FAQs on the Principles of Women's Choices in Maternity Care

Last Updated: 29/10/2026

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Following the launch of our Principles for Supporting Women's Choices in Maternity Care Principles in August 2025 and the subsequent webinar held on 8 September 2025, a number of questions have been raised by stakeholders. These Frequently Asked Questions have been developed to address the common themes and queries received since the launch and webinar, and to provide further clarification and guidance on the Principles in practice.

Question 1: What are the NMC's Principles for Supporting Women's Choices in Maternity Care, and how and why did you develop them?

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The Principles were published to help midwives and maternity services provide safer, more personalised, and person-centred care.

Developed collaboratively with women, maternity service users and a range of stakeholders across the UK, the Principles are grounded in real-world practice and designed to support professionals when women make decisions about care, including choices outside of standard pathways.

They aim to ensure women's views and preferences remain central to care planning, while enabling midwives and employers to navigate complex situations in line with the NMC Code and professional standards.

They were also developed to support Trusts and Health Boards when developing ways of working and guidelines in line with our Code, Standards of proficiency for midwives and these Principles.

We expect ongoing discussion by employers together with their legal and clinical teams so that midwives can support all women with their midwifery care choices, in line with NMC's expectations and our standards.

The webinar explored the Principles in detail and addressed questions from practitioners and stakeholders about their practical application.

Question 2: What are the key things the Principles say about the role of the midwife?

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Our Standards of proficiency for midwives state that the role of the midwife is to respect and enable the human rights of women and children and their priority is to ensure that care always focuses on the needs, views, preferences, and decisions of the woman and the needs of the newborn infant. A midwife needs to provide all the information and evidence the woman needs to make those decisions; this will include any risks or challenges to the choices they are making, and any reasonable alternative options.

Women can decide to accept or decline any advice, care or treatment given by the midwife. Midwives should respect, support and document this in line with the Code. For example, midwives need to respect a woman's decision to accept

r decline care such as declining antenatal screening, and/or opting for a home birth in circumstances, or with risks, hat are outside local guidance.

Their choices should be documented in their records whilst continuing to care and build a positive, supportive elationship with the woman. This reflects our Standards which underpin a midwife's practice.

A midwife should also be treated with respect in all their contact with women and families, and should feel physically nd psychologically safe. We say in our Principles that a midwife should not be put in any situation that compromises heir own safety; yet employers also has a responsibility to ensure they are not put into situations where they are nsafe. That said, it is also important to acknowledge that there is a distinction between being unsafe and feeling ncomfortable. In order to provide human rights-centred care, midwives will sometimes need to support choices that eave them feeling uncomfortable. This is one of the reasons why it is so important that employers provide strong upport for midwives (see further FAQ 7 below).

The role of the midwife is to give midwifery care to all childbearing women and work with the multiprofessional team where the woman has additional needs or develops complications. Midwifery care is still offered if a woman is declining ecommended midwifery or obstetric care. This is to ensure the ongoing health and wellbeing of the woman and baby.

Question 3: Can anyone call themselves a midwife?

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The title of 'midwife' is protected in law, which means it is a criminal offence (under Article 44 of the Nursing and Midwifery Order 2001 (NMO 2001)) for someone to use the title of midwife when they are not entitled to do so, if they have the intention to deceive. It is a separate offence (under Article 45 of the NMO 2001) for anyone other than a egistered midwife or a registered medical practitioner (or their supervised students) to 'attend' a woman in childbirth. Attend' for this purpose means carrying out clinical midwifery activities. An example may include performing an episiotomy or monitoring and interpreting the fetal heart rate.

Childbirth is not defined in legislation. We use the ordinary meaning of childbirth as the 'act or process of giving birth to a baby' to refer to the onset of established labour (first stage of labour), the birth (second stage of labour), expulsion of he placenta and membranes (third stage of labour), and the immediate postnatal period (first six hours after birth). This means birth partners, including doulas and family members, present during childbirth, must not provide any midwifery or medical care to a woman in childbirth. The NMC regulates midwives but not doulas.

The only exception would be in cases of sudden or urgent necessity, but we will consider carefully any evidence of pre-planned attendance at childbirth, as opposed to acting out of sudden or urgent necessity.

f there are any concerns that someone who is not a registered midwife or registered medical practitioner is 'attending' a woman in childbirth (i.e. is providing clinical care), a concern can be raised with us for investigation by emailing egistration.investigations@nmc-uk.org.

Question 4: How do the Principles relate to the NMC's Code and Standards?

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All midwives can be supported in their practice by using the Code, the Standards of proficiency for midwives, the Principles for supporting women's choices in maternity care and other guidance and supporting information to promote women's autonomous and informed choices. They also guide the development of practice within local settings, particularly where a woman is asking for care outside of local guidance.

Question 5: Can women choose to have a freebirth?

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Freebirth is legal in the UK and is not necessarily a safeguarding concern unless there is a formally diagnosed lack of capacity to make decisions, or there are other issues such as domestic abuse. A woman has the right to remain in her home to receive care. Where there is a freebirth that is planned, the midwives involved need to be clear about the plan of care and what care the woman will accept.

t is important that there is a joint approach to care planning where a freebirth is planned so that each member of the multidisciplinary team is familiar with the intentions and rights of the woman. Each Trust/Board will have their own

guideline about how many midwives will attend the woman's home.

The Principles state that, "For a known freebirth, be clear prior to labour about arrangements with the local maternity services and whether or not a midwife will attend if called". Following questions we have received about this language we would like to clarify that, if a person in labour calls requesting midwifery assistance at home then (regardless of whether that person had previously planned a freebirth), it would be expected that midwives would attend that birth, assuming that the homebirth service is running and midwives are available.

Question 6: What do the Principles say about women's rights to make choices?

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A woman has a right to NHS maternity care and Birthrights in their factsheet about NHS services state:

Everyone is legally entitled to medical attention from healthcare professionals throughout their pregnancy, childbirth and after their baby is born. This includes all standard scans, blood tests, midwifery and obstetric care and specialist care if needed. This is because serious and occasionally life-threatening complications can occur in pregnancy and childbirth so maternity care is considered 'immediately necessary' even if you have been told that your pregnancy is low risk.'

The Birthrights factsheet - your rights states that:

- Everyone has a right to receive safe and appropriate maternity care.
- Every woman and birthing person has a right to maternity care that respects their fundamental human dignity.
- Everyone has a right to privacy and confidentiality.
- Every woman and birthing person is free to make choices about their own pregnancy and childbirth, even if their caregivers do not agree with them.
- Everyone has a right to equality and freedom from discrimination.

Birthrights also say in their factsheet on social services and maternity care that:

Midwives and doctors should never refer you to children's social services on the basis of your birth choices alone, or because you do not want to accept certain aspects of care. They must have a reasonable belief that your baby is threatened with significant harm once it is born. You do not have to accept any medical or midwifery care or treatment during childbirth.'

We reiterate this point about referral to safeguarding in our Principles:

Be aware that a woman opting for a freebirth does not constitute a safeguarding concern unless there is a formally diagnosed lack of capacity to make decisions or there are other issues such as domestic abuse'.

The NMC Code requires a midwife to document the advice and care they give about any conversations they have with the woman and her partner. The entries enable clear communication between all healthcare professionals involved in the care.

We acknowledge that women may make decisions that could incur more risk and may also decline midwifery care. The Principles require that midwives support the rights of women to accept or decline any or all aspects of midwifery care and it is important that women's choices are properly documented by the midwives.

The Principles stipulate that employers should:

Assess the feasibility of requests where a woman asks for a midwife to be present at a home birth but not providing direct care to the woman, such as being asked to wait outside the birthing space during labour.'

Following questions we have received on what exactly is meant by this language, we would like to clarify that, if a person in labour calls requesting midwifery assistance at home then (regardless of whether that person had previously planned a freebirth), it would be expected that midwives would attend that birth, assuming that the homebirth service is running and midwives are available.

By contrast, if a midwife is requested to be present in the home but, for example, just outside the door to the birth room or in another room, we would usually expect such a request to be supported and accommodated. Declining one aspect of care, namely the midwife carrying out constant visual assessments, does not mean that the woman/birthing person is declining all care, and high quality, non-coercive discussions should be offered by midwives antenatally to ensure that the woman is fully informed as to what monitoring and other options are open to her during her homebirth, and the

midwives are clear what types of care and support the woman would like to accept.

Question 7: How do the Principles support anti-racist midwifery care?

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Black and Asian women are more likely to die during pregnancy or in the immediate postnatal period, and their babies are more likely to be stillborn.

The situation is totally unacceptable and is a national emergency.

The Principles include that women using maternity services should feel safe with care that meets their physical, psychological, social, cultural, and spiritual needs and expectations.

They reflect that part of the role of the midwife is to provide care that is respectful, fair, free from discrimination and without bias, including any bias against protected characteristics.

They state that employers' roles includes ensuring that every request for a particular care option is considered individually, with the woman's circumstances considered and options explored as to how their rights could be upheld.

And at the NMC, they'll sit alongside our new anti-racism principles, which set clear expectations for registrants, employers and education providers to embed anti-racist, culturally safe, bias-aware practice across nursing and midwifery.

Question 8: What other support is available for midwives?

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We also recognise the impact this may have on the midwives involved. Midwives need to have access to support from their senior midwives and the multidisciplinary team so that they feel enabled and supported to deliver the care that the woman is requesting. The PMA (Professional Midwifery Advocate) role has been developed in England with the equivalent role in the devolved nations) by the NHS and local providers to support midwives, but we do not regulate the role.

Midwives need to professionally develop throughout their whole careers so that they are able to care competently and confidently for all women using maternity services. Midwives are expected to provide care based on the best available evidence and use this evidence to inform conversations with women, their partners, and families, as appropriate to their needs and preferences. Midwives also care for women who have additional needs or develop complications, always using trauma-informed care to promote physical and psychological safety.

Birthrights also state in their factsheet that, "Everyone has a right to equality and freedom from discrimination.

Failure to provide adequate maternity care, lack of respect for dignity, invasions of privacy, procedures carried out without consent, failure to provide adequate pain relief without medical contraindication, unnecessary or unexplained medical interventions, and lack of respect for women and birthing people's choices about where and how a birth takes place, may all violate human rights law.

Sadly, there is evidence that too many women and birthing people in the UK are experiencing maternity care that does not respect their basic rights.

Strain on under resourced maternity services, a culture of excessive emphasis on clinical policy rather than individualised care, and misunderstanding of basic legal responsibilities, all contribute to poor quality care that can lead to violations of dignity and autonomy." (FAQs - Birthrights)

We say in the Principles that employers should, "Ensure that every request for a particular care option is considered individually, with the woman's circumstances considered and options explored as to how their rights could be upheld."

A woman can refuse to receive decline care at any point in their maternity journey whilst still requesting their place of birth. The Principles can be used to guide conversations about the care they wish to have.

The Principles (p.6) state that women should have a personalised care and support plan which the midwife develops in partnership with them. The Standards of proficiency for midwives state that a midwife should, "Effectively implement, review, and adapt an individualised, evidence-informed care plan for the woman and her newborn infant across the continuum, involving her partner and family as appropriate. effectively implement, review and adapt an individualised,

evidence informed care plan." (6.64). Our suite of standards documents should be used together to guide a midwife's practice.

Women can decide that they do not want the midwife to be in the birth space and only come into the room if a complication arises. It is important for the midwife to document all the discussions, care given and the care declined.

It is acknowledged that dealing with emergency situations can be very challenging for midwives. Midwives need to have continued and ongoing education, so they are well-prepared to handle a range of scenarios and be involved in care plans that are developed for women to meet their requests for care. This will involve having senior midwifery support and access to their advice when required. Psychological support after traumatic events is important for all those involved, both parents and the maternity team.

Question 9: What did the NMC's freebirth survey say?

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We were aware that women choosing to freebirth is becoming more frequent but there was a lack of data around its frequency. We decided to conduct a survey with Directors/Head of Midwifery, across the UK, to find out about how frequently it was occurring. The survey gave us a 'snapshot' of what was happening in relation to freebirths associated with Trusts/ Health Boards. It did not ask for detailed responses about the woman who were choosing to give birth without a midwife present. Therefore, the data is not meant to be complete and does not identify parity, risk factors or details about trauma/mental health problems. It is not intended to be a comparative piece of work with other key reports such as MBRRACE-UK.

We are working with the NHS to encourage the routine collection of good, meaningful data around free births. It's important to distinguish freebirths from planned homebirths and births before arrival (BBA) and how best to keep women physically, psychologically, culturally and socially safe.

Due to the limitations of the survey, we are only sharing highlights from the responses in our webinar and presentations.

Question 10: What is the role of a doula?

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A doula is an unregulated, non-medical professional who provides emotional and practical support during pregnancy, birth, and the postnatal period. Doulas work for their clients and alongside midwives and doctors if their clients so wish, but do not take on a clinical role.

Doulas do not advise but provide informational support to enable women to make informed decisions about maternity care, in addition to practical and physical support. They support all kinds of births and different parenting choices, in maternity units and the community.

We worked with Doula UK to support the development of the Principles. We collaborated on a video to shed light on the differences between the professions, how the professions can work together to support positive maternity experiences, and how women can access support from both.

Doulas and birth workers have a range of names and titles and are not regulated or represented by any single body. Doula UK have a Code of Conduct for their members detailing the role and scope of practice of a doula: https://doula.org.uk/about-doula-uk/policies/code-of-conduct

NMC and Doula UK discuss the differing roles of a midwife and a doula

The NMC has teamed up with Doula UK to launch a new video resource – clarifying the distinct roles that midwives and doulas play for women and families.

The video series bring together Jacqui Williams, the NMC's Senior Midwifery Advisor, and Leila Baker, Doula UK Director. They shed light on the differences between the professions, as well as how the professions can work together to support positive maternity experiences, and how women can access support from both.



Webinar: Principles for supporting women’s choices in maternity care

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This webinar outlines the principles and research findings, and also hosts a panel presentation from Doula UK, the National Police Chiefs' Council and the London Ambulance Service.



Additional information

This factsheet has been developed from the questions asked in a webinar launching the Principles for supporting women's choices in maternity care on 8 September 2025.

The words woman and women have been used throughout the Principles as this is the way the majority of those who are pregnant and having a baby will identify. For the purposes of the Principles, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity.

Birthrights is a registered charity and the leading authority on the human rights of women and birthing people during pregnancy and birth in the UK. We believe that all women and birthing people should be able to exercise their right to make informed decisions about their bodies and care, and to do so free from discrimination, coercion and violence. We champion rights by supporting women and birthing people, training healthcare professionals, holding systems and institutions to account, and making visible diverse experiences of maternity care. More information here.

Doula UK is a non-profit community interest company led by and for the members. More information here