Submission by the Australian Nursing and Midwifery Federation

Submission to the Select Committee on Women's Health

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Australian Nursing & Midwifery Federation

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Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

5. The ANMF thanks the Select Committee on Women's Health (the Committee) for the opportunity to provide feedback on broader systemic issues and service gaps affecting the health of women living in Australia through the Women's Health Inquiry (the Inquiry).

6. The ANMF's membership is predominantly female. This reflects the composition of the nursing and midwifery professions, with women comprising 88% and 98% of the professions respectively.[1] Thus a significant proportion of our members, and the nursing and midwifery workforces, experience women's health care both professionally and personally,

[1] Nursing and Midwifery Board. 2026. *Nursing and midwifery in 2024/25*. Accessed 24 September 2026 at https://www.nursingmidwiferyboard.gov.au/News/Annual-report

strengthening their contribution to this Inquiry.

7. Whilst the ANMF welcomes a focus on women's health, we simultaneously question the need for this inquiry when there many existing inquiries, reviews, and reports documenting the systemic issues affecting women's health and health care access from menarche through to menopause. These include, but are not limited to the:

   - National Women's Health Strategy 2020-2030
   - National Women's Health Advisory Council, established in 2022-23, including the #EndGenderBias Survey and Report (2024)
   - Woman-centred care: Strategic directions for Australian maternity care services (2019)
   - Senate Community Affairs References Committee – Inquiry into Universal Access to Reproductive Healthcare (2023)
   - New South Wales Select Committee on Birth Trauma (2024)
   - Queensland Mental Health Select Committee, including focus on perinatal mental health service gaps (2022)
   - Victorian Parliament Inquiry into Perinatal Services (2018)
   - Australian Longitudinal Study on Women's Health (1996 onwards)
   - South Australian Select Committee on Endometriosis (2025)
   - Victorian Inquiry into Women's Pain (2025)
   - Tasmanian Select Committee on Reproductive, Maternal and Paediatric Health Services in Australia (2024)
   - National Consensus Framework for Rural Maternity Services (2nd Edition, 2025)
   - Australian Clinical Practice Guideline: Effective mental health care in the perinatal period (Centre of Perinatal Excellence, 2023)

8. It is well established that gender bias in medicine is a barrier to women accessing effective healthcare. In 2023, the National Women's Health Advisory Council launched the End gender bias in Australia's healthcare system survey identifying that "women and girls face unique challenges in Australia's healthcare system, which can lead to poorer health results like delayed diagnosis and treatment, over prescribing and dismissal of pain." The #EndGenerBias Survey report was released in 2024 identifying "gender bias in health care had far-reaching impact on women's lives including feelings of abandonment, shame, blame and self-doubt; significant financial burden, lost education and career opportunities; and, delayed diagnosis and treatment led to disease progression, fewer treatment options and worse health outcomes[2]. Gender bias was experienced most in relation to sexual and reproductive health and chronic pain – a significant focus of this Inquiry.

9. The ANMF have long advocated for increased investment in women's health and maternity care. Better outcomes in women's health and wellbeing have benefits for workforce participation, individuals and their families, and for the broader community. According to the McKinsey Health Institute, investing in women's health could save up to US$1 trillion annually[3]. This inquiry is an opportunity to reflect on the learnings and recommendations from the extensive work undertaken to date and take meaningful action that changes the current narrative around women's health.

The Nursing and Midwifery Workforces

10. Nurses and midwives, who make up the majority of the health workforce, have the expertise to vastly improve access to women's health care across Australia. Nurse and midwife-led models of care have been shown to increase healthcare access, enhance health outcomes, and prevent and manage chronic disease.[4]

[2] Australian Government Department of Health and Aged care and National Women's Health Advisory Council. 2024. *#EndGenderBias Survey Summary Report.* Accessed 24 September 2026 at https://www.health.gov.au/resources/publications/endgenderbias-survey-results-summary-report?language=en

[3] Bijloo, I, de Smit N, Yarde, F, Hehenkamp, WJK, van Vilsteren, C, Khor, DZW et al. 2026. *Why investing in women's health is a societal imperative*, The Lancet, 407(10532): 926-929 doi: 10.1016/S0140-6736(26)00404-6.

[4] Beks, H., Clayden, S., Shee, W. et al. 2023. *Evaluated nurse-led models of care implemented in regional, rural, and remote Australia: A scoping review. Collegian*, 30 (6), 769–778.

11. The ANMF recommends upscaling nurse and midwife-led models of care to improve access to maternity care and women's health services, including pain services, for women, girls and gender diverse people. This is supported by the Victorian Inquiry into Women's Pain[5].

12. However, for nurse and midwife-led models of care to be effective in addressing women's health care needs, the needs of the nursing and midwifery workforce must be addressed.

13. Australia faces a shortfall of over 70,000 nurses by 2035.[6] Queensland Health has recently reported challenges in maintaining nursing and midwifery workforce in rural and regional areas, highlighting attraction and retention challenges and this is echoed across jurisdictions by ANMF members. Elliot el al., (2025) reported that the recruitment, retention and survivability of rural nurses and midwives are growing concerns in Australia. They further highlight that in Australia, nurses are considered the "backbone of rural healthcare" as they account for 68% of the workforce in remote and very remote locations, and rural midwives also play a crucial role in delivering comprehensive maternity care and supporting overall healthcare services in these communities.[7]

14. The Midwifery Futures Report highlighted significant workforce shortages across all workplace settings, especially in rural and remote settings, and inadequate numbers of students and new graduates. One in three midwives, including many not yet at retirement age, are considering leaving the profession impacted by the stress, distress and low job satisfaction of working in the Australian maternity care system.[8] ANMF midwifery members report the disconnect between midwifery scope of practice and underutilisation of midwifery skills and expertise contribute to intentions to leave the profession. Midwives want to provide the care they are

[5] Victorian Department of Health. 2025. *Bridging the Gender Pain Gap – The inquiry into Women's Pain Report 2025*. Accessed 28 September 2026 at https://www.health.vic.gov.au/sites/default/files/2025-11/bridging-the-gender-pain-gap-pain-inquiry-report.pdf

[6] Australian Nursing and Midwifery Journal. 2024. *Australia facing shortfall of over 70,000 nurses by 2035, report reveals*. Accessed 24 September 2026 at https://anmj.org.au/australia-facing-shortfall-of-over-70000-nurses-by-2035-report-reveals/

[7] Elliott, J., O'Malley, L., Walker, C., Erp, A. V., Martin, P., Chong, H. S., Sangelaji, B., & Fallon, T. 2025. *Retention patterns of the public sector nursing and midwifery workforce in regional and rural settings of southern Queensland, Australia: a 12-year retrospective analysis.* BMC nursing, 24(1), 722. https://doi.org/10.1186/s12912-025-03324-1

[8] Nursing and Midwifery Board of Australia. 2024. *Midwifery Futures: The Australian Midwifery Workforce Project.* Accessed 22 September 2026 at https://www.nursingmidwiferyboard.gov.au/News/Midwifery-Futures

skilled and educated to provide yet system design significantly hinders this ambition.

15. Attraction and retention of nurses and midwives must be a key priority for addressing women's health care inequities and improving access. The recommendations of the National Nursing Workforce Strategy, the Nurse Practitioner Workforce Plan, the Unleashing the Potential of our Health workforce (Scope of Practice) Review and the Midwifery Futures Report must be urgently acted upon. This includes, but is not limited to:

    - improving workplace culture
    - investing in nurse and midwife early career transitions and capabilities
    - minimum standards for safe workloads. Nurses and midwives must be enabled to dedicate the time to provide safe, quality care, holistic care and care coordination
    - creating pathways for nurses and midwives to advance practice and specialisation in women's health such as nurse practitioner roles, endorsed midwife roles, advanced practice midwife, and sexual and reproductive health care
    - policy to support nurse and midwife prescribing, authority for MBS-eligible referrals to practitioners in a multidisciplinary care team, and innovative models of care
    - funding reform such as block, rather than fee per service, funding.
    - expansion of regional and remote nursing and midwifery workforce incentives
    - building greater diversity into the nursing and midwifery workforces through programs and education re-design to support Aboriginal and Torres Strait Islander peoples, and culturally and linguistically diverse people to enter the professions
    - broader social system reform to provide housing, childcare, and other services in underserved communities to support health workforce growth.

Response to Terms of Reference

16. To avoid repetition, responses to the Inquiry's Terms of Reference (ToR) have been grouped into the following key themes:

- Women's pain
- Reproductive eave
- Rural and remote health care
- The maternity care continuum
- Postnatal Care
- Assisted Reproductive Technology

Theme 1: Women's Pain

17. This section pertains to ToR I, J and K.

18. Women, girls and gender diverse people assigned female at birth experience recurrent, severe, or long-lasting pain conditions across many aspects of their lives, including menstruation, endometriosis, Polyendocrine Metabolic Ovarian Syndrome, adenomyosis, pelvic pain, pregnancy-related pain, birth trauma, pelvic floor disorders, musculoskeletal conditions and autoimmune diseases. Many women seeking care for pain report not being listened to or taken seriously. Symptoms dismissed as stress, anxiety or a normal part of being female, leads to delayed diagnosis, fragmented care and poorer outcomes. Women's pain is undervalued and under-investigated and not afforded the same level of attention or clinical consideration as other health issues. Women from CALD communities are more likely to be labelled hysterical or have their pain minimised due to racial bias and racism in the healthcare system[9].

19. The cumulative impact can leave women feeling unheard, unsupported, and reluctant to seek further care, leading to poorer health outcomes and prolonged suffering.

20. This is compounded by the historical exclusion of women from medical research. This exclusion has created significant gaps in the evidence base that informs practice including how diseases present, progress and respond to treatment specifically in women, and medical conditions affecting the female reproductive system or predominantly women.

21. For example:

- Medical conditions affecting the population are more likely to be misdiagnosed in females as the diagnostic criteria have been based on a male experience of that condition. For example, women are less likely to receive treatment for heart attacks or angina in hospital, they are delayed in receiving lifesaving treatments, and have poorer outcomes related to heart pain compared to men as they don't present with the typical

[9] Victorian Department of Health. 2025. *Bridging the Gender Pain Gap – The inquiry into Women's Pain Report 2025*. Accessed 22 September 2026 at https://www.health.vic.gov.au/sites/default/files/2025-11/bridging-the-gender-pain-gap-pain-inquiry-report.pdf

diagnostic signs and symptoms that are based on male presentations.[10]

- Lipoedema is a profoundly gendered health issue, affecting almost exclusively women and an example of the impact of historical research bias resulting in health conditions predominantly affecting women receiving little research investment, policy attention, clinical recognition or health professional education. For decades, women with lipoedema have been misdiagnosed, dismissed or told their symptoms simply reflect obesity or lifestyle choices. This lack of recognition has contributed to inequitable access to diagnosis and treatment, with women often left to personally fund costly ongoing management, including compression garments, specialist therapies and, where required, surgical treatment.
- Lack of scientific evidence describing how medicines are metabolised by women and the effect of cyclical hormonal changes on absorption and effectiveness, where these aspects of pharmacokinetics and pharmacodynamics are a documented reason to exclude women from pharmacological research[11].

22. Access to effective pain management is further compounded by broad health care system deficits - long public waiting lists, workforce shortages, geographical barriers, fragmented care, funding inequalities, and the cost of specialists, physiotherapy, psychology and other allied health services. According to a 2024 survey of ANMF Vic branch members looking at the experience of women's pain, the wait time for The Women's Hospital, Melbourne, pelvic floor clinic was 2.5 years.

23. As has been highlighted in previous sections, in 2024, the Victorian Government launched a landmark Inquiry into Women's Pain[12]. More than 13,000 girls, women, gender diverse people, carers and health practitioners and professionals shared their experiences of pain and

[10] Heart Foundation. ND. *For professionals: Women and heart disease*. Accessed 10 September 2026 at https://www.heartfoundation.org.au/for-professionals/women-and-heart-disease-for-professionals
[11] Younes, S. 2024. *The relationship between gender and pharmacology,* Current Research in Pharmacology and Drug Discovery, Volume 7, 2024, 100192, ISSN 2590-2571, https://doi.org/10.1016/j.crphar.2024.100192.
[12] Victorian Department of Health. 2025. *Bridging the Gender Pain Gap – The inquiry into Women's Pain Report 2025*. Accessed 28 September 2026 at https://www.health.vic.gov.au/sites/default/files/2025-11/bridging-the-gender-pain-gap-pain-inquiry-report.pdf

interactions with the health system to address that pain. The Inquiry report identified a dismissive and disrespectful health care system driven by medical misogyny has and is contributing to poorer outcomes for women, girls, and gender diverse people. The Inquiry resulted in 27 recommendations targeting 7 key areas to inform improved models of care and service delivery for women's pain. These key learnings provide essential guidance for the current Women's Health Inquiry.

24. The ANMF contends that the findings and recommendations from this report must be considered by the Commonwealth and other jurisdictions as sufficient evidence to warrant and inform policy and reform beyond Victorian borders. Further inquiry and investigation only delays long overdue action and perpetuates the legacy of medical misogyny.

25. Furthermore, the ANMF recommends national adoption of the Victorian Women's Pain Standard Framework to ensure women, girls and gender diverse people are taken seriously and believed while talking about pain, respected as decision makers about their body, treatment and care, and given choices and practical support to manage their pain safely and effectively.

26. Improving care for women, girls and gender diverse people experiencing pain also requires:

- greater access to specific women's health care services, including nurse and midwife led specialist services, specialist GPs and allied health care,
- development of diagnostic criteria relating to pain presentations in women to support earlier diagnosis and management of women's pain,
- equality in out-of-pocket costs for women's health care comparative to other health care expenditure,
- greater awareness of gender bias in healthcare,
- improved clinician education
- investment in women's health research
- reframing societal normalisation of women's pain through community education

Endometriosis and pelvic pain – an example of women's pain management

27. Endometriosis continues to be under-recognised, contributing to significant delays in diagnosis, with many women waiting an average of between 6 and 8 years between the onset of symptoms and diagnosis. [13]

28. The ANMF welcomes increased funding within the 2026-27 Commonwealth Budget to expand access to Endometriosis and Pelvic Pain Clinics.[14] The initial network of clinics have provided care to over 10,000 women and girls and provided more than 28,000 services to those with endometriosis and persistent pelvic pain conditions.[15] However, this expansion is a starting point with only 2 clinics to serve regional, rural and remote communities.

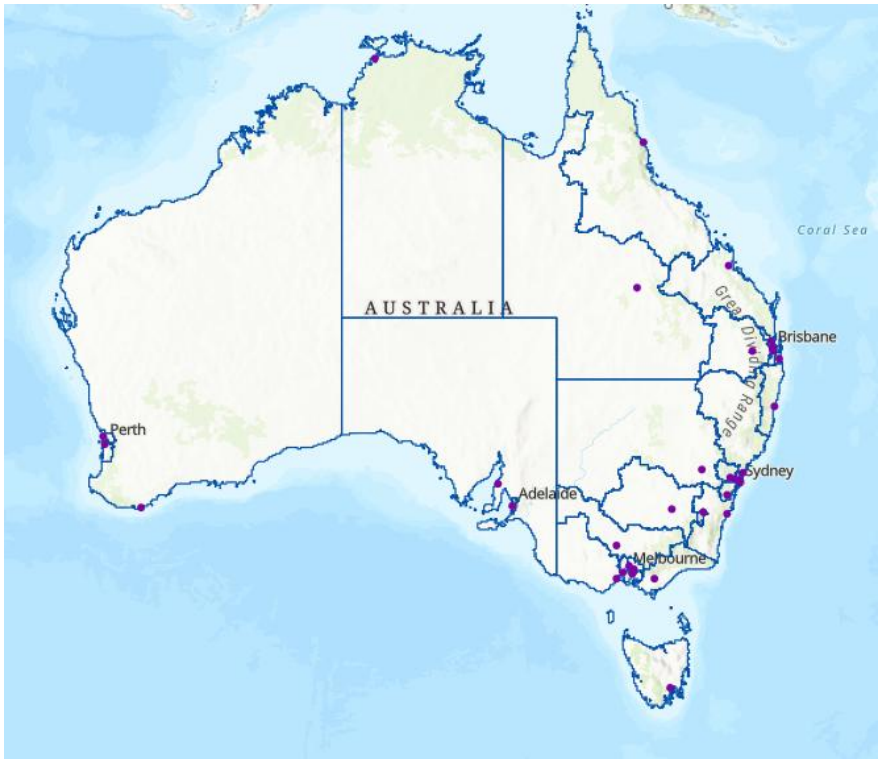


Figure 1 - Current endometriosis and pelvic pain clinics (retrieved from Australian Government)[16]

[13] Australian Government (AIHW). 2025.. *Endometriosis – What is endometriosis?* Accessed 22 September 2026 at https://www.aihw.gov.au/reports/chronic-disease/endometriosis/contents/what-is-endometriosis

[14] Australian Government. 2026. *New national tool to improved endometriosis care*. Accessed 22 September 2026 at https://ministers.pmc.gov.au/white/new-national-tool-improve-endometriosis-care

[15] Australia Government. 2026. *New Endometriosis and Pelvic Pain Clinic for Western Queensland Women*. Accessed 22 September 2026 at https://www.health.gov.au/ministers/the-hon-rebecca-white-mp/media/new-endometriosis-and-pelvic-pain-clinic-for-western-queensland-women?language=en

[16] Australian Government (Department of Health, Disability and Ageing). 2026. *Endometriosis and pelvic pain*. Accessed 22 September 2026 at https://www.health.gov.au/our-work/endometriosis-and-pelvic-pain-clinics

29. The ANMF suggests that further women's health and pain services are urgently required to meet demand, with a particular focus on communities that experience poor health care access (such as rural and regional communities, Aboriginal and Torres Strait Islander peoples and women from CALD communities). Policy and reform must look beyond traditional models of care that involve an over reliance on medical practitioners, to enable access to timely and cost-effective health care.

30. As previously noted, nurse and midwife-led models of care have been shown to increase healthcare access, enhance health outcomes, and prevent and manage chronic disease.[17] The ANMF recommends upscaling nurse and midwife-led models of care to improve access to pain services for women, girls and gender diverse people. This is supported by the Victorian Inquiry into Women's Pain.

31. Examples include:

- The Julia Argyrou Endometriosis Centre at Epworth Health Care launched in November 2021, providing patient-centred care for those experiencing endometriosis. Over the first 12 months of service delivery, most nurse consultations occurred virtually by video telehealth, enabling patients to receive timely and accessible care, particularly for those in regional or rural areas. The centre's vision is to reduce the personal and societal impact of endometriosis, by prevention, early diagnosis and patient centred holistic treatment. They strongly believe that a nurse-led multidisciplinary clinic is a feasible and effective clinical model for endometriosis care.[18]
- the Bendigo Community Health Service Endometriosis and Pelvic Pain Clinic opened in 2024. Bringing together nurses, GPs, physiotherapies and psychology support, the service aims to provide holistic, evidence-based treatment while helping patients better understand their condition and actively participate in decisions about their care. Over

[17] Beks, H., Clayden, S., Shee, W. et al. 2023. *Evaluated nurse-led models of care implemented in regional, rural, and remote Australia: A scoping review*. *Collegian*, 30 (6), 769–778

[18] Tyson, K., et al. 2024. *The endometriosis nurse coordinator – A new paradigm for endometriosis multidisciplinary care: a commentary, Journal of Endometriosis and Uterine Disorders*, 8, 100086.

520 people have accessed the clinic since it opened, receiving holistic, wrap around care, that begins with a comprehensive consultation with a nurse.[19]

32. Nurse-led community-based models of care exist in Queensland and the A.C.T. These walk-in clinics provide vital healthcare services, that are accessible, affordable, and divert non-emergent health care away from busy emergency departments.[20] Whilst these models can experience significant wait times and require additional resourcing, they offer a scalable model to meet the need for comprehensive women's pain services.

33. As previously noted, for nurse and midwife-led models of care to be effective in meeting women's health needs the nursing and midwifery workforces must be supported and enabled to practice to their full scope of practice. This includes, but is not limited to:

- investing in nurse and midwife early career transitions and capabilities
- minimum standards for safe workloads. Nurses and midwives must be enabled to dedicate the time to provide safe, quality care, holistic care and care coordination
- creating pathways for nurses and midwives to advance practice and specialisation in women's health such as nurse practitioner roles, endorsed midwife roles, advanced practice midwife, and sexual and reproductive health care
- policy to support nurse and midwife prescribing, authority for MBS-eligible referrals to practitioners in a multidisciplinary care team, and innovative models of care
- improving workplace culture
- funding reform such as block, rather than fee per service, funding.
- expansion of regional and remote nursing and midwifery workforce incentives
- building greater diversity into the nursing and midwifery workforces through programs and education re-design to support Aboriginal and Torres Strait Islander peoples, and

[19] Fedele, R. 2026. *A nurse's role in endometriosis and pelvic pain care*. Australian Nursing and Midwifery Journal, Accessed 12 October 2026 at https://anmj.org.au/a-nurses-role-in-endometriosis-and-pelvic-pain-care/
[20] Queensland Government. (2026, August). *Nurse-led walk-in clinics.* Accessed 22 September 2026 at https://www.qld.gov.au/health/services/community-health/nurse-led-walk-in-clinics

culturally and linguistically diverse people to enter the professions

- broader social system reform to provide housing, childcare, and other services in underserved communities to support health workforce growth.

Theme 2: Reproductive Leave

34. Reproductive leave relates to ToR A, C, I, J, K, L, and M.

35. The ANMF recognises that the issues that are supported by reproductive leave are experienced by women and men, however for the purposes of this submission, the focus will remain on women's health issues.

36. Reproductive leave supports women's health and workforce participation. Women experience sex-specific health issues throughout their lives that can require time away from work. Currently, many rely on personal or carer's leave to manage these needs and social stigma towards women's health issues has perpetuated gender inequalities. For example, women and their families experiencing early pregnancy loss have historically been encouraged to dismiss grief. Time away from work for early pregnancy loss has long been managed by women, fathers and non-birthing parents within standard personal leave allowances designed for other purposes. A Commonwealth funded project, Miscarriage Matters,[21] aims to raise awareness of the impact of miscarriage, recognising and validating the physical and psychological health impacts of pregnancy loss. Formal bereavement leave would further validate the health impacts of early pregnancy loss, and support physical recovery and mental health. Additionally, research has shown that women are retiring seven years before men on average and twelve years before their desired age of retirement due to inadequate workplace support to address the symptoms of perimenopause and menopause.[22]

[21] Australian Government, Department of Health, Disability and Ageing. 2025. *Miscarriage Matters.* Accessed 26 September 2026 at https://www.health.gov.au/miscarriage-matters?language=en

[22] Australian Council of Trade Unions. 2024. *Women pushed out of work early due to 'taboo' menopause issues [Internet]*. Melbourne: ACTU; 2024 Jul 30.

37. Dedicated reproductive leave recognises these health realities and reduces pressure on existing leave entitlements which in turn, supports women to remain engaged in the workforce. [3]

38. Other health issues affecting women that would benefit from reproductive leave include menstruation, pregnancy, contraception, and chronic conditions such as polyendocrine metabolic ovarian syndrome (PMOS) and endometriosis as well as fertility and hormone therapy.

39. The ANMF urges the government to include 10 days of reproductive leave in the National Employment Standards (NES), which exists for some workers in union-negotiated collective agreements [23]. However, if introduced under the NES, would allow all workers to obtain 10 days reproductive leave regardless of whether or not they are employed under a collective bargaining agreement.

Theme 3: Rural and Remote Health Care

40. Acknowledging and addressing the challenges of women's health care in rural and remote communities pertains to ToR A, B, C, D, D, F, G, H, I, J, K, L, and M.

41. The challenges of health care access in rural and remote areas of Australia are well documented. As of 30 June 2023, 27% of Australians lived outside of major cities, yet the both the health workforce and health infrastructure is heavily concentrated in metropolitan areas, leaving many rural and remote communities with chronic shortages of primary health care practitioners such as nurses, midwives and medical practitioners, compounded by little to no local access to multidisciplinary and specialist care [24].

42. These access gaps translate to measurably worse health outcomes with people living in rural and remote areas experiencing higher rates of chronic disease, injury and preventable hospitalisations, along with lower life expectancy compared to those in major cities, with the

[23] Australian Council of Trade Unions (ACTU). 2026. *Unions push for new universal right to 10 days paid reproductive leave. Australian Council of Trade Unions*, 6 March 2026.
[24] Australian Institute of Health and Welfare. 2025. *Rural and remote health.* Accessed 24 September 2026 at https://www.aihw.gov.au/reports/rural-and-remote-health

disparity most pronounced for Aboriginal and Torres Strait Islander people, who make up a larger proportion of the remote population and face compounding social and economic disadvantage[25].

43. The Victorian Inquiry into Women's Pain found that women living in regional and rural areas, Aboriginal and Torres Strait Islander women, LGBTIQA+ communities and women with disabilities face greater challenges in accessing and navigating healthcare, often travelling long distances or experiencing systemic discrimination. [26]

44. The 2nd Edition National Consensus Framework for Rural Maternity Services [27] details key elements for safe, high quality, respectful care, that whilst provided within a maternity context, align in principle with those identified in the Victorian Inquiry into Women's Pain, and the Victorian Women's Pain Standard Framework.[28] The ANMF recommends that the strategies identified in the 2nd Edition National Consensus Framework for Rural Maternity Services be applied to address women's health care more broadly within rural and remote communities.

[25] ibid
[26] Victorian Department of Health. 2026. *Inquiry into Women's Pain*. Accessed 22 September 2026 at https://www.health.vic.gov.au/womens-health-and-wellbeing-program/inquiry-into-womens-pain
[27] Australian Government, Department of Health, Disability and Ageing, 2025. *2nd Edition National Consensus Framework for Rural Maternity Services.* Accessed 24 September at https://www.health.gov.au/news/release-of-the-2nd-edition-national-consensus-framework-for-rural-maternity-services?language=en
[28] Victorian Department of Health. 2026. *Women's Pain Standard Framework.* Accessed 24 September 2026 at https://www.health.vic.gov.au/womens-health-and-wellbeing-program/victorian-pain-standard

Theme 4: The Maternity Care Continuum

45. The next section will provide a response to the pregnancy and postpartum ToR C, E and F.

46. Pregnancy (antenatal), birth (intrapartum) and postnatal (postpartum) care do not exist in isolation.

47. Greater investment is needed in continuity of maternity care models, particularly midwifery continuity of care models. These models not only support improved maternity and neonatal birth outcomes but also physical wellbeing, mental health and wellbeing, infant feeding, parenting confidence, family adjustment and early identification of emerging concerns. Midwife-led models of care result in more positive experiences for women during pregnancy, labour, and postpartum. Women are also less likely to experience a caesarean section or instrumental birth with forceps or a ventouse. For these models cost savings are reported across the full continuum of the perinatal period.[29]

48. A best-practice maternity care model would prioritise continuity of relationship with a known midwife and integrated referral pathways from the first trimester of pregnancy through to extended postnatal support that reflects the reality that many women and birthing people's physical and psychological needs continue well beyond the early postpartum period. Particular consideration must be given to strengthening continuity models for population groups that experience health care inequity including but not limited to Aboriginal and Torres Strait Islander peoples, people living in regional and rural communities, culturally and linguistically diverse populations, and communities experiencing health workforce shortages and diminishing service access.

49. Whilst midwifery led continuity of care models such as midwifery group practice (MGP) and maternity antenatal postnatal service (MAPS) are recognised as beneficial for women and babies, midwives working in these models identify the challenges of work-life balance. As

[29] Sandall, J., Fernandez Turienzo, C., Devane, D., Soltani, H., Gillespie, P., Gates, S. et al. 2024. *Midwife continuity of care models versus other models of care for childbearing women. The Cochrane Database Syst*. Rev. 2024 Apr: 2024(4). Doi: 10.1002/14651858.CD004667.pub6

previously noted, the midwifery workforce is in crisis. The interaction between care model design, workforce conditions and organisational context continues to present significant challenges to implementation and expansion of continuity of care models. Examining these elements also creates opportunity for innovations. For example, services could consider how local policy can be used to create continuity across all models of care, rather than confining continuity to designated continuity of care models. This could include adopting key features of continuity care models such as longer appointment times, on call support, and more comprehensive postnatal care beyond hospital discharge.

50. Greater access to part time and flexible working arrangements can support midwives to participate and remain engaged in the workforce around their caring and other responsibilities, while maintaining continuity for women and birthing people. Investing in midwifery leadership, management support, administrative support, infrastructure, workforce backfill, organisational understanding of continuity of care models and appropriate remuneration will support innovation and development of care models that meet the needs of women and birthing people whilst creating satisfying and attractive roles for midwives. These elements are particularly important in regional, rural and remote settings where there may be greater need for flexible and adaptable model design to attract and retain midwives.

51. To support continuity of care across private and public health services, midwives need to be enabled to practice to their full scope of practice across all contexts. Current jurisdictional inconsistencies affecting midwives across public and private settings, including privately practising midwives (PPMs) admitting rights, access to Medicare Benefits Scheme (MBS) items for homebirth care, and utilisation of the endorsement for scheduled medicines for midwives, create barriers to timely care and continuity of care.

Maternity care for Aboriginal and Torres Strait Islander peoples

52. Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Health Medical Services (AHMSs) play a critical role in delivering culturally safe, holistic and community-led maternity care. These services are well placed to provide continuity of care throughout the

antenatal and postpartum periods, incorporating not only clinical care but also social, emotional, culturally sensitive care and family support. By delivering care within a culturally safe environment and through trusted relationships, ACCHSs and AHMSs can improve engagement with maternity services, strengthen health outcomes and support women and families to access care that is responsive to their individual and community needs.

53. Examples of these include:

- the Baggarrook Yurrongi Model which has supported more than 1000 Aboriginal Torres Strait Islander women and their families through three Victorian metropolitan health services. Research has shown women receiving care through this model were more likely to have a healthy birth, with few babies born preterm, at low birthweight or requiring admission to a neonatal intensive care unit.[30]
- the Dhelkuk Dangatuk Baring or "Healthy New Journe" program about to be launched by Bendigo Health, Victoria, based on the Baggarrook Yurrongi Model, and co-designed with the Bendigo & District Aboriginal Co-operative, Mallee District Aboriginal Services, Victorian Aboriginal Community Controlled Health Organisation and Njernda Aboriginal Corporation.
- Waminda South Coast Women's Health and Welfare Aboriginal Corporation in New South Wales. This program provides culturally safe, holistic, wrap-around care that integrates clinical excellence with cultural, spiritual and family support, ensuring women can access safe and respectful care throughout pregnancy, birth and early childhood. A key strength of the model is Waminda's Minga Gudjaga Midwifery Practice, which delivers continuity of care by allocating each woman a primary midwife from early pregnancy through to six weeks after birth. Waminda's achievements have gained national recognition as an innovative and effective model of Aboriginal-led healthcare. For rural, regional and remote communities, where women often face long travel distances, limited maternity services and fragmented care, the Waminda model provides

[30] La Trobe University. 2026. *First Nations maternity model expands to Bendigo.* Accessed 12 October 2026 at https://www.latrobe.edu.au/news/articles/2026/release/first-nations-maternity-model-expands-to-bendigo

a practical blueprint for replication.

54. Expanding access to antenatal and postpartum services especially in rural and remote areas through AHMSs can help address barriers experienced by Aboriginal and Torres Strait Islander women, including transport, service accessibility, cultural safety and trust in the health system. Community-controlled models of care are also well positioned to provide wrap-around support and facilitate connections to other health, social and community services, supporting improved outcomes for women, babies and families.

55. Not unlike MGP models, midwives working within Aboriginal and Torres Strait Islander maternity services often carry a significant cultural load and manage high caseloads to ensure Aboriginal and Torres Strait Islander women are able to access culturally safe and appropriate care if they choose. This additional responsibility, combined with existing workforce pressures, can impact the sustainability of these models and highlights the need for greater workforce investment and support to ensure all women can access culturally safe continuity of care.

Erosion of midwifery care and best practice approaches

56. Many publicly funded maternity services do not provide care for women and pregnant people until 15 – 20 weeks gestation, despite recommendations for antenatal care to commence before 10 weeks. Women and gender diverse people experiencing complications of early pregnancy or poor mental health often report struggling with poorly coordinated care and lack of support in the first and second trimester of pregnancy. For example, despite significant short- and long-term health impacts,[31] hyperemesis gravidarum (severe, persistent nausea and vomiting during pregnancy) is often dismissed as a woman not coping with a common pregnancy symptom (mild nausea and vomiting of pregnancy). This demonstrates that existing systems are insufficient to adequately support health and wellbeing, often resulting in recurrent presentations to emergency departments. Access to midwifery care from the first trimester must be incorporated into future care models to improve physical and mental health

[31] Maslin, K. & Dean, C. 2021. *Nutritional consequences and management of hyperemesis gravidarum: a narrative review. Nutrition Research Reviews,* 35(2): 308-318. DOI https://doi.org/10.1017/S0954422421000305 Accessed 10 September 2026 at https://www.cambridge.org/core/journals/nutrition-research-reviews/article/nutritional-consequences-and-management-of-hyperemesis-gravidarum-a-narrative-review/23F4AB3DCAEA146CFFFB346D3BC0B652

outcomes.

57. There is also poor investment in the time required to provide antenatal care. Midwifery members employed in antenatal clinics often report short, rushed appointment times with minimal opportunity to practice to their full scope and provide comprehensive midwifery care. Together with the increasing number of screening, assessment and documentation requirements introduced into routine maternity care over recent years, this has led to increasing workload pressures.

58. The COVID-19 pandemic further exacerbated this issue, with many antenatal education programs and classes suspended due to service delivery constraints. In many areas, these programs have not been fully re-instated, leaving women with fewer opportunities to receive education and reducing dedicated time for midwives to provide health promotion and education.

59. Over the past 15 years there has also been a trend towards shorter postnatal admissions to discharge with 51.2% of discharges occurring by day 2 in 2023 compared to 36.3% in 2010. Women or birthing people who experience, what has been considered a normal birth, are often discharged within 6-24 hours. Despite shorter admission duration, postnatal care in the home including domiciliary midwifery care services has not been adapted to accommodate the reduced contact. Thus, early hospital discharge in the postpartum period has resulted in the erosion of postnatal care, and the value of midwifery care to women, people giving birth, newborns and their families has been lost. Admission to postnatal wards are generally reserved for acute maternal or neonatal presentations that require medical intervention. This will be discussed in further detail below in the response to best practice postnatal care.

60. The NSW birth Trauma Inquiry highlighted the critical importance of antenatal and postnatal education. The inquiry found that inadequate preparation for pregnancy, labour, birth and the postpartum period was a contributing factor to some women's experiences of birth trauma and subsequently recommended several improvements to antenatal and breastfeeding education.

61. The foundation of midwifery practice is to work in partnership with women and people from pre-conception care, through pregnancy, birth and the postnatal period. Midwifery practice provides support, care and advice to promote health and wellbeing, and timely access to medical care or other appropriate interventions where required.[32] Midwives need workloads that support the provision of comprehensive, holistic care that they are educated and skilled to deliver to ultimately support women and gender diverse people across the maternity continuum.

62. An unintended consequence of the all-encompassing definition of a PPM as articulated by the Nursing and Midwifery Board of Australia (NMBA) and lack of professional indemnity insurance (PII) products for non-endorsed PPMs, is the emergence of a market for unregulated health workers (however titled) offering antenatal education, postnatal care and support, breastfeeding support and newborn services (such as parental support). As there are no defined standards of care, clinical governance arrangements or quality assurance for unregulated health workers, this may expose women and gender diverse peoples requiring maternity care services to preventable and unnecessary risk that is not in their best interest. Whilst in the past year, PII products for non-endorsed midwives have become available, these products are not universally available and there remains a gap in the market for access to private midwifery care where public services are not meeting the needs of all women and gender diverse people.

Pain management in maternity care

63. The Victorian Inquiry into Women's Pain detailed that women and gender diverse people receiving maternity care are expected to manage pain across the continuum of pregnancy and are not afforded appropriate pain management.

[32] International Confederation of Midwives. 2024. *International Definition and Scope of practice of the Midwife.* Accessed 22 September 2026 at https://internationalmidwives.org/resources/international-definition-of-the-midwife/

64. For example, women who:

- have had an episiotomy/perineal tear, or caesarean section are afforded less pain relief, expected to care for their newborn with minimal assistance, with little recuperation and recovery time all while caring for a family. Women are expected to tolerate pain to balance the risks to the infant, such as being cared for by a sedated caregiver or receiving small amounts of opioids through breastmilk, rather than addressing the compounding issues.
- experience symphysis pubis dysfunction during pregnancy are often left with little alternative but to access personal leave or enter parental leave earlier than they have planned. Resulting in ongoing financial impacts associated with a reduced income, extensive impacts on their personal lives and ability to socialise, with ongoing physical and socioeconomic impacts associated with the isolation experienced as a consequence of their pain and healthcare needs.

65. We must reexamine this paradigm in which society views pain in pregnancy and following birth as inevitable and normal, and simultaneously expects women to care for others, whilst women are not provided with the supports they need to recover and care for themselves. This must include research into pain medication use in pregnant and breastfeeding women and investing in new therapies specifically to meet this need, shifting the narrative from "bouncing back" after pregnancy and birth to acknowledging the impact this has on physical and emotional wellbeing. Social structures to support pregnancy and the postnatal period must be strengthened including through enhanced leave entitlements for both parents.

Mental health care in maternity care

66. According to the AIHW mental health conditions are the leading cause of disease burden in Australian women of child-bearing age (15-44 years), with the perinatal period considered to be a time of increased risk[33]. Poor perinatal mental health can have significant impacts on

[33] Australian Institute of Health and Welfare. 2024. *Perinatal mental health screening in Australia.* Accessed 24 September 2025 at https://www.aihw.gov.au/reports/mothers-babies/perinatal-mental-health-screening-australia/contents/what-is-perinatal-mental-health

women, and has been associated with adverse obstetric and pregnancy outcomes, with attributable long-term impacts on the baby. The accessibility of mental health services is essential.

67. Mental health care plans, provide a maximum of 10 visits to eligible individuals with a psychologist supported by the MBS. This does not adequately support the mental health impacts of pre-conception, pregnancy, birth and the transition to parenting. Both parents must be eligible for additional mental health support beyond the current 10 MBS funded visits.

68. The Inquiry must also consider investing in innovative perinatal mental health support programs. Rural and remote communities have poorer mental health outcomes compared to those in major cities, and they are inherently disadvantaged for health care access. There is an urgent need for a specialised, resourced and sustainable mental health nursing workforce. Mental health nurses are a critical part of the current mental health workforce but overlooked in the context of perinatal mental health. To improve access to perinatal mental health care, governments and health services should utilise the mental health nurses, who are the largest clinical occupational group dedicated to mental health, and one of the most geographically dispersed professions.[34]

Sexual and reproductive health care

69. Effective reproductive health education and contraceptive counselling should form part of routine antenatal and postpartum care and be tailored to individual needs and future reproductive intentions.

70. Workforce pressures, generic multidisciplinary models of care, and short appointments and/or lengths of stay can limit opportunities for meaningful discussions about contraception, birth spacing, recovery, sexual health and future pregnancy planning. Strengthening continuity of care models and improving staffing levels would support more comprehensive and ongoing education throughout the perinatal period.

[34] Productivity Commission. 2020. *Mental Health Inquiry Report*. Retrieved from https://www.pc.gov.au/inquiries-and-research/mental-health/report/

71. The comprehensive skills of nurses and midwives are often overlooked in generic multidisciplinary models of care (e.g. in mental health). Utilising nursing and midwifery skills across all contexts of practice to engage in meaningful discussions regarding sexual and reproductive health is an opportunity to engage with women from menarche to menopause rather than restrict sexual and reproductive health care to birthing women and people. Expanding and appropriately funding nurse and midwife-led models of sexual and reproductive health care including extended scope models for endorsed midwives, advanced midwifery care and nurse practitioners, would improve continuity of care, increase access to contraception and reproductive health services, and provide women with timely support from trusted clinicians.

Family Centred Care

72. Whilst this is in an inquiry into women's health, it must be acknowledged that the health and wellbeing of supports surrounding women and birthing parents affects their health. Partners and support persons may also experience significant mental health challenges with the transition to parenting, particularly following traumatic births, neonatal illness, stillbirth or infant loss. Additionally, pregnancy is a time when violence towards women is known to increase[35]. Thus, best-practice pregnancy and postnatal care should incorporate family-centred approaches that recognise and support the wellbeing of mothers, birthing parents, fathers, non-birthing partners and other significant care givers. This includes, but is not limited to, the inclusion of fathers/partners and non-birthing parents in screening and support pathways throughout pregnancy and the postnatal period, education programs preparing for the birth and parenting, health promotion education and inclusive practitioner practices.

[35] Centre of Perinatal Excellence. ND. *Abuse or family violence in pregnancy*. Accessed 24 September 2026 at https://www.cope.org.au/pregnancy/looking-after-yourself-in-pregnancy/abuse-violence-and-past-trauma/abuse-or-family-violence-in-pregnancy

Research, education and training for health care professionals working in maternal care

73. The maternity workforce crisis impacts midwifery education. Student midwives are experiencing reduced access to mentorship and fewer opportunities to develop clinical skills required to complete their studies. Nurses undertaking postgraduate study to become midwives are often used to meet workforce shortages and fill roster gaps. This can limit opportunities for supported clinical learning, leaving some graduates less confident and experienced across key areas of midwifery practice. The lack of support is contributing to increasing numbers of students withdrawing from midwifery programs (resulting in fewer graduates entering the workforce), burnout upon entering the profession or entering the profession feeling underprepared.

74. A difficult transition into the profession contributes to the attrition seen among early career midwives. A workforce survey conducted by the New South Wales Nursing and Midwifery Association in 2025 identified a 10% reduction in respondents with 5 to 9 years' experience compared with those in the 0 to 4 years' experience category, highlighting the ongoing challenges in retaining midwives beyond their first years of practice.

75. Access to continuing professional development and education in rural and remote areas present additional challenges due to the geographic spread of services and workforce constraints. In many districts, clinical midwifery educators are required to support multiple facilities across large distances, with reduced opportunities for regular face-to-face education. Travel requirements, limited backfill arrangements and workforce shortages can also make it difficult for midwives to access professional development and mandatory training, further contributing to workforce pressures.

76. These challenges are often amplified for Aboriginal and Torres Strait Islander midwives and students, particularly where education is not delivered in a culturally safe and responsive manner.

77. The ANMF recommends:

- funded supernumerary transition positions for registered undergraduate students of midwifery (however titled) to support the transition from student to registered practitioner and consolidate workforce confidence and capability.

- protected time available for midwives to attend education. Due to clinical staffing shortfalls, study days are frequently cancelled, and midwives are often redeployed from training activities.

- Strengthening recruitment, retention and progression pathways for Aboriginal and Torres Strait Islander peoples through investment in Indigenous-led curriculum design and teaching, culturally safe learning environments, and support structures that enable students to remain connected to family, community and culture throughout their education and training.

- Examination of the impact arbitrary qualification to practice course requirements have on learning outcomes, competence to practice and transition to registered practitioner.

Theme 5: Postnatal Care

78. The following section addresses ToR A, B, D, G and H.

Best practice postpartum care

79. Nationally, there are many existing services that provide postpartum healthcare, including the delivery of physical and mental health support and services for mothers and their partners, including for those who have experienced infant loss.

80. However, whilst these services exist, the capacity to achieve best practice approaches to postpartum health care are significantly limited by resourcing, with dwindling service allocation, high workloads and long wait lists impeding timely identification of need, early intervention and high-quality care that meets the needs of women, people giving birth, newborns and their families. Reduced opportunity for consultation and review by health

practitioners further delays identification, intervention and management of complications. This is compounded by fragmented service delivery, poor care coordination, normalisation of postnatal recovery with or without complications and an ever-diminishing value placed on the contribution of midwifery to primary health care.

81. Research demonstrates women are unsatisfied with postnatal care and consistently report this is the poorest aspect of their maternity care.[36][37] Postnatal care is increasingly focused on meeting clinical medical discharge criteria rather than undertaking a holistic assessment of physical recovery, mental health, social circumstances, infant feeding needs, parenting confidence and available support networks.

82. Challenges also exist within the broader service system. Access to specialist physical and mental health services frequently relies on eligibility criteria, service boundaries and time-limited programs. Women who do not meet referral thresholds, exceed service cut-offs, or are unable to continue privately funded care due to out-of-pocket costs, can find themselves without adequate ongoing support during a period when physical recovery, mental health concerns, infant feeding challenges or grief may still be significant.

83. These experiences can be particularly difficult for women living in regional, rural and peri-urban communities where access to specialist services is limited and travel requirements can increase both financial and emotional burdens.

84. Women recovering from complex births, perineal trauma, caesarean sections, pregnancy complications or significant mental health challenges may require support well beyond the traditional postnatal period. Failure to address these ongoing needs can have lasting impacts on physical health, emotional wellbeing, attachment and bonding, workforce participation and

[36] Schmied, V., Myors, K., Burns, E., Curry, J., Pangas, J., & Dahlen, H. G. 2024. A *mixed methods study of the postnatal care journey from birth to discharge in a maternity service in New South Wales, Australia*. *BMC Health Services Research*, *24*(1), 1530. Accessed 24 September at https://doi.org/10.1186/s12913-024-11995-w

[37] Zadoroznyj, M., Brodribb, W. E., Young, K., Kruske, S., & Miller, Y. D. 2015. *"I really needed help": What mothers say about their post-birth care in Queensland, Australia. Women and Birth*, *28*(3), 246–251. Accessed 24 September 2026 at https://doi.org/10.1016/j.wombi.2015.03.001

family life.

85. As identified in the response to Theme 4: The Maternity Care Continuum, over the past 15 years there has been a trend towards shorter postnatal admissions to discharge. Yet despite the shorter admission duration, postnatal care in the home or domiciliary midwifery care has not changed. Thus, early hospital discharge in the postpartum period has resulted in the erosion of postnatal care, and the value of midwifery care to women, people giving birth, newborns and their families has been lost, with longer admissions to postnatal wards reserved for acute maternal or neonatal presentations requiring medical intervention.

86. Whilst midwives are competent and skilled to provide maternity care where medical complexities are present, the foundation of midwifery practice is to work in partnership with women and people from pre-conception care, through pregnancy, birth and the postnatal period to provide support, care and advice to promote health and wellbeing, and timely access to medical care or other appropriate interventions where required[38] . In the postpartum period, alongside commonly acknowledged clinical tasks such as physical health assessment and monitoring, midwives are educated and competent to provide holistic care that includes, but is not limited to:

- health counselling and education to support a transition to parenthood, and prevent and/or understand risks and warning signs of complications for the woman, birthing parent, newborn and other caregivers;
- assisting parents to understand and provide newborn care that promotes optimal short- and long-term outcomes including hygiene, infant behaviour, infant feeding including breastfeeding support, and responsive parenting and developing secure attachment; and,
- supporting, assessing and monitoring the emotional and mental health of the woman, or birthing parent and other caregivers, including fathers.

[38] International Confederation of Midwives. 2024. *International Definition and Scope of practice of the Midwife.* Accessed 22 September 2026 at https://internationalmidwives.org/resources/international-definition-of-the-midwife/

87. A consequence of under-resourcing postpartum care is the under-utilised expertise of midwives, poor job satisfaction, gaps in health service delivery, poor satisfaction in postnatal care and suboptimal short- and long- term health outcomes for women and babies[39].

88. This is also amid Australia's midwifery workforce 'crisis'. One in three midwives, including many not yet at retirement age, are considering leaving the profession impacted by the stress, distress and low job satisfaction of working in the Australian maternity care system.[40] ANMF midwifery members report the disconnect between midwifery scope of practice and under-utilisation of midwifery skills and expertise contribute to intentions to leave the profession. Midwives want to provide the care they are skilled and educated to provide, yet system design significantly hinders this ambition.

89. The ANMF strongly recommends that national postnatal service standards be developed that detail minimum resourcing and service requirements to deliver comprehensive postnatal care to all women, people giving birth, newborns and their families both within health services and in the community.

90. National postnatal service standards must re-instate midwifery care in the postnatal period as a universal primary health care intervention. This standard must detail the resourcing required for midwives to be enabled to practice to their full scope of practice including recognition of the time to provide comprehensive, inclusive care, timely referrals, care coordination and health education that meets the needs of women, gender diverse people, newborns and their families, including fathers and non-birthing parents. This translates to national mandated midwife ratios in maternity health services and an upscaling of postnatal care in the home/domiciliary programs that recognises the midwifery care needs of all women and gender diverse people giving birth. Moving from hospital to home must be viewed as a transition in care location not a discharge from the service. The duration and number of home

[39] Schmied, V., Myors, K., Burns, E., Curry, J., Pangas, J. & Dahlen, H. 2024. *A mixed methods study of the postnatal care journey from birth to discharge in a maternity service in New South Wales, Australia.* Accessed 22 September 2026 at https://link.springer.com/article/10.1186/s12913-024-11995-w

[40] Nursing and Midwifery Board of Australia. 2024. *Midwifery Futures: The Australian Midwifery Workforce Project.* Accessed 22 September 2026 at https://www.nursingmidwiferyboard.gov.au/News/Midwifery-Futures

visits must be increased to replace the care previously provided within a hospital admission before early discharge practices were introduced.

91. These guidelines must also detail:

- multidisciplinary access to support timely referral and follow up including, but not limited to specialist lactation services, psychology/psychiatry, and physiotherapy that extends beyond a cursory postnatal eligibility criteria (often as little as two weeks following the birth).
- Specific resourcing for women and families who experience pregnancy and infant loss (detailed below).
- A requirement for Aboriginal and Torres Strait Islander women to have access to culturally safe, continuity-based maternity and postpartum services that are designed and delivered in partnership with Aboriginal communities and Aboriginal health organisations.
- A requirement for women from CALD backgrounds to have access to postnatal care that aligns with their beliefs and practices.
- Strengthened and streamlined referral pathways across GP, obstetric, midwifery, maternal and child family health nursing, physiotherapy and mental health services.
- Chronic disease management beyond 6 weeks. For example, gestational diabetes and pre-eclampsia are both associated with long term health risks. Structured long term follow up, not one-off checks, needs to be embedded into standard postnatal care and not reliant on self-referral.

Perinatal Loss

92. The National Stillbirth Action Plan[41] and Care Around Stillbirth and Neonatal Death: Clinical Practice Guideline[42] highlight the importance of care continuity and communication between health providers, inclusive and culturally sensitive care, private physical spaces for bereaved parents, and parental leave reform.

93. The abovementioned guidelines also recommend a national education program for the maternity workforce and for health services to ensure people who care for bereaved families receive support to counterbalance the psychological impact that may lead to burnout and skilled-workforce attrition.

94. The following comment by a Victorian midwife in private practise supporting families navigating perinatal loss highlights the importance of actioning the recommendations of the National Stillbirth Action Plan and extending these actions to early pregnancy loss.

> *"Women experiencing pregnancy loss often move between multiple services and repeatedly have to explain their story. There is often no single clinician coordinating their care from diagnosis through to recovery. These gaps exist regardless of the gestation they experienced loss, and bereaved families deserve maternity care rather than to be treated as though they are simply patients experiencing a medical event."*

95. It is essential that perinatal loss care is accessible to all women to support long-term physical and mental health.

96. Many women report additional trauma is experienced when care is provided in generalist settings (noisy emergency departments) or alongside families with newborns. Inappropriate settings result in substantial psychological impact for these women and their families. Private spaces and appropriate care must be provided for families experiencing pregnancy loss. The

[41] Australian Government, Department of Health. 2020. *National Stillbirth Action and Implementation Plan.* Accessed 22 September 2026 at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan?language=en

[42] The Centre of Research Excellence in Stillbirth and Perinatal Society of Australia and New Zealand. 2024. *Care around Stillbirth and Neonatal Death: Clinical Practice Guideline*. Accessed 22 September 2026 at https://learn.stillbirthcre.org.au/learn/casand/

Butterfly Room, established by Sunshine Coast University Hospital (SCUH) is an example of this being done successfully.[43]

The cost and accessibility of postpartum healthcare

97. Access to specialist supports, including perinatal mental health care, pelvic health physiotherapy, lactation support and other allied health services, is often restricted by service eligibility criteria, workforce shortages, geographical barriers and out-of-pocket costs. There is increasing reliance on private health services, and a user pays system for multidisciplinary postpartum health care resulting in significant service gaps. Women, at a time of increasing financial burden associated with reduced earning potential, are needing to weigh up accessing health care against other financial burdens.

98. Across the board, there needs to be increased investment in publicly available maternity multidisciplinary supports, included but not limited to breastfeeding support services, mental health support services, including mother and baby units, and physiotherapy, including pelvic health services.

99. An example echoes previous ANMF requests of the Australian Government to commit to full and ongoing funding of the Australian Breastfeeding Association (ABA) to allow them to continue their vital work in supporting and creating a breastfeeding enabled environment for all people living in Australia, including continued provision of their 24/7 National Breastfeeding Helpline.

[43] NSW Health. 2025. *Pregnancy, newborn loss or stillbirth support strengthened as Butterfly Room opens*. Accessed 22 September 2026 at https://www.nsw.gov.au/departments-and-agencies/wslhd/pulse/all-news/pregnancy-newborn-loss-or-stillbirth-support-strengthened-as-butterfly-room-opens

Paid Parental Leave

100. The cost and accessibility of postpartum care is affected by social policy and reform beyond service access and availability.

101. The ANMF acknowledges and welcomes the recent improvements to the Commonwealth Paid Parental Leave Scheme and welcomes the increase in paid parental leave from 20 to 26 weeks, alongside the introduction of superannuation contributions. However, to achieve meaningful and sustained progress towards gender equality, the scheme should be further extended to 52 weeks of paid parental leave. Expanding access to paid parental leave would support greater gender equity in caring responsibilities, strengthen women's workforce participation, and address the persistent economic and structural inequalities associated with unpaid care.[44]

102. Access to employer-funded Paid Parental Leave is not standardised across the workforce. While many employers provide paid parental leave as a supplement to the Commonwealth Paid Parental Leave Scheme, significant sections of the workforce do not have access to employer-funded paid entitlements. The proposed model would establish a minimum income floor through the government scheme, with employers required to top up the payment to the worker's full ordinary rate of pay. This approach would provide greater consistency and income security for working parents, while ensuring that access to paid parental leave is not dependent on an individual's employer or employment conditions.[45]

103. The ANMF has also called for the removal of the legislative requirement to have completed 12 months of service before being able to access unpaid parental leave. The current requirement can create significant professional and financial challenges for employees who have not yet reached the 12-month service threshold.[2] In circumstances where unpaid parental leave is unavailable, employees may face the difficult choice of returning to work before they are ready or resigning from their employment to care for their newborn,

[44] Australian Council of Trade Unions. 2023. *Increase in parental leave welcomed to address gender inequality [Internet].* Melbourne: ACTU; 2023 Oct 19. Available from: ACTU

[45] Australian Nursing & Midwifery Journal. 2026. *ANMF calls for stronger parental leave and safety protections in National Employment Standards [Internet].* 2026 Jun 11. Available from: ANMJ

potentially leaving them without job security or financial stability. Removing the 12-month service requirement would provide greater flexibility and protection for new parents and support more equitable access to parental leave, regardless of length of service.

Existing policies, programs and healthcare initiatives addressing postpartum care

104. ANMF members consistently report there is a disconnect between aspirational care delivery and the realities of what the health system provides. Existing policies, programs and healthcare initiatives addressing postpartum care are often under resourced, fragmented, and lack data to support their efficacy (or lack thereof).

The South Australian Select Committee into Stillbirth – adaptable to many contexts.

105. As highlighted in the opening comments in response to this Inquiry, there many broad inquiries, reviews, and reports documenting the systemic issues affecting women's health and health care access from menarche through to menopause, many of which encompass or relate to postpartum care. Many of these reports address a specific area of women's health and/or maternity care, yet provide recommendations that can apply across many contexts.

106. The South Australian Select Committee into Stillbirth report was released in October 2025 after examining stillbirth prevention, bereavement care, models of care, data collection, workforce education and support for families following infant loss. The Committee's terms of reference specifically considered continuity of care, follow-on care after stillbirth, mental health support, healthcare professional training, and data collection and reporting systems. The report recommended improving access to midwifery continuity of care models; strengthening education and training for healthcare professionals in stillbirth prevention and bereavement care; improving support for families in subsequent pregnancies following loss; enhancing data collection and reporting systems; increasing access to specialist bereavement and counselling services, particularly for regional and rural families.

107. While these recommendations were developed in response to stillbirth, many are equally applicable to postpartum care more broadly. Continuity of care models, adequate workforce capacity, access to specialist mental health and bereavement services, culturally safe care, and equitable access for regional and rural communities remain central to improving outcomes for women and families throughout the postpartum period. Ongoing implementation and evaluation of these recommendations should be supported by Commonwealth and State and Territory governments.

Strategy development and implementation

108. The Strategic Directions for Woman-Centred Care and the National Breastfeeding Strategy both detail key principles to inform best practice postnatal care yet neither have an implementation plan to measure their impact nor progress towards their intended purpose. Any proposed policies, strategies and initiatives in response to this Inquiry must be accompanied by a tangible implementation plan to progress and monitor improvements to women's health care including postpartum care.

Data, policy reform, community impact

109. Policy reform can have a meaningful impact on care delivery however with a lack of data examining postnatal care there is a risk of unintended consequences for the community.

110. Recent changes affecting PII availability for PPMs is an example of the community impact of policy on access to maternity care. Many jurisdictions are identifying that PPMs will cease providing services as a result of increasing insurance and regulatory pressures. In several cases, these midwives were providing care in regional and rural communities where maternity workforce availability was already fragile. The loss of these services has and will reduce access to midwifery care and further widened service gaps.

111. Appropriate funding mechanisms, policy and insurance arrangements are critical to maintaining both public and private postpartum care options and improve access for women and families. Improved data collection regarding is required to understand the impact of policy

change on the community.

Data collection, reporting and monitoring processes and allocation of research efforts

112. Australia has a strong maternity research sector and continues to generate high-quality evidence to guide maternity policy and practice. However, research suggests it can take an average of 15 to 17 years for new evidence to be routinely translated into healthcare practice.[46] This highlights the importance of investing not only in research, but also in implementation, education and workforce development to ensure evidence-based care is consistently delivered to women and families.

113. Current postpartum data collection focuses largely on maternal and infant outcomes around the time of birth, with limited collection of longer-term information relating to maternal wellbeing, parent-infant attachment, infant mental health and developmental outcomes. This creates a significant evidence gap, the postpartum period is recognised as a critical time for the development of infant social, emotional and psychological wellbeing. However, maternal mental health, continuity of care, infant feeding support and family circumstances are also evidenced to influence infant outcomes, yet these are not routinely measured beyond the early postnatal period.

114. Improved national data collection and longitudinal analysis are required to better understand long-term maternal and infant outcomes, identify emerging trends, evaluate models of care and inform service planning. Data collection should include measures relating to consumer experience, continuity of care, access to services, cultural safety and outcomes for Aboriginal and Torres Strait Islander women and families, such as, but not limited to:

- suicide rates up to 5 years postpartum
- women's health screening participation
- postpartum care parameters

[46] Rubin, Rita. 2023. *It Takes an Average of 17 Years for Evidence to Change Practice. The Burgeoning Field of Implementation Science Seeks to Speed Things Up. JAMA,* 329 (16): 1333-1336. Doi: 10.1001/jama.2023.4387

- breast feeding monitoring
- return-to-work and workforce participation by women following birth
- perinatal data collection beyond 6 weeks postpartum

Theme 6: Assisted Reproductive Technology

L) Best practice approaches to assisted reproduction treatments

115. The ANMF recently provided feedback to the public consultation undertaken by the Australian Commission on Safety and Quality in Health Care (ACSQHC) draft on the Assisted Reproductive Technology (ART) Standards. According to ACSQHC these standards have been developed to assist with the reform of ART services to strengthen the quality consistency and transparency of care across Australia.

116. The ANMF suggests recommendations from this inquiry take into consideration existing processes and consultations that have occurred as part of this ART service reform.

117. Broadly, best practice approaches to assisted reproductive technology care should:

- be person-centred, evidence-based, trauma-informed and accessible.
- include comprehensive information regarding treatment options, risks, success rates, costs, emotional wellbeing and reproductive decision-making.
- support continuity of care
- be delivered in a manner that is inclusive, culturally safe and responsive to the diverse needs of women, families and individuals accessing treatment
- ensure equitable access regardless of geographic location, socioeconomic status and CALD background
- seek to protect people considering or receiving ART treatment from false or misleading marketing regarding the potential outcomes of treatment
- seek to protect people from service profiteering

118. Fertility and ART services are concentrated in metropolitan areas, creating significant barriers for people living in regional, rural and remote communities who may face considerable travel, accommodation and out-of-pocket costs to access care. Workforce shortages in regional and rural areas further contribute to inequitable access to fertility services. Expanded use of

telehealth, outreach services and innovative models of care may assist in improving access, however these approaches should complement rather than replace direct clinical care.

119. Clinical miscarriage rates for IVF pregnancies generally range from 14% to 20%, closely mirroring unassisted pregnancies. As noted above, families experiencing pregnancy loss currently have access to limited support. Moreover, such support is also inconsistently applied.

120. NSW Health recognises early pregnancy loss (before 20 weeks) through the Early Pregnancy Loss Certificate and offers access to the Perinatal Infant Mental Health Services (PIMHS), which provide psychiatric care, counselling, and perinatal support. Whilst these are integral foundational steps in supporting grieving families, evidence from the NSW Birth Trauma Inquiry highlighted that when implemented in isolation, they fall short of meeting the complex needs of families.[47] Expanding access to specialised, affordable and timely support is essential in protecting families' long-term mental health. This is not a nationally consistent approach, extending bereavement leave entitlements for losses before 20 weeks would provide much-needed time for recovery.

121. Pertinent to the nursing and midwifery workforce, the simultaneous care of families experiencing pregnancy loss, alongside those with a continuing pregnancy, occurs regularly. This practice can adversely affect the mental wellbeing of nurses and midwives, who must constantly adjust their approach, and communication to sensitively meet the often-contrasting emotional needs of those in their direct care. To remedy this, the ANMF recommends the funded appointment of a specialised bereavement nurse or midwife (however named) to support grieving families.

[47] Select Committee on Birth Trauma. 2024. *Birth Trauma, Report No. 1 of the Select Committee on Birth Trauma*. NSW Parliament

M) Access and affordability issues relating to fertility and assisted reproduction treatments

122. As noted in response to ToR L, access to assisted reproductive treatments, including IVF, is restricted by financial, geographic, cultural, and systemic barriers.

123. Cost remains the most significant obstacle, with patients facing high out-of-pocket expenses for IVF cycles, medications, and donor gametes, even after partial MBS rebates and the limited support of state-funded Affordable IVF programs. The ANMF contends that these rebates ultimately fall short of addressing the true costs of treatment. Specifically, the average cost of a single IVF cycle in Australia is between $10,000 and $15,000, and with only one-third of women achieving a live birth on their first cycle, many must undergo multiple rounds, incurring significant out-of-pocket expenses.[48]

124. Rebates are not available to women seeking fertility preservation (such as egg freezing), despite the rising number of women choosing this option due to financial insecurity and social pressures.[49] This is particularly concerning given the broader context of gender inequity, women nationally continue to face an 11% gender pay gap, and many delay childbearing because of the high cost of living, including mortgage repayments, food, and projected childcare costs.

125. The ANMF asserts that fertility preservation is a pressing gender equity and women's health issue with data indicating that the number of women choosing to freeze their eggs is increasing, therefore additional Government Initiatives are paramount and should be available for all.

126. Access to rebates is further restricted by rigid and somewhat outdated eligibility thresholds. A second phase of the program is limited to households with an annual income of $116,000 or less, recipients of Family Tax Benefit, or holders of a Health Care Card. The ANMF contends that more than half of Australian households earn above this income threshold in 2026,

[48] IVF Australia. Nd. IVF treatment costs. Accessed 8 September 2026 at https://www.ivf.com.au/ivf-cost/ivf-costs
[49] ibid

excluding many working families from support. This includes nurses and midwives, whose household incomes often fall just above the threshold, despite enduring high living expenses and financial pressures. These rigid eligibility rules risk reinforcing inequities by leaving middle-income women and families without the assistance they need. Access to fertility care must not be determined by income or socioeconomic status, fertility rebates should be available to all individuals seeking fertility support, ensuring equitable access to care regardless of financial circumstances

127. Although publicly funded fertility clinics operate within public hospitals, community awareness of these subsidised services remains low. Online searches for local IVF clinics are often dominated by paid advertising from private providers, which further obscures public options. This lack of awareness fosters a perception that fertility treatment is unattainable in Australia and drives some families to pursue "fertility tourism," seeking lower-cost ART procedures overseas. However, such pathways expose individuals to significant risks, including unregulated donor practices, inadequate consent processes, and broader health and safety concerns.

128. Geographic inequity also persists, with most fertility clinics concentrated in metropolitan areas, forcing families in regional, rural and remote communities to travel long distances, incurring additional costs for transport and accommodation. Even when some aspects of care, such as blood tests or ultrasounds, can be undertaken locally, rural and regional areas often lack sufficient pathology or imaging services. This creates delays in obtaining results, which for IVF cycles must be reported on the same day to be clinically useful and fragments care increasing risk of poor outcomes. As a result, regional and rural patients face compounded disadvantages that metropolitan families simply do not encounter.

129. Approximately 6.0% of Aboriginal and Torres Strait Islander peoples live in remote areas, whilst 9.4% live very remotely.[50] Moreover, the proportion of the total population who identify

[50] Australian Institute of Health and Welfare. 2024. *Aboriginal and Torres Strait Islander Health Performance Framework-Summary Report*. Accessed 22 September 2026 at https://www.indigenoushpf.gov.au/Report-overview/Overview/Summary-Report

as being Aboriginal and/or Torres Strait Islander increases with remoteness. The ANMF acknowledges the profound connection to land and Country in First Nations culture. This connection not only shapes identity but also encompasses responsibilities, spirituality, social kinship, and emotional well-being. Due to this, reliance on westernised medical practices in isolation, travelling for healthcare, and the implementation of telehealth services for fertility support and assisted reproductive treatment is not always conducive with Cultural Safety in rural and remote communities.

130. Culturally safe healthcare is imperative in improving access and addressing the service gaps for Aboriginal and Torres Strait Islander families in rural and remote communities. Nurses and midwives are well placed to work collaboratively with Aboriginal Health Workers (AHWs), to foster trustworthy, and compassionate professional relationships with the state's most vulnerable families.

131. Aboriginal and Torres Strait Islander communities experience disproportionately higher rates of infertility, influenced by risk factors such as sexually transmitted infections, polyendocrine metabolic ovarian syndrome, and obesity, as well as the broader social determinants of health, including poverty, poor housing, and limited access to healthcare.[51] Women in these communities earn, on average, 35% less than Australian men, making the high cost of ART unattainable for many. Furthermore, there is reduced access to donor gametes that reflect cultural and genetic diversity.

132. Expanding regional fertility hubs linked to metropolitan clinics, supported by telehealth consultations and follow-up, would reduce the travel burden. However, the risks of fragmented care, and time critical services which require in-person attendance such as ultrasound in regional, rural and remote areas must be considered in developing these models. Increasing travel and accommodation subsidies to reflect actual costs would also make access fairer. Outreach programs and mobile fertility services could bring specialist care closer to rural communities, while targeted investment in local diagnostic capacity would reduce harmful

[51] Gilbert, E; Boyle, J: Campbell, S et al (2020) Infertility in Aboriginal and Torres Strait Islander people: A cause for concern? The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 60: 479–481 DOI: 10.1111/ajo.13158

delays.

133. Cultural and social barriers include, limited culturally appropriate resources, and challenges faced by LGBTQ+ families in navigating donor and parenting arrangements. There is also a lack of accessible, impartial education about treatment options, with an overreliance on information that is often profit-driven.[52] [53]Finally, psychological barriers such as stigma, isolation, and inadequate mental health support can discourage individuals and couples from seeking or continuing treatment.

134. To overcome such barriers, the ANMF recommends expanding publicly funded ART programs including broader subsidies for IVF, donor gametes, and fertility preservation, making treatments more affordable and equitable. Strengthening regional service delivery through telehealth consultations, satellite clinics, and travel support schemes would improve access for rural communities. Investment in donor recruitment campaigns and culturally inclusive education resources would help meet the needs of diverse families.

135. Clearer legal and policy frameworks for LGBTQIA+ families and surrogacy arrangements are paramount in improving service equity. Embedding holistic care that includes counselling, peer support, and culturally safe services within ART pathways is integral. It would not only address the psychological burden, but ensure that reproductive care is accessible, compassionate and inclusive.

Any related matters

136. Whilst the issues herein are important and warrant consideration, the Inquiry Terms of Reference do not adequately address the full breadth of women's health. Critical components of women's health across the lifespan, that have substantial impacts on health outcomes, quality of life and access to care have been omitted from this Inquiry, including but not limited to menopause and perimenopause, termination of pregnancy, early pregnancy counselling,

[52] Attinger SA, Jackson E, Karpin I et al.2024. *Addressing the consequences of the corporatization of reproductive medicine. Medical Law Review*. 1;32(4):444-467. doi: https://doi.org/10.1093/medlaw/fwae018
[53] Zadeh, A A. 2025. *Private equity and reproductive medicine: "fertile breeding ground" – a physician's perspective". Reproductive Biology and Endocrinology*. 1;23 (1):113 doi: https://doi.org/10.1186/s12958-025-01446-4

polyendocrine metabolic ovarian syndrome, premenstrual dysphoric disorder, sexually transmitted infections and blood-borne viruses, and participation in preventative health screening programs.

137. Furthermore, many health conditions disproportionately affect women. This needs to be considered and examined.

138. The inequities experienced in women's health cannot be separated from broader societal inequities and gender bias against women. Including, but not limited to:

- Gendered violence. Inaction on gendered violence perpetuates inequality and disadvantages women already at risk of chronic health conditions and poor access to health care. According to the Australin Institute of Health and Welfare "*in 2024, if no woman had experienced intimate partner violence, the disease burden among women due to homicide and violence would have been reduced by 49%.*"[54]
- Health disadvantage associated with a cultural and linguistically diverse (CALD) background. 36% of women aged 15 and over were born overseas.[55] According to the Victorian Pain Inquiry, women with a CALD background are less likely to have access to comprehensive healthcare planning, due to bias they face resulting from racism or social stigma. 3.1% of the female population identify as Aboriginal or Torres Strait Islander peoples.
- Economic disadvantage. 14% of females in all age groups are living under the poverty line. [56] "*Compared to men, women have lower average weekly earnings, undertake more hours of unpaid work, have a lower median superannuation balance, are more likely to have a bachelor's degree or above, are less likely to be employed.*"[57]
- Intersectionality needs to be considered as a separate issue to those identified in the

[54] Australian Institute of Health and Welfare. 2026. *Family, domestic and sexual violence: health outcomes.* Accessed 24 September 2026 at https://www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/health-outcomes
[55] https://www.aihw.gov.au/reports/women/female-health/contents/who-are
[56] ibid
[57] Australian Institute of Health and welfare. 2025. *The health of women in Australia.* Accessed 10 September 2026 at https://www.aihw.gov.au/reports/women/the-health-of-women-in-australia

ToR and integrated as much as possible across the TORs.

139. Thus, addressing health care inequities requires broad reform that enables women to achieve genuine economic and social equality (such as equal pay, shared responsibility for unpaid caring work, and secure retirement savings), and live in a society free of violence, racism and stigma, alongside reform within the health system itself.

Conclusion

140. The ANMF thanks the Senate Select Committee on Women's Health for the opportunity to provide this feedback on broader systemic issues and service gaps affecting the health of women living in Australia. It is imperative that recommendations from this Inquiry coincide with a commitment from Government to take action to address the systemic and long endured challenges for women accessing health care that meets their needs and promotes quality of life.