End Coercion in Maternity Care in the UK

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Executive Summary

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Introduction

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1. Introduction

The starting point for our campaign was a high number of reports in the last 12 months to our Advice and Information Service about coercive practices and discriminatory policies resulting in unequal care and the denial of rights. In 2025, more than 20% (112) of the service users supported by our Information and Advice Service referred to the use of coercive practices.

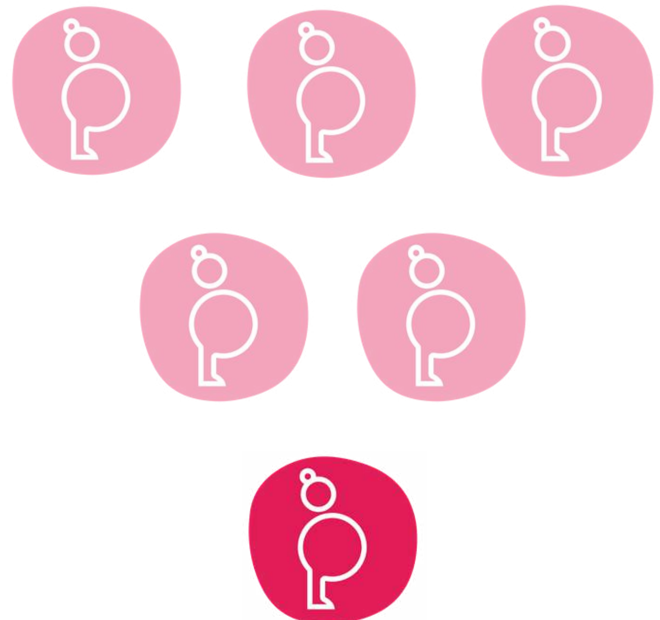
Coercion has no place in maternity care.

We are extremely worried that the elevated number of cases we are seeing is evidence of a growing erasure of our human rights in maternity.

This report sets out to understand the way in which a growing blame culture that prioritises ease for Trusts over personalised, rights-based, care, is putting both women and birthing people and healthcare professionals at risk. Blanket application of guidelines, Trust fear of litigation, healthcare professionals' fear of personal or professional repercussions, and structural inequality mean that women and birthing people who make informed, personalised choices, are too often labelled "out of guidance".

With this label they face coercion, safeguarding referrals, or even legal threats, this being especially true for many Black, Brown, migrant, and marginalised women and birthing people.

Women and birthing people in contact with challenging systems such as the criminal justice and children's social care systems are also a marginalised group facing stigma and judgement. Those less able to advocate for themselves are denied crucial information, which deepens inequities and clinical risk. Healthcare professionals who support them face threats of disciplinary action and isolation. This culture undermines informed choice, perpetuates systemic racism, and causes lasting trauma for women and birthing people and professionals alike.



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Methodology

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2. Methodology

Our research methodology consists of:

- women and birthing people and 63 healthcare professionals an online call for evidence (including two online surveys) in which a total of responded to two online surveys.
- a thorough review of our Information and Advice Service cases,
- consultation with community groups/partners and other charities who work with LGBTQIA+ birthing people of colour and refugee,
- asylum-seeking and migrant women,
- in-depth interviews,
- and a review of our Training activities.

Almost all experiences occurred within the past 10 years, with more than 90 cases happening in the last five years. Respondents came from Trusts across the UK, including Northern Ireland, Wales, and Scotland, offering a recent and geographically diverse picture of maternity care.

Many healthcare professionals who responded to our survey expressed reluctance to have their experiences shared publicly (even anonymously) due to fears of job loss, bullying, and harassment.

Their responses reflect a climate of professional risk that mirrors the wider culture of blame and fear within maternity services.

Altogether, we've heard from nearly 300 people who shared their experiences of coercion: whether directly as the pregnant person affected, or those who witnessed coercive actions from colleagues or others within the system.

One woman we spoke to had social services and the police called because she was trying to change service provider.

She felt they tried to portray her *"as though I was the aggressive, angry black woman. They said I wasn't letting anyone see the baby and called social services and police."*

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What does coercion look and sound like?

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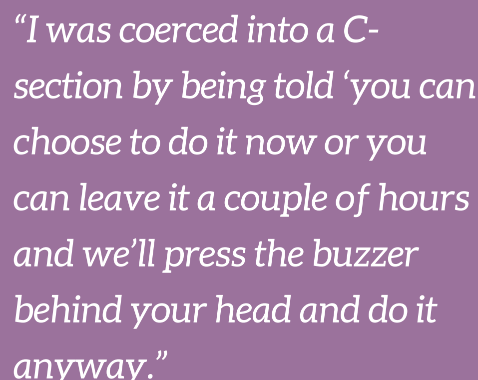
3. What does coercion look and sound like?

Qualitative accounts from our surveys, Advice Service and in-depth interviews with women and birthing people and healthcare professionals reveal a broad spectrum of coercive behaviours, ranging from subtle pressure and manipulation to explicit threats and intimidation.

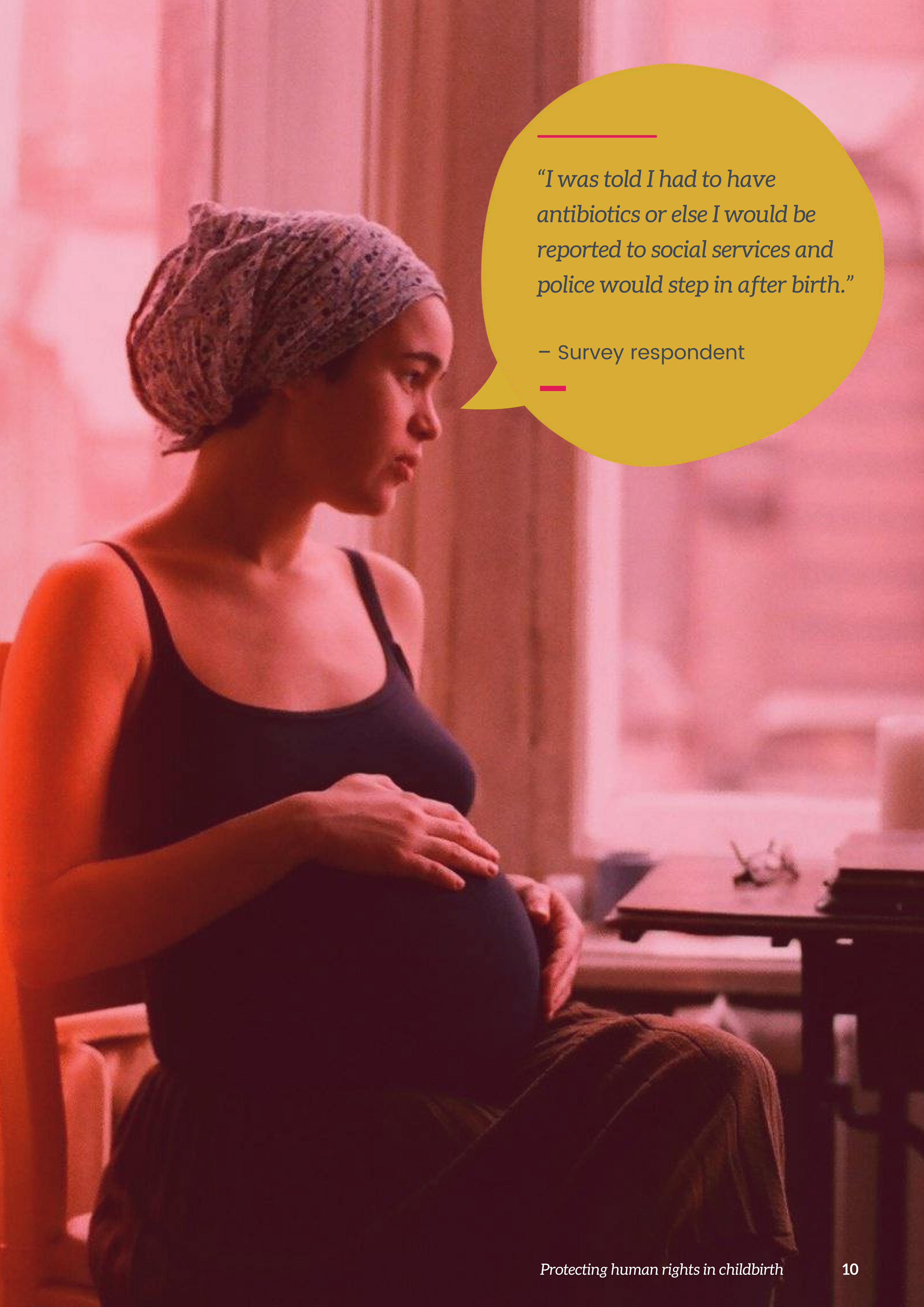
These experiences demonstrate patterns of behaviour that compromise informed consent, bodily autonomy, and trust in care.



> *"I was coerced into a C-section by being told 'you can choose to do it now or you can leave it a couple of hours and we'll press the buzzer behind your head and do it anyway."*
>
> – Survey respondent

Common practices include:

- Frequent use of permission-based language (e.g., "you're not allowed").
- Judgmental or fear-inducing comments, escalating to overt threats such as "If you don't do X, your baby will die".
- Use of stigmatising language to dismiss personalised decisions as "out of guidance," triggering further coercion.
- Threats linked to refusing antibiotics or scans, sometimes including the threat of referral to social services.
- Being mocked, belittled, or infantilised.
- Pressure to undergo induction, or accept sweeps or vaginal examinations without meaningful consent.
- Misinformation or lack of information about risks, leading to an inability to make informed choices.
- Withholding information about what is happening during birth, with some people only discovering later.
- Providing false information about risks to the baby or women and birthing person, or misleading explanations about procedures.


"I was told I had to have antibiotics or else I would be reported to social services and police would step in after birth."
– Survey respondent

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Coercion and the Law

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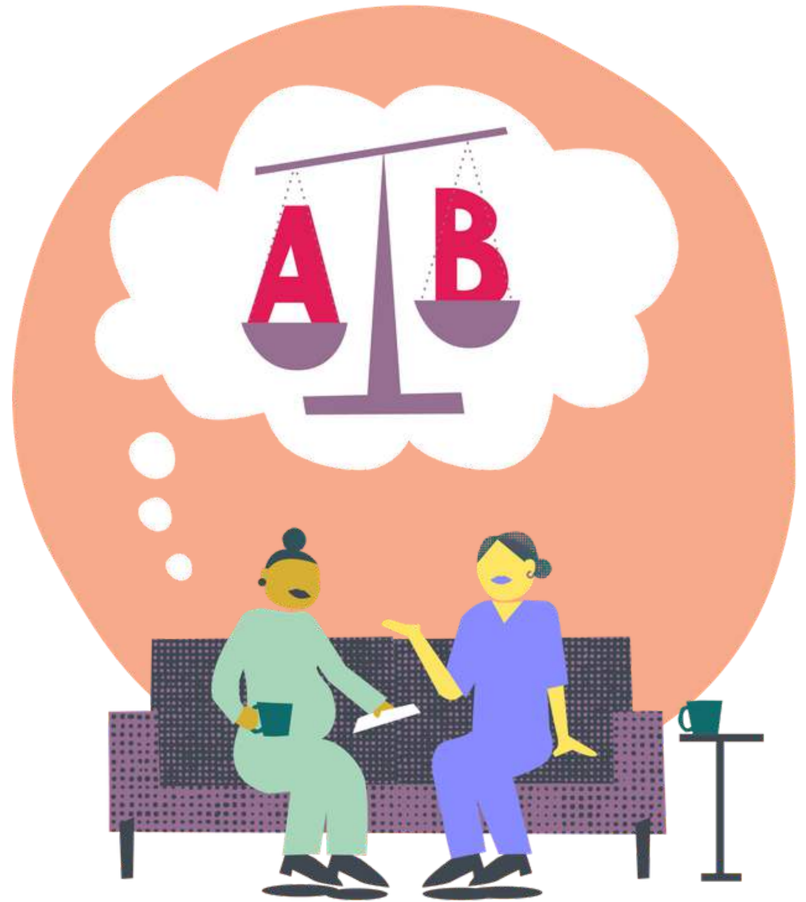
4. Coercion and the Law

The law across the UK requires that healthcare professionals support all pregnant women and birthing people to make their own informed decisions about their care, by offering to provide information about the material risks and benefits of the clinically recommended treatment or care option, as well as the material risks and benefits of all reasonable alternative options *(Montgomery v Lanarkshire Health Board [2015] UKSC 11; McCulloch v Forth Valley Health Board [2023] UKSC 26).*



"The midwives attending my homebirth threatened to leave (withdraw care) if I didn't 'consent' to a vaginal exam I did not want."

The information should be provided in a language the woman or birthing person can understand and it should be personalised to their particular circumstances.

Importantly, the information provided must be balanced and unbiased so, for example, it would not satisfy the standard to only share the benefits of the option recommended by the clinician, and only the risks of all other reasonable alternatives (or alternatives not being mentioned at all).

Similarly, if pressure is applied by the healthcare professional to ensure that a woman or birthing person chooses a particular option, this wholly undermines informed consent.

"They broke my waters without explanation of need, risk or benefit. They forced me into an epidural. They gave me an episiotomy and the only information I was given was "I'm going to cut you" and I tried to run away and screamed "no" but they did it anyway."

– Survey respondent

" *As an older mum who wanted a natural birth I was bullied and bullied by consultant obstetricians.*

I was told my only 'choices' were c section or induction in hospital. I was not given balanced information to make these decisions. "

– Survey Respondent

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Key summary findings

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5. Key summary findings

We found there to be widespread use of coercive practices against women and birthing people in maternity services.

The common themes which emerged from across the evidence are:

1 Structural racism and discrimination in maternity care

- Black, Brown, migrant, and Traveller communities were disproportionately targeted for referrals and surveillance.
- Racialised risk profiling, leading to unnecessary interventions (e.g., drug testing), being labelled "out of guidance" by default, and birth place and birth choice options being unjustly and unlawfully denied.

2 Widespread use of coercive practices: verbal and physical

- Use of permission-based and authoritative language ("not allowed")
- Provision of biased, incomplete and inaccurate information, all of which undermines informed decision-making.
- Pressure to accept medical procedures without informed consent
- Use of physical coercion

3 Routine, inappropriate threats of referral

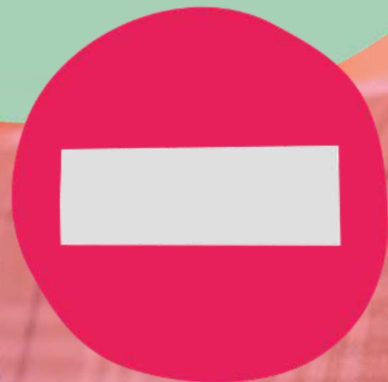
- Threats of referral to children services, capacity assessments and even police involvement purely due to certain treatment options being declined.

4 Health care professionals fearful of regulatory consequences, bullying and isolation

- Fear among staff of legal, internal, or regulatory consequences for themselves where women and birthing people make choices that fall outside hospital guidelines ("my pin is on the line"), leading to coercion and lack of support for individualised choices.
- Bullying and isolation of healthcare professionals who support out-of guidance decisions or challenge coercive practices.

"I was heavily pressured to comment 'not allowed' 'won't support' 'this will have to be referred to safeguarding'.

I was bullied, harassed and victimised for supporting women's choices and standing up for fellow midwives."



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Calls to Action

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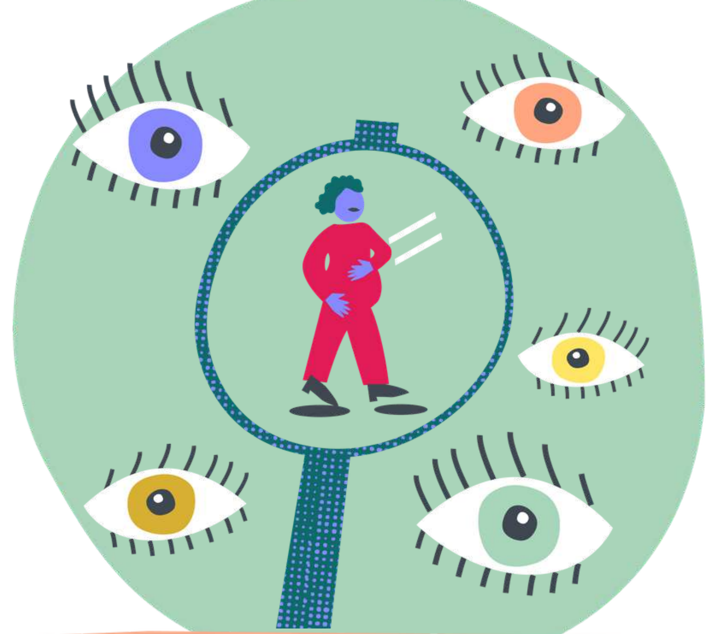
6. Calls to Action

Based on the evidence gathered through our online surveys, qualitative interviews, intel from community groups and other charities, and analysis from our Advice and Information Service and Training team, we have identified four calls to action to tackle coercion in the maternity system:



1 We call on all Integrated Care Boards (ICBs), Local Maternity and Neonatal Systems (LMNS) and Trusts to publicly commit to ending racialised, discriminatory practices in maternity.

- In particular, all Trusts must ensure there is clear, comprehensive guidance on when social services referrals should, and should not, be made. There must also be monitoring of implementation to track and stop any discriminatory practices.
- We call on the UK Government to end the policy of charging some women and birthing people for maternity care.

2 Introduce safeguards against coercive practices, including routine monitoring of consent practices, clinical note accuracy, safeguarding referral patterns and guideline development and usage.

- We call on all ICBs, LMNS and Trusts to publicly commit to urgently ending coercive practices in maternity.

3

Improve healthcare professionals' knowledge about rights-based care, informed choice and consent, with mandatory training on human rights law across all maternity staff, including obstetrics, anaesthetics and neonatal care.

- We call on all ICBs and Trusts to commission and integrate human rights law training.

"I really believe that Birthrights training should be mandatory for all HCPs working in maternity care UK wide."

4

Ensure safe staffing and safe working environments in all elements of maternity services, ensuring staff can raise concerns without fear of reprisal and are enabled to facilitate rights-centred, personalised care rather than defensive practice.

- We call on the government to ring-fence funding to end chronic understaffing in maternity care.
- We call on all ICBs and Trusts to ensure that staffing is safe and so are working environments for healthcare professionals, within all maternity care settings including triage, home birth services, birth centres and post-natal care. And the restriction of those services should be a rare, unexpected occurrence, not a routine, chronic concern.