



Senator Marielle Smith
Chair
Select Committee on Women's Health
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Senator Marielle Smith

Congratulations on the establishment of the Select Committee on Women's Health.

Thank you for the opportunity to make a submission to this Inquiry into Women's Health, but more than that, thank you for conducting this Inquiry. Please find attached our submission which focuses on maternity and the transition to mothering in Australia proposing recommendations which could make a significant difference to the wellbeing of women during maternity. When women thrive, the benefits ripple outward to their babies, families and communities.

We would welcome the opportunity to meet with the Committee to expand on our submission, and to introduce you our consumers who can share their own lived experience.

Thank you and kind regards,

A handwritten signature in blue ink that reads "Ellen O'Keeffe".

Ellen O'Keeffe
President
9 October 2026



Submission on Women's Health with a focus on Maternity and the transition to Mothering in Australia

Submitted to Senator Marielle Smith
Chair
Senate Select Committee on Women's Health
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Date 9 October 2026

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Introductory Statement

Australia already has strong evidence, clinical guidelines and national strategies describing what high-quality maternity care should look like. The problem is not a lack of evidence. It is the failure to consistently translate that evidence into systems, structures and accountability. As a result, a woman's experience and outcomes depend heavily on where she lives, which provider she sees and which model of care she can access. Midwifery continuity of carer, the model with the strongest evidence base, is available at fewer than half (46%) of Australia's maternity services (AIHW).

Too often, maternity care operates as reactive medical risk management. Clinical safety is vital, but on its own it does not meet the social, emotional and practical needs of women and their families. Reform requires a prevention-first, primary health approach: a system that actively wraps around a woman to promote her health, prevent harm, and support her through pregnancy, birth, recovery and becoming a mother. By centring care on human rights, evidence-based practices, and community connection, we can ensure every woman is seen, heard and supported to emerge from her transition to motherhood well, whole, and thriving. (Australian Government Department of Health, 2019; WHO, 2018a).

Maternal Health Matters is a registered charity based in Canberra and working Australia-wide. Our mission is to ensure all women receive respectful maternity care: care that respects women's autonomy, dignity, feelings, choices and preferences. Through campaigns, education, policy advocacy and engagement with communities and government, we promote maternity services that are equitable, culturally safe, evidence-based, timely and focused on the needs of the woman.

This submission addresses the Committee's terms of reference on pregnancy and postpartum care, in particular paragraphs (1)(a) best-practice postpartum healthcare, (b) women's experiences in the postpartum period, (c)

pregnancy and postpartum care models, (d) the cost and accessibility of postpartum healthcare, (f) education and training for healthcare professionals, and (h) data collection, reporting and monitoring.

Our five priority recommendations are:

- **A National Clinical Care Standard for Maternity Services**, linked to accreditation and measured through women's reported experiences and outcomes.
- **Midwifery continuity of care** as the foundation of primary maternity care, with multidisciplinary escalation according to need.
- **A whole-woman postpartum care pathway** for the 12 months after birth, addressing unmet physical and mental health needs.
- **Funding reform**, including Medicare support for midwifery, that rewards prevention and continuity rather than clinical throughput.
- **Community-based antenatal education and public awareness**. Fund independent, community-based antenatal education and peer support that continues after birth. Complement this with public education on healthy pregnancy and mothering to rebuild community knowledge and support.

A prevention-first, woman-centred maternity care system

Maternal health encompasses the physical, mental, and social well-being of women across the full continuum of preconception, pregnancy, childbirth, and the postpartum period (up to 12 months after birth). (Australian Government Department of Health, 2019; WHO, 2022).

The premise

What do women need to experience pregnancy, birth and early motherhood in good health, with confidence, agency, safety, connection and appropriate support; and what health system best provides that?

The health and wellbeing of women is an outcome in its own right. Improving infant outcomes is an important consequence of supporting women, not a substitute for women's health as the primary objective.

Pregnancy, labour, birth and breastfeeding are normal physiological processes, not illnesses. Technological advances and surgical skills can save lives when appropriately used. However, without valid indications, routine intervention can transform a normal biological process into a potentially harmful medical procedure. Australia must address both sides of this challenge: *too-little-too-late* and *too-much-too-soon*. (WHO, 2018a; WHO, 2018b, Lancet 2016, Cárdenas 2025).

Maternity care is healthcare for women

There is a danger that maternity care turns women into the vehicle for improving infant outcomes. That is precisely what the Select Committee on Women's Health should challenge. Women should not receive care primarily because: *healthy mothers produce healthier babies*. Women are themselves the primary recipients and rights-holders of care. The baby benefits because the woman is supported, not the other way around. Maternal wellbeing has seven interconnected dimensions:

- **Physical health and recovery**: physiological function during pregnancy, bodily healing after birth, sleep, nutrition and physical activity.
- **Mental and emotional health**: emotional wellbeing and prevention of distress, including recovery from a difficult or traumatic birth, which increases the risk of postpartum mental health conditions.
- **Reproductive and sexual health**: reproductive system care and sexual wellbeing.
- **Identity and adjustment**: navigating the profound physical, emotional and identity changes of becoming a mother, and growing confidence in her body and her capacity to care for her baby.
- **Relationships and connection**: adapting to changes in her relationships, and having family, peer and community support so that no woman navigates this transition alone.

- **Autonomy and birth experience:** the right to make informed, self-directed decisions, and a birth experience that leaves her feeling safe, respected and confident.
- **Social and economic circumstances:** housing, income, safety and access to resources, where disadvantage increases the risk of complications, preterm birth and maternal mortality.

Respectful maternity care

When we support a woman and provide respectful maternity care, we protect both the woman and the child.

Every woman has the right to maternity care that protects her dignity, privacy, confidentiality, autonomy and freedom from harm and mistreatment. Women have the right to make informed decisions about their own bodies and to accept or decline recommended care.

Respectful maternity care is not an optional interpersonal ideal. It is a fundamental component of safe, high-quality care.

Women should be treated as competent adults and as partners in decision-making. Health professionals must provide transparent, balanced information about the benefits, risks and alternatives to recommended interventions. *Women need health professionals on tap, not on top.*

Maternity care should be primary and preventive healthcare

Australia should not judge its maternity care system primarily by how effectively it identifies and treats risk and illness. It should also judge success by whether maternity and primary-health-care systems create the conditions in which women remain healthy, supported, connected and confident as they navigate pregnancy, birth and the transition to motherhood.

Social isolation, inadequate housing, financial stress, family violence, insecure employment, lack of practical support and previous trauma cannot be solved by a screening questionnaire. Women sometimes need another woman who has been through it, a trusted midwife, practical postpartum support, a local mothers' group, culturally appropriate community support, help navigating services, or simply sufficient time with someone who listens. Screening has its place but relying on it alone can leave women feeling like passive subjects in a medical system rather than people who need a community around them.

A prevention-first model therefore combines universal health-promoting maternity care with additional support according to need.

Continuity should be the foundation

For uncomplicated pregnancy, the primary maternity care provider should be a midwife, working within a system with ready access to GP, obstetric, mental-health and other specialist expertise when required.

Midwifery continuity of care provides what women need from a primary maternity care provider: someone who knows them, understands pregnancy and birth, builds confidence, provides education and support, recognises emerging health issues, coordinates care and escalates when specialist care is required. The evidence is strong. A 2024 Cochrane review of sixteen trials involving around 18,000 women found that women receiving midwife continuity of care were less likely to have a caesarean section, an instrumental birth or regional analgesia, were more likely to have a spontaneous vaginal birth, and generally reported more positive experiences of care, with cost savings in the antenatal and intrapartum periods (Sandall et al., 2024 and McKelvin 2021). There is also emerging evidence that continuity of care reduces anxiety and depression during the perinatal period (Cibralic et al., 2023).

This does not mean midwives instead of doctors. It means a midwife *as the primary maternity care provider, with multidisciplinary escalation according to need.*

Community-based antenatal education: building the village

Antenatal education is a form of primary prevention and should therefore extend beyond preparation for labour and birth. Women need reliable information and support to maintain their own physical and emotional health, their relationships and the positive functioning of their family unit. Education should address the physical and psychological changes that occur during pregnancy and the transition to parenthood, maternal wellbeing, relationship impacts, family of origin influence, infant communication and care, realistic expectations of the postnatal period and pathways to help.

The objective is not simply to transfer information. It is to build the village.

Establishing peer connections during the antenatal period can reduce isolation, build confidence, normalise help-seeking and create a social safety net around a new parent. In this way, community-based antenatal education can contribute to preventive health and strengthen social connection. These peer networks may also support early access to primary health care by helping parents recognise when they or others may be struggling, encouraging help-seeking and facilitating timely connections with appropriate services. The WHO antenatal-care framework similarly emphasises information, education, communication and support as components of a positive pregnancy experience (WHO, 2016).

A National Clinical Care Standard for Maternity Services

Maternal Health Matters recommends that the Australian Commission on Safety and Quality in Health Care develop a *National Clinical Care Standard for Maternity Services*, developed in collaboration with women and consumers and embedded within existing accreditation and quality frameworks.

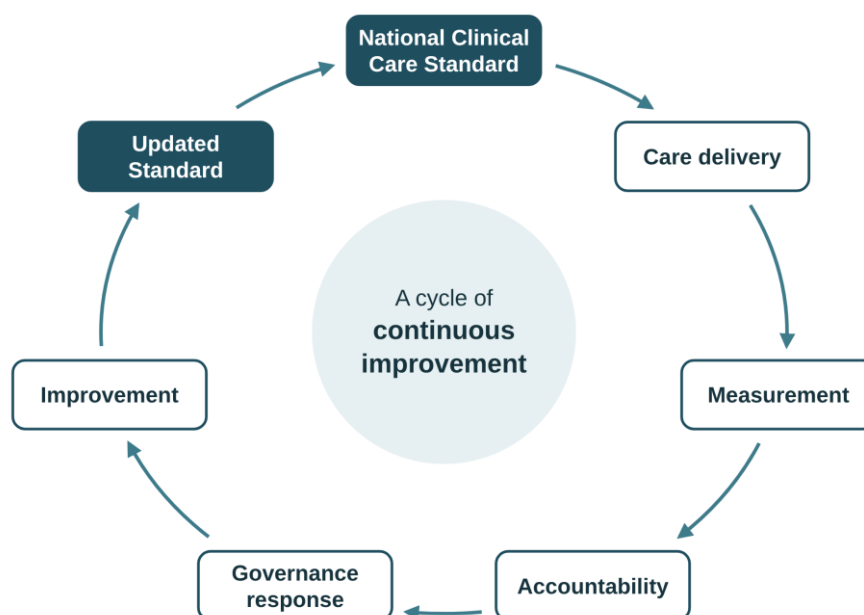


Figure 1. How a National Clinical Care Standard would drive continuous improvement in maternity services

The Standard should translate the principles of safety, quality, equity and person-centred care into clear and measurable expectations covering:

- health promotion, prevention and early intervention;
- physiological pregnancy, birth and postnatal care;
- continuity of care and therapeutic relationships;

- informed decision-making and informed consent;
- respectful and culturally safe care;
- access to midwifery continuity for uncomplicated pregnancy;
- timely recognition and management of complications;
- referral and escalation;
- integration between primary, community and hospital services;
- maternal and neonatal outcomes;
- women's reported experiences and outcomes;
- equity of access to appropriate care; and
- reduction of unwarranted variation.

The Standard should become the benchmark against which all maternity services are designed, delivered and measured.

Key recommendations

To achieve this vision, Maternal Health Matters asks that the Committee support the following twelve recommendations. Recommendations 1 to 4 are our highest priorities:

1. **A National Clinical Care Standard for Maternity Services.** That the Australian Government task the Australian Commission on Safety and Quality in Health Care with developing a National Clinical Care Standard for Maternity Services, co-designed with women and consumers, linked to health-service accreditation, and monitored through Women's Reported Experience Measures and Women's Reported Outcome Measures covering continuity, consent, equity and clinical outcomes. (ACSQHC, 2021; ACSQHC, 2026).
2. **Midwifery continuity of care.** That the Australian Government, working with the states and territories, establish midwifery continuity of care as the foundation of primary maternity care, with equitable access and seamless multidisciplinary escalation, and guarantee comprehensive professional indemnity insurance for midwives so the model can be sustained in all settings, safeguarding women, practitioners and the public. (WHO, 2018a; Sandall et al., 2016; AIHW, 2025)
3. **Postpartum care: from maternity to well woman.** That the Australian Government fund a whole-woman postpartum care pathway for the 12 months after birth, including continuity of carer into the postnatal period, clear guidance for women on what to expect in recovery, routine assessment of unmet physical and mental health needs, and shared decision-making, with targeted investment to eliminate health inequities. The postnatal period is a critical window of profound physical and emotional adaptation, yet current systems often fail to meet women's needs during it, and there is emerging evidence that continuity of care can reduce maternal anxiety and depression (Cibralic et al., 2023).
4. **Funding and financing reform.** That the Australian Government reform Medicare and other financing mechanisms to support midwifery care and to reward prevention, continuity and comprehensive care rather than clinical throughput.
5. **Community-based antenatal education and public awareness.** That the Australian Government fund independent, community-based antenatal education, separate from health services, as a vehicle to "build the village": peer support groups that continue after birth and cover the physical, social and psychological transitions, relationship changes and infant communication. This should be complemented by broad public education on healthy pregnancy and mothering, to counter the loss of community-level experience that comes with smaller families (Heinonen 2021).

6. **A prevention-first approach to maternal wellbeing.** That the Australian Government adopt a prevention-first approach to maternal wellbeing that targets the social determinants of health and strengthens social and community connection, rather than relying primarily on clinical screening, diagnosis and treatment. (Australian Government Department of Health, 2019; WHO, 2016; WHO, 2022, Muggleton, 2022 and Shanahan, 2022).
7. **Respectful maternity care and partnership in practice.** That the Australian Government work with professional bodies, education providers and accreditation authorities to embed respectful maternity care, human rights and informed consent across policy, education and accreditation, including training health professionals to work in partnership with women (using frameworks such as the Family Partnership Model), backed by robust mechanisms for reporting, redress and ongoing improvement (WHO, 2018a).
8. **Equitable access for women in priority populations.** That the Australian Government fully implement the recommendations of the *Ending the postcode lottery* report to ensure First Nations, culturally and linguistically diverse, rural, remote, those with a disability, teenagers, those with pre-existing illness, those with lived experience of trauma and socially disadvantaged women (Australian Government Department of Health, 2019; AIHW, 2025). An overlooked area is support for older mothers, proactively addressing the intersection of perimenopause and the distinct physical, emotional, and professional impacts of becoming a mother later in life. At advanced maternal age, professional mastery and corporate competence do not necessarily translate to the challenges of parenting, creating a need for more tailored support. (Ahmad 2024).
9. **A stronger consumer voice.** That women and consumers be given a formal role in the governance of maternity services, so that services are designed, delivered and evaluated in the direct interest of women, babies and families.
10. **Recognising the economic impacts of birth.** That the Australian Government address maternal health and the transition to parenthood in its intergenerational and workforce policy, including the economic impacts of birth on women identified in the Committee's terms of reference (paragraph (1)(b)).
11. **Family violence in pregnancy and the postpartum period.** That the Australian Government strengthen primary, secondary and tertiary prevention of family violence during pregnancy and the postpartum period, targeting root causes, prioritising early intervention and requiring explicit reporting of family violence incidence in pregnancy.

These reforms would move Australia from a system that manages a woman's medical risk to one that promotes her health, prevents harm and supports her through pregnancy, birth and the transition to motherhood. A woman who is known by her care provider is a woman whose complications are recognised early and who reaches specialist care the moment she needs it. Supporting women well is not in tension with safety. It is how safety is achieved.

Conclusion

Women's health and wellbeing is an outcome in its own right. Every woman should experience pregnancy, birth and mothering with confidence, agency, safety, connection and the support she needs.

The organising principle for reform should be prevention-first: designing maternity care around sustained, respectful relationships in which women are heard, informed, empowered, connected and supported to thrive. When women thrive, the benefits ripple outward to their babies, families and communities. Access to this experience should not depend on where a woman lives, her circumstances, or how well she can navigate the health system.

Our health system has a vital role to play in making this possible. It should be designed not simply to respond when problems arise, but to create the conditions in which women can flourish throughout their journey into motherhood.

Every woman should have the opportunity to enter motherhood feeling valued, supported and empowered and the maternity system should be designed to make that possible.

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