SUBMISSION

Senate Select Committee on Women's Health

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Submission to the Senate Select Committee on Women's Health
The Rural Women's Health Equity Gap: Access to Postpartum Care and Pain Management in Regional Victoria

Submitted by: Women's Health Grampians
Date: 9 October 2026

Executive summary

Women's Health Grampians (WHG) welcomes the opportunity to provide a rural and regional perspective to the Senate Select Committee on Women's Health. Drawing on WHG's research, community engagement and lived-experience evidence across the Grampians, this submission demonstrates that women's health inequities are shaped by place. Access to healthcare cannot be measured simply by whether a service exists. For women and gender diverse people living in rural and regional communities, meaningful access is shaped by distance, workforce availability, waiting times, affordability, continuity of care, privacy, disability accessibility, provider capability and whether people are listened to and believed.

WHG's evidence shows that these barriers have practical consequences for people seeking contraception, abortion and other reproductive healthcare. The Tell Your Story project collected 110 survey responses and five in-depth interviews across the Grampians region. Participants described difficulty obtaining timely appointments, limited local services, the need to travel to larger centres, financial and other costs associated with accessing care, concerns about privacy and the challenges of navigating fragmented services. In some parts of the region, local provision does not meet demonstrated demand, highlighting the gap between nominal availability and meaningful access.

The evidence is particularly strong in relation to women's pain and the way pain is assessed and managed. Participants described severe pelvic and menstrual pain, painful IUD insertion and removal, inadequate information and preparation about pain, limited access to local anesthetic or sedation, and experiences of pain being dismissed or downplayed. WHG's disability engagement further identified experiences of pain and symptoms being attributed to anxiety or mental health, repeated retelling of personal circumstances, inadequate reasonable adjustments and difficulty navigating referrals. Together, this lived experience points to systemic issues in how women's pain is recognised, communicated and responded to.

WHG's evidence also demonstrates that inequities can be compounded by disability, affordability and the realities of living in smaller communities. The cost of healthcare extends beyond the clinical fee to include travel, accommodation, childcare, lost income and support-person costs. For people with a disability, the additional time, support and adjustments required to access care can create further barriers. Privacy and continuity are also particularly important in regional communities, where people may be reluctant to discuss sensitive reproductive health issues or may repeatedly have to explain their circumstances to different providers.

WHG considers these findings to reflect systemic barriers rather than isolated experiences. The evidence points to the need for women's health policy and service planning to adopt a genuine rural and regional equity lens and to measure meaningful access, rather than simply the presence of services. This includes strengthening local and regional workforce capability; improving access to evidence-based pain assessment and management; addressing the full financial and practical cost of accessing care; making accessibility and reasonable adjustments a proactive responsibility of services; improving referral pathways and navigation; and strengthening continuity of care.

WHG also urges the Committee to recognise the value of place-based women's health organisations in identifying regional gaps, gathering lived experience, building workforce capability and translating evidence into practical change. Women and gender diverse people living in regional communities should not have to leave their communities, absorb significant additional costs or repeatedly advocate for their needs to receive safe, respectful and appropriate healthcare. Regional equity must be treated as a fundamental part of women's health policy and service design.

1. About Women's Health Grampians

Women's Health Grampians (WHG) is a Victorian women's health service established in 1991 and funded by the Victorian Department of Health. WHG is one of Victoria's regional and statewide women's health services and works to improve the equality, health and wellbeing of women and gender diverse people in the Grampians region and beyond.

WHG's catchment covers 11 Local Government Areas—Ararat, Ballarat, Golden Plains, Hepburn, Hindmarsh, Horsham, Moorabool, Northern Grampians, Pyrenees, West Wimmera and Yarriambiack—across more than 48,000 square kilometres. The region includes major regional centres, rural towns and remote communities across the Central Highlands, Grampians Pyrenees and Wimmera.

WHG works at a population and systems level with government, health and community organisations, using evidence, community engagement, advocacy, education, partnerships and service development to improve women's health and wellbeing and address gender inequality.

WHG has particular expertise in sexual and reproductive health, gender equality and prevention of violence against women, alongside work in mental health and wellbeing, chronic disease and other areas affecting women's health. Our work is grounded in a regional and place-based understanding of the barriers created by distance, workforce availability, socioeconomic circumstances and the interaction of gender inequality with other forms of disadvantage.

2. The Victorian Women's Health Services Network context

WHG is part of the Victorian Women's Health Services Network, which brings together statewide and regional women's health services across Victoria. The Network provides a statewide framework while enabling regional services to apply local knowledge, relationships and evidence to the particular circumstances of their communities.

WHG's contribution to this submission is therefore informed by both its role within Victoria's women's health system and its direct place-based experience across a large rural and regional catchment. This distinction is important: regional access cannot be understood simply by considering whether a service exists somewhere in the state. The location of services, workforce capacity, continuity, travel requirements, cost, privacy and the ability to obtain clinically appropriate care all shape whether a service is genuinely accessible.

3. Purpose and scope of this submission

WHG welcomes the establishment of the Senate Select Committee on Women's Health and appreciates the opportunity to provide evidence from a rural and regional perspective. This submission draws primarily on WHG's own research, community engagement and lived-experience evidence, particularly:

- Tell Your Story (2024): lived experiences of accessing contraception and abortion services in the Grampians region;
- WHG Community Connectors: Disability Final Report – Part 1 Engagement (2025); and
- Gender Inequality in the Grampians Report (2024).

The evidence is especially relevant to Terms of Reference 5, 6, 9, 10 and 11, with related implications for Terms 4, 7, 8, 14, 15 and 16. WHG does not have direct evidence to address every term of reference and has not attempted to fill those gaps with evidence from outside its own work.

3. Key recommendations

1. Embed a rural and regional equity lens in Commonwealth women's health policy, funding, service planning, research and evaluation, including measures of travel time, workforce availability, waiting periods, continuity and out-of-pocket costs.
2. Recognise the full cost of accessing women's healthcare in regional areas, including transport, accommodation, childcare, time away from work and support-person costs, rather than assessing affordability only through the clinical fee.
3. Strengthen regional access to contraception, abortion and other sexual and reproductive healthcare, with service planning based on demonstrated local demand and the capacity of services to provide timely care.
4. Improve access to evidence-based pain assessment and management for women and gender diverse people, including appropriate information about expected pain, analgesia, local anaesthetic, sedation and non-pharmacological options where clinically appropriate.
5. Invest in workforce education and capability in contemporary women's health, sexual and reproductive healthcare, pain, disability inclusion, trauma-informed practice, LGBTQIA+ inclusion, cultural diversity and communication that supports informed choice.
6. Make accessibility and reasonable adjustments a proactive responsibility of health services. Services should ask about access requirements before appointments and provide sufficient time and flexibility for people who require adjustments.
7. Improve referral pathways and navigation in rural and regional areas, including transparent information about service availability, waiting times, eligibility and what a service can and cannot provide.
8. Strengthen continuity of care, recognising that continuity supports trust, privacy, communication and willingness to discuss sensitive reproductive health issues.
9. Ensure regional women's health services and place-based organisations are resourced to gather lived experience and translate it into service planning, workforce development, policy and advocacy.

10. Improve data collection so that regionality, disability and other intersecting factors can be identified and monitored rather than hidden within statewide averages.

4. Rurality is a health equity issue

The Grampians region covers a very large geographic area with substantial variation in population density and service availability. WHG's evidence shows that the practical consequences of this geography are experienced directly by people seeking healthcare.

In Tell Your Story, 45% of participants disagreed that they could easily make an appointment with a local healthcare provider about contraception or abortion. Participants commonly described GP waits of two to four weeks, while 8% reported having no regular healthcare provider. Wimmera and Grampians Pyrenees participants were among those most likely to report difficulty obtaining a timely appointment.

The burden becomes particularly significant where care is not available locally. Sixty-six per cent of participants agreed or strongly agreed that travelling to a larger city for an abortion would be difficult. Participants identified travel costs, time off work, childcare, emotional impacts and travelling without a support person as barriers. Sixty per cent indicated that covering the financial cost of an abortion would be difficult.

For regional women, therefore, the question of access is not adequately answered by the existence of a service elsewhere in the state. A service can be legally available and technically accessible while remaining practically inaccessible because of distance, cost, workforce shortages, waiting periods or the absence of continuity and appropriate support.

The health and wellbeing of women across the Grampians are also shaped by broader regional and rural pressures, including drought, bushfires and other natural disasters, as well as family and gender-based violence. These circumstances can compound existing barriers to healthcare, affecting safety, financial security, mental health and wellbeing, and the ability to access timely and appropriate support. In a region where distance, workforce shortages and limited local services already create challenges, these pressures reinforce the importance of women's health policy that recognises the broader social, economic and environmental conditions influencing health. WHG considers these intersecting regional factors important to equitable service planning and highlights the need for further attention to how they affect women's health and access to care.

5. Contraception and abortion: access, choice and continuity

WHG has worked in sexual and reproductive health for more than a decade, including research into rural GPs and unintended pregnancies and the Increasing Reproductive Choices Grampians Regional Partnership Group. This work has sought to improve local service provision, referral pathways and provider capability, particularly in areas experiencing geographic or social isolation, disability or low income.

WHG's Tell Your Story evidence shows continuing unevenness in local provision. The evidence indicates that local early medical abortion provision was below patient demand in 10 of the region's 11 LGAs, and that five Victorian LGAs with no early medical abortion provision were in the Grampians at the time of the referenced data. IUD service provision was reported as meeting only around half of patient demand, with provision significantly below demand in seven LGAs.

Participants also described uncertainty about where to obtain IUD insertion and lengthy waits for specialist removal. These findings demonstrate why service availability needs to be considered alongside workforce capacity, referral pathways, waiting times and continuity.

WHG also notes the strong relationship between ease of appointment access and confidence in discussing reproductive healthcare. Among participants who found appointments easy, 65% were comfortable discussing abortion, compared with 36% among those who did not find appointments easy. Continuity is therefore not merely a consumer preference; it can influence whether people feel able to disclose information, ask questions and participate in informed decision-making.

6. Women's pain, being believed and appropriate responses

WHG's evidence strongly supports the Committee's focus on women's experiences of recurrent, severe and long-lasting pain and on the responses they receive from the health system.

Tell Your Story includes experiences of severe pelvic pain affecting work and daily life, debilitating menstrual and ovulation pain, painful IUD insertion and removal, and concerns that pain was downplayed or inadequately addressed. Two participants did not proceed with IUD insertion because their provider could not offer or arrange sedation or anaesthetic. One participant accessed insertion under general anaesthetic through private health insurance and reported $1,500 in out-of-pocket costs.

Participants also described being insufficiently prepared for the pain associated with early medical abortion and called for better information, stronger pain relief and greater access to non-pharmaceutical options such as TENS.

WHG's Community Connectors disability engagement strengthens this evidence. Participants described pain and symptoms being attributed to anxiety or mental health and reported that being listened to and receiving needed support was a rarity rather than the norm. Participants explicitly observed that women's pain was not taken as seriously as men's, despite being debilitating and life-impacting.

WHG considers that the Committee should view these experiences as evidence of a broader systemic problem in how women's pain is assessed, communicated and managed. The evidence does not provide a quantified measure of medical misogyny and WHG does not seek to make that claim. It does, however, provide clear lived-experience evidence of dismissal, inadequate recognition of pain and gendered assumptions.

7. Disability, accessibility and reasonable adjustments

The evidence also demonstrates that general service availability does not necessarily equal appropriate accessibility. In Tell Your Story, 9% of respondents identified as having a disability, and respondents experiencing disability were more likely to report difficulty affording abortion.

Participants in WHG's disability engagement described services that did not proactively ask about reasonable adjustments or accessibility needs. This placed the responsibility on the individual to identify and negotiate their own access requirements.

Participants also described the burden of repeatedly explaining their circumstances because information already provided was not read or carried between services. For people living with disability, chronic illness or pain, this repeated retelling was described as fatiguing and re-traumatising.

Participants wanted more time and support during appointments, trauma-informed and inclusive practitioners, accessible information, transparent waiting times, clear referral pathways and practical assistance to reach the right service. These are not specialist extras; they are features of an accessible health system.

8. Workforce capability and education

WHG's evidence indicates that provider capability is an important determinant of whether people can exercise informed choice and obtain appropriate care.

In Tell Your Story, nine participants identified education or training as an area requiring change; seven wanted more reproductive health information or education; four identified a need for greater provider training in women's health or sexual and reproductive healthcare; and participants identified needs relating to LGBTQIA+ care and cultural and gender diversity.

WHG recommends investment in regional workforce development that includes contemporary women's health, contraception and abortion, pain assessment and management, disability inclusion, trauma-informed care, LGBTQIA+ health, cultural diversity, communication and informed consent.

Regional workforce development should be linked to service planning. Training alone cannot overcome the absence of local services, but strengthening local capability can reduce unnecessary travel, improve referral pathways and support continuity.

9. Affordability and the hidden cost of regional healthcare

The evidence shows that affordability must be understood as the total cost of obtaining care. For regional women, this may include clinical fees, medicines, diagnostic costs, travel, accommodation, childcare, lost income and the cost of a support person.

WHG found that 60% of Tell Your Story participants indicated that covering the financial cost of an abortion would be difficult. The evidence also found a strong relationship between affordability and travel: 78% of participants who said an abortion would be difficult to afford also said travelling to a larger city would be difficult.

Disability can compound these costs. The evidence indicates that respondents experiencing disability were more likely to report difficulty affording abortion, while disability engagement identified the additional time and support required to access services.

10. Privacy, trust and continuity in small communities

Regional healthcare occurs within smaller communities where privacy can be a particular concern. Tell Your Story participants described fears that private information could become known publicly.

Continuity of care was also important. Participants valued seeing the same clinician and described the difficulty of repeatedly starting again with different doctors. WHG's evidence suggests that continuity contributes to trust, confidence, privacy and willingness to discuss sensitive reproductive health issues.

Service planning should therefore consider continuity as an access and quality issue, not simply as a consumer preference.

11. What people told WHG good care looks like

Across WHG's engagement, participants identified the following features of good care:

- a non-judgmental environment;
- being treated as an individual rather than a number;
- clinicians who provide factual information without imposing personal beliefs;

- enough time to discuss options, benefits, risks and treatment choices;
- clinicians who understand current treatment options and listen;
- kindness, respect and attention to sensory and accessibility needs;
- clear information about what to expect, including pain and pain-relief options;
- continuity and follow-up;
- services that proactively ask about reasonable adjustments;
- honest information about service availability and waiting times; and
- practical support to navigate to the service that can provide appropriate care.

12. Implications for policy and service design

WHG's evidence points to a broader principle: women's health policy should measure meaningful access, not merely nominal service availability.

System issue	What should be measured or addressed
Regional availability	Local service supply, workforce capacity, travel time, referral pathways and waiting periods.
Affordability	Total out-of-pocket cost including travel, accommodation, childcare, lost income and support-person costs.
Pain management	Whether people receive appropriate assessment, information, analgesia and access to clinically appropriate options.
Disability accessibility	Whether services proactively identify reasonable adjustments and provide adequate time and support.
Continuity	Ability to see a consistent provider or service and avoid repeated retelling of health information.
Navigation	Transparent information about what services provide, eligibility, waiting times and where to go next.
Equity	Data disaggregated by region, disability and other relevant intersecting factors.

13. Evidence limitations and areas requiring further research

WHG's evidence is primarily regional and qualitative, supplemented by survey findings and regional service-demand data. It is not intended to estimate the prevalence of these experiences across Australia. The evidence is most useful in identifying patterns, barriers and consumer-defined priorities that may otherwise be invisible in aggregate service-utilisation data.

WHG encourages the Committee to consider how national and state data collections can better identify rural and regional differences, disability-related barriers and other intersecting factors. The lack of sufficiently localised data for some population groups is itself an important evidence gap.

14. Conclusion

WHG's experience across the Grampians demonstrates that women's health inequity is shaped by place. Women and gender diverse people living in rural and regional communities can face long waits, limited local services, significant travel and financial burdens, fragmented referral pathways, concerns about privacy and continuity, and barriers related to disability and accessibility.

The evidence also demonstrates the importance of how healthcare is delivered. People want to be listened to, believed, respected and given enough information and time to make informed decisions. For women experiencing pain, appropriate assessment and pain management are fundamental to safe and respectful healthcare.

WHG urges the Committee to ensure that its recommendations recognise rural and regional women's health as an equity issue and that national women's health policy is designed around meaningful access, not simply the presence of services. Place-based women's health organisations should be recognised and resourced as partners in gathering lived experience, identifying regional system gaps, building workforce capability and translating evidence into practical change.

Appendix A – Alignment with the Committee's Terms of Reference

Term	Subject	WHG evidence
ToR 4	Cost and accessibility of postpartum/allied health care	Related evidence on regional affordability, travel, disability accessibility, waiting times and chronic pain services.
ToR 5	Antenatal/postpartum reproductive health support and contraception	Strong evidence on contraception, abortion, service availability, demand, provider capability and informed choice.
ToR 6	Research, education and training for healthcare professionals	Evidence on participant calls for workforce education and provider capability.
ToR 7	Government policies, programs and initiatives	Evidence identifies the need for regional service planning and policy that reflects local demand and barriers.
ToR 8	Data collection and research	Evidence demonstrates the value of lived experience and identifies gaps in localised and intersectional data.
ToR 9	Recurrent, severe or long-lasting pain	Strong evidence on pelvic, menstrual, IUD-related and chronic pain.
ToR 10	Responses to pain and medical misogyny	Lived experience of pain being dismissed, downplayed or attributed to anxiety/mental health; WHG does not quantify medical misogyny.

ToR 11	Barriers to effective pain management	Strong evidence on local anaesthetic/sedation, analgesia, specialist access, waiting times, cost and information.
ToR 14–15	Medical devices and complaints	Limited direct evidence in the WHG material; WHG does not seek to fill this gap.
ToR 16	Related matters	Regional equity, disability inclusion, continuity, navigation and affordability are relevant cross-cutting issues.

Appendix B – WHG evidence base

- Women's Health Grampians (2024), Tell Your Story – Lived experiences of accessing contraception and abortion services in the Grampians region.
- Women's Health Grampians (2025), Community Connectors: Disability Final Report – Part 1 Engagement.
- Women's Health Grampians (2024), Gender Inequality in the Grampians Report.
- Women's Health Grampians, Sexual & Reproductive Health program information and background on the Increasing Reproductive Choices Grampians Regional Partnership Group.

References and supporting web sources

- Parliament of Australia, Senate Select Committee on Women's Health – inquiry page and Terms of Reference (accessed October 2026).
- Women's Health Grampians, Who We Are (accessed October 2026).
- Women's Health Grampians, Sexual & Reproductive Health (accessed October 2026).
- Women's Health Victoria, Victorian Women's Health Services Network: statewide and regional map (2024).

Prepared by Women's Health Grampians | October 2026