



Submission: **Select Committee on Women's Health**

October 2026

Keli McDonald

CEO, NRWC

Phone: 02 6742 6831

Email: ceo@nrwc.com.au

Website: www.nrwc.com.au

Kathleen Tonini

NRWC Policy Writer

Phone: 02 6742 6831

Email: ceo@nrwc.com.au

Website: www.nrwc.com.au

Acknowledgements

The National Rural Women's Coalition (NRWC) acknowledges the Traditional Owners of the land on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and future. We value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We extend our respect to Aboriginal and Torres Strait Islander women who for thousands of years have preserved the culture and practices of their communities on Country. This land was never surrendered, and we acknowledge that it always was and always will be Aboriginal land. We acknowledge that Australian governments have been complicit in the entrenched disadvantage, intergenerational trauma and ongoing institutional racism faced by Aboriginal and Torres Strait Islander people. We recognise that Aboriginal and Torres Strait Islander people must lead the design and delivery of services that affect them for better life outcomes to be achieved.

About the National Rural Women's Coalition

The National Rural Women's Coalition (NRWC) is a national advocacy organisation representing women in regional, rural and remote (RRR) Australia. We support policies that enhance gender equity, social inclusion, and economic participation, particularly for women and children in under-resourced areas. The NRWC works to amplify the voices of RRR women, ensuring that their unique challenges, such as limited access to services, geographic isolation, and economic disparities are understood, highlighted and addressed through policy advocacy, programs and initiatives. This work is crucial because RRR women often face greater inequities and have access to fewer resources than their urban counterparts.

The NRWC's represents women, in all their diversity, living in rural, regional and remote Australia and is supported through peak member organisations, Australian Local Government Women's Association, Australian Women in Agriculture, National Rural Health Alliance, Women in Seafood and Transport Women Australia Limited.

Executive Summary

Roughly 7 million people – or 28 per cent of the Australian population – live in rural and remote areas. People living in rural and remote areas have higher rates of hospitalisation, death and injury and also have poorer access to, and use of, primary health care services, than people living in major cities.ⁱ According to the National Rural Health Alliance, each person in rural Australia is missing out on nearly \$1,218 a year of healthcare access, which equates to a total annual rural health spending deficit of \$9.23 billion.ⁱⁱ

Because of this service gap, rural, regional and remote people must travel, pay more, delay or even forego the care they need. For rural women, this disadvantage is compounded by their gender, and the need for tailored healthcare, including sexual and reproductive care, throughout their lives. Rural women have poorer access to maternity and postpartum services, reproductive healthcare and face heightened barriers to getting their pain treated properly due lack of services and provider choice, higher costs and delays getting appointments.

To ensure women's voices were included in this submission, the National Rural Women's Coalition (NRWC) conducted an online survey which was completed by 162 rural, regional and remote women. The survey asked for their experiences of the healthcare included in this Committee's terms of reference including postpartum care, pain management and fertility. The results were striking in their consistency, noting long delays, high costs, difficulties getting their travel costs reimbursed and lack of female GPs and women's health specialists. Some of the comments women shared included:

"Limited choice, lack of continuity of care due to locums, need to self-advocate fiercely to be listened to."

"There is no such thing as women's healthcare in rural Australia! Yes we can potentially get in to see a GP but they are not specialists in women's healthcare. I am fortunate that I was able to eventually see a woman's healthcare specialist in Adelaide. But the wait period and travel times are part of our lives but come at a huge cost ment[ally], financially and physically!"

The NRWC supports the establishment of the Select Committee on Women's Health and wishes to draw attention to the ways rural, regional and remote women require new, and tailored approaches to deliver adequate care. The National Women's Health Strategy identifies women and girls from rural and remote Australia as a priority group for improved care, as well as Aboriginal and Torres Strait Islander women (59 per cent of whom live outside metropolitan areas).ⁱⁱⁱ

In relation to the terms of reference of this Committee, NRWC recommends the Commonwealth consider the following measures to improve service provision for rural, regional and remote women:

1. Increased funding for maternity services in rural, regional and remote areas including reopening hospital services, supporting more General Practitioner Obstetricians and rural and community midwifery/birthing services
2. Introduce Medicare funding for postpartum healthcare including a standard amount of pelvic floor physiotherapy, lactation support and mental health services.
3. Fund co-located and multidisciplinary women's health service hubs including contraception, low risk pregnancy care, postpartum care (physiotherapy, lactation support), abortion care and menopausal care in rural and remote areas.
4. Investigate subsidising allied health providers to operate in regional, rural and remote areas to maintain access to services in thin markets.
5. Nationalise and increase subsidy rates for state based patient transport schemes to reduce out of pocket costs for regional, rural and remote women accessing health care
6. Prioritise and fund more female health practitioners including GPs, and Nurse Practitioners in rural, regional, and remote Australia
7. Improve specialised training for rural and regional health practitioners (including nurses) to enable wider provision of abortion services and require all public hospital services to provide medical and surgical abortion services.

1. Best practice approaches to postpartum healthcare, including the delivery of physical and mental health support and services for mothers and their partners including those who have experienced infant loss;

Best practice postpartum healthcare for rural, regional and remote women is service delivery that is co-designed with community, provided close to home and provides continuity of care by known carers. However, this is not the standard of care that most regional, rural and remote women experience when giving birth and postpartum.

The context for understanding current birth and postpartum care in regional Australia is the significant decline in maternity services in rural areas. While there is no recent data to quantify this, between 1992–2011, there was a 41% reduction in the total number of maternity units in Australia which are associated with rurality.^{iv} Women in rural areas lack birthing services, as well as antenatal and postnatal care close to home. They experience challenges when their local rural hospital does not offer a maternity service and they must travel long distances to give birth. This fundamentally prevents the provision of best practice physical and mental health services for women and their babies postpartum. It is at odds with best practice including midwifery continuity of care and Birthing on Country/Birthing in our Community models recommended by the Australian College of Midwives.^v

Due to different health risk factors related to rurality, and compounded by the lack of service availability, rural mothers face poorer health outcomes. More rural mothers smoke during pregnancy, more babies are born prematurely, and there are lower rates of exclusive breastfeeding. They also have higher rates of unplanned pregnancies, infant mortalities, low birthweights and preterm babies.^{vi} Rural women are more likely to experience haemorrhage after birth or be admitted to ICU. The closure of maternity services has coincided with a 47% increase in babies born before the mother arrived at the hospital, for example on the side of the road.^{vii} Some states like NSW have acknowledged this rise and are working to introduce more homebirth options and reopen some closed regional maternity units.^{viii}

Current market and population-based models have failed rural, regional and remote women. New models are needed and they must be designed to overcome the higher cost of providing services in areas where the population is more dispersed, whilst recognising that women have specific, lifelong healthcare needs that should be provided in their communities.

2. Women's experiences in the postpartum period, including the physical, psychological, emotional and economic impacts of birth;

Rural, regional and remote women have reported that isolation and fragmented care can compound the negative impacts of birth. Postpartum care, just like birthing services, are not equally accessible for rural, regional and remote women and their families. Providing high-quality postpartum care is extremely difficult when women must travel to access services. One study of rural Victorian women found that all participants raised transportation and distance as a barrier to accessing care. This was articulated as travelling large distances (up to three hours one way) to receive

care, financial burden created by fuel costs, physical exhaustion due to travel and waiting times and finding transportation (when public transport was unavailable).^{ix} This study also raised the range of other support services for example perinatal mental health services, lactation support, physiotherapy and home midwifery services that are not consistently available. One participant estimated she was travelling 1,000kms a week to access pregnancy care.^{ix}

In some regions, women must relocate to a metropolitan centre to give birth, because the services simply do not exist within a reasonable distance of her home. In cases where women must travel to a metropolitan centre to give birth, it is extremely difficult to maintain continuity of care. One mother from the Wheatbelt region who had experienced good continuity of care throughout her pregnancy noted that this did not extend when giving birth in a metropolitan centre.

"[it was stressing me] not knowing anybody that was dealing with me... every single midwife that worked in the hospital in the 24 hours had done an internal on me." vii

Isolation also compounds trauma surrounding birth and postpartum for regional, rural and remote women, in particular when staying away from home to give birth. One mother described birthing her second child alone, as there was no one in Perth to take care of her other child:

When I gave birth, I was totally alone... we had my other child with us and no one to look after her so my husband couldn't come in with me. vii

Travelling long distances and staying away from home significantly reduces the likelihood of a woman having a positive birth experience due to fragmentation of care and women being less supported and able to advocate for themselves before, during and after the birth of their baby.

NRWC'S recent online survey highlighted the brutal reality of having to travel long distances for birth and postpartum care. Comments from women included:

"We should'[nt] ... be expected to go to Perth or Port Hedland to have our children. We want to have them home...we don't have to stress about how to get back especially freshly postpartum."

"The system is a joke, not enough access to female doctors, if you live in a non-birthing town you have to uproot your family for 6+ weeks with no support. The [PATS] system is ridiculous, only covers for one town where the prices for accommodation are extortionate"

"The anxiety you feel when pregnant, living in a regional town where you cannot actually give birth at the local hospital... Anxiety over having to travel 60-70kms+ to the next nearest town when in labour, as well as having difficulty getting an appointment with local GPs."

“I’ve tried to access a 6 week postpartum checkup. ..because we only have one gp in town who isn’t taking new patients I have to fly back to Perth for a 6 week check up”

Birth trauma is not just about medical outcomes, but when women’s choices are not respected and when they have no agency in their experience. A nation-wide University of Western Sydney survey of 6,101 women found that 39.2% of comments were from women who wanted to avoid a repeat of their previous pregnancy and birth experience. They wanted to better advocate for themselves, get more informed about their choices, and avoid certain birth interventions.^x Giving birth is life-changing for women in both positive and negative ways. Without support from partners, support people and care providers that know and understand their patients, women are more likely to have their choices and concerns ignored or overridden. This is much more difficult for women without their support systems nearby and without a known provider leading their care.

3. Best practice pregnancy and postpartum care models to support long-term maternal physical and mental health;

Best practice pregnancy and postpartum care models prioritise continuity of care, a mother’s choice and agency and allows women to be supported by their community. The World Health Organisation defines a positive postnatal experience as one in which women, newborns, partners, parents, caregivers and families receive information, reassurance and support in a consistent manner from motivated health workers; where *a resourced and flexible health system recognizes the needs of women and babies*, and respects their cultural context.^{xi} Rural, regional and remote women in Australia do not have access to this standard of care in a consistent manner, in particular a system that is well resourced and flexible.

To achieve best practice for regional, rural and remote birthing women, prioritisation should be given to rebuilding and maintaining rural maternity care. The Australian College of Rural and Remote Medicine (ACRRM) has identified this should include re-establishment of closed facilities, retaining existing services, and establishing new models of care, tailored to meet the needs of rural and remote communities.^{xii}

Women in remote and rural communities prefer to stay close to home throughout their pregnancy and birth. They seek care that is safe, culturally respectful, and tailored to their unique life circumstances. For low socioeconomic groups, financial stressors, separation from family, and lack of transportation options can all impact care decisions and health outcomes.^{xii}

The urban-centric service models that rely upon higher populations have failed to provide high-quality services for rural, regional and remote women and their families when it comes to antenatal, birthing and postpartum care. New models are needed that can provide postpartum care in innovative ways to overcome cost and infrastructure barriers to providing health care in regional areas. These should be co-located, multidisciplinary, community led, provide continuity of care beyond birth and include essential postpartum care including physiotherapy, lactation support, mental health services and connection with other mothers.

The cost and accessibility of postpartum healthcare, including:

- 1. infant feeding supports,**
- 2. mental health supports and services,**
- 3. physiotherapy services, including pelvic health services, and**
- 4. related allied health services;**

Affordable and tailored postpartum care is not widely accessible to women across Australia, and barriers to access are even higher in rural, regional and remote Australia. Medicare coverage for physiotherapy is limited to through a Chronic Disease Management Plan despite pelvic floor physiotherapy being increasingly recognised as an essential component of postpartum care.^{xiii} Lactation support services are supported under Medicare up until 6 weeks postpartum if provided by an endorsed midwife.^{xiv} This is extremely limited, short term, and many women do not know they can access this support or need support outside the time it is available. Comprehensive and universal provisions under Medicare for postpartum lactation services and pelvic floor physiotherapy should be a national priority.

The cost and accessibility of postpartum care is a continuing problem for mothers in rural, remote and regional Australia. Australia-wide there is an identified shortage of many allied health services, including occupational therapy, pharmacy, physiotherapy, psychology, rehabilitation counselling, social work, sonography.^{xv} The National Rural Health Alliance highlighted the maldistribution of allied health professionals per 100,000 population, with much lower rates in MM3 (large rural towns), MM4 (medium rural towns), MM5 (small rural towns), MM6 (remote communities), and MM7 (very remote communities) areas, with MM5 areas showing the lowest rates.^{xvi} In many allied health professions (e.g., physiotherapy, podiatry, pharmacy, optometry) the growth in rural and remote areas is significantly less than in metropolitan areas. These geographic differences contribute to the disparities in health of the rural and remote population through increased wait times for services, increased travel times for healthcare, and less access to primary healthcare.^{xv}

NRWC's online survey found that approximately 28% of women who had recently accessed postpartum care said it cost them between \$1000 and \$5000 including travel, accommodation and childcare costs. Approximately 40 per cent waited between 3 and 8 weeks for an appointment. More than 32 per cent said they travelled between 200 and 500km (one way) to access an appointment. Twenty-four per cent travelled more than 500kms (one way). More than 63 per cent said they had no choice of care provider. Challenges can also arise when it comes to privacy and small communities. One mother stated:

"Post partum mental health is hard to navigate in a small rural community when you don't want people to know you aren't doing well."

Breastfeeding has a widely recognised range of health benefits for both babies and mothers. 'Optimal breastfeeding' in early childhood lowers rates of illness and death in mothers and children and correlates with higher cognitive function later in life.^{xvii} However, Australian breastfeeding rates show a strong decline in the months after a

baby is born and only 63% of babies received breast milk at 6 months (and 33% received breast milk at 12 months).^{xviii} Breastfeeding rates decline with remoteness, with 38% of infants in Major Cities exclusively breast fed for the first six months, compared with 27% in Remote areas.

A study of breastfeeding in rural Australia found that clinicians and mothers both noted there were significant demands for breastfeeding support services in rural/regional areas.^{xix} Mothers seeking non-urgent breastfeeding care in rural and regional areas were negatively affected by understaffed health services. Clinicians mentioned their services were stretched, and there were long delays before breastfeeding mothers could access non-urgent care. Poor service access, coupled with the early discharge from hospital, leaves breastfeeding mothers insufficiently supported during the establishment of breastfeeding.

A study of rural mothers from Western Australia's wheatbelt region showed that hospitals and other health services provided little to no follow-up for rural mothers, for the management of both emotional and physical trauma. As one participant described:

"[after the birth, there was] no aftercare whatsoever. I was left on my own. There was no referral for how to fix my pelvic floor. No stress debriefing or anything. We don't have any services out here, but they didn't help me to find anything in Perth."^{vii}

The same study identified that recovering from emergency caesarean birth in geographical isolation meant that they had few options for assistance. One mother described:

...the first six weeks [after birth] were pretty rough. Especially after having the c-section because I couldn't lift my child and we are 15 kilometres from town so it's not like I could walk, you know, just put baby in the pram and walk to go and get milk or whatever. If I can't go out, I'm literally stuck on the farm.

4. Antenatal and postpartum reproductive health support and education, including contraceptive care;

Women living in rural areas are more likely to experience an unintended pregnancy than those in metropolitan areas. They have less access to contraception and abortion care, due in part to geographical isolation, high costs and limited providers.^{xx}

To address the shortage of healthcare services in remote and rural communities, capacity building should be provided to additional sections of the healthcare workforce, for example nurses and Aboriginal health workers. Moving to nurse-led models of care in smaller communities would provide more options for women and take the strain off the broader healthcare infrastructure.^{xxiii}

While provision of long-acting reversible contraception and early medical abortions can be safely provided in primary care settings, relatively few general practitioners have undertaken the necessary training and even less in rural areas. The limited

number of health practitioners able to provide LARC and early medical abortion is a significant barrier to women accessing timely and safe contraception and abortion care in Australia.^{xx}

xx

5. Research, education and training on pregnancy and postpartum care for healthcare professionals working in maternal care;

The lack of healthcare workers in rural communities impacts women in specific ways. Concerns about privacy, stigma, cultural safety and poor reproductive healthcare literacy among primary care professionals and the wider community all contribute to difficulty in receiving adequate health care for women in rural, regional and remote areas.^{xxi}

The loss of maternity services extends beyond the delivery of birthing care. According to the Australian College of Rural and Remote Medicine, loss of maternity services is associated with a progressive deskilling of the medical workforce and a downgrading of facilities and overall level of services.^{xii}

One way to improve services for rural women is to increase the number of general practitioners with obstetric and gynaecological training (GPO), upskill midwives and nurse practitioners where appropriate and increase the number of female health practitioners.

NRWC notes the Australian College of Rural and Remote Medicine (ACRRM) training pathway includes an option to specialise in obstetrics and gynaecology (to become a GPO). ACRRM state that the Rural Generalist GP is essential to enabling effective service delivery for rural women close to home, as they can provide continuity of care from antenatal to postnatal stages, as well as obstetric, in-patient and emergency care.^{xiii} Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) highlight the need to develop a rural O&G specialist training pathway, support GP upskilling and support and recognise the role of GPOs in delivering women's health services in rural, regional and remote areas.^{xiii} Greater investment in GPOs to deliver services to rural, regional and remote women can underpin improved and shared care across a range of health care providers.

Despite evidence indicating that health professionals' education and training is an important element in effectively increasing rates of exclusive breastfeeding, this area is still not well addressed and continues to impact the care of breastfeeding mother.^{xix} NRWC supports greater investment in breastfeeding education and support to the range of health care providers operating in rural and remote areas, and support for specialist lactation consultants to be supported by Medicare.

6. Existing Commonwealth, state and territory government policies, programs and healthcare initiatives addressing postpartum care;

Rural women are also often asked to relocate to a town or city with a birthing facility two to four weeks (and sometimes more) prior to their due date depending on distance to travel and assessed level of risk. This places considerable financial and other burdens on expectant mothers, their partners and families. Not all women have

the flexibility to leave their family, home or livelihood for extended periods without serious negative impacts.^{xxiii}

The various state-based patient transport subsidy schemes are inequitable and inadequate, with different subsidy rates and eligibility^{xxiv} and subsidy rates that often fall short of the real cost of travelling for medical care. The study of rural mothers in Western Australia showed they were under-informed about the Patient Assisted Travel Scheme:

'I don't know when or where mothers can get information about the PATS. There's that money and it's just available and they just don't know about it. ..sometimes I showed the form to GPs and they were like, 'what is this?'

'I should have been told [about the PATS]. The GP never told me, the hospital never told me, not the obstetrician, no one. That's the main thing I want you to know for your study.'

NRWC supports a national review of the operation of patient transport subsidy schemes to ensure they provide consistent and adequate subsidisation for patients in rural, regional and remote Australia.

7. Data collection, reporting and monitoring processes and allocation of research efforts relating to postpartum healthcare

NRWC supports greater targeted investment in research and data collection about rural women's health, including pregnancy, postpartum, fertility and reproductive health services. NRWC supports the Commonwealth's increased investment in women's health including in pelvic pain, endometriosis and Medicare rebates but notes this still overlooks the true breadth of disparities across women's health care, research, systems, funding, and policies.^{xxv} For rural, regional and remote women, the disparities are even greater. Better research, data collection and pilots and trials to determine what works best to deliver services in thin markets, with a focus on women's health, is needed.

8. The ways in which women and girls experience recurrent, severe, or long-lasting pain conditions;

Rural, regional and remote women face additional barriers accessing healthcare, including for long lasting pain conditions. The Victorian Government's recent Inquiry into Women's Pain (the first in the nation) received 13,000 responses. Women living in rural Victoria reported additional challenges when accessing pain care including extensive travel for care and limited provider choices.^{xxvi} Respondents highlighted a lack of GPs, specialists and allied health practitioners in regional and rural areas, with 65% of rural and regional respondents reporting long wait times as a challenge to seeking care for pain.^{xxvi} When access to GPs, specialists and allied health services is limited, women's pain goes untreated, their conditions worsen, and their quality of life declines. Not only do women have to travel further and pay more, but they also have fewer choices of provider and often delay treatment.

9. Women's experience in seeking appropriate healthcare responses to pain, including experiences of medical misogyny;

Women's experiences of having their pain dismissed, being disrespected and receiving inadequate treatment of their pain are well established.^{xxvii} For rural, regional and remote women, this is likely to be exacerbated by lack of access to care providers, delays getting treatment and fewer choices of providers. One participant in NRWC's online survey specifically noted the need for female doctors:

"Need more access to female gps. I don't feel comfortable with males for most female related issues."

10. Barriers to effective pain management, including the range and affordability of available treatments;

Women pay more and are more likely to delay their treatment.^{xxviii} Rural women experience additional barriers including accessing timely appointments, paying more (fuel and accommodation or public transport costs) and having access to fewer providers.

Results from NRWC's online survey showed 45 per cent of women accessing pain treatment said the experience was difficult. Close to 30% estimated they were out of pocket \$5000 or more to access this service. Twenty eight percent said they had waited between 6 and 12 months to get an appointment and approximately 22% said they had waited for more than 12 months. Roughly 37% travelled between 200 and 500kms (one way) and around 33% travelled more than 500kms (one way). 63% had no choice in their provider. Some of the survey participants articulated their challenges:

"Ultrasound and imaging - long distances to travel. Gynaecologists who are dismissive of pain /endometriosis."

"I was experiencing severe vaginal and vulval pain due to perimenopause. It took several months and a lot of travel and money to finally find a doctor who could diagnose and treat me. I am now on HRT. I cannot say enough about the Jean Hailes Institute in Melbourne who took me seriously and were able to help. I now see them via Telehealth."

11. Best practice approaches to assisted reproduction treatments;

NRWC supports targeted approaches to support rural, regional and remote women and their families to access fertility treatments. For example, increasing subsidy rates provided by patient transport subsidy schemes to properly accommodate women and their families travelling to access healthcare. Currently these schemes pay well below the true costs of accommodation and fuel, limiting their ability to support women and reduce out of pocket costs for rural women and their families.

12. Access and affordability issues relating to fertility and assisted reproduction treatments;

Like most other health services, rural, regional and remote women and their families do not have equal access to fertility and assisted reproductive treatments. Rural women must travel long distances, take time off work, stay overnight and pay accommodation costs if they require fertility and ART.^{xxxix} A Queensland study found that most participants travelled well over 200 km to access assisted reproductive services. In addition to travel times and costs, rural patients reported issues with long wait times for appointments, costs for scans and tests performed outside of the clinic and sometimes needing to spend extended periods of time away from home.^{xxx}

NRWC's survey showed more than 45% of women completing the survey that had accessed fertility treatment rated their experience accessing services as difficult. Close to 45% said it cost them \$5000 or more and around 30% said they waited more than 6 -12 months for an appointment. Around 25% travelled 500 kms (one way) or more to access an appointment and approximately 33 per cent travelled between 200 and 500 kms (one way). 72 per cent said they had no choice in provider.

13. The regulation of medical devices used in women's healthcare treatments, including risk assessments, monitoring and reporting;

NRWC has no information or advice regarding regulation of medical devices.

14. The role of relevant regulators and other agencies in responding to complaints regarding medical devices; and

NRWC has no information or advice regarding regulation of medical devices.

15. Any related matters

NRWC notes that large parts of rural, regional and remote Australia are underserved when it comes to termination services. This is a critical issue for rural women and their families. In Queensland, there are nine listed surgical abortion providers, none further west than Longreach.^{xxxi} Access to surgical abortion in regional Western Australia, which has only decriminalised abortion in 2024, is unclear.^{xxxii} Of the 24 high disadvantage regional and rural LGAs in Victoria, 67% did not have any listed surgical abortion providers, 45% did not have any listed medication abortion providers and 60% did not have any listed medication abortion dispensing pharmacies.^{xxxiii} In NSW, large areas of the state are abortion care 'deserts'. The only public hospitals in NSW openly providing abortion outside of a medical emergency are in Broken Hill, Newcastle and the Royal Women's Hospital in Sydney.^{xxxiv} Given that an estimated one in four women will have an abortion in their lifetime,^{xxxv} termination services should be considered essential frontline service, not a specialist, optional service that women should have to travel to access.

ⁱ Rural and Remote Health. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health>

ⁱⁱ National Rural Health Alliance. (2026). *The forgotten health spend: How much does Australia spend on rural, regional and remote health?* National Rural Health Alliance. <https://www.ruralhealth.org.au/the-forgotten-health-spend-report>

ⁱⁱⁱ Australian Institute of Health and Welfare. (2025). *Profile of First Nations people*. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/australias-health/profile-of-indigenous-australians>

^{iv} J Longman, J., Kornelsen, J., Pilcher, J., Kildea, S., Kruske, S., Grzybowski, S., Robin, S., Rolfe, M., Donoghue, D., Morgan, G. G., & Barclay, L. (2017). Maternity services for rural and remote Australia: Barriers to operationalising national policy. *Health Policy*, 121(3), 1161–1168.

^v Australian College of Midwives. (n.d.). Submission – Health impacts of alcohol inquiry. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Disability/Healthimpactsalcohol/Submissions

^{vi} National Rural Health Alliance. (2025). Rural mothers and babies deserve better this World Health Day. <https://www.ruralhealth.org.au/media-release/rural-mothers-and-babies-deserve-better-this-world-health-day/>

^{vii} Shackleton, E., Fisher, C., Bosco, A., & Slack-Smith, L. (2023). 'We country women need advocacy': Birthing narratives from the Western Australian Wheatbelt region. *Australian Journal of Rural Health*, 31(5), 886–896. <https://doi.org/10.1111/ajr.13013>

^{viii} Pezet, L. (2026, September 22). Rate of babies born before reaching hospital climbs in regional NSW. *ABC News*. <https://www.abc.net.au/news/2026-09-22/babies-born-before-arriving-at-hospital-climbs-regional-nsw/107106782>

^{ix} Faulks, F., Shafiei, T., Mogren, I., & Edvardsson, K. (2024). 'It's just too far...': A qualitative exploration of the barriers and enablers to accessing perinatal care for rural Australian women. *Women and Birth*, 37(6), 101809. <https://doi.org/10.1016/j.wombi.2024.101809>

^x Keedle, H., & Dahlen, H. (2023, September 5). Opinion: More than 6,000 women told us what they wanted for their next pregnancy and birth. Here's what they said. *Western Sydney University*. <https://www.westernsydney.edu.au/news-centre/stories/2023/opinion-more-than-6000-women-told-us-what-they-wanted-for-their-next-pregnancy-and-birth-heres-what-they-said>.

^{xi} World Health Organization. (2022). *WHO recommendations on maternal and newborn care for a positive postnatal experience*. World Health Organization. <https://www.who.int/publications/i/item/9789240045989>

^{xii} Australian College of Rural and Remote Medicine. (2026). *Remote and rural maternity services: College position statement*. https://www.acrrm.org.au/docs/default-source/all-files/college-position-statement---rural-and-remote-maternity-services.pdf?sfvrsn=bd1ca4c7_4

^{xiii} Birth Trauma Australia. (2026, May 14). Birth Trauma Australia partners with Queensland Mental Health Commission to strengthen GP care for birth-related trauma. <https://birthtrauma.org.au/birth-trauma-australia-partners-with-queensland-mental-health-commission-to-strengthen-gp-care-for-birth-related-trauma/>

^{xiv} Allgrove, C. (n.d.). *Medicare rebate for lactation consultant midwife Perth*. Midwife Catherine. <https://midwifecatherine.com.au/medicare-rebate-lactation-consultant-midwife-perth/>

^{xv} Australian Centre for Disability Health Services. (2025). *Rural and remote allied health workforce: Final report*. <https://acdhs.edu.au/wp-content/uploads/2025/03/Rural-Remote-AH-Workforce-Final-Report-20250322.pdf>

^{xvi} National Rural Health Alliance. (2025). *Rural health in Australia: Snapshot 2025*. National Rural Health Alliance. <https://www.ruralhealth.org.au/wp-content/uploads/2025/02/NRHA-Rural-Health-in-Australia-Snapshot-2025.pdf>

^{xvii} Briana J Jegier, Julie P Smith, Melissa C Bartick, The economic cost consequences of suboptimal infant and young child feeding practices: a scoping review, *Health Policy and Planning*, Volume 39, Issue 9, November 2024, Pages 916–945, <https://doi.org/10.1093/heapol/czae069>

-
- ^{xviii} Australian Institute of Health and Welfare. (n.d.). *Australia's mothers and babies: Breastfeeding practices*. <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/breastfeeding-practices>
- ^{xix} Doyle, G. R., Mitchell, E. K. L., & McArdle, A. (2026). Experiences of breastfeeding complications in rural and regional Victoria: Perspectives from mothers and clinicians. *Australian Journal of Rural Health*, 34(1), e70154. <https://doi.org/10.1111/ajr.70154>
- ^{xx} Botfield, J. (2022, September 22). Increasing access to reproductive health care. *Partyline, National Rural Health Alliance*. <https://www.ruralhealth.org.au/partyline/article/increasing-access-reproductive-health-care.html>
- ^{xxi} Missing the mark: Gender inequity and medical misogyny. *Partyline, National Rural Health Alliance*. <https://www.ruralhealth.org.au/partyline/article/missing-mark-gender-inequity-and-medical-misogyny.html>
- ^{xxii} Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2024). *Rural, regional and remote strategy: Summary*. RANZCOG. <https://ranzcof.edu.au/wp-content/uploads/Rural-Regional-Remote-Strategy-Summary.pdf>
- ^{xxiii} Rural Doctors Association of Australia. (2021). *Rural maternity services in Australia: Policy position*. https://rdawa.com.au/common/Uploaded%20files/_Aus/Policy/Rural%20maternity%20services%20in%20Australia.pdf
- ^{xxiv} National Rural Health Alliance. (2024). *Patient assisted travel schemes: A guide*. National Rural Health Alliance. <https://www.ruralhealth.org.au/publication/fact-sheet/patient-assisted-travel-schemes-guide/>
- ^{xxv} Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (n.d.). *Budget falls short of recognising women's health as a cost-of-living issue*. <https://ranzcof.edu.au/news/budget-falls-short-of-recognising-womens-health-as-a-cost-of-living-issue/>
- ^{xxvi} Department of Health, Victoria. (2025). *Bridging the gender pain gap: The Inquiry into Women's Pain report 2025*. Victorian Government. <https://www.health.vic.gov.au/sites/default/files/2025-11/bridging-the-gender-pain-gap-pain-inquiry-report.pdf>
- ^{xxvii} Brown, M. (2025, November 9). Women's pain inquiry finds Victorians' suffering worsened by male-centred healthcare system. *ABC News*. <https://www.abc.net.au/news/2025-11-09/womens-pain-inquiry-victoria-released/105988930>
- ^{xxviii} May, N., (2024a). How much does the gender health gap cost? For Alyse, it's \$400,000. *The Guardian*. <https://www.theguardian.com/australia-news/2024/nov/12/alyse-chronic-health-conditions-have-cost-her-400000-doctors-say-the-system-unfairly-penalises-women>
- ^{xxix} Deakin University. (n.d.). *Aussie parents in rural areas struggle to access IVF treatment*. Deakin University. <https://www.deakin.edu.au/about-deakin/news-and-media-releases/articles/aussie-parents-in-rural-areas-struggle-to-access-ivf-treatment>
- ^{xxx} Mackay, A., Taylor, S., Anderson, E., & Glass, B. (2026). The right to have a family should not be determined by your postcode: Rural community experiences with fertility care. *Australian Journal of Rural Health*, 34(4), e70237. <https://doi.org/10.1111/ajr.70237>
- ^{xxxi} Children by Choice. (n.d.). Service finder. <https://findaservice.childrenbychoice.org.au/>
- ^{xxxii} Surgical abortion up to 13 weeks is available in Dunsborough, other locations are not listed. Government of Western Australia Department of Health. (n.d.). Abortion: Information for patients. <https://www.health.wa.gov.au/~media/Corp/Documents/Health-for/Abortion/Abortion-CHO-approved-information-for-patients>
- ^{xxxiii} Realising Access Abortion and Contraception Inequities and Enablers in Victoria. (2024). https://www.whv.org.au/wp-content/uploads/2024/12/Knowledge-Paper_2024.10.21_Realising-access-abortion-and-contraception-inequities-and-enablers-in-Victoria_Full-report_Nov_Fulltext-PDF.pdf
- ^{xxxiv} The Guardian. (2024, December 17). NSW abortion deserts: Just three of 220 public hospitals provide terminations. <https://www.theguardian.com/australia-news/2024/dec/17/nsw-abortion-deserts-just-three-of-220-public-hospitals-provide-terminations-research-finds>, and The Guardian. (2024, December 16). How hard is it to access an abortion in NSW? <https://www.theguardian.com/australia-news/ng-interactive/2024/dec/16/how-hard-is-it-to-access-an-abortion-in-nsw-these-maps-show-the-deserts-for-care-in-the-state>

^{xxxv} Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (n.d.). Clinical guideline: Abortion care. <https://ranzcog.edu.au/wp-content/uploads/Clinical-Guideline-Abortion-Care.pdf>