FIVEXMORE

THE FIVE X MORE BLACK MATERNITY EXPERIENCES REPORT: CONTINUING THE CONVERSATION ON BLACK MATERNAL CARE IN THE UK

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NOTE FROM THE CO-FOUNDERS

Atinuke Awe and Clotilde Abe

Co-founders of Five x More

There is no moment more critical in a woman's life than the journey into motherhood and yet for far too many Black women in the UK, that journey is marked by fear, dismissal and unequal care.

When we published the first Black Maternity Experiences Report in 2022, we did so to shine a light on truths too often ignored. That report wasn't just data. It was a collective testimony that challenged the system to listen, and since then, we've seen real momentum begin to build.

In the three years since, Black maternal health has moved from the margins to the mainstream. Stories once confined to community spaces are now reaching national platforms. For example, earlier in 2025, Coronation Street, a British soap opera with millions of viewers per episode, featured a powerful Black maternal health storyline. We were proud to consult on the development of this narrative, ensuring it reflected the lived experiences of Black women and helped raise national awareness of the disparities they face during pregnancy and childbirth.

We also delivered a TedX London Talk in January 2025 titled "The fight to save Black mothers lives" as well as running our annual national campaign that began in 2020 - the 'UK Black Maternal Health Awareness Week', reaching over half a million people in just one year alone through our social media posts.

This growing visibility is matched by political and policy movement. At the time of writing this, a dedicated Black maternal health inquiry is taking place and a new Maternity and Neonatal investigation and Taskforce is being launched, with a stated commitment to tackling racial and socioeconomic disparities. And for the first time, a major UK political party has committed to setting explicit targets to close the maternal mortality gap for Black and Asian women, showing a willingness to not only address the issue but actually put in place tangible steps to reduce the disparities we know all too well.

Yet the reality remains stark. Black women are still 2.9 times more likely to die during pregnancy or the postnatal period. While this figure may suggest a marginal change from previous years, the difference is not statistically significant. At the same time, the rate for White women has increased, meaning that the gap may appear to have narrowed on paper, but the reality is far more complex.

NOTE FROM CO-FOUNDERS (CONTINUED)

For this reason, we have returned to the voices of Black women with this second Black Maternity Experiences Survey. We wanted to know what has changed and what hasn't. Over 1,100 Black women responded, with nearly half completing the survey in the first 24 hours. These numbers speak volumes. They refute the harmful myth that Black women don't participate in research and reaffirm our long-held belief that when you create spaces that are safe, trusted and community-led, Black women do speak, and they do so with power and clarity.

The findings of this report are significant. Whilst more women are self-advocating, many are still being ignored. Experiences of poor treatment and discrimination remain widespread.

Perhaps most concerning of all, women continue to report that the care they received did not reflect the ratings or reassurances they were given. There is a widening gap between what is measured and what is truly felt.

We acknowledge that this report is built on the courage and honesty of these Black women and it is an honour to not only serve them but to represent them in front of policy and change makers. We know it's not all bad and we wanted to ensure that, although few and far between, those positive experiences were also included in this report because we can learn from them, too.

Our sentiment is clear. Fix it for Black women, fix it for all women.

Atinuke Awe and Clotilde Abe,
Co-founders of Five x More

FOREWORD

As I write this foreword, the latest evidence session in the UK parliament's Health and Care Select Committee's inquiry into Black Maternal Health has just concluded. Findings of the inquiry are awaited. The evidence from more than 800 Black and Black mixed heritage women encompassed within this report emphasises the importance of an ongoing focus on improving Black maternal health and care as well as improving Black women's experiences of maternity care. While the survey shows a few green shoots of positive experience, numerous women still report being dismissed, experiencing microaggressions and maternity care systems not delivering individualised, culturally appropriate care for Black women. Women described experiences of labelling and direction towards high-risk care pathways solely on the basis of their race and ethnicity with no apparent medical justification.

Following the transformative "Six Steps" approach championed by Five x More, many women described advocating strongly to receive respectful care but with consequent feelings of the exhaustion of self-advocacy.

These findings come on a background of persistent inequalities in outcomes for Black women and babies compared to their White counterparts. Recognising that maternal deaths are uncommon – one Black woman dies for every 3500 Black women who give birth – each woman must be recognised as an individual who leaves behind orphaned children, family and friends. One White woman dies among every 8200 giving birth, showing the extent of the difference we still need to tackle. We know that similar differences are seen in severe maternal complications and baby deaths.

What then has changed since the last Five x More survey in 2022 and what can we learn from this latest report to help progress to a position of equity for Black women and women of Black mixed heritage? Although a significant disparity still exists in comparison to White women, maternal mortality rates are decreasing for Black women, falling from a peak in 2015-17. Sixty percent of women rated their antenatal and labour care as good or of a high standard, and the survey findings very clearly show that compassionate care can be transformative.

I would like to thank Five X More and all the women who took the time to share their experiences to enable a continued focus on this high priority area for action.

Marian Knight,
Professor of Maternal and Child Population Health, National Perinatal Epidemiology Unit (NPEU) and University of Oxford Lead for the MBRRACE-UK Confidential Enquiries into Maternal Deaths

ACKNOWLEDGEMENTS

This report exists because of the many people who believed in its importance and gave generously of themselves to make it happen.

To the Black women who opened up to us through this survey: you are at the heart of this report. You shared not only your experiences, but you also trusted us with your highs and lows. We don't take that trust lightly, and your stories will continue to move through the world, creating understanding and demanding change.

To everyone else who made this work possible, from our expert panel who shared their passion and expertise, the health professionals for sharing their knowledge and the reviewers who pushed us to ask more questions. Our special thanks go out to Dr Michelle Peter and Reyss Wheeler, our researchers who took the numbers and quotes and brought the data to life. Thank you for believing in the power of these stories and helping us tell them with the care they deserve.

We would also like to acknowledge the team at Clifford Chance who have supported us right from the beginning.

Finally, to our wider community, thank you for continuing to believe in us and for all your support.

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Dr Michelle Peter – Researcher and Senior Social Scientist

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Expert Panel

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Rt Hon Anneliese Dodds Labour (Co-op) – MP for Oxford East

Arnie Puntis – Senior Research and Policy Manager, NHS Race and Health Observatory

Dr Aziza Sesay – GP and Women's Health Advocate

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Councillor Evelyn Akoto – Cabinet Member for Health & Wellbeing, Southwark Council

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Dr Rumbi Mutenga – Doctor and Founder of Glacier Health

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EXECUTIVE SUMMARY

The state of maternity care for Black women

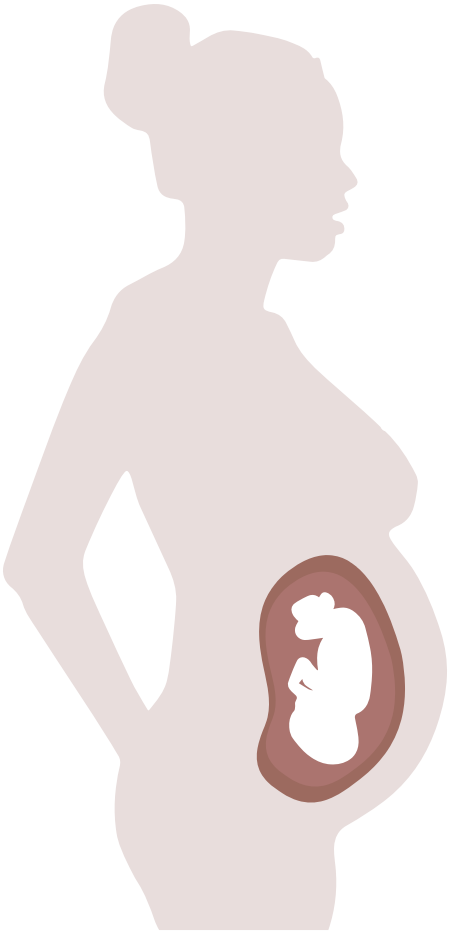
Black women in the UK continue to face disproportionately high risks during pregnancy, childbirth and the postnatal period. Despite a growing body of research and increasing policy attention, the gap in outcomes between Black and White women shows little sign of closing. In 2022, we launched the first national survey of its kind, placing Black women's voices at the centre of the conversation on maternity care. That report revealed a pattern of systemic racism, poor communication and harmful assumptions – experiences that were not merely distressing, but also resulted in long-term harm for some Black women.

Since then, we have seen political promises, institutional reviews and bold statements of intent. But have they led to meaningful change? This latest survey sets out to provide evidence and insight into what has improved, what has not, and where action is still needed.

What did we do?

The Black Maternal Experiences Survey gathered responses from 1164 Black and Black mixed-heritage women across the UK who had been pregnant between July 2021 and March 2025, of which 845 were retained for analysis. Using a mix of quantitative and qualitative questions, we explored experiences across antenatal care, labour and delivery, and the postnatal period.

What did we find?



- **60%** of Black women rated their antenatal care as good or high quality.
- **54%** experienced challenges with healthcare professionals.
- **28%** of Black women reported discrimination and, of these, **25%** said that this was due to issues around race.
- **45%** raised concerns during labour or birth; of these, **49%** felt their concerns were not properly addressed.
- **23%** of Black women did not receive the pain relief they requested, and **40%** of these women were given no explanation.
- Only **39%** received advice on nutrition, and just **27%** were spoken to about exercise at their booking appointment.
- Just 1 in 5 women **20%** had been informed on how to make a complaint, and only **8%** pursued a formal process.

EXECUTIVE SUMMARY (CONTINUED)

What has stayed the same?

Discrimination remains widespread. Racial bias was the most commonly cited reason for discrimination, echoing the findings of our 2022 report.

Black women are still being ignored. From antenatal appointments to postnatal care, women described having to push to be believed, especially when in pain or distress.

Poor communication and limited empathy persist. Women described care that felt rushed, impersonal or dismissive with limited opportunity for shared decision-making.

Basic rights are not being communicated. Key information, such as how to raise a concern or request a debrief, is not being routinely shared, leaving women without clear pathways for support.

What's new this time?

Black women are entering maternity care more prepared. Compared to 2022, more women reported researching their rights and preparing to self-advocate, not as a choice, but as a necessary survival strategy.

High-risk labels are applied without clear justification. Many Black women felt that their care options were influenced by their race, with limited explanation provided for the clinical need behind certain interventions.

Consistency is more important to Black women than ever. Women strongly expressed the need to see the same midwife or team throughout pregnancy. Where this type of care was achieved, experiences were positive, but these cases were not common.

Self-advocacy is rising but is emotionally draining. The burden of protecting oneself in a biased healthcare system is taking a toll on Black women's wellbeing.

Women's care ratings are disconnected from their reality. A number of women rated their care as "good" but went on to describe negative experiences of their maternity care, suggesting a worrying normalisation of substandard treatment.

What the evidence tells us?

Despite recent campaigning and rising political attention, the lived reality for Black women accessing maternity care in the UK has not fundamentally changed. Racism, both structural and interpersonal, continues to shape Black women's maternity experiences. On top of this, poor communication, lack of empathy and unequal power dynamics leave Black women feeling unsupported and unsafe.

What has changed, however, is Black women themselves. More are entering maternity care informed and ready to advocate – though we note that self-advocacy is more often a survival mechanism, not a sign of progress. When women feel they must fight to be heard or believe they need to prepare for biased assumptions before even arriving at hospital, the system is failing them.

EXECUTIVE SUMMARY (CONTINUED)

What the evidence tells us (continued)?

Reassuringly, we saw that personalised, compassionate care can make a tangible difference. Black women who received this kind of care remembered it and felt safer because of it, highlighting that high-quality, respectful care is not only possible but is already happening in some places. What is needed now is for this type of care to be the norm, not the exception.

Importantly, this report serves as a clear reminder that privilege does not shield Black women from poor or harmful maternity care. Specifically, our findings challenge the notion that income, education, or language fluency are protective: many of the experiences described in this work are those of highly educated, native-English speaking women in employment. When racial inequity is embedded in the system, social and economic privilege is not enough to ensure safe or respectful care.

Improved care for Black women requires real accountability and investment in the workforce as a core component of safety in maternity care. Until then, Black women will continue to carry the burden of keeping themselves safe in a system that too often overlooks or devalues their needs.

Moving forward for Black women

Achieving meaningful change requires national action, and this report outlines the steps needed to get there. Crucially, these changes will not only improve outcomes for Black women but also raise the standard of care for all who use maternity services. Our recommendations set out 6 key actions to improve the quality, equityand experience of maternity care. A detailed overview of all recommendations can be found on page 50.

Recommendation	Action
1. Improve access to complaints and support mechanisms in maternity care.	Increase the awareness of, and engagement with, an improved Patient Advice and Liaison Service (PALS).
2. Support earlier diagnosis, safer care and better outcomes across the maternity pathway.	Strengthen clinical knowledge, resources and training on conditions that disproportionately affect Black women.
3. Support informed consent and access to pain management.	Introduce a Mandatory Pain Relief Explanation Policy in all NHS maternity settings.
4. Improve transparency, trust and access to support.	Install maternity rights posters in all NHS maternity settings.
5. Champion informed care before, during and after pregnancy.	Develop a national digital health information pack for Black women.
6. Drive safe, joined up and personalised care.	Advance existing digital maternity record systems.

INTRODUCTION

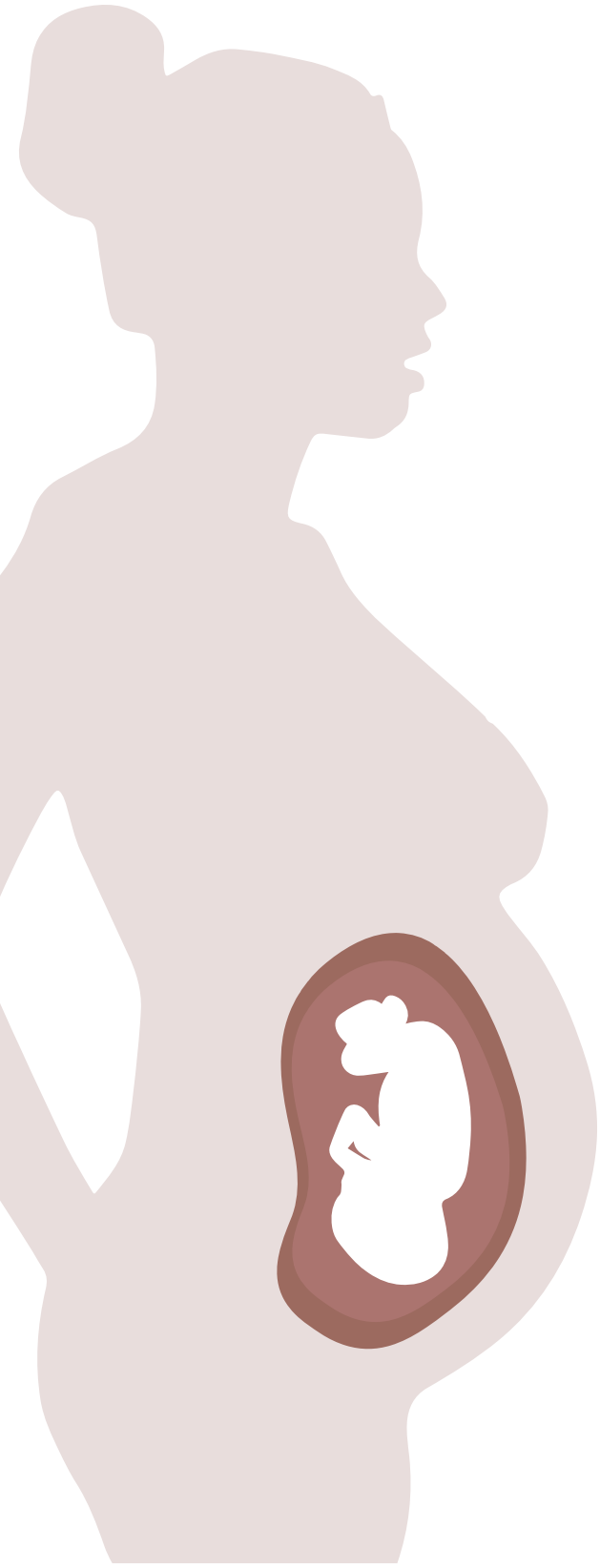
1 INTRODUCTION

In the UK, the maternal health of Black women remains a critical public health issue.

As has been the case for many years now, Black women continue to face disproportionately worse maternal outcomes compared to women from other ethnic groups. The most recent MBRRACE-UK report highlighted that Black women are still significantly more likely than White women to die during pregnancy, childbirth or the postnatal period[1]. The disparities extend beyond mortality, with Black women facing higher rates of stillbirth[2], preterm birth[3] and maternal morbidity[4]. While intersecting factors such as age and socioeconomic status have been cited as explanations for these disparities, evidence consistently shows that the gaps remain even after adjusting for these variables[5 6]. This enduring inequality, supported by qualitative evidence[7], strongly suggests that structural and systemic racism continue to shape the maternal health outcomes experienced by Black women in the UK.

In 2021, we at Five x More conducted the first national survey of its kind, with the subsequent report launching in 2022. The report centred the voices of over 1,300 women of Black and Black mixed heritage to explore their experiences of maternity care in the UK[8]. Our report revealed a pattern of discriminatory practices, microaggressions and neglect within National Health Service (NHS) maternity services that negatively impacted Black women. Over half had faced challenges with healthcare professionals, and several had experienced discrimination, most commonly due to race. Many women described feeling unheard and stereotyped, with some recounting traumatic experiences where urgent clinical needs were ignored or belittled. The findings exposed three core themes that underpinned negative experiences: the attitudes, knowledge and assumptions held by healthcare professionals (HCPs). These factors manifested in dismissive interactions, inadequate pain management, culturally insensitive care and unequal treatment that resulted in not only poorer clinical outcomes but also long-lasting emotional and psychological harm.

Since the publication of that report, the topic of racial and ethnic maternal health disparities has continued to gain momentum at the highest levels of health and policy. In December 2022, the NHS Race and Health Observatory released a comprehensive review of existing policy interventions aimed at tackling maternal and neonatal ethnic health inequalities. The report highlighted acute failings in care and called for urgent reform in training, clinical protocols and data systems[9].



In March 2023, the Women and Equalities Committee reinforced these calls, urging the implementation of targeted measures to reduce maternal health disparities.

However, the Conservative government at the time rejected the need for specific targets, asserting that the disparities were "complex" and that a fixed target or strategy was not "the best approach towards progress"[10]. They defended this position by citing the embedding of equity within NHS England's Three-Year Delivery Plan for Maternity and Neonatal Services, claiming this framework was sufficient to tackle the inequalities[11]. The current Labour government has taken a markedly different stance. In their 2024 manifesto, they committed to setting explicit targets aimed at closing the Black and Asian maternal mortality gap, signalling a stronger political will to address racial disparities in maternity care[12].

Complementing this political pressure, the All-Party Parliamentary Group (APPG) for Black Maternal Health has continued to advocate for change through evidence sessions and parliamentary engagement. In practice, some NHS trusts have piloted Midwifery Continuity of Carer (MCoC) models– a model of care that can improve trust between midwives and woman[13], reduce health inequalities and improve maternal and neonatal clinical outcomes for women with social risk factors[14]. The Royal College of Obstetricians and Gynaecologists (RCOG)[15] has also acknowledged the need for key areas of change to address maternal health inequalities.

We have continued to campaign relentlessly for meaningful change and are regularly invited into government spaces, contribute as keynote speakers at leading maternal health and equity conferences, and develop essential resources specifically for Black parents. In October 2024, the Five x More app was launched. The app is a culturally tailored pregnancy and parenting platform that provides expert guidance, community support and trusted information designed to improve Black maternal health and empower Black mothers throughout their pregnancy journey. In addition, we host national awareness campaigns such as the annual UK Black Maternal Health Awareness Weeks, amplify community voices, and advocate fiercely for the rights of Black women to receive the safe, respectful and high-quality maternity care they and all people deserve.

This has been a demanding and often challenging journey, and yet, as the latest statistics show, the outcomes remain substantially worse for Black women.

It is for this reason that we once again turn to Black women who we consider experts by lived experience. In the context of heightened visibility and the emergence of multiple strategies addressing Black maternal health, we ask: Has anything truly changed? Have the concerns raised in our original report been taken seriously? Are healthcare professionals now delivering more responsive, informed and equitable care? Our 2022 report highlighted powerful examples where compassionate and person-centred care led to positive maternity experiences for Black women. But are such experiences now becoming the norm, or do they remain, as they were then, few and far between?

To answer these questions, we asked women living in the UK and identifying as Black or as having Black mixed heritage to complete a survey about their experiences of maternity care during the antenatal, labour and delivery, and postnatal period. Our aim was to uncover whether experiences have improved since the last report to identify persistent or emerging barriers to equitable care and to understand how increased policy and institutional attention may have translated, if at all, into better outcomes and experiences for Black women.

Language and inclusivity

Throughout this report, we use the term "women" to describe those who have accessed maternity services. We recognise that not all people who become pregnant or give birth identify as women. We have chosen this approach for readability and to reflect the language used by the majority of participants, while acknowledging the need for gender-inclusive care and language in all aspects of maternity services.

We are mindful of the importance of representing the views of all pregnant women and birthing people and the survey was open to anyone in the UK who identified as Black or Black mixed heritage, including people from LGBTQIA+ or non-binary backgrounds. For consistency, we felt it important that the language used in this report reflects the language used in the survey. We therefore refer to "Black women" and "Black mixed heritage women" throughout this report.

Disclaimer

Please note that this report includes discussion of traumatic and uncomfortable birthing experiences which some readers may find distressing.

METHODS

2 METHODS

Study design

We used a cross-sectional online survey to explore the maternity care experiences of Black and Black mixed heritage women living in the UK. The survey captured both quantitative and qualitative responses, using closed-ended questions with open-text fields to allow respondents to provide further details. This approach enabled us to assess measurable trends whilst also allowing space for narratives to emerge. Whilst the aim of the survey was to compare experiences from the 2022 report with those of the present day, the current survey was not identical to the one conducted in 2021. We retained many of the same core concepts and topics but refined our approach by improving the wording and framing of questions to support clearer interpretation and more meaningful responses.

Participants

The survey was open to those who 1) Identified as Black or as having Black mixed heritage (including Black Caribbean, Black African, Black British, or any multi-ethnic background that included Black heritage); 2) Had been pregnant between July 2021 and March 2025; and 3) Were living in the UK at the time of their maternity experience.

Recruitment and data collection

Recruitment was through a targeted social media campaign, using platforms such as Instagram, TikTok, newsletters and LinkedIn. Posts were shared by community groups, national maternity organisations, health professionals and social media influencers. Recruitment messaging emphasised the importance of centring Black women's voices.

The survey was open from 5 February 2025 to 4 April 2025 and was hosted on a secure digital platform accessible via a web link. Before beginning the survey, participants were provided with an online information sheet and asked to give informed consent. The survey consisted of a series of multiple-choice and Likert-scale type questions covering various aspects of maternity care, including antenatal support, labour and delivery, postnatal care, communication with healthcare professionals, access to pain relief and experiences of racism or discrimination.

Data analysis

Quantitative data from the closed-ended questions were analysed descriptively to identify frequencies and proportions. Qualitative responses from open-text fields were analysed thematically. This included initial coding of the data followed by the identification of recurring patterns, sentiments and themes. Although we present the quantitative and qualitative findings in separate sections, illustrative quotes from answers to the open-text questions are occasionally included alongside quantitative results to provide additional context and insight. This approach helps to enrich the interpretation of survey responses and highlight the reasoning behind patterns observed in the data.

FINDINGS

3 FINDINGS

Participant demographics and contextual insight

This report presents the findings from women who were pregnant between July 2021 and March 2025, who identified as Black or of Black mixed heritage (**Table A**), and who received their maternity care in the UK. Of the 1,164 people who provided responses to the survey, surveys from 845 respondents were retained for analysis. Surveys were excluded if a respondent did not meet the eligibility criteria, or answers beyond the demographic and background questions were not provided. As questions were not mandatory, response counts vary across questions and may not always amount to the total number who took part in the survey. Due to rounding to zero decimal places, the individual percentages may not sum to exactly 100%.

The majority of respondents (68%, n=572) resided in London or the South East of England (**Table B**).

Table A. Participant ethnicity

Ethnicity	%	N
Black British / African	41	343
Black British / Caribbean	28	234
Mixed Ethnicity – Black British Caribbean and White	18	151
Black Mixed Other	5	41
Black British / African and Caribbean	4	35
Mixed Ethnicity – Black British African and White	3	25
Black Other	2	16
Grand Total	**100**	**845**

Table B. Participant residential region at the time of pregnancy

Region	%	N
London and South East	68	572
The Midlands	13	111
East of England	6	48
North of England	9	74
South West of England	3	29
Wales	1	6
Scotland	<1	3
Northern Ireland	<1	2
Grand Total	**100**	**845**

Table C. Highest level of education at the time of pregnancy

Level of Education	%	N
BA / BSc	56	472
Postgraduate e.g., MA/MSc, PhD	29	243
Post-16 Certificate or Diploma	6	49
A-Level (1+)/ Or equivalent e.g. Scottish Higher level	6	48
GCSE (5+)/ Or equivalent e.g. Scottish N5	3	24
No formal qualification	0.8	7
Level 4	0.2	2
Grand Total	**100**	**845**

Table D. Participant age at the time of pregnancy

Age	%	N
26-35	72.9	616
36-45	19.3	163
18-25	7.2	61
11- 15	0.4	3
45 +	0.1	1
16-17	0.1	1
Grand Total	**100**	**845**

Table E. Participant relationship status at the time of pregnancy

Relationship status	%	N
Married	56.0	466
Unmarried	23.0	195
Single	13.0	112
Civil partnership	6.0	51
Divorced	0.5	4
Separated	0.5	4
Widowed	0.1	1
Grand Total	**100**	**833**

Most women (73%, n=616) were aged 26–35 during their pregnancy (**Table D**) and over half were married (55%, n=466, **Table E**). The majority identified as Christian (68%, n=577, **Table F**), spoke English as their first language (88%, n=743), reported no disability (94%, n=791) or additional learning needs (96%, n=814), and identified their gender as female (99.6%, n=842).

Table F. Participant religion

Religion	%	N
Christian	70	577
No religion	22	178
Muslim	7	56
Any other religion	2	14
Grand Total	**100**	**825**

Of the 86% who referred to a previous pregnancy, 90% (n=660) reported a live birth, and 10% (n=70) experienced outcomes including miscarriage, ectopic pregnancy, neonatal death or termination for medical reasons (**Table G**).

Table G. Pregnancy outcomes reported by participants

Age	%	N
Full-term birth (39 weeks 0 days – 40 weeks 6 days)	42	357
Early-term birth (37 weeks 0 days – 38 weeks 6 days)	17	140
Late-term birth (41 weeks 0 days – 41 weeks 6 days)	13	107
Premature birth (before 37 weeks)	5	40
Post-term birth (after 42 weeks)	2	16
Miscarriage (loss of pregnancy before 23+6 weeks)	5	40
Stillbirth (loss of pregnancy after 24 weeks)	2	13
Neonatal death (within 28 days of birth)	1	7
Ectopic pregnancy (the embryo implants itself outside of the womb)	1	5
Termination for medical reasons	0.5	4
Molar pregnancy (embryo and placenta did not develop the way they should after conception)	0.1	1
Prefer not to say	14	115
Grand Total	**100**	**845**

Figure 1. Number of pregnancies participants had between July 2021 and March 2025

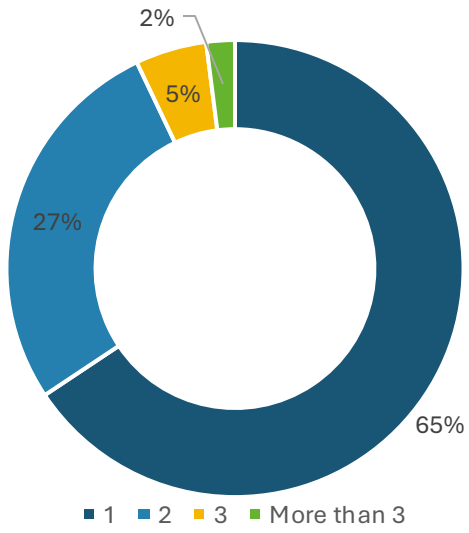
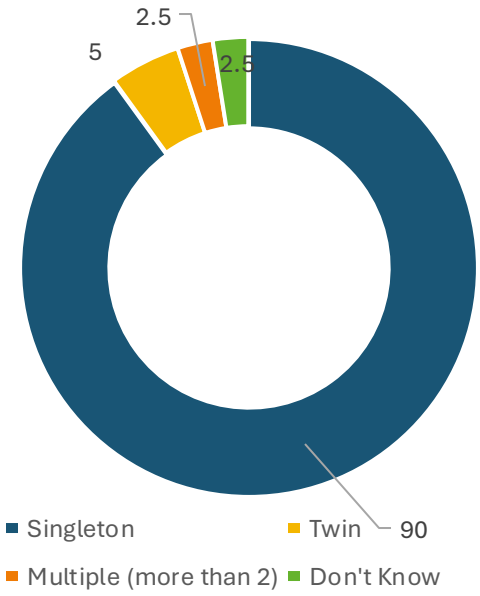


Figure 2. Percentage of participants with a singleton, twin or multiple pregnancy



Most participants reported having one pregnancy during this period. However, 35% (n=295) had two or more pregnancies (**Figure 1**). 14% (n=115) were pregnant at the time of the survey, while data from the remaining 86% (n=730) referred to a previous pregnancy. The vast majority (96%) had had singleton pregnancies, with only 4% (n=39) reporting twins or a multiple pregnancy (**Figure 2**).

Figure 3. Household income at the time of pregnancy

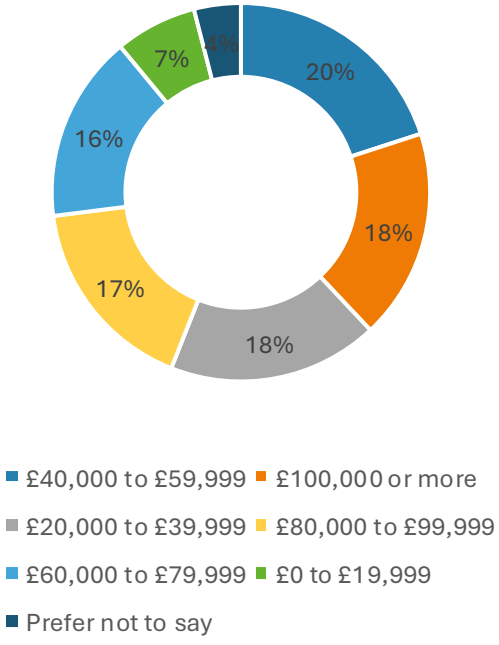
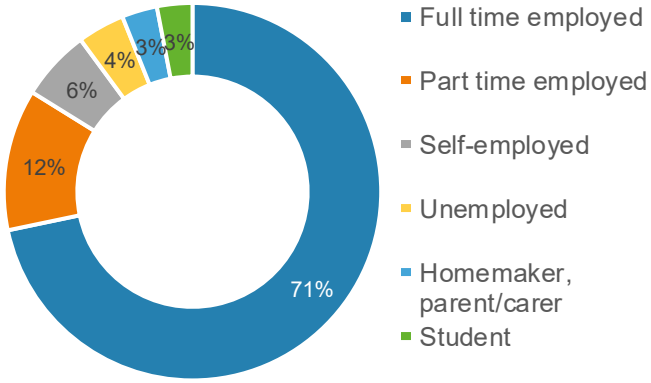


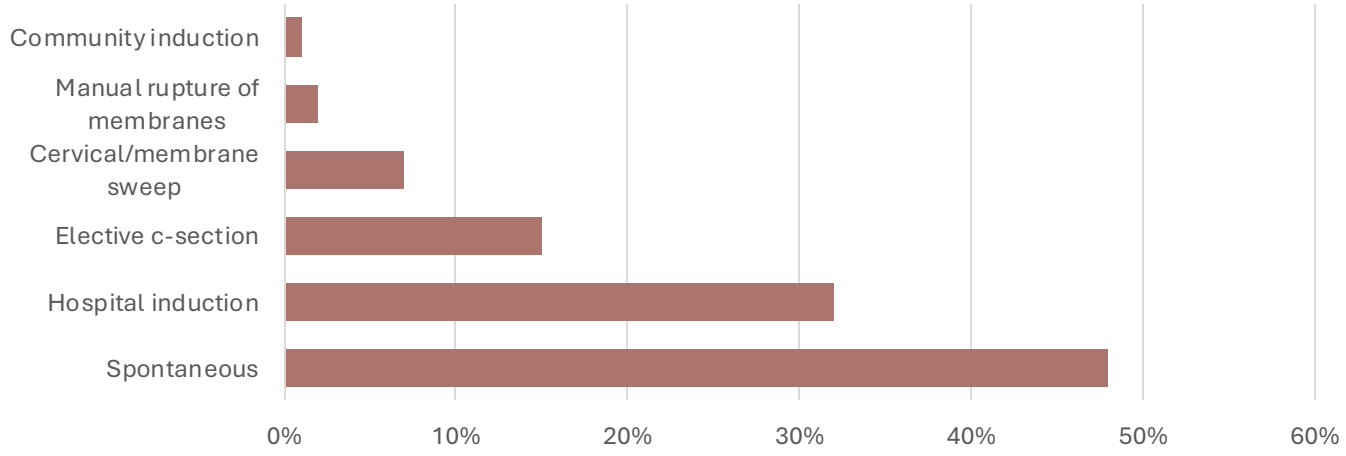
Figure 4. Participant employment status at time of pregnancy



The participant sample was highly educated and had higher than average earnings. A notable 85% (n=715) held a bachelor's degree or higher (**Table C**), and 51% (n=430) reported a household income of £60,000 or above (median = £60,000 to £69,999) (**Figure 3**). Additionally, 89% (n=750) were in paid employment during their pregnancy (**Figure 4**).

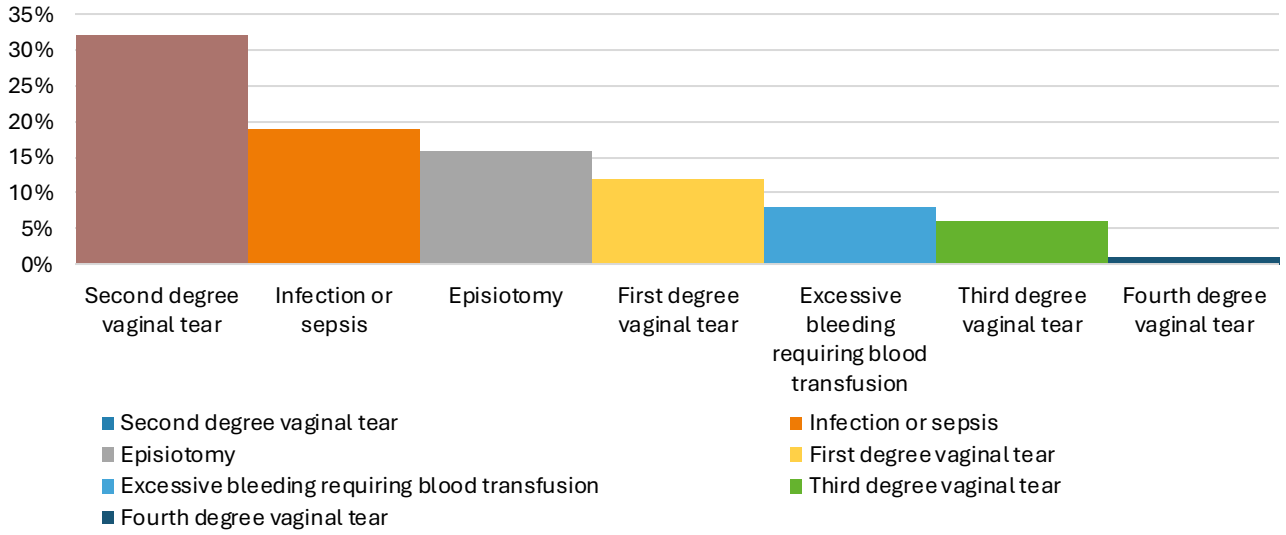
Amongst women who had a live birth, 48% (n=322) reported spontaneous labour. However, interventions were common: 31% (n=205) had a labour induced in hospital (**Figure 5**).

Figure 5. Percentage of women whose labour began with or without intervention



The most frequently reported mode of delivery was vaginal birth without instruments (48%, n=333), followed by emergency caesarean (30%, n=207) and elective caesarean (14%, n=97, **Figure 6**). More than half (43%; n=170) reported immediate physical complications. Of these, 20% (n=34) had experienced excessive bleeding requiring a blood transfusion and 19% (n=76) had had an infection or sepsis.

Figure 6. Percentage of women reporting cuts, tears and infections after birth



Women were asked about where their labour and delivery had taken place. Of those who provided an answer to this question, almost all (95%, n=657) gave birth in a hospital. A minority (5%, n=32) had a home birth. As a result, most women (86%, n=595) received care on a postnatal ward.

Quantitative survey findings

To highlight both systemic barriers and opportunities for equity, this section presents the experiences of Black and Black mixed heritage women across the whole group. No meaningful differences were identified between regional or ethnic groups.

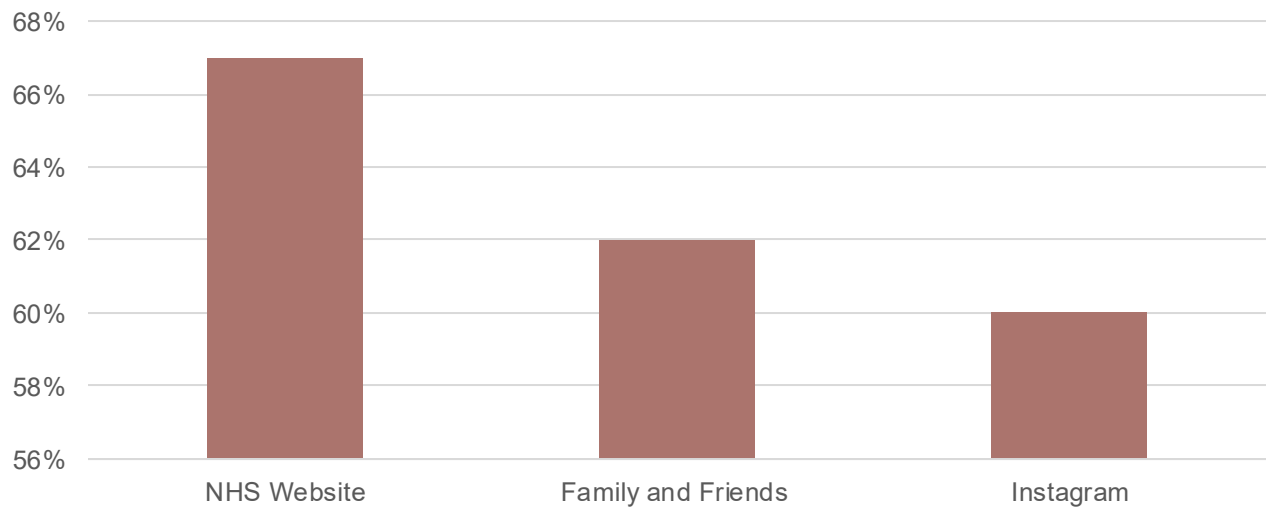
1. Use and engagement with services

To assess service engagement, participants were asked about their first points of contact, types of services used, and healthcare professionals encountered.

Early engagement with maternity services was common: 90% (n=760) had their first antenatal appointment within the first trimester, and 99% (n=836) attended sonography/scan appointments. Among those who saw a midwife after the first trimester (9%, n=76), reasons for this included: not feeling the need to engage early (22%, n=17), unawareness of pregnancy until after the first trimester (14%, n=11), and previous negative experiences (8%, n=6). There were also instances where women were not seen until after the first trimester because of appointment availability. One woman described how "the hospital kept cancelling my appointment" and another reported that she was seen after the first trimester because "that's when they could fit me in".

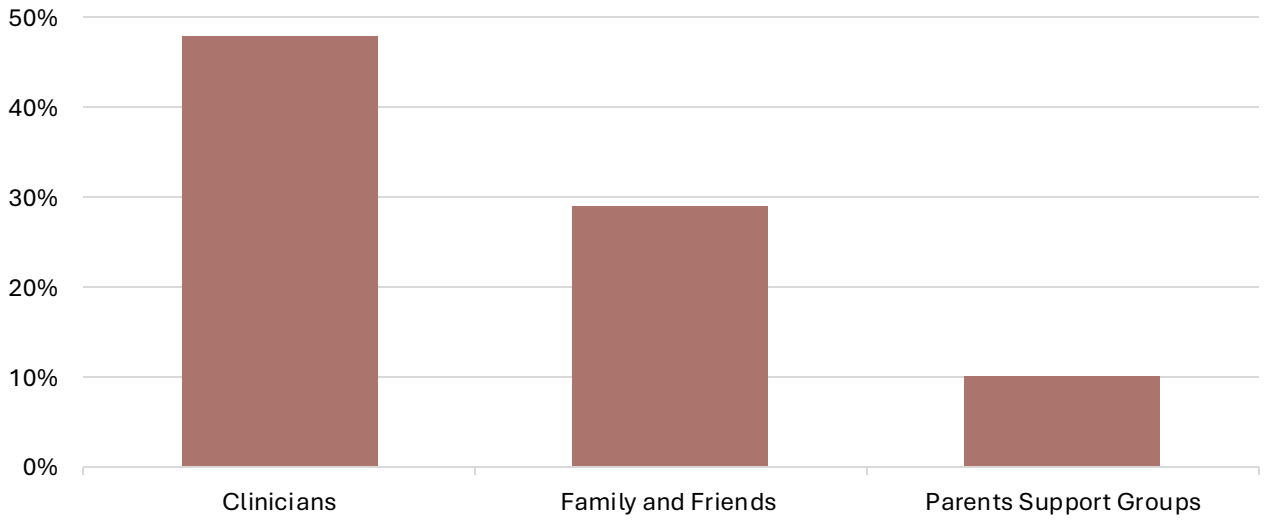
Use of private or non-NHS services was limited - only 11% (n=85) of respondents accessed private professionals. However, digital and informal sources of information were widely used (**Figure 7**). The three most used sources were: NHS website (67%, n=463); Family and friends (62%, n=426); Instagram (60%, n=415).

Figure 7. Sources of information on antenatal, labour and delivery and postnatal



When ranking the value of sources of information the three sources most commonly ranked in first position were: Advice from clinicians (n=322); family and friends (n=197); parent support groups (n=71, **Figure 8**).

Figure 8. Sources of information ranked the most valued by participants



2. Health, care and support needs

Pre-existing health conditions were reported by 31% (n=260) of women. Of these women, the most common conditions reported were fibroids, polycystic ovary syndrome, asthma and mental health issues (**Table H**). Of those with pre-existing conditions, 80% (n=208) reported that their condition was discussed during antenatal care.

Table H. Summary of pre-existing health conditions reported by women

Pre-existing condition	%	N
Fibroids	18	48
Polycystic ovary syndrome	18	47
Asthma	13	34
Mental health issue	8	21
Hypertension and high blood pressure	8	20
Endometriosis	7	18
Autoimmune disease	4	11
Anaemia	3	9
Other fertility/ reproductive health issues	3	9
Neurological disorders	3	9
Hormone or chemical imbalances i.e., hyperthyroidism, high prolactin etc.	3	9
Heart issues	3	7
Bowel disease/ issues	3	7
Blood disorders	2	6
Fibromyalgia/ chronic pain	2	6
Other joint or bone issues	2	6
Migraines/ Headaches	2	5
Scoliosis	2	5
Diabetes Type 2	2	4
Skin conditions	2	4
Sickle cell trait	2	4
Adenomyosis	1	3
Arthritis	1	3
Diabetes Type 1	1	3
Digestive conditions	1	3
Sickle cell disease	1	3
Inflammatory diseases	1	2
Vasospastic Disorder	1	2
Sexually transmitted infection/ diseases	1	2
Sleep disorder	0.4	1

Across the whole dataset, 25% (n=213) developed pregnancy-induced health conditions.

Amongst those with pre-existing conditions, 38% (n=81) went on to develop a pregnancy-related condition. Of the 211 women who shared their pregnancy condition with us, the most common conditions were gestational diabetes (45%, n=95) and pre-eclampsia (24%, n=50, **Table I**).

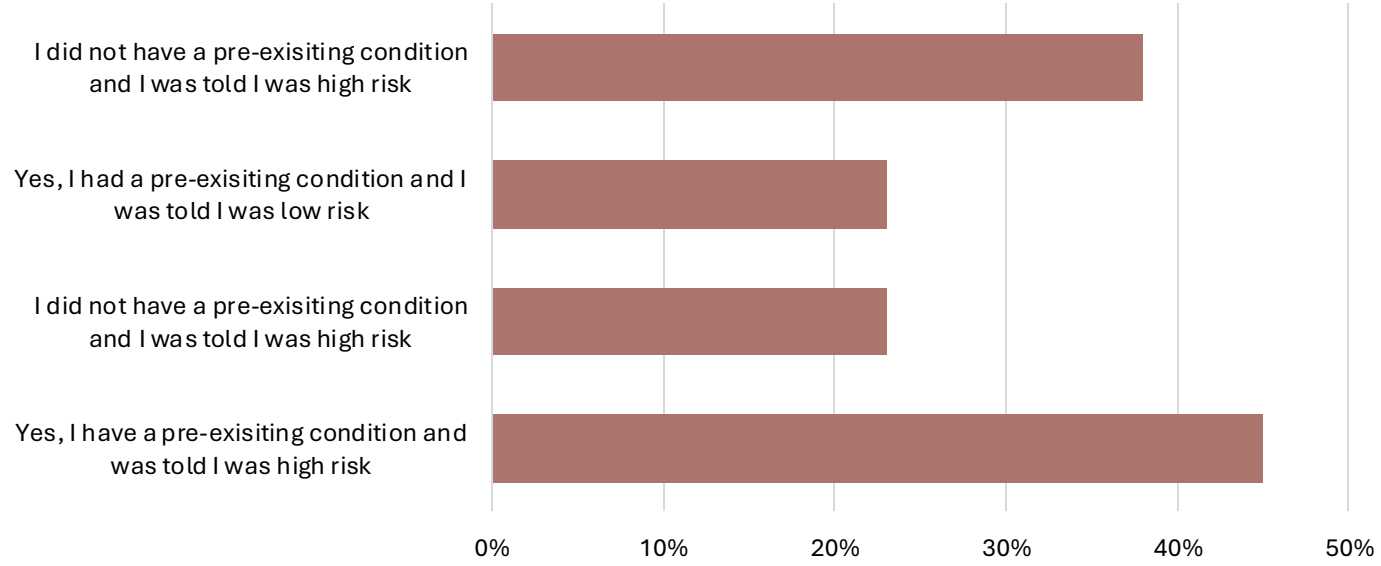
Table I. Summary of pre-existing health conditions reported by women

Pregnancy-induced condition	%	N
Gestational diabetes	45	95
Pre-eclampsia	24	50
Hyperemesis Gravidarum	11	23
High blood pressure (not diagnosed as pre-eclampsia)	11	23
Anaemia	2	5
Joint pain (including bursitis and pelvic girdle pain)	2	4
Vaginal Bleeding	1	3
Obstetric cholestasis	1	3
Mental health issue	1	2
Incompetent cervix	1	2
Low PAPP-A	1	2
Polyhydramnios	1	2
Deep vein thrombosis	1	2
Group B strep	1	2
B12 deficiency	<1	1
Gestational thrombocytopenia	<1	1
Pancreatitis	<1	1
Fibroid degeneration	<1	1

When asked whether they had been informed of their pregnancy risk level, 30% (n=226) of those who were able to remember said they were not told. Of those who reported being told their risk level, 47% (n=247) stated that they were told their pregnancy was high risk, and 53% (n=283) said that they were told their pregnancy was low risk.

Almost twice as many women with pre-existing conditions were told their pregnancy was high risk compared to those who did not have a pre-existing condition (43%, vs 23%, **Figure 9**).

Figure 9. The self-reported risk status of a woman's pregnancy and whether or not she had a pre-existing condition.



Importantly, key pregnancy protective factors were not routinely discussed at first appointments. Only 39% (n=329) and 27% (n=232) of women reported diet/nutrition and exercise were discussed, respectively. In addition, local maternity support services were discussed in only 19% (n=160) of cases (**Table J**).

Table J. Topics women reported were discussed at their initial appointment

Pregnancy Information	%	N
Previous health history	76	646
Folic acid	75	634
Wider issues e.g. Family background, employment status, housing, social services/worker (any other services)	71	602
Mental health (previous or existing history / and if second baby)	67	569
Smoking status	63	530
Domestic abuse	57	478
Medication prescribed or unprescribed (recreational drug use)	53	448
Birth options e.g. home birth, midwife led birth etc.	47	398
Prenatal screening tests	47	398
Vitamins	47	394
Nutrition / diet	39	329
Antenatal class	32	274
Exercise in pregnancy	27	232
Female genital mutilation (FGM)	26	222
Pelvic floor	23	192
Local maternity organisations	19	160
MNVP (Maternity Neonatal Voice Partnership)	3	29

3. Standard of care

a) Care during the antenatal period

Women were asked to rate the standard of their care during the antenatal period.60% (n=502) rated their antenatal care as "good" or of a "high standard" Some women felt they had a "really good experience" or compared their care to previous pregnancies:

"I had a fantastic experience this time round with a phenomenal home birthing team. I had such a traumatic experience with my child at another trust in 2020. This was so cathartic." (F78, Black British Caribbean, aged 26-35)

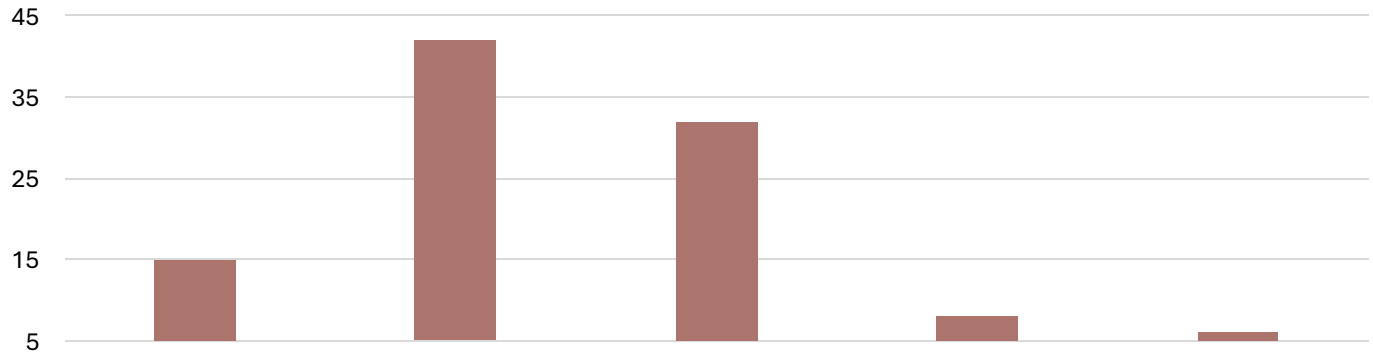
Others who rated their care as "good" reported that staff had been attentive and responsive to their needs:

"I was very well informed about everything and had my questions answered in a caring and professional way." (F146, Black British Caribbean, aged 36-45)

In our 2022 report, 27% of women rated their antenatal care as unsatisfactory. This time, only 12% (n=99) rated their antenatal care negatively as being "poor" or "very poor". Of these responses, women reported healthcare professionals (HCPs) as being "rude" or "dismissive". Women also expressed concerns that their medical histories were overlooked. For instance, one woman reported that her low iron levels were identified late in pregnancy, despite having informed HCPs of her history with this condition. Another woman stated:

"There was very little consideration given to how my fibroids or hip would react to pregnancy…No one had checked my notes so had no knowledge of my hip operation." (F690, Black British Caribbean, aged 26-35).

Figure 10. Standard of care rating during the antenatal period.



b) Care during labour and delivery

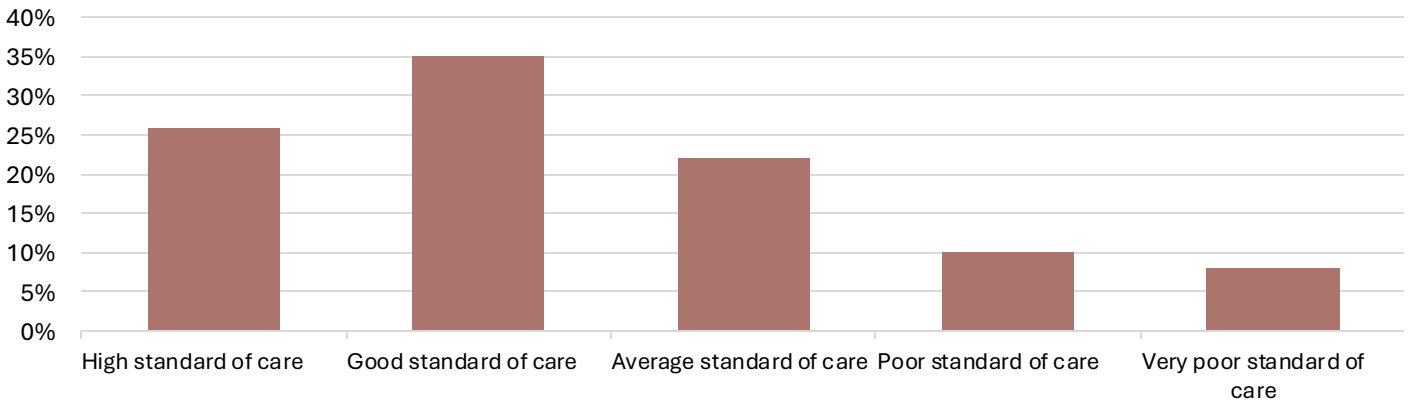
Ratings on standard of care during labour and delivery were similar to the antenatal period, with 61% (n=416) rating it as "good" or of a "high standard". Some women described their experiences as "amazing" and "caring", explaining that they had felt supported, and that HCPs had kept them informed throughout:

> ***"The staff on the labour ward were lovely. Very reassuring and calm. When there was a problem with my daughter's heart rate, the midwife told me she had pressed an alarm and explained what was going to happen." (F11, Mixed ethnicity - Black British Caribbean and White, aged 26-35)***

Another woman reflected on a memorable experience despite noting staff shortages amongst the maternity care team during her labour:

"The staff were amazing and professional considering they were understaffed that night. They really took care of me and my partner. I thank God that I had an amazing experience." (F41, Black British African, aged 26-35)

Figure 11. Standard of care rating during labour and delivery



Notably, some women provided ratings of care during labour and delivery that appeared to contradict their experiences. For example, one woman who rated her care as "good" recounted undergoing a procedure to which she did not consent:

> ***"Unfortunately, one of the midwives caring for me gave me a sweep without asking permission. This made me feel very uncomfortable and unsafe." (F312, Mixed Ethnicity – Black British African and White, aged 26-35)***

Another woman who rated her care as "good" explained that her needs were not met, and that HCPs were inattentive during her labour:

> ***"I gave birth at [HOSPITAL] midwife led unit. They have a policy (apparently) where women are not allowed to give birth on a bed…This is something I find ridiculous…We were able to compromise and find some foam-filled padding/cushioning to lie on, but this so-called policy, is barbaric to me and something I will never forget…I was left for a very long time before they returned to stitch up the vaginal tear. I remember I was cold and shaking from adrenaline and had to keep sending my husband out to find out where they were." (F172, Black British African, aged 36-45)***

Seventeen percent (n =117) rated their care during labour and delivery as "poor" or "very poor", a notable decrease from 42% in 2022. Similarly to themes present in women's descriptions of care in our last survey, poor experiences related to women feeling dismissed or ignored by HCPs:

"All of my cries for help were ignored…I had informed them of previous deliveries being very quick, but she [the midwife] refused to take the information on board. I was left to labour alone in a room…After the birth, I was not moved to a postnatal ward - and was told because of this I would not be offered any food." (F71, Black British African, aged 36-45)

Nearly half of all women raised concerns during labour and birth (45%, n=307). Of those, 49% (n=149) were unhappy with how their concerns were addressed. During labour, pain relief options were explained to 74% (n=391) of women. When asked if they had received the pain relief they had asked for, 23% (n=113) said they had not. Of those who did not receive the pain relief they had asked for, 40% (n=42) said that they were not given an explanation as to why it had been declined. One woman stated:

"I asked for pain relief but was told they had no gas and air on my ward despite me seeing others have it. They gave me a paracetamol and told me I wasn't in labour. My baby was born 10 minutes later." (F1014, Black British Caribbean, aged 36-45)

c) Care on the postnatal ward

When asked how satisfied they were with the care that they received on the postnatal ward in hospital, just 22% (n=129) said that they were "very satisfied". Amongst these women, there were reports of HCPs being "very accommodating", "one call away", and "exceptional":

> ***"The nurses were readily available even at odd hours in the night when I needed support with the baby, especially with expressing and breastfeeding as a first-time mum." (F904, Black British African, aged 26-35)***

"The care for myself and my baby was top-notch, with regular check-ups on me and baby's vitals." (F389, Black British African, aged 26-35)

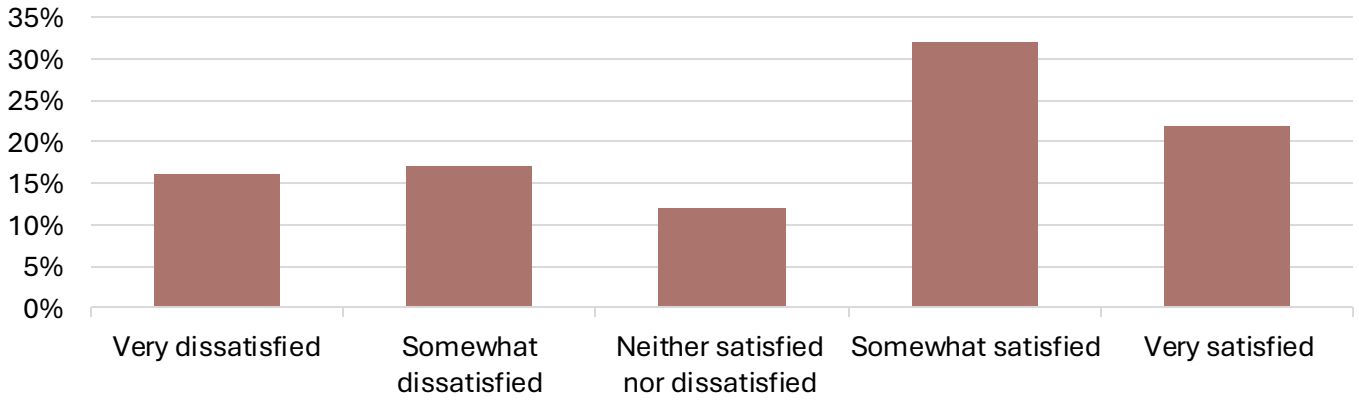
Experiences of those who stated that they were "somewhat satisfied" (32%, n=190) were more mixed. Some were ambivalent with no strong feelings either way, describing their care as "fine" and reporting that "on the whole it was okay". Others however, in a similar manner to the reports of care during labour and delivery, described experiences of care that were at odds with their rating of being "somewhat satisfied". One woman, who claimed to be "somewhat satisfied" with her care on the postnatal ward, described an experience in which she had not been supported with breastfeeding:

"The head midwife told me I was not producing enough colostrum for the baby and encouraged me to bottle/formula feed which then subsequently affected my breastfeeding journey. I felt her bias made her assume I wouldn't be able to breastfeed properly. However, turns out I was producing enough when I spoke to the lactation consultant the next day." (F241, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

Other women described experiencing discriminatory behaviour from healthcare professionals, feeling that they were shown less empathy and provided with less support than other women:

"The nurses seemed more receptive and caring to my non-Black counterparts in the ward. For me, they did the bare minimum…The difference was crystal clear." (F1051, Black other ethnicity, aged 36-45)

Figure 12. Satisfaction rating for women's postnatal ward experiences



Similar experiences were recounted by others:

"I realised the interaction and education they give to the White people was different. They were calm, friendly and helped them laugh, but when they approached me, they were very straightforward. More like in a rush to leave." (F461, Black British African, aged 26-35)

"I noticed the nurses speaking to other new mums about their feeding choices however, in my 12 hours on the ward, nobody came to speak to me about mine and whether I was confident/comfortable with breastfeeding." (F799, Black British Caribbean, aged 36-45)

Amongst those who rated being "somewhat dissatisfied" or "very dissatisfied" with their care on the postnatal ward (33%, n=197), there were accounts of wards that were "dirty", "smelly" and "a ridiculous temperature". Women described inattentiveness, staff shortages and HCPs who were "dismissive", "rude" and "nonchalant":

"The nursing team were awful, very unhelpful and it seemed like they were doing me a favour rather than doing their job…I had extreme abdominal pains the following evening after my c-section. It was so bad I had to attend A&E for a CT scan…The nursing team made excuses saying they could not wheel me to A&E because they didn't know where it was. In the end, one of the registrars wheeled me to A&E. It was just an awful experience, and I should have really complained." (F167. Black British African, aged 36-45)

Some women also reported poor communication, with information often delivered without compassion.

"I waited over an hour to be assisted to the bathroom. I had been given no communication about my health and the care plan that was to follow. When asked about discharge I was laughed at and told doctors won't be coming as it was a Sunday." (F48, Mixed – Black other ethnicity, aged 18-25)

"I had an emergency c-section and had to constantly call the nurses to give me adequate pain relief…I was in excruciating pain and also was sick for 13 hours and received more support from other mothers and their partners on their ward than from the midwives…I was treated really poorly…There were a few lovely nurses I came across who were kind, empathetic and helpful but unfortunately, the majority were not." (F541, Black British Caribbean, aged 26-35)

d) Care during the postnatal period

Women were asked to rate the standard of their care during the postnatal period – that is, their experience of care once they had been discharged from the hospital or from the homebirth team, if relevant. 56% of women (n=382) reported that their care was "good" or of a "high standard" during this time. Experiences of "high standard" care often related experiences of care from HCPs who went beyond their remit and who made women feel "empowered":

"I needed additional breastfeeding support, a community midwife came to me and spent nearly 2 hours giving me support, which I am grateful for." (F227, Black British African, Aged 26-35)

Yet again, there was evidence of inconsistency between women's ratings of care and the experiences they described. One woman, for example, rated her care during the postnatal period as "good" but went on to recount a concerning incident where a healthcare professional lacked knowledge of the implications of her baby's sickle cell carrier status. This uncertainty subsequently affected her baby's care, as a nurse was unsure whether a routine vaccination could be administered:

> ***"The health visitor told me my baby was a sickle cell carrier but did not know what that meant. This was the first time I had been told this but fortunately I know what it means…But if I didn't know the details it could be very distressing. They should have training on this. Also, a nurse giving my baby his immunisations did not know what it [sickle cell trait] was either and originally refused to give one vaccination in case it was affected by it.." (F747, Mixed Ethnicity – Black British African and White, aged 36-45)***

In 2022, between 23%-31% of women expressed concerns about the postnatal care they received from different healthcare professionals including midwives, health visitors and their general practitioner (GP). In 2025, where ratings of care were felt to be average (16%, n=85), there were often concerns about the accuracy of GP advice, with many feeling that their

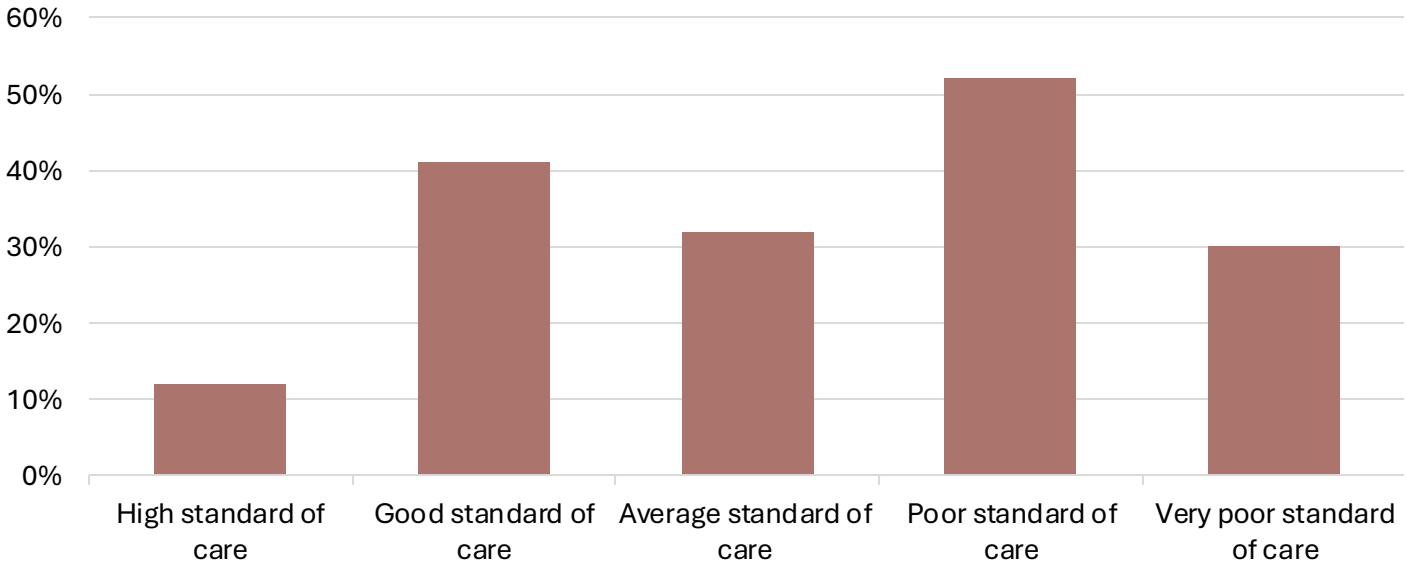
6–8-week postnatal check-up with the GP was not thorough and that the GP lacked knowledge:

> ***"The GP barely checked me at the 6-8week appointment and gave me incorrect advice (that I didn't need contraception because I was breast feeding)." (F562, Black British African, aged 26-35)***

One woman described her GP as "clueless", and others felt that the appointment was "pointless" and "a complete waste of time". Similar sentiments were expressed by others:

"My 6-8 weeks check-up was very vague. It was on the phone, and I felt like the GP was rushing me and just ticking boxes." (F463, Black British African, aged 26-35)

Figure 13. Standard of care rating for postpartum experiences with healthcare professionals



A number of women who rated their postnatal care as "poor" described brief, superficial check-ups and reported that HCPs had often failed to ask important questions about their physical and mental health:

"My GP appointment lasted 20 minutes and I had to stress that I required this appointment. No information provided around mental health support or my emotional wellbeing." (F949, Black British African, aged 36-45)

Others reported that the GP appointment focused on some issues and not others:

> ***"The GP glossed over and even seemed amused when discussing post-natal depression and support during the appointment. Signs that I may have needed additional support were not addressed even when raised by me. Their main concern was getting me to take contraception." (F1001, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)***

There were also reports of delays in the identification of significant problems with the health of women's babies. For instance, one woman whose baby took some time to return to their birth weight attributed this to different professionals giving her "conflicting advice". Another woman stated:

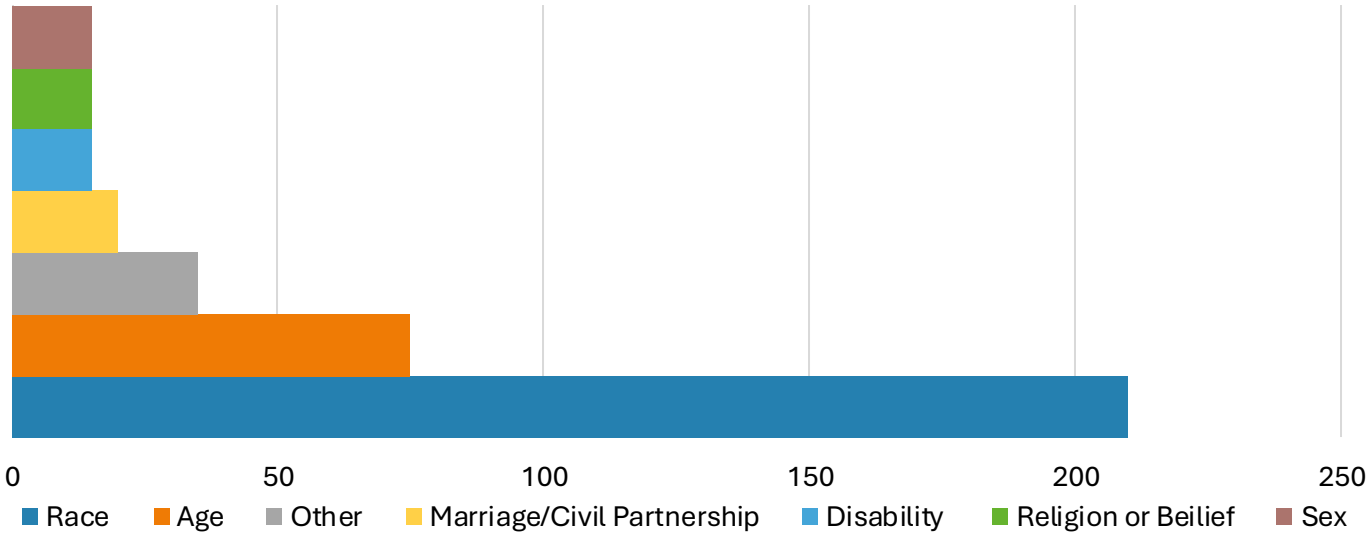
"My baby had an undiagnosed broken collar bone which I raised concerns about the lack of arm movement on day 1. I was told I was a new mum and reading into things…I was told I was wasting the NHS services…3 months later an x-ray at the paediatric department showed a broken collar bone which based on the healing would have been from birth." (F1067, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

4. Complaints and feedback

More than half of women (54%, n=458) said that they experienced challenges with HCPs, as was the same in our 2022 report. However, 28% (n=237) reported experiencing discrimination, a 15% decrease in the overall feeling of being discriminated against, compared to our 2022 data. Despite this, the reasons for discrimination most commonly expressed by women remained the same: race (25%, n=207) and age (9%, n=75). Of those who stated other reasons for discrimination, weight and body type were commonly cited. One woman said that she felt "judged for having a BMI of 30", whilst another stated:

> ***"Some midwives fat shamed me, for example, telling me they didn't have a cuff the size of my arm to check my blood pressure and sending me to another clinic to continue my appointment." (F240, Black British African, aged 26-35)***

Figure 14. Perceived reasons for experiences of discrimination during pregnancy (numbers denote raw figures)



Encouragingly, 69% (n=474) felt confident knowing who to contact if they had concerns about their or their baby's health. However, only 20% (n=167) of women shared that they were given information on how to make a complaint (Figure 15). While 31% (n=259) submitted a formal or informal complaint, just 8% (n=69) pursued a formal process. A further 29% (n=249) did not complain but were dissatisfied with their experience (Figure 16)

"I did not make a formal complaint as I believe it would make no difference, the midwife that was refusing my pain relief was an older midwife who seemed to be completely set in her ways." (F71, Black British African, aged 36-45)

Figure 15. Percentage of women who were or were not provided with information on how to make a complaint at any time in their maternity journey

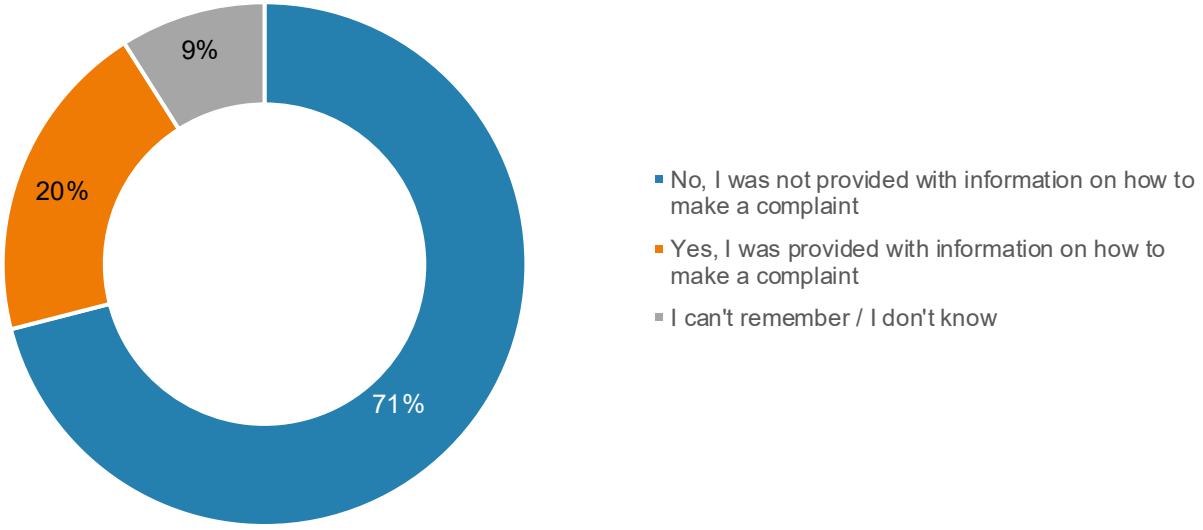
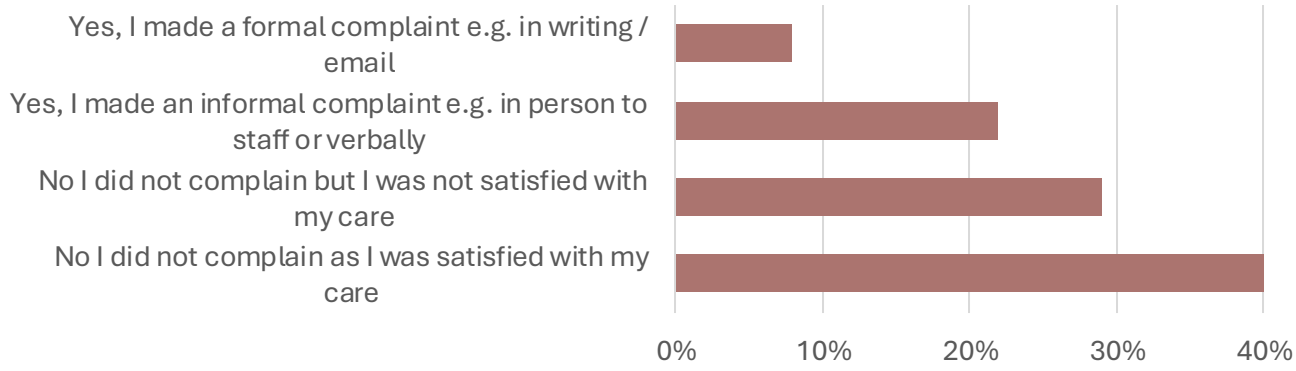
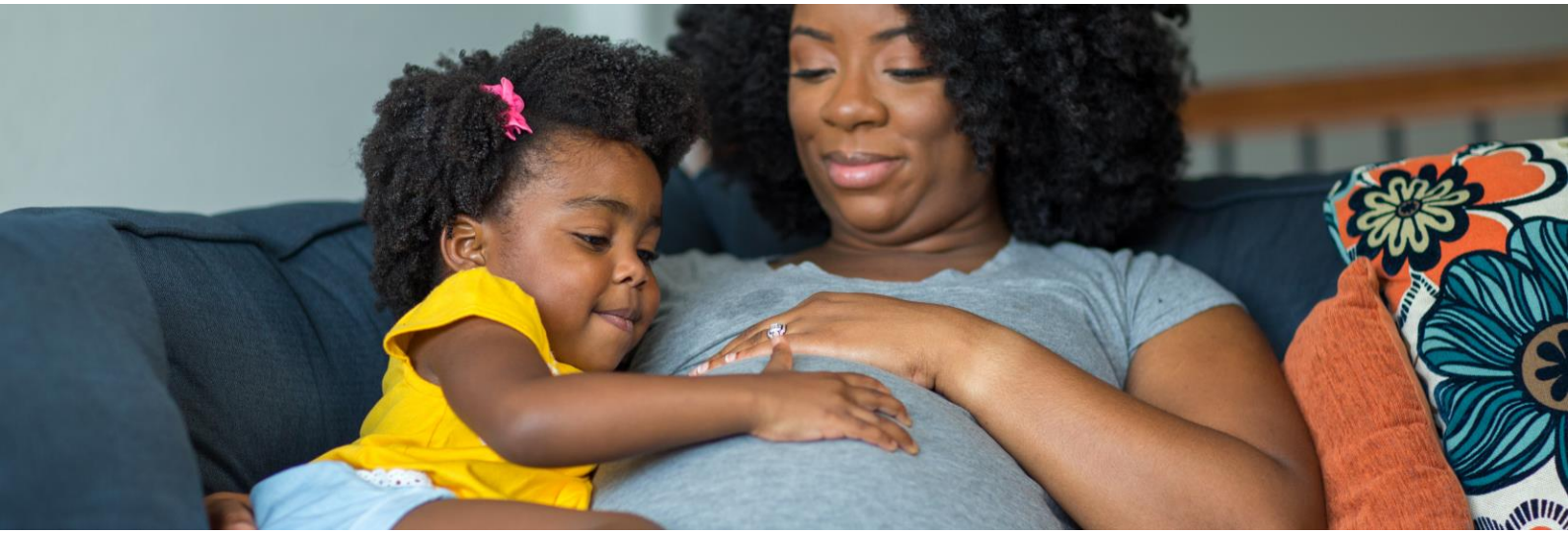


Figure 16. Percentage of women who did or did not make a complaint about their experience of maternity care.





71% of respondents (n=600) were unaware that they could request an after-birth debrief. Of the 11% (n=90) who requested a debrief, 17% did not receive one (n=15). One third reported that they did not find their debrief helpful (n=29) whilst half stated that it was (51%, n=45), with reports that the debrief was an opportunity to "highlight where things had gone wrong". One woman reflected:

"It was good to review the bad experiences and practices I had witnessed with someone who could alter things in the hospital. I wasn't completely satisfied with the outcome but at least I felt heard and that I had had some influence in making it better for future mothers and babies." (F494, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

Qualitative survey findings

Qualitative analysis of Black women's experiences across the maternity care continuum highlighted both the structural and interpersonal factors that shaped these women's care journeys. While some described moments of compassion and empowerment, the dominant narrative was one of dismissal, poor communication, unmet needs, and systemic inequities, exposing the social, emotional, and clinical consequences of a maternity system that still too often fails to listen, protect, or respect Black women. The findings below fit within five themes that were derived from the qualitative responses reported.

1. Begging to be believed

The pain of not being listened to, echoed throughout nearly every stage of the maternity journey. It was a central concern in our previous report, and it is disheartening to see that, despite the calls for change, Black women are still fighting to have their voices heard in moments when it matters most. Across antenatal appointments, labour and birth, and the postnatal period, women described being ignored, not believed, and dismissed by healthcare professionals (HCPs). This disregard occurred even in moments of clear distress or danger, and in some cases, contributed to adverse outcomes.

Women described having to repeat themselves, advocate strongly for attention, and being taken seriously only once their condition visibly worsened. One woman explained that HCPs had "dismissed everything…until it was too late."

There were further reports of delays in responding to urgent symptoms, failure to escalate care, and inconsistent application of clinical guidelines. These lapses and dismissal of concerns led to feelings of fear and, at times, tangible harm.

> ***"I had a miscarriage at 13 weeks and went to A&E. I showed them the fetus and told them I wasn't bleeding. I asked whether I needed any scans just to see if everything came out. They said I was fine. A week later, I found out that the placenta was still inside and passed out in my house due to blood loss as it tried to leave the uterus. The ambulance took about 4 hours to come to get me. When I was finally taken to A&E, and waiting for a while, a person removed it with tweezers and no anaesthetic." (F255, Black British African and Caribbean, aged 26-35)***

During labour, disbelief from HCPs took on a particularly distressing dimension, with several women describing being dismissed by triage staff or being denied epidurals because it was "too late". One woman explained:

"[The] ward matron did not believe I was in active labour even though my contractions were 1 minute apart. After being left for 22hrs with no pain relief or examination, I demanded a doctor examine me to find out I was 7cm dilated." (F355, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

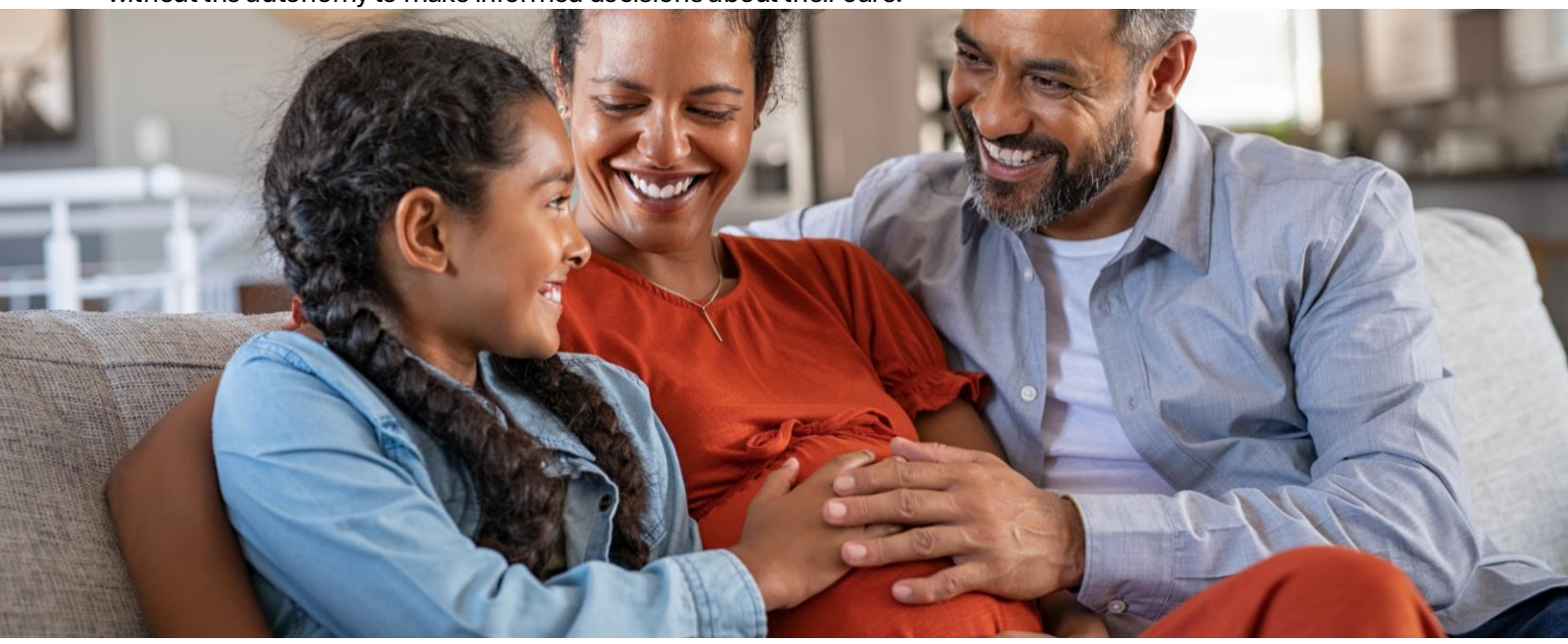
Another stated:

"They did not listen. I told them I needed to push, and they dismissed me for a while until my sister pushed for them to examine me, and then they found that I was fully dilated. My labour progressed very quickly, and they were not prepared to respond quickly." (F35, Black British African, aged 18-25)

Some explicitly noted a racial dimension to the disbelief from HCPs:

> ***"I was told I didn't need anything stronger than paracetamol, meanwhile a non-Black patient in the same bay was given gas and air immediately." (F300, Black British African, aged 36-45)***

Crucially, Black women reported that when they were not loudly vocalising their pain or perceived to be visibly distressed, HCPs would assume that they were managing their pain - a perception influenced by harmful stereotypes of Black women being naturally strong and more resilient than women from other groups. This "strong Black woman" narrative contributed to women's suffering being downplayed or overlooked altogether. The quantitative findings reported above reveal that 113 out of 815 women reported not receiving the pain relief they asked for and that 42 of these 113 women were not told why it was being withheld. This left them in the dark and without the autonomy to make informed decisions about their care.



Critically, this experience was not limited to the labour period. In the postnatal period, women also reported being ignored when expressing physical or emotional pain and some were told that their pain or symptoms were normal even when they knew something was wrong:

> ***"After the birth, I was unable to stand up and doctors ignored my plea. They told me I was fine. I was unable to walk or sit up and was in a lot of pain. When I buzzed for pain killers and assistance with changing, I heard the staff say, 'oh gosh, I'm not going, who's going?'. No one attended until the next morning." (F170, Black British Caribbean, aged 26-35)***

There was also evidence of the unequal distribution of pain relief during postnatal procedures. One woman recalled learning that others had been given medication for the same procedure that she had endured without being offered any pain relief:

"If not for my knowledge in healthcare being a former student nurse or speaking English - I wouldn't be taken seriously. I also didn't get offered pain relief during catheter induction, but other women did, I discovered, after. Black mothers' pain isn't taken seriously at all." (F77, Black British African, aged 18-25)

Underlying the dismissal of women's concerns was a noticeable lack of empathy from some professionals:

> ***"I feel like my choice of a c-section was belittled by the hospital and was told it was the easy way out and that I couldn't just open and close the lid every time I had a baby." (F591, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)***

The emotional toll of being ignored was considerable and could make women feel dehumanised:

"I had to walk to the toilet and empty the catheter myself several times a day which was difficult because I honestly could not move. I was in pain…I was made to feel like an inconvenience and like it was something I should manage myself. There was no compassion…the midwives would watch or ignore me as I struggled to walk alone, carrying the bag of urine, trying not to feel ashamed." (P35, Black British African, aged 18-25)

This lack of basic support and compassion during postnatal care was found to compound existing fears of institutional neglect and deepened women's mistrust of the healthcare system. One woman described:

"The labour ward was filled with midwives who were rude, insensitive and actually really malicious. One in particular targeted me in my most vulnerable state while my breast milk had not come in, not even with colostrum…I was struggling to feed my baby…when I had asked her for some advice…she responded to me with a bunch of personal questions such as 'where is your mother?' and 'did you not research anything before you had a baby?'… I really heavily regret not reporting her, but I had no capacity. I had to focus on healing." (F737, Black British African, aged 26-35)

For others, concerns being ignored resulted in physical and psychological harm:

> ***"I had a c-section done without enough anaesthetic. As much as I tried to voice that I could feel the cold spray, I was ignored. During the incision, I screamed due to pain, but I was told it's not pain that I'm feeling but pressure. I screamed throughout the whole 8-10 minutes while the obstetrician took the baby out. I was only put under GA after the baby was taken out. My experience was not positive at all but horrific and traumatising." (F109, Black British African, aged 26-35)***

2. Experiences of racism and cultural harm

Experiences of racism, bias, and cultural insensitivity were evident across all stages of the maternity pathway. Women described being judged or treated differently due to their race and ethnicity. In many cases, racism was not overt but embedded in the assumptions and behaviours of staff. As identified from the quantitative findings reported earlier, 47% of women reported being labelled as "high-risk". For many, this risk category was assigned without proper clinical justification. One woman explained:

"As a Black woman it seems they desire to put that high-risk label on you." (F42, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

Another woman who believed she was being treated as high-risk for no other reason than because she was Black, expressed frustration at overhearing professionals talking about her, simply because she was advocating for herself:

"The midwives' advice on Black women having high-risk conditions in pregnancy is making them very judgemental towards us and sometime misses the real problem at hand. During my care I was told I was at high risk of gestational diabetes, however I was struggling with high blood pressure. The diabetic midwife was imposing a diabetic pathway on me rather than checking my blood pressure. The saddest bit is when you leave the consulting room, and you can overhear them badmouthing you for not listening to them." (F461, Black British African, aged 26-35)

Similarly, another woman who was wrongly assumed to have gestational diabetes, despite testing negative, said that a doctor made her feel as though she was a "burden".

In other cases, the racism was more explicit and deeply harmful. In one instance, a HCP compared maternity care in England to care in Africa in an attempt to make the woman feel grateful that she was not giving birth there.

> ***"[The] health visitor said in Africa they let their women die, so it was lucky I had the care I did in the UK. This was problematic on multiple levels…she was ignorant and racist, and quite frankly reflected my entire experience of the medical system while pregnant." (F563, Black British Caribbean, aged 26-35)***

The insensitivity of the language used by a nurse on the postnatal ward left one woman feeling unsettled and unsure of the nurse's intent."

"Immediately after birth a nurse said to me "aren't you glad you got that monkey out of you"…I was so so shocked. I didn't know if she meant it as a joke or if she was just blatantly racist…I sent myself home early…I couldn't sit there knowing she may come back". (F324, Black British African, aged 18-25)

Some reflected on how such interactions went on to affect their entire perception of care:

"I felt my experience as a Black woman was horrible and quite frankly, I'm scared for my life and will not have another pregnancy…it was ruined by negligence." (F1137, Black British Caribbean, aged 36-45)

Others highlighted how staff lacked understanding or respect for their needs, with understaffing and limited resources compounding the poor quality of care:

"They seemed rushed off their feet constantly. One of the HCAs was constantly trying to intimidate me…I didn't feel safe or cared for there - I couldn't wait to go home. I barely slept and although I notified the hospital of this, no one took it seriously…It was just terrible." (F792, Black British Caribbean, aged 26-35)

This absence of empathy could lead to emotional distress. For instance, one first-time mother described being chastised by a midwife for not bringing her own milk, which left her feeling inadequate:

> ***"The midwives were not relatable. They didn't help with showing me how to breast feed, one looked like they didn't really want to touch me." (F197, Black British Caribbean, aged 26-35).***

Some women withdrew from seeking help because they expected to be misunderstood or mistreated. In this context, the few positive encounters stood out all the more precisely because they were so rare:

> ***"Every single person that was involved in my care, midwives, anaesthetist, consultants were all lovely, attentive as much as possible and listened to me." (F96, Black British African, aged 26-35)***

3. Self-advocacy and unequal power dynamics

Many Black women described the need to advocate strongly for themselves in order to receive safe and respectful care. While self-advocacy was sometimes empowering, it was more often described as exhausting and necessary due to failures in communication. Women frequently encountered vague explanations, conflicting messages, or no information at all - especially during labour or after medical interventions. Some conveyed that the options provided to them were not "framed as a choice", which made it difficult to make informed decisions:

"I had low papp-A and the midwives were very keen to tell me I couldn't have a home or birth centre birth. They were quite abrupt at some points without fully explaining why. They also mentioned early induction or c-section and were very blasé about it. I then contacted an independent midwife who help me advocate for myself." (F59, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

When communication failed, women felt they had to "speak up" and assert themselves. A number of women felt that they had to "fight for everything" and advised that women be "clued up" before attending appointments:

"I did my own research and was ready to advocate for myself. I also had my partner primed and ready to have my back." (F989, Mixed – Black other ethnicity, aged 36-45)

"I knew what kind of birth experience I wanted and so from the beginning I refused to let them push their medical "panics" and scares on me." (F42, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

Not all women felt that they were given the opportunity to advocate for themselves and some described being given medication or being subject to procedures without explanation or consent. For instance, one woman reported being "bullied into an induction", whilst another described feeling pressured into having a caesarean section:

"The obstetrician on shift that day was shouting at me to go in to have a c-section. She came with multiple people in the room which made the whole interaction very intimidating." (F48, Black Mixed Other Ethnicity, aged 18-25)

This lack of shared decision-making reinforced unequal power dynamics, where HCPs made decisions on behalf of patients rather than with them.

> ***"I will say that as a Black woman if you are recommended a said treatment and the obstetrician in your hospital don't want to offer you that, move to another hospital! I lost my baby because I was recommended a cerclage at 13 weeks, but the obstetrician declined and used me to teach other doctors. At 20 weeks my cervix opened and that was when they took me in for cerclage. They sent student doctors to perform that, and they broke my water instead. Infection kicked in and that was how I lost my precious daughter." (F97, Black British African, aged 26-35)***

Even when patients had clinical knowledge and tried to be involved in their own care, their views were not always considered valuable:

"If I did not have the understanding, context or means to pay privately to get the diagnosis, my daughter would have continued to drop weight and deteriorate. The midwife was clearly not trained to see tongue tie but also repeatedly dismissed my concerns…For context, I am a Black British medical doctor!" (F172, Black British African, aged 36-45)

4. Missed accountability and unresolved harm

Notably, around half of women (49%) who experienced poor care did not lodge a formal complaint. Key barriers included emotional exhaustion and a lack of information about the process. One woman explained that she "was too distressed" and just "didn't have the capacity". Another said:

"I was just consumed and overwhelmed about becoming a new mum. I only realised how badly I was treated after having my son." (F167, Black British African, aged 36-45)

Others expressed confusion or a lack of knowledge about "where or how to complain". For some, the adjustment to motherhood meant they did not have the emotional resources, with one woman reporting that her focus after birth was simply "being there for my baby". There was also a deep mistrust in the system's willingness to respond, with the common view that there is "no point" because "no one will do anything". A few feared retaliation or worsening care as a result of raising concerns:

"My priority was my health and worrying about whether there would be ramifications." (F110, Black British African, aged 36-45)

Several women reported that they had only processed their traumatic experiences long after the birth, at which point it felt too late to speak up:

"When I finally came to a place of reflecting on my experience it felt too late to raise a complaint." (F1164, Black British Caribbean, aged 26-35)

For many, having a postnatal debrief offered a chance to ask questions and emotionally process what had happened during pregnancy or birth. Many found their debrief disappointing, overly clinical or, in some cases, dishonest. One woman described it as "absolutely useless", whilst another lamented that, during her debrief, the obstetrician involved in her care had "lied and did not take accountability". Some women were never offered a debrief or were offered one long after the emotional impact had peaked, making it difficult for them to "make sense of what happened". However, when done well, a debrief could be powerful, informative and "very helpful":

> ***"She validated my fears and sadness and feelings of injustice." (F563, Black British Caribbean, aged 26-35)***

5. Positive experiences: compassion makes all the difference

While many accounts reflected poor care, women also shared powerful stories of kindness, empathy, and attentiveness - experiences that stood out as protective and, in some cases, profoundly healing. Compassionate care was often described as transformative, especially during moments of uncertainty or trauma. Women used words like "amazing" and "absolutely brilliant" to describe midwives who took the time to listen and offer emotional support. These moments were not just appreciated but were remembered as pivotal. For instance, one woman stated:

"I had a lovely midwife who made me feel comfortable and empowered. She delivered my baby safely and tried to follow my birth plan as closely as possible." (F1107, Black British Caribbean, aged 18-25)

Another shared:

"The care was fantastic me and my baby where very well looked after by all the nurses and doctors." (F544, Black British African, aged 26-35)

Consistency and connection also emerged as key. Where teams were familiar to the woman and engaged in her care, women reported feeling "listened to" and "involved in the process". The reassurance of having someone recognisable to turn to, made a significant difference in how supported women felt:

> ***"I felt that I could reach out to my midwife when I was worried or concerned about how I was feeling. She met me after all her appointments without a booking to make sure I was okay. I felt that I had a really good care experience from someone who went above and beyond." (F152, Black British Caribbean, aged 36-45)***

"I was given a dedicated midwife because of high risk factors and gestational diabetes, the continuity and support were reassuring. It was nice to be remembered and for issues to be remembered. She made me feel very safe and comfortable." (F663, Black British African, aged 36-45)

Some credited specific staff for changing the trajectory of their experience, with reports of how individuals had "made all the difference". Others reflected on the care they received with genuine gratitude, particularly when HCPs were compassionate even in challenging contexts:

"I had a very positive experience during my antenatal period. It was still a little difficult after Covid. But every health professional I came into contact with was helpful and supportive." (F683, Black British Caribbean, aged 18-25)

Accounts like these demonstrate that high-quality, person-centred care is not only possible, but already happening in some parts of the system:

> ***"I recognise that the NHS is understaffed, but in all three experiences I did not feel like a second thought. I felt listened to and because of my own research that I had done, I knew what to advocate for and ask for whenever I needed it. I believe that I am fortunate and this experience that I have had also needs to be shared because there are trusts that are doing it right." (F1149, Black British African, aged 26-35)***

Suggestions and improvements for a future maternity service

At the end of the survey, we asked women to share their solutions, ideas and experiences of good practice that did or would have improved their maternity care. The suggestions outlined below present a consistent call for maternity care that is empathetic and person-centred and provide a valuable roadmap for improving care for those most affected by maternal health inequities.

Of the 52 suggestions for improving maternity care, more than a quarter emphasised the importance of clinicians listening to Black women, taking their concerns seriously, and believing them when they say they are in pain.

"Listen to women's concerns. We often know what's going to happen before it does. Provide risks/benefits of each treatment. Do not gaslight women - if they are telling you something please listen to them and take them seriously." (F927, Mixed Ethnicity – Black British Caribbean and White, aged 26-35)

Women also called for person-centred care, highlighting the need for maternity services that recognise the emotional, physical, and psychological vulnerability that women often experience during pregnancy and childbirth. One woman explained that maternity care should not be a "one size fits all approach" and that care "has to be nuanced". Another highlighted the emotional weight of childbirth and the importance of HCPs recognising the uniqueness of each birth experience. She reflected:

> ***"For them it may be a job and they see these things all the time, but for us this is a once in a lifetime experience. I will never have a first, second, etc child again, and this is MY baby, MY birth and I have every right to be concerned." (F1157, Black British African and Caribbean, aged 26-35)***

This statement highlights the mismatch between routine clinical practice and the once-in-a-lifetime nature of the birthing experience for each individual woman. It underscores the need for HCPs to approach every birth with sensitivity, recognising that for the woman involved, this is a defining and emotionally charged moment. Respecting and validating those feelings through person-centred care is essential for building trust and ensuring women feel seen and supported.

The need for greater empathy and emotional support from HCPs was highlighted. One woman stated:

> ***"All mums deserve to be heard…not to be told we're too loud or to 'toughen up love' as we lean into the contractions." (F627, Black British African, aged 26-35)***

These words highlight the harm caused by insensitive remarks and a lack of compassion during a vulnerable time. Further stressing the need for improved training, this woman demanded that nurses and midwives "be better educated on empathy and care techniques", reinforcing the broader demand for maternity staff to provide not only clinical expertise but also emotional reassurance throughout the birthing experience.

Crucially, women emphasised the importance of culturally sensitive care when supporting Black women. The need for all maternity care staff to undergo education and training around race, bias, and the specific needs of ethnic minority families was highlighted. The provision of "special advocates for dealing with Black women" was felt to be a good first step.

DISCUSSION AND CONCLUSIONS

4 DISCUSSION AND CONCLUSIONS

Our aim with this work was to uncover whether maternity experiences have improved since 2022, and whether increased attention on racial and ethnic maternal health inequalities has led to transformation in care for Black women. Based on the findings, the answer is disheartening.

Despite heightened public and institutional awareness, many of the issues identified in our 2022 report remain unresolved. Although some women described moments of compassion and support, Black women continue to be dismissed, and their pain frequently minimised or ignored. Our findings also challenge harmful stereotypes: the majority of women in our sample engaged with maternity services early, demonstrating that they care deeply about their pregnancy and health. This directly contradicts assumptions that Black women are disengaged or hard to reach. Black women simply want the right to safe and respectful maternity care. Yet, poor communication and the persistence of both overt and subtle racism continue to undermine their wellbeing and clinical outcomes. These enduring patterns reveal that, despite shifts in policy discourse, meaningful change has yet to be realised.

Where are maternity services still falling short for Black women?

One of the most troubling aspects of this report is the persistent and multi-layered presence of racism in Black women's maternity experiences. We note that a quarter of those who reported experiencing discrimination said that this was due to race, and that these occurrences took many forms.

In some cases, racism was overt. For example, a health visitor compared maternal deaths in Africa to care in the UK, implying that the woman should feel grateful to receive care in this country. In another instance, a nurse made a deeply offensive comment, likening a Black mother's baby to a monkey while she was recovering on a postnatal ward - a remark steeped in racist history, as such comparisons have long been used to dehumanise Black people and reinforce harmful stereotypes. In other cases, racism was more subtle; Black women described being treated as inherently high-risk without, what they felt to be, adequate justification.

Although perhaps well-intentioned, this approach can backfire if not accompanied by clear communication. When a high-risk condition is identified, it should be followed by an appropriate response and a care plan developed in partnership with the woman. Notably, twice as many women with pre-existing health conditions were told their pregnancy was high-risk compared to those without. This medical categorisation was felt by women to reflect a deeper racialised assumption that positions Black women's bodies as problems to be managed, rather than individuals to be cared for.

This framing of Black women as high-risk is particularly troubling when considered alongside missed opportunities for preventative care. Over half of the women reported that diet and nutrition were not discussed at their booking appointment, and over three-quarters said the same for exercise. This is particularly concerning given that both diet and physical activity are recommended to lower gestational weight gain which is protective against gestational diabetes[16], yet half of those in this study with gestational diabetes were categorised as high-risk but had not had discussions with a healthcare professional (HCP) about diet or physical activity.

The absence of these conversations in early maternity care represents a missed opportunity to reduce risk and further illustrates how inequities in service delivery can contribute to poor maternal health outcomes for Black women.

We speculate that the categorisation of Black women as high-risk may reflect a form of over-cautiousness driven by increased public and institutional awareness of racial disparities in maternity outcomes. Some women reported being offered additional scans without adequate explanation. Uncertainty towards their clinical relevance and mistrust in HCP motivations could lead some to decline these appointments. While vigilance is important, when it is poorly communicated, care shifts from protection to paternalism, undermining women's autonomy and reinforcing power dynamics where decisions are made for rather than with women. There is a need, therefore, for personalised care for Black women - care that responds to individual needs but that does not profile women.

Perhaps most damaging was the lack of empathy and disbelief when Black women raised concerns or voiced their pain. Across other health contexts, Black people are less likely to be given pain medication and, if given, this medication is in lower quantities[17], [18]. Similarly, our findings show that Black women's symptoms were regularly downplayed, and their pain ignored. We found that one in five women who requested pain relief did not receive it and of those, 40% were given no explanation for the refusal. This behaviour from clinicians, also apparent in our 2022 report, feeds into the harmful "strong Black woman" narrative which views Black women as naturally resilient or impervious to pain[19]. Not only does this perception dehumanise Black women and deny them their vulnerability, but it also leads to delays in intervention.

The racialised experiences reported here cannot be separated from the power imbalances that permeate Black women's interactions with healthcare professionals. We see that informed consent, a fundamental principle of healthcare, was sometimes absent, and that some women felt pressured into procedures or were given medication without clear explanation. Even when women had clinical knowledge themselves, this power imbalance persisted, highlighting that education does not afford protection against the authority that some healthcare professionals assume over Black women's bodies. The majority of women in this survey were highly educated, spoke English as their first language, and were relatively affluent yet still reported poor maternal outcomes, both clinically and psychologically. This finding, which aligns with wider research[20,21], reflects a broader pattern in which social factors such as education and income - typically protective against adverse health outcomes - do not offer the same safeguarding for Black women.

It is important to understand that this convergence of racism and power asymmetry is not accidental. It stems from long-standing systemic bias across different settings in which Black women are simultaneously over-scrutinised and under-supported[22,23]. The examples in this report speak not only to poor communication in the moment, but to a long-standing hierarchy in which Black women are not seen as autonomous decision-makers in their own care.

As was highlighted in our 2022 report, the issue of accountability remains a major barrier to progress. Many women in this study who experienced poor care chose not to make a formal complaint, often citing emotional exhaustion, fear of retribution, or a lack of faith in the system. When women feel unsafe to raise concerns, poor care goes unchallenged. This lack of accountability may also help explain a striking disconnect in the data: despite rating their antenatal, labour, and postnatal care as “good” or as being of a “high standard”, a surprising number of women went on to further describe traumatic or even harmful clinical experiences. For example, one woman reported feeling deeply distressed after an obstetrician opened a conversation about her gestational diabetes with the words, "You know your baby could die?". Yet, she still rated the care she received as high quality. This contradiction suggests a troubling normalisation of substandard care. When poor experiences are rarely acknowledged or addressed, it can erode expectations of what good care looks like. If the benchmark for “acceptable” is so low, it raises important questions about how Black women have internalised their experiences and the care to which they believe they deserve.

For this reason, services must be redesigned to include routine accountability mechanisms including regular audits of racial disparities in outcomes and experiences, transparent reporting, and patient feedback systems specifically attuned to race-based concerns. Systems of feedback must centre anecdotal voice alongside quantifiable outcomes to ensure leaders of maternity services understand the lived experience of women accessing maternity care.

Accountability for delivering continuity must sit with leadership teams, with performance indicators tied to equity outcomes. Critically, this work cannot be left to a few passionate individuals. This approach must be prioritised as a core principle of safe and ethical care.

Encouragingly, a recent announcement from Secretary of State for Health and Social Care, Wes Streeting, signals a welcome response to these long-standing concerns and reflects a shift towards embedding accountability into maternity leadership, rather than relying on individual vigilance24. The Health and Social Care Secretary’s plan includes a national, independent investigation into maternity and neonatal services that includes a rapid review of up to ten of the worst-performing trusts, and broader inquiry by the end of 2025. In parallel, a new National Maternity and Neonatal Taskforce, chaired by the Secretary, will bring together clinicians, bereaved families, and campaigners to address failures in accountability, with a particular focus on racial and social inequities. The initiative also promises the rollout of a digital safety-flag system in every maternity unit to identify early signs of risk and trigger intervention. This national framework, if implemented with transparency and genuine community oversight, may begin to address the structural failures that have allowed substandard care, especially for Black women, to persist unchallenged.

How are Black women's experiences different this time?

Alongside these enduring structural issues, we witnessed a growing awareness amongst Black women of their vulnerability within the system and a corresponding rise in self-advocacy.

Unlike our previous findings, the responses in this survey reflect a consciousness amongst Black women regarding the racial disparities in maternal health outcomes, signalling a shift in how they are approaching maternity care. Women in this study described the need to be hypervigilant, well-informed, and assertive. They also explained feeling forced to "fight for everything" and described the need to repeat themselves simply to receive basic care.

However, self-advocacy, whilst at times empowering, was also exhausting. The burden of self-advocacy in healthcare, particularly in the face of racism, has been found to contribute to higher levels of stress, anxiety, and medical mistrust25. This emotional toll is often not just the result of one specific experience, but part of a broader pattern of cumulative harm. The "weathering" hypothesis[26] offers a framework for understanding how repeated exposure to systemic racism and the stress of navigating hostile healthcare systems can negatively impact health over time - a pattern that may help explain some of the findings in this report. Many of the women's accounts reflect the toll of cumulative stress and ongoing vigilance. These insights underscore the urgent need to reform maternity so that self-advocacy is no longer a necessity for basic safety and dignity.

The preference for continuity also emerged powerfully in this report. Compared to our findings in 2022, this time around Black women strongly expressed the need for HCPs who knew their history and could offer a sense of relational continuity. Women who receive this type of care have been found to report positive experiences of care[27] and this model is often preferred for its personalised approach which fosters trust and empowerment for both women and midwives[28]. Our findings echo this: where women saw the same midwife or clinical team, they reported positive experiences, linking these to both emotional and clinical benefits. Notably, many women had expected that they would receive this type of care and were disappointed when this expectation was not met. This highlights the need for clear expectation-setting at the outset of maternity care so that women understand that, whilst it may not be possible to see the same clinician throughout pregnancy, this will not compromise the quality of their care. For this to be a reality, maternity services must be resourced and structured to support well-staffed teams that can deliver personalised patient-centred care. Improvements to digital infrastructure will, therefore, be critical for ensuring shared access to up-to-date care records across settings, in order to reduce reliance on women having to repeat their medical history to different HCPs.

Finally, women in this study described overstretched midwives and understaffed units, which they felt were significant factors contributing to fragmented care and poor communication.

However, this does not fully explain the unequal outcomes we observe: if resource constraints were the sole cause, we would expect poor outcomes across all groups. Instead, the consistently worse experiences reported by Black women point to the persistent influence of systemic racism - an issue that cannot be addressed by staffing solutions alone.

Where do we go from here?

Amongst these accounts of being unheard and unsupported, there was evidence of compassionate care that made a meaningful difference to Black women. Women remembered acts of kindness and warmth as transformative. Such experiences remind us that person-centred care requires intention.

So, whilst we are heartened to see greater advocacy and awareness among Black women, we remain disappointed that they continue to fight for respectful maternity care. The experiences reported here show that systemic racism and power imbalances are still forcing Black women to do the work of keeping themselves safe.

As maternity services strive to improve, it is vital that Black women are not only heard but actively involved in shaping the care they receive. Their insights and solutions must be central to efforts aimed at creating equitable, safe, and compassionate maternity care for all.

RECOMMENDATIONS

5 RECOMMENDATIONS

Based on the findings of the Black Maternity Experiences Survey 2025, we present six key recommendations.

These recommendations aim to drive systemic, equitable change in maternity care, with a strong emphasis on practical implementation. Each recommendation is grounded in evidence and lived experience and is accompanied by actionable interventions designed to support delivery, accountability, and lasting impact.

1. Increase the awareness of and engagement with an improved Patient Advice and Liaison Service (PALS)

This can be achieved by improving access to complaints and support mechanisms in maternity care.

Our findings show that only 20% of women were informed about how to make a complaint, and nearly one-third who were dissatisfied with their care chose not to do so, highlighting a serious gap in access, awareness, and trust. This is further underscored by data from NHS Resolution, which reports that maternity claims accounted for 40% of the £2.3 billion paid out in compensation and related costs[29].

To address this, we recommend the following:

- Develop a centralised NHS PALS website
- Clearly display information on maternity rights, feedback pathways and complaints processes on the PALS website
- Improve awareness of PALS and its roles and responsibilities among pregnant and postpartum women through campaigns within hospital and community settings

Responsible stakeholders: NHS England/ Department of Health and Social Care, NHS PALS, Transformative Directorate at NHS England, Local Trust Boards, National Maternity and Neonatal Taskforce.

2. Strengthen clinical knowledge, resources, and training on conditions that disproportionately affect Black women

This can be achieved by supporting earlier diagnosis, safer care, and better outcomes across the maternity pathway.

We continue to call for increased awareness of health conditions that disproportionately impact Black women. We recommend the following actions:

- Increase the visibility and representation of darker skin tones in medical illustrations, diagnostic guidance, and clinical education materials used in maternity services.
- Embed mandatory training for healthcare professionals and maternity staff on conditions that disproportionately affect Black women, including both clinical content and the impact of delayed or missed diagnoses.
- Ensure training and educational materials cover a wide range of relevant conditions across the maternity journey:
  - *Pre-existing conditions*: uterine fibroids, polycystic ovary syndrome (PCOS), asthma, hypertension, mental health conditions.
  - *Antenatal conditions*: preeclampsia, gestational diabetes, hyperemesis gravidarum, high blood pressure, anaemia.
  - *Postnatal conditions*: hypertrophic and keloid scarring, perineal wound infections, postnatal mental health conditions.

Responsible stakeholders: NHS England/ Department of Health and Social Care, NHS Race and Health Observatory, National Maternity and Neonatal Taskforce.

3. Install pain relief explanation posters in all NHS maternity settings

This can be achieved by supporting informed consent and access to pain management.

Our findings reveal that 1 in 5 women did not receive their requested pain relief, and 40% were not given an explanation highlighting serious gaps in communication, consent, and trust.

To address this, we recommend that every NHS trust adopts a clear and consistent approach to informing women and birthing people about their pain relief options through the following measures:

- Display co-designed, visually accessible posters in all maternity care environments
- Ensure posters list all available pain relief options in plain, inclusive language,
- Use these materials to complement, not replace, verbal communication.

Responsible stakeholders: NHS England / Department of Health and Social Care, NHS Race & Health Observatory.

4. Install maternity rights posters in all NHS maternity settings

This can be achieved by improving transparency, trust, and access to support.

Many women are unaware of their basic rights during maternity care, leading to missed opportunities for support and redress. We recommend every NHS trust displays co-designed, clearly written posters outlining key entitlements such as the right to request a debrief or raise concerns.

Posters should:

- Use a standardised national template with space for local contact details
- Feature simple, empowering language (no legal jargon).
- Be translated into priority languages.
- Reinforce verbal information where staff capacity is limited.

Responsible stakeholders: NHS England / Department of Health and Social Care, NHS Race & Health Observatory.

5. Develop a national digital health toolkit for women

This can be achieved by championing informed care before, during, and after pregnancy.

Women need access to clear, culturally relevant information across their reproductive journey. We recommenda downloadable, mobile friendly resource, printable and translatable, covering:

- Puberty (age 11+): guidance on puberty, menstrual health, bodily autonomy, consent, and where to seektrusted advice.
- Pre-pregnancy: guidance on pre-existing conditions, reproductive planning, family history, and pre-conception checks.
- During pregnancy: signs of key pregnancy-induced conditions, self-advocacy tips, care rights, and trustedsupport sources.
- Post-pregnancy: risks to monitor, what to expect at check-ups, and links to community-basedpostnatal support.

Responsible stakeholders: NHS England/ Department of Health and Social Care, NHS Race and HealthObservatory, Transformation Directorate at NHS England.

6. Advance existing digital maternity record systems

This can be achieved by driving safe, joined up, and personalised care.

Fragmented and incomplete records force women to repeatedly explain their history and lead to gaps in care.

NHS maternity services should integrate maternity records into the NHS App and Single Patient Record to give women real time visibility and control over their care. This aligns with the NHS's commitment to making the NHS App a "doctor in the pocket" and "a gold standard tool for patient access, knowledge and choice".

We recommend:

- Creating a dedicated maternity section within the NHS App, giving women:
    - A clear, user-friendly view of their notes, care plans, and test results.
    - The ability to track upcoming, leave feedback, and access trusted advice.
    - Real-time updates across all care settings: GP, community midwife, hospital. Integration across and between community and hospital IT systems.
- Real-time access for all professionals involved in a woman's care, including community midwives, consultants, and GPs.
- Documentation training for HCPs to support accurate, complete, and context-rich records.
- A user-friendly, patient-facing view to increase transparency and help women track and understand their care.

Responsible stakeholders: Transformation Directorate at NHS England, NHS England/ Department of Health and Social Care.

STRENGTHS AND LIMITATIONS

6 STRENGTHS AND LIMITATIONS

Key strengths of this study include the large sample size which improves the reliability of the findings, and the mixed-methods approach which allowed us to capture both broad trends and deeper insights into Black women's experiences of care. A limitation of this study is that there may be reporter bias with those with negative experiences more likely to respond. Additionally, responses from Black women from low-income households and women whose native language was not English were limited, meaning the findings may not fully reflect the experiences of those most affected by health inequalities. Notably, many high-income Black women in the sample still reported poor care, suggesting outcomes could be even worse for those with social risk factors.

NOTES

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