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ORIGINAL RESEARCH

'We country women need advocacy': Birthing narratives from the Western Australian Wheatbelt region

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Abstract

Introduction: This study describes the experiences of eight mothers from the Wheatbelt region of Western Australia who shared their stories of travelling and/or temporarily relocating for birth.

Objective: The aim of this study was to describe rural and remote Western Australian mothers' experiences of travelling long distances and/or relocating to give birth.

Design: This study was based on Crotty's four elements of qualitative research. This study was underpinned by a constructivist epistemology, a feminist theoretical lens and a narrative approach using semistructured, story-based interviews. Participants narrated their stories of birthing away from home by telephone interview.

Findings: Five major themes were identified utilising thematic analysis. These were (1) feeling forgotten in the system, (2) accessibility and choice, (3) compounded social isolation, (4) doing it hard: financial and logistical challenges and (5) building strength: advocating for myself and baby.

Discussion: Mothers' stories were reflective of current and historical failures of rural maternal health policy, including widespread closures of rural birthing hospitals. Mothers described the logistical barriers they faced with little support and suggested multiple solutions that would improve their experiences.

Conclusion: Mothers faced significant obstacles which impeded their access to equitable maternal healthcare. This study highlights the complexities of birthing as a rural mother and the need to address maternal health inequities between rural and metropolitan women.

KEYWORDS

healthcare accessibility, maternal health, maternal health policy, rural birthing, rural health, rural mothers, Western Australia

What this paper adds

- Insight into the lived experiences of necessary travel for childbirth.
- Clarity on what may improve rural mother's birthing experiences.
- A detailed account of the specific barriers faced by rural mothers when navigating metropolitan medical systems.

What is already known on this subject

- Rural mothers face significant inequities due to isolation from health services.
- Mothers typically must temporarily relocate to their nearest metropolitan centre for 2–4 weeks to give birth.
- There are little data collected on these experiences.

1 | INTRODUCTION

Rural, regional and remote (rural) mothers in Australia are uniquely placed in their experiences of birth and parenthood. This is due to the frequent requirement for them to travel and/or relocate to be closer to maternity services, being separated from their support networks and being required to pay for extra costs such as accommodation and fuel when attending appointments or giving birth.[1] Over the years 1992–2011, approximately 41% of rural birthing units closed nationally.[2] This coincided with a 47% increase in babies born before the mother arrived at the hospital, for example on the side of the road.[2]

The distribution of maternity services across rural Australia is based on the number of births in any given catchment.[3] The more remote the mother, the less likely she is to be close to a hospital or unit providing birthing services.[3] Depending on the availability of local health services, mothers typically relocate for 2–4 weeks (or sometimes longer) for birth and may also travel significant distances to attend some or all perinatal appointments.[1] The availability of maternal health services varies between areas and may be dependent on the skillset of healthcare workers in each community.[3]

Strategic directions for Australian maternity care services may not sufficiently support rural mothers. Priorities outlined in the 2010 and 2019 maternity health strategies are analogous and yet to be realised.[4,5] In the most recent national strategy, 'Woman-centred care: Strategic directions for Australian Maternity Services' (WCC Strategy) released in 2019, there is no mention of the importance of mothers' ability to choose the setting in which they will give birth.[5,6] This omission may disproportionately impact rural mothers, whose choices are already significantly limited.[1]

Findings of this research document the experiences of rural mothers who were required to travel and/or temporarily relocate for birth: what it is like to relocate for birth, and how this impacts mothers' well-being. The research question for this study was 'how do rural mothers experience travelling and/or temporarily relocating for birth?' focusing on mothers from the Wheatbelt region of Western Australia.

2 | MATERIALS AND METHODS

2.1 | Study design

This study was designed using Crotty's framework for qualitative research.[7] It used a constructivist epistemology in recognition that knowledge is generated in a socially mediated context.[7] A feminist theoretical foundation and narrative methodology complemented this which allowed mothers to narrate their birth experiences within a woman-centred framework.[7–9]

The interview schedules were developed using Turner's criteria for writing interview questions.[10] As recommended by Turner, the interview questions were open-ended, neutral in wording, singular (in that only one question is asked at a time), clear and contextually relevant (no wording that the participant may not understand), and avoidant of 'why' questioning.[10]

2.2 | Setting

This study was undertaken in the Wheatbelt, a large region in the south of WA. The Wheatbelt is a primarily agricultural region with a highly dispersed population of approximately 75 000 over 154 862 square kilometres, with no major regional centre.[11] Only two of 25 hospitals in the Wheatbelt provide obstetric care for low-risk birth.[12] As such, many mothers travel a minimum of approximately 65 and an average of 255 kilometres to receive care in Perth, the capital city of WA, or another regional centre, for some or all perinatal and intrapartum care.

This study was undertaken by a team of four female researchers. The primary interviewer (ES) had an

affiliation with the Wheatbelt region, where some members of her extended family live. Authorship expertise included midwifery, paediatrics, social work, sociology and social epidemiology. An advisory group was also consulted which included cognate clinical and nonclinical expertise.

Importantly, this study included participants who gave birth during the COVID-19 pandemic. During this time, there have been widely varying and constantly changing regulations to travel, including from rural to metropolitan areas as well as restrictions on hospital visitors and the presence of birth partners.

2.3 | Participants and recruitment

Participants were mothers who lived in the Wheatbelt region of WA and who had given birth during the past 5 years. All mothers gave birth during the COVID-19 pandemic, and thus, the focus is on this specific experience. Mothers must have travelled over 100 kilometres or have temporarily relocated to give birth. Only mothers who were fluent in English were included.

Participants were recruited using purposive sampling. Initially, recruitment materials were sent to general practitioner clinics and childcare centres that agreed to assist with recruitment by displaying posters at their venues. A recruitment flyer was also posted to a Wheatbelt Facebook group. ES contacted a relative who lived in the Wheatbelt at the time of giving birth and recruited her to the study. A child health nurse then heard about the study and shared the details with her network. Snowball sampling was then used through these channels.

In total, nine mothers provided written consent and eight participated in an interview. One mother did not complete an interview due to scheduling conflicts and was not rescheduled due to data saturation, when no new themes emerged in the interviews.[13] ES initially made contact with the participants over the telephone to discuss the study and develop rapport. All mothers provided basic demographic details including date of birth, number of births, location, and where they travelled to give birth. All mothers had a male partner at the time they gave birth. These data are provided in Table 1 using participant pseudonyms.

The Socio-Economic Indexes for Areas (SEIFA) scores were identified to give an indication of the level of socio-economic disadvantage in the mother's towns of residence. The SEIFA quintiles are based on the Index of Relative Socio-economic Disadvantage (IRSD) interactive map which rates relative socio-economic disadvantage from 1 (most disadvantaged) to 5 (least disadvantaged).[14]

TABLE 1 Central East Wheatbelt mothers: Participant information.

Participant Pseudonym	Age	Parity	SEIFA IRDS rating	Birthing location
Jill	34	2	2	Perth
Mary	36	4	3	Perth
Cath	32	2	2	Bunbury
Anna	30	4	2	Perth
Sue	39	3	2	Perth
Ellie	35	1	1	Perth
Jo	38	1	3	Perth
Maggie	43	2	3	Perth

2.4 | Ethics statement

This study received approval from the University of Western Australia (UWA) Human Research Ethics Committee (2021/ET001072). All mothers gave verbal and written informed consent before participating in the study.

2.5 | Data collection

Data collection began on the 23rd of March and continued until the 26th of April 2022. Data were collected by ES through one-on-one semistructured interviews over the telephone. Telephone calls were recorded, and recordings were immediately transferred to a secure university data storage system. Singular interviews lasted approximately 60 minutes. All data were deidentified in the transcription process. The interviews began with the question, 'Could you tell me, in your own words, your experience from when you realised you were pregnant?'

2.6 | Data analysis

Braun & Clarke's six-step approach to thematic analysis was utilised to construct a narrative of birthing as a Wheatbelt mother.[15,16] ES transcribed interview data verbatim, and all researchers familiarised themselves with the data. Coding was facilitated by NVivo12. Initial codes were generated and abstracted to themes and subthemes, which were reviewed by all authors. A thematic map was

FIGURE 1 Thematic map[1]

generated to examine and explain the links, depth and interrelationships of the generated themes. Pertinent quotes illustrative of the data from each theme were selected.

3 | RESULTS

Five themes were identified in the data analysis: (1) feeling forgotten in the system, (2) accessibility and choice, (3) compounded social isolation, (4) doing it hard: financial and logistical challenges and (5) building strength: advocating for myself and baby. A thematic map to represent this is provided in Figure 1.

3.1 | Feeling forgotten in the system

Many mothers felt anonymous in metropolitan medical settings and that they were underprepared by health professionals. The subthemes within this category are 'feeling like a number in metrocentric environments', 'coping with birth trauma', 'impacts of COVID-19' and 'lack of information'.

[1]The Royal Flying Doctor Service is a health service that transports those in critical condition to their nearest hospital via plane.[17]

3.1.1 | Feeling like a number in metro-centric environments

Mothers who did not have the opportunity to build positive and ongoing relationships with health professionals felt that interactions were impersonal. Mary shared her experience:

> I felt they were too busy, that you were just a number. I was called other people's names, and I was like no I'm Mary*. It wasn't so much of a personal experience.

3.1.2 | Coping with birth trauma

Participants felt that hospitals and other health services provided little to no follow-up for rural mothers, for the management of both emotional and physical trauma. Jill described this:

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

Mothers identified that recovering from emergency caesarean birth in geographical isolation meant that they had few options for assistance. Maggie described recovering from her caesarean:

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

3.1.3 | Impacts of COVID-19

All study participants gave birth at least once during the COVID-19 pandemic. Anna described how she felt policy regarding COVID-19 restrictions was uncompassionate towards rural pregnant women specifically:

> We were unsure of what COVID was and how bad it was going to be. [We didn't want] to get stuck in Perth and not [be able to] get [my] husband in or out or if he'd be able to be there or not

3.1.4 | Lack of information

Mothers felt that they had been underprepared for birthing as rural women. They were particularly underinformed in relation to the funding they could claim through the Patient Assisted Travel Scheme (PATS).[2] Ellie and Jill shared their grievances:

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

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

[2]The Patient Assisted Travel Scheme (PATS) allows rural patients to reclaim funds for travel and accommodation when relocating to receive medical care [18]

Mothers felt that the available services were neither advertised nor accessible. Cath described how she was unaware of her options for birthing hospitals:

> [It] probably wasn't until I was halfway through the pregnancy that I was finding out [about] Northam, they had a midwifery program.

3.2 | Theme 2: Accessibility and choice

Mothers felt that their isolation and lack of local access to birthing services meant they were not able to freely choose the circumstances under which they would give birth. The subthemes within this category are 'lack of local resources resulting in a lack of agency', travel as a barrier to care' and 'fragmented vs. continuity of care'.

3.2.1 | Lack of local resources resulting in lack of agency

A lack of local maternal health resources in the Wheatbelt meant that mothers were limited in their choice of where to give birth. Sue explained that since she lived far from the Wheatbelt birthing hospital in Northam, she would have to find accommodation either way, so she preferred to travel to a larger, better-resourced hospital in Perth:

> Being [three hours] from Northam you've got to stay somewhere anyway. So [there are] not really many options.

Sue also explained how a lack of medical resources contributed to anxiety that something would go wrong during pregnancy, and the appropriate medical resources would not be available to her and the baby:

> I did have a bit of a scare the other week with this pregnancy... I couldn't get into [my local service]. Like I couldn't get a CTG done, it was on a Sunday.

3.2.2 | Travel as a barrier to care

Mothers described the pressure to travel to a metropolitan centre 2 weeks prior to their due date. Ellie described how giving birth in the country may require emergency support from the Royal Flying Doctor Service.

> It does seem a bit ridiculous going down two weeks beforehand. But you don't want to be giving birth in the Royal Flying Doctors as well, so that's quite a tricky one

Mothers expressed that they were aware of the risk of birth in transit, which informed their choice to relocate to Perth 2 weeks before birth. Anna described a conversation between herself and a midwife about potentially foregoing the 2-week relocation:

> ...the midwife said, 'If you start giving birth you need to stop at a roadhouse'.

3.2.3 | Fragmented vs. continuity of care

Mothers described their experiences with both fragmented care and/or a continuity of care model. Jo described her experience with continuous care during pregnancy and fragmented care once she entered a metropolitan environment for birth:

> I ended up going to Northam which is an hour and a half from where we live. She was brilliant the lady there. So, I ended up seeing her as my GP for the whole way.

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

3.3 | Theme 3: Compounded social isolation

Participants felt that their geographic isolation compounded a lack of support after birth. The subthemes within this category are 'feeling separate from family and/or home', 'need for connection with other rural mothers', 'isolation due to COVID-19' and 'partner separation due to agricultural work'.

3.3.1 | Feeling separate from family and/or home

Mothers' experiences varied depending on the level of social support they had near their birthing hospital. Jill described birthing her second child alone, as there was no one in Perth to take care of her other child:

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

Anna expressed that being in the hospital while most of her friends and family were back in the country was a lonely experience:

> Those who live in Perth, they have 20 people that come and stand around the bed and you're there by yourself.

3.3.2 | Need for connection with other rural mothers

Maggie described the importance of connecting with other mothers who shared their rural living experiences:

> I think sharing the experience with other rural women is very valuable because they get it... the good things and the challenges of where we live.

This prompted Maggie to go out of their way to reach out to new parents in the area:

> I try to invite lots of mums whom we don't tend to see a lot around town [to playgroup]. I think... they aren't necessarily struggling but [might be] feeling a bit isolated.

3.3.3 | Isolation due to COVID-19

Rural mothers are already isolated geographically, and the participants felt that the COVID-19 pandemic compounded their isolation in the hospital and at home. Jo described being separated from her parents when pregnant:

> So, I got to see [my parents] at, I think I was 30 weeks, and by the next time I saw them, I'd had [the baby]. I didn't get to see my family for 10 weeks and show off the baby bump.

COVID-19 hospital policies meant that sometimes fathers were asked to leave the hospital shortly after the birth. Jo and Anna experienced this:

> [my partner] could come to the birth but the second we were back on the ward she was maybe two hours old, and he was kicked out.

> I think [the baby] had been born three hours earlier … I wasn't quite expecting it so soon, I knew it was going to happen, but he's travelled a long way.

3.3.4 | Partner separation due to agricultural work

The Wheatbelt is a largely agricultural region. Many work casually and/or seasonally. The implications of this are that for certain periods of the year, work and income generation cannot be flexible. Jo's family relies on income from inflexible employment arrangements, so staying in Perth without her partner was a practical decision:

> [At home], I'd be on my own completely because my husband works on the tractor maybe 22 hours a day. So, we thought it would be a better option for me to stay in Perth in case we had complications.

Maggie decided on an induced birth to ensure her partner could be present in the delivery room:

> [When I spoke about my husband's work limitations], the obstetrician said, 'oh look we'll induce you.' then it could work around my husband's roster as well.

3.4 | Theme 4: 'Doing it hard', financial and logistical challenges

Mothers described being under stress when getting organised before birth. The subthemes within this category are 'huge financial and logistical demands of relocation and travel', 'problems with the Patient Assisted Travel Scheme (PATS)', 'partner taking time off work' and balancing the needs of multiple children'.

3.4.1 | Huge financial and logistical demands of relocation and travel

Mothers identified the considerable financial pressures they were under to organise accommodation, transportation and funding for their stay near their birthing hospital. Jill described the stress of finding self-funded accommodation in an unfamiliar city:

> [My husband and I] didn't have any family in Perth at the time, so we didn't know where to stay. We found a little unit, but it had no furniture. By the time we moved in there, we had to stay on a blow-up mattress that kept deflating…I remember my husband found me crying in the hallway… It was awful having no furniture and not knowing when I would need to go in for birth

Mothers were unsure of how long they should book accommodation for. For Anna, this meant having to find extra accommodation if they were required to stay near their birthing hospital for longer than expected:

> [My husband and I] can't afford to stay down there for a couple of weeks. It was horrendous with [my] other three [births] because we were saving up for the whole pregnancy just knowing we had to be [in Perth] but not knowing how long we have to be [in Perth] for.

3.4.2 | Problems with the Patient Assisted Travel Scheme

Mothers who attempted to access or who accessed PATS described difficulties in claiming funds. Mary described her experience trying to access the funds she was entitled to:

> With the third child [PATS] wouldn't approve [my claim]… they were like 'oh we don't have enough funding available', yeh, so I had all the receipts and I fought with them for a good year over it to the point where I just gave in.

When mothers did find out about PATS, it was often too late for them to claim. Jill felt aggrieved that she was not able to receive the funds she was entitled to, and it became too late to claim:

> The only reason I found out about PATS is because a woman mentioned it to me at the hardware store… I couldn't believe I had self-funded all the hotels and fuel and time off work and that my partner had lost income too.

3.4.3 | Partner taking time off work

Mothers who had partners working in agriculture and/or casual roles felt financial pressure regarding travelling for birth. Jo described the isolation this caused her:

> [my husband] didn't get to come back the next day because he had come back [to the farm] to finish seeding. It's seasonal, so if you don't get your seeds in the ground then you don't get a crop and you don't get paid.

3.4.4 | Balancing the needs of multiple children

Mothers who had other children found that their subsequent pregnancies were more challenging due to a requirement to balance multiple children's needs. Maggie described this:

> My first pregnancy was a lot easier because I wasn't having to work with taking the second child to appointments.

> By the time you've taken a child in a car to Perth for two and a half hours and they've sat in the car … that was definitely a lot harder than with my first when I didn't have another child in tow.

3.5 | Theme 5: Building strength: Advocating for myself and baby

The power and resilience of rural mothers were demonstrated by their ability to create opportunities for mother-to-mother connection in their communities and to advocate for their needs. The subthemes within this category are 'self-advocacy' and 'realising my power'.

3.5.1 | Self-advocacy

Mothers became experts on exactly what they, their communities and rural families more broadly need. Anna discussed the importance of increasing the accessibility of birthing services throughout the Wheatbelt:

> I think having birthing facilities out here would be massive. Merredin would be a very hot spot I think because you've got all our little towns who would travel there.

> …[after] going through [the traumatic birth at a regional birthing suite] … there definitely needs to be standards that are changed and availability for the mum to stay in the hospital and recover, not be shunted, and told 'yep go stay at this accommodation' or something.

3.5.2 | Realising my power

Giving birth and overcoming adversity as a rural mother allowed women to realise their own power and resilience. Mary demonstrated this:

> Although I went through [a traumatic birth] it is sort of a positive thing as well just reassuring you that you are human, you can produce these little creatures … you know you've overcome that so you can conquer anything.

Mothers reflected on their experiences and acknowledged the power of motherhood and how this may or may not manifest in delivery rooms. Jill reflected on this:

> I think birth should be about the woman. I just want to say that I feel like birth was something that happened to me, rather than something I experienced

4 | DISCUSSION

The findings of this study describe the experiences of mothers living in the Wheatbelt (Wheatbelt mothers) who birthed away from home. Mothers explained how they perceived their rurality to have negatively impacted their birthing and perinatal experiences. They identified that having little access to local maternity services made things difficult for themselves and their families. They felt they had no choice in their relocation for birth, and that a minimum of 2 weeks away from home significantly exacerbated financial, logistical and emotional stress, which sometimes contributed to pressure to induce their births. They were empathetic to the experiences of other rural mothers and showed a desire to create positive change. Mothers advocated for their needs and were clear about what would help their communities to cope with the realities of geographical isolation.

4.1 | Slow politics, slow progress

As highlighted in the introduction section of this paper, inequities for rural mothers are not adequately addressed in national policy. The most recent policy document, the WCC Strategy, emphasises four key priority areas for the provision of maternity care including 'ensuring safety,

respect, choice, and access'.[5] The predecessor of the WCC Strategy, the National Maternity Services Plan (NMSP), highlights similar points, with a particular focus on accessibility.[4] Since the release of the NMSP in 2010, there is evidence to suggest that rural mothers have experienced decreased access to maternity services.[1,2]

The lack of action following the release of national policy is reflected in the stories of mothers in the current study. For example, participants felt that Wheatbelt mothers in previous generations had opportunities to give birth locally that are nonexistent today. The stories of Wheatbelt mothers in this study were also comparable with a similar piece of research published in New South Wales (NSW) in 2008 by Dietsch et al.[19] Mothers' stories in both studies suggest that the challenges of birthing as a rural mother may have remained unchanged or potentially worsened over the past 15 years and that policy has not adequately supported rural mothers over time.

In the years that the NMSP guided policy, the Australian Rural Birthing Index was developed as a toolkit for the allocation of maternity healthcare resources.[20] The purpose of the ARBI is to allow healthcare planners to consider geographic location, social vulnerability and level of isolation when determining the appropriate level of maternity care in any one location.[20] Though the ARBI was released in 2015, the 2019 WCC Strategy makes little mention of the ARBI, other than a recommendation to enable its use.[5] This suggests that despite surmounting evidence and enablers (such as the ARBI) justifying a tangible commitment to the priorities of the WCC Strategy, little may have been achieved and implemented, or at least there is much to be anticipated.

In addition to a lack of policy and practice that prioritises the requirements for rural mothers to access equitable care, a need for improvement of rural maternal health care is emphasised by national bodies such as the Rural Doctors Association of Australia (RDAA), the National Rural Health Alliance and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[1,21,22] Importantly, the WCC Strategy recommendations for supporting rural pregnant mothers were not reflective of this recommendation.[1,5] For example, the RDAA recommends the reopening of maternity services in rural areas, which is omitted in the WCC Strategy.[1,5] The current study highlights and contributes to evidence from an established body of work, suggesting that rural mothers have been neglected both in policy and practice.

4.2 | Logistical and practical barriers for mothers

Wheatbelt mothers found it difficult to access a continuity of care model from their rural locations. They spoke highly of healthcare workers whom they were able to build relationships with however, many felt 'handballed' between different medical professionals throughout their pregnancy, birth and postnatal period. The mothers were aware of emergency assistance available, such as the RFDS, however, found essential and ongoing health maintenance more difficult to access.[18] Their stories were reflective of current issues within the Australian rural health workforce including challenges with retention of GPs.[23] For example, 111 GPs exited the WA rural health workforce in 2020–2021 alone.[24] Transience in the workforce may also limit mothers' choices regarding which healthcare provider they see.[23] For example, mothers may switch healthcare providers, or struggle to find a new provider within a reasonable distance if they are unhappy with their local service.

Mothers also faced practical barriers regarding the presence of partners and/or support people during childbirth and when attending appointments. First, having multiple children posed challenges such as who would care for the older children while the mother was away. Additionally, mothers' ability to have their partner present during the birth was also impacted by their partner's profession, especially if their partners worked in seasonal or casual roles. This caused some families to feel forced to choose between having their partner present at birth and family income. There is evidence to say that paid parental leave for partners is supportive of mother and baby health.[25] This study may have highlighted an opportunity for future research into these issues, as there are few options for mothers besides relying on extended family for financial assistance and childcare—which may or may not be available.

4.3 | Potential solutions

More research is needed on this topic; however, mothers did share similar ideas as to what could improve their perinatal and birthing experiences. These were reopening local services, increasing the capacity of current local services including the use of community midwives, more efficient use of shared care and telehealth, better information dissemination, especially regarding available subsidies, and more opportunities for social connection between mothers. There is evidence to support the uptake of these recommendations. For example, research conducted in 2014 and 2021 showed that mothers' stress could be negated should they be given the option to birth locally.[26,27] The COVID-19 pandemic has normalised the use of telehealth, which has been long known to benefit rural populations, though more research may be needed on how this impacts pregnancy and birth specifically.[28–31]

4.4 | Study limitations

There are strengths to this study in terms of the birth experiences of rural women required to travel to give birth. However, as with all qualitative inquiry, there were some limitations. Firstly, there was little diversity within the sample. The sample only included mothers living in the Central East Wheatbelt of WA, all had a male partner and were from English-speaking backgrounds. A larger study that captures the perspectives of diverse mothers in other regional areas will assist in creating positive changes for rural mothers. Separate studies focusing on the experiences of rural mothers from Aboriginal and Torres Strait Islander backgrounds are necessary, as well as single mothers, who do not speak English fluently, who experience medical conditions such as gestational diabetes, or who face other unique disadvantages. The COVID-19 pandemic may have limited the study as it resulted in both positive and negative changes that may or may not remain beyond the pandemic. Telephone interviews may have limited the study, as participants' nonverbal communication could not be observed.

5 | CONCLUSION

This study describes lived experiences on an important issue faced by many rural mothers. With little in-depth research being conducted over recent years, there is a need to centre the voices of mothers who travel for birth in future research and policy. The findings of this study highlight the need for more comprehensive research, including qualitative and quantitative data, to represent rural mothers' experiences of travelling for birth. Improving the health of rural mothers and their babies may begin through the practical application of funding and other assistance to reduce stress. The experiences of Wheatbelt mothers were reflected in national policy suggesting the findings of this study are translatable to other areas of the country.

AUTHOR CONTRIBUTIONS

Esther Shackleton: Conceptualization; methodology; formal analysis; data curation; project administration; writing – original draft. **Colleen Fisher:** Methodology; supervision; writing – review and editing; conceptualization. **Anna Bosco:** Methodology; supervision; writing – review and editing. **Linda Slack-Smith:** Conceptualization; methodology; supervision; writing – review and editing.

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CONFLICT OF INTEREST STATEMENT

No conflicts of interest.

ETHICS STATEMENT

This study received approval from the University of Western Australia (UWA) Human Research Ethics Committee (2021/ET001072).

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