February 27, 2026

National Women's Council Submission to Joint Committee on Health (National Maternity Strategy)

National Women's Council

Introduction

Founded in 1973, the National Women's Council (NWC) is the leading representative organisation working for women's rights and women's equality on the island of Ireland. We represent and derive our mandate from our membership, which includes nearly 200 groups and organisations from a diversity of backgrounds, sectors and locations across Ireland. As a membership organisation, NWC is uniquely placed to represent and communicate the concerns of women in Ireland. We understand that women's rights and equality are impacted by social determinants that are complex and have many intersections, and that is an important mandate of our work.

NWC convenes and is a member of several key networks in which issues relating to women's health, particularly women's mental health, reproductive justice, menstrual health and overall access to gender sensitive health care throughout the life cycle are a common theme, such as the Department of Health's Women's Health Taskforce and Endometriosis Advisory Group, the Women's Mental Health Network, and the National Women and Infant Programme's Public & Patient Partnership. As an organisation, NWC is funded both from grants from Government, the largest being the Department of Children, Equality, Disability, Integration and Youth, from state agencies including HSE and Pobal, from fundraising and from our members and individual supporters.

NWC women's health work, funded by the HSE, focuses on three pillars: (1) support the development and implementation of the Women's Health Action Plan by contributing to the Women's Health Taskforce, (2) support and advocate for gender sensitive and trauma-informed mental health services through the full implementation of HSE's Sharing the Vision, including addressing barriers related to perinatal mental health in Ireland, and (3) promote and advocate for sexual and reproductive health and justice.

We recently released, in collaboration with the Department of Health, the report *Our Health, Our Voices*[1] that presented the findings from the listening forum designed to fulfil Action 1E of the Women's Health Action Plan and build upon the 2021 Women's Health Taskforce "radical listening" exercises. We conducted 73 listening sessions and interviews, and a collective event, and engaged with Traveller women, Roma women, migrant women, disabled women, LGBTQ+ communities, older women, women experiencing homelessness and addiction, and survivors of domestic, sexual and gender-based violence (DSGBV). The results of this report showed among others, the remaining challenges to accessibility of healthcare services highlighting some deep-rooted systemic issues with respect to nearly all forms of discrimination, resulting in exclusion and a lack of gender-sensitive care

[1] National Women's Council of Ireland, *Our Health, Our Voices*, 2025

within the Irish healthcare system. Women from minority ethnic backgrounds, disabled women, LGBTQ+ individuals, and young and older women all recounted experiences of bias, dismissal, and systemic barriers to equitable care.

Furthermore, in 2024 we released the report *Perinatal Mental Health: Listening to Women and Shaping the Road Ahead*[2] that explored the experiences of marginalised women accessing the Specialist Perinatal Mental Health Services: Model of Care for Ireland in 2017, created after the release of the National Maternity Strategy 2016-2026. Among others, this report highlighted that despite progress in Ireland's Model of Care, challenges remain, such as the need for further integration of Specialist Perinatal Mental Health Services (SPMHS) with general maternity and mental health services, the absence of a dedicated Mother and Baby Unit (MBU), workforce constraints, resource shortages, and limited and often lack of disaggregated data available on women's experiences – including in relation to ethnicity and disability.

NWC welcomes the opportunity to make this submission to the Joint Committee on Health. This submission builds on our extensive research and consultation not only with our membership but also with women in all their diversity – including Traveller women, Roma women, migrant women, disabled women, LGBTQ+ individuals, and victims and survivors of domestic, sexual and gender-based violence (DSGBV) - who have actively participated from our women's health research. We are convinced that there is still a pressing need of consolidating a maternity system that is built on opportunity and continuity of care and accessible to all women without exception. Maternity care is a core part of women's health care and a human right, not simply a clinical service, it needs to be women-centred and evidence-based. It is critical that a new Maternity Strategy is rooted in women's experiences, in all their diversity.

National Maternity Strategy

The National Maternity Strategy 2016-2026 was a strategic step towards a holistic care model for women and families. There have been some significant and positive developments, including greater provision of midwifery-led care, which furthered a positive shift from purely obstetrics led care, the creation of integrated special perinatal mental health services, and greater resourcing and prioritisation of postnatal support thought initiatives such as the postnatal hubs. However, there are still significant limitations in terms of implementation and appropriateness of the actions to which the

[2] National Women's Council of Ireland, Perinatal Mental Health: Listening to Women and Shaping the Road Ahead, 2024

Department of Health committed to in the Strategy. There are still fundamental distances between what the system is offering and the specific needs of women, babies and families during and after pregnancy. The way that a woman is taken care of during and after pregnancy will have a significant impact in motherhood and overall quality of life; the National Maternity Strategy is still not providing the options for women to make informed choices about their pregnancy, labour and postpartum. For example, there are still no standalone birth centres, there are still limited options for home birth and limited care options, including the absence of a Mother and Baby Unit. Against the backdrop where women are increasingly choosing less medicalised birthing experiences in response to past distressing medical maternal experiences. The National Survey on Birth[3] found only one in three (34%) first time mothers had a spontaneous vaginal birth compared to two in three (66%) of mothers with one or more previous births. Highlighting most births in Ireland are medicalised, with physiological birth being the exception rather than common practice. It is well known that choice in maternity care improves safety, satisfaction and overall health outcomes. On the other hand, there is still a question regarding continuity of care, a point that is particularly concerning regarding mental health support in antenatal and postnatal period.

We will present below the key critical gaps and challenges remaining in the implementation of the National Maternity Strategy along with specific recommendations on key actions.

Critical gaps and challenges

Implementation and Resourcing

There are important limitations in the implementation and resourcing of the National Maternity Strategy:

- **The Strategy is often not matched with the required workforce planning, funding and infrastructure**. There are reported shortages in staff that often generate pressure on midwives and obstetric teams. This is also something that was present in the HSE's latest Maternal Experience Survey 2025 (and that has been repetitive in previous surveys), for example, "*Many participants described not receiving enough support and assistance from healthcare staff while they were staying in hospital after the birth of their baby. Participants felt that in many cases this was due to the busy postnatal wards not having enough staff available to help*."[4]

[3] Findings of a National Survey on Birth in Ireland, ULRR, 2025
[4] National Maternity Experience Survey 2025

- Another example is the response capacity of mental health services for mothers. Up to one in five women will experience mental health difficulties during pregnancy or in the first year after birth. As a result, **existing SPMHS are increasingly overstretched**. Hub sites have become extremely busy, with some, including the National Maternity Hospital and the Rotunda Hospital, experiencing a doubling of clinical activity. This level of demand is widely recognised as unsustainable and has limited the ability of hub teams to provide the level of support to spoke sites originally envisaged under the Model of Care and has resulted into extensive waitlists.
- **The long overdue new National Maternity Hospital is still undelivered**. As NWC recommended in the recent CEDAW Shadow Report[5], it is imperative to have a new state of the art maternity hospital that can contribute to the delivery of safe, modern and fully resourced care that reflects international best practices. It is widely recognised that the existing facilities are outdated and inadequate to offer the quality of care needed for women and babies but also to support the demand on services.
- **Despite the expansion of maternity hospitals providing termination of pregnancy, there are still important limitations in terms of service delivery** and alignment with WHO guidance and best clinical practices[6]. Improvement of termination of pregnancy care is long overdue, and a strategy aligned with the recommendations of the Independent Abortion Review is much needed.

Better data collection, monitoring and evaluation practices

- A recurrent limitation in women's health that is particularly critical in maternal health and lacking in this Strategy is the **appropriate collection of disaggregated equality data across the different services.** Moving towards reliable disaggregated data should be a priority of the Strategy. The necessity of disaggregated data has equally been highlighted by the introduction of the National Equality Data strategy calling for Government Departments to make a commitment to collect, use or disseminate equality data. Currently, available data cannot not be disaggregated by maternity experiences based on ethnicity or disability, for example, which is internationally considered best practice. While important insights in terms of the experience of people accessing maternal healthcare are collected by the National Maternity Experiences

[5] NWC Member Shadow Report 2025
[6] World Health Organization, Abortion care guidance, 2022

Survey, the truth is that this is not providing a full picture of care, and it is leaving behind experiences from groups that are often underrepresented.

- This disaggregated data collection is critical for care **improvement for all pregnancy related events**, including pregnancy and delivery, abortion, miscarriage, still birth, post-partum complications, post-partum mental health events, among others.
- It is critical that a new Maternity Strategy incorporates data collection systems and variables that allow a proper **monitoring and evaluation** of its implementation; to this point it is important to consider resources to include an IT system shared by all maternity services.
- **The lack of this disaggregated data significantly impacts quality of care.** Understanding specific needs based on ethnicity, disability and other determinants of health is critical to support women effectively during and after pregnancy and identify potential predictors of preventable health issues. For example, in-take data on ethnicity is particularly important for some women, including Traveller women, due to risks of delays in Beutler test for Galactosaemia considering the high rates among Travellers[7].
- **Better data collection is also the opportunity for more precise research and quality improvement,** both crucial for the evaluation of the impact and implementation of the Strategy but also to continue understanding the experiences and needs of women in all their diversity based not only in a qualitative approach but also considering their health outcomes, engagement with the health system, adherence to care and treatment when needed, among others.

Perinatal Mental Health

Since the inception of the Specialist Perinatal Mental Health Services (SPMHS), significant progress has been made nationally regarding perinatal mental health. The allocation of €3.6 million in funding has enabled all 19 maternity hospitals nationwide to establish six consultant-led, multidisciplinary hub teams operating across major maternity hospitals, along with 13 spoke sites staffed by Perinatal Mental Health Midwife posts. However, while this progress is welcomed, there are still barriers to access, particularly for marginalised women:

- **Maternity services are not equally distributed across the country, resulting in clear geographic disparities in access to and quality of care**. Findings from the National Maternity Experience Survey 2025[8] highlighted ongoing gaps, with 20% of respondents reporting that

[7] Pavee Point, Information for Pregnant Women, 2023.
[8] National Maternity Experience Survey 2025

they were not given enough support for their mental health after the birth of their baby. This underscores that, despite national investment and structural reform, many women continue to experience inconsistencies in postnatal mental health support.

- **Ensuring consistent staffing levels, expanding community-based supports, and strengthening outreach** services in underserved regions will be key to guaranteeing that every woman in Ireland, regardless of where she lives, has timely access to high-quality perinatal mental health care.
- While women experiencing more severe mental health difficulties can access Perinatal Mental Health Midwife services, women attending spoke sites do not receive directly provided specialist perinatal mental health care and are instead managed by Liaison Mental Health Services, where available, or by Adult Community Mental Health Teams. Women are still being forced to leave their babies, families and support networks if they need specialised mental health care, **there is a pressing need for a Mother and Baby Unit that is long overdue and still not delivered**[9]And is the only element of the Specialist Perinatal Mental Health Services that is yet to be delivered.
- **Strengthening continuity of care beyond the first year postpartum is therefore essential to ensure sustained recovery, reduce long-term morbidity, and prevent women from re-presenting in crisis**. There are significant gaps in community follow-up once a woman reaches the end of the first postnatal year, at which point they no longer meet the criteria for specialist perinatal services. Many women continue to experience ongoing mental health difficulties beyond this timeframe, yet structured transition pathways into primary care psychology services or Adult Community Mental Health Teams are inconsistent and, in some areas, limited. The absence of a clearly defined, resourced follow-on pathway can result in abrupt discharge, fragmented care, and increased risk of relapse.

Postnatal care

Postnatal care is often described by women as the weakest part of the system**. Women perceive that pregnancy and delivery are treated in Ireland as a medical event that is considered complete six weeks after labour**. It is evident that postpartum support often ends prematurely.

[9] National Women's Council of Ireland, Perinatal Mental Health: Listening to Women and Shaping the Road Ahead, 2024

- Presently, there is **limited support after the last appointment with the GP standardised at week 6 after delivery**. This standard leaves women and families without consistent support, often limiting access to breastfeeding guidance, mental health services and overall support.
- **Postnatal care remains neglected, inconsistently delivered, and diversely inaccessible**. Despite the profound physical and mental changes that follow childbirth, support during this period is often fragmented. For example, the Maternal Health and Maternal Morbidity in Ireland (MAMMI) Study[10] findings show the challenges with **assuming that physical health concerns resolve shortly after labour, as it is the case with Ireland's short post-natal period.**
- The evidence indicates that significant health needs persist well beyond this period. Depressive symptoms are common during and after pregnancy. Among MAMMI participants, **9.3% reported depressive symptoms before pregnancy, rising to 12.2% during pregnancy. Prevalence increased further to 17.7% at three months postpartum, with 13.4% at six months and 12.8% at one year after birth**. Despite this, almost half of women (49.0%) reported not being asked about feelings of depression or low mood by their GP, and 33.7% were not asked by a midwife or public health nurse. There is no evidence for the short postnatal period guidelines in Ireland, instead there is evidence clearly showing the need of an extension of care beyond the 6-week mark.
- Access to care is not universal. **Not all women receive or are able to access the recommended GP consultations, and many face financial and logistical barriers**, including out-of-pocket costs, limited appointment availability, lack of childcare, and transportation challenges. These barriers to care are particularly pronounced for marginalised women.
- **Presently maternity and post-natal services consistently place the onus on women**. At a time when many are recovering from birth and adjusting to their new reality, the burden should not fall on them to determine the care they receive. Instead, postnatal services should be available, consistent and designed to anticipate and meet women's needs. Equitable postnatal care ensures consistent follow-up, removes systemic barriers, and is accessible to all those who need it.

Gender sensitive and trauma informed approaches

The National Maternity Strategy 2016-2026 was a significant step towards the understanding of the pressing need of improving health care for women during and after pregnancy. However, for a new National Maternity Strategy to be considered women centred it needs to include, the considerations listed above and the following considerations:

[10] MAMMI Study Research - Trinity College Dublin

- All the events surrounding pregnancy and delivery are critical moments for women's lives which is why **it is imperative to** adopt **an intersectional lens in every step of a National Maternity Strategy**. There is no one size fits-all approach in maternal health, it is vital that women's voices in all their diversity are heard and considered to create a new strategy that provides comprehensible support to women and families.
- **There is an over-representation of marginalised women in pregnancy and post-partum complications** with the Maternal Death Enquiry Ireland[11] reporting women living in the most deprived areas continue to have the highest maternal mortality rates and that there remains a more than three-fold difference in maternity mortality rates in the UK amongst women from Black ethnic backgrounds, and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women. In Ireland **much remains unknown due to lack of appropriate data collection**. It is critical to reduce the persistent inequalities for Traveller and Roma women, including other minority ethnic groups, migrant women, disabled women.
- There is a pressing need for **increasing the representation of women and people in all their diversity amongst staff** – It is crucial that Traveller, Roma, disabled women, for example, can see themselves represented in the healthcare system and staff body in order to achieve structural change and meaningful inclusion, and to ensure there is culturally appropriate care throughout the entire process.

Recommendations for a new National Maternity Strategy

- **Co-create a New National Maternity Strategy with civil society** to reflect the specific needs of women in all their diversity considering key actions to ensure continuity of care and improved health outcomes.
- **Establish a woman-centred, state-of-the-art National Maternity Hospital** without further delay, with independent governance and budgeting.
- **Make equality data collection a core pillar of the new National Maternity Strategy** ensuring that information systems are interconnected based on the guidelines of best practices.
- **Fund research that includes more diverse experiences** of the journey of maternity and maternity care pre, during pregnancy and post-partum.

[11] Maternal Death Inquiry Ireland 2024

- Implement the **Independent Abortion Review and expand abortion care in line with international human rights standards**, including WHO guidance and best clinical practice, to ensure timely, equitable, and local access.
- **Urgently establish Ireland's first Mother and Baby Unit and invest in the updated Specialist Perinatal Mental Health Model of Care**. This must include enhanced specialist, primary, and community-level supports; targeted actions for marginalised groups; and trauma-informed, gender-responsive, and culturally sensitive care.
- **Extend Ireland's postnatal care period of 6 weeks postpartum to at least 3 months.** Ensuring consistent follow-up to allow for adequate identification and response to women's ongoing physical and mental health needs.
- The Maternity Strategy needs to **consider and integrate care along all the pregnancy-related events and broader women's health** – e.g. reproductive health, abortion, fertility, menopause, etc.
- **Design concrete actions that support affordable and accessible care** for women in all their diversity for the entire first year post-partum ensuring continuity or care and support.