

WOMEN SPEAK AUSTRALIA

SUBMISSION TO THE SENATE SELECT COMMITTEE ON WOMEN'S HEALTH

Postpartum Care, Maternal Mortality, Contraceptive Care, Sex-Specific Data and Medical Device Monitoring

4 October 2026

INTRODUCTION

Women Speak Australia (WSA) is an independent, non-partisan national advocacy organisation. WSA advocates for laws and policies that recognise the material reality of biological sex and its importance to women's safety, privacy, dignity, equality and participation in public life.

This submission is confined to postpartum care, its measurement, and the monitoring of devices used in women's healthcare. It addresses Terms of Reference 1 to 5, 8, 14 and 15.

1. THE WOMAN WHO WAS PREGNANT IS THE PATIENT

Terms 1 and 3. The Nursing and Midwifery Board of Australia Midwife standards for practice are framed within a woman-centred approach. In those standards, "woman" means the person giving birth. The standards include her baby, partner and family in the field of care and keep the woman as the focus of the professional relationship. Woman-centred care, as defined there, covers her physical, emotional, psychosocial, spiritual and cultural needs, her ownership of health information, her dignity and her decision-making.¹

That definition is clinical. Pregnancy, birth and the puerperium produce pathology in the female patient: haemorrhage, genital-tract trauma, infection, hypertensive disease, thromboembolism, pelvic-floor injury and lactation difficulty. Those events are not properties of the household. A partner's inclusion is justified where it supports her care, including after infant loss. It is not a basis for moving the clinical record, consent or the outcome measure off the woman who was pregnant.

The Commonwealth strategy Woman-centred care: Strategic directions for Australian maternity services (2019) sets the same frame, from conception to 12 months after the pregnancy or birth, and requires care to be equitable, safe, woman-centred, informed and evidence-based. Policy and service documents should retain terminology that identifies the woman as the patient, so that maternal outcomes remain identifiable in the record and in reporting.²

¹Nursing and Midwifery Board of Australia, Midwife standards for practice.

<https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/midwife-standards-for-practice.aspx>.

²Department of Health, Woman-centred care: Strategic directions for Australian maternity services, 5 November 2019.

<https://www.health.gov.au/resources/publications/woman-centred-care-strategic-directions-for-australian-maternity-services>.

2. MATERNAL DEATH DOES NOT END AT DISCHARGE

Terms 1, 3 and 8. For the maternal mortality ratio, a maternal death is the death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of duration and site, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes. Deaths from 43 to 365 days are late maternal deaths and are outside that ratio.³

In 2023, 27 women were reported to have died during pregnancy or within 42 days of the end of pregnancy. Of these, 23 were classified as maternal deaths, three were coincidental and one was unclassified. Of the 23, 52 per cent were direct and 48 per cent indirect. Fifty-nine per cent occurred after birth, 18 per cent during birth or within 24 hours, and 24 per cent during pregnancy.⁴

Of 197 maternal deaths in 2014–2023, 37 per cent occurred while the woman was pregnant, 18 per cent during birth or within 24 hours, and 45 per cent after birth. Of the post-birth deaths, 58 per cent occurred within 1 to 13 days. These proportions exclude deaths after miscarriage or termination, because timing is not routinely reported for those cases.⁵

In 2021–2023, more than 886,000 women gave birth. Eighty-one died during or within 42 days of the end of pregnancy. Fifty-nine of those deaths were direct or indirect, a maternal mortality ratio of 6.7 per 100,000 women giving birth. Twenty-one were coincidental. Forty of the 59 (68 per cent) occurred in hospital, 14 (24 per cent) at home and four (6.8 per cent) elsewhere.⁶

Two limits follow. The ratio stops at 42 days, so cardiomyopathy, thromboembolism, sepsis and suicide after that day are not in the headline rate. The early post-birth cluster, especially days 1 to 13, sits across discharge. A system that audits the birth admission and not the following fortnight will miss the period in which almost half of classified maternal deaths occur. The 42-day line is a surveillance convention. It is not a clinical statement that risk has ended.

3. CAUSE OF DEATH AND THE CONTENT OF FOLLOW-UP

Terms 1 and 2. In 2021–2023 the most frequent causes of maternal death were non-obstetric haemorrhage (8 deaths, 14 per cent), cardiovascular disease (7, 12 per cent), sepsis (7, 12 per cent) and amniotic fluid embolism (6, 10 per cent). Direct deaths were led by amniotic fluid embolism (6), obstetric haemorrhage (4), sepsis (3), suicide (3) and thromboembolism (3, of which two were pulmonary). Indirect deaths were led by cardiovascular disease (7), non-obstetric haemorrhage (6) and sepsis (4). Over 2021–2023 the leading causes were cardiovascular disease, sepsis, suicide and thromboembolism.⁷

³ Australian Institute of Health and Welfare, Maternal deaths in Australia 2021–2023, summary, released 21 May 2026. <https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia-2021-2023/contents/summary>.

^{4,5,6} Australian Institute of Health and Welfare, Australia's mothers and babies: Maternal deaths, updated 28 November 2025 <https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-australia>.

⁷ Australian Institute of Health and Welfare, Maternal deaths in Australia 2021–2023, causes of maternal deaths. <https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia-2021-2023/contents/causes-of-maternal-deaths/causes-of-maternal-deaths>.

Postpartum haemorrhage is a major cause of morbidity, and obstetric haemorrhage remains a direct cause of death. It was not the leading cause of maternal death in the latest triennium. Secondary postpartum haemorrhage, from 24 hours to six weeks, is outside primary-haemorrhage indicators and inside the same window as the post-birth deaths.⁸

Of the 59 maternal deaths in 2021–2023, 47 were reviewed for contributing factors. Review committees identified 36 factors relating to 25 deaths. Professional-care factors were identified in 13 deaths: inadequate staffing, failure or delay in emergency response, and failure to offer or follow recommended best practice. Factors in the woman, family or social situation were identified in 11 deaths, and access-to-care factors in 5. Of the factors identified, 40 per cent were assessed as likely to have contributed to the death and 52 per cent as possibly having contributed. These are system findings. They are not findings against named clinicians or services. The Australian Institute of Health and Welfare describes them as lessons and opportunities for improvement.⁹

The cause list sets the content of postpartum follow-up. A check limited to contraception and infant feeding will not detect secondary haemorrhage, puerperal sepsis, postpartum hypertension and pre-eclampsia, venous thromboembolism, peripartum cardiomyopathy, or evolving suicidality. Each is already in the mortality classification.

4. MORBIDITY THAT OUTLASTS THE BIRTH ADMISSION

Terms 2 and 4. Death is the rare end of a larger injury burden.

Haemorrhage

Primary postpartum haemorrhage is blood loss from the genital tract within 24 hours of birth. It is major at 1,000 mL or more. In 2023, 3.9 per cent of women giving birth vaginally, and 4.4 per cent giving birth by caesarean section, had a major primary postpartum haemorrhage of 1,000 mL to less than 1,500 mL. A further 2.4 per cent and 2.0 per cent respectively lost 1,500 mL or more. South Australian data were excluded from the 2023 indicator. Most women who haemorrhage have no identified risk factor. Associated morbidity includes transfusion, severe anaemia, psychological distress and interruption of breastfeeding. The indicator does not capture secondary haemorrhage.¹⁰

Perineal and pelvic-floor injury

Among women who gave birth vaginally in 2023, 18 per 100 had an intact perineum, down from 25 per 100 in 2014. Second-degree laceration occurred in 32 per 100 and first-degree laceration in 24 per 100. Third- or fourth-degree laceration occurred in 2.7 per 100 of all

^{8, 10} Australian Institute of Health and Welfare, National Core Maternity Indicators: Major primary postpartum haemorrhage. South Australia is excluded from the 2023 figures.
<https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators/contents/birth-outcome-indicators/major-primary-postpartum-haemorrhage>.

⁹ Australian Institute of Health and Welfare, Maternal deaths in Australia 2021–2023, Investigations. Of 59 deaths, 47 were reviewed; 36 factors related to 25 deaths.
<https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia-2021-2023/contents/clinical-characteristics-and-investigations/investigations>.

vaginal births. Episiotomy was recorded in 23 per 100 vaginal births. A woman may be counted under both episiotomy and a laceration.¹¹

Third- or fourth-degree tears occurred in 4.6 per cent of vaginal first births. The rate was 5.3 per 100 after instrumental vaginal birth and 2.2 per 100 after non-instrumental vaginal birth. Third- and fourth-degree tears involve the anal sphincter and, in fourth-degree tears, the anorectal mucosa. The Australian Institute of Health and Welfare classifies them as severe perineal trauma and notes the association with perineal pain, incontinence and dyspareunia. These injuries are a pain and continence problem under term 4. Persistent symptoms require assessment, pelvic-floor physiotherapy and a route to specialist referral. Access is the policy question.¹²

Mental health, infant loss and feeding

Suicide was a leading cause of maternal death over 2014–2023 and accounted for three direct deaths in 2021–2023. The Australian Postnatal Care Guidelines include social and emotional screening, care after a traumatic birth, and bereavement support. Screening is not a treatment. Women who experience miscarriage, stillbirth or neonatal death need a clinical and psychological pathway, not an optional adjunct. Feeding support belongs in the same recovery picture: lactation is a maternal physiological function, and anaemia, perineal pain, caesarean recovery and mental-health disorder all affect it. Term 4 is met by clinical feeding support organised around the mother and the infant.^{13 14}

5. POSTPARTUM CONTRACEPTIVE CARE

Term 5. Antenatal and postpartum reproductive health support, including contraceptive care, is part of recovery. It is not a separate social program. Ovulation can return from about 21 days after birth. A woman who does not wish to conceive needs a method in place before then. Lactational amenorrhoea is effective only while stated conditions are met: the infant is under six months, menses have not returned, and breastfeeding is fully maintained. It is not a default method.¹⁵

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists contraception guideline (C-Gyn 3), adapted from the UK Faculty of Sexual and Reproductive Healthcare, treats an interpregnancy interval under 12 months as associated with preterm birth, low birthweight and babies small for gestational age. It supports

¹¹ Australian Institute of Health and Welfare, Australia's mothers and babies: Perineal status.

<https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/perineal-status>.

¹² Australian Institute of Health and Welfare, National Core Maternity Indicators: Third and fourth degree tears. Instrumental rate 5.3 per 100; non-instrumental 2.2 per 100; vaginal first births 4.6 per cent.

<https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators/contents/birth-outcome-indicators/third-and-fourth-degree-tears>.

^{14, 13} Cumpston M et al., Living Evidence for Australian Pregnancy and Postnatal Care (LEAPP), Medical Journal of Australia, 23 September 2026. Postnatal guidelines: 149 recommendations as at August 2026.

<https://www.mja.com.au/journal/2026/224/9/living-evidence-for-australian-pregnancy-and-postnatal-care-leapp-transforming-the-australian-pregnancy-and-postnatal-care-guidelines>.

¹⁵ Sexual Health and Family Planning ACT, Postnatal contraception fact sheet, December 2025. Pregnancy can occur from 21 days after birth. Lactational amenorrhoea criteria are set out there.

<https://www.shfpact.org.au/factsheets/Post-Natal-Contraception-Dec-25.pdf>.

insertion of an intrauterine device within 48 hours of an uncomplicated vaginal or caesarean birth. If that window is missed, insertion is generally deferred to four weeks. Long-acting reversible contraception is the most effective reversible option. Insertion after discharge depends on a trained practitioner and on cost.¹⁶

Education and consent belong to the woman who has given birth. Antenatal discussion, a documented plan before discharge, and a funded route to insertion or prescription inside the first 21 days are the practical content of term 5. Immediate postpartum insertion should be available in public maternity units, not only by later referral. This submission does not address abortion law.

6. MEASUREMENT

Term 8. Guidelines, definitions and sex recording are one problem. A national rate is useful only if the population and the definitions stay stable.

The Living Evidence for Australian Pregnancy and Postnatal Care program, commissioned in 2023 with the Australian College of Midwives and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, has produced living Australian Postnatal Care Guidelines. By August 2026 those guidelines contained 149 recommendations across more than 20 topics, including discharge planning, secondary postpartum haemorrhage, perineal healing, social and emotional screening, bereavement, psychological birth trauma and infant feeding. The figure of 95 recommendations was the count at first release. Guidelines do not create physiotherapy appointments, mental-health treatment, specialist referral or insertion capacity. Implementation should be reported against access.¹⁷

Maternal deaths are reviewed by state and territory committees. There is no standardised national method of identifying and collecting maternal-death data, and no nationally agreed process of reporting and investigation. Definitions and collection methods for hypertensive disorders of pregnancy in the National Perinatal Data Collection vary by jurisdiction, and Australian Capital Territory data have been unavailable for some analyses. The 2023 major-haemorrhage indicator excluded South Australia. A rate built on non-equivalent definitions cannot answer whether a model of care has changed maternal outcome.^{18 19}

Sex recording is the other condition. The National Perinatal Data Collection and the National Maternal Mortality Data Collection are sex-based. Australian Institute of Health and Welfare maternity reporting uses “woman” and “mother” because the collections record

¹⁶RANZCOG, Contraception Clinical Guideline (C-Gyn 3). Interpregnancy interval under 12 months; intrauterine insertion within 48 hours, otherwise generally at four weeks. <https://ranzocg.edu.au/wp-content/uploads/Contraception-Clinical-Guideline.pdf>

¹⁷The Living Evidence for Australian Pregnancy and Postnatal Care program LEAPP. <https://livingevidence.org.au/living-guidelines/leapp/>

¹⁸Australian Institute of Health and Welfare, Maternal deaths in Australia 2021–2023, Technical notes. <https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia-2021-2023/contents/technical-notes>

¹⁹Australian Institute of Health and Welfare, National Core Maternity Indicators: Major primary postpartum haemorrhage. South Australia is excluded from the 2023 figures. <https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators/contents/birth-outcome-indicators/major-primary-postpartum-haemorrhage>.

sex and do not record gender. Who haemorrhages, who sustains a third-degree tear, who dies, and which model of care changes those rates, cannot be answered if the female population is no longer identifiable. Other characteristics may be collected in addition. They cannot replace sex where the exposure is pregnancy and birth.²⁰

7. DEVICES, MONITORING AND COMPLAINTS

Terms 14 and 15. Urogynaecological mesh is the clearest Australian example of a device used in women's healthcare whose harm was not captured by the approval system in time. Mesh was implanted for pelvic organ prolapse and stress urinary incontinence, conditions that are more common after vaginal birth and severe perineal injury. Benefit was counted at insertion. Pain, exposure, infection, dyspareunia, voiding difficulty and reoperation often appeared later.²¹

In November 2017 the Therapeutic Goods Administration cancelled the approval of specified transvaginal mesh devices used for pelvic organ prolapse. Those devices can no longer be supplied. From 1 December 2018, urogynaecological mesh applications have been Class III, the highest device class. Sponsors of devices approved under the former Class IIb classification had to lodge new applications by December 2020. As of 11 December 2020, four Class III mid-urethral sling devices remained approved, all in the GYNECARE TVT range, for stress urinary incontinence rather than for the cancelled prolapse indication. The Senate inquired into the number of women implanted and related matters. The Therapeutic Goods Administration continues to ask patients and practitioners to report adverse events.²²
²³

The regulatory sequence shows both a correction and a remaining gap. Cancellation and up-classification were late relative to the volume of implantation. Adverse-event reports, Australian Health Practitioner Regulation Agency notifications and state and territory health-complaints bodies do not form one record of what happened to the woman after the index procedure. A device or procedure used to treat birth injury, prolapse, incontinence or pelvic pain is incompletely evaluated if complications after discharge are not ascertainable, by sex, by the regulator. This submission does not ask the Committee to determine any named device or practitioner. It asks that terms 14 and 15 be applied to that surveillance and complaints gap.

²⁰ Australian Institute of Health and Welfare, maternity reporting uses woman and mother because the National Perinatal Data Collection and National Maternal Mortality Data Collection record sex and do not record gender.
<https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/technical-notes/data-sources>.

²¹ Therapeutic Goods Administration, Urogynaecological (transvaginal) surgical mesh hub. Specified prolapse meshes cancelled in 2017 and no longer supplied. <https://www.tga.gov.au/resources/explore-topic/urogynaecological-transvaginal-surgical-mesh-hub>.

^{22,23} Therapeutic Goods Administration, Australian transvaginal surgical mesh regulatory actions, updated 20 December 2023. Class III from 1 December 2018. Four Class III mid-urethral sling devices approved as at 11 December 2020.
<https://www.tga.gov.au/resources/explore-topic/urogynaecological-transvaginal-surgical-mesh-hub/australian-transvaginal-surgical-mesh-regulatory-actions>.

RECOMMENDATIONS

Recommendation 1. State the patient expressly

Governments and health services should retain, in maternity and postnatal documents, the position in the Midwife standards for practice that the woman who is pregnant or who has given birth is the patient. Partner and family involvement should be specified as support for her care, including after infant loss, and not as a substitute category.

Recommendation 2. Match follow-up to the period of death

Pathways should cover the first 14 days after birth as a period of elevated risk, not only the birth admission and a six-week visit. Follow-up should be capable of detecting secondary haemorrhage, puerperal sepsis, postpartum hypertension, thromboembolism, cardiac symptoms and suicidality.

Recommendation 3. Report the guidelines against access

Implementation of the Australian Postnatal Care Guidelines should be reported against access to perineal review, pelvic-floor physiotherapy, mental-health treatment, bereavement care and clinical feeding support. Term 4 is an access question.

Recommendation 4. Provide postpartum contraception before day 21

Public maternity services should discuss contraception antenatally, record a plan before discharge, and offer a funded method, including immediate postpartum intrauterine insertion where clinically appropriate, in time for the return of ovulation. Education and consent should remain with the woman who has given birth.

Recommendation 5. Publish comparable morbidity

Nationally agreed definitions and collection rules should cover primary and secondary postpartum haemorrhage, hypertensive disorders, sepsis, and third- and fourth-degree tears, with jurisdictional exclusions reported. A rate that is not comparable should not be treated as a national outcome.

Recommendation 6. Keep sex in the maternal collections

The National Perinatal Data Collection and the National Maternal Mortality Data Collection should continue to record biological sex. Where another characteristic is collected, it should be additional. Pregnancy, birth and puerperal outcomes should remain reportable for the female population.

Recommendation 7. Extend surveillance past 42 days

Governments should examine a consistent method for ascertaining late maternal death and selected severe morbidity from 43 to 365 days, at least for cardiac disease, thromboembolism, sepsis and suicide, so that the ratio's cut-off is not mistaken for the end of risk.

Recommendation 8. Use the review findings without naming services

National reporting should continue to separate professional-care factors from access factors and social factors. Training and emergency-response planning should be directed at the professional-care factors already identified: delayed response and failure to follow recommended practice.

Recommendation 9. Join up device surveillance and complaints

For devices and procedures used to manage birth injury, prolapse, incontinence or pelvic pain, the Therapeutic Goods Administration, the Australian Health Practitioner Regulation Agency and state and territory complaints bodies should be able to see complications beyond the index admission, by sex. Cancellation and Class III status for urogynaecological mesh should be treated as the minimum lesson, not as the close of terms 14 and 15.

CONCLUSION

In 2021–2023, 59 women died of causes related to or aggravated by pregnancy, a ratio of 6.7 per 100,000 women giving birth. Over the preceding decade, 45 per cent of maternal deaths with known timing occurred after birth, and more than half of those within 13 days. In 2023, fewer than one in five women who gave birth vaginally had an intact perineum, and 2.7 per cent sustained a third- or fourth-degree tear. Contraceptive care is part of the same recovery. Device monitoring failed women once, on mesh, and is not yet a single record after discharge.

Those figures justify the Committee's postpartum terms. They also set a limit. Small death counts support attention to timing, cause and professional-care factors. They do not support findings against named providers. What they support is a maternity system that keeps the woman who was pregnant as the patient, follows her through the period in which she is most likely to die, offers contraception before she can conceive again, records her sex and her complications in a comparable way, and requires the same follow-up of devices used to treat the injuries of birth.

Submitted By:

Dr Elizabeth Caballero

Retired GP

President, Women Speak Australia