Appendix 4 - Mode of birth

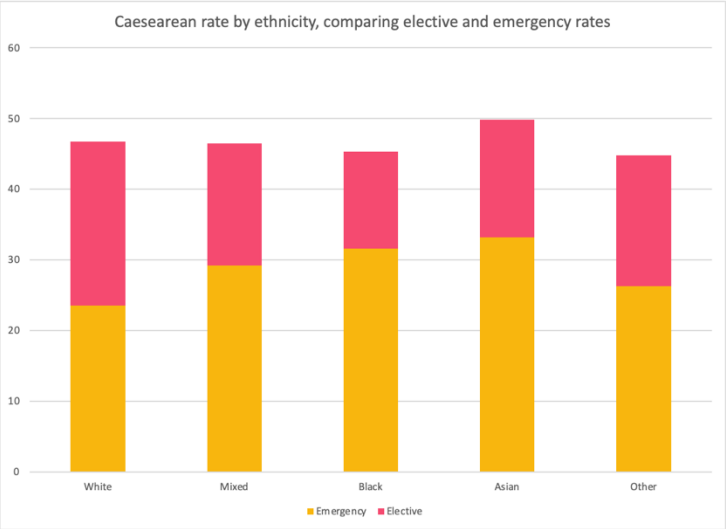

Figure 1 - Caesearean rate by ethnicity

The chart illustrates the total number of caesarean sections by maternal ethnicity, broken down into elective and emergency procedures. While the overall number of caesarean births appears broadly similar across ethnic groups, there are notable differences in the proportions of elective versus emergency caesareans. For example, Black and Asian women show higher rates of emergency caesareans compared to elective procedures, whereas White and Mixed ethnicity women have a more balanced distribution. These differences are striking and suggest multifactorial causes, potentially including variations in maternal health, access to early antenatal care, communication barriers, or systemic biases in the provision of planned caesareans. Further investigation into these disparities is warranted to understand underlying drivers and ensure equitable, personalised maternity care for all women.

Actions and next steps

1) Investigate underlying causes through detailed case reviews
   - Conduct targeted audits of emergency caesarean cases by ethnicity to identify recurring themes such as late presentation, communication issues, or delays in escalation.
   - Engage local Maternity Voices Partnerships (MVPs) to incorporate service user perspectives into this analysis.
2) Enhance early access to antenatal care
   - Strengthen outreach and education in communities with higher emergency caesarean rates, ensuring women book promptly and receive personalised care plans that reduce risks later in pregnancy.
3) Improve culturally competent shared decision-making
   - Train staff in culturally sensitive counselling to support informed choices about birth options, addressing barriers that may deter planned caesareans when clinically indicated.
4) Address health inequalities contributing to higher emergency rates
   - Integrate targeted interventions for common risk factors, such as hypertension, diabetes, or obesity, which disproportionately affect some ethnic groups and increase emergency caesarean likelihood.
5) Monitor and publish caesarean section rates by ethnicity
   - Regularly track elective and emergency caesarean rates stratified by ethnicity at site and LMNS level, sharing data transparently to support accountability and continuous improvement.
6) Co-design solutions with communities
   - Partner with local community groups and voluntary organisations to develop tailored information resources, birth planning support, and culturally appropriate antenatal classes.

Appendix 5 - Stillbirth rates

Figure 2 - Infographic illustrating disparity in stillbirth rates

The graphic illustrates stark disparities in stillbirth rates across different ethnic groups in North West London. White women experience a stillbirth rate of 0.7 per 1,000 births, whereas Asian women face a rate of 2.1 per 1,000 and Black women 2.8 per 1,000 — representing threefold and fourfold increases in risk compared to White women, respectively. These differences are significant and highlight persistent inequalities in maternity outcomes. Such disparities are likely multifactorial, reflecting the combined effects of social determinants of health, pre-existing health conditions, differential access to antenatal care, communication barriers, and structural racism within healthcare systems. Addressing these inequities is essential to achieving safe, personalised, and equitable maternity care for all families.

1. **Strengthen continuity of care models**

Prioritise continuity of carer pathways for Black and Asian women, shown to reduce stillbirth risk by improving trust, engagement, and timely escalation of concerns.

2. **Targeted community outreach and education**

Co-produce culturally tailored information on warning signs of reduced fetal movement, healthy pregnancy behaviours, and when to seek care, working with local community leaders and faith groups.

3. **Enhanced risk assessment and surveillance**

Implement earlier and more frequent fetal growth and wellbeing assessments for women at higher risk of stillbirth, ensuring prompt intervention when concerns arise.

4. **Improve staff training on structural inequalities**

Deliver mandatory training for maternity staff on how social, cultural, and systemic factors contribute to disparities, equipping them to provide culturally competent, personalised care.

5. **Monitor and share disaggregated outcomes data**

Routinely collect, analyse, and publish stillbirth rates by ethnicity at site and LMNS levels to drive accountability and inform local action plans.

6. **Collaborate with MVPs and community groups**

Engage Maternity Voices Partnerships and grassroots organisations in reviewing services and developing strategies to reduce ethnic disparities in stillbirth.