Co-production in maternal health services: creating culturally safe spaces, respecting difference and supporting collaborative solutions.

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Structural and social barriers to healthcare contribute significantly to the poorer health outcomes observed among minoritized ethnic people around the world [1,2]. Globally, women who are a member of an ethnic group that is a minority in their country of residence have been reported to receive sub-optimal maternity care. This can include access challenges, poorer quality of care and support, as well as discrimination [3,4]. This global pattern is mirrored in UK maternity services where Black, Asian and minoritized ethnic groups are at greater risk of severe morbidity and death during pregnancy, childbirth and postnatally than their white counterparts [5]. Poor maternal outcomes have been attributed to intersecting factors, including social circumstances, cross cultural communication barriers, and organizational factors, which combine to delay help-seeking, reduce access and negatively impact experiences of care [6,7]. Poor communication is a persistent complaint, and those giving birth describe feeling that they are not listened to or understood by health providers. Repeated negative experiences, including exposure to racism and discrimination, engenders a lack of trust in the health system which in turn can deter access to services and widen inequalities [8,9].

The NHS policy goal of reducing UK health inequalities, and in particular addressing poor maternal outcomes for Black women stimulated the work of Aryasinghe et al who report in this edition of BMJ Quality and Safety on their work to reduce inequalities in maternity care for this population [10,11]. Aryasinghe et al used a co-production approach to build trust between service providers and service users to deliver meaningful service improvement. They used detailed and inclusive consultation with community and voluntary sector partners, and deliberately set out to listen to those most affected by inequalities. This work revealed stark differences in priorities between the healthcare professionals and leaders, and people using maternity services, and powerfully illustrates the value of co-production.

Co-production approaches can be especially effective when trying to reorient service improvement to the perspective of service users, however, as the paper by Aryasinghe et al shows, it takes work, resources and a willingness to hear new ideas. While terms like co-production and co-design are frequently used these approaches are not always enacted well. In this editorial, we take a closer look at co-production as an approach that can ensure that people using maternity services are listened to and understood.

How does co-production listen to service users?

Co-production is a values driven approach in which researchers, practitioners and members of the public work together, sharing power and responsibility from the start to the end of the project, including the generation of knowledge. At its heart this approach assumes that communities and individuals with lived experience are best placed to help design and deliver change, and that they

bring skills and knowledge of equal importance to that of the health professionals in this process [12].

Aryasinghe et al describe working with local community partners to engage with people who have lived experience of the maternity system. This approach supported people to feel safe in the research process, because the partner organisation had an enduring relationship with the community beyond the research. This is reflective of good practice [13]. Community organisations can provide wrap around support for people involved in research, following up after events, offering signposting and feeding back project findings. This can grow individual and collective social capital; for partner organisations by reinforcing their value within the community as they create gateways for change-making; for individuals by being involved, and knowing that their voices are being heard. Working in this way can build trust – in research or in health services, and may create opportunities to challenge structural barriers, or widen participation. Aryasinghe et al describe how some participants were able to share their traumatic experiences for the first time in the co-production process because the trusted community organisation used trauma informed language and facilitated group meetings, helping to create the safe space needed for participants to feel heard.

Co-production takes time, for relationship building to allow honest, high quality conversations [13]. It can be messy and may produce unexpected findings. Therefore it is necessary to be flexible and adaptable, allowing people to join in or drop out during the process, use alternative or creative methods and be open to new or surprising findings [14,15]. This can be challenging for those used to directing research or generating their own solutions. 'Sharing the pen' and truly allowing perspectives of people with lived experience to be considered equally, requires new skills and strategies [13]. Challenges also exist for research participants too. Their presence once, or multiple times may rely on other people or resources (childcare, transport) as well as commitment to the research ideas. It is important to reduce barriers to participation [16], but also recognise practical and resource constraints. In their study, Aryasinghe et al conducted a single episode workshop but supported participation by asking facilitators to document and share responses with a wider group.

Creative methods have been shown as valuable to democratise research and empower underserved groups' participation [17]. These methods promote inclusion, explore how to move beyond language and literacy barriers, and meet multiple or complex needs so that even where the time participants can give is limited it still adds value. Community partners can also support health service colleagues to review ways of working, be more collaborative and creative. This results in co-learning for all parties during the research process. Aryasinghe et al used text-based, word-storming activities and took the time to sense check their findings with participants and ensure all voices were heard. However, while their participants were diverse, people not confident in the English language were not included. We know from a growing corpus of work that these women and families are particularly vulnerable within our maternity systems, and more efforts need to be made to hear their voice [7] for example by engaging with community partners before conducting co-production workshops.

Cultural safety as the foundation of co-production

Aryasinghe et al used trauma informed approaches to support women to share their experiences and feel safe. This is welcome but more can be done to create culturally safe spaces from the beginning of engagement. In Aryasinghe et al's work, community participants wanted advocacy mechanisms, but this was not on the health professionals' list of priorities. This exposed an

important gap and barrier to improvement. Community participants prioritised the need for culturally competent care and communication. The term cultural competency is touted as a solution to the disparities in care experience reported by people from minoritized ethnic groups. However, the concept is limited as it focuses on acquiring knowledge, skills and attitudes, and it infers a 'static' level of achievement rather than dynamic responses to diversity, and the tailoring of care delivery to meet varied social, cultural, and linguistic needs [18]. Ideas about cultural competency can perpetuate the view that ethnic groups are homogeneous, and 'other', set apart from the dominant culture, and this can encourage a focus on individual rather than structural roots of inequalities.

It may be preferable to use the term 'cultural safety' to change thinking about power relationships and patients' rights [18]. This concept rejects the notion that health providers should focus on learning cultural customs of different ethnic groups. Instead, cultural safety seeks to achieve better care through being aware of difference, considering power relationships, implementing reflective practice, and by supporting the patient/participant to determine whether an encounter is safe [19]. While some participants in Aryasinghe et al's study felt safe to share their experience for the first time, principles of cultural safety should inform the whole co-production process through continuous dialogue and self-reflexivity [16].

Critical theorists argue that inequalities are evidence of systemic racism, and propose that we examine the racialised allocation of resources and power to see how structural and systemic racism intertwine to reproduce the power imbalances for racialized populations [20]. Cultural safety requires health practitioners to examine the potential impact of their own culture on clinical interactions [20]. This requires health providers to question their own biases, attitudes, assumptions, stereotypes and prejudices that may contribute to lower quality healthcare for some. In Aryasinghe et al's prioritisation project, the participants recognised the power imbalances in their help seeking, and felt unable to speak up or feel listened to: this demonstrated a lack of cultural safety.

Conclusion

As maternity disparities continue to widen globally it is clear new approaches and solutions are required. There are a growing number of examples where principles of participation and co-production have been pragmatically incorporated into traditional research and health service improvement processes. To build trust for meaningful engagement it is essential to engage in reflective, ethical, and collaborative decision making with communities. Starting from an equal level, partners must work together to create culturally safe spaces, respecting difference and supporting collaborative solutions. Committing to the 'co' in co-production through the whole process involves significant effort but can yield significant reward. The co-production approaches used by Aryasinghe et al, open up opportunities for further learning and normalisation of this way of working.

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