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Transforming care for all

The 16th national Current Issues in Midwifery conference, organised by *British Journal of Midwifery* (BJM), this year took ‘Transforming maternity services, improving care’ as its central theme. Alongside policy sessions, many speakers chose to focus on improving care for the most vulnerable women in maternity services. Over the 2-day event, presentations addressed a vast range of issues, from addiction to female genital mutilation.

According to research presented by Jenny McLeish, of the National Perinatal Epidemiology Unit, many vulnerable women had positive experiences of maternity services, praising the ‘consistently kind care’ and the signposts to other sources of support. However, the same study also found examples of negative attitudes that left women scared to complain, for fear of being branded a ‘troublemaker’.

Thankfully, there are those working to help and support the most vulnerable. At the *BJM* Midwifery in Practice Awards, stories were told of midwives supporting women with addiction, perinatal mental health nurses addressing barriers to treatment and charities working to prevent the separation of homeless women and their babies. Although these services may be isolated or few, their existence is a positive sign that risk factors are being identified and care adapted for marginalised populations.

However, although the barriers to accessing care may be obvious for some women, it is important that invisible barriers are also recognised and addressed. In her presentation, McLeish asked: ‘if two-thirds of women are satisfied with maternity care, who is left out?’ The answer: women who were young, black and minority ethnic (BME), single mothers or on a low income—factors that may not be obvious disadvantages in maternity services.

Indeed, even the most successful woman can be vulnerable, as Serena Williams (2018), no less, recently showed, in her account of the pulmonary embolism and abdominal haematoma that she experienced in childbirth (Philby, 2018; Williams, 2018). Williams is 36, married and wealthy, but as a BME woman, she is at risk, with studies finding that 46% of deaths among

African-American women were preventable (compared to 33% among white women) (Berg et al, 2005), and that black, college-educated women who gave birth in hospital were more likely than white women who never finished high school to experience severe complications (New York City Department of Health and Mental Hygiene, 2016).

These are stark findings and should not be ignored. Although solutions will be the work of months of research, improvements can nevertheless begin in individual maternity settings, by starting conversations with women of all backgrounds in order to address inequalities in healthcare, however hidden. As Lisa Ramsey, Service User Voice Policy Manager for Maternity at NHS England expressed during her presentation at the conference: ‘If we only ever hear from white, middle class women, we will only create maternity services that tailor to those women’. Once problems are identified, maternity services excel at providing kind, supportive and transformative interventions, but the challenge is to identify where more work still needs to be done. As Audre Lorde once famously said: ‘I am not free while any woman is unfree, even when her shackles are very different from my own.’ **BJM**

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