbirth (Estriplet *et al.*, 2022). There may be some reasons behind it including lower access to community care, preterm birth and clinical vulnerability and cultural, family, and stigma-related barriers. Limited access to resources, poverty, housing/financial pressures, and fragmented healthcare systems have consistently been associated to increased psychological distress among minority perinatal mothers (Estriplet *et al.*, 2022). These barriers can overcome with culturally appropriate mental health care and their barrier free access to all group of people despite any kind of racism and discrimination. In addition, there need to be prioritize high-risk subgroups people who are mostly suffer from this mental problem.

The study demonstrated that structural disparities were a very common phenomena of inequitable maternal health outcomes among ethnic minorities. This may be caused by mixed effects of socioeconomic disadvantages, persistent language barriers and inadequate interpretation services, and the disproportionate belief on overstretched healthcare systems. These findings is persistent with previous study which demonstrated that women from various ethnic backgrounds often face economic hardships, lower levels of educational attainment, and limited employment opportunities (Wallace, *et al.*, 2016). There needs to be increase in the co-production and implementation of culturally competent training for healthcare professionals. In addition, incorporates a community-based, peer support programmed led by and for ethnic minority women.

Racism and discrimination present significant obstacles to achieving equitable access to maternal healthcare services. Studies shown that medical professionals sometimes neglect pain complaints, cultural expressions, social values, or information from minority individuals (MacLellan *et al.*, 2022a; Obionu *et al.*, 2023). According to research on Canadian women, communication barriers, a lack of knowledge, social isolation, cultural attitudes, insufficient health care resources, and the expense of medications and services are the main obstacles that immigrant women face while trying to obtain and navigate

maternity services in Canada (Heslehurst *et al.*, 2018). These incidents erode trust, complicate collaborative decision-making, and foster feelings of dread and dehumanization during one of life's most sensitive times. A majority of Black women in the UK have reported experiencing bias from healthcare providers based on their race, with younger individuals demonstrating higher levels of discrimination (Swords et al., 2022). Around sixty-five percent of Black respondents indicated that they had encountered racist attitudes or actions from medical professionals, which rose to 75% among Black adults (Iacobucci, 2022). Marginalized ethnic populations experience poorer maternity and newborn health outcomes (Hollowell *et al.*, 2012; Khan, 2021). For instance, women from minority ethnic groups are more likely to experience preterm births, stillbirths, or the death of a newborn (Knight *et al.*, 2018). This review also highlighted the significant social disparities that were a key contributor. Similarly, research by Higginbottom *et al.*, (2013) demonstrated the critical role of social support as a fundamental social determinant of health for migrant women. Social isolation, often exacerbated by migration status, language barriers, and disconnection from traditional kinship networks, deprives women of the practical and emotional buffering that support systems provide against stress and poor health outcomes (Phillimore, 2016). Concurrently, cultural norms, such as prioritizing family needs over maternal autonomy or discouraging the expression of health concerns due to a sense of duty or stoicism would inhibit women from seeking timely and appropriate medical care (MacLellan *et al.*, 2022b). A multi-level strategy that simultaneously strengthens social support structures while transforming healthcare services to be genuinely inclusive and responsive to the needs of an ethnically diverse population.

This analysis identifies that disparities within the healthcare system create barriers that make it hard for some groups to get proper care on time, and the lack of consistent follow-up care causes people to lose trust in health services. Non-English-speaking ladies had trouble getting information because of poor communication with medical staff. Somali women said that health workers' harsh and biased attitudes prevented them from accessing information (Davies and Bath, 2001). There might be some other reasons behind this including complex booking systems, inflexible appointment scheduling, language and communication gaps, and a lack of culturally competent care, that actively impede timely engagement with health services. This results in delayed diagnosis and management of complication (NHS England, 2022).

Therefore, to overcome this serious problem in maternity band mental health outcomes in ethnic women, two comprehensive policies should be Implemented.

1. There should established a top-down structural reforms in maternity services that mandate anti-racism and cultural safety training
2. A bottom-up initiative is essential which includes the formal integration and sustainable funding of community-led support programs as a fundamental part of an equitable maternity healthcare system.

5.3 Review strengths and limitations

This systematic review presents rigorous and comprehensive outcomes of ethnic women faced in terms of maternal and mental health outcomes. While most previous studies have typically focused on either maternal health or mental well-being, this review highlights their interconnectedness, providing a more holistic understanding of maternal experiences. Second, the review employed a systematic approach guided by the PRISMA framework, thereby enhancing methodological rigor and transparency. Additionally, a well-structured and comprehensive search strategy has been employed across multiple databases to identify a wide range of relevant studies. Importantly, the inclusion of both quantitative and qualitative peer-reviewed studies makes it more comprehensive and increases its strength.

However, this review has some limitations. First, the review included only studies conducted within the UK. While this allowed for a focused exploration of the UK context, it limits the generalizability of the findings to other regions, such as those worldwide. Second, only studies published in English and within the last ten years were considered. The study did not conduct any statistical analysis, such as a meta-analysis, as it employed both quantitative and qualitative methods. The study, which was published in a different language, was not included in our analysis. A longitudinal cohort study can be conducted in the future to evaluate the long-term impact of perinatal experiences on the maternal healthcare service and health outcomes of ethnic minority women.

Chapter 6: Conclusion

In conclusion, this review shows that the experience of maternity care for ethnic minority women in the UK is greatly influenced by inequity. The findings demonstrated the underscore the roots of these issues in structural racism and intersecting social factors. The study highlighted the perceived discrimination, systemic barriers, and social isolation which create barriers to equitable maternity outcomes. This means transformations from simply providing services to a culturally inclusive, anti-racism, and fostering good connection with communities. To achieve equitable maternity care for all women in the UK, targeted structural interventions are necessary.

Women often concealed mental health struggles due to intense fear of judgment and stigma within their communities, a strategy that ultimately reinforced their loneliness and prevented help-seeking. This review reflects the complex, interlocking mechanisms interpersonal, cultural, structural, and social system that actively manufacture these disparities. The review reveals a corrosive experience of othering and discrimination. Women consistently reported feelings of disempowerment, dismissal, and reduction to stereotypes by healthcare professionals. This cultural insensitivity, whether explicit or arising from unconscious bias, erodes trust at a time of heightened vulnerability. Furthermore, this review reflects that ethnic minority women in the UK face disproportionately higher risks of perinatal depression, anxiety, and psychological distress. But they remain less likely to receive timely diagnoses or treatment.

Structural barriers, underdiagnosis, and inequities in care intersect with stigma, cultural expectations, and mistrust of healthcare services. Black African women were significantly less likely to receive a depression diagnosis than White British women and correspondingly less likely to use antidepressant medication. Deep-rooted stigma within many communities, often internalized as pressure to embody resilience and suppress suffering exemplified by narratives such as the "strong Black woman" trope creates an internal barrier to help-seeking. This challenge is exacerbated by an external healthcare system that is ill-equipped to recognize symptoms within diverse cultural frameworks, lacks awareness of its own specialist services, and fails to offer pathways that are perceived as safe, relevant, or trustworthy.

Moreover, patient–provider communication is a central determinant of birth satisfaction for ethnic minority women. Positive communication, characterized by listening, cultural

responsiveness, and inclusion in decision-making, enhanced satisfaction even in the context of clinical challenges. Addressing disparities in birth satisfaction therefore requires systematic efforts to improve midwives' and maternity staff's cultural competence, promote shared decision-making, and prioritize empathetic engagement. This review underscores the necessity of employing an intersectional lens. Ethnic minority and migrant women had poorer mental health and reduced access to care. Quantitative evidence established the scale of this issue. Factors such as migration status, English language proficiency, religion, and the presence or absence of local family support networks intersect with ethnicity to create unique landscapes of risk and protection.

6.1 Recommendations

To translate the findings of this systematic review into tangible improvements in care and outcomes, the following specific and actionable recommendations are proposed for key stakeholder groups.

6.1.1. For National Policymakers

I. Mandate Standardized Anti-Racism Training: Issue a national mandate requiring all maternity and perinatal mental health staff to complete a certified, annual training programmed on anti-racism and cultural safety, co-designed and delivered by experts from ethnic minority backgrounds.

II. Implement a Targeted Workforce Strategy: Launch a national recruitment drive to increase ethnic minority representation in midwifery, health visiting, and perinatal psychology. This should include funded scholarship programs and clear career progression pathways to support retention.

III. Commission Integrated Care Pathways: Use financial incentives to reward NHS Trusts for successfully integrating perinatal mental health specialists into routine maternity appointments and for demonstrably co-producing service designs with local ethnic minority community groups.

6.1.2. For Healthcare Providers

I. Establish Transparent Reporting Mechanisms: Create and promote an easy-to-use, anonymized digital platform for staff and service users to report incidents of racial discrimination or cultural insensitivity. Ensure a guaranteed feedback loop within 28 days regarding the actions taken.

II. Scale Up Continuity of Carer Models: Prioritize the implementation of continuity of midwife models. Set and publish annual targets for the percentage of ethnic minority women who receive care from a known midwife throughout their pregnancy and postnatal period.

III. Develop Accredited Patient Resources: Commission a centralized digital library of patient information resources that are multilingual, audio-visual, and co-produced with target communities to ensure they are culturally appropriate and enhance health literacy. All materials should include a quality assurance kitemark.

6.1.3. For Frontline Clinicians and Practitioners

I. Practice Cultural Humility: Cultivate an approach of cultural humility, a lifelong commitment to self-evaluation and critique, redressing power imbalances, and developing mutually beneficial partnerships.

II. Act as a Proactive Advocate: Formally document and act as the key advocate for patients facing barriers, taking direct responsibility for booking interpreters, escalating concerns about dismissive treatment, and ensuring care plans are individually tailored and understood.

6.1.4. For Future Research

I. Intervention-Based Studies: Designed and conducted intervention studies based on different types of strategies to see effectiveness of the intervention. Priorities research funding for robust trials evaluating the efficacy of specific interventions, such as the impact of continuity of carer on birth outcomes for Black women or the effectiveness of digital CBT tools tailored for South Asian women.

II. Conduct Longitudinal Cohort Studies: Develop a dedicated longitudinal cohort study to track the long-term impact of perinatal experiences on the mental and physical health of ethnic minority women and their children, controlling for socioeconomic and intersectional factors.

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Appendix 1

Dataset link: The dataset excel file can be found with the following link: https://docs.google.com/spreadsheets/d/10uEDuveSp1-wfArM72nEaYfr3MTpfUibfgkR1etb-ao/edit?usp=sharing

Appendix 2

Critical Appraisals

CASP (2024) Critical Appraisal Tool for Qualitative Research

Question	**Studies**			
	(Conneely *et al.*, 2023)	(Pilav *et al.*, 2022)	(Sergio A Silverio	(Chitongo *et al.*, 2022)

			et al., 2023)	
Was there a clear statement of the aim of the research?	Y	Y	Y	Y
Is qualitative methodology appropriate?	Y	Y	Y	Y
Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y
Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	Y
Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y
Has the relationship between researcher and participants been adequately considered?	Y	Y	Y	Y
Have ethical issues been taken into consideration?	Y	Y	Y	Y
Was the data analysis sufficiently rigorous?	Y	Y	Y	Y
Is there a clear statement of findings?	Y	Y	Y	Y
How valuable is the research?	8	9	7	6

JBL (2017) critical appraisal checklist for analytical cross-sectional studies.

Questions	**Studies**							
	(Solomon *et al.*, 2022)	(Wang *et al.*, 2024)	(Saville, 2022)	(Cook *et al.*, 2019)	(Singh *et al.*, 2015)	(Mercer *et al.*, 2019)	(Gibson-Smith *et al.*, 2015)	(Thomson, Cook, Crossland, M. C. Balaam, *et al.*, 2022)
Were the criteria for	Y	Y	Y	Y	Y	Y	Y	Y

inclusion in the sample clearly defined?								
Were the study subjects and the setting described in detail?	Y	Y	Y	Y	Y	Y	Y	Y
Was the exposure measured in a valid and reliable way?	Y	Y	Y	Y	Y	Y	Y	Y
Were objective, standard criteria used for measurement of the condition?	Y	Y	Y	Y	Y	Y	Y	Y
Were confounding factors identified?	Y	Y	Y	Y	Y	Y	Y	Y
Were strategies to deal with confounding factors stated?	Y	Y	Y	Y	Y	Y	Y	Y
Were the outcomes measured in a	Y	Y	Y	Y	Y	Y	Y	Y

valid and reliable way?								
Was appropriate statistical analysis used?	Y	Y	Y	Y	Y	Y	Y	Y

JBL (2017) Critical Appraisal Checklist for Cohort studies

Questions	**Studies**		
	(Bamber *et al.*, 2023)	(Geddes-Barton *et al.*, 2024)	(Fernandez de la Cruz *et al.*, 2015)
Were the two groups similar and recruited from the same population?	N	N	N
Were the exposures measured similarly to assign people to both exposed and unexposed groups?	N/A	N/A	N/A
Was the exposure measured in a valid and reliable way?	Y	Y	Y
Were confounding factors identified?	Y	Y	Y
Were strategies to deal with confounding factors stated?	Y	Y	N
Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)?	N/A	N/A	N/A
Were the outcomes measured in a valid and reliable way?	Y	Y	Y
Was the follow up time reported and sufficient to be long enough for outcomes to occur?	N/A	N/A	N/A

Was follow up complete, and if not, were the reasons to loss to follow up described and explored?	N/A	N/A	N/A
Were strategies to address incomplete follow up utilized?	N/A	N/A	N/A
Was appropriate statistical analysis used?	Y	Y	Y

Overall Appraisal (key points) of all studies (Source: CASP, 2024) – with examples

APPRAISAL SUMMARY: Key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.			
Studies	**Positive/Methodologically sound**	**Negative/Relatively poor methodology**	**Unknowns**
(Bamber *et al.*, 2023)	Large sample size, well structured; consistent exposure measurement (ethnicity) using standardised HES categories; outcome	Potential misclassification bias from hospital coding; Observational design limits causal inference	No qualitative exploration of underlying causes for observed disparities; Unclear whether differences in anaesthetic care are associated with downstream maternal or neonatal health outcomes
(Gibson-Smith *et al.*, 2015)	Diverse sample size; Used standard diagnostic interviews (SCID-I) for mental health assessment; Robust statistical methods	Cross-sectional design limits causal inference; Potential recall bias in self-reported data (e.g., trauma, immigration status); Small	Long-term mental health outcomes post-pregnancy; Underlying mechanisms (e.g., discrimination, access to care); Cultural variations

		subgroup sizes in stratified analyses	in mental health expression.
(Conneely *et al.*, 2023)	Included diverse sample group; Used rigorous methodolology; Identified actionable barriers (e.g., stigma, mistrust) and facilitators; Highlighted how ethnicity, culture, and migration intersect to shape care experiences.	Participants were already engaged with PMHS, potentially missing those who disengaged due to negative experiences; Remote interviews during COVID-19 may have influenced responses	Long-term impact of PMHS engagement on maternal/child outcomes; Effectiveness of recommended interventions; Experiences of women who never accessed PMHS despite need.
(Thomson, Cook, Crossland, M. C. Balaam, *et al.*, 2022)	Appropriate design for exploring lived experiences of minority ethnic women; Thematic analysis rigorously conducted with inter-rater reliability checks; Ethical approval obtained, with informed consent	Small sample size (N=18) limits transferability of findings; Telephone interviews (due to COVID-19) may have reduced rapport and depth of responses.	Long-term engagement with perinatal services post-intervention is unclear; cultural humility training on service delivery was not empirically tested.
(Pilav *et al.*, 2022)	Mixed-methods design (survey, interviews, community consultations) provides comprehensive insights; Diverse sample (104 participants from minoritised ethnic backgrounds) captures varied perspectives; Equity lens explicitly addresses systemic racism and discrimination, aligning with	Potential for recall bias (e.g., experiences of discrimination over a 2-year period); Some ethnic groups (e.g., Black, Arab) had very few participants, limiting representativeness.	Long-term impact; Findings focus on North-West England; relevance to other UK regions or countries with different healthcare systems is uncertain.

	contemporary health equity goals.		
(Sergio A Silverio *et al.*, 2023)	Rigorous qualitative methodology: Representation across multiple minority ethnic groups (e.g., Black, Asian, Mixed) captures varied perspectives; Clear Theoretical Contribution	Small Sample Size, 14 participants, though saturation was achieved; Participants skewed toward older (mean age 36), educated women; Potential recall bias in retrospective accounts of maternity experiences.	Whether findings can drive policy shifts in NHS maternity services remains untested; discrimination directly correlates with adverse maternal outcomes.
(Singh *et al.*, 2015)	Diverse Sample: Included White, Black, and Asian participants, allowing for cross-ethnic comparison; Comprehensive Measures: Used validated tools (e.g., Nottingham Onset Schedule) and developed the EPAS to assess culturally mediated illness attributions; Statistical Rigor: Controlled for multiple confounders (e.g., DUP, religious practice) in logistic regressions.	Small Sample Size: 123 participants (45 White, 35 Black, 43 Asian); Selection Bias: Low recruitment rate (26% of patients); excluded severely ill or non-engaging patients; Retrospective Data: Illness attributions and service encounters relied on recall, potentially introducing bias.	Why supernatural attributions predict faith-based help-seeking more strongly in Asians than Blacks remains unclear; Migrant generation's role in pathways was unexplored due to sample constraints.
(Solomon *et al.*, 2022)	Large sample size (n=724) with ethnically diverse participants, enhancing generalizability for older women with HIV in the UK; Used validated tools (PHQ-	Cross-sectional design limits causal inference; Sampling bias: Only included women attending HIV clinics, excluding	Long-term trends in mental health/socioeconomic outcomes are unknown; Impact of structural racism on healthcare

	4, Duke-UNC scale) for mental health and social isolation; Intersectional framework addresses multiple social determinants (ethnicity, gender, HIV status).	those not engaged in care; Lack of data on key variables (e.g., HIV stigma, racism, detailed income), which could further explain disparities.	access is inferred but not directly measured; Cultural competency of mental health services was not evaluated.
(Geddes-Barton *et al.*, 2024)	Large, nationally representative sample (1,178,756 primiparous women) enhances generalizability; Used English National Hospital Episode Statistics (HES APC), a comprehensive administrative database; Employed the English Maternal Morbidity Outcome Indicator (EMMOI) for severe maternal morbidity (SMM); Adjustment for confounders	Area-based deprivation (IMD) may not reflect individual-level socioeconomic status; Missing data: Some covariates (e.g., racism, care quality) were unmeasured, potentially biasing results; Cross-sectional design: Limits causal inference between deprivation/ethnicity and SMM.	Unclear how chronic stressors (e.g., systemic racism) manifest as SMM over time; Mechanisms: Pathways linking deprivation/ethnicity to SMM (e.g., healthcare discrimination) remain unexplored; ntervention efficacy: No data on whether targeted policies reduce disparities.
(Wang *et al.*, 2024)	Large, nationally representative sample (16,835 participants) with quotas for gender, age, ethnicity, and regional coverage; Used PHQ-2, GAD-2, MAKS, CAMI, and BACE scales to measure mental health symptoms, knowledge, attitudes, and barriers; Multilevel	Quota sampling may introduce selection bias, despite efforts to match population demographics; Reliance on self-reported measures (e.g., care-seeking intention) may be affected by recall or social desirability bias;	Stability of geographical disparities over time is unclear; Openness to virtual care may not reflect actual access among socioeconomically disadvantaged groups.

	regression identified key predictors (e.g., mental health knowledge as the strongest driver of care-seeking intention).	Limits causal inference; unable to determine if predictors (e.g., knowledge) directly cause changes in care-seeking.	
(Saville, 2022)	Large, representative sample (n=23,303) from the National Survey for Wales; Robust latent class analysis to define identity groups; Comprehensive adjustment for socio-demographic and geographic confounders; Clear distinction between ethnic and civic identities, enhancing theoretical framework.	Cross-sectional design limits causal inference; Self-reported health measures may introduce bias; Limited exploration of mechanisms behind health disparities (e.g., social capital, discrimination); Ethnically Diverse group is heterogeneous; sub-analyses underpowered.	Long-term health trends for identity groups unexplored; Impact of unmeasured confounders (e.g., discrimination, healthcare access).
(Chitongo *et al.*, 2022)	Qualitative design captures rich, contextual insights from midwives; Thematic analysis with researcher triangulation enhances trustworthiness; Focus on ethnically diverse London setting addresses gaps in UK-specific literature.	Single-site study limits generalizability; Small sample (n=20) may underrepresent diverse perspectives; Potential selection bias due to voluntary participation; Self-reported data may introduce bias.	Long-term impact of proposed interventions (e.g., community hubs) is untested; Perspectives of women receiving care are absent; Transferability to non-urban or non-high-risk settings is unclear.

(Cook *et al.*, 2019)	Large dataset (13,166 referrals) enhances statistical power; Direct comparison of referral rates to census data provides robust equity analysis; Focus on London's diverse population addresses UK-specific gaps; Clear methodology for data matching and chi-squared tests.	Limited to 19/32 London CCGs, risking selection bias; Missing ethnicity data (8.9%) may skew results; Assumes equal dementia prevalence across ethnic groups despite evidence of higher risk in some BAME populations; No data on diagnosis rates or severity.	Generalizability outside London is unclear; Impact of awareness campaigns vs. systemic changes on referral patterns is unknown; No longitudinal data to assess trends or policy impacts.
(Mercer *et al.*, 2019)	Large dataset (32,087 patients) enhances statistical power; Uses real-world Trust data, reflecting actual clinical practice; Robust analysis (chi-square tests, effect sizes) to compare ethnic disparities; Addresses understudied area (secondary mental health care).	Retrospective design limits causal inferences: Ethnicity groupings ("White," "Black," "Other") are broad and mask heterogeneity within groups; Potential bias in self-reported CORE-OM/10 outcomes	Cultural appropriateness of psychological therapies for minority groups is unexplored; Impact of socioeconomic factors on disparities is not analyzed; Reasons for dropout (e.g., therapeutic alliance) are unexamined.