End coercion in maternity care in the UK

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Contents

Foreword 4-5

Acknowledgements 7-8

1 About Birthrights 9-10

2 Why this report matters 11-13

3 Key summary findings 14-15

4 Calls to Action 16-18

5 The law, Methodology and what coercion can look like 19-24

a. Coercive practices and the law 20

b. Informed consent - a note on "Outside of guidance" 21

c. Methodology - how did we collect evidence? 22-23

d. What does coercion look and sound like? 24

6 Key findings and evidence: 25-61

a. Structural racism and discrimination in maternity care 27-36

b. Widespread use of coercive practices, verbal and physical 37-43

c. Routine, inappropriate threats of referrals and social services. 44-51

d. Healthcare professionals fearful of regulatory consequences, bullying and isolation 52-61

7 What good looks like 62-66

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Foreword

This report makes for difficult reading. Birth should be a peak moment of autonomy, when each person is empowered and supported to make choices about their body, their care, and their child's entrance into the world. Sadly, the information collected by Birthrights shows that that is not always the case. Coercive practices are embedded, it would seem, in NHS maternity.

Survey respondents describe intimate examinations performed without consent, interventions pushed or denied for spurious reasons, excessive red tape and obstacles around choices perceived as 'out of guidance', inappropriate and punitive use of social service involvement and a culture that prioritises the demands and protocols of the service over the wishes of the service user. Individuals who are marginalised and minoritised are, as with so many injustices, most likely to encounter coercion. This is, of course, entirely unacceptable.

People's human rights must not be violated at the very time when they should be honoured and upheld.

While staff who practice coercively must be held to account, this report shows that the situation is not a simple us-versus-them problem. Healthcare professionals who observe coercive practices also feel stifled by toxic, repressive workplace cultures. They report feeling unable to raise concerns, fearful of bullying, ostracism, discipline or regulatory action should they fail to toe the institutional line.

A lack of training about human rights means that even those staff who would like to speak out – those who know when something just doesn't feel, sound or look right – lack the confidence to do so.

The end result is what midwives have described as a psychologically unsafe working environment, and when midwives feel psychologically unsafe, they are unable to ensure the safety of those in their care. It is hardly surprising that large numbers of midwives have told Birthrights that such deeply entrenched structural pressures have compelled them to leave the profession.

Likewise, service users must be respected and empowered at every step of their journey, from the first booking appointment to the final postnatal contact. The information they receive must be accurate, comprehensive, culturally appropriate, trauma-informed and unbiased, their choices must be welcomed and upheld without undue pressure, and they must feel able to push back against coercion whenever and wherever it occurs.

With this report, Birthrights brings this problem to the fore, but the organisation is also uniquely placed to offer solutions.

Maternity care in the UK is at an inflection point.

The public are tired of endless investigations, enquiries and recommendations with no prospect of meaningful change. Now, when the situation is so critical, we have an opportunity to rebuild our system on a rights-based framework.

This report offers a warning, but also a way forward.

Leah Hazard
Midwife, author and activist

Scan the QR code to learn more, or go to: www.bit.ly/aboutBR

Birthrights is here to champion the fundamental rights of women and birthing people during pregnancy and birth across the UK.

Acknowledgements

Birthrights would like to extend its sincere gratitude to:

All the women and birthing people who have shared their experiences with us as part of this research with the hope that this leads to long term change. We know this may have been distressing and re-traumatising, and we hope we have done justice to your experiences. Your contribution to movements for change is deeply valued and we will continue to honour this beyond the publication of this report.

The healthcare professionals, doulas and birth activists who have spoken out against coercive practices and policies that too often deny those in their communities access to their rights. We stand with you in your fight for justice for women and birthing people. We see you and we see the toll doing this work without support or resource can take. Together we will create a safer, more just system for all.

The Birthrights staff team - in particular Hazel Williams, Laura Mullarkey, Miranda Atty, Celine Raynaud, Lora Evans, and Elif Ege - who made this report possible. Our trustees, in particular Roisin Mulroney and Dr. Annabel Sowemimo.

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We'd also like to thank all our generous individual donors and supporters.

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1

About Birthrights

1. About Birthrights

Birthrights is the leading authority on the human rights of women and birthing people during pregnancy and birth in the UK.

We believe that all women and birthing people should be able to exercise their right to make informed decisions about their bodies and care, and to do so free from discrimination, coercion and violence.

Yet we know that those already facing the deepest inequalities suffer the greatest harm in maternity care. That's why we champion rights by supporting women and birthing people, training healthcare professionals, holding systems and institutions to account, and amplifying diverse experiences of maternity care.

Birthrights was co-founded by human rights barrister, Elizabeth Prochaska and doula and author Rebecca Schiller more than 10 years ago because no other organisation in the UK was looking at the breadth of issues in maternity care through a human rights lens.

We continue to offer rights-based information on everything from maternal request caesarean to unassisted birth. Alongside the information we provide to women and birthing people and their supporters, we also engage directly with Trusts and hospitals.
As well as campaigning for change as a critical friend, and where necessary and possible taking legal action.

> *When we set out, human rights weren't part of the conversation in maternity care, but our work has changed that and made a real difference to the lives of women and birthing people.*
>
> — Elizabeth Prochoska, Birthrights co-founder

2

Why this report matters

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2. Why this report matters

Birthrights has become increasingly concerned about the growing use of coercion in maternity care.

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.

Via our Information and Advice Service, as well as an online call for evidence, interviews, consultation with community groups and other charities who work with LGBTQIA+ birthing people of colour and refugee, asylum-seeking and migrant women and birthing people, we've heard from nearly 300 people who bravely shared their experiences of coercion – from manipulation and pressure to accept induction of labour to explicit threats of social services referral and intimidation.

The culture of coercion in maternity services is grounded in a long history of patriarchal and racist medical practice, marked by a fundamental lack of respect for bodily autonomy and consent. In the current crisis in maternity care, these historical reflexes remain evident, with coercive practices continuing to sit at the centre of the system. Addressing these practices is therefore not peripheral; it is central to creating a safe, equitable, rights-respecting maternity system.

We felt strongly that it was important to launch this campaign ahead of the conclusion of Baroness Amos' National Maternity and Neonatal Investigation later this year, to best ensure that the calls to action in this report are acted upon swiftly.

We truly hope that the evidence contained here, from women, birthing people, healthcare professionals, birth workers and community groups, can be used to plan better care in the future.

3

Key summary findings

3. 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 and which are covered in this report 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.

This report sets out the findings and evidence for each of these themes, but it also includes some examples about good practice in providing rights-respecting maternity care.

4

Calls to action

4. 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. End racialised and discriminatory practices, including disproportionate social services referrals, unnecessary drug testing, and NHS charging rules.

- 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.

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.

5

The law, methodology and what coercion can look like

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5. The law, methodology and what coercion can look like

a. Coercive Practices 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 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.

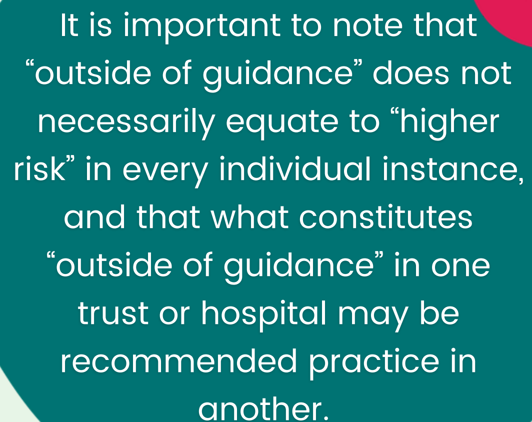
Examples we have heard include healthcare professionals telling women and birthing people that they must accept a vaginal examination or they will not be able to be admitted to the birth centre, that they must accept monitoring every fifteen minutes or midwives will not support their homebirth, that they must attend all antenatal appointments or they will be referred to children's services, and that maternal request caesareans "are not allowed here".

Many healthcare professionals and trusts incorrectly fear legal exposure from supporting women and birthing people's informed choices, simply because those choices fall outside of hospital guidance. As a result, they may act coercively to ensure "in guidance" choices are made.

The irony is that it is acting coercively which creates the real legal concern.

b. Informed decision-making - a note on "Outside of Guidance"

"Outside of guidance" is a term used by some Trusts and NHS bodies to describe situations when pregnant women and birthing people make decisions that are different from those recommended in, or envisaged by, local or national maternity care guidelines.



We recognise that Trusts and healthcare professionals need to have guidelines to ensure that care offered complies with their duty to provide consistent, evidence-based care in line with national standards.

However, it is imperative that guidelines are always written and used in a way that protects, rather than undermines personalised care, and the woman or birthing person's unique circumstances, needs and choices must remain the focus and priority. They must not be appplied in a blanket way.

Birthrights firmly believes that, rather than fixating on "out of guidance" scenarios, the priority across maternity services should be to ensure that personalised care and informed decision-making are embedded as standard practice for all, in line with the human rights-based framework.

Personalised care—care that recognises each individual's experiences and needs—is not optional; nor does it only apply in "out of guidance" scenarios. It is a fundamental human right and not supporting this exposes Trusts to legal liability. Supporting personalised care and informed decision making is also embedded in professional standards[1].

Upholding their rights, and supporting women and birthing people to make informed choices about their bodies and their care, is essential to delivering truly safe and respectful maternity care.

[1]: NMC Code 2018; NMC Principles for Supporting Women's Choices in Maternity Care 2025; RCM Care Outside Guidance 2022; GMC Professional Standards on Decision Making and Consent.

c. Methodology - how did we collect evidence?

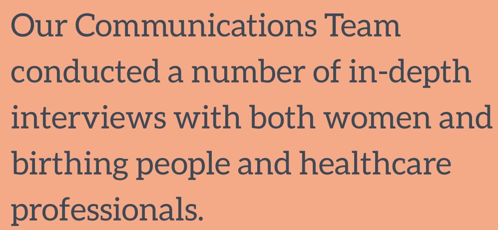
Our research methodology consists of:

- an online call for evidence in which a total of **104 women and 63 healthcare professionals** 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.

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.

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.



Our Communications Team conducted a number of in-depth interviews with both women and birthing people and healthcare professionals.

Issues consistently raised included women and birthing people being:

- Pressured to accept an induction of labour
- Threatened with social services
- Coerced into a caesarean

[Please download our Case Studies resource for more information.]

d. What does coercion look and sound like?

Coercive practices are widespread across maternity services.

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.

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 which triggers further coercion, such as:

"out of guidance".

- 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.

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

- 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.

6

Key findings and evidence

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6. Key findings and evidence

a. Structural racism and discrimination in maternity care

Findings

Racism and discrimination are embedded in coercive maternity care practices. The criminal justice system and safeguarding mechanisms are structurally racist and discriminatory.

Racialised risk profiling leads to some groups being labelled "out of guidance" by default, triggering coercive practices and interventions, including unwanted inductions, exclusion from home birth or birth centre options and pressure to accept testing for diabetes or drugs.

Evidence

Between January 2025 and January 2026, Birthrights' Advice and Information Service supported 17 cases which included specific incidences of racism and discrimination.

Racism and pigeonholing

During one qualitative interview, the interviewee revealed feeling like they had been pigeonholed based on their Asian ethnicity:

"Looking at me the registrar automatically assumed that I probably have gestational diabetes as I am Asian and that my baby was "too big" for an Asian baby. But my husband's family are all six feet tall. They put me on a pathway for likely induction. I asked if I could return for a repeat scan to check. I asked if I could be tested for diabetes instead of being presumed. They said 'no there's no point and it's too late in the pregnancy. It's probably likely that you are'."

"I didn't agree to the decision [to have an induction of labour].
I rang the midwife the next day as I wasn't happy and would rather have a stretch and sweep. They said I should talk to the consultant.
I didn't see the consultant till after midnight! The decision was final; I needed an induction as my baby was "too big" for an Asian baby."

"I was so upset and felt lost for words."

"I felt that I would be made to feel guilty if something happened to my baby if I didn't go ahead. I got a phone call the same morning I returned home and my induction was booked that day!

When I came to the hospital, the midwife said, 'your records say we have to treat you as diabetic. Are you diabetic?'

I said no and explained what happened. She called a Doctor and I ended up being treated NOT diabetic and induced anyway."

Reports reveal that women and birthing people from Black, Brown, migrant, Traveller, and other marginalised communities are disproportionately referred to social services and threatened with social services referrals[2].

One interviewee had the police called on her and was referred to social services due to wanting to change care provider. After unsettling and coded racist remarks, she asked to be transferred to a different team. She said:

"I felt like they weren't listening to me. I was losing trust in them. My doula said I could request to be transferred. I sent a message on the Saturday asking to formally request to be transferred to a different team. I thought that was the end of it. On the Monday night, they came banging on the door while I was breastfeeding my baby. I was a bit scared. My husband was home, he told me the midwives were here. My husband works from home, so background noise really matters. He told them 'you're going to get me in trouble [at my job]'".

"I found out that they made out that he said it about me, 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."

"But I had told them [the original midwives] that I didn't want to see them. I had already asked to be transferred."

[2]:https://arc-sl.nihr.ac.uk/news-insights/latest-news/black-and-mixed-ethnicity-pregnant-women-and-those-living-poorer-areas Summary-Maternal-Health-Inequalities-Guidance.pdf

Congenital Dermal Melanocytosis

Campaigners have highlighted concerns about NHS discrimination and a lack of cultural sensitivity and awareness toward families from ethnic communities around congenital dermal melanocytosis. These concerns point to systemic failings in recognising and responding appropriately to the specific health needs of ethnically diverse populations, contributing to unequal treatment and potential harm.

The same interviewee who had social services and police called on her was also told her baby had a 'suspicious' bruise.

"At the hospital it was confirmed that it was not a bruise, it was Mongolian Blue Spot [congenital dermal melanocytosis]. This was day nine after giving birth."

> *I was so scared they were going to take my baby away.*

NHS charging policies

Hostile immigration policies persist in the NHS. NHS charging policies are used as a tool of coercion, creating pressure on women and birthing people to comply with medical advice or interventions out of fear of financial consequences or restricted access to care.

People who are subject to charging rules [such as certain migrants] may feel compelled to agree to, or decline, procedures, attend or decline appointments, or disclose personal information they would otherwise withhold, simply to avoid being billed, denied treatment, or reported to immigration authorities. This dynamic undermines trust, autonomy, and the right to make informed choices about care.

Case study

Agnes* contacted Maternity Action when she was 38 weeks pregnant for advice about the bill she received from the NHS for her maternity care. Agnes was destitute and had no recourse to public funds. She had fled an abusive relationship and was living with a friend.

Following each midwife appointment, Agnes* received another invoice from the Overseas Visitor Team. Agnes had high blood pressure and had been asked to attend more frequent appointments for monitoring. Agnes* told Maternity Action that she was thinking about not attending the next appointment because of the increased stress she was feeling due to the mounting costs. The average bill for NHS maternity care is £7,500.

Agnes* was scared to contact the Overseas Visitor Team at the hospital because she didn't have any money to pay the bill. She was worried about giving birth as she had heard people say that staff from the Overseas Visitor Team visit women in hospital after they had given birth demanding money.

**not her real name. Maternity Action is the leading charity in the UK working to end NHS charging, for more information see: https://maternityaction.org.uk/nhs-maternity-care-and-charging/.*

Women and birthing people in prison

Prison creates a unique environment of extreme power imbalance, where coercion is constant and normalised, and decisions are made based on institutional convenience rather than clinical necessity.

Pregnant women and birthing people in prison are systematically denied autonomous, rights-based maternity care.

Birth choices are routinely restricted, with induction enforced as a default practice, effectively normalizing coercion as standard procedure. Access to antenatal education, advocacy, or independent support is severely limited, leaving women isolated, uninformed of their rights, and unable to challenge the system.

Overlapping forms of discrimination: birth choices and place of birth

Findings

Women and birthing people often face significant discriminatory barriers to making autonomous decisions about their birth, including choices about place and type of care. Racially biased clinical pathways, body-shaming attitudes, and ageism are frequently used coercively to restrict access to home births or midwife-led settings, while pressuring individuals into hospital births or medical interventions against their preferences.

These overlapping forms of discrimination not only undermine informed choice and bodily autonomy but also reveal systemic inequalities, shaping whose preferences are respected and how care is provided.

Evidence

One respondent shared difficulties in choosing the type of care and birth they wanted based on their BMI. They mentioned feeling pressured to comply with certain tests (e.g. glucose test) and described condescending attitudes linked to their race:

“I had a perfectly healthy pregnancy, spontaneous labour, no pain relief. Had to fight to get in the pool because of high BMI but got it "signed off" by higher ups because me and baby were perfectly healthy. Got to 10cms on my own just fine. Obstetrician turns up and wasn't happy with me being in the pool & demanded I get out and on the bed on my back with my legs in stirrups. I said no and then ignored her. She then became more and more aggressive with me and lied multiple times going from "your pelvis is the wrong shape to birth him" to "he's in distress and his head is swollen".

“She pushed constantly for a c-section but the midwife kept saying the baby and I were fine and fighting with the Doctor about it. Forced into forceps delivery only to find out nothing was ever wrong with either of us, so it was totally medically unnecessary. The doctor was just impatient, fat-phobic and controlling.”

“We were both left permanently injured and our whole family traumatised.”

One interviewee said:

“Women need to be listened to.”

“Just because someone is older or has a higher BMI does not mean they can't labour easier than someone who has a lower BMI and is in their early twenties. All the interventions need to stop. Our births are not to be made easier for the staff around at the time.”

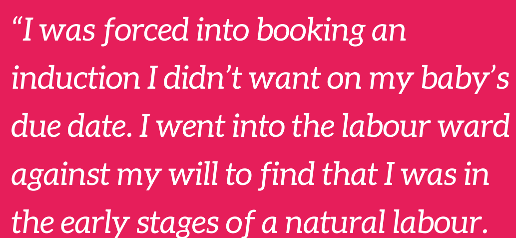
A survey respondent shared that despite multiple calls for assistance during labour, midwives did not arrive in time for their birth, during which the baby suffered head trauma. When midwives eventually attended, staff minimized the injury, delayed urgent scans, and accused the mother of drug or alcohol use, recording concerns about her care of the baby.

She was subjected to unnecessary drug testing and threatened with a social services referral, while staff seemed more focused on questioning her than addressing her baby’s serious injuries. The baby was later diagnosed with a fractured skull and brain bleed, requiring urgent treatment, and an independent review confirmed the mother’s account and criticized the midwives’ delayed response and coercive treatment.

“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 put through multiple extra unneeded scans and then pressurised to agree to one of these options.”

“I was not given balanced information to make these decisions.”



"I was forced into booking an induction I didn't want on my baby's due date. I went into the labour ward against my will to find that I was in the early stages of a natural labour.

All I wanted to do was go home where I would be comfortable and relaxed. The midwife refused this until I had been seen by the consultant. (They never even appeared to see me.)"

"I was offered no pain meds or any chance to move around. I had suffered the loss of a previous child on this labour ward. I had birth trauma from being there."

— Survey respondent

Discrimination based on disability

Findings

Women and birthing people with disabilities face unique and intersecting forms of discrimination in maternity care, which compound existing inequalities related to race, gender or socio-economic status[3]. Respondents reported coercive practices, neglect, and harassment that ignored their specific needs and pre-agreed care plans.

Evidence

One person shared via our Advice Service instances of harassment and discrimination against a pregnant woman with diagnoses of Autism, Asperger's[4] and epilepsy by social services. The mother of the pregnant woman was told she couldn't attend meetings to support her daughter and advocate for her. Threats were made to remove the baby.

One respondent to our survey reported being induced for labour and left alone in transitional labour without pain relief and denied access to the labour ward until giving birth in a corridor.

She had felt forced into an induction simply because of her BMI and age.

"I was admitted in the hospital for an induction of labour, as I was an older mother with a high BMI (I had no other issues and was considered healthy)."

One survey respondent (a healthcare professional) reported an instance where the doctor assumed that neurodivergent or disabled patients could not make informed decisions, overriding both the individual and their family based solely on the clinician's judgment, where the midwife also felt powerless to take action.

[3]:https://static1.squarespace.com/static/5d79d3afbc2a705c96c5d2e5/t/67c6f2e8737742464786f2d9/1741091563201/v5_MB_+UK+Maternity+Care+Report.pdf
[4]: Asperger's is no longer recognised as a diagnosis as per https://www.autism.org.uk/advice-and-guidance/what-is-autism/the-history-of-autism/asperger-syndrome but we are honouring the language used by the pregnant person.

Another respondent described having to clean up her own amniotic fluid on a dirty bathroom floor while fully dilated.

When finally transferred to the labour ward, she was pressured to consent to forceps and, after refusing, was given an episiotomy without her consent.

She has a disability and had a pre-agreed care plan, but this was not implemented or recorded, so staff were unaware of her needs. Her partner was sent home, leaving her alone throughout. She was transferred to a recovery room before she was ready and later shouted at for not tidying up.

She stated that the Trust has since admitted failings and confirmed there is no disability policy in place. The respondent described her treatment as discriminatory and abusive, noting poor hygiene standards among staff.

b. Widespread use of coercive practices: verbal and physical

Key findings from our survey of 104 women and birthing people revealed:

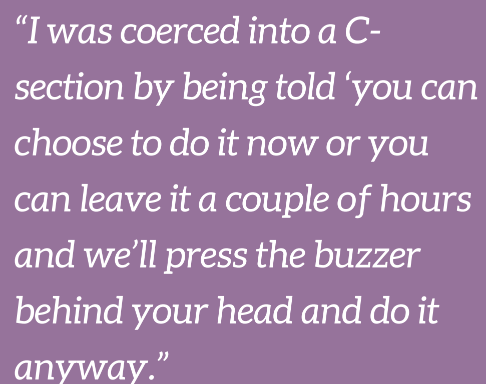
- Lack of information necessary for informed consent
- Restrictions on choice
- Lack of personalised care

92% of respondents reported that they were not provided with all the information they needed before making a decision about their care.	**81%** of respondents said they were told they were "not allowed" to make a particular choice about their birth.	**81%** of respondents reported that their birth was described or recorded as "out of guidance" due to their personalised needs and choices.

Findings

Pressure to accept medical procedures without informed consent

Women and birthing people who contacted our Advice and Information Service and responded to our surveys frequently described being pressured or coerced into accepting medical procedures without their meaningful consent. These accounts detail situations in which individuals felt pushed into **vaginal examinations, sweeps, antibiotics, or other interventions** through threats of care being withdrawn and scaremongering rhetoric around harm to their baby.



"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

Evidence

"I was at home and my birth plan said no vaginal exams. The midwife kept saying that she wanted to do one because if I wasn't far along she could go home and I'd progress quicker without her there (my contractions had eased off when she arrived). I very reluctantly agreed to a vaginal examination so I could get rid of her and after it was done the midwife said:

'...and I gave you a sweep whilst I was there to get things moving'.

"I felt so disgusting and honestly like I had been sexually assaulted in that moment. It was horrible."

– Survey respondent

"I was told that I was having a sweep and would be put on the list for an induction. I politely declined, after laughing at the way it was being suggested. I was then told of the risks and that I was

'doubling' the *risk of a stillborn baby.*

Statistically I understand it, and luckily I was informed but if I had felt particularly vulnerable that day it may have changed my action. It did make me anxious for the rest of my pregnancy though, although I knew in my heart the baby will come when it's ready, I was impacted by the use of certain language."

– Survey respondent

"...When I went to the maternity assessment unit at 41 + 5 for monitoring a midwife asked if I would have a vaginal examination to which I consented but said I did not want a stretch and sweep. When her hand was inside me she said, I'm just going to move my fingers round a bit OK?

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

"I was completely vulnerable with her basically violating me and just let it happen. I was in shock after."

– Survey respondent

"The midwives said they didn't believe I was in labour, so would have to leave, unless I was willing to prove I was in labour with a vaginal examination. I had it in my notes that I didn't want any vaginal examination due to past sexual trauma.

I 'consented' (under threat of care withdrawal) to the vaginal examination, the midwives stayed, and I gave birth 6 hours later. I was offered other vaginal examinations during labour, even though my notes said not to offer at all. I did not feel that the midwives were on my side."

– Survey respondent

Failure to facilitate informed decision making

Findings

Women and birthing people repeatedly described situations in which informed consent was not properly obtained, and where the information provided about risks, procedures, or available options was incomplete, inaccurate, or deliberately misleading. While it is important to acknowledge the challenges faced by healthcare professionals in facilitating proper, legally sound informed consent (particularly in rapidly unfolding emergency situations), these pressures cannot justify the failure to meet legal and ethical standards in maternity care provision. Many of the accounts shared in this report reveal repeated instances where failures to communicate properly and to seek informed consent resulted in coercive and harmful experiences for women and birthing people.

Respondents reported **being denied clear explanations, pressured into interventions based on unsubstantiated claims of risk, and told that alternative options were unavailable** (even when their notes later stated, incorrectly, that these had been offered.)

Evidence

One respondent reported being repeatedly told they needed to undergo examinations and interventions that were described as necessary due to "risk" to their baby. They stated that professionals either refused to explain what the risk was or provided information that turned out to be inaccurate when the respondent later reviewed their notes.

They were told that if they did not consent to certain procedures, more invasive interventions would be carried out instead.

One respondent shared that they were assigned to the delivery suite without any prior discussion. **They were told that a caesarean section would put their baby at risk, without an explanation, which left them feeling they had no choice but to consent to forceps —despite this being something they had explicitly stated they did not want.**

They later learned during a debrief, four months after the birth, that a manual rotation had also been performed without their knowledge.

During the complaints process, the respondent stated that staff denied the events occurred, though the Ombudsman later upheld their complaint and compensation was awarded. They described the attempts to deny and cover up the events as completely eroding their trust in the service, leaving them feeling they will never feel safe accessing care there again.

"I was planning a homebirth but went into hospital for pre-labour rupture of membranes (PROM) (alone) where

"I was bullied into an induction of labour."

"During the induction there was a constant stream of misinformation. They told me my induction was urgent and I would put my baby's life at risk if I went home and continued with my plan of a homebirth. This was then changed by the next shift to "we have no space on the labour ward so we are pausing you after having the pessary".

There were so many choices I was coerced into: two midwives told me I should really have an epidural or I would be in unbearable pain even though I asked for the opportunity to start on the lowest dose of syntocinon to see how I coped. I will never be able to prove it but I feel they gave me quite a lot as I instantly went to having 5 contractions in 10 mins and of course then accepted an epidural."

"I felt I wasn't heard or listened to and had no autonomy in my experience."

"The advice I was given was moulded to fit what suited them on the day - have the induction if it's quiet, pause the induction if they are busy etc."

"My partner who is black was perceived as aggressive in trying to advocate for me."

My baby was IVF and I was out of guidance because I "should" have delivered her by 39 weeks. When I declined induction during pregnancy at 36 weeks I was told how precious my baby was and all the language was about how I shouldn't risk her safety to pursue a birth I wanted, like to birth at home was a selfish, silly notion. Because I had previously experienced loss the discussion around stillbirth as if it was a fait accompli if I didn't accept induction was really triggering."

– Survey respondent

Physical coercion

Findings

In some cases, coercive practices reached the level of physical coercion and force. Women and birthing people described situations in which their refusals were ignored and they were restrained. These accounts reveal a profound breach of bodily autonomy, where individuals were denied the legal right to refuse treatment and subjected to interventions they clearly and repeatedly declined.

Evidence

The following testimony illustrates the severity of these experiences and the trauma caused when coercion crosses into physical violation:

"Told I would be 'killing my baby' if I didn't agree with their recommendation."

"Also had 10 staff members telling me personal accounts of having an epidural ('I had one', 'my wife had one', 'you don't get a gold star for not having one') because I declined... Coercion throughout."

"Began in antenatal appointments when I was given blood tests without consent ('we have to take bloods...'), bullied into having a gestational diabetes test I didn't want and being told 'just hop up on the bed' on multiple occasions with no explanation why."

*"I was asked, at one point to go for a growth scan and I tried to decline but was told I 'had to' go.
When I went into labour there was possible mild meconium and, being very informed, I declined all treatment for this at this stage and, not being in active labour, chose to leave, but the doctor and midwife stood in the doorway and would not let me."*

"Had I not known about meconium, I'd be completely in the dark as they did not explain it but instead used it to pressure me into augmentation."

"During my labour I was put on monitors without explanation; when I asked to stop or took them off they just put them back on. I was told they wanted to put a "little clip" on baby's head to monitor them and I questioned this, knowing it was actually a barb that pierces the baby's scalp but they denied this and kept saying "no it is a clip"."

"I declined on multiple occasions but they did it anyway."

"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

c. Routine, innapropriate threats of referrals and social services

Findings

Women and birthing people reported being threatened with **referrals to social services as a means of pressuring them to accept certain procedures or comply with care decisions they had not initially chosen.**

In some cases, these threats were linked to the consequences of asserting their autonomy or making lawful choices about their care.

- 20% of survey respondents experienced threats of a social services referral.
- Between January 2025 and January 2026, Birthrights dealt with 54 cases in our Advice and Information Service that are specifically about social service/safeguarding referral threats, unnecessary referrals and police involvement.

Women and birthing people are often threatened with social services involvement due to their own, their partners', or family members' past contact with social care when they want to make personalised informed choices. This can create lasting stigma, where unrelated issues (such as mental health needs or welfare support) are used to justify referrals. Evidence shows that the prevalence of fear of safeguarding action, particularly among marginalised communities, leads to undermining of trust, autonomy, and access to safe maternity services.

We recognise that in some instances, when there is a real safeguarding risk, referrals to social services are essential. However, referrals must never be used as a tool of coercion and all interactions with service users must be respectful and follow a rights-based approach.

Evidence

"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

One person who contacted our Advice and Information Service shared that she was referred to social services based on discriminatory assumptions about her benefits status and ability to provide for her child.

The referral cited vague concerns about her mental health, despite her being open about her condition and actively receiving treatment, and included an incorrect reference to cannabis use. She also had previous involvement with social care, which appeared to influence the referral.

One person who contacted our Advice and Information Service reported being referred to social services solely because their partner, who is Albanian, had recently been released from prison, which was unrelated to any abuse, substance use, or other similar factors.

The person shared that the partner is on probation and is currently contesting deportation through immigration proceedings while they are undergoing pregnancy and that the social services referral added significant stress during their pregnancy.

Similarly, evidence from Friends, Families and Travellers' maternity report[5] indicates that fear of social services involvement is a pervasive concern for Gypsy and Traveller mothers, significantly affecting their engagement with maternity and wider health services. Many reported delaying or avoiding appointments due to concerns that disclosing mental health issues, housing difficulties, or prior social care involvement could trigger safeguarding action.

Instances were described where routine referrals, such as for housing support, escalated into safeguarding investigations, leaving lasting mistrust. Participants also described feeling monitored, judged, or compelled to be fully compliant to avoid suspicion, contributing to ongoing anxiety and disengagement from care. These issues are consistently raised in caseworker interactions and are expected to be further explored in upcoming maternity-focused community consultations.

[5]: *https://www.gypsy-traveller.org/wp-content/uploads/2025/03/Extended-Maternal-Health-Inequalities-Guidance-2.pdf*

"In all three of my pregnancy and births despite asking and being very clear about my wishes and feelings, this was ignored."

"I was threatened with social services over and over again.

I requested repeatedly for reasonable adjustments and it was ignored."

"I had the disability nurse come in and ask consultants on my behalf why reasonable adjustments weren't being accommodated and they apologised to her and continued to ignore me."

One survey respondent shared being threatened with social service referrals when she wanted to discharge because of the absence of post-natal care after a caesarean. **She was threatened with a safeguarding referral and told she would not be allowed to leave with the baby.**

Another respondent described a similar threat after a home birth where they are informed that they would be reported to social services if they didn't attend hospital immediately after birth, while they were in labour at home.

"I was hooked up to IV meds and asked repeatedly to have them removed so I could see my son in NICU they refused, despite the medication causing rare side effects."

"I felt so frustrated that from weeks 20-36 I didn't go to any appointments so that I didn't have to listen or put up with requests being ignored."

"My mental health took a massive decline because of it, so I arranged a meeting with the mental health midwife and she hijacked the appointment to do a passport (which was never looked at again) and put me on a parenting course because I felt coerced to agree to one."

– Survey respondent

Impact of social services involvement on bodily autonomy

Findings

One person who contacted our Advice and Information Service shared how their bodily autonomy had been severely undermined as a result of the involvement of children's services.

They shared how they are “treated different to every other woman who is pregnant”. In particular, they explained that, whilst they had wanted to wait for spontaneous labour to begin (an informed choice made with their own and their baby's best interests in mind), they had been advised by their solicitor that declining an induction offered by the Trust might be looked at unfavourably by children's services, and could lead to a reversal of the decision that had recently been made to allow the mother to keep her baby after birth.

Unecessary Mental Capacity assessment threats

Findings

7% of survey respondents reported being threatened with a capacity assessment because they made, or discussed, a choice that healthcare professionals did not agree with.

Many women and birthing people report experiencing wrongful assumptions about their mental capacity, or that capacity assessments are applied coercively. These assessments are sometimes used to pressure individuals into particular decisions or to penalize choices that healthcare professionals disagree with, undermining rights-based care.

There is also a clear intersection between social care involvement and perceptions of mental health or capacity.

Whether genuine concerns or misrepresented as such, assessments and threats (such as warnings of social services referral) are often used to control or punish women making non-normative choices, particularly when they have a history of disclosed mental health issues.

Evidence

One person shared through our Advice and Information Service tthat **they were referred to social services simply for being past their due date, declining certain aspects of care, and continuing to plan a home birth.**

They reported that social services arrived at their home and that they were threatened with a mental capacity assessment.

One person shared via our Advice and Information Service that **they were referred to social services for a 'brain injury'**, reflecting a wrongful and discriminatory assumption that this automatically affects a person's mental capacity.

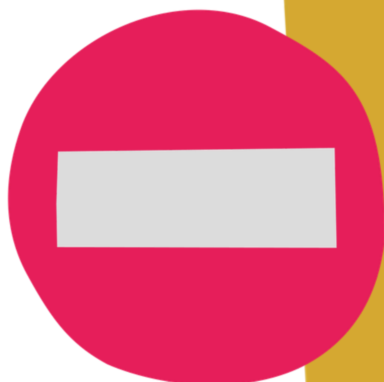
Unassisted birth and coercive practices

Findings

Many women and birthing people report that when their choices such as home birth, birth centre care, or VBAC are denied, dismissed, or undermined, they feel their autonomy is eroded, sometimes leaving unassisted birth (meaning a birth without medical professionals present) as their only viable option. Unassisted birth is a lawful choice, but when it arises from fear, distrust, or previous coercion, it reflects systemic failures in maternity care rather than a free, informed decision.

Even after choosing unassisted birth, women often face further coercion or scrutiny from healthcare and social services, including false allegations, emergency interventions, and referrals to Children's Services, highlighting the ongoing tension between lawful birth choices and institutional attempts to control or punish women for exercising their rights.

Respondents describe experiences of repeated coercion, unnecessary interventions, and misinformation, which have led some to pursue unassisted births to protect their bodily autonomy.



Previous experiences of coercive practices and unassisted birth

Findings

Pressure toward unassisted birth
30% of respondents felt pressured into considering unassisted birth (meaning a birth without medical professionals present) because their choices and needs were not listened to, or due to previous negative experiences and birth trauma.

Many women and birthing people report that past experiences of coercion in maternity care have led them to choose unassisted birth in subsequent pregnancies as a way to reclaim autonomy and protect their bodily integrity.

Evidence

One respondent reported choosing an unassisted birth in 2023 due to a profound lack of trust in local maternity services following their first birth. During that birth, they were repeatedly pressured to undergo examinations and interventions that were later revealed to be unnecessary. Their questions about perceived risks were ignored or misrepresented, and they were told that refusal could lead to more invasive procedures.

Alternative care options were denied, despite being recorded in the notes as offered and declined. The respondent described being coerced into theatre, subjected to a forceps delivery and an episiotomy without informed consent, resulting in injuries to both themselves and their baby.

Attempts to raise complaints were initially denied or dismissed, though the Health Ombudsman ultimately upheld their case and awarded compensation.

> The experience left them feeling deeply betrayed and unsafe within the maternity system.

Another survey respondent shared a pattern of coercive and disrespectful practices experienced across her four births, which made her feel like she was forced into choosing unassisted birth.

Coercion after unassisted birth

Even though unassisted birth is a lawful and autonomous choice, women and birthing people can face coercion, scrutiny, and punitive actions from healthcare and social services afterwards, often based on bias or misunderstandings about their birth choices, despite acting responsibly and seeking care when needed.

A survey respondent shared that after having unassisted birth, they brought their baby to hospital on day two due to feeding concerns. The baby was admitted to NICU following complications after surgery.

The respondent reported poor communication about prescribed medication and said they believed that the hospital had referred them to Children's Services, due to bias against their birth and lifestyle choices.

Police involvement led to an emergency protection order based on what the respondent described as false information.

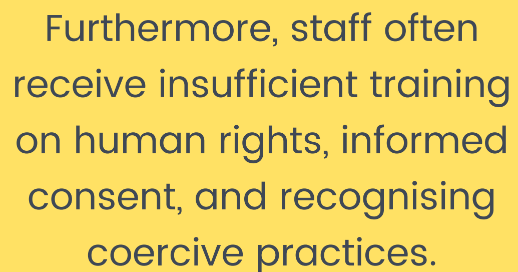
Following an eight-week community assessment, Children's Services concluded there were no concerns.

d. Healthcare professionals fearful of regulatory consequences, bullying and isolation

Findings

Coercive practices within maternity care are often shaped by systemic challenges rather than the actions of individual staff. Many healthcare professionals report observing coercive practices. But most feel unable to raise concerns, whether that's due to the limitations of mechanisms enabling them to speak up, fear of formal complaints or regulatory action and a feeling of being replaceable as in many areas there is a scarcity of available jobs.

These constraints hinder professionals' ability to fully advocate for women and birthing people, contributing to coercion and underscoring the need for strengthened systemic support, guidance, and training.



One survey respondent described their midwife's openness about the team's lack of training and fear regarding an "out of guidance" home birth. While the respondent appreciated the midwife's honesty, they also described how it created a sense of coercion: the disclosure of fear and discomfort felt like pressure to abandon their choice, rather than genuine support for their autonomy.

Insights from Healthcare Professionals on Coercive Practices

Healthcare professionals who contacted us through our online survey or our information and support service described a range of coercive practices affecting women and birthing people that they witness in maternity care.

These include:

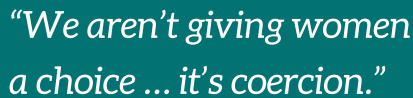
- lack of adequate information to enable informed consent,
- the framing or selective presentation of information in ways that limit meaningful choice,
- the use of fear-based messaging,
- unconsented procedures (such as vaginal examinations),
- inappropriate mandatory referrals (including to other NHS services)
- language such as *"we need to do this or the baby will die,"* which they feel removes any real sense of autonomy,
- Negative, discouraging, or judgmental responses from obstetric teams and other staff disproportionately target women and birthing people who seek personalised care (that is unfairly named as "out-of-guidance")

Evidence

One example that healthcare professionals reported was that women and birthing people are often pressured into induction of labour, encouraged to persist with induction even when it is clearly not progressing, or discouraged from opting for a caesarean section despite repeated requests.

According to these accounts, pressure can come from both medical staff and senior midwives, effectively overriding the women and birthing people's clearly expressed preferences.

"I just feel like we are harming women by having to follow these 'guidelines' which are causing more harm than good."



"We aren't giving women a choice ... it's coercion."

"We think we are giving women a choice but the language used is scaring them into thinking well if I don't do what the doctor says then my baby will die or something awful will happen. When in actual fact an early induction before labour starts naturally and the body and baby are ready is one of the biggest contributors to adverse outcomes and birth trauma."

– Survey respondent

One interviewee told us:

"I have frequently witnessed coercion around vaginal examinations. Whether that's women being told they can't be admitted without having one or being 'persuaded' to have one if the routine four hours has come around but they've declined. I've informed a senior midwife and the doctor on shift that the woman I was caring for did not want a vaginal examination at that time, only for the doctor to say, 'I'll go in and persuade her.' There was no clinical urgency for this examination."

One survey respondent described the routine use of negative, overly alarmist or absolutist language which, even when intended to inform, can function as fear-based persuasion rather than balanced risk communication. They reported that communication skills and the nuance required in conversations with patients are often below the standard expected from professionals.

Healthcare professionals express frustration about coercive practices in maternity care and consistently highlight the structural drivers behind them.

These include the dominant coercive culture within services, staffing shortages, and insufficient time with women and birthing people. They also warn that these practices are being passed on to the next generation, as student midwives and trainees are educated within the same environment, normalising coercion as part of routine care.

One interviewee explained:

"'Everyday coercions' are often communicated by 'this is what is going to happen' instead of explaining the rationale & asking people what they would like to happen.

The phrase 'we/I need to ... e.g. check your blood pressure' (adding 'Is that OK?') is often used.

"I think telling people we 'need to' do something, however innocuous it might be, without explaining the rationale & making it clear that saying no is an acceptable option, is coercive - as nobody wants to challenge or question their midwife when they are in such a vulnerable & dependent position."

A survey respondent raised concerns around losing the women and birthing person's confidence in the system. They reported that although they wished to offer clearer, more accurate information, they felt constrained by a culture in which contradicting colleagues could confuse women and birthing people or be perceived as undermining the clinical team, further complicating the already fragile landscape of trust.

Different forms of coercion experienced by healthcare professionals

Healthcare professionals, particularly midwives, reported that coercive dynamics within maternity services do not only affect women and birthing people; they also shape the working conditions and professional autonomy of staff themselves. Midwives described encountering forceful, intimidating, or threatening behaviours from colleagues and senior staff when attempting to uphold informed consent or support women and birthing people's choices.

Structural factors further reinforce these dynamics. Junior midwives, in particular, are highly susceptible to pressure from senior staff within hierarchical team structures. Safeguarding is repeatedly emphasised across services, generating a heightened sense of accountability (and fear) about being held responsible if concerns are missed. Yet in the context of chronic understaffing, limited resources, and the absence of continuity of care, safeguarding often becomes a tick-box exercise. Assumptions and judgements are used as tools to secure compliance rather than to genuinely support women and birthing people, embedding coercive practices even more deeply into routine maternity care.

One midwife reported that Trust solicitors threatened them after they attempted to develop structured pathways for women seeking care outside standard recommendations.

One midwife described a case in which, after several planned home births were deemed "out of guidance," the team lead contacted the women directly, implying that the midwife may have unduly influenced their decisions and probing for potential complaints.

"On a number of occasions I have felt 'blamed'/ 'made responsible' when women have chosen to 'birth outside of guidance' and there are poor outcomes."

"There is a lack of insight that if a woman has capacity and has made a fully informed decision then we need to support her in that and that HCPs do not need to agree with the woman's fully informed decisions to be able to support them in whichever way the woman will allow.

The doors need to be kept open. Women need to know we are still there if they need us or change their minds. The current climate of fear and lack of support will only push women into seeking advice from non registered birth workers and social media because they feel these are the only forums where their wants will be heard first.We have run multiple Birthrights education days at my trust but unless this training is mandated, only the HCPs who are already enlightened and aware of human rights law will attend."

– Survey respondent

Bullying and silencing

Midwives also described the absence of psychologically safe working environments, where raising concerns is discouraged and often met with hostility. Many reported persistent pressure from senior clinicians (particularly consultants) to enforce decisions on women and birthing people, even when these decisions directly contradict the individual's stated preferences. Some midwives spoke of being bullied, dismissed, or silenced when they attempted to provide balanced information or challenge unsafe or rights-violating practices. Others described feeling unable to question clinicians, even in situations where it was clear that the clinician lacked relevant knowledge or was making inaccurate claims, leaving midwives powerless to advocate for the women in their care.

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

"I didn't do it because of my own personal values and integrity.

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

"I watch my colleagues walk away from promotion as they are bullied from above and below."

"I was spuriously referred to NMC on trumped up allegations – all completely unfounded and dropped by NMC but only after it taking a year to get to that point.

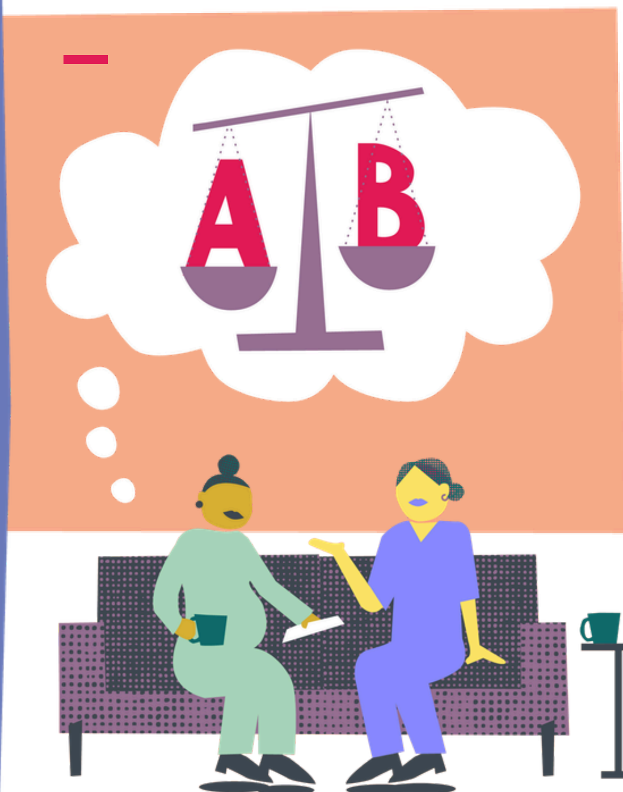
When I asked the NMC what they planned to do to protect midwives from this behaviour and to punish the Trust I was told there was nothing could be done."

– Survey respondent

Some are choosing to become independent midwives as a result.

"It was trying independent midwifery or leaving midwifery. Leaving midwifery completely would have been very sad – I love this job. I know (without sounding like an egotistical human) that I'm really good at being a midwife – but I wasn't able to be a great midwife in a system that doesn't really care about its staff or its clients. Independent midwifery has given me back my passion for midwifery. I have the time to really build a relationship with the women and birthing people in my care, to be able to talk things through with them without an ounce of coercion or fearmongering."

– Interviewee



"I wasn't able to be a great midwife in a system that doesn't really care about its staff or its clients."

Legal teams threat

Respondents also raised concerns about the involvement of Trust legal teams when women make informed decisions that fall outside standard clinical guidelines. Attempts to create supportive pathways for these decisions were sometimes met with strong opposition from Trust legal teams.

In such cases, midwives reported facing significant pressure to comply with recommended interventions or monitoring, reinforcing a coercive and intimidating environment that constrains autonomy for women and birthing people and healthcare professionals alike.

Midwives leaving the profession

From mid-March to June 2025, we collected responses from trained, practising, and student midwives to better understand the challenges they face within the profession. Findings from that survey highlighted significant structural pressures: midwives reported burnout, bullying, and multiple barriers to career progression. Training was described as inadequate, particularly in relation to complex situations, bereavement care, and physiological birth. Many midwives qualified without ever attending a home birth.

As a result, large numbers felt unsupported and chose to leave the profession.

Responses to the current survey on coercive practices echo these concerns. Healthcare professionals described feeling pushed out of the system either forced to leave entirely or compelled to work independently. Several shared experiences of being "retrained" or redirected away from supporting women and birthing people's choices, often as a means of preventing them from practising in a rights-based way. For many, this erosion of professional autonomy and values ultimately led them to leave the profession altogether.

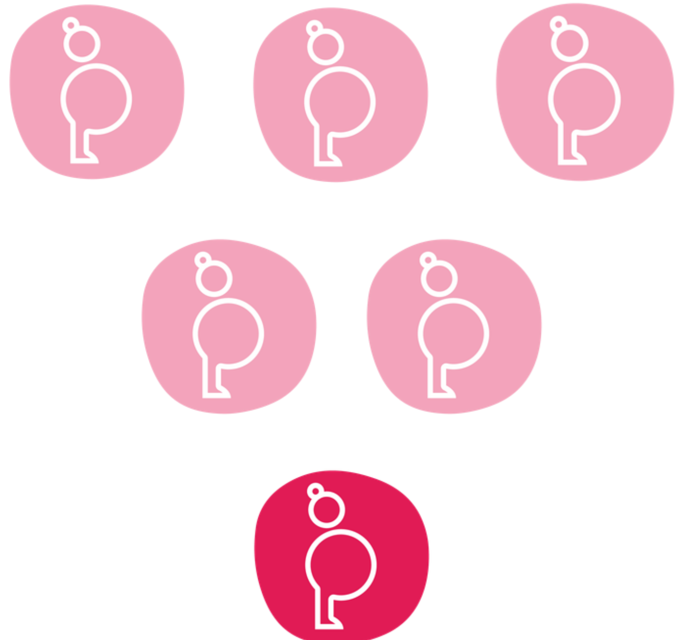
"There is no jobs at my trust or any of the trusts in my area. This has really made me feel dejected and unwanted after working so hard for nearly 3 years!"

"Have not yet seen a homebirth in 1.5 years of training."

"I don't feel like there is a future in the NHS, the senior roles are so unappealing, who wants to be a Matron or HOM when you will be abused on all sides and never have any work life balance."

"I have moved into children's safeguarding as midwifery is so dire".

"Expert midwives are underfunded and undervalued"



Evidence

"I'm seeing an unprecedented increase in referrals to the Birth Choices and Personalised Care Planning Clinic I lead... I've never experienced such a challenged trust...no sustainable homebirth team (staffed from the labour ward, midwives scared and in-experienced, and only 0.4% of our annual birth rate), poor antenatal and postnatal continuity, no MLU.

Women locally don't have choice over the places they can birth and they deserve better. No wonder women want to birth at home 'outside of guidance'. I'm finding it increasingly difficult to engage women with MDT discussions because of the threat of coercion...so

"I'm often the bridge or the middleman and receive a lot of challenge for supporting women's choices."

– Survey respondent

"I don't feel I was prepared well enough to advocate for the women and birthing people I support. I mostly felt I was indoctrinated into a system that puts its own needs above the women we support."

Another survey respondent said:

"Women are regularly given info that is not 100% accurate such as 'it's just a little clip on baby's head'. I recently heard a woman asking if oxytocin augmentation is safe - the answer was 'yes, perfectly safe'.
I wanted to tell her the truth but then I didn't want to confuse her and for her to think that doctors and midwives weren't a team. Which on the whole we usually are quite a good team.

I would have challenged the doctor about it later on but a lot was happening on the labour ward and I didn't get the chance to. Many years ago (different trust) I heard a registrar telling a woman with an undiagnosed breech that there was a 10 % chance the baby would die without a LSCS. (She had a vaginal breech when the consultant got there and all was ok)."

When asked how the system could better support healthcare professionals to deliver rights-respecting, consistent personalised care, one midwife told us:

"An understanding of human rights in childbirth needs to be ingrained – from university and then continuously through practice. This training needs to be multidisciplinary. Doctors and midwives need to train together."

"How can we expect staff who aren't treated with respect to always provide empathetic care?

This has to change. Better working conditions are only one piece of the puzzle."

Another said:

"Staff need to be treated well to be able to provide truly respectful and compassionate care."

"The culture of maternity units is that it's considered normal to not get a break, to even be able to go to the toilet or have a drink on shift."

"Service-user perspectives embedded into all training will help staff understand the harms they can unwittingly & unintentionally cause.

Parallels with grooming come to mind & could be presented in training - how a coercive pattern of behaviour is set up & then escalated."

7

What good looks like

7. Good practice examples: informed consent and non-coercion are possible

One interviewee suggested:

"All midwives and doctors should have regular training on human rights in childbirth, with scenarios and maybe even role-playing too.

Hospital staff are overworked and there is such a fear of litigation and for some Trusts they have very damning reports looming over them, which makes them buckle down on intervention, coercion and disrespectful practices.

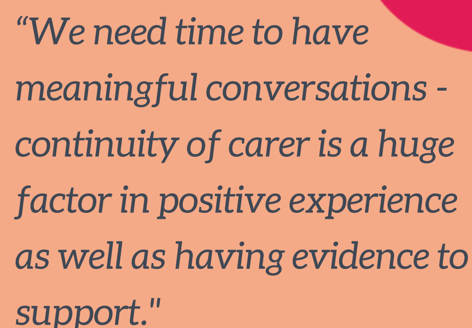
I don't know if this idea will ever be feasible in the NHS but almost like independent consultants who can come and assess the workplace culture and see what could be improved. Because it's wild to me that the culture of different maternity units can vary so much."

"We need to find the examples of exemplary practice – and I know they exist! – and figure out how we can transplant them to other units."

Another said:

"Training around human rights in maternity needs to be embedded right from the start and explicit examples discussed frequently in the same way that clinical situations are."

"I'd love for MNVP leads etc to be present at so much more and have regular opportunities to feed back to clinical staff. Sharing individual stories (positive and otherwise) could reinforce theoretical teaching."



"We need time to have meaningful conversations - continuity of carer is a huge factor in positive experience as well as having evidence to support."

Consultant midwife and academic Dr Anna Madeley said:

"Through my ongoing research and that of my colleagues, I know there are pockets of excellence in non-coercive practice, and these tend to be the simple things such as giving time and space for some to make their decisions, supported by the wider teams and a degree of preparedness for when women say no, or don't confirm to normative expectations.

“Consultant midwives were key people in my study to act as a bridge between the challenges of providing rights respecting care and clinical pressures on services."

Midwife Tracy Miller said:

"At the Norfolk and Norwich Hospital (NNUH) we have a robust, longstanding (5 years) homebirth team, made up of 6 experienced midwives. Supporting us to support birth choices is the "Out of Guidance Guideline" which we refer to when any woman/birthing person (WBP) is making choices outside of other local and national guidance pertaining to pregnancy, labour and birth. In my own practice, I feel able to have unbiased, non-coercive and current evidence-based conversations with WBP to promote and support informed decision making.”

“We record this as a Personalised Intrapartum Plan (PIP) which is then available for all care providers to read/support. Examples are WBP choosing to have homebirths with risk factors such as previous caesarean section, previous postpartum haemorrhage, raised BMI, suspected large or small fetus, declining aspects of recommended routine care in labour amongst others. This guidance is implemented maternity wide including the collocated Midwife Led Birthing Unit.”

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

“Locally, we have had 1 x half day training in 2024. Otherwise, the guideline mentioned above was discussed at annual mandatory training for midwives over the course of 1 year in an attempt to capture all midwives and presented at the monthly Clinical Governance meetings periodically in an attempt to capture the medical team.”

Sophie, an independent midwife, said:

"I get to really care and support women working this way, I get to work in a way that truly aligns with my values."

"When we do engage with the NHS with clients, relationships are thankfully good, but I am also then present in the role of advocate – and not being tied to the hospital means being able to advocate for our clients 100%. I'm sad that having an independent midwife is not an option available to all women."

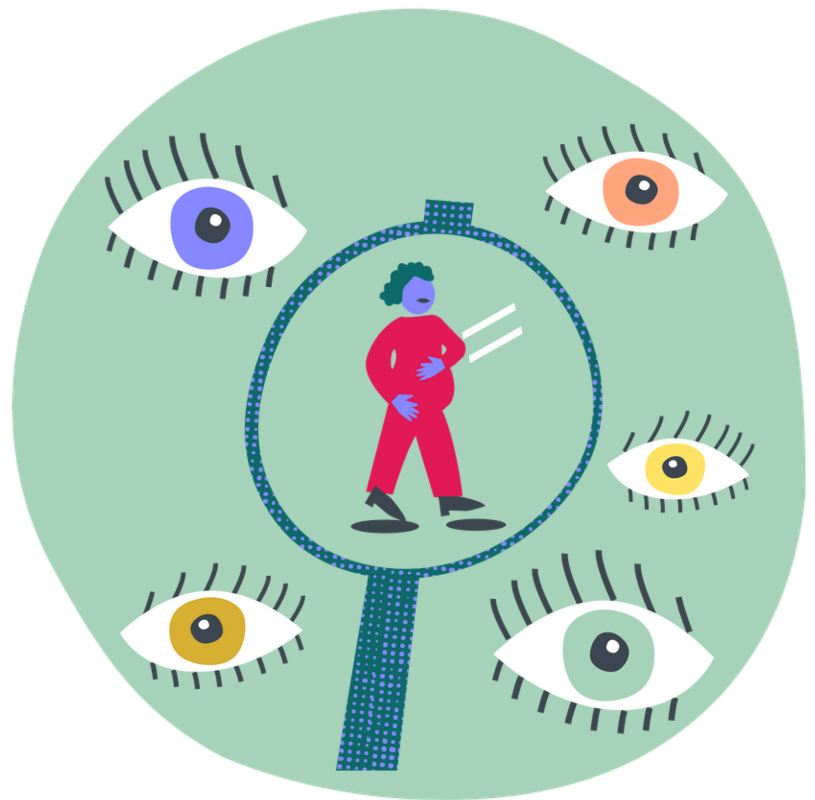
A survey respondent shared:

"On the whole though, at my hospital women are respected and there is good out of guidance support from the matrons for us and for the women. I have no qualms supporting a woman in her choice, I give her the info such as CTG is recommended in this situation by the Trust and RCOG etc but I reassure her that it is ok for her to make her own choices and we can talk about it further if she wants to."

"I would then document and inform the manager on call but I would absolutely support her choice. I have been a midwife for 30 years though and I have way more experience of normal birth than most midwives do now. I do think that this gives me confidence in many ways that is difficult to get now that there is just so much intervention."

An obstetrician told us:

"Delivering sensitive and interactive session around trauma-informed care and informed consent, and using verbatim examples from patient notes has been a really powerful way of illustrating how the concepts apply in reality and exploring how pressures and assumptions affect practice."



"This does need protected time and psychological safety for colleagues to fully engage with uncomfortable topics and self-reflection."

"Weaving patient stories through simulation sessions and direct quotes was a game-changer and I'd love to see this as routine in PROMPT/other training simulation rather than the traditional skills drills that are more cold and clinical, losing the human side and appreciation of how those situations might feel for the person on the receiving end."